

(SVAP USCDI v4) Test Data for 170.315 (b) (1) - Transitions of Care

Ambulatory Setting

I. INTRODUCTION

This document contains sample test data that can be used for the certification towards objective 170.315(b)(1). This section of the Code of Federal Regulations Title 45 documents the required Health IT technology to be able to create, send and receive a summary care record formatted according to the Consolidated CDA (C-CDA) Release 2.1 and be able to receive a summary care record formatted according to the C-CDA Release 1.1.

A) Test of 45 CFR 170.315 (b) (1)

The following is the summary of test data presented herein for 170.315(b)(1) criteria.

Conventions used in the document:

1. The test data outlined below has both required and optional data that is specified to help the vendors create C-CDA's with the appropriate context and follow the HL7 C-CDA best practices. The optional data is indicated by enclosing them in []. For e.g. [Medical Record Custodian] or [Allergy Substance].
 - a. When a narrative or text block is surrounded by [] the entire narrative block is optional.
 - b. When a column heading is surrounded by [] the data represented by the column is optional. For e.g. [Allergy Substance], the display name is optional.
 - c. When the data within a table cell is surrounded by [] the data within the cell is optional. For e.g. The information recipient Dr Albert Davis is optional from a certification standpoint. Vendors can include it in their C-CDA's to comply with HL7 C-CDA IG and best practices.

[Information Recipient]	[Dr Albert Davis]
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- d. The C-CDA IG allows display names and text elements to be optionally included in the structured entries. Hence the above optional markings designated by [] in the test data are with respect to the structured entries in the XML. If a certification criteria requires visual display of the structured data (for e.g View, Download and Transmit - VDT), then the vendors have to display the coded data elements in their English representation. For example Medication Name, Problem Name, Vital Sign Name which are English representations of the coded data have to be displayed for the VDT criteria even though they are marked optional in the test data.

2. Additional clarifications are added with the keyword **“Note”**.
3. Data that needs to be visually inspected by the ATL’s in the generated C-CDA’s are indicated by the key word **“Visual Inspection”**.
4. Guidance for No Information Sections: When the test data instructions specify “No Information” for certain data elements, vendors are expected to use the HL7 recommended best practices to represent the information. However vendors don’t have to include sections and entries not required by the document template to represent “No information”.
5. Guidance to Change Test Data: Vendors can work with their ATLs to change the test data specified below. ATLs have been provided a document on how to use the test tools to verify SUT’s capabilities when the test data is changed. This document has also been posted as part of ETT Google Group thread: https://groups.google.com/forum/#!topic/edge-test-tool/fDYr_kqp9_g

To exemplify 170.315 (b) (1), the following clinical scenario will be employed.

Document Narrative:

[Ms. Alice Newman is a 45 year old female with a history of Hypertension, Hypothyroidism, Iron deficiency and is a recipient of Renal Allograft visits Neighborhood Physicians Practice on 6/22/2015 at 10am EST. The patient disclosed history of nausea, loose stools and weakness. After initial examination the patient was found to have fever, she was administered necessary medications and after examining the history of the patient and the lab results, the doctor suspected anemia. So the patient was referred to Community Health Hospitals an Inpatient facility to get appropriate treatment and was asked to watch for appropriate changes in body temperature, blood pressure and take nebulizer treatment as needed.]

Note: The test data provided in the document was captured during this encounter including historical data. The contextual data provided is to help the vendors create their C-CDA documents using appropriate data. Vendors can ignore the contextual data if it is not required for C-CDA generation; however the generated C-CDA is expected to contain the data relevant to the criteria as specified in the regulation.

II. HEADER DATA

Note: The following data is part of the medical record header identifying the contextual information necessary when exchanging data.

A) USCDI Data Class/Element: Patient Demographics

USCDI Data Elements	Contextual Data Elements required for the Medical Record encoding to C-CDA IG	Details	Additional Information
Patient Name (First Name, Last Name, Previous Name, Middle Name, Suffix)		First Name: Alice Last Name: Newman Middle Name: Jones Previous Name: Alicia Suffix:	The Previous Name specified is the Patient's Birth Name and should be coded accordingly.
Sex		Female (F)	
Date of Birth		5/1/1970	
Race		White (2106-3)	
Ethnicity		Not Hispanic or Latino (2186-5)	
Preferred Language		English (en)	
Current Address	Home Address	1357, Amber Dr, Beaverton, OR-97006	
Phone Number		Mobile: 555-777-1234 Home: 555-723-1544	
Email			
Gender Identity		Asked but Unknown (ASKU nullFlavor)	To be represented as Gender Identity Observation
Sexual Orientation		Unknown (UNK nullFlavor)	To be represented as Sexual Orientation Observation

B) Relevant Information regarding the Visit

Note: The information in this table is provided for context and to help populate the required elements in the C-CDA Header along with any ONC Health IT Certification Program-required data elements.

USCDI Data Class/ Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
	Referring or Transitioning Providers Name	Full Name: Dr Albert Davis First Name: Albert Last Name: Davis	

USCDI Data Class/ Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
	Office Contact Information	Full Name: Tracy Davis First Name: Tracy Last Name: Davis Telephone: 555-555-1002 Address: 2472, Rocky place, Beaverton, OR-97006	
	[Author/Legal Authenticator/ Authenticator of Electronic Medical Record]	[Dr Albert Davis Date: 6/22/2015]	
	[System that generated the document]	[Neighborhood Physicians Practice EMR]	
	[Informants]	[Matthew Newman (Spouse) First Name: Matthew Last Name: Newman]	
	[Medical Record Custodian]	[Neighborhood Physicians Practice]	
	[Information Recipient]	[Dr Albert Davis]	
	[Visit Date]	[6/22/2015]	
Care Team Members	Care Team Members	Dr Albert Davis (Primary Care Provider Function - 453231000124104), (NPI – 9941339100) Tracy Davis (Professional nurse – 106292003) Telephone: 555-555-1002 Address: 2472, Rocky place, Beaverton, OR-97006	This is expected to be codified in the Care Team Members section.

USCDI Data Class/ Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
Related Person	[Other Participants in event]	[Mr Rick Holler (Grand Parent) First Name: Rick Last Name: Holler Mr Matthew Newman (Spouse) First Name: Matthew Last Name: Newman (Mr Rick and Mr Matthew have the same address as Ms Alice)]	
	[Event Documentation Details or Documentation of Event]	[Dr Albert Davis 30 minute encounter Event Code = Fever]	[Code for Fever Finding: 386661006 , Code System: SNOMED-CT]

III. BODY DATA

Note: The following data is part of the medical record details identifying the relevant clinical data captured as part of the visit.

A) USCDI Data Class/Element: Allergies and Intolerances

Note: Allergies and Intolerances are to be represented using the Allergies and Intolerances Section. The Start Date is to be represented using the effectiveTime data element of Allergy Intolerance Observation as biologically relevant time.

Code	CodeSystem	[Allergy Substance]	Reaction	Severity	[Timing Information]	Concern Status
7980 (IN)	RxNorm	Penicillin G	Hives (code-247472004, SNOMED-CT)	Moderate	Start Date – 5/10/1980,	Active
733 (IN)	RxNorm	Ampicillin	Hives (code-247472004, SNOMED-CT)	Moderate	Start Date – 5/10/1980,	Active

Code	CodeSystem	[Allergy Substance]	Reaction	Severity	[Timing Information]	Concern Status
111088007	SNOMED-CT	Latex	Skin rash (code-271807003 SNOMED-CT)	Moderate	Start Date – 5/10/1990,	Active

B) USCDI Data Class/Element: Medications

Note: Timing information (Start and End Dates) are to be represented using the effectiveTime data element in the Medication Activity entry.

Code	CodeSystem	[Medication Name]	[Timing Information]	Route	Frequency	Dose	Indication	Dispense Data
309090 (SCD)	RxNorm	Ceftriaxone 100 MG/ML	6/22/2015 – Start Date 6/30/2015 – End Date	Injectable	Two times daily	1 unit	Fever Problem Observation	Fill Status = Completed , Repeat Number = 2, quantity = 6
209459 (SBD)	RxNorm	Tylenol 500mg	For 10 days, starting from 6/22/2015	Oral	As needed	1 unit	Fever Problem Observation	

Medication Instructions For All Medications Identified Above: (Visual Inspection – ATL’s need to visually inspect the System Under Test (SUT) generated C-CDA for the text content, the validator will validate the presence of the Medication Instructions entry. Only the text content needs to be visually inspected.)

- Do Not Take on Empty Stomach

Medication Adherence For All Medications Identified Above:

Observation Code	Observation code’s CodeSystem	Observation Code [Display Name]	Observation Value	Observation Value’s CodeSystem	Observation Value [Display Name]
71799-1	LOINC	Adherence to prescribed medication instructions [Reported]	1156699004	SNOMED-CT	Complies with drug therapy (finding)

[Informant Information for Adherence data: This data can be coded as an informant participant for the Observation]

- Information provided by the Patient
 - Code = 116154003, CodeSystem = SNOMED-CT, Display Name = Patient (person)

C) USCDI Data Class/Element: Problems

Note: Timing information is to be represented using the effectiveTime data element in the Problem Observation. Start Date is to be used as Onset Date and End Date as Resolution Date.

Code	CodeSystem	[Problem Name]	[Timing Information]	Concern Status	Diagnosis Date
59621000	SNOMED-CT	Essential hypertension (Disorder,)	10/5/2011 – Onset Date	Active	9/1/2010
83986005	SNOMED-CT	Severe Hypothyroidism (Disorder)	12/31/2006 – Onset Date	Active	12/31/2006
236578006	SNOMED-CT	Chronic rejection of renal transplant (disorder)	12/31/2011 – Onset Date	Active	12/31/2011
386661006	SNOMED-CT	Fever (finding)	6/22/2015 – Onset Date	Active	6/20/2015
238131007	SNOMED-CT	Overweight (finding)	12/31/2006 – Onset Date, 6/1/2007 – Resolution Date	Completed	1/1/2006
733423003	SNOMED-CT	Food Insecurity (finding)	6/22/2015	Active	

D) Encounter Diagnoses

Note: If a SUT only supports ICD-10 instead of SNOMED-CT, they could work with their ATLs to use a ICD-10 code. Vendors can generate an Encounter Identifier of choice and the Validator checks for the Encounter Identifier to be present in the Encounter Section/Encounter Activity/id element.

Code	CodeSystem	[Description]	Date Recorded	Service Delivery Location	Encounter Type
386661006	SNOMED-CT	Fever – Finding	6/22/2015	Neighborhood Physicians Practice Address: 2472, Rocky place, Beaverton, OR-97006, Facility Type (Code = 1242-7, CodeSystem = Healthcare Service Location Code System)	Ambulatory Encounter CPT Code = 99202

Note: Facility Identifiers can be created by the Vendor and the validator will only check for the presence of the participantRole/id element. It can be NPI, Tax Id or some other random id that is used to identify the facility.

E) USCDI Data Class/Element: Immunizations

Note: Additional Notes represent why the Immunization was cancelled and there are no specific notes applicable to the completed immunizations.

Vaccine Code	CodeSystem	[Vaccine Name]	Date	Status	[Lot Number]	[Manufacturer Name]	Additional Notes
106	CVX	Tetanus and diphtheria toxoids	1/4/2012	Completed	2	Immuno Inc.	N/A
166	CVX	influenza, intradermal, quadrivalent, preservative free	6/22/2015	Cancelled	No Lot number provided – Vendors need to use NullFlavor	Immuno Inc.	Immunization was not given - Patient rejected immunization

F) USCDI Data Class/Element: Vital Signs

Code	Code System	[Vitals Name]	Timing Information	Value and Units
8302-2	LOINC	Height	6/22/2015, [10:05 EST]	Value=177 units=cm
29463-7	LOINC	Weight	6/22/2015, [10:05 EST]	Value=88 units=kg
8462-4 (Diastolic)	LOINC	Blood Pressure- Diastolic	6/22/2015, [10:08 EST]	Value=88 units=mm[Hg]
8480-6 (Systolic)	LOINC	Blood Pressure- Systolic	6/22/2015, [10:08 EST]	Value=145 units=mm[Hg]
8867-4	LOINC	Heart Rate	6/22/2015 [10:10 EST]	Value=80 Units=/min
59408-5	LOINC	O2 % BldC Oximetry	6/22/2015 [10:12 EST]	Value=95 units=%
3150-0	LOINC	Inhaled Oxygen Concentration	6/22/2015 [10:12 EST]	Value=36 units=%
8310-5	LOINC	Body Temperature	6/22/2015 [10:15 EST]	Value=38 units=Cel
9279-1	LOINC	Respiratory Rate	6/22/2015 [10:15 EST]	Value=18 units=/min
96607-7 - (Average BP) 96608-5 – (Systolic Mean) 96609-3 – (Diastolic Mean)	LOINC	Average Blood Pressure	6/22/2015 [10:15 EST]	Value = 143/82 units = mm[Hg]

Note: Use the LOINC codes for Systolic and Diastolic Mean values to represent the average BP components.

G) USCDI Data Class/Element: Smoking Status

Note: The C-CDA IG specifies how Smoking Status has to be represented using a combination of Tobacco Use and Smoking Status templates. Vendors are expected to follow the C-CDA IG to encode these data elements appropriately.

Element Description	[Description]	Start Date	End Date	Code	Code System
Current Smoking Status	Current every day smoker	6/22/2015	-	449868002	SNOMED-CT

H) USCDI Data Class/Element: Procedures

Note: Target Site is provided for context, vendors may or may not choose to include this as part of the C-CDA entries. Date is to be represented using the effectiveTime data element in the Procedure Activity Procedure entry.

Code	[Procedure Name]	[Date]	[Target Site]	Status	[Service Delivery Location]
(56251003) – SNOMED-CT	Nebulizer Therapy	6/22/2015	82094008- Lower Respiratory Tract Structure, Code System – SNOMED-CT	Completed	Neighborhood Physicians Practice Telephone: 555-555- 1002 Address: 2472, Rocky place, Beaverton, OR-97006
175135009 (SNOMED-CT)	Introduction of cardiac pacemaker system via vein	10/5/2011	9454009 – Structure of subclavian vein, Code System - SNOMED-CT	Completed	Community Health Hospitals. Telephone: 555-555-1003 Address: 3525, Newberry Avenue, Beaverton, OR-97006.

- I) USCDI Data Class/Element: Clinical Notes (**Visual Inspection** – ATL’s need to visually inspect the System Under Test (SUT) generated C-CDA for the text content, the validator will validate the presence of the notes section and entry. Only the text content needs to be visually inspected.)

I.1 Procedure Note:

Dr Albert Davis examined Ms Alice Newman and found that the pacemaker is operating properly and the breathlessness is due to high fever and anxiety.

J) USCDI Data Class/Element: Laboratory Tests

Note: The pending Urinalysis lab test has no results yet and is a future event and has to be coded accordingly. The HL7 best practice to code a pending lab test is to represent it with a planned observation in the Plan of Treatment section.

Test Code	Code System	[Name]	Date
24357-6	LOINC	Urinalysis macro (dipstick) panel	6/22/2015
24357-6	LOINC	Urinalysis macro (dipstick) panel	6/29/2015

K) USCDI Data Class/Element: Laboratory Values/Results

Note: The results below correspond to the Urinalysis lab test on 6/22/2015. Additionally when units are not present then the result value does not require any specific unit. The Result Status for all the results are completed.

Result Code	Code System	[Name]	Result Value and Units	Date	Reference Range	Interpretation
5778-6	LOINC	Color of Urine	YELLOW	6/22/2015	YELLOW	N - Normal
5767-9	LOINC	Appearance of Urine	CLEAR	6/22/2015	CLEAR	N - Normal
5811-5	LOINC	Specific gravity of Urine by Test strip	1.015	6/22/2015	1.005 – 1.030	N - Normal
5803-2	LOINC	pH of Urine by Test strip	Value=5.0 units=[pH]	6/22/2015	5.0-8.0	N - Normal
5792-7	LOINC	Glucose [Mass/volume] in urine by test strip	Value=50 units=mg/dL	6/22/2015	Neg	L - Low
5797-6	LOINC	Ketones [Mass/Volume] in urine by test strip	Negative	6/22/2015	Negative	N - Normal
5804-0	LOINC	Protein[Mass/Volume] in urine by test strip	Value=100 units=mg/dL	6/22/2015		

Specimen Information for the 6/22/2015 Urinalysis Panel (24357-6):

Specimen Code	Specimen Code System	Specimen [Display Name]	Specimen Collection Body Site Code	Specimen Collection Body Site Code System	[Specimen Collection Body Site Display Name]
122575003	SNOMED CT	Urine Specimen (specimen)	827038004	SNOMED CT	Normal External Genitalia

Note: Specimen Identifier can be generated by the Vendor and the validator will only validate for the presence.

Specimen Condition for the 6/22/2015 Urinalysis Panel (24357-6):

Specimen Condition Code	Specimen Condition Code System	Specimen Condition [Display Name]
125152006	SNOMED CT	Specimen satisfactory for evaluation

- L) Clinical Tests and Clinical Result (**Visual Inspection** – ATL’s need to visually inspect the System Under Test (SUT) generated C-CDA for the text content, the validator will validate the presence of the notes section and entry. Only the text content needs to be visually inspected.)

Note: Clinical Results may be just text or PDF attachments and hence it may not be represented as a structured value. This has to be validated by visual inspection.

Test Code	Code System	[Test Name]	Date	[Result]
44975-1	LOINC	EKG	6/22/2015	0.4 seconds

- M) USCDI Data Class/Element: Unique Device Identifiers for a Patient’s Implantable Device(s)

Note: Device Code is provided for context, vendors may or may not choose to include this as part of the C-CDA entries. Also the implantable device identified below was introduced as part of the procedure documented in the procedure section namely “Introduction of cardiac pacemaker system via vein”.

UDI	Assigning Authority	[Device Code]	[Scoping Entity]
(01)00643169007222(17)160128(21)BLC200461H	FDA	704708004 - Cardiac resynchronization therapy implantable pacemaker, CodeSystem – SNOMED-CT	FDA

- N) USCDI Data Class/Element: Assessment and Plan of Treatment:

- a. **Assessment (Visual Inspection** – ATL’s need to visually inspect the System Under Test (SUT) generated C-CDA for the below narrative content)
 - i. The patient was found to have fever and Dr Davis is suspecting Anemia based on the patient history. So Dr Davis asked the patient to closely monitor the temperature and blood pressure and get admitted to Community Health Hospitals if the fever does not subside within a day.

- b. **Plan of Treatment (Visual Inspection)**– ATL’s need to visually inspect the System Under Test (SUT) generated C-CDA for the below narrative content)
- Get an EKG done on 6/23/2015.
 - Get a Chest X-ray done on 6/23/2015 showing the Lower Respiratory Tract Structure.
 - Take Clindamycin 300mg three times a day as needed if pain does not subside/
 - Schedule follow on visit with Neighborhood Physicians Practice on 7/1/2015.

O) SDOH Assessment

The following is a social history assessment on hunger vital signs. This has to be represented using the Assessment Scale Observation within the Social History section.

Assessment Code	Code System	[Display Name]	Status and Date	Value of the Assessment
88121-9	LOINC	Hunger Vital Signs	Completed on 6/22/2015	2 (Integer)
Assessment Questions to be represented as Assessment Scale Supporting Observation				
88122-7	LOINC	(I/We) worried whether (my/our) food would run out before (I/we) got money to buy more	Completed on 6/22/2015	LA28397-0 (LOINC code - Often true)
88123-5	LOINC	Within the past 12Mo the food we bought just didn't last and we didn't have money to get more	Completed on 6/22/2015	LA28397-0 (LOINC code - Often true)

P) SDOH Intervention

This information is to be represented as a Planned Procedure in the Plan of Treatment section.

Intervention Code	Code System	[Display Name]	Proposed Date
467771000124109	SNOMED-CT	Assistance with application for food pantry program	Authored on 6/22/2015 to be acted on 6/23/2015

- Q) USCDI Data Class/Element: Goals (**Visual Inspection** – ATL’s need to visually inspect the System Under Test (SUT) generated C-CDA for the below narrative content)
- a. Get rid of intermittent fever that is occurring every few weeks.
 - b. Need to gain more energy to do regular activities

R) SDOH Goal

The data presented in the table has to be represented as a Goal Observation.

Goal Code	Code System	[Display Name]	Achieve By Date
161036002	SNOMED-CT	Housing Adequate (finding)	8/31/2015

- S) USCDI Data Class/Element: HealthConcerns (**Visual Inspection** – ATL’s need to visually inspect the System Under Test (SUT) generated C-CDA for the below narrative content)
- a. Chronic Sickness exhibited by patient
 - b. HealthCare Concerns refer to underlying clinical facts
 - i. Documented HyperTension problem
 - ii. Documented HypoThyroidism problem
 - iii. Watch Weight of patient

T) SDOH Health Concern

This data has to be represented in the Health Concerns Section using the Health Concern Act wrapping a Problem Observation.

Health Concern Data:

Code	CodeSystem	[Health Concern Name]	[Timing Information]	Concern Status
75310-3	LOINC	Health Concern	6/22/2015	Active

Problem Observation Data:

Code	CodeSystem	[Problem Name]	[Timing Information]	Concern Status
733423003	SNOMED-CT	Food insecurity	6/22/2015	Active

U) Reason For Referral:

Referral Code	CodeSystem	Timing Information	Referral Status	Indication Code For Referral
310449005	SNOMED-CT	6/22/2015	Active	Problem Observation data related to Fever in Problems Section

Ms Alice Newman is being referred to Community Health Hospitals Inpatient facility because of the high fever noticed and suspected Anemia.

V) Functional Status (The below observation is to be represented as a Functional Status Observation)

Functional Condition	Code	Code System	Date
Dependence on Cane	105504002	SNOMED-CT	5/1/2005

W) Disability Status (The below observation is to be represented as Disability Observation in Functional Status Section)

CUBS Disability Status Answer	Code	Code System	Date
I'm Vulnerable - I sometimes or periodically have acute or chronic symptoms affecting housing, employment, social interactions, etc.	LA29243-5	LOINC	6/22/2015

The below data has to be represented as an Assessment Scale Observation associated with the Disability Status observation identified above.

Disability Assessment Answer	Assessment Question Code	Assessment Questions Code System	Date
Code - LA33-6, CodeSystem – LOINC, Display - YES	69859-7 Display - (Do you have serious difficulty walking or climbing stairs?))	LOINC	6/22/2015

X) Substance Use

The following is a social history assessment on Substance Use. This MUST be represented using the Assessment Scale Observation within the Social History section.

Assessment Code	Code System	[Display Name]	Status and Date	Value of the Assessment
82666-9	LOINC	Drug Abuse Screening Test-10[DAST-10]	Completed on 6/22/2015	3 (Moderate Level)
Assessment Questions to be represented as Assessment Scale Supporting Observation				
68525-5	LOINC	Have you used drugs other than those required for medical reasons?	Completed on 6/22/2015	Yes (LOINC code LA33-6)
68528-9	LOINC	Have you had “blackouts” or “flashbacks” as a result of drug use?	Completed on 6/22/2015	No (LOINC code LA 32-8)

Y) Alcohol Use

The following is a social history assessment on Alcohol Use. This has to be represented using the Assessment Scale Observation within the Social History section.

Assessment Code	Code System	[Display Name]	Status and Date	Value of the Assessment
72109-2	LOINC	Alcohol Use Disorder Identification Test - Consumption [AUDIT-C]	Completed on 6/22/2015	2
Assessment Questions to be represented as Assessment Scale Supporting Observation				
68518-0	LOINC	How often do you have a drink containing alcohol?	Completed on 6/22/2015	2-4 times a month (LOINC code LA18927-6)
68520-6	LOINC	How often do you have 6 or more drinks on 1 occasion?	Completed on 6/22/2015	Never (LOINC code LA6270-8)

Z) Physical Activity Assessment

The following is a social history assessment on Physical Activity. This has to be represented using the Assessment Scale Observation within the Social History section.

Assessment Code	Code System	[Display Name]	Status and Date	Value of the Assessment
77582-5	LOINC	International Physical Activity Questionnaire Self-Administered Short Form [IPAQ]	Completed on 6/22/2015	Moderate (LOINC code = LA6751-7)
Assessment Questions to be represented as Assessment Scale Supporting Observation				
88393-4	LOINC	During the last 7 days, on how many days did you walk for at least 10 minutes at a time to go from place to place [IPAQ]	Completed on 6/22/2015	4 days/week Value =4 UCUM units (d/wk)

AA) Mental Status (To be represented as a Mental Status Observation)

Mental Status Observation	Code	Code System	Date
Amnesia	48167000	SNOMED-CT	5/1/2005

BB) Basic Occupation and Occupation Industry (These data elements are to be represented as Basic Occupation and Basic Occupation Industry Observations)

USCDI Data Elements	Code	Code System	Date
Basic Occupation	37-2011.00.028742 [Display Name: (Odd Jobs Day Worker [Janitors and Cleaners, Except Maids and Housekeeping])]	2.16.840.1.114222.4.5.327	6/22/2015
Basic Occupation Industry	561720.002294 [Display Name: (Building cleaning services, interior [Janitorial Services])]	2.16.840.1.114222.4.5.327	6/22/2015

CC) Tribal Affiliation (This data element has to be represented as a Tribal Affiliation Observation)

USCDI Data Elements	Details	Code System	Date
Tribal Affiliation	65 [Display Name: (Coquille Indian Tribe)]	2.16.840.1.113883.5.140	6/22/2015

DD) Pregnancy Status

USCDI Data Elements	Details	Code System	Date
Pregnancy Status	60001007 [Display Name: (Not Pregnant)]	SNOMED CT	6/22/2015

EE) Health Insurance Information

USCDI Data Elements	Start Date
Coverage Status	1/1/2015

USCDI Data Elements	Code	Code System	Translation Code	Translation Code System
Coverage Type	PR	Insurance Type Code (OID: 2.16.840.1.113883.6.255.1336)	72	Source of Payment Typology, OID: 2.16.840.1.113883.3.221.5

USCDI Data Elements	Code	Code System	[Display Name]
Relationship To Subscriber	FAMDEP	HL7RoleCode (OID: oid:2.16.840.1.113883.5.111)	Family dependent

USCDI Data Element	Value
Member Identifier	88800933502
Subscriber Identifier	888009335
Group Identifier	Root - 2.16.840.1.113883.19 Extension – Acme Gold Plan
Payer Identifier and Other information	Payer Identifier: Root - 2.16.840.1.113883.19 Payer Name: Example Payer Organization Address: 1234 Insurance Road City: Blue Bell State: MA Country : US Telecom: (555)555-1515

FF) USCDI Data Class/Element: Clinical Notes (**Visual Inspection** – ATL’s need to visually inspect the System Under Test (SUT) generated C-CDA for the text content, the validator will validate the presence of the notes section and entry. Only the text content needs to be visually inspected.)

T.1 Progress Note Narrative:

Ms Alice Newman seems to be developing high fever and hence we recommend her to get admitted to a nearby hospital using the provided referral.

GG) Treatment Intervention Preference

Details	Code System	Date	Value (String or ED)
75773-2 [Display Name: (Goals, preferences, and priorities for medical treatment [Reported])]	LOINC	6/22/2015	If I am in chest pain or breathlessness, please contact my cardiologist "Mr Cardio Specialist" at "Happy Cardiologists" before treating.

HH) Care Experience Preference

Details	Code System	Date	Value (String or ED)
95541-9 [Display Name: (Care experience preference)]	LOINC	6/22/2015	For any heart related procedure, I would like to speak my cardiologist friend "Mr Cardio Specialist" at "Happy Cardiologists" before the procedure.