Change	Reason for Change
302.a drug-drug, drug allergy	
In the Informative Test Description section • Added clarification to the example for adjust notifications	To provide clarification. The example provided was being considered exclusive.
302.c Problem List	
In the Informative Test Description section • Added the sentence "The test also evaluates conformance to the problem list vocabulary standards."	To provide clarification regarding evaluation of problem vocabulary standards' use during the test
• Added "The test procedure is not prescriptive about the method used to modify the problem list. For example, modifying a problem list does not require modifying an existing instance of a problem. Modification can be accomplished through changing the status of an existing problem or entering a new problem."	To help clarify definition of "modify" for this test procedure
• Added "The Vendor provides part of the test data and NIST provides part of the test data for this test procedure."	To provide clarification regarding source of the test data for this test procedure
In the Test Data section • Added once for both the Ambulatory and IP Test Data the following statement: "All status data and dates are Vendor-supplied; dates are to include month, day and year; no standard date format is required."	To clarify expectation for Vendor-supplied date data
• Changed "Status: Active" to "Status: Vendor-supplied (e.g. Active)" and so forth	To allow the Vendor to use their Status terms
• Changed the word "change" to "modify"	To be consistent with the verbiage in the criterion
• Added **"Date Modified**: Vendor-supplied (e.g. *Month DD*, 2010)" to "Modify Problems" Test Data sections including Amb and IP for "Revised Problem List"	To give Vendor the option to provide these data for the test
• Added **"**Date Modified: Vendor-supplied (e.g. *Month DD*, 2010)" to "Retrieve Problems" Test Data including Amb and IP "List of All Problems"	To give Vendor the option to provide these data for the test
302.d Active Med List	
In the Informative Test Description section • Changed the words "edit "and "change" to "modify"	To be consistent with the verbiage in the criterion
• Corrected typographical errors with Ambulatory/Inpatient wording	

Change	Reason for Change
• Added “The test procedure is not prescriptive about the method used to modify the problem list, for example, modifying a medication list does not require modifying an existing instance of a medication. Modification can be accomplished through discontinuing/inactivating an existing medication on the list and entering a new instance of the medication.”	To help clarify definition of “modify” for this test procedure
In the Normative Test Procedure section • Corrected numbering of test procedure and test references	
• Corrected typographical errors with Ambulatory vs Inpatient wording	
In the Test Data section • Changed the word "Change" to "Modify"	To be consistent with the verbiage in the criterion
• Corrected numbering of test data	
• Deleted “Esidrix”	Esidrix is no longer marketed
302.e Med Allergy List	
In the Informative Test Description • Changed the word “changing” to “modifying”	To be consistent with the verbiage in the criterion
• Added “The test procedure is not prescriptive about the method used to modify the allergy list. For example, modifying a medication allergy list does not require modifying an existing instance of a medication allergy. Modification may be accomplished through inactivating or deleting an existing medication allergy on the list and entering a new instance of the medication allergy.”	To help clarify definition of “modify” for this test procedure
In the Normative Test Procedures section • Added reference to Test Data section	To help clarify for the Tester the location of the test data in the test procedure document
• Changed the word “entered” to “modified”	To be consistent with the verbiage in the criterion
In the Test Data section • Changed the word “change” to “modify”	To be consistent with the verbiage in the criterion
• Changed “Status: Active” to “Status: Vendor-supplied (e.g. Active)” and so forth	To allow the Vendor to use their Status terms
• Changed Reaction to only one (for instance changed “diarrhea, vomiting” to just “vomiting”)	Test Data included multiple reactions for some of the allergies; documentation of a single reaction fulfills the criterion requirement
• Deleted modifications where user entered additional med allergy Reaction	To be consistent with intent of the criterion and not require more than one med allergy reaction per med allergy
302.f.1 Vital Signs	

Change	Reason for Change
In the Informative Test Description section • Added "The test procedure is not prescriptive about the method used to modify vital signs. For example, modifying vital signs does not require modifying an existing instance of vital signs. Modification may be accomplished through inactivating or deleting existing vital signs in the patient's EHR and entering a new instance of vital signs."	To help clarify definition of "modify" for this test procedure
In the Normative Test Procedures section • Added verbiage instructing Tester to select only one data set from the Test Data	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
In the Test Data section • Recalculated all weight data starting with the metric kg weight, and changed standard weight to nn lbs or nn lbs nn oz	To facilitate use of Test Data
• Added inches only to height data	For EHRs that only support inches to be entered into the height field
• Changed the word "change" to "modify"	To be consistent with the verbiage in the criterion
302.f.2 BMI	
In the Test Data section • Added the url for the CDC BMI Calculator used for this test data • Added "Use of the CDC BMI Calculator is not required. It is recognized that other BMI calculators may have slightly different algorithms and the derived BMI may not be exactly the same as the test data below. It is the Tester's discretion to determine if the BMI value calculated during the test is comparable to the test data."	Added to enable Testers and Vendors to use the same calculation tool used by NIST Added 1) to clarify the intended purpose of NIST providing the CDC url and 2) to give the Testers guidance on how to evaluate the calculated result
302.f.3 Growth Charts	
In the Test Data section • Recalculated all weight data starting with the metric kg weight, and changed standard weight to nn lbs or nn lbs nn oz	To facilitate use of Test Data
• Added inches only to height data	For EHRs that only support inches to be entered into the height field
302.g. Smoking Status	
In the Informative Test Description section • Added information regarding smoking status recodes	To inform Testers/Vendors of the expectation for this test procedure regarding the recodes
• Added "The test procedure is not prescriptive about the method used to modify smoking status. For example, modifying a smoking status does not require modifying an existing instance of a smoking status. Modification may be accomplished through inactivating or deleting an existing smoking status in the patient's EHR and entering a new instance of the smoking status."	To help clarify definition of "modify" for this test procedure

Change	Reason for Change
• Added "These stored recodes need not be displayed to the user."	To inform Testers/Vendors of the expectation for this test procedure regarding the recodes
In the Normative Test Procedure section • Added information about smoking status recodes	To inform Testers/Vendors of the expectation for this test procedure regarding the recodes
In the Test Data section • Added clarification of the six iterations of the modify test data	To inform Testers/Vendors of the expectation for this test procedure regarding testing the EHR's modification capabilities
• Added sixth iteration of the modify test data	To enable testing of all the smoking status options required by the criterion
• Changes Test Data for TD170.302.g – 3: Electronically retrieve patient smoking status	To be in sync with the sixth iteration of the modify test data added on page 7
302.h. Incorporate Lab Results	
In the Normative Test Procedures section • Added verbiage instructing the Tester to select only one data set from the Test Data section	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
In the Test Data section • LOINC Codes deleted	LOINC codes not required by criterion
• Unit of measure typographical error corrected for sodium and potassium	
• Two data sets added	To provide additional test data sets from which Testers may choose
302.i Generate Patient Lists	
In the Informative Test Description • Added verbiage to Select and to Sort and Retrieve	To help Testers/Vendors understand the expectation for this test procedure regarding sorting
In the Normative Test Procedure section • Added verbiage to Sort and Retrieve Required Test Procedure	To help Testers/Vendors understand the expectation for this test procedure regarding sorting
In the Test Data section • Added another set of test data examples	To provide more variety in the test data examples for Testers/Vendors
170.302.j Medication Reconciliation	
In the Informative Test Description section • Changed verbiage to: "The Tester validates that one of the medication lists is a current medication list in the patient's electronic record, and that all of the medication lists created by the Vendor are viewable electronically as separate lists and can be compared by the user"	To help Testers/Vendors understand the expectation for this test procedure regarding electronically comparing two or more medication lists
In the Normative Test Procedures section • In TE170.302.j – 1.01, replaced "online" with "viewable electronically and comparable as separate lists"	To help Testers/Vendors understand the expectation for this test procedure regarding <u>electronically</u> comparing two or more medication lists
• In IN170.302.j – 1.01, replaced "online" with "viewable electronically and can be compared by the user"	To help Testers/Vendors understand the expectation for this test procedure regarding <u>electronically</u> comparing two or more medication lists
170.302.k Submission to Immunization Registries	
In the Normative Test Procedure section: • Deleted "Country" from patient address data	Correction

Change	Reason for Change
• Added VE170.302.k – 1.02 In Vendor Required Information	To help Testers/Vendors understand the expectation for this test procedure regarding Vendor-supplied test data to be recorded in the existing patient record
• Added TE170.302.k – 1.01 and TE170.302.k – 1.02 • Added verbiage to IN170.302.k – 1.01	To help Testers/Vendors understand the expectation for this test procedure regarding selecting one data set from the Test Data and Vendor-supplied data
• Added verbiage instructing Tester to select only one data set from the Test Data	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
In the Test Data Message Structure section • Changed MSH 5 from "Sending Facility" to "Receiving Application"	Correction
• Changed MSH 6 from "Sending Facility" to "Receiving Facility"	Correction
• Deleted "Country" from PID segment	Correction
In Test Data section • Corrected Zip codes	
• Replaced discontinued CVX codes/vaccines with new CVX codes/vaccines	Correction
• Modified test data to match conformance tool/spreadsheet on NIST web site	
• Added PID-13.2 Telecommunication Use Code	Recommended by HL7/industry SMEs
• Deleted "Country" from all patient address data	Correction
170.302.m Patient specific education resources	
In the Informative Test Description section • Added CMS verbiage regarding how the EPs and EHs "should utilize certified EHR technology in a manner where the technology suggests patient-specific educational resources based on the information stored in the certified EHR technology."	To help Testers/Vendors understand the expectation for this test procedure regarding the intended connection between the patient data in the EHRs and the patient-specific educational resources
• Added/modified verbiage for the Identify and Provide sections	To help Testers/Vendors understand the expectation for this test procedure regarding 1) the number of education resources required for each patient, 2) the number of patients to be included in the test 3) how the education resources might be derived 4) how the Tester might accomplish the queries for the resources
In the Normative Test Procedure section • Added "and the education resources identified in the DTR170.302.m – 1: Electronically Identify Patient-specific Education Resources test" to TE 2.01 and IN 2.01	To clarify for Testers the expectation that education resources identified in the Identify test should be used in the Provide test
• Added/modified verbiage for TE170.302.m – 1.01 and IN170.302.m – 1.01	To help Testers/Vendors understand the expectation for this test procedure regarding 1) the number of education resources required for each patient, 2) the number of patients to be included in the test
• Deleted "based on, at a minimum, data elements included in the patients' problem lists, medication lists, and laboratory test results" in TE 2.01, 2.02 and IN 2.01	To avoid unnecessary repetition in the verbiage
302.n Automate Measure Calculation	

Change	Reason for Change
In the Certification Criteria section added text from the ONC FR Preamble which explains the requirement to automatically calculate the denominator	To provide the basis for the test procedure to require automatic calculation of the denominators for all percentage-based measures.
In the Informative Test Description section: • Added ONC guidance that the vendor-supplied numerator and denominator information may be automatically recorded by the EHR or recorded by the user. • Revised the Record section to describe how the test procedure will be conducted in a way that is consistent with the ONC guidance	NIST has received several questions about whether the EHR must automatically record the numerator and denominator for all of the percentage-based measures. NIST has discussed these questions with CMS and ONC, resulting in a determination that while it is highly desirable that the EHR be capable of automatically recording the numerator and denominator without user input, there may be situations in which the user needs the capability to record numerator and/or denominator information in the EHR. The NIST test procedure has been adjusted accordingly.
In the Normative Test Procedure the following changes have been made: • VE170.302n -1.03 added the phrase 'if not recorded automatically' • TE170.302n-1.01 revised the test procedure wording to "If the EHR automatically records the numerator and denominator for the measure, the Tester proceeds to DTR170.302.n – 2.. If the EHR does not automatically calculate numerator and/or denominator, using the EHR function(s) identified by the Vendor, the Tester shall electronically record the numerator and denominator • IN170.302.n-1.01 changed the word 'entered' to 'recorded'; removed the sentence starting with 'The Tester will evaluate, to the extent possible…"; added the phrase ".. supports recording the numerator and denominator for" • TE170.302.n-2.01 - changed the word 'entered' to 'recorded'	To align the test procedure with the ONC guidance described above. To provide the option for the vendor to identify whether the numerator and/or denominator will be recorded automatically or recorded by user input or some combination of the two processes. Note that 'record' and 'calculate' are two different concepts in the ONC criterion. In the test procedure, 'record' refers to the action(s) associated with recording information in the EHR which can subsequently be utilized in the 'calculate' activity to determine the numerator and denominator for a measure. The actual processes of recording and calculating may involve the use of analytical or data warehouse-like modules which analyze EHR data to calculate the numerator and denominator. If used, these analytical capabilities need to be incorporated into the test. To provide guidance to the Tester on how to proceed if the EHR automatically records, or manually records the numerator and/or denominator To provide guidance to the Tester that the EHR must support recording the numerator and denominator for all of the percentage based MU measures.
In the Conformance Tools section, removed the text referring to an automated test tool	This comment is not applicable to percentage-based measures. It only applies to the Clinical Quality measures.
304.a. CPOE Amb	
In the Informative Test Description: • Added verbiage to clarify that modify does not require modifying an existing instance of an order	To help clarify definition of "modify" for this test procedure
In the Normative Test Procedures Section • Added references to Test Data section	To help clarify for the Tester the location of the test data in the test procedure document

Change	Reason for Change
• Added verbiage instructing Tester to select only one data set from the Test Data	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
• Added verbiage instructing Tester to select a data set from the Test Data that corresponds to the data set selected for DTR170.304.a – 1: Electronically Record and Store Orders in an Ambulatory Setting	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
• Added verbiage instructing Tester to select a data set from the Test Data that corresponds to the data set selected for DTR170.304.a – 1: Electronically Record and Store Orders in an Ambulatory Setting	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
In the Test Data section: • Added an another test data set	To provide clarification based on public feedback regarding order data provided by NIST. Previously only 1 set of order data was included in this TP and it is beneficial to have more than one.
• Changed the word “change” to “modify”	To be consistent with the verbiage in the criterion
• Corrected “Disp #150 ml to “Disp #100 ml”	To correct a math error in the Test Data
304.b Electronic Prescribing	
In the Informative Test Description section, page x, the following changes have been made: • Added explanation that the XML versions of NCPDP SCRIPT are incorporated into the test procedure • Added explanation about how the medications vocabulary requirement has been incorporated into the test procedure • Added explanation in the inspection test guide section to describe how the Tester should evaluate ‘accurate and complete’	NIST is collaborating with an NCPDP task group to validate the test procedure. Various changes have been recommended by the task group in order to align the test procedure with the NCPDP standards. Additional details are included in other parts of this Release Note. As discussed in the NCPDP task group, the phrase ‘accurate and complete’ refers to the representation of the test data in the EHR. It does not require an evaluation of whether the prescription is complete or valid.
In the Normative Test Procedure section, the following changes have been made: • Added EDIFACT and XML versions of SCRIPT in the appropriate sections of the the test procedure.	NIST has confirmed with NCPDP that the XML format for SCRIPT is officially incorporated within the standard referenced by ONC in their Final Rule.

Change	Reason for Change
In the Test Data section the following changes have been made: • The grouping by test data set have been removed • The prescription data has been rewritten in plain English language • Some prescriptions were modified to reflect the availability of the medications in specific packaging • Controlled substance prescriptions were removed entirely from the test data • Instructions have been added that the Tester shall select two or more prescriptions which are supported in the EHR.	As discussed in the NCPDP task group, there are various ways in which an EHR may implement the components of a prescription and various codes or abbreviations which may be implemented in an EHR. By writing the test data in plain English, the test does not require specific abbreviations, and the Tester can focus on the accuracy and completeness of the data in the EHR which may include evaluating that abbreviations or codes displayed by the EHR meet the intent of the plain English text supplied in the test data. The Tester is instructed to select test data prescriptions which are supported in the EHR. This clarification is provided to allow for the possibility that some EHRs may not be configured to support certain types of packaging or other requirements in the prescription. There is no requirement that the EHR be capable of generating all of the prescriptions in the test data.
In Appendix A the following changes have been made: • Added NCPDP's guidance on how the ONC-specified medications vocabulary should be evaluated for conformance in the SCRIPT NEWRX message. • Added the relevant XML tags to the tables • Made minor technical adjustments in order to fully conform to the published NCPDP conformance statements.	As discussed in the NCPDP task group, these changes align the test procedure with the NCPDP standards.
304.c. Record Demographics AMB	
In the Informative Test Description • Added "The test procedure is not prescriptive about the method used to modify the patient demographics. For example, modifying patient demographics does not require modifying an existing instance of patient demographics. Modification may be accomplished through updating existing patient demographics by entering new patient demographics."	To help clarify definition of "modify" for this test procedure
In the Normative Test Procedures Section • Added verbiage instructing Tester to select only one data set from the Test Data	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
• Added verbiage for the Modify test steps instructing Tester to select a data set from the Test Data that corresponds to the data set selected for the Electronically Record Patient Demographics test	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
In the Test Data section • For Modify Patient Demographics, updated "Change" to "Modify"	To be consistent with the verbiage in the criterion
304.f Electronic Copy of Health Information	
In Certification Criteria section, Section III.D of the preamble - RxNorm verbiage added	To be consistent across all CCD-CCR-related test procedures

Change	Reason for Change
In the Informative Test Description section • Changed verbiage "using vocabulary coded values" to "using the specified vocabularies"	To clarify
In Normative Test Procedure section • Added verbiage instructing Tester to select only one data set from the Test Data	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
In the Test Data section	
• Updated Test Data introduction verbiage	To include verbiage related to Vendor-supplied test data; added reference to source for LOINC codes
• For Medication Allergies, (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) was added	To explain why the SNOMED Allergy Type Code is included in the Test Data
• For Medication Allergy, heading changed from “SNOMED Allergy Code” to “SNOMED Allergy Type Code”	To be in sync with HITSP/C83 requirements
• <Information Source> defined	To explain to Testers/Vendors why these data are included in the Test Data
• <Information Source> moved to beginning of each data set	To facilitate understanding the purpose of these data in the Test Data
• For the Medication List in each data set in the Test Data section, added "generic and brand names for medications are provided to allow for specific configuration of the individual EHRs"	To explain to Testers/Vendors why these data are included in the Test Data
• "Time" of Birth deleted in heading and test data	Data not required by criterion
• In Med Allergy List, all previous SNOMED allergy codes were replaced with SNOMED allergy type code data "416098002 – Drug Allergy (disorder)"	To clarify for Testers/Vendors why these data are included in the Test Data
• Med Allergy List header changed from "Date Recorded" to "Adverse Event Date"	Clarification based on comment suggestion
• RxNorm codes in Medication List o If RxNorm code shown in Medication List could no longer be found for the medication, the row with this medication was deleted in the Medication List o If previous RxNorm code did not apply to both the Brand and Generic med names, this code was replaced with an RxNorm code that does apply to both the Brand and Generic med names	To promote accuracy in Test Data
• In Med List, correction was made if Brand name was in the Generic name column and Generic name was in the Brand name column	To promote accuracy in Test Data
• Type column removed from Problem List, Med Allergy List, and Diagnostic Test Results	Data not required
• The Medication/Agent Allergy data changed to "Vendor-supplied (including medication/agent allergy and associated RxNorm code)"	To facilitate capture of the RxNorm code for the medication allergy data in a manner most convenient to the EHRs.
• Only one row now displays in each Medication Allergy list in each data set	The other rows were deleted as they were no longer necessary

Change	Reason for Change
304.h Clinical Summaries	
In the Informative Test Description • Verbiage referencing "using vocabulary coded values" changed to "using the specified vocabularies" throughout document	To make verbiage easier to understand
In the Required Test Procedure steps • Added verbiage instructing Tester to select only one data set from the Test Data	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
In the Test Data section	
• Updated Test Data introduction verbiage	To include verbiage related to Vendor-supplied test data; added reference to source for LOINC codes
• For Medication Allergies, (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) was added	To explain why the SNOMED Allergy Type Code is included in the Test Data
• "Time" of Birth deleted in heading and test data	Data not required by criterion
• In Med Allergy List, all previous SNOMED allergy codes were replaced with SNOMED allergy <u>type</u> code data "416098002 – Drug Allergy (disorder)"	To clarify for Testers/Vendors why these data are included in the Test Data
• For Medication Allergy, heading changed from “SNOMED Allergy Code” to “SNOMED Allergy Type Code”	To be in sync with HITSP/C83 requirements
• <Information Source> defined	To explain to Testers/Vendors why these data are included in the Test Data
• <Information Source> moved to beginning of each dataset	To facilitate understanding the purpose of these data in the Test Data
• For the Medication List in each data set in the Test Data section, added "generic and brand names for medications are provided to allow for specific configuration of the individual EHRs"	To explain to Testers/Vendors why these data are included in the Test Data
• "Time" of Birth deleted in heading and test data	Data were not required
• Med Allergy List header changed from "Date Recorded" to "Adverse Event Date"	Clarification based on comment suggestion
• RxNorm codes in Medication List o If RxNorm code shown in Medication List could no longer be found for the medication, the row with this medication was deleted in the Medication List o If previous RxNorm code did not apply to both the Brand and Generic med names, this code was replaced with an RxNorm code that does apply to both the Brand and Generic med names	To promote accuracy in Test Data
• In Med List, correction was made if Brand name was in the Generic name column and Generic name was in the Brand name column	To promote accuracy in Test Data
• Type column removed from Problem List, Med Allergy List, and Diagnostic Test Results	Data were not required

Change	Reason for Change
• The Medication/Agent Allergy data = "Vendor-supplied (including medication/agent allergy and associated RxNorm code)"	To facilitate capture of the RxNorm code for the medication allergy data in a manner most convenient to the EHR Vendors. [Commenter feedback expressed concern about the lack of RxNorm codes for the medication allergies in the CCD/CCR-related TPs.]
• Only one row now displays in each Medication Allergy list in each data set	The other rows were deleted as they were no longer necessary
304.i Exchange Clinical Information and Patient Summary Record	
In the Informative Test Description • Verbiage referencing "using vocabulary coded values" changed to "using the specified vocabularies" throughout document	To make verbiage easier to understand
In Required Test Procedure steps • Added verbiage instructing Tester to select only one data set from the Test Data	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
In the Test Data section	
• Updated Test Data introduction verbiage	To include verbiage related to Vendor-supplied test data; added reference to source for LOINC codes
• For Medication Allergies, (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) was added	To explain why the SNOMED Allergy Type Code is included in the Test Data
• For Medication Allergy, heading changed from “SNOMED Allergy Code” to “SNOMED Allergy Type Code”	To be in sync with HITSP/C83 requirements
• <Information Source> defined	To explain to Testers/Vendors why these data are included in the Test Data
• <Information Source> moved to beginning of each dataset	To facilitate understanding the purpose of these data in the Test Data
• For the Medication List in each data set in the Test Data section, added "generic and brand names for medications are provided to allow for specific configuration of the individual EHRs"	To explain to Testers/Vendors why these data are included in the Test Data
• "Time" of Birth deleted in heading and test data	Data were not required
• In Med Allergy List, all previous SNOMED allergy codes were replaced with SNOMED allergy type code data "416098002 – Drug Allergy (disorder)"	To clarify for Testers/Vendors why these data are included in the Test Data
• Med Allergy List header changed from "Date Recorded" to "Adverse Event Date"	Clarification based on comment suggestion
• RxNorm codes in Medication List o If RxNorm code shown in Medication List could no longer be found for the medication, the row with this medication was deleted in the Medication List o If previous RxNorm code did not apply to both the Brand and Generic med names, this code was replaced with an RxNorm code that does apply to both the Brand and Generic med names	To promote accuracy in Test Data

Change	Reason for Change
• In Med List, correction was made if Brand name was in the Generic name column and Generic name was in the Brand name column	To promote accuracy in Test Data
• Type column removed from Problem List, Med Allergy List, and Diagnostic Test Results	Data were not required
• The Medication/Agent Allergy data changed to "Vendor-supplied (including medication/agent allergy and associated RxNorm code)"	To facilitate capture of the RxNorm code for the medication allergy data in a manner most convenient to the EHRs.
• Only one row now displays in each Medication Allergy list in each data set	The other rows were deleted as they were no longer necessary
306.a. CPOE IP	
In the Informative Test Description section • Added verbiage to clarify that modify does not require modifying an existing instance of an order	To help clarify definition of "modify" for this test procedure
In the Normative Test Procedures section • Added references to Test Data section	To help clarify for the Tester the location of the test data in the test procedure document
• Added verbiage instructing Tester to select only one data set from the Test Data	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
• Added verbiage instructing Tester to select a data set from the Test Data that corresponds to the data set selected for DTR170.306.a – 1: Electronically Record and Store Orders in an Inpatient Setting	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
• Added verbiage instructing Tester to select a data set from the Test Data that corresponds to the data set selected for DTR170.306.a – 1: Electronically Record and Store Orders in an Inpatient Setting	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
In the Test Data Section • Added an another set of test data	Previously only 1 set of order data and it is beneficial to have more than one.
• Changed the word "change" to "modify	To be consistent with the verbiage in the criterion
306.b. Record Demographics IP	
In the Informative Test Description section • Added the following sentence, "The test procedure is not prescriptive about the method used to modify the patient demographics. For example, modifying patient demographics does not require modifying an existing instance of patient demographics. Modification may be accomplished through updating existing patient demographics by entering new patient demographics."	To help clarify definition of "modify" for this test procedure
In the Normative Test Procedures section • Added verbiage instructing Tester to select only one data set from the Test Data	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
• Added verbiage instructing Tester to select a data set from the Test Data that corresponds to the data set selected for the Electronically Record Patient Demographics test	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets

Change	Reason for Change
• Added verbiage instructing Tester to select a data set from the Test Data that corresponds to the data set selected for the Electronically Record Patient Demographics test	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
In the Test Data section • Updated the Modify Patient Demographics test data from “Change” to “Modify”	To be consistent with the verbiage in the criterion
306.d.1 Electronic Copy of Health Information	
In the Certification Criteria section, Section III.D of the preamble - RxNorm verbiage added	To be consistent across all CCD-CCR-related test procedures
In the Informative Test Description section • Verbiage referencing "using vocabulary coded values" changed to "using the specified vocabularies" throughout document	To make verbiage easier to understand
In the Normative Test Procedures section • Added verbiage instructing Tester to select only one data set from the Test Data	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
In the Test Data section	
• Updated Test Data introduction verbiage	To include verbiage related to Vendor-supplied test data; added reference to source for LOINC codes
• For Medication Allergies, (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) was added	To explain why the SNOMED Allergy Type Code is included in the Test Data
• For Medication Allergy, heading changed from “SNOMED Allergy Code” to “SNOMED Allergy Type Code”	To be in sync with HITSP/C83 requirements
• <Information Source> defined	To explain to Testers/Vendors why these data are included in the Test Data
• <Information Source> moved to beginning of each data set	To facilitate understanding the purpose of these data in the Test Data
• For the Medication List in each data set in the Test Data section, added "generic and brand names for medications are provided to allow for specific configuration of the individual EHRs"	To explain to Testers/Vendors why these data are included in the Test Data
• "Time" of Birth deleted in heading and test data	Data were not required
• In Med Allergy List, all previous SNOMED allergy codes were replaced with SNOMED allergy type code data "416098002 – Drug Allergy (disorder)"	To clarify for Testers/Vendors why these data are included in the Test Data
• Med Allergy List header changed from "Date Recorded" to "Adverse Event Date"	Clarification based on comment suggestion

Change	Reason for Change
• RxNorm codes in Medication List o If RxNorm code shown in Medication List could no longer be found for the medication, the row with this medication was deleted in the Medication List o If previous RxNorm code did not apply to both the Brand and Generic med names, this code was replaced with an RxNorm code that does apply to both the Brand and Generic med names	To promote accuracy in Test Data
• In Med List, correction was made if Brand name was in the Generic name column and Generic name was in the Brand name column	To promote accuracy in Test Data
• Type column removed from Problem List, Med Allergy List, Diagnostic Test Results, and Procedure List	Data were not required
• The Medication/Agent Allergy data changed to "Vendor-supplied (including medication/agent allergy and associated RxNorm code)"	To facilitate capture of the RxNorm code for the medication allergy data in a manner most convenient to the EHR Vendors.
• Only one row now displays in each Medication Allergy list in each data set	The other rows were deleted as they were no longer necessary
306.f Exchange Clinical Information and Patient Summary Record	
In the Certification Criteria section, Section III.D of the preamble - RxNorm verbiage added	To be consistent across all CCD-CCR-related test procedures
In the Informative Test Description section • Verbiage referencing "using vocabulary coded values" changed to "using the specified vocabularies" throughout document	To make verbiage easier to understand
In Required Test Procedure steps • Added verbiage instructing Tester to select only one data set from the Test Data	To inform Testers/Vendors of the expectation for this test procedure regarding use of the test data sets
In the Test Data section	
• Test Data introduction verbiage updated	To include verbiage related to Vendor-supplied test data; added reference to source for LOINC codes
• For Medication Allergies, 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)	To explain why the SNOMED Allergy Type Code is included in the Test Data
• For Medication Allergy, changed heading from “SNOMED Allergy Code” to “SNOMED Allergy Type Code”	To be in sync with HITSP/C83 requirements
• <Information Source> defined	To explain to Testers/Vendors why these data are included in the Test Data
• <Information Source> moved to beginning of each dataset	To facilitate understanding the purpose of these data in the Test Data
• Beside "Medication List" in each data set, added "generic and brand names for medications are provided to allow for specific configuration of the individual EHRs"	To explain to Testers/Vendors why these data are included in the Test Data
• "Time" of Birth deleted in heading and test data	Data were not required

Change	Reason for Change
• In Med Allergy List, all previous SNOMED allergy codes replaced with SNOMED allergy type code data "416098002 – Drug Allergy (disorder)"	To clarify for Testers/Vendors why these data are included in the Test Data
• Med Allergy List header changed from "Date Recorded" to "Adverse Event Date"	Clarification based on comment suggestion
• RxNorm codes in Medication List o If RxNorm code shown in Medication List could no longer be found for the medication, the row with this medication was deleted in the Medication List o If previous RxNorm code did not apply to both the Brand and Generic med names, this code was replaced with an RxNorm code that does apply to both the Brand and Generic med names	To promote accuracy in Test Data
• In Med List, correction was made if Brand name was in the Generic name column and Generic name was in the Brand name column	To promote accuracy in Test Data
• Type column removed from Problem List, Med Allergy List, Diagnostic Test Results, and Procedure List	Data were not required
• The Medication/Agent Allergy data changed to "Vendor-supplied (including medication/agent allergy and associated RxNorm code)"	To facilitate capture of the RxNorm code for the medication allergy data in a manner most convenient to the EHR Vendors.
• Only one row now displays in each Medication Allergy list in each data set	The other rows were deleted as they were no longer necessary
306.g Labs to PH	
In the Normative Test Procedures section • VE170.306.g – 1.01 to 1.04: added patient demographic, Performing Organization, Ordering Provider, and Ordering Facility data to be entered by Vendor	Required data for this test procedure
• VE170.306.g – 1.05: added Vendor-supplied laboratory test order and result data to be identified to the Tester for recording in the existing patient record	Required data for this test procedure
• DTR170.306.g – 3: Electronically Submit Laboratory Test Results o Inspection Test Guide - Corrected numbering typos o Deleted IN170.306.g – 3.02 second option: "The Tester shall visually inspect the submitted lab result message to verify that the LOINC codes entered during the DTR170.306.g – 1: Electronically Record Laboratory Test Results test are contained in the message"	Option not required for this test procedure

Change	Reason for Change
In the Test Data section • Content of the Test Data Message Structure tables in TDMS170.306.g: Submit Laboratory Test Results was updated to match the downloadable tools and the web application validation service available at http://xreg2.nist.gov:8080/HL7V2MuValidation2011	Required data for this test procedure
• A Test Data Message Structure table with Data Elements from the HL7 SFT Software Segment was added	Required data for this test procedure
• North Dakota Zip Code corrected from 54102 to 58102	Correction
• California Zip Code corrected from 94607 to 94605	Correction
• Column for HL7 message "Location" added to all data set tables	To facilitate use of test data by Testers
• Data Elements were added to all data set tables to match all HL7 message Locations included in the test procedure for message Segments SFT, PID, ORC, OBR, OBX, and SPM	To facilitate use of test data by Testers
• NIST-supplied examples for Vendor-supplied test data provided for the Data Elements matching all HL7 message Locations included in the test procedure for message Segments SFT, PID, ORC, OBR, OBX, and SPM where non-Vendor-supplied test data is required	To facilitate use of test data by Testers
• LOINC codes were added for both the OBR and OBX segments, and LOINC codes were changed for the Stool Culture for Diarrhea data set:	Required data for this test procedure
• The following Data Sets were deleted: o Lead Poisoning & Pertussis o Malaria & Anthrax o Pertussis	Data not required for this test procedure
• Added three Data Sets for Lead Poisoning	To facilitate use of test data by Testers
• Modified the following Data Sets o Anthrax o Hepatitis C o Stool Culture for Diarrhea	To facilitate use of test data by Testers
• Changed all Performing Organization Addresses	To facilitate use of test data by Testers
• Added Performing Organization Information for all data sets	Required data for this test procedure
• Added Ordering Provider Information for all data sets	Required data for this test procedure
In the Test Data Message Structure section • Changed MSH 5 from "Sending Facility" to "Receiving Application"	Correction
• Changed MSH 6 from "Sending Facility" to "Receiving Facility"	Correction
306.h Advanced Directives	
In the Normative Test Procedures section • Added "indicator/content" verbiage	To clarify test procedure for Testers/Vendors

Change	Reason for Change
• In IN170.306.h – 1.01, deleted reference to examples in TD170.306.h	Correction