The Office of the National Coordinator for
Health Information Technology

2015 Edition §170.315(f)(4) Transmission to Cancer Registries

Testing Components:

Test Procedure Version 1.2 – Last Updated 4/28/16

Please consult the Final Rule entitled: *2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications* for a detailed description of the certification criterion with which these testing steps are associated. We also encourage developers to consult the Certification Companion Guide in tandem with the test procedure as they provide clarifications that may be useful for product development and testing.

Note: The order in which the test steps are listed reflects the sequence of the certification criterion and does not necessarily prescribe the order in which the test should take place.

Required Tests

(f)(4) Transmission to cancer registries. Create cancer case information for electronic transmission in accordance with:

(i) The standard (and applicable implementation specifications) specified in §170.205(i)(2);

Standard(s): 170.205(i)(2) - HL7 Implementation Guide for CDA© Release 2: Reporting to Public Health Cancer Registries from Ambulatory Healthcare Providers, Release 1.1, April 2015.

Test Tool: Cancer Report Validator (CRV)

Criteria ¶	System Under Test	Test Lab Verification
(i)	1. The user enters the cancer information for each of the test cases referenced from the Home Tab of the CRV. All test cases are required. Note that health IT developers should select the appropriate test case for Test Case 1, based on their module's capability. 2. The Health IT Module creates a cancer case document based on the standard specified in §170.205(i)(2), HL7 Implementation Guide for CDA© Release 2: Reporting to Public Health Cancer Registries from Ambulatory Healthcare Providers, Release 1.1, April 2015, for each test case as outlined below:	1. The tester verifies that the Health IT Module includes the source cancer information correctly and without omission through Visual Inspection, using the test data associated with the selected test case. 2. The tester imports the cancer reports into the test tool for validation based on each test case listed, and uses the Validation Report produced by the test tool to verify the report indicates passing without error to confirm that the cancer report is conformant to the HL7 Implementation Guide for CDA© Release 2: Reporting to Public Health Cancer Registries from Ambulatory Healthcare Providers, Release 1.1, April 2015.

Criteria ¶	System Under Test	Test Lab Verification
(i), continued	Modules that collect radiation treatment data: • Test_Case_1a_Complete_Record_With_Radiation Modules that do not collect radiation treatment data: • Test_Case_1b_Complete_Record_Without_Radiation ALL Health IT Modules : • Test_Case_2_Cancer_Diagnosis_With_No_Treatment • Test_Case_3_Two_Cancer_Diagnoses • Test_Case_4_Two_Cancer_Diagnoses_Update • Test_Case_5_Non-reportable	3. The tester verifies that the Health IT Module's supplied cancer document in step 2 is accurate and without omission using the Context-based Validation Report, the Juror Document, and through additional Visual Inspection, checking for equivalent text for: a. content for all section level narrative text; and b. display names: if the context-based validation indicates a mismatch, equivalent entries are allowable. 4. Negative Test: For Test_Case_5_Non-reportable, the tester verifies using Documentation that the non-reportable test case does not generate a CDA report

(ii) At a minimum, the versions of the standards specified in § 170.207(a)(4) and (c)(3).
Standard(s): §170.207(a)(4) - International Health Terminology Standards Development Organization (IHTSDO) Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) U.S. Edition, September 2015 Release
§ §170.207(c)(3) - Logical Observation Identifiers Names and Codes (LOINC®) Database version 2.52, Released June 2015

Criteria ¶	System Under Test	Test Lab Verification
(ii)	The cancer case information is in accordance with §170.207(a)(4) and §170.207(c)(3).	The tester uses Visual Inspection of the Health IT Module configuration file or Documentation to verify cancer case information are represented using the named §170.207(a)(4) SNOMED CT® standard and the named §170.207(c)(3) (LOINC®) Standard.

Document History

Version Number	Description of Change	Date
1.0	Final Test Procedures	January 20, 2016
1.1	Removed the reference to Juror Document in (i) Test Lab Verification step 3.	March 21, 2016
1.2	Inserted reference to the Juror Document now available	April 28, 2016

Dependencies: For all related and required criteria, please refer to the Master Table of Related and Required Criteria.