SOCIAL SECURITY ADMINISTRATION ELECTRONIC HEALTH DOCUMENT IMPLEMENTATION GUIDE FOR A HEALTHCARE PARTICIPANT

VERSION 5.0

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1.0 Introduction

The Social Security Administration's (SSA) Agency Strategic Plan charts the course that will enable us to maintain a strong level of performance on core workloads and work toward long-term improvement of our service to the public. One of the key goals as expressed in the strategic plan is to improve the speed and quality of our disability claims processing. The Health IT program directly supports that goal. For the past several years, the SSA has been a leader in the use of Health IT in the federal sector. The SSA was the first government agency to use the Nationwide Health Information Network (now called eHealth Exchange) for Production purposes.

1.1 PURPOSE OF GUIDE

The SSA has created this implementation guide to assist in clinical document exchange between a healthcare participant and itself. This guide provides information about required SSA data elements that may not be explicitly mentioned in the standards listed below. All SSA data elements are compliant with these standards and do not contradict them. This guide will also clarify complex areas of the Heath Information Technology Standards Panel (HITSP) C32/C83, Health Level Seven (HL7) Continuity of Care Document (CCD), HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, and HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm) Draft Standard for Trial Use Release 2.1 specifications that contain required SSA data elements. The healthcare participant should use this implementation guide to assist in generating a well-formed CDA document.

1.2 ASSUMPTIONS AND REQUIRED CONTENT SPECIFICATIONS

This guide assumes that the reader has general knowledge of the Extensible Markup Language (XML) and the business workflow of clinical document exchange. This guide also assumes the reader has a strong knowledge of the following health IT content specifications:

- HL7 Clinical Document Architecture
  - Release 2.0
- HL7 Continuity of Care Document (CCD)
  - Release 1.0
- HL7 Implementation Guide for History and Physical Notes
  - DSTU Release 1.0
- HL7 Unstructured Document
  - DSTU Release Rev 1.2
- IHE PCC Medical Documents Specification
  - IHE PCC TF Revision 9.0
- HITSP TN 901 - Technical Note for Clinical Documents
  - Version 1.0
- HITSP/C32 Summary Documents Using HL7 CCD Component
  - Version 2.5
- HITSP/C83 CDA Content Modules Component
  - Version 2.0
- HITSP/C80 Clinical Document and Message Terminology Component
  - Version 2.0
- HITSP/C154 Data Dictionary Component
  - Version 1.0
- HITSP/C62 Unstructured Document

  - Version 1.1
- HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation
  - DSTU Release 1.1 (July 2012)
- HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm) Draft Standard for Trial Use Release 2.1
  - DSTU Release 2.1 (August 2015)

1.3 SSA C32/CCDA STRUCTURED DOCUMENT

The SSA uses the HITSP/C32 v2.5 Implementation Guide to constrain the HL7 Continuity of Care Document. Data elements and structure that are not defined in the C32/C83 specifications are defaulted to definitions in the HL7 CCD specification, and if absent there, to definitions in HL7 Clinical Document Architecture (CDA) (unless otherwise noted in this guide). Please also be aware of additional requirements per Integrating the Healthcare Enterprise (IHE) standards.

Secondly, the SSA uses the HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, DSTU Release 1.1. For the remainder of this implementation guide, this document will be referred to as CCDA R1.1 for sake of space.

Thirdly, the SSA also uses the HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm) Draft Standard for Trial Use Release 2.1. For the remainder of this implementation guide, this document will be referred to as CCDA R2.1 for sake of space.

1.4 SSA SUPPORTED STRUCTURED DOCUMENT TYPES

Document Name	Document ID	Document Extension
HL7 CCD	2.16.840.1.113883.10.20.1	N/A
HITSP/C32	2.16.840.1.113883.3.88.11.32.1	N/A
CCDA R1.1 CCD	2.16.840.1.113883.10.20.22.1.2	N/A
CCDA R1.1 History and Physical Note	2.16.840.1.113883.10.20.22.1.3	N/A
CCDA R1.1 Consultation Note	2.16.840.1.113883.10.20.22.1.4	N/A
CCDA R1.1 Diagnostic Imaging Report	2.16.840.1.113883.10.20.22.1.5	N/A
CCDA R1.1 Procedure Note	2.16.840.1.113883.10.20.22.1.6	N/A
CCDA R1.1 Operative Note	2.16.840.1.113883.10.20.22.1.7	N/A
CCDA R1.1 Discharge Summary	2.16.840.1.113883.10.20.22.1.8	N/A
CCDA R1.1 Progress Note	2.16.840.1.113883.10.20.22.1.9	N/A
CCDA R2.1 Care Plan (V2)	2.16.840.1.113883.10.20.22.1.15	2015-08-01
CCDA R2.1 Consultation Note (V3)	2.16.840.1.113883.10.20.22.1.4	2015-08-01
CCDA R2.1 CCD (V3)	2.16.840.1.113883.10.20.22.1.2	2015-08-01
CCDA R2.1 Diagnostic Imaging Report (V3)	2.16.840.1.113883.10.20.22.1.5	2015-08-01
CCDA R2.1 Discharge Summary (V3)	2.16.840.1.113883.10.20.22.1.8	2015-08-01
CCDA R2.1 History and Physical Note (V3)	2.16.840.1.113883.10.20.22.1.3	2015-08-01
CCDA R2.1 Operative Note (V3)	2.16.840.1.113883.10.20.22.1.7	2015-08-01
CCDA R2.1 Procedure Note (V3)	2.16.840.1.113883.10.20.22.1.6	2015-08-01
CCDA R2.1 Progress Note (V3)	2.16.840.1.113883.10.20.22.1.9	2015-08-01
CCDA R2.1 Referral Note (V3)	2.16.840.1.113883.10.20.22.1.14	2015-08-01
CCDA R2.1 Transfer Summary (V2)	2.16.840.1.113883.10.20.22.1.13	2015-08-01
CCDA R2.1 Patient Generated Document (V2)	2.16.840.1.113883.10.20.29.1	2015-08-01

1.5 DOCUMENT CONVENTIONS

The key words "SHALL", "SHALL NOT", "SHOULD", "SHOULD NOT", "MAY", and "NEED NOT" in this document are to be interpreted as described in the HL7 Version 3 Publishing Facilitator's Guide (http://www.hl7.org/v3ballot/html/help/pfg/pfg.htm).

1.6 UNDERSTANDING THE GUIDE

The following instructions will help the healthcare participant understand this guide and how it is to be used to layout the C32/CCDA structured documents. Each section of this document is broken out into a general section description that contains section optionality information, and a content section that contains guidance**.**

Content

The purpose of this section is to clarify content within the XML and to provide guidance on complex standards or SSA based requirements. If there are questions regarding any sections of this document or ideas about ways to improve the process, please alert the SSA Project Manager at any time.

2.0 Header

2.1 HEADER INFORMATION

The Header section is a **Required – (R)** section. Please refer to HITSP C32/C83, CCD, CDA, and CCDA specifications for additional guidance on this section.

> **Note**:
> The HL7 Implementation Guide for History and Physical Notes specification has important constraints and requirements for a CDA Header section. Please review the Header chapter of this document before proceeding.
>
> The CCDA R1.1/R2.1 specification has important constraints and requirements for a CCDA Header section. Please review Section 2 "General Header Template"of this document before proceeding.

3.0 Header Participants

3.1 PERSONAL INFORMATION

The Personal Information section is a **Required – (R)** section. This section SHALL be implemented in compliance with the HITSP/C83 or CCDA R1.1 or CCDA R2.1 specification. There are no additional SSA data elements, constraints, or optionality changes. Please refer to HITSP C32/C83, CCD, HL7 Implementation Guide for History and Physical Notes (header only), CDA, and CCDA specifications for guidance on this section.

3.2 HEALTHCARE PROVIDERS

The Healthcare Provider section is a **Required – (R)** section. This section SHALL be implemented in compliance with the HITSP/C83 or CCDA R1.1 or CCDA R2.1 specification. The SSA will either accept a National Provider Id (NPI) or a Local Provider Id. Please refer to HITSP C32/C83, CCD, HL7 Implementation Guide for History and Physical Notes (header only), CDA, and CCDA specifications for guidance on this section.

4.0 C32/CCDA Document Sections

The section optionality in this section may differ from that listed in referenced content specifications.

4.1 ASSESSMENT AND PLAN

The Assessment and Plan section is **Required if Known – (R2)**. This section SHALL be implemented in compliance with the CCDA R1.1 or CCDA R2.1 specification. For a CCDA R1.1 or CCDA R2.1 Progress Note, CCDA R1.1 or CCDA R2.1 Consultation Note, CCDA R1.1 or CCDA R2.1 Procedure Note, and a CCDA R1.1 or CCDA R2.1 History and Physical Note, it is an **Optional – (O)** section.

4.2 COMPLICATIONS

The Complications section is **Required if Known – (R2)**. This section SHALL be implemented in compliance with the CCDA R1.1 or CCDA R2.1 specification. For a CCDA R1.1 or CCDA R2.1 Procedure Note, and a CCDA R1.1 or CCDA R2.1 Operative Note, it is a **Required – (R)** section.

4.3 CONDITION

The Condition section is **Required if Known – (R2)**. This section SHALL be implemented in compliance with the HITSP/C83 or CCDA R1.1 or CCDA R2.1 specification. There are no additional SSA data elements, constraints, or optionality changes.

4.4 ENCOUNTERS

The Encounters section is **Required if Known – (R2)**. This section SHALL be implemented in compliance with the HITSP/C83 specification. Guidance in this section has been provided to support SSA data elements. Please refer to HITSP C32/C83, CCD, CDA, and CCDA specifications for more information on this section.

Including Documents in the Encounters Section

The SSA prefers that any documents associated with a particular encounter entry (e.g. Discharge Summary) be included in the Encounters Section. Documents included in the Encounter section SHALL NOT be included in any other section. Each document included in the narrative block of the Encounter Section SHALL be encompassed by a tag with a unique ID to serve as a reference from a structured entry back to that document in the narrative block. Please see Continuity of Care Document Section 3 CCR Body Representation, CONF-29, CCDA R1.1 CONF-15972, or CCDA R2.1 CONF:1198-15972.

Encounter Location Mapping

For C32, refer to HL7 CCD Section 3.15.2.2 for further guidance.

For CCDA, refer to CCDA R1.1 Section 5.21 or CCDA R2.1 Section 3.98 for further guidance.

4.5 FUNCTIONAL STATUS

The Functional Status section is **Required if Known – (R2)**. This section SHALL be implemented in compliance with the HITSP/C83 or CCDA R1.1 or CCDA R2.1 specification. There are no additional SSA data elements, constraints, or optionality changes. Please refer to HITSP/C83, CCD, CDA, and CCDA specifications for additional guidance on this section.

Content of Functional Status

The HL7 Continuity of Care Document defines the content of the Functional Status section as:

> "Functional Statuses can be expressed in 3 different forms. They can occur as a Problem (see section ***3.5 Problems***), a Result (see section ***3.13 Results***) or as text. Text can be employed if and only if the Functional Status is neither a Problem nor a Result. Functional Statuses expressed as Problems include relevant clinical conditions, diagnoses, symptoms and findings. Results are the interpretation or conclusion derived from a clinical assessment or test battery, such as the Instrumental Activities of Daily Living (IADL) scale or the Functional Status Index (FSI)."

The CCDA R1.1 defines the content of the Functional Status section as:

> "The patient's functional status may be expressed as a problem or as a result observation. A functional or cognitive status problem observation describes a patient's problem, symptoms or condition. A functional or cognitive status result observation may include observations resulting from an assessment scale, evaluation or question and answer assessment."

The CCDA R2.1 defines the content of the Functional Status section as:

> "The Functional Status Section contains observations and assessments of a patient's physical abilities. A patient's functional status may include information regarding the patient's ability to perform Activities of Daily

Living (ADLs) in areas such as Mobility (e.g., ambulation), Self-Care (e.g., bathing, dressing, feeding, grooming) or Instrumental Activities of Daily Living (IADLs) (e.g., shopping, using a telephone, balancing a check book). Problems that impact function (e.g., dyspnea, dysphagia) can be contained in the section."

4.6 HISTORY OF PAST ILLNESS

The History of Past Illness section is **Required if Known – (R2)**. This section SHALL be implemented in compliance with the CCDA R1.1 or CCDA R2.1 specification. For a CCDA R1.1 or CCDA R2.1 Consultation Note, CCDA R1.1 or CCDA R2.1 Discharge Summary, and a CCDA R1.1 or CCDA R2.1 Procedure Note it is an **Optional – (O)** section. For a CCDA R1.1 or CCDA R2.1 History and Physical Note, it is a **Required – (R)** section.

4.7 MEDICATIONS

The Medications section is **Required if Known – (R2)**. This section SHALL be implemented in compliance with the HITSP/C83 or CCDA R1.1 or CCDA R2.1 specification. Please refer to HITSP C32/C83, CCD, CDA, and CCDA specifications for more information on this section.

4.8 MEDICAL EQUIPMENT

The Medical Equipment section is **Required if Known – (R2)**. This section SHALL be implemented in compliance with the HITSP/C83 or CCDA R1.1 or CCDA R2.1 specification. Please refer to HITSP C32/C83, CCD, CDA, and CCDA specifications for more information on this section.

4.9 MENTAL STATUS

The Mental Status section is **Required if Known – (R2)**. This section SHALL be implemented in compliance with the CCDA R2.1 specification. Please refer to the CCDA R2.1 specification for more information on this section.

4.10 PHYSICAL EXAM

The Physical Exam section is **Required if Known – (R2)**. This section SHALL be implemented in compliance with the HITSP/C83 or CCDA R1.1 or CCDA R2.1 specification. Please refer to HITSP/C83 Section 2.2.1.18, CCDA R1.1 Section 4.38, or CCDA R2.1 Section 2.47 for more information on this section.

Content of Physical Exam

The SSA will accept HITSP/C83 Condition Module entries (as constrained in the HITSP/C83 for this section) as well as HITSP/C83 Result Module/Vital Signs Module entries in the Physical Exam section.

The SSA will accept the CCDA R1.1 or CCDA R2.1 Problem subsection as well as the CCDA R1.1 or CCDA R2.1 Results/Vital Signs subsections in the Physical Exam section (as constrained in the CCDA R1.1 or CCDA R2.1).

4.11 PLAN OF CARE

The Plan of Care section is **Required if Known – (R2)**. The SSA requests that all "Plan of Care" data be present in the Narrative Block of the Plan of Care section.

4.12 PROCEDURES

The Procedures section is **Required if Known – (R2)**. This section SHALL be implemented in compliance with the HITSP/C83 or CCDA R1.1 or CCDA R2.1 specification. Guidance in this section has been provided on account of SSA data elements. Please refer to HITSP C32/C83, CCD, CDA, and CCDA specifications for more information on this section.

Including Documents in the Procedures Section

The SSA prefers that any documents associated with a particular procedure entry (e.g. Operative Report) to be included in the Procedures Section. Each document included in the narrative block of the Procedure Section SHALL be encompassed by a tag with a unique ID to serve as a reference from a structured entry back to that document in the narrative block. Please see Continuity of Care Document Section 3 CCR Body Representation, CONF-29 or CCDA R1.1 CONF-15598, CONF-15903, or CONF-15910, or CCDA R2.1 CONF:1098-19189.

Procedure Location Mapping

For C32, refer to HL7 CCD CONF-437 and CCD Section 3.15.2.2 for further guidance.

For CCDA, refer to CCDA R1.1 Section 5.61, 5.62, or 5.63 or CCDA R2.1 Section 3.98 for further guidance.

4.13 RESULTS

The Results section is **Required if Known – (R2)**. This section SHALL be implemented in compliance with the HITSP/C83 or CCDA R1.1 or CCDA R2.1 specification. Guidance in this section has been provided on account of required SSA data elements and complex entry structure. Please refer to HITSP C32/C83, CCD, CDA, and CCDA specifications for more information on this section.

Result Entry Structure

Results may be expressed as either a single observation entry, as a test battery, or as a test cluster in an organizer.

Result Text Field

The SSA uses the observation/text element as a "Result Text" field where a sending system can place additional text about a particular result. This field SHALL be populated as per Continuity of Care Document section 3 CCR Body Representation, CONF-29 CCDA R1.1 CONF-9109, or CCDA R2.1 CONF:1198-19212.

4.14 POSTPROCEDURE DIAGNOSIS

The Postprocedure Diagnosis section is **Required if Known – (R2)**. This section SHALL be implemented in compliance with the CCDA R1.1 or CCDA R2.1 specification. For a CCDA R1.1 or CCDA R2.1 Procedure Note, it is a **Required – (R)** section.

4.15 PROCEDURE FINDINGS

The Procedure Findings section is **Required if Known – (R2)**. This section SHALL be implemented in compliance with the CCDA R1.1 specification. For a CCDA R1.1 or CCDA R2.1 Procedure Note, it is an **Optional – (O)** section. For a CCDA R1.1 or CCDA R2.1 Operative Note, it is a **Required – (R)** section.

4.16 SOCIAL HISTORY

The Social History section is **Required if Known – (R2)**. This section SHALL be implemented in compliance with the HITSP/C83 or CCDA R1.1 or CCDA R2.1 specification. There are no additional SSA data elements, constraints or optionality changes; however some guidance has been provided. Please refer to HITSP C32/C83, CCD, CDA, and CCDA specifications for more information on this section.

Social History Free Text

For C32, Social History Free Text [19.03] in the HITSP/C83 specification maps to observation.text in the Social History section. This field SHALL be populated as per Continuity of Care Document section 3 CCR Body Representation, CONF-29.

For CCDA, Social History Free Text in the CCDA R1.1 or CCDA R2.1 maps to the observation.text in the Social History section.

4.17 VITAL SIGNS

The Vital Signs section is **Required if Known – (R2)**. This section SHALL be implemented in compliance with the HITSP/C83 or CCDA R1.1 or CCDA R2.1 specification. There are no additional SSA data elements, constraints, or optionality changes. Please refer to HITSP C32/C83, CCD, CDA, and CCDA specifications for more information on this section.

5.0 Production Data Lessons and Additional Guidance

The following section is meant to provide guidance on the creation of the C32/CCDA documents based on SSA's Production experiences.

5.1 VALID XML

During the creation of a C32/CCDA structured document, the healthcare participant SHALL ensure that the data placed into the C32/CCDA structured document does not cause the XML to be invalid. In XML, there are characters that require special encoding. Additionally, Byte Order Marker (BOM) SHALL NOT be present in the XML file.

Example:
The less-than character '<' must be encoded as < when it is part of a the document context and has clinical significance, such as a lab whereby the intent is to indicate 'less-than'. Special encoding SHALL not be used as part of an XML element or attribute value.

For additional information, the healthcare participant SHOULD refer to the latest edition of the World Wide Web Consortium (W3C) Extensible Markup Language (XML) specification.

5.2 HL7 2.X MESSAGE DELIMITERS

During the creation of a C32/CCDA structured document, the healthcare participant SHALL convert HL7 2.x message delimiters into the appropriate C32/CCDA data elements.

Example:
If the health participant's source for information is an HL7 2.x message and the tilde represents a line feed, then the participant SHALL encode the tilde as a
 element.

5.3 ID GENERATION

During the creation of a C32/CCDA structured document, the clinical statement ids should be generated in a manner that would enable the identification of the clinical statement if it were included on a separate C32/CCDA structured document.

Example:
If the same procedure is identified on two different C32/CCDA structured documents, then the id of that procedure would be the same.

5.4 RESTRICTED CDA ELEMENTS

The SSA does not currently accept external references such as the usage of CDA <linkHtml> element. All data and content as part of the exchange process SHALL be included in the CDA document transmitted by the healthcare participant.

5.5 USE OF PROPRIETARY CODE SETS

It is permissible to use a proprietary code set if the required code set is not available. However, this must be discussed and agreed upon with the SSA before implementation.

5.6 CODESYSTEM OIDS FOR PROPRIETARY SYSTEMS

The SSA recommends sub-arcing an OID assigned to the participant and putting that value in the codeSystem attribute. For example, Test HIE's OID is 2.16.840.1.113883.3.1839. Test HIE could sub-arc the OID to look like:

2.16.840.1.113883.3.1839.5 = Test HIE Lab Systems
- 2.16.840.1.113883.3.1839.5.1 = Proprietary code set 1
- 2.16.840.1.113883.3.1839.5.2 = Proprietary code set 2

The SSA also requests the name of the proprietary code set in the codeSystemName attribute.

5.7 DATA/REFERENCE USAGE WITH TEXT AND ORIGINALTEXT ELEMENTS

Data can appear directly in text and originalText elements as can reference elements that point to the narrative block. In most cases, structured data is derived from the narrative block. For this reason, the SSA requests that references to the narrative block be used instead of entering data directly into text/originalText elements unless explicitly stated in a HL7, HITSP, IHE, or CCDA specification for a particular field. Please see Continuity of Care Document section 3 CCR Body Representation, CONF-29 for more information on how references work. Additionally, data shall not be placed directly into a text/originalText element and also have a reference into the narrative block. This is an unnecessary duplication of data and could cause a potentially ambiguous situation if the data do not match up exactly.

5.8 NARRATIVE BLOCK ORDERING PREFERENCE

The SSA prefers that data be organized and applied to the narrative block in reverse chronological order: most recent to oldest. This request will help facilitate human readability of the narrative block when rendered. This preference is in special regard to Encounters and Procedures section narrative block(s), but can be applied generally.

6.0 HITSP/C62 UNSTRUCTURED DOCUMENT

The SSA uses HITSP/C62 v1.1 to exchange unstructured document content, such as text, PDF/A, and images rendered in PDF/A. Please also be aware of additional requirements per Integrating the Healthcare Enterprise (IHE) standards.

6.1 HEADER INFORMATION

The Header section is **Required – (R)**. Please refer to HITSP/C62 and CDA specifications for additional guidance on this section.

6.2 HITSP/C62 NONXMLBODY

ClinicalDocument/component/nonXMLBody/text @mediaType SHALL be "application/pdf" for PDF/A, or "text/plain" for plain text.

ClinicalDocument/component/nonXMLBody/text@representation SHALL be present. The @representation attribute for both PDF/A and plaintext scanned content will be "B64".

7.0 HL7 UNSTRUCTURED DOCUMENT

The SSA uses HL7 Unstructured Document DSTU Release Rev 1.2 to exchange unstructured document content, such as TXT, PDF, RTF, HTML, GIF, TIF, JPEG, and PNG.

7.1 HEADER INFORMATION

The Header section is **Required – (R)**. Please refer to HL7 Unstructured Document and CDA specifications for additional guidance on this section.

7.2 HL7 NONXMLBODY

The ClinicalDocument element SHALL contain component/nonXMLBody/text element. The text element SHALL have a representation attribute with the value of B64, a mediaType attribute, and contain the media content.

The value of @mediaType SHALL be drawn from the value set 2.16.840.1.113883.11.20.7.1 SupportedFileFormats STATIC 20100512

Value Set: SupportedFileFormats 2.16.840.1.113883.11.20.7.1	
Word Processing/Narrative Formats	**Code**
MSWORD	application/msword
PDF	application/pdf
Plain Text	text/plain
RTF Text	text/rtf
HTML	text/html
Graphic Formats	**Code**
GIF Image	image/gif
TIF Image	image/tiff
JPEG Image	image/jpeg
PNG Image	image/png

Note: The SSA restricts the usage of file referencing in our exchange process. Healthcare participants SHALL NOT provide a HL7 unstructured document with a ClinicalDocument/component/nonXMLBody/text/reference/@value

7.3 CLINICAL CONTENT PREFERENCE

In the case of dynamically generated documents, the SSA requests the content provided as text when possible, as opposed to images rendered in PDF, MSWORD, HTML, etc.

8.0 CCDA UNSTRUCTURED DOCUMENT

The SSA uses the CCDA R1.1 and CCDA R2.1 to exchange unstructured document content, such as TXT, PDF, RTF, HTML, GIF, TIF, JPEG, and PNG.

8.1 HEADER INFORMATION

The Header section is **Required – (R)**. Please refer to CCDA specifications for additional guidance on this section.

8.2 CCDA NONXMLBODY

The ClinicalDocument element SHALL contain component/nonXMLBody/text element. The text element SHALL have a representation attribute with the value of B64, a mediaType attribute, and contain the media content.

The value of @mediaType SHALL be drawn from the value set 2.16.840.1.113883.11.20.7.1 SupportedFileFormats STATIC 20100512

Value Set: SupportedFileFormats 2.16.840.1.113883.11.20.7.1 STATIC 20100512	
Word Processing/Narrative Formats	**Code**
MSWORD	application/msword
PDF	application/pdf
Plain Text	text/plain
RTF Text	text/rtf
HTML	text/html
Graphic Formats	**Code**
GIF Image	image/gif
TIF Image	image/tiff
JPEG Image	image/jpeg
PNG Image	image/png

Note: The SSA restricts the usage of file referencing in our exchange process. Healthcare participants SHALL NOT provide a CCDA unstructured document with a ClinicalDocument/component/nonXMLBody/text/reference/@value

8.3 CLINICAL CONTENT PREFERENCE

In the case of dynamically generated documents, the SSA requests the content provided as text when possible, as opposed to images rendered in PDF, MSWORD, HTML, etc.

9.0 NATIVE DOCUMENTS & DOCUMENT PREFERENCES

The SSA can accept the following file types as part of document exchange: MSWORD, PDF, Plain Text, RTF Text, GIF, TIF, TIFF, JPEG, PNG, and HTML.

9.1 DOCUMENT PREFERENCES

All document preferences apply to HITSP/C62, HL7 Unstructured, CCDA Unstructured, and Native Document Types where appliciable.

Healthcare participants SHALL NOT password protect or encrypted files in the exchange process.

For the applicable files types:
Preferred DPI (Dots per inch) is 200 x 200
Color schema- bitonal
Compression CCHIT Group 4

The preferred layout and size is portrait and paper size (letter, dimensions - 8.5”x11”) respectively.

In the case of dynamically generated documents, the SSA requests the content provided as text when possible, as opposed to images rendered in PDF, MSWORD, HTML, etc.

9.2 HYPERLINKS AND EMBEDDED MEDIA

The SSA requests that healthcare participants omit hyperlinks and embedded media such as audio or video from exchanged documentation. The documents should be self-contained.

9.3 DICOM

The SSA does not support usage of Digital Imaging and Communications in Medicine (DICOM) images at this time. Additionally, this restriction extends to DICOM usage in HITSP/C62, HL7 Unstructured Document, and CCDA Unstructured Documents.

The SSA does support the usage of DICOM narrative text (section.text) pertaining to images (i.e. Findings).