

Description

At 9:00 AM the next day, August 18, 2015, the patient is visited by the surgeon and an attending physician who perform a physical to check for signs and symptoms of any post-operation complications. The patient reports that he is not experiencing any chest pain. The physicians both observe that the patient has signs of cardiac arrhythmia (I49.9), but conclude that he is otherwise in good condition. They clear the patient for discharge. At 12:00 PM the patient goes home.

Mountainview General Hospital reports inpatient syndromic surveillance data to the state health department (SHD) for all new patient discharges once per day. At 1:00 AM on August 19, 2015, the hospital's electronic health record module for syndromic surveillance data assembles and transmits an ADT^A03 Discharge message about this encounter to SHD.

Comments

This Test Case provides an example of an inpatient visit where syndromic surveillance data are sent to a public health agency in accordance with [guidelines recommended by the International Society for Disease Surveillance](#). The dates and times in this test case illustrate the sequence of clinical and messaging events. Since the exact dates and times are not reproducible when modeling the test case with EHR technology, only date and time format will be validated within tester submitted test data. ICD-10 diagnosis codes are acceptable with or without decimals.

Pre Condition

A01-Admission message is sent before A03-Discharge message.

Post Condition

No PostCondition

Test Objectives

This test case examines a Health IT Module's ability to create ADT^A03 Discharge message within PHIN Messaging Guide's conformance requirements.

Evaluation Criteria

No evaluation criteria

Notes for Testers

HIT developers must demonstrate that their system supports ICD-9CM, ICD-10CM, and SNOMED CT value sets in order to be conformant to the PHIN Syndromic Surveillance Messaging Guide, Rel2.0, April 2015. If an HIT developer identifies the Inpatient setting as the only health care setting applicable to their system, the Tester must execute the certification testing for this Test Step by having the system create messages (1) using the ICD-10CM codes provided in the test data for PV2-3 and DG1-3 in a test message, (2) using clinically appropriate (equivalent to the ICD-10CM codes provided in the test data) and valid ICD-9CM codes provided by the vendor for PV2-3 and DG1-3 in a test message, and (3) using clinically appropriate (equivalent to the ICD-10CM codes provided in the test data) and valid SNOMED CT codes provided by

the vendor for PV2-3 and DG1-3 in a test message. The Tester must perform visual inspection of the test messages created by the system in order to determine whether PV2-3 and DG1-3 fields are populated with appropriate and valid ICD-9CM and SNOMED CT codes.

ICD-10CM codes are provided in the test data for coding the admit/encounter reason and final diagnosis. If the vendor uses different but equivalent ICD-10CM codes than the ones provided, the Tester may ignore errors generated by the Test Tool related to incorrect code when the ICD-10 codes used in the message are determined to be valid codes.

ICD-10CM and ICD-9CM diagnosis codes are acceptable with or without decimals.

Visit Number ID (PV1-19.1) must be populated with the same value for all messages included in this Test Case to reflect the requirement in real-world installations. Test Tool does not automatically test for this requirement, so Testers must manually inspect the messages to verify that PV1-19.1 is the same for all Test Step messages for a given Test Case.