2014 Edition
Test Scenario Data for §170.314(f)(5) Cancer case information –
ambulatory setting only
For Feedback 1.0 ■ September 11, 2013

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Health Information Technology

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Reference the Test Scenario Procedure for Test Scenario Data implementation guidance.

TD170.314(f)(5) Cancer Case Information – Myra Jones

Electronically Record Cancer Case Information

A user records three instances of cancer case information for the test patient(s).

Record Instance 1:
Digital rectal exam: Nodular, hard prostate noted
PSA Score: 7
Sextant biopsy: Adenocarcinoma, Grade 1, in 1 of 6 core biopsies
Diagnosis: Adenocarcinoma of Prostate

Record Instance 2:
Physical exam: Within normal limits, no swelling, soreness, or enlargement
Diagnostic tests: Blood smear and bone marrow aspiration
Diagnosis: Indolent Chronic Lymphocytic Leukemia

Record Instance 3:
Physical exam: Irregularly shaped, 3 cm ulcerated pigmented lesion located on left upper back and enlarged axillary lymph nodes
Chest x-ray: Irregular mass in the left upper lobe of the lung
Diagnosis: Malignant melanoma with possible metastasis to lymph nodes and the lung

Electronically Change Cancer Case Information

A user changes the three instances of cancer case information recorded for the test patient(s).

Change Instance 1: Mark words as error and enter replacement words.
(Strikethrough is used only to indicate to the Tester and Vendor which words are error and does not prescribe how the EHR is to mark the words as error)
Digital rectal exam: ~~Nodular, hard,~~ **Normal** prostate noted
PSA Score: ~~7~~ 2
~~Sextant Biopsy: Adenocarcinoma, Grade 1, in 1 of 6 core biopsies~~
Diagnosis: ~~Adenocarcinoma of~~ Normal Prostate, **no evidence of Adenocarcinoma**

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Change Instance 2: Add words to the Information

Physical exam: Within normal limits, no swelling, soreness, or enlargement

Reported symptoms: Continuous fatigue, weight loss

Diagnostic tests: Blood smear and bone marrow aspiration

Diagnosis: Indolent Chronic Lymphocytic Leukemia

Change Instance 3: Cancer case information was entered into the wrong
patient's record. Mark all information as entered in error.

*(Strikethrough is used only to indicate to the Tester and Vendor that the entire
note is to be marked as error and does not prescribe how the EHR is to mark the
note as error)*

~~Physical Exam: Irregularly shaped, 3 cm ulcerated pigmented lesion located on
left upper back and enlarged axillary lymph nodes~~

~~Chest x ray: Irregular mass in the left upper lobe of the lung~~

~~Diagnosis: Malignant melanoma with possible metastasis to lymph nodes and the
lung~~

Electronically Access Cancer Case Information

A user accesses and displays the three instances of cancer case information that were
recorded and changed.

Access Instance 1:

Digital rectal exam: Normal prostate noted

PSA Score: 2

Diagnosis: Normal Prostate, no evidence of Adenocarcinoma

Access Instance 2:

Physical exam: Within normal limits, no swelling, soreness, or enlargement

Reported symptoms: Continuous fatigue, weight loss

Diagnostic tests: Blood smear and bone marrow aspiration

Diagnosis: Indolent Chronic Lymphocytic Leukemia

Access Instance 3: All information has been marked as error.

*(Strikethrough is used only to indicate to the Tester and Vendor that the entire
note was marked as error and does not prescribe how the EHR is to indicate it is
error data)*

~~Physical exam: Irregularly shaped, 3 cm ulcerated pigmented lesion located on
left upper back and enlarged axillary lymph nodes~~

~~Chest x ray: Irregular mass in the left upper lobe of the lung~~

~~Diagnosis: Malignant melanoma with possible metastasis to lymph nodes and the
lung~~

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TD170.314(f)(5) Cancer Case Information – Data Set # 2

Electronically Record Cancer Case Information

A user records three instances of cancer case information for the test patient(s).

Record Instance 1:
Physical exam: Left lower quadrant tenderness
Procedure performed: Needle biopsy of left ovary
Diagnosis: Mucinous cystadenoma of the left ovary

Record Instance 2:
Diagnosis: infiltrating duct carcinoma of right breast
Procedures performed: Biopsy, lumpectomy
Plan: Chemotherapy regimen of Cytoxan x 4 cycles

Record Instance 3:
History: Breast cancer
Reported symptoms: Severe back pain
Diagnostic test: CT of lumbar spine
Findings: Osteolytic lesion in the lumbar body L4 consistent with metastatic
breast cancer

Electronically Change Cancer Case Information

A user changes the three instances of cancer case information recorded for the test patient(s).

Change Instance 1: Mark words as error and enter replacement words.
(Strikethrough is used only to indicate to the Tester and Vendor which words are error and does not prescribe <u>how</u> the EHR is to mark the words as error)
Physical exam: ~~Left~~ **Right** lower quadrant tenderness
Procedure performed: Needle biopsy of ~~left~~ **right** ovary
Diagnosis: Mucinous cystadenoma of the ~~left~~ **right** ovary

Change Instance 2: Add words to the Information
Diagnosis: infiltrating duct carcinoma of right breast
Procedures performed: Biopsy, lumpectomy, **and sentinel lymph node surgery**
Plan: Chemotherapy regimen of **Adriamycin and** Cytoxan x 4 cycles

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Change Instance 3: Cancer case information was entered into the wrong patient's record. Mark all information as entered in error.

(Strikethrough is used only to indicate to the Tester and Vendor that the entire note is to be marked as error and does not prescribe how the EHR is to mark the note as error)

~~History: Breast cancer~~

~~Reported symptoms: Severe back pain~~

~~Diagnostic test: CT of lumbar spine~~

~~Findings: Osteolytic lesion in the lumbar body L4 consistent with metastatic breast cancer~~

Electronically Access Cancer Case Information

A user accesses and displays the three instances of cancer case information that were recorded and changed.

Access Instance 1:

Physical exam: Right lower quadrant tenderness

Procedure performed: Needle biopsy of right ovary

Diagnosis: Mucinous cystadenoma of the right ovary

Access Instance 2:

Diagnosis: infiltrating duct carcinoma of right breast

Procedures performed: Biopsy, lumpectomy, and sentinel lymph node surgery

Plan: Chemotherapy regimen of Adriamycin and Cytoxan x 4 cycles

Access Instance 3: All information has been marked as error.

(Strikethrough is used only to indicate to the Tester and Vendor that the entire note was marked as error and does not prescribe how the EHR is to indicate it is error data)

~~History: Breast cancer~~

~~Reported symptoms: Severe back pain~~

~~Diagnostic test: CT of lumbar spine~~

~~Findings: Osteolytic lesion in the lumbar body L4 consistent with metastatic breast cancer~~

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TD170.314(f)(5) Cancer Case Information – Data Set # 3

Electronically Record Cancer Case Information

A user records three instances of cancer case information for the test patient(s).

Record Instance 1:
Symptoms: Blood in stool and intermittent constipation
Diagnostic test: Screening colonoscopy
Findings: Colon polyp
Diagnosis: One adenomatous polyp in the colon
Plan: Refer for surgical consultation

Record Instance 2:
Diagnosis: Stage 4 malignant melanoma of the right back
Treatment provided: High-dose interferon-2

Record Instance 3:
Diagnosis: Stage IIIB colon cancer
Treatment provided: External beam radiation
Plan: Continue external beam radiation for 6 weeks, then evaluate for boost
modality therapy

Electronically Change Cancer Case Information

A user changes the three instances of cancer case information recorded for the test
patient(s).

Change Instance 1: Mark words as error and enter replacement words.
*(Strikethrough is used only to indicate to the Tester and Vendor which words are
error and does not prescribe <u>how</u> the EHR is to mark the words as error)*
Symptoms: Blood in stool and ~~intermittent~~ **chronic** constipation
Diagnostic test: Screening colonoscopy
Findings: Colon ~~polyp~~ **polyps**
Diagnosis: ~~One adenomatous polyp~~ **Multiple adenomatous polyps** in the colon
Plan: Refer for surgical consultation

Change Instance 2: Add words to the Information
Diagnosis: Stage 4 malignant melanoma of the right back
Treatment provided: High-dose interferon-2
Plan: Referral to a surgical oncologist for resection

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Change Instance 3: Cancer case information was entered into the wrong patient's record. Mark all information as entered in error.
(Strikethrough is used only to indicate to the Tester and Vendor that the entire note is to be marked as error and does not prescribe <u>how</u> the EHR is to mark the note as error)
~~Diagnosis: Stage IIIB colon cancer~~
~~Treatment provided: External beam radiation~~
~~Plan: Continue external beam radiation for 6 weeks, then evaluate for boost modality therapy~~

Electronically Access Cancer Case Information

A user accesses and displays the three instances of cancer case information that were recorded and changed.

Access Instance 1:
Symptoms: Blood in stool and chronic constipation
Diagnostic test: Screening colonoscopy
Findings: Colon polyps
Diagnosis: Multiple adenomatous polyps in the colon
Plan: Refer for surgical consultation

Access Instance 2:
Diagnosis: Stage 4 malignant melanoma of the right back
Treatment provided: High-dose interferon-2
Plan: Referral to a surgical oncologist for resection

Access Instance 3: All information has been marked as error.
(Strikethrough is used only to indicate to the Tester and Vendor that the entire note was marked as error and does not prescribe <u>how</u> the EHR is to indicate it is error data)
~~Diagnosis: Stage IIIB colon cancer~~
~~Treatment provided: External beam radiation~~
~~Plan: Continue external beam radiation for 6 weeks, then evaluate for boost modality therapy~~

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Version Number	Description of Change	Date
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