

## Test Procedure for §170.306 (f) Exchange Clinical Information and Summary Record

This document describes the test procedure for evaluating conformance of complete EHRs or EHR modules<sup>1</sup> to the certification criteria defined in 45 CFR Part 170 Subpart C of the Final Rule for Health Information Technology: Initial Set of standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology as published in the Federal Register on July 28, 2010. The document<sup>2</sup> is organized by test procedure and derived test requirements with traceability to the normative certification criteria as described in the Overview document located at [http://healthcare.nist.gov/docs/TestProcedureOverview\\_v1.pdf](http://healthcare.nist.gov/docs/TestProcedureOverview_v1.pdf). The test procedures may be updated to reflect on-going feedback received during the certification activities.

The HHS/Office of the National Coordinator for Health Information Technology (ONC) has defined the standards, implementation guides and certification criteria used in this test procedure. Applicability and interpretation of the standards, implementation guides and certification criteria to EHR technology is determined by ONC. Test procedures to evaluate conformance of EHR technology to ONC's requirements are defined by NIST. Testing of EHR technology is carried out by ONC-Authorized Testing and Certification Bodies (ATCBs), not NIST, as set forth in the final rule establishing the Temporary Certification Program (*Establishment of the Temporary Certification Program for Health Information Technology, 45 CFR Part 170; June 24, 2010.*)

Questions about the applicability of the standards, implementation guides or criteria should be directed to ONC at [ONC.Certification@hhs.gov](mailto:ONC.Certification@hhs.gov). Questions about the test procedures should be directed to NIST at [hit-tst-fdbk@nist.gov](mailto:hit-tst-fdbk@nist.gov). Note that NIST will automatically forward to ONC any questions regarding the applicability of the standards, implementation guides or criteria. Questions about functions and activities of the ATCBs should be directed to ONC at [ONC.Certification@hhs.gov](mailto:ONC.Certification@hhs.gov).

### CERTIFICATION CRITERIA

This Certification Criterion is from the Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology Final Rule issued by the Department of Health and Human Services (HHS) on July 28, 2010.

§170.306 (f) Exchange clinical information and patient summary record.

- (1) Electronically receive and display. Electronically receive and display a patient's summary record from other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, and procedures in accordance with the

---

<sup>1</sup> Department of Health and Human Services, 45 CFR Part 170 Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, Final Rule, July 28, 2010.

<sup>2</sup> Disclaimer: Certain commercial products are identified in this document. Such identification does not imply recommendation or endorsement by the National Institute of Standards and Technology.

- standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2). Upon receipt of a patient summary record formatted in the alternative standard, display it in human readable format.
- (2) Electronically transmit. Enable a user to electronically transmit a patient's summary record to other providers and organizations including, at a minimum, diagnostic results, problem list, medication list, medication allergy list, and procedures in accordance with:
- (i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and
  - (ii) For the following data elements the applicable standard must be used:
    - (A) Problems. The standard specified in §170.207(a)(1) or, at a minimum, the version of the standard specified in §170.207(a)(2);
    - (B) Procedures. The standard specified in §170.207(b)(1) or §170.207(b)(2);
    - (C) Laboratory test results. At a minimum, the version of the standard specified in §170.207(c); and
    - (D) Medications. The standard specified in §170.207(d).

Per Section III.D of the preamble of the Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, Final Rule where the exchange clinical information and patient summary record certification criterion is discussed:

- “Overall this certification criterion is very similar to the certification criterion applicable to Complete EHRs and EHR Modules designed for an ambulatory setting. As a result, our responses and subsequent changes to the certification criterion above are also applicable to this certification criterion.”
- “To provide guidance and clarification to the industry, we will recognize any source vocabulary that is identified by NLM's RxNorm Documentation as a source vocabulary included in RxNorm. We are therefore revising the standard to state: “Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.” We note that in section 3.1, of the most recent release of the “RxNorm Documentation (06/07/10, Version 2010-3),” NLM has identified the following source vocabularies as being included in RxNorm.
  - GS - Gold Standard Alchemy
  - MDDB - Medi-Span Master Drug Data Base
  - MMSL - Multum MediSource Lexicon
  - MMX - Micromedex DRUGDEX
  - MSH - Medical Subject Headings (MeSH)
  - MTHFDA - FDA National Drug Code Directory
  - MTHSPL - FDA Structured Product Labels
  - NDDF - First DataBank NDDF Plus Source Vocabulary
  - NDFRT - Veterans Health Administration National Drug File - Reference Terminology
  - SNOMED CT - SNOMED Clinical Terms (drug information)
  - VANDF - Veterans Health Administration National Drug File

## INFORMATIVE TEST DESCRIPTION

This section provides an informative description of how the test procedure is organized and conducted. It is not intended to provide normative statements of the certification requirements.

This test evaluates the capability for a Complete EHR or EHR Module to receive, display, generate and transmit patient summary records including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, and procedures in the formats and vocabularies specified by the referenced standards. Per the FR criterion, the test procedure does not evaluate the capability to send and receive other types of patient information in the patient summary record. Since transport standards are not specified, the transmission portion of the test focuses on the ability to 1) generate a patient summary record and transfer it to an external conformance testing tool for verification of the patient summary instance, and 2) verify the ability to transmit the patient summary record using the transport technology defined by the Vendor.

The Vendor provides part of the test data and NIST provides part of the test data for this test procedure.

The test procedure is organized into two sections:

- Receive and Display - evaluates the capability to receive and display (render) a patient summary record in the EHR when received in HL7 CCD format and when received in ASTM CCR format. The patient summary record includes diagnostic test results, problem list, medication list, medication allergy list, and procedures. Included in the test procedure is an evaluation of the capability of the EHR to display (render) in human readable format the received patient summary record that is formatted in the alternative standard
  - The Tester sends to the EHR the Vendor-supplied test data and/or NIST-supplied test data/examples for diagnostic test results, problem list, medication list, medication allergy list, and procedures in HL7 CCD format
  - Using Vendor-identified EHR functions, the Tester displays the received CCD test data and validates that the rendered data is complete and presented in human readable format
  - The Tester sends to the EHR the Vendor-supplied test data and/or NIST-supplied test data/examples for diagnostic test results, problem list, medication list, medication allergy list, and procedures formatted in ASTM CCR format
  - Using Vendor-identified EHR functions, the Tester displays the received CCR test data and validates that the rendered data is complete and presented in human readable format
- Generate and Transmit – evaluates the capability to generate and transmit a patient summary record from the EHR in either HL7 CCD or ASTM CCR format as selected by the Vendor. The patient summary record includes diagnostic test results, problem list, medication list, medication allergy list, and procedures. Included in the test procedure is an evaluation of the capability to use specified vocabularies as defined by the referenced standards

- Using Vendor-identified functions, the Tester enters the Vendor-supplied test data and/or NIST-supplied test data/examples for diagnostic test results, problem list, medication list, medication allergy list, and procedures into the EHR
- The Tester generates the Patient Summary Record in the format selected by the Vendor (either HL7 CCD or ASTM CCR) and transfers it from the EHR to a NIST conformance test tool
- Using Vendor-identified functions, the Tester transmits the Patient Summary Record to a receiving system (either a Tester's receiving system or a Vendor-identified system) using the Vendor-identified transport technology of the EHR. This may require configuration on the part of the Tester's receiving system
- The Tester validates that the generated patient summary record is complete and in conformance
- The Tester validates that the transmitted Patient Summary Record was transmitted by the EHR

For this portion of the test, the medications test data will be evaluated for vocabulary conformance to the medications source vocabulary identified by the Vendor as implemented in the EHR. This may require a manual inspection of the test data in the patient summary record instance.

## REFERENCED STANDARDS

### §170.205 Content exchange and implementation specifications for exchanging electronic health information.

#### Regulatory Referenced Standard

The Secretary adopts the following content exchange standards and associated implementation specifications:

#### (a) Patient Summary Record.

(1) Standard. Health Level Seven Clinical Document Architecture (CDA) Release 2, Continuity of Care Document (CCD) (incorporated by reference in §170.299). Implementation specifications. The Healthcare Information Technology Standards Panel (HITSP) Summary Documents Using HL7 CCD Component HITSP/C32 (incorporated by reference in §170.299).

(2) Standard. ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369 (incorporated by reference in §170.299).

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

#### Regulatory Referenced Standard

The Secretary adopts the following code sets, terminology, and nomenclature as the vocabulary standards for the purpose of representing electronic health information:

#### (a) Problems

§170.207 Vocabulary standards for representing electronic health information.	Regulatory Referenced Standard
<p>(1) <u>Standard</u>. The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions.</p>	<p>45 CFR 162.1002(a)(1).            (1) <i>International Classification of Diseases, 9th Edition, Clinical Modification, (ICD–9–CM), Volumes 1 and 2</i> (including The Official ICD–9–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.</p>
<p>(2) <u>Standard</u>. International Health Terminology Standards Development Organization (IHTSDO) Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) July 2009 version (incorporated by reference in §170.299).</p>	
<p>(b) <u>Procedures</u>.</p>	
<p>(1) <u>Standard</u>. The code set specified at 45 CFR 162.1002(a)(2).</p>	<p>45 CFR 162.1002(a)(2).            (2) <i>International Classification of Diseases, 9th Edition, Clinical Modification, Volume 3 Procedures</i> (including The Official ICD–9–CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients reported by hospitals:            (i) Prevention.            (ii) Diagnosis.            (iii) Treatment.            (iv) Management.</p>
<p>(2) <u>Standard</u>. The code set specified at 45 CFR 162.1002(a)(5).</p>	<p>45 CFR 162.1002(a)(5).            (5) The combination of <i>Health Care Financing Administration Common Procedure Coding System (HCPCS)</i>, as maintained and distributed by HHS, and <i>Current Procedural Terminology, Fourth Edition (CPT–4)</i>, as maintained and distributed by the American Medical Association, for physician services and other health care services. These services include, but are not limited to, the following:            (i) Physician services.            (ii) Physical and occupational therapy services.            (iii) Radiologic procedures.            (iv) Clinical laboratory tests.            (v) Other medical diagnostic procedures.            (vi) Hearing and vision services.            (vii) Transportation services including ambulance.</p>
<p>(c) <u>Laboratory test results</u></p>	
<p><u>Standard</u>. Logical Observation Identifiers Names and Codes (LOINC®) version 2.27, when such codes were received within an electronic transaction from a laboratory (incorporated by reference in §170.299).</p>	
<p>(d) <u>Medications</u></p>	

§170.207 Vocabulary standards for representing electronic health information.	Regulatory Referenced Standard
<p><u>Standard.</u> Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.</p>	<p>As of 6/10/2010 the following source vocabularies are listed by NLM:                      GS Gold Standard Alchemy                      MDDB Medi-Span Master Drug Data Base                      MMSL Multum MediSource Lexicon                      MMX Micromedex DRUGDEX                      MSH Medical Subject Headings (MeSH)                      MTHFDA FDA National Drug Code Directory                      MTHSPL FDA Structured Product Labels                      NDDF First DataBank NDDF Plus Source Vocabulary                      NDFRT Veterans Health Administration National Drug File - Reference Terminology                      SNOMED CT SNOMED Clinical Terms (drug information)                      VANDF Veterans Health Administration National Drug File</p>

## NORMATIVE TEST PROCEDURES

### Derived Test Requirements

- DTR170.306.f.1 – 1: Electronically Receive and Display HL7 CCD Patient Summary Record
- DTR170.306.f.1 – 2: Electronically Receive and Display ASTM CCR Patient Summary Record
- DTR170.306.f.2 – 1: Electronically Generate and Transmit HL7 CCD or ASTM CCR Patient Summary Record

### **DTR170.306.f.1 – 1: Electronically Receive and Display HL7 CCD Patient Summary Record**

#### Required Vendor Information

- VE170.306.f.1 – 1.01: Vendor shall provide communications configuration information and patient identifiers necessary to send test patient summary records in HL7 CCD format to the EHR
- VE170.306.f.1 – 1.02: Vendor shall identify the EHR function(s) that are available to view an HL7 CCD formatted patient summary record in human readable format when received from an external source

#### Required Test Procedure

- TE170.306.f.1 – 1.01: Tester shall select one test data set from TD170.306.f.
- TE170.306.f.1 – 1.02: Tester shall select patient summary record data from Vendor-supplied test data and/or NIST-supplied test data/examples for the selected data set in TD170.306.f.
- TE170.306.f.1 – 1.03: Using the Vendor-supplied test data and/or NIST-supplied test data/examples, Tester shall send the patient summary to the EHR
- TE170.306.f.1 – 1.04: Using the EHR function(s) identified by the Vendor and the NIST-supplied Inspection Test Guide, the Tester shall display and verify that the patient summary record test data are received in the EHR, including
  - Diagnostic test results

- Problem list
- Medication list
- Medication allergy list
- Procedure list

### Inspection Test Guide

IN170.306.f.1 – 1.01: Using the Vendor-supplied test data and/or the NIST-supplied test data/examples in the TD170.306.f data set selected by the Tester, Tester shall verify that the received patient summary record test data are complete, correct and viewable in the EHR in human readable format, including

- Diagnostic test results
- Problem list
- Medication list
- Medication allergy list
- Procedure list

### **DTR170.306.f.1 – 2: Electronically Receive and Display ASTM CCR Patient Summary Record**

#### Required Vendor Information

VE170.306.f.1 – 2.01: Vendor shall provide communications configuration information and patient identifiers necessary to send test patient summary records in ASTM CCR format to the EHR

VE170.306.f.1 – 2.02: Vendor shall identify the EHR function(s) that are available to view an ASTM CCR formatted patient summary record in human readable format when received from an external source

#### Required Test Procedure

TE170.306.f.1 – 2.01: Tester shall select one test data set from TD170.306.f.

TE170.306.f.1 – 2.02: Tester shall select patient summary record data from Vendor-supplied test data and/or NIST-supplied test data/examples for the selected data set in TD170.306.f

TE170.306.f.1 – 2.03: Using the Vendor-supplied test data and/or NIST-supplied test data/examples, Tester shall send the patient summary record in ASTM CCR format to the EHR

TE170.306.f.1 – 2.04: Using the EHR function(s) identified by the Vendor and the NIST-supplied Inspection Test Guide, the Tester shall display and verify that the patient summary record test data are received in the EHR, including

- Diagnostic test results
- Problem list
- Medication list
- Medication allergy list
- Procedure list

### Inspection Test Guide

IN170.306.f.1 – 2.01: Using the Vendor-supplied test data and/or the NIST-supplied test data/examples in the TD170.306.f data set selected by the Tester, Tester shall verify that the received patient summary record test data are complete, correct and viewable in the EHR in human readable format, including

- Diagnostic test results
- Problem list
- Medication list
- Medication allergy list
- Procedure list

### **DTR170.306.f.2 – 1: Electronically Generate and Transmit HL7 CCD or ASTM CCR Patient Summary Record**

#### Required Vendor Information

VE170.306.f.2 – 1.01: Vendor shall identify the standard format they will use for this test (CCD or CCR)

VE170.306.f.2 – 1.02: Vendor shall identify a patient with an existing record in the EHR to be used for this test

VE170.306.f.2 – 1.03: Vendor shall identify the EHR function(s) available to 1) select the patient, 2) enter patient summary record data into the EHR, 3) send the patient summary record data from the EHR to an external system

VE170.306.f.2 – 1.04: Vendor shall identify the medications source vocabulary implemented within the EHR

#### Required Test Procedures

TE170.306.f.2 – 1.01: Tester shall select one test data set from TD170.306.f.

TE170.306.f.2 – 1.02: Tester shall select patient summary record test data from Vendor-supplied test data and/or NIST-supplied test data/examples for the selected data set in TD170.306.f

TE170.306.f.2 – 1.03: Using the Vendor-supplied test data and/or NIST-supplied test data/examples and the EHR function(s) identified by the Vendor, the Tester shall select the patient's existing record and enter the patient summary record test data

TE170.306.f.2 – 1.04: Using the EHR function(s) identified by the Vendor, the Tester shall send the patient summary record in the vendor-selected format to a NIST-supplied test tool as described in the Conformance Test Tools section of this test procedure

TE170.306.f.2 – 1.05: Using the NIST-supplied test tool and the NIST-supplied Inspection Test Guide, the Tester shall verify that the patient summary record test data are transmitted correctly and without omission by the EHR, including

- Diagnostic test results
- Problem list
- Medication list
- Medication allergy list
- Procedure list

TE170.306.f.2 – 1.06: Using the EHR function(s) identified by the Vendor, the Tester shall transmit the Patient Summary Record to an external receiving system using the Vendor-identified transport technology of the EHR. The receiving system may either be a Tester's receiving system that is configurable to use the transport technology of the EHR system or module, or a Vendor-identified system capable of receiving from the EHR system or module

### Inspection Test Guide

IN170.306.f.2 – 1.01: Using the Vendor-supplied test data and/or the NIST-supplied test data/examples in the TD170.306.f data set selected by the Tester, Tester shall verify that the patient summary record test data are entered into the EHR correctly and without omission

IN170.306.f.2 – 1.02: Using the Vendor-supplied test data and/or the NIST-supplied test data/examples in the TD170.306.f data set selected by the Tester, Tester shall verify that all of the patient summary record test data are stored in the patient's record, including

- Diagnostic test results
- Problems
- Medications
- Medication allergies
- Procedures

IN170.306.f.2 – 1.03: Tester shall verify that the patient summary record test data are sent to the NIST-supplied test tool by the EHR, including

- Diagnostic test results
- Problems
- Medications
- Medication allergies
- Procedures

IN170.306.f.2 – 1.04: Using the NIST-supplied conformance testing tool identified in the Conformance Test Tools section of this test procedure, Tester shall verify that the patient summary record test data transmitted to the NIST-supplied test tool are complete and correct, and that the received test data are conformant to the referenced content (CCD or CCR) and vocabulary standards. The Tester shall verify that the medications source vocabulary values map correctly to the RxNorm values supplied in the TD170.306.f data set selected by the Tester. The vocabulary verification may require manual inspection of the data

IN170.306.f.2 – 1.05: Tester shall verify that the transmitted Patient Summary Record was received by the external receiving system based on the transport technology and configuration necessary to communicate with the EHRs systems

## TEST DATA

This Test Procedure requires the vendor to supply part of the test data. The Tester shall address the following:

- Vendor-supplied test data shall ensure that the functional and interoperable requirements identified in the criterion can be adequately evaluated for conformance
- Vendor-supplied test data shall strictly focus on meeting the basic capabilities required of an EHR relative to the certification criterion rather than exercising the full breadth/depth of capability that an installed EHR might be expected to support
- Tester shall record as part of the test documentation the specific Vendor-supplied test data that was utilized for testing

Part of the test data is provided by NIST for this Test Procedure to ensure that the functional and interoperable requirements identified in the criteria can be adequately evaluated for conformance, as well as to provide consistency in the testing process across multiple ONC-Authorized Testing and Certification Bodies (ATCBs). The NIST-supplied test data focus on evaluating the basic capabilities required of EHR technology, rather than exercising the full breadth/depth of capability that an installed EHR might be expected to support. The test data is formatted for readability of use within the testing process. The format is not prescribing a particular end-user view or rendering. No additional requirements should be drawn from the format.

The Tester shall use and apply the NIST-supplied test data during the test, without exception, unless one of the following conditions exists:

- The Tester determines that the Vendor product is sufficiently specialized that the NIST-supplied test data needs to be modified in order to conduct an adequate test. Having made the determination that some modification to the NIST-supplied test data is necessary, the Tester shall record the modifications made as part of the test documentation.
- The Tester determines that changes to the test data will improve the efficiency of the testing process; primarily through using consistent demographic data throughout the testing workflow. The Tester shall ensure that the functional and interoperable requirements identified in the criterion can be adequately evaluated for conformance and that the test data provides a comparable level of robustness.

Any departure from the NIST-supplied test data shall strictly focus on meeting the basic capabilities required of EHR technology relative to the certification criterion rather than full breadth/depth of capability that installed EHR technology might be expected to support.

The Test Procedures require that the Tester enter the test data into the EHR being evaluated for conformance. The intent is that the Tester fully controls the process of entering the test data in order to ensure that the data are correctly entered as specified in the test procedure. If a situation arises where it is impractical for a Tester to directly enter the test data, the Tester, at their discretion, may instruct the Vendor to enter the test data, so long as the Tester remains in full control of the testing process, directly observes the test data being entered by the Vendor, and validates that the test data are entered correctly as specified in the test procedure.

This material contains content from LOINC® (<http://loinc.org>). The LOINC table and LOINC codes are copyright © 1995-2010, Regenstrief Institute, Inc. and the Logical Observation Identifiers Names and Codes (LOINC) Committee.

**TD170.306.f.: Exchange clinical information and patient summary record**

<Information Source> is the author for the entire document and is required in HITSP/C32. Individual entries (e.g., Medications, Allergies) may also have authors, but are not required to have them. If an individual entry does not have a specific author, the author of the entire document is assumed to be the author.

Patient Summary Record - Data Set #1

<Information Source> for all data for this patient: Vendor-supplied (e.g., Fatima Goyal, MD)

**Patient**

Name	Date of Birth	Gender	Identification Number	Identification Number Type	Address/Phone
Vendor-supplied (e.g., Ann Toliver)	Vendor-supplied (e.g., 07/16/1950)	Vendor-supplied (e.g., Female)	Vendor-supplied (e.g., 989285998)	Vendor-supplied (e.g., Medical Record Number)	Vendor-supplied (e.g., 353 Wine Street Flint, Michigan 48503 810-673-8378)

**Problem List**

ICD-9 Code	Patient Problem	Status	Date Diagnosed
428.0	Congestive Heart Failure	Vendor-supplied (e.g., Active)	Vendor-supplied (e.g.,02/22/2010)
410.90	Acute Myocardial Infarction	Vendor-supplied (e.g., Resolved)	Vendor-supplied (e.g.,09/16/2007)

SNOMED Code	Patient Problem	Status	Date Diagnosed
42343007	Congestive Heart Failure	Vendor-supplied (e.g., Active)	Vendor-supplied (e.g.,02/22/2010)
57054005	Acute Myocardial Infarction	Vendor-supplied (e.g., Resolved)	Vendor-supplied (e.g.,09/16/2007)

**Medication List** (Use RxNorm code or the Vendor-supplied code that is mapped to the RxNorm code listed in the test data; generic and brand names for medications are provided to allow for specific configuration of the individual EHRs)

RxNorm Code	Product	Generic Name	Brand Name	Strength	Dose	Route	Frequency	Date Started	Status
201372	Medication	captopril	Capoten	25 mg	Vendor-supplied (e.g., 1 Tablet)	PO	Vendor-supplied (e.g., TID)	Vendor-supplied (e.g., 02/25/2010)	Vendor-supplied (e.g., Active)
200820	Medication	spironolactone	Aldactone	25 mg	Vendor-supplied (e.g., 1 Tablet)	PO	Vendor-supplied (e.g., QID)	Vendor-supplied (e.g., 02/25/2010)	Vendor-supplied (e.g., Active)
309888	Medication	digoxin	Lanoxin	125 mcg	Vendor-supplied (e.g., 1 Tablet)	PO	Vendor-supplied (e.g., Q Day)	Vendor-supplied (e.g., 02/25/2010)	Vendor-supplied (e.g., Active)
628958	Medication	potassium chloride	Klor-Con	10 mEq	Vendor-supplied (e.g., 1 Tablet)	PO	Vendor-supplied (e.g., BID)	Vendor-supplied (e.g., 02/25/2010)	Vendor-supplied (e.g., Active)

**Medication Allergy List** (The SNOMED Allergy Type Code is required by HITSP/C83, which is a component of the HITSP/C32 implementation guide specified by ONC in the Final Rule)

SNOMED Allergy Type Code	Medication/Agent Allergy	Reaction	Adverse Event Date
416098002 -- Drug Allergy (disorder)	Vendor-supplied (including medication/agent allergy and associated RxNorm code)	Vendor-supplied (e.g., Wheezing)	Vendor-supplied (e.g., 03/02/2007)

**Diagnostic Test Results** (Vendor may provide test results as test panel)

LOINC Code	Test	Result	Abnormal Flag	Date Performed
2951-2	Sodium	136 mEq/L	Vendor-supplied (e.g., normal)	Vendor-supplied (e.g., 02/24/2010)
2823-3	Potassium	4.2 mEq/L	Vendor-supplied (e.g., normal)	Vendor-supplied (e.g., 02/24/2010)
2075-0	Chloride	98 mEq/L	Vendor-supplied (e.g., normal)	Vendor-supplied (e.g., 02/24/2010)
2951-2	Sodium	128 mEq/L	Vendor-supplied (e.g., below normal)	Vendor-supplied (e.g., 02/22/2010)
2823-3	Potassium	3.2 mEq/L	Vendor-supplied	Vendor-supplied

LOINC Code	Test	Result	Abnormal Flag	Date Performed
			(e.g., below normal)	(e.g., 02/22/2010)
2075-0	Chloride	96 mEq/L	Vendor-supplied (e.g., below normal)	Vendor-supplied (e.g., 02/22/2010)

**Procedure List**

ICD-9 Code	Procedure	Status	Date Performed
00.66	Percutaneous transluminal coronary angioplasty	Vendor-supplied (e.g., Completed)	Vendor-supplied (e.g., 09/17/2007)
37.21	Cardiac catheterization	Vendor-supplied (e.g., Completed)	Vendor-supplied (e.g., 10/01/2006)

CPT Code	Procedure	Status	Date Performed
92982	Percutaneous transluminal coronary angioplasty	Vendor-supplied (e.g., Completed)	Vendor-supplied (e.g., 09/17/2007)
93501	Cardiac catheterization	Vendor-supplied (e.g., Completed)	Vendor-supplied (e.g., 10/01/2006)

Patient Summary Record - Data Set #2

<Information Source> for all data for this patient: Vendor-supplied (e.g., Jackson Shoals, MD)

**Patient**

Name	Date of Birth	Gender	Identification Number	Identification Number Type	Address/Phone
Vendor-supplied  (e.g., Ruth Warholde)	Vendor-supplied  (e.g., 05/20/1954)	Vendor-supplied  (e.g., Female)	Vendor-supplied  (e.g., 9836469798)	Vendor-supplied  (e.g., Medical Record Number)	Vendor-supplied  (e.g., 225 Park Street Morton, Illinois 61550 309-354-9385)

**Problem List**

ICD-9 Code	Patient Problem	Status	Date Diagnosed
434.91	Cerebrovascular Accident (Stroke)	Vendor-supplied (e.g., Resolved)	Vendor-supplied (e.g., 07/09/2009)

ICD-9 Code	Patient Problem	Status	Date Diagnosed
496.0	Chronic Obstructive Pulmonary Disease	Vendor-supplied (e.g., Chronic)	Vendor-supplied (e.g.,08/12/2007)
401.9	Hypertension, essential	Vendor-supplied (e.g., Chronic)	Vendor-supplied (e.g.,05/16/2006)

SNOMED Code	Patient Problem	Status	Date Diagnosed
230690007	Cerebrovascular Accident (Stroke)	Vendor-supplied (e.g., Resolved)	Vendor-supplied (e.g.,07/09/2009)
13645005	Chronic Obstructive Lung Disease	Vendor-supplied (e.g., Chronic)	Vendor-supplied (e.g.,08/12/2007)
59621000	Essential Hypertension	Vendor-supplied (e.g., Chronic)	Vendor-supplied (e.g.,05/16/2006)

**Medication List** (Use RxNorm code or the Vendor-supplied code that is mapped to the RxNorm code listed in the test data; generic and brand names for medications are provided to allow for specific configuration of the individual EHRs)

RxNorm Code	Product	Generic Name	Brand Name	Strength	Dose	Route	Frequency	Date Started	Status
205326	Medication	lisinopril	Zestril	30 mg	Vendor-supplied (e.g.,1 Tablet)	PO	Vendor-supplied (e.g., Q Day)	Vendor-supplied (e.g.,07/15/2009_	Vendor-supplied (e.g., Active)
213169	Medication	clopidogrel	Plavix	75 mg	Vendor-supplied (e.g.,1 Tablet)	PO	Vendor-supplied (e.g., Q Day)	Vendor-supplied (e.g.,07/15/2009)	Vendor-supplied (e.g., Active)
212549	Medication	amlodipine	Norvasc	5 mg	Vendor-supplied (e.g.,1 Tablet)	PO	Vendor-supplied (e.g., Q Day)	Vendor-supplied (e.g.,07/15/2009)	Vendor-supplied (e.g., Active)
836370	Medication	ipratropium bromide monhydrate	Atrovent inhaler	18 mcg/puff	Vendor-supplied (e.g.,2 puffs)	By oral inhalation	Vendor-supplied (e.g., QID)	Vendor-supplied (e.g.,08/14/2007)	Vendor-supplied (e.g., Active)

**Medication Allergy List** (The SNOMED Allergy Type Code is required by HITSP/C83, which is a component of the HITSP/C32 implementation guide specified by ONC in the Final Rule)

SNOMED Allergy Type Code	Medication/Agent Allergy	Reaction	Adverse Event Date
416098002 -- Drug Allergy (disorder)	Vendor-supplied (including medication/agent allergy and associated RxNorm code)	Vendor-supplied (e.g., Nausea, vomiting, rash, dizziness, headache)	Vendor-supplied (e.g., 03/25/2003)

**Diagnostic Test Results** (Vendor may provide test results as test panel)

LOINC Code	Test	Result	Abnormal Flag	Date Performed
718-7	Hemoglobin	14 g/dl	Vendor-supplied (e.g., normal)	Vendor-supplied (e.g., 02/17/2010)
4544-3	Hematocrit	40%	Vendor-supplied (e.g., normal)	Vendor-supplied (e.g., 02/17/2010)
2951-2	Sodium	138 mEq/L	Vendor-supplied (e.g., normal)	Vendor-supplied (e.g., 02/17/2010)
2823-3	Potassium	3.6 mEq/L	Vendor-supplied (e.g., normal)	Vendor-supplied (e.g., 02/17/2010)
630-4	Urine culture, routine	Negative: No growth	Vendor-supplied (e.g., normal)	Vendor-supplied (e.g., 10/02/2008)

**Procedure List**

ICD-9 Code	Procedure	Status	Date Performed
66.39	Bilateral tubal ligation	Vendor-supplied (e.g., Completed)	Vendor-supplied (e.g., 06/14/1990)

CPT Code	Procedure	Status	Date Performed
58600	Bilateral tubal ligation	Vendor-supplied (e.g., Completed)	Vendor-supplied (e.g., 06/14/1990)

Patient Summary Record - Data Set #3

<Information Source> for all data for this patient: Vendor-supplied (e.g., Louis Randolph, MD)

**Patient**

Name	Date of Birth	Gender	Identification Number	Identification Number Type	Address/Phone
Vendor-	Vendor-supplied	Vendor-	Vendor-supplied	Vendor-supplied	Vendor-supplied

supplied (e.g., Lorraine Blevins)	(e.g., 04/16/1957)	supplied (e.g., Female)	(e.g., 967385998)	(e.g., Medical Record Number)	(e.g., 1020 Stuart Street Morton, Illinois 61550 309-374-8938)
--------------------------------------	--------------------	----------------------------	-------------------	-------------------------------	--

**Problem List**

ICD-9 Code	Patient Problem	Status	Date Diagnosed
715.35	Right hip osteoarthritis	Vendor-supplied (e.g., Resolved)	Vendor-supplied (e.g., 02/12/2010)
414.01	Coronary Artery Disease (CAD)	Vendor-supplied (e.g., Chronic)	Vendor-supplied (e.g., 05/05/2002)

SNOMED Code	Patient Problem	Status	Date Diagnosed
239872002	Right hip osteoarthritis	Vendor-supplied (e.g., Resolved)	Vendor-supplied (e.g., 02/12/2010)
53741008	Coronary Arteriosclerosis	Vendor-supplied (e.g., Chronic)	Vendor-supplied (e.g., 05/05/2002)

**Medication List** (Use RxNorm code or the Vendor-supplied code that is mapped to the RxNorm code listed in the test data; generic and brand names for medications are provided to allow for specific configuration of the individual EHRs)

RxNorm Code	Product	Generic Name	Brand Name	Strength	Dose	Route	Frequency	Date Started	Status
855320	Medication	warfarin	Coumadin	3 mg	Vendor-supplied (e.g., 1 Tablet)	PO	Vendor-supplied (e.g., Q Day)	Vendor-supplied (e.g., 02/15/2010)	Vendor-supplied (e.g., Active)
213169	Medication	clopidogrel	Plavix	75 mg	Vendor-supplied (e.g., 1 Tablet)	PO	Vendor-supplied (e.g., Q Day)	Vendor-supplied (e.g., 05/15/2002)	Vendor-supplied (e.g., Active)
212549	Medication	amlodipine	Norvasc	5 mg	Vendor-supplied (e.g., 1 Tablet)	PO	Vendor-supplied (e.g., Q Day)	Vendor-supplied (e.g., 07/15/2009)	Vendor-supplied (e.g., Active)

**Medication Allergy List** (The SNOMED Allergy Type Code is required by HITSP/C83, which is a component of the HITSP/C32 implementation guide specified by ONC in the Final Rule)

SNOMED Allergy Type Code	Medication/Agent Allergy	Reaction	Adverse Event Date
416098002 -- Drug Allergy (disorder)	Vendor-supplied (including medication/agent allergy and associated RxNorm code)	Vendor-supplied (e.g., Hives)	Vendor-supplied (e.g.,06/06/1998)

**Diagnostic Test Results** (Vendor may provide test results as test panel)

LOINC Code	Test	Result	Abnormal Flag	Date Performed
718-7	Hemoglobin	11.2 g/dl	Vendor-supplied (e.g., below normal)	Vendor-supplied (e.g.,06/05/2009)
4544-3	Hematocrit	34%	Vendor-supplied (e.g., below normal)	Vendor-supplied (e.g.,06/05/2009)
34714-6	Prothrombin Time/ International Normalized Ratio (PT/INR)	3.1	Vendor-supplied (e.g., normal)	Vendor-supplied (e.g.,06/05/2009)

**Procedure List**

ICD-9 Code	Procedure	Status	Date Performed
81.51	Total Hip Replacement, Right	Vendor-supplied (e.g., Completed)	Vendor-supplied (e.g.,02/14/2010)
37.21	Cardiac catheterization	Vendor-supplied (e.g., Completed)	Vendor-supplied (e.g.,05/05/2002)

CPT Code	Procedure	Status	Date Performed
27130	Total Hip Replacement, Right	Vendor-supplied (e.g., Completed)	Vendor-supplied (e.g.,02/14/2010)
93501	Cardiac catheterization	Vendor-supplied (e.g., Completed)	Vendor-supplied (e.g.,05/05/2002)

Patient Summary Record - Data Set #4

<Information Source> for all data for this patient: Vendor-supplied (e.g., Mary Pfiffer, MD)

**Patient**

Name	Date of Birth	Gender	Identification Number	Identification Number Type	Address/Phone
Vendor-supplied  (e.g., Paul Jackson )	Vendor-supplied  (e.g., 03/08/1962)	Vendor-supplied  (e.g., Male)	Vendor-supplied  (e.g., 998787349)	Vendor-supplied  (e.g., Medical Record Number)	Vendor-supplied  (e.g., 754 Samuel Street, Blanchard, Oklahoma 73010 405-228-9292)

**Problem List**

ICD-9 Code	Patient Problem	Status	Date Diagnosed
410.90	Acute Myocardial Infarction	Vendor-supplied (e.g., Resolved)	Vendor-supplied (e.g., 07/12/2010)
414.01	Coronary Artery Disease (CAD)	Vendor-supplied (e.g., Chronic)	Vendor-supplied (e.g., 07/05/2000)

SNOMED Code	Patient Problem	Status	Date Diagnosed
57054005	Acute Myocardial Infarction	Vendor-supplied (e.g., Resolved)	Vendor-supplied (e.g., 07/12/2010)
53741008	Coronary Arteriosclerosis	Vendor-supplied (e.g., Chronic)	Vendor-supplied (e.g., 07/05/2000)

**Medication List** (Use RxNorm code or the Vendor-supplied code that is mapped to the RxNorm code listed in the test data; generic and brand names for medications are provided to allow for specific configuration of the individual EHRs)

RxNorm Code	Product	Generic Name	Brand Name	Strength	Dose	Route	Frequency	Date Started	Status
198039	Medication	nitroglycerin	Nitroglycerin	400 mcg	Vendor-supplied (e.g., 1 Tablet)	SL	Vendor-supplied (e.g., PRN chest pain)	Vendor-supplied (e.g., 07/15/2010)	Vendor-supplied (e.g., Active)
213169	Medication	clopidogrel	Plavix	75 mg	Vendor-	PO	Vendor-	Vendor-supplied	Vendor-supplied

RxNorm Code	Product	Generic Name	Brand Name	Strength	Dose	Route	Frequency	Date Started	Status
					supplied (e.g., 1 Tablet)		supplied (e.g., Q Day)	(e.g., 07/05/2000)	(e.g., Active)
212549	Medication	amlodipine	Norvasc	5 mg	Vendor-supplied (e.g., 1 Tablet)	PO	Vendor-supplied (e.g., Q Day)	Vendor-supplied (e.g., 07/05/2000)	Vendor-supplied (e.g., Active)

**Medication Allergy List** (The SNOMED Allergy Type Code is required by HITSP/C83, which is a component of the HITSP/C32 implementation guide specified by ONC in the Final Rule)

SNOMED Allergy Type Code	Medication/Agent Allergy	Reaction	Adverse Event Date
416098002 -- Drug Allergy (disorder)	Vendor-supplied (including medication/agent allergy and associated RxNorm code)	Vendor-supplied (e.g., Rash and anaphylaxis)	Vendor-supplied (e.g., 07/12/2010)

**Diagnostic Test Results** (Vendor may provide test results as test panel)

LOINC Code	Test	Result	Abnormal Flag	Date Performed
14647-2	Total cholesterol	230 mg/dl	Vendor-supplied (e.g., above high normal)	Vendor-supplied (e.g., 07/15/2010)
14927-8	Triglycerides	175 mg/dl	Vendor-supplied (e.g., above high normal)	Vendor-supplied (e.g., 07/15/2010)
718-7	Hemoglobin	12.6 g/dl	Vendor-supplied (e.g., below normal)	Vendor-supplied (e.g., 2/18/2010)
4544-3	Hematocrit	42%	Vendor-supplied (e.g., normal)	Vendor-supplied (e.g., 2/18/2010)

**Procedure List**

ICD-9 Code	Procedure	Status	Date Performed
00.66	Percutaneous transluminal coronary angioplasty	Vendor-supplied (e.g., Completed)	Vendor-supplied (e.g., 07/15/2010)

CPT Code	Procedure	Status	Date Performed
92982	Percutaneous transluminal coronary angioplasty	Vendor-supplied (e.g., Completed)	Vendor-supplied (e.g., 07/15/2010)

Patient Summary Record - Data Set #5

<Information Source> for all data for this patient: Vendor-supplied (e.g., Kathryn Thomson, MD)

**Patient**

Name	Date of Birth	Gender	Identification Number	Identification Number Type	Address/Phone
Vendor-supplied (e.g., Christine Taylor)	Vendor-supplied (e.g., 09/22/1965)	Vendor-supplied (e.g., )Female	Vendor-supplied (e.g., 9787478034)	Vendor-supplied (e.g., Medical Record Number)	Vendor-supplied (e.g., 754 Angel Street Marshalltown Iowa 50158 641-544-9988)

**Problem List**

ICD-9 Code	Patient Problem	Status	Date Diagnosed
540.0	Acute Appendicitis	Vendor-supplied (e.g., Resolved)	Vendor-supplied (e.g., 01/09/2010)
434.91	Cerebrovascular Accident (Stroke)	Vendor-supplied (e.g., Resolved)	Vendor-supplied (e.g., 07/09/2009)
250.02	Diabetes Mellitus, Type 2	Vendor-supplied (e.g., Active)	Vendor-supplied (e.g., 03/30/2009)

SNOMED Code	Patient Problem	Status	Date Diagnosed
74400008	Appendicitis	Vendor-supplied (e.g., Resolved)	Vendor-supplied (e.g., 01/09/2010)
230690007	Cerebrovascular Accident (Stroke)	Vendor-supplied (e.g., Resolved)	Vendor-supplied (e.g., 07/09/2009)
44054006	Diabetes Mellitus, Type 2	Vendor-supplied (e.g., Active)	Vendor-supplied (e.g., 03/30/2009)

**Medication List** (Use RxNorm code or the Vendor-supplied code that is mapped to the RxNorm code listed in the test data; generic and brand names for medications are provided to allow for specific configuration of the individual EHRs)

RxNorm Code	Product	Generic Name	Brand Name	Strength	Dose	Route	Frequency	Date Started	Status
-------------	---------	--------------	------------	----------	------	-------	-----------	--------------	--------

RxNorm Code	Product	Generic Name	Brand Name	Strength	Dose	Route	Frequency	Date Started	Status
213169	Medication	clopidogrel	Plavix	75 mg	Vendor-supplied (e.g., 1 Tablet)	PO	Vendor-supplied (e.g., Q Day)	Vendor-supplied (e.g., 07/15/2009)	Vendor-supplied (e.g., Active)
205875	Medication	glyburide	Diabeta	2.5 mg	Vendor-supplied (e.g., 1 Tablet)	PO	Vendor-supplied (e.g., Q AM)	Vendor-supplied (e.g., 03/30/2009)	Vendor-supplied (e.g., Active)
200801	Medication	furosemide	Lasix	20 mg	Vendor-supplied (e.g., 1 Tablet)	PO	Vendor-supplied (e.g., BID)	Vendor-supplied (e.g., 02/25/2008)	Vendor-supplied (e.g., Active)
628958	Medication	potassium chloride	Klor-Con	10 mEq	Vendor-supplied (e.g., 1 Tablet)	PO	Vendor-supplied (e.g., BID)	Vendor-supplied (e.g., 02/25/2008)	Vendor-supplied (e.g., Active)

**Medication Allergy List** (The SNOMED Allergy Type Code is required by HITSP/C83, which is a component of the HITSP/C32 implementation guide specified by ONC in the Final Rule)

SNOMED Allergy Type Code	Medication/Agent Allergy	Reaction	Adverse Event Date
416098002 -- Drug Allergy (disorder)	Vendor-supplied (including medication/agent allergy and associated RxNorm code)	Vendor-supplied (e.g., Rash, dizziness, headache)	Vendor-supplied (e.g., 06/05/2008)

**Diagnostic Test Results** (Vendor may provide test results as test panel)

LOINC Code	Test	Result	Abnormal Flag	Date Performed
14771-0	Fasting Blood Glucose	136 mg/dl	Vendor-supplied (e.g., above high normal)	Vendor-supplied (e.g., 07/15/2010)
2823-3	Potassium	4.4 mEq/L	Vendor-supplied (e.g., normal)	Vendor-supplied (e.g., 07/15/2010)
14927-8	Triglycerides	188 mg/dl	Vendor-supplied (e.g., above high normal)	Vendor-supplied (e.g., 07/15/2010)

**Procedure List**

<b>ICD-9 Code</b>	<b>Procedure</b>	<b>Status</b>	<b>Date Performed</b>
47.09	Emergency Appendectomy	Vendor-supplied (e.g., Completed)	Vendor-supplied (e.g.,01/09/2010)

<b>CPT Code</b>	<b>Procedure</b>	<b>Status</b>	<b>Date Performed</b>
44950	Emergency Appendectomy	Vendor-supplied (e.g., Completed)	Vendor-supplied (e.g.,01/09/2010)

## CONFORMANCE TEST TOOLS

The following testing tools are available to evaluate conformance to the standards referenced in this test procedure:

- HL7 CCD/HITSP C32 – NIST provides an HL7 CCD/HITSP C32 validation tool designed specifically to support this test procedure. The tool is available in two forms:
  - a downloadable package for local installation available at <http://xreg2.nist.gov/cda-validation/mu.html>
  - a web-accessible validator which is hosted by NIST available at <http://xreg2.nist.gov/cda-validation/mu.html>

Support for these tools is available by contacting

[Andrew McCaffrey](mailto:andrew.mccaffrey@nist.gov) (andrew.mccaffrey@nist.gov)

Computer Scientist

National Institute of Standards and Technology (NIST)

Information Technology Laboratory

- ASTM CCR – Open Health Data provides an ASTM CCR validation tool designed specifically to support this test procedure. The tool is available through the following:
  - Files can be retrieved from the SourceForge site:  
<http://sourceforge.net/projects/ccrvalidator>
  - Direct link to the file:  
<http://sourceforge.net/projects/ccrvalidator/files/ValidationService/1.0/ValidationService-1.0.war/download>
  - Source code location:  
<http://ccrvalidator.svn.sourceforge.net/viewvc/ccrvalidator/branches/>
- HL7 CCD style sheet – HL7 provides a style sheet to render HL7 CCD structured documents as part of the CCD specifications package. Contact HL7 directly for the specification package.

The following information is provided to assist the Tester in interpreting the conformance reports generated by the NIST conformance testing tools.

The HL7 CCD/HITSP C32 and ASTM CCR validation tools evaluate individual conformance statements which have been derived from the standards and implementation guides identified in the Final Rule and the test data provided in this test procedure. The validation tools evaluate the submitted CCD/CCR instance for each conformance statement, and then produce a conformance report. The Tester should consider that a report containing only Affirmative and Warning messages indicates general conformance to the standard and test data expectations. If reported, Errors should be considered as significant departures from the standard or test data requirements which need to be corrected in order to claim conformance. ATCBs will need to further analyze each error to determine if, in the context of meeting the criterion and overall meaningful use objective, the error results in a failure of the Test Procedure by the EHR technology. The tester may need to inspect test data values derived from required vocabularies and code sets.

## Document History

Version Number	Description	Date Published
0.5	Original draft version	April 9, 2010
1.0	Updated to reflect Final Rule	July 21, 2010
1.0	Updated to remove "Pending" from header	August 13, 2010
1.1	<ul style="list-style-type: none"> <li>• Removed "draft" from introductory paragraph</li> <li>• In the Certification Criteria section, Section III.D of the preamble – RxNorm verbiage was added</li> <li>In the Informative Test Description section                             <ul style="list-style-type: none"> <li>• Changed verbiage "using vocabulary coded values" to "using the specified vocabularies"</li> </ul> </li> <li>In the Normative Test Procedure section                             <ul style="list-style-type: none"> <li>• Added verbiage instructing Tester to select only one data set from the Test Data</li> </ul> </li> <li>In the Test Data section                             <ul style="list-style-type: none"> <li>• Updated the Test Data introduction verbiage</li> <li>• Defined &lt;Information Source&gt;</li> <li>• Moved &lt;Information Source&gt; data to beginning of each data set and made it Vendor-supplied data</li> <li>• Deleted "Time" of Birth in heading and test data</li> <li>• Removed Type column from Problem List, Medication Allergy List, Diagnostic Test Results, and Procedure List</li> <li>• For the Medication List in each data set                                     <ul style="list-style-type: none"> <li>○ Added (Use RxNorm code or the Vendor-supplied code that is mapped to the RxNorm code listed in the test data; generic and brand names for medications are provided to allow for specific configuration of the individual EHRs)</li> <li>○ Deleted any medications for which an RxNorm code could no longer be found</li> <li>○ Replaced any RxNorm codes that did not apply to both the brand and generic medication names</li> <li>○ Corrected any instances where brand name was in the generic name column and generic name was in the brand name column</li> </ul> </li> <li>• For the Medication Allergy List in each data set                                     <ul style="list-style-type: none"> <li>○ Added (The SNOMED Allergy Type Code is required by HITSP/C83, which is a component of the HITSP/C32 implementation guide specified by ONC in the Final Rule)</li> <li>○ Changed heading from "SNOMED Allergy Code" to "SNOMED Allergy Type Code"</li> <li>○ Replaced all previous SNOMED allergy code data with SNOMED allergy <u>type</u> code data "416098002 – Drug Allergy (disorder)"</li> <li>○ Changed the Medication/Agent Allergy data to "Vendor-supplied (including medication/agent allergy and associated RxNorm code)"</li> <li>○ Changed heading from "Date Recorded" to "Adverse Event Date"</li> <li>○ Deleted all but one row of Medication Allergy List data in each data set</li> </ul> </li> </ul> </li> </ul>	September 24, 2010