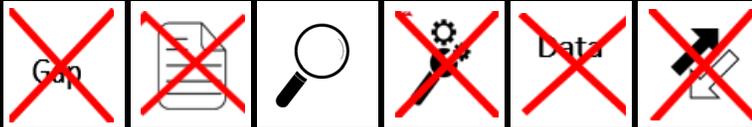


## 2015 Edition §170.315(f)(5) Transmission to public health agencies – electronic case reporting

Testing Components:



Test Procedure Version 1.1 – Last Updated 10/30/15

Please consult the Final Rule entitled: *2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications* for a detailed description of the certification criterion with which these testing steps are associated. We also encourage developers to consult the Certification Companion Guide in tandem with the test procedure as they provide clarifications that may be useful for product development and testing.

*Note: The order in which the test steps are listed reflects the sequence of the certification criterion and does not necessarily prescribe the order in which the test should take place.*

### Required Tests

(f)(5)(i) Consume and maintain a table of trigger codes to determine which encounters may be reportable.

Standards: None

Criteria ¶	System Under Test	Test Lab Verification
(i)	<ol style="list-style-type: none"> <li>The Health IT module consumes a table of trigger codes to determine which encounters may be reportable.</li> <li>The Health IT module maintains a table of trigger codes to determine which encounters may be reportable.</li> </ol>	<ol style="list-style-type: none"> <li>The tester verifies that the Health IT module can consume a table of trigger codes that determine which encounters should initiate an initial case report being sent to public health.</li> <li>The tester verifies that the Health IT module is able to maintain a table of trigger codes that determine whether encounters are reportable.</li> </ol>

(ii) Match a patient visit or encounter to the trigger code based on the parameters of the trigger code table.

Standards: None

Criteria ¶	System Under Test	Test Lab Verification
(ii)	<ol style="list-style-type: none"> <li>The Health IT module matches one or more patient visits or encounters that will be reportable based on the parameters of the trigger code table.</li> </ol>	<ol style="list-style-type: none"> <li>The tester verifies that the Health IT module can correctly match a patient encounter or visit based on the parameters of the trigger code table.</li> </ol>

**(iii) Case report creation.**

Create a case report for electronic transmission:

- (A) Based on a matched trigger from paragraph (f)(5)(ii);
- (B) That includes, at a minimum,
  - (1) The Common Clinical Data Set
  - (2) Encounter diagnoses Formatted according to at least one of the following standards:
    - (i) The standard specified in § 170.207(i)
    - (ii) At a minimum, the version of the standard specified in § 170.207(a)(4);
  - (3) The provider's name, office contact information, and reason for visit
  - (4) An identifier representing the row and version of the trigger table that triggered the case report.

**Standards:**

§ 170.207(i) Encounter diagnoses. Standard. The code set specified at 45 CFR 162.1002(c)(2) for the indicated conditions.

45 CFR 162.1002(c)(2) International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (including The Official ICD-10-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following conditions:

- (i) Diseases.
- (ii) Injuries.
- (iii) Impairments.
- (iv) Other health problems and their manifestations.
- (v) Causes of injury, disease, impairment, or other health problems.

Additional Standards called out by reference to the Common Clinical Data Set:

§ 170.207(q)(1) [International Telecommunication Union E.123:Notation for national and international telephone numbers, e-mail addresses and web addresses and International](#) and [Telecommunication Union E. 164: The international public telecommunication numbering plan](#)

§ 170.207(n)(1) Birth sex must be coded in accordance with HL7 Version 3 attributed as follows:

- (i) Male. M
- (ii) Female. F
- (iii) Unknown. UNK

§ 170.207(f)(1) [The Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, Statistical Policy Directive No. 15, as revised, October 30, 1997](#)

§ 170.207(f)(2) ["Race & Ethnicity – CDC" code system in the PHIN Vocabulary Access and Distribution System \(VADS\), Release 3.3.9](#)

§ 170.207(g)(2) [Request for Comments \(RFC\) 5646: Tags for Identifying Languages](#)

§ 170.207(h) Smoking status must be coded in one of the following SNOMED CT® codes:

- (1) Current every day smoker. 449868002
- (2) Current some day smoker. 428041000124106
- (3) Former smoker. 8517006
- (4) Never smoker. 266919005

- (5) Smoker, current status unknown. 77176002
- (6) Unknown if ever smoked. 266927001
- (7) Heavy tobacco smoker. 428071000124103
- (8) Light tobacco smoker. 428061000124105

§ 170.207(a)(4) [International Health Terminology Standards Development Organization \(IHTSDO\) Systematized Nomenclature of Medicine Clinical Terms \(SNOMED CT®\)](#), U.S. Edition, September 2015 Release,

§ 170.207(d)(3) [RxNorm](#), a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine, September 8, 2015 Release

§ 170.207(c)(3) [Logical Observation Identifiers Names and Codes \(LOINC®\) Database version 2.52](#)

§ 170.207(m)(1) [The Unified Code of Units of Measure, Revision 1.9](#)

§ 170.207(b)(3) [CDT](#)

§ 170.207(b)(2) [CPT-4](#)

§ 170.207(b)(4) [ICD-10-PCS](#)

§ 170.207(e)(3) [HL7 Standard Code Set CVX—Vaccines Administered, updates through June 18, 2015](#)

§ 170.207(e)(4) [National Drug Code Directory— Vaccine Codes, updates through August 3, 2015](#)

Criteria ¶	System Under Test	Test Lab Verification
(iii)(A)	1. The Health IT module creates a case report for the patient encounter(s) based on a matched trigger from (f)(5)(ii).	1. The tester verifies that the Health IT module can create a case report for the patient encounter(s) based on a matched trigger from (f)(5)(ii) that conforms to the standard specified in § 170.207(a)(4).

<p><b>(iii)(B)</b></p>	<ol style="list-style-type: none"> <li>1. The case report generated for the patient encounter(s) based on a matched trigger from (f)(5)(ii) includes where applicable: <ul style="list-style-type: none"> <li>• Encounter diagnoses using the standard specified in § 170.207(i) or, at a minimum, the version of the standard specified in § 170.207(a)(4);</li> <li>• The provider's name, office contact information, and reason for visit; and</li> <li>• An identifier representing the row and version of the trigger table</li> </ul> </li> <li>2. The following content from the Common Clinical Data Set is included: <ul style="list-style-type: none"> <li>• Patient Name</li> <li>• Sex constrained including birth sex</li> <li>• Date of Birth</li> <li>• Race and Ethnicity</li> <li>• Preferred language</li> <li>• Smoking Status</li> <li>• Problems constrained</li> <li>• Medications constrained</li> <li>• Medication Allergies</li> <li>• Laboratory Tests constrained</li> <li>• Laboratory Values(s)/Result(s)</li> <li>• Vital Signs</li> <li>• Procedures constrained</li> <li>• Care Team Member(s)</li> <li>• Immunizations constrained</li> <li>• Unique Device Identifier(s) for a Patient's Implantable Device(s)</li> <li>• Assessment and Plan of Treatment</li> <li>• Goals</li> <li>• Health Concerns</li> </ul> </li> </ol> <p>The complete list of the Common Clinical Data Set and associated standards can be referenced in <a href="#">Table 8</a> of the Final Rule.</p>	<ol style="list-style-type: none"> <li>1. The tester verifies that the content of the case reports produced for reporting include all of the ONC supplied test data correctly and without omission.</li> <li>2. The tester verifies the content of the case report produced for reporting includes all applicable content according to the specified standard.</li> <li>3. The tester verifies the content of the case report produced for reporting includes the Common Clinical Data Set where applicable, using visual inspection.</li> </ol>
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## Document History

Version Number	Description of Change	Date
1.0	Released for Comment - NPRM	March 31, 2015
1.1	Released for Comment - FR	October 30, 2015

Dependencies: For all related and required criteria, please refer to the [Master Table of Related and Required Criteria](#).