Appendix B

Appendix B - Consolidated CDA

The Consolidated CDA Implementation Guide (C-CDA IG) is developed by US stakeholders through the HL7 standardization process. Version 1.1 of the Implementation guide is a requirement for Certified EHRT in the Meaningful Use Stage 2 program, and version 2.1 is required for MU3 and newer regulations.

The C-CDA Implementation Guide is organized in a hierarchy of templates. The top-level templates are the document-level templates, which contain a header template, and several section templates. Some section-level templates are only described as narrative templates, with no associated discrete data entries. Other section-level templates contain either optional or required discrete data entries. The following sections contain an overview of the relevant templates.

B.1 Document Templates

The document template used is NOT required and the implementer can use any appropriate valid document template type from the HL7 C-CDA R2.1 IG. The reasons we are not requiring a specific document type:

- The ONC 2015 Edition specifications that support the MU Incentive program among other programs, does not mandate specific templates for transitions and referrals. That rule allows for and requires a minimum set of document templates: Summarization of Episode Note CCD, Referral Note, Discharge Summary (inpatient setting only). This means that EH/CAH/EP participants in the programs that utilize the 2015 Edition may be sending any one of these document types upon patient transition/referral and/or at the end of an encounter generally or specifically in response to a referral. To maximize synergy between this federal program and the requirements of 360x, 360x allows any template to be used.
- The ONC 2015 Edition imposes the “common clinical data set” (CCDS) to be included in all of the document types. The CCDS greatly extends the minimum requirements of any one document type and makes all of them very much the same.
- The Reason for Referral is required per 360X on any referral request which would be an acceptable extension of any document type (required for Referral Note) and allow it to be classified as a referral request
- The C-CDA that is most appropriate for the completion of a referral, may be a generic document such as a summarization of episode CCD or it may be a document type specific to the type of referral; e.g., Consultation note, Diagnostic Imaging Report, Procedure Report. Therefore, constraining 360X compliance to a single document type, regardless of referral type, would be an artificial, limiting constraint

Convention/Legend: While the HL7 C-CDA IG nor the ONC CCDS or AMA, do not explicitly have these conventions, all have similar designations so we summarize them as:

- R = section is required and may not be null. Per HL7 C-CDA IG, the non-null / entries required template would be used. Per ONC or AMA, the data should be populated if available and an assertion of “no data available” should be populated if not available.
- RE = section is required but may be empty. Per HL7 C-CDA IG, the entries required template may be used with null indicators or entries optional template may be used. Per ONC or AMA, the data should be populated if available, appropriate, and not covered elsewhere in the document.
- O = section and data are both optional.
- * (required or optional) Addition to template means that this section or data is not explicitly listed in the HL7 C-CDA IG at all or at least as part of the document definition. The C-CDA architecture is defined so that additional sections may be added, but the rows marked as addition to template would require that addition outside the defined template definition.