# Test Criteria: 170.315.b.5 Common Clinical Data Set Summary Record – Receive

|  |  |
| --- | --- |
| **Testing Result** |  |
| Participant and Product-with-version |  |
| Setting (Ambulatory or Inpatient) |  |
| Test Proctor |  |
| Test Date |  |
| Test Result | Pass:  Fail:  No Attempt: |
| Error Description (if applicable) |  |
| Modifications to Product Under Test |  |
| Additional Software Used |  |
| Additional Proctor Notes |  |

### Overview

In this document you will find:

* [Test Data and Test Tools](#_Test_Data_and)
* [Standards Support](#_Demonstrate_Standards_Support)
* [Drummond Test Report (Instructions, Expected Results, Points to Remember)](#_170.315(b)(5)_Common_Clinical)
* [Test Procedures](#_Test_Procedures)
* [Appendix A: Testing Guide](#_Appendix_A:_Testing)
* [Appendix B: ONC Criteria](#_Appendix_B:_ONC)
* Appendix C: CCDS Reference [Table](#_Appendix_C:_CCDS)

### Version of ONC Test Method

1.0

### Scope of Proctoring Sheet

The ONC test method associated with this criterion is the only approved test method for EHR Meaningful Use certification. This Proctoring Sheet is not a replacement test method but a test procedure document for performing the ONC test method and recording the results. Proctoring Sheet describe test data, test criteria and expected results. It is assumed the Health IT developer or Participant under Test is familiar with the associated ONC test method.

# Robustness and Reliability Requirement

To satisfy the module criteria, it is expected that the Product-Under-Test is able to complete the testing requirements reliably, including repeat testing with the same result without error, and with a satisfactory level of robustness. This includes unexpected error messages produced through normal operation, multiple unintended restarts of the application or any other “buggy” facets of the product displayed while testing. These errors are record in the Additional Proctor Notes of the proctor sheet. Lack of reliability and robustness of design will result in failure of the module.

# Test Data and Tools

|  |  |
| --- | --- |
| **Test Data Source:** | ONC-Supplied  DG-Supplied:  Developer-Supplied: |
| **Pre-Test Data Setup:**  Not applicable. | |
| **Test Data:**  Test data is downloaded from the ETT [C-CDA R2.1 Validator](https://ttpedge.sitenv.org/ttp/#/validators) using the “Receiver SUT Test Data” selection:   * + Inpatient Setting: “170.315\_b5\_CCDS\_Inp” (All .xml Samples)   + Ambulatory Setting: “170.315\_b5\_CCDS\_Amb” (All .xml Samples)   + Negative Tests: “NegativeTesting\_CCDS” (All .xml samples) | |
| **Test Tools:**  Edge Test Tool – Message Validators: [C-CDA R2.1 Validator](https://ttpedge.sitenv.org/ttp/#/validators) | |

# Demonstrate Standards Support

|  |  |
| --- | --- |
| **Test Result:** | PASS:  FAIL:  No Attempt: |
| **Instructions:** Implement support for standards to demonstrate compliance when receiving summary care records. | |

|  |  |  |
| --- | --- | --- |
| **§170.205 Content Exchange Standards – Patient Summary Record.** | | |
|  | §170.205(a)(3) | [HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, DSTU Release 1.1 (US Realm) Draft Standard for Trial Use July 2012](http://www.hl7.org/implement/standards/product_brief.cfm?product_id=258) |
|  | §170.205(a)(4) | [HL7 Implementation Guide for CDA Release 2 Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use Release 2.1, August 2015](http://www.hl7.org/implement/standards/product_brief.cfm?product_id=379) |
| **§170.207 Vocabulary standards for representing electronic health information \*** | | |
|  | §170.207(a)(4) | [IHTSDO SNOMED CT®, U.S. Edition, September 2015 Release](https://www.nlm.nih.gov/healthit/snomedct/us_edition.html) |
|  | §170.207(b)(2) | 45 CFR 162.1002(a)(5)—combination of HCPCS and CPT-4 |
|  | §170.207(b)(3) | 45 CFR 162.1002(a)(4)—Code on Dental Procedures and Nomenclature. |
|  | §170.207(b)(5) | 45 CFR 162.1002(c)(3)—ICD-10-PCS |
|  | §170.207(c)(3) | LOINC® Database version 2.52. |
|  | §170.207(d)(3) | RxNorm, September 8, 2015 Release. |
|  | §170.207(e)(3) | HL7 CVX—Vaccines Administered, updates through August 17, 2015. |
|  | §170.207(e)(4) | National Drug Code Directory—Vaccine Codes, updates through August 17, 2015. |
|  | §170.207(f)(1) | OMB as revised, October 30, 1997. |
|  | §170.207(f)(2) | CDC Race and Ethnicity Code Set Version 1.0 (March 2000) (incorporated by reference in § 170.299). |
|  | §170.207(g)(2) | Request for Comments (RFC) 5646 (incorporated by reference in § 170.299). |
|  | §170.207(h) | Smoking status constrained codes from SNOMED CT®. |
|  | §170.207(k)(1) | LOINC® version 2.51 (minimum codes: 8480-6, 8462-4, 8302-2, 3141-9, 8867-4, 9279-1, 8310-5, 59408-5, 39156-5, and 8478-0) |
|  | §170.207(m) | Numerical references—(1) Standard. The Unified Code of Units of Measure, Revision 1.9 (incorporated by reference in § 170.299). |
|  | §170.207(n)(1) | Birth sex must be coded in accordance with HL7 Version 3 Standard, Value Sets for AdministrativeGender and NullFlavor (incorporated by reference in § 170.299), attributed as follows:  (i) Male. M (ii) Female. F  (iii) Unknown. nullFlavor UNK |
| **§170.210 Standards for health information technology to protect electronic health information created, maintained, and exchanged.** | | |
|  | §170.210(g) | Synchronized clocks. The date and time recorded utilize a system clock that has been synchronized following (RFC 1305) Network Time Protocol, (incorporated by reference in §170.299) or (RFC 5905) Network Time Protocol Version 4, (incorporated by reference in §170.299). |

# 170.315(b)(5) Common Clinical Data Set Summary Record - Receive

|  |  |
| --- | --- |
| **Test Result:** | PASS:  FAIL:  No Attempt: |
| **Instructions:** User imports/receive all required Continuity of Care Document, Referral Note and Discharge Summary test case CCDA files which are validated, parsed and displayed in full and by individual sections based on user preference. | |
| **Expected Test Result:**   * Enable a user to receive a transition of care/referral summary formatted in accordance with the standards adopted in § 170.205(a)(3) and § 170.205(a)(4) using the Continuity of Care Document, Referral Note, and (for inpatient settings only) Discharge Summary document templates, and at a minimum: * **The Common Clinical Data Set;** * **Encounter diagnoses**. Formatted according to at least one of the following standards: the standard specified in §170.207(i) or at a minimum, the version of the standard specified in § 170.207(a)(4); * **Cognitive Status;** * **Functional Status;** * **Ambulatory setting only**. The reason for referral; and referring or transitioning provider's name and office contact information; and * **Inpatient setting only**. Discharge Instructions. * Demonstrate the following functionalities for the document received in accordance with paragraph (b)(5)(i) of this section: * **Validate C-CDA conformance** – system performance. Detect valid and invalid transition of care/referral summaries including the ability to:  1. Parse each of the document types formatted according to the following document templates: Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary. 2. Detect errors in corresponding “document-templates,” “section-templates,” and “entry-templates,” including invalid vocabulary standards and codes not specified in the standards adopted in § 170.205(a)(3) and § 170.205(a)(4). 3. Identify valid document-templates and process the data elements required in the corresponding section-templates and entry-templates from the standards adopted in § 170.205(a)(3) and § 170.205(a)(4). 4. Correctly interpret empty sections and null combinations; and 5. Record errors encountered and allow a user through at least one of the following ways to: (i) Be notified of the errors produced. (ii) Review the errors produced.  * **Display** in human readable format the data included in transition of care/referral summaries received and formatted according to the standards specified in § 170.205(a)(3) and § 170.205(a)(4). * **Display section views**. Allow for the individual display of each section (and the accompanying document header information) that is included in a transition of care/referral summary received and formatted in accordance with the standards adopted in § 170.205(a)(3) and § 170.205(a)(4) in a manner that enables the user to:   1. Directly display only the data within a particular section;   2. Set a preference for the display order of specific sections; and   3. Set the initial quantity of sections to be displayed. | |
| **Points to Remember:**   * The use of the C-CDA CDA XSL style sheet will not be sufficient to meet the requirements of the “Display” provision. * See [Appendix C](#_Appendix_C:_CCDS) for CCDS Reference Table. | |

### Test Procedures

**1.1 CCDS Summary Record - Receive**

|  |  |
| --- | --- |
|  | Health IT developer downloads test data files for the applicable setting **170.315\_b5\_ccds\_\*.xml** and imports into the HIT module. |

<INSERT LINK TO CCDA TEST FILES >

|  |  |
| --- | --- |
|  | Using health IT module functionality, user successfully receives all CCDA document templates for each sample test case for the appropriate health care setting and displays in human readable format:   * **Continuity of Care Document;** * **Referral Note; and** * *Inpatient setting only:* **Discharge Summary** |

<INSERT SCREEN SHOT – Receiving Continuity of Care>

<INSERT SCREEN SHOT – Receiving Referral Note>

<INSERT SCREEN SHOT – Receiving Discharge Summary>

**1.2 Validate and Display**

|  |  |
| --- | --- |
|  | Proctor visually inspects each C-CDA document is *parsed and validated.* For those successfully validated, verifyeach *displays* in human readable, non-coded format of required standards and vocabulary codes are accurate and without omission *(see* [*Appendix C*](#_Appendix_C:_CCDS) *for “CCDS Reference Table”):*   * **The Common Clinical Data Set;** * **Encounter Diagnosis;** * **Cognitive Status;** * **Functional Status;** * *Ambulatory setting only***: Reason for referral, referring provider name and contact info; and** * *Inpatient setting only***: Discharge Instructions** |

<INSERT SCREEN SHOTS>

**1.3 Display Section Views**

|  |  |
| --- | --- |
|  | Using health IT module functionality, user can select individual sections display in human readable format for all document types:   * **Continuity of Care Document** * **Referral Note** * *Inpatient setting only***: Discharge Summary** |
|  | User sets preferences on which sections to display. |
|  | User demonstrates control of the display order for specific sections. |
|  | User demonstrates control of the initial quantity of sections to display. |

<INSERT SCREEN SHOTS>

**1.4 Error Detection and Handling**

|  |  |
| --- | --- |
|  | Health IT developer downloads negative test data files “**NT\_\*\_.xml**” for the applicable setting and imports into the health IT module. |

<INSERT LINK TO CCDA NEGATIVE TEST FILES >

|  |  |
| --- | --- |
|  | Using health IT module functionality, user successfully parses and rejects all CCDA document templates for each sample negative test case for the appropriate health care setting:   * **Continuity of Care Document;** * **Referral Note; and** * *Inpatient setting only:* **Discharge Summary** |
|  | Proctor verifies health IT module correctly identifies errors in the CCDA document and identifies the C-CDA document as invalid. |
|  | Errors encountered during the parsing and processing of the C-CDA documents are recorded. User is either notified of the errors produced **OR** can review all of the recorded errors using the health IT module. |

<INSERT SCREEN SHOTS>

# Appendix A: Testing Guide

*This appendix contains more details and background on the testing requirements, including explanation on underlying standards, notable issues and best practice suggestions.*

Rev 01-Mar-2016 Additions

* The scope of this criterion is limited to the Consolidated CDA (C-CDA) Continuity of Care Document (CCD), Referral Note, and (for the inpatient setting only) Discharge Summary document templates.
* We recommend health IT developers and providers follow the guidance provided in the [HL7 Implementation Guide: S&I Framework Transitions of Care Companion Guide to Consolidated-CDA for Meaningful Use Stage 2, Release 1 – US Realm](http://www.hl7.org/implement/standards/product_brief.cfm?product_id=374). This Companion Guide includes industry best practices guidance for consistent implementation of the CCDA Release 1.1 standard, including mapping Common MU Data Set elements into the C-CDA standard. We understand that HL7 is developing a Companion Guide for C-CDA Release 2.1 and intend to update this document once it becomes publicly available. In the meantime, we recommend developers follow the guidance provided by the HL7 CDA Example Task Force for implementation of the CCDA Release 2.1 standard.
* Ambulatory setting only – The user is able to receive a C-CDA (formatted to either Release 1.1 or Release 2.1) that also includes the reason for referral and the referring or transitioning provider’s name and office contact information.
* Inpatient setting only – The user is able to create a C-CDA (formatted to either Release 1.1 or Release 2.1) that also includes the discharge instructions.
* Health IT Modules are required to be able to receive C-CDAs formatted to both CCDA Release 1.1 and 2.1. While Release 2.1 largely ensures compatibility between CCDA Release 1.1 and 2.0, it does not guarantee compatibility without further development effort.
* In order to facilitate the translation of SNOMED CT® codes to ICD-10-CM in administrative systems, developers are encouraged to reference the publicly available mapping that the National Library of Medicine provides.
* The C-CDA Cognitive Status Observation template has been deprecated in Release 2.1 and has been replaced with the Mental Status Observation template. Developers should use the Mental Status Observation template for cognitive status and be aware that the CCDA validator will issue an error if the deprecated Cognitive Status Observation is used instead.
* Testing for the receipt of C-CDA Release 1.1 documents will offer two options – to test either a non-specified C-CDA document or a CCD. Health IT Modules will not be tested for C-CDA Release 1.1 Referral Note and Discharge Summary document templates. Note that Health IT Modules will be tested for receipt of all three document templates (i.e., CCD, Referral Note, and (for inpatient settings only) Discharge Summary) for C-CDA Release 2.1.
* Error notification should be made available to authorized users of the receiving organization who can deal with the errors as appropriate and the error may be resolved by a support analyst or end user.
* There is no requirement that users be interrupted to be notified of errors, only that the user can access and review the errors.
* Receiving systems are not expected to translate codes from a source that has not formatted the data according to the applicable vocabulary standard required by the C-CDA Releases 1.1 and 2.1. However, receiving systems would be expected to identify data not formatted according to the applicable vocabulary standard as an error.

# Appendix B: ONC Criteria and Standards

*This appendix contains copy of the relevant ONC criteria and standards for this proctor sheet as a reference. In the event of a discrepancy with the ONC Final Rule, the ONC Final Rule takes precedence.*

**§170.315(b)(5) *Common Clinical Data summary record - receive.***

1. Enable a user to receive a transition of care/referral summary formatted in accordance with the standards specified in § 170.205(a)(4) using the Continuity of Care Document, Referral Note, and (for inpatient setting only) Discharge Summary document templates that includes at a minimum:
2. The Common Clinical Data Set.
3. Encounter diagnoses. Formatted according to at least one of the following standards:

(1) The standard specified in § 170.207(i).

(2) At a minimum, the version of the standard specified in § 170.207(a)(4).

1. Cognitive status.
2. Functional status.
3. Ambulatory setting only. The reason for referral; and referring or transitioning provider's name and office contact information
4. Inpatient setting only. Discharge instructions.
5. Validate and Display
6. Validate and Display - Demonstrate the functionalities for the document received in accordance with paragraph (b)(5)(i) of this section:

(A) Validate C-CDA conformance – system performance. Detect valid and invalid transition of care/referral summaries including the ability to:

(1) Parse each of the document types formatted according to the following document templates: Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary.

(2) Detect errors in corresponding “document-templates,” “section-templates,” and “entry-templates,” including invalid vocabulary standards and codes not specified in the standards adopted in § 170.205(a)(3) and § 170.205(a)(4).

(3) Identify valid document-templates and process the data elements required in the corresponding section-templates and entry-templates from the standards adopted in § 170.205(a)(3) and § 170.205(a)(4).

(4) Correctly interpret empty sections and null combinations; and

(5) Record errors encountered and allow a user through at least one of the following ways to: (i) Be notified of the errors produced. (ii) Review the errors produced.

(B) Display. Display in human readable format the data included in transition of care/referral summaries received and formatted according to the standards specified in § 170.205(a)(3) and § 170.205(a)(4).

(C) Display section views. Allow for the individual display of each section (and the accompanying document header information) that is included in a transition of care/referral summary received and formatted in accordance with the standards adopted in § 170.205(a)(3) and § 170.205(a)(4) in a manner that enables the user to:

(1) Directly display only the data within a particular section;

(2) Set a preference for the display order of specific sections; and

(3) Set the initial quantity of sections to be displayed.

**§170.102 – Definitions**

***Common Clinical Data Set*** means the following data expressed, where indicated, according to the specified standard(s):

(1) *Patient name.*

(2) *Sex.* (ii) The standard specified in § 170.207(n)(1).

(3) *Date of birth.*

(4) *Race.* (ii) For certification to the 2015 Edition health IT certification criteria:

(A) The standard specified in § 170.207(f)(2);

(B) The standard specified in § 170.207(f)(1) for each race identified in accordance § 170.207(f)(2).

(5) *Ethnicity.* (ii) For certification to the 2015 Edition health IT certification criteria:

(A) The standard specified in § 170.207(f)(2);

(B) The standard specified in § 170.207(f)(1) for each ethnicity identified in accordance § 170.207(f)(2).

(6) *Preferred language.* (ii) The standard specified in § 170.207(g)(2).

(7) *Smoking status.* The standard specified in § 170.207(h).

(8) *Problems.* (ii) At a minimum, the standard specified in § 170.207(a)(4).

(9) *Medications.* (ii) At a minimum, the standard specified in § 170.207(d)(3).

(10) *Medication allergies.* (ii) At a minimum, the standard specified in § 170.207(d)(3).

(11) *Laboratory test(s).* (ii) At a minimum, the standard specified in § 170.207(c)(3).

(12) *Laboratory value(s)/result(s).*

(13) *Vital signs.* (ii) For certification to the 2015 Edition Health IT certification criteria:

(A) The patient's diastolic blood pressure, systolic blood pressure, body height, body weight, heart rate, respiratory rate, body temperature, pulse oximetry, and inhaled oxygen concentration must be exchanged in numerical values only; and

(B) In accordance with the standard specified in § 170.207(c)(3) and with the associated applicable unit of measure for the vital sign measurement in the standard specified in § 170.207(m)(1).

(C) *Optional.* The patient's BMI percentile per age and sex for youth 2-20 years of age, weight for age per length and sex for children less than 3 years of age, and head occipital-frontal circumference for children less than 3 years of age must be recorded in numerical values only in accordance with the standard specified in § 170.207(c)(3) and with the associated applicable unit of measure for the vital sign measurement in the standard specified in § 170.207(m)(1). For BMI percentile per age and sex for youth 2-20 years of age and weight for age per length and sex for children less than 3 years of age, the reference range/scale or growth curve should be included as appropriate.

(15) *Procedures*—(i)(A) At a minimum, the version of the standard specified in § 170.207(a)(4), or § 170.207(b)(2); or

(B) For technology primarily developed to record dental procedures, the standard specified in § 170.207(b)(3).

(ii) *Optional.* The standard specified in § 170.207(b)(5).

(16) *Care team member(s).*

(17) *Immunizations.* In accordance with, at a minimum, the standards specified in § 170.207(e)(3) and (4).

(18) *Unique device identifier(s) for a patient's implantable device(s).* In accordance with the “Product Instance” in the “Procedure Activity Procedure Section” of the standard specified in § 170.205(a)(4).

(19) *Assessment and plan of treatment.* (i) In accordance with the “Assessment and Plan Section (V2)” of the standard specified in § 170.205(a)(4); or

(ii) In accordance with the “Assessment Section (V2)” and “Plan of Treatment Section (V2)” of the standard specified in § 170.205(a)(4).

(20) *Goals.* In accordance with the “Goals Section” of the standard specified in § 170.205(a)(4).

(21) *Health concerns.* In accordance with the “Health Concerns Section” of the standard specified in § 170.205(a)(4).

**§170.205 Content Exchange Standards – Patient Summary Record.**

**(a)(3) *Standard.*** HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, DSTU Release 1.1 (US Realm) Draft Standard for Trial Use July 2012.

**(a)(4) *Standard.*** HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 1—Introductory Material, Release 2.1 and HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 2—Templates and Supporting Material, Release 2.1 (incorporated by reference in § 170.299).

**§170.207 Vocabulary standards for representing electronic health information.**

**(a)(4) *Standard*.** IHTSDO SNOMED CT®, U.S. Edition, September 2015 Release.

**(b)(2) *Standard*.** 45 CFR 162.1002(a)(5)—combination of HCPCS and CPT-4

**(b)(3) *Standard.*** 45 CFR 162.1002(a)(4)—Code on Dental Procedures and Nomenclature.

**(b)(5) *Standard.*** 45 CFR 162.1002(c)(3)—ICD-10-PCS

**(c)(3) *Standard.*** LOINC® Database version 2.52.

**(d)(3) *Standard.*** RxNorm, September 8, 2015 Release.

**(e)(3) *Standard.*** HL7 CVX—Vaccines Administered, updates through August 17, 2015.

**(e)(4) *Standard.*** National Drug Code Directory—Vaccine Codes, updates through August 17, 2015.

**(f)(1) *Standard.*** OMB as revised, October 30, 1997.

**(f)(2) *Standard.*** CDC Race and Ethnicity Code Set Version 1.0 (March 2000) (incorporated by reference in § 170.299).

**(g)(2) *Standard.*** Request for Comments (RFC) 5646 (incorporated by reference in § 170.299).

**(h) *Standard.*** Smoking status constrained codes from SNOMED CT®.

**(k)(1) *Standard.*** LOINC® version 2.51 (minimum codes: 8480-6, 8462-4, 8302-2, 3141-9, 8867-4, 9279-1, 8310-5, 59408-5, 39156-5, and 8478-0)

***(m) Numerical references—(1) Standard.*** The Unified Code of Units of Measure, Revision 1.9 (incorporated by reference in § 170.299).

**(n)(1) *Standard*.** Birth sex must be coded in accordance with HL7 Version 3 Standard, Value Sets for AdministrativeGender and NullFlavor (incorporated by reference in § 170.299), attributed as follows:

(i) Male. M

(ii) Female. F

(iii) Unknown. nullFlavor UNK

**§170.210 Standards for health information technology to protect electronic health information created, maintained, and exchanged.**

(g) Synchronized clocks. The date and time recorded utilize a system clock that has been synchronized following (RFC 1305) Network Time Protocol, (incorporated by reference in §170.299) or (RFC 5905) Network Time Protocol Version 4, (incorporated by reference in §170.299).

# Appendix C: CCDS Reference Table

# *This appendix contains a reference guide to evaluate the Common Clinical Data Set and additional elements are populated accurately and without omission.*

**CCDS Reference Table**

[2015 Common Clinical Data Set](https://www.healthit.gov/sites/default/files/2015Ed_CCG_CCDS.pdf)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Test Data** | **CCDS** | **Standard** |
|  |  | Patient Name | **<Not applicable>** |
|  |  | Sex; including Birth sex | **§170.207 (n)(1)** |
|  |  | Date of Birth | **<Not applicable>** |
|  |  | Race | **§170.207 (f)(2)** mapped to **§170.207(f)(1);**  **§170.207(f)(2)** |
|  |  | Ethnicity | **§170.207 (f)(2)** mapped to **§170.207(f)(1); §170.207(f)(2)** |
|  |  | Preferred Language | **§170.207 (g)(2)** |
|  |  | Smoking Status | **§170.207 (h)** |
|  |  | Problems | **§170.207 (a)(4)** |
|  |  | Medications | **§170.207 (d)(3)** |
|  |  | Allergies | **§170.207 (d)(3)** |
|  |  | Lab Tests | **§170.207 (m)(1)** |
|  |  | Lab Values(s)/Results | **<Not applicable>** |
|  |  | Vital Signs | **§170.207 (k)(1), §170.207 (m)(1)** |
|  |  | BMI (Optional) | **§170.207 (c)(3), §170.207 (m)(1)** |
|  |  | Procedures | **§170.207 (a)(4)**  **§170.207 (b)(2)** |
|  |  | Procedures (Optional: for dental systems) | **§170.207 (b)(3)** |
|  |  | Procedures (Optional) | **§170.207 (b)(5)** |
|  |  | Care Team Member(s) | **<Not applicable>** |
|  |  | Immunizations | **§170.207 (e)(3), §170.207 (e)(4)** |
|  |  | Unique Device Identifier(s) for a Patient’s Implantable Device(s) | **“Product Instance” in the “Procedure Activity Procedure Section” of the standard specified in § 170.205(a)(4)** |
|  |  | Assessment and Plan of Treatment | **In accordance with the “Assessment and Plan Section (V2)” of the standard specified in § 170.205(a)(4); or**  **In accordance with the “Assessment Section (V2)” and “Plan of Treatment Section (V2)” of the standard specified in § 170.205(a)(4).** |
|  |  | Goals | **Goals Section” of the standard specified in § 170.205(a)(4) for certification to the 2015 Edition health IT certification criteria.** |
|  |  | Health Concerns | **In accordance with the “Health Concerns Section” of the standard specified in § 170.205(a)(4) for certification to the 2015 Edition health IT certification criteria.** |
|  | **Test Data** | **Data Element** | **Standard** |
|  |  | Encounter diagnoses | **§170.207 (i) or §170.207 (a)(4)** |
|  |  | Cognitive Status | **<Not applicable>** |
|  |  | Functional Status | **<Not applicable>** |
| **AMBULATORY ONLY** | | | |
|  | **Test Data** | **Data Element** | **Standard** |
|  |  | Reason for referral | **<Not applicable>** |
|  |  | Referring or transitioning provider’s name and office contact information | **<Not applicable>** |
| **INPATIENT ONLY** | | | |
|  | **Test Data** | **Data Element** | **Standard** |
|  |  | Discharge Instructions | **<Not applicable>** |
|  |  | Patient matching | **§170.207 (f)(1)** Mapped to **§170.207 (f)(2); §170.207 (f)(2)** |

# Change Log

|  |  |
| --- | --- |
| Revision | Change Description |
| 01-Oct-2016 | Updated hyperlinks for ONC-hosted ETT. Updates test data filenames. |
| 01-Jun-2016 | Added hyperlinks to standards list. |
| 01-May-2016 | Corrected Race and Ethnicity entries on “CCDS Reference Table” to clarify 170.207(f)(2) should be mapped to 170.207(f)(1). |
| 01-Mar-2016 | Initial Release. |
|  |  |
|  |  |
|  |  |

**About Drummond Group LLC**

Drummond Group LLC is a global software test and certification lab that serves a wide range of vertical industries.  In healthcare, Drummond Group tests and certifies Controlled Substance Ordering Systems (CSOS), Electronic Prescription of Controlled Substances (EPCS) software and processes, and Electronic Health Records (EHRs) – designating the trusted test lab as the only third-party certifier of all three initiatives designed to move the industry toward a digital future. Founded in 1999, and accredited for the Office of the National Coordinator Health IT Certification Program as an Authorized Certification Body (ACB) and an Authorized Test Lab (ATL), Drummond Group continues to build upon its deep experience and expertise necessary to deliver reliable and cost-effective services. For more information, please visit <http://www.drummondgroup.com> or email [ehr@drummondgroup.com](mailto:ehr@drummondgroup.com)

END OF DOCUMENT