Description

While the patient is prepared for transport within the hospital for HBOT, the clinical staffers complete an admission record. The admit reason is recorded as, "Accidental exposure to carbon monoxide," (SNOMED CT code 242383002). Southern Midwest Medical Center reports syndromic surveillance data to the city health department (CHD). At 8:35 AM on February 1, 2010, the hospitals electronic health record module for syndromic surveillance data assembles and transmits an Admission message about this encounter to SHD.

Comments

This Test Case provides an example of an ED visit for which the patient's chief complaint is captured as free-text, working diagnosis and final diagnosis are captured with SNOMED CT codes, the patient is discharged from the ED and admitted for inpatient care, and the Admit/Encounter Reason is captured with a SNOMED CT code. Dates and times are provided in this test case to 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

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

Post Condition

No PostCondition

Test Objectives

This test step examines a Health IT Module's ability to create ADT^A01 Admission message within the PHIN Messaging Guide's conformance requirements for syndromic surveillance.

Evaluation Criteria

Message Validation Report

Notes for Testers

PV1-2 may be populated with either "E" or "I".

An OBX segment in the A01 message provides the originating visit type information through Facility/Visit Type. The admit described in the ED_Visit_Admit Test Scenario originated in the emergency department; therefore, "261QE0002X^Emergency Care^HCPTNUCC" is in the OBX.5 field in the Example A01 Message. Per ONC, the OBX.5 field may be populated with "1021-5^Inpatient practice setting^HSLOC" for certification testing. The Tool performs automated validation to check for either of those values.

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).

A SNOMED CT code is provided in the test data for coding the admit reason. The Tool is designed to accept the following SNOMED CT codes without generating an error related to the admit/encounter reason:

��� 242383002 - Accidental exposure to carbon monoxide (used in Test Story)
��� 420057003 - Accidental poisoning by carbon monoxide
��� 95875007 - Exposure to carbon monoxide (event)

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

The ICD-10 CM code is acceptable with or without decimals.

Visit Number ID (PV1-19.1) for the ADT^A01 message in this Test Case may be populated with the same value as in the ADT^A04, ADT^A08, and ADT^A03 messages; however, as the way an actual installation works will determine whether an A01 message has the same or a different Visit Number ID in PV1-19.1 for a patient admitted from the ED, the PV1-19.1 for the ADT^A01 message is allowed to be populated with a different value than the value in the ADT^A04, ADT^A08, and ADT^A03 messages for this Test Case. Test Tool does not automatically test for this requirement, so Testers must manually inspect the message to verify whether the value of PV1-19.1 is the same as or different from the value in the other Test Step messages for this Test Case.