The Office of the National Coordinator for Health Information Technology

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

Testing Components: Health IT developer self-declaration to the testing outcomes

Test Procedure Version 1.1 – Last Updated 09/21/17

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) *Transmission to public health agencies – electronic case reporting*.

(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)	1. The Health IT Module consumes a table of trigger codes to determine which encounters may be reportable. 2. The Health IT Module maintains a table of trigger codes to determine which encounters may be reportable.	1. The tester reviews documentation supplied by the health IT developer describing the means by which the Health IT Module can consume a table of trigger codes that will be used to determine which encounters should initiate an initial case report being sent to public health. 2. The tester reviews documentation supplied by the health IT developer describing the means by which the Health IT Module is able to maintain updates to a table of trigger codes from the prior step.

(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)	1. The Health IT module matches one or more patient visits or encounters to the parameters of the trigger code table.	1. The tester reviews documentation supplied by the Health IT Vendor describing the means by which the Health IT module can correctly match a patient encounter or visit based on the parameters of the trigger code table.

(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.

Data Elements and Vocabularies applicable to the Common Clinical Data Set (CCDS) – Outlined in the Common Clinical Data Set Reference Document

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 reviews documentation supplied by the Health IT Vendor describing the set of data elements the Health IT module can create making up a case report for the patient encounter(s) based on a matched trigger from (f)(5)(ii).

Criteria ¶	System Under Test	Test Lab Verification
(iii)(B)	• The case report generated for the patient encounter(s) based on a matched trigger from (f)(5)(ii) includes where applicable: • 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); • The provider's name, office contact information, and reason for visit; and • An identifier representing the row and version of the trigger table. • The following elements from the Common Clinical Data Set should be included: • Patient Name • Sex • Date of Birth • Race and Ethnicity • Preferred language • Problems • Medications • Laboratory Tests • Laboratory Values(s)/Result(s) • Vital Signs • Procedures • Care Team Member(s) • Immunizations • Assessment and Plan of Treatment	1. Completed with the prior criterion (iii)(A).

Document History

Version Number	Description of Change	Date
1.0	Final test procedure	August 11, 2017
1.1	As of September 21, 2017, Test Procedure has been moved to Attestation/Developer self-declaration only	September 21, 2017

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