

Description

At 5:41 PM, the patient dies. The working diagnoses (ICD-10-CM S02.112A and S06.9X3A) are resolved/inactivated, and the final diagnoses are S06.0X8A (Concussion with LOC of any duration with death due to other cause prior to regaining consciousness) and S02.112A (Type III occipital condyle fracture, initial encounter for closed fracture). Western Regional Medical Center reports syndromic surveillance data to the state health department (SHD). At 6:00 PM on July 17, 2012 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 ED visit where the patient's demographic information is unavailable at registration, admit/encounter reason is captured as a coded value using an ICD-10 CM code, two working diagnoses and a final diagnosis are captured using ICD-10 CM codes, and the patient dies. 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 a Health IT Module, only date and time format will be validated within tester submitted test data.

Pre-condition

A08-Update message is sent before the A03-Discharge message.

Post-Condition

No PostCondition

Test Objectives

This test step examines a Health IT Module's ability to create ADT^A03 Discharge message within PHIN Messaging Guide's conformance requirements for emergency department (ED) data.

Evaluation Criteria

Message Validation Report

Notes

Per ONC, for certification testing HIT developers must demonstrate that their system supports either the ICD-10 CM or SNOMED CT value set and are no longer required to demonstrate support for the ICD-9 CM value set (this policy is not conformant to the PHIN Syndromic Surveillance Messaging Guide, Rel2.0, April 2015).

ICD-10 CM codes are provided in the test data for coding the admit/encounter reason and final diagnoses. If the HIT developer uses different but equivalent ICD-10 CM codes than the ones provided or uses equivalent SNOMED CT codes, the Tester may ignore errors generated by the Test Tool related to incorrect code/name of coding system when the ICD-10 CM or SNOMED CT code data used in the message are determined via visual inspection to be valid data.

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

This Test Step does not prescribe the method used by the Health IT Module to change a working diagnosis to a final diagnosis. The Test Step only validates a specific ADT message type.

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.