i. This playingEntity/name **MAY** be used for the vehicle name in text, such as Normal Saline (CONF:81-10087).

Figure 142: Drug Vehicle Example

3.23 Encounter Activity (V3)

[encounter: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.49:2015-08-01 (open)]

Table 270: Encounter Activity (V3) Contexts

Contained By:	Contains:
Planned Intervention Act (V2) (optional)	Service Delivery Location (optional)
Intervention Act (V2) (optional)	Indication (V2) (optional)
Encounters Section (entries optional) (V3) (optional)	Encounter Diagnosis (V3) (optional)
Encounters Section (entries required) (V3) (required)	

This clinical statement describes an interaction between a patient and clinician. Interactions may include in-person encounters, telephone conversations, and email exchanges.

Table 271: Encounter Activity (V3) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
encounter (identifier: urn:hl7ii:2.10	5.840.1.1	13883.10.20	.22.4.49:2	2015-08-01)	
@classCode	11	SHALL		1198- 8710	urn:oid:2.16.840.1.113883.5.6 (HL7ActClass) = ENC
@moodCode	11	SHALL		1198- 8711	urn:oid:2.16.840.1.113883.5.1 001 (HL7ActMood) = EVN
templateId	11	SHALL		1198- 8712	
@root	11	SHALL		1198- 26353	2.16.840.1.113883.10.20.22.4 .49
@extension	11	SHALL		1198- 32546	2015-08-01
id	1*	SHALL		1198- 8713	
code	11	SHALL		1198- 8714	urn:oid:2.16.840.1.113883.3.8 8.12.80.32 (EncounterTypeCode)
originalText	01	SHOULD		1198- 8719	
reference	01	SHOULD		1198- 15970	
@value	01	SHOULD		1198- 15971	
translation	01	MAY		1198- 32323	
effectiveTime	11	SHALL		1198- 8715	
sdtc:dischargeDispositionCode	01	MAY		1198- 32176	
performer	0*	MAY		1198- 8725	
assignedEntity	11	SHALL		1198- 8726	
code	01	MAY		1198- 8727	urn:oid:2.16.840.1.114222.4.1 1.1066 (Healthcare Provider Taxonomy)
participant	0*	SHOULD		1198- 8738	
@typeCode	11	SHALL		1198- 8740	urn:oid:2.16.840.1.113883.5.9 0 (HL7ParticipationType) = LOC
participantRole	11	SHALL		1198- 14903	Service Delivery Location (identifier: urn:oid:2.16.840.1.113883.10. 20.22.4.32
entryRelationship	0*	MAY		<u>1198-</u>	

XPath	Card.	Verb	Data Type	CONF#	Value
				8722	
@typeCode	11	SHALL		1198- 8723	urn:oid:2.16.840.1.113883.5.1 002 (HL7ActRelationshipType) = RSON
observation	11	SHALL		1198- 14899	Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.1 0.20.22.4.19:2014-06-09
entryRelationship	0*	MAY		1198- 15492	
act	11	SHALL		1198- 15973	Encounter Diagnosis (V3) (identifier: urn:hl7ii:2.16.840.1.113883.1 0.20.22.4.80:2015-08-01

- 1. **SHALL** contain exactly one [1..1] **@classCode="**ENC" (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 **STATIC**) (CONF:1198-8710).
- 2. **SHALL** contain exactly one [1..1] **@moodCode="**EVN" (CodeSystem: HL7ActMood urn:oid:2.16.840.1.113883.5.1001 **STATIC**) (CONF:1198-8711).
- 3. SHALL contain exactly one [1..1] templateId (CONF:1198-8712) such that it
 - a. **SHALL** contain exactly one [1..1] **@root="**2.16.840.1.113883.10.20.22.4.49" (CONF:1198-26353).
 - b. **SHALL** contain exactly one [1..1] **@extension="**2015-08-01" (CONF:1198-32546).
- 4. **SHALL** contain at least one [1..*] **id** (CONF:1198-8713).
- 5. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from ValueSet **EncounterTypeCode** urn:oid:2.16.840.1.113883.3.88.12.80.32 **DYNAMIC** (CONF:1198-8714).
 - a. This code **SHOULD** contain zero or one [0..1] **originalText** (CONF:1198-8719).
 - i. The originalText, if present, **SHOULD** contain zero or one [0..1] **reference** (CONF:1198-15970).
 - 1. The reference, if present, **SHOULD** contain zero or one [0..1] **@value** (CONF:1198-15971).
 - a. This reference/@value **SHALL** begin with a '#' and **SHALL** point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:1198-15972).

The translation may exist to map the code of EncounterTypeCode (2.16.840.1.113883.3.88.12.80.32) value set to the code of Encounter Planned (2.16.840.1.113883.11.20.9.52) value set.

- b. This code MAY contain zero or one [0..1] translation (CONF:1198-32323).
- 6. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:1198-8715).
- 7. MAY contain zero or one [0..1] sdtc:dischargeDispositionCode (CONF:1198-32176). Note: The prefix sdtc: SHALL be bound to the namespace "urn:hl7-org:sdtc". The use of the namespace provides a necessary extension to CDA R2 for the use of the dischargeDispositionCode element

- a. This sdtc:dischargeDispositionCode **should** contain exactly [0..1] code, which **SHOULD** be selected from ValueSet 2.16.840.1.113883.3.88.12.80.33 NUBC UB-04 FL17-Patient Status (code system 2.16.840.1.113883.6.301.5) DYNAMIC or, if access to NUBC is unavailable, from CodeSystem 2.16.840.1.113883.12.112 HL7 Discharge Disposition (CONF:1198-32177).
- b. This sdtc:dischargeDispositionCode **SHOULD** contain exactly [0..1] codeSystem, which **SHOULD** be either CodeSystem: NUBC 2.16.840.1.113883.6.301.5 OR CodeSystem: HL7 Discharge Disposition 2.16.840.1.113883.12.112 (CONF:1198-32377).
- 8. MAY contain zero or more [0..*] performer (CONF:1198-8725).
 - a. The performer, if present, SHALL contain exactly one [1..1] assignedEntity (CONF:1198-8726).
 - i. This assignedEntity MAY contain zero or one [0..1] code, which SHOULD be selected from ValueSet Healthcare Provider Taxonomy urn:oid:2.16.840.1.114222.4.11.1066 DYNAMIC (CONF:1198-8727).
- 9. **SHOULD** contain zero or more [0..*] participant (CONF:1198-8738) such that it
 - a. **SHALL** contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ParticipationType urn:oid:2.16.840.1.113883.5.90 STATIC) (CONF:1198-8740).
 - b. SHALL contain exactly one [1..1] Service Delivery Location (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.32) (CONF:1198-14903).
- 10. MAY contain zero or more [0..*] entryRelationship (CONF:1198-8722) such that it
 - a. **SHALL** contain exactly one [1..1] **@typeCode=**"RSON" Has Reason (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 STATIC) (CONF:1198-8723).
 - b. SHALL contain exactly one [1..1] Indication (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.19:2014-06-09) (CONF:1198-14899).
- 11. MAY contain zero or more [0..*] entryRelationship (CONF:1198-15492) such that it
 - a. SHALL contain exactly one [1..1] Encounter Diagnosis (V3) (identifier: urn:h17ii:2.16.840.1.113883.10.20.22.4.80:2015-08-01) (CONF:1198-15973).

Table 272: EncounterTypeCode

Value Set: EncounterTypeCode urn:oid:2.16.840.1.113883.3.88.12.80.32

(Clinical Focus: Concepts that represent an interaction between a patient and clinician. Interactions may include in-person encounters, telephone conversations, and email exchanges.),(Data Element Scope: Indicator of an encounter),(Inclusion Criteria: CPT codes found in the following CPT sections: 99201-99499 E/M

99500-99600 home health (mainly nonphysician, such as newborn care in home) 99605-99607 medication management

98966-98968 non physician telephone services),(Exclusion Criteria: Only codes as defined in the inclusion criteria)

This value set was imported on 6/24/2019 with a version of 20190517.

Value Set Source:

https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.88.12.80.32/expansion

Code	Code System	Code System OID	Print Name
98966	CPT4	urn:oid:2.16.840.1.113883.6.12	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
98967	CPT4	urn:oid:2.16.840.1.113883.6.12	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

98968	CPT4	urn:oid:2.16.840.1.113883.6.12	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99091	CPT4	urn:oid:2.16.840.1.113883.6.12	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days
99201	CPT4	urn:oid:2.16.840.1.113883.6.12	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or

			family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99202	CPT4	urn:oid:2.16.840.1.113883.6.12	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99203	CPT4	urn:oid:2.16.840.1.113883.6.12	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting

			problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99204	CPT4	urn:oid:2.16.840.1.113883.6.12	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent faceto-face with the patient and/or family.
99205	CPT4	urn:oid:2.16.840.1.113883.6.12	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting

			problem(s) are of moderate to high severity. Typically, 60 minutes are spent face- to-face with the patient and/or family.
99211	CPT4	urn:oid:2.16.840.1.113883.6.12	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

Figure 143: Encounter Activity (V3) Example

```
<encounter classCode="ENC" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.49" extension="2015-08-01" />
    <id root="2a620155-9d11-439e-92b3-5d9815ff4de8" />
    <code code="99213" displayName="Office outpatient visit 15 minutes"</pre>
codeSystemName="CPT-4" codeSystem="2.16.840.1.113883.6.12">
        <originalText>
            <reference value="#Encounter1" />
        </originalText>
        <translation code="AMB" codeSystem="2.16.840.1.113883.5.4" displayName="Ambulatory"</pre>
codeSystemName="HL7 ActEncounterCode" />
    <effectiveTime value="201209271300+0500" />
    <performer>
        <assignedEntity>
        </assignedEntity>
    </performer>
    <participant typeCode="LOC">
        <participantRole classCode="SDLOC">
            <templateId root="2.16.840.1.113883.10.20.22.4.32" />
        </participantRole>
    </participant>
    <entryRelationship typeCode="RSON">
        <observation classCode="OBS" moodCode="EVN">
            <templateId root="2.16.840.1.113883.10.20.22.4.19" extension="2014-06-09" />
            . . .
        </observation>
    </entryRelationship>
</encounter>
```

3.24 Encounter Diagnosis (V3)

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.80:2015-08-01 (open)]

Table 273: Encounter Diagnosis (V3) Contexts

Contained By:	Contains:
Health Concern Act (V2) (optional)	Problem Observation (V3) (required)
Risk Concern Act (V2) (optional)	
Encounter Activity (V3) (optional)	

This template wraps relevant problems or diagnoses at the close of a visit or that need to be followed after the visit. If the encounter is associated with a Hospital Discharge, the Hospital Discharge Diagnosis must be used. This entry requires at least one Problem Observation entry.