(your state)

Meaningful Use Quality Assurance Testing Guide

This guide is intended for—

1. Eligible professionals who meet the requirements for Meaningful Use (MU).
2. Providers who diagnose or treat cancer patients and want to begin reporting their patient cancer data to (your state) using the Clinical Document Architecture (CDA) format.

This document outlines the data quality standards required for reporting data to (your state, national standards provide a link) using the CDA format, which is required for the MU incentive. Certain fields are required in the CDA document to pass the quality assurance review. Providers should configure the Electronic Health Record (EHR) so that valid data is entered in the required fields before testing with (your state).

Quality Assurance Testing Requirement

Following the successful submission of a test CDA document for MU, eligible providers must pass quality assurance testing before actual submission can occur. It is important to note that EHR certification does not guarantee that EHR software meets your business needs or the (your state) requirements. Furthermore, to ensure complete and correct data are recorded, (your state) has set high standards for data completeness, quality, and timeliness. (your state) measures adherence to these standards during a data quality assessment of new interfaces. This assessment process includes a Data Quality Assurance (DQA) report.

Compliance with follow-up submission requires eligible professionals to adhere to the quality assurance testing process. Eligible professionals must demonstrate active engagement in quality assurance testing by following the steps listed on the next page. After providers have passed the quality assurance testing process, production submission can occur. Providers must continue their current method of data entry into (your state) until they have successfully passed the steps on the next page.

Quality Assurance Testing Steps

Providers must complete the following six steps to meet the quality assurance testing requirements. Along with the six steps, tips are listed for providers to achieve each step.

Step 1 - Document transport

- Connectivity to (your state) for submission is enabled through the (your state's information network, provide link).
- Review (your state's, provide link) transport preference and connectivity requirements.
- Work with your vendor to make sure your CDA documents are formatted correctly.

Step 2 - Validate the certified EHR captures the required fields

- Review the required fields table (provide link).

Step 3 - Validate the certified EHR contains the correct codes and sections

- Review codes and sections as outlined in (your state, national standards provide link) submission guide.

Step 4 - Message format validation

- Send sample CDA documents to (your state). Documents must comply with the (your state, national standards) CDA specification. (provide link)

Step 5 - Content validation

- (your state) will conduct a data quality analysis and provide feedback on the content of the document you will continue to send.

Step 6 - Go-live

- Prior to go-live, you must complete a (your state) Responsibilities and Contact Information Form (provide link) and send to (your state) contact (provide link). This form assigns your provider staff to monitor the data feed and correct errors. (your state) staff use the information from this form to coordinate training sessions.
- After you have passed content validation and have been trained by (your state), the documents will be transmitted to production.

Quality Assurance Criteria

Required Fields – All required fields should be included in the CDA document. *It is a production requirement to include all of the required fields.* The required fields should not contain filler or "dummy" data. If there is no value in a required field because it was not entered or because the value is unknown, the appropriate "flavor of null" should be provided. Fields that cannot be left empty are identified in the (your state, national standards provide link) specification guide. Required fields are listed below.

Conformance (Optionality Constraints)

The optionality constraints in this implementation guide use the Health Level Seven (HL7) Consolidated CDA conformance verbs—

"The keywords **SHALL, SHOULD, MAY, NEED NOT, SHOULD NOT,** and **SHALL NOT** in this document are to be interpreted as described in the HL7 Version 3 Publishing Facilitator's Guide.

- **SHALL:** an absolute requirement.
- **SHALL NOT:** an absolute prohibition against inclusion.
- **SHOULD/SHOULD NOT:** best practice or recommendation. There may be valid reasons to ignore an item, but the full implications must be understood and carefully weighed before choosing a different course.
- **MAY/NEED NOT:** truly optional; can be included or omitted as the author decides with no implications.

The keyword **"SHALL"** allows the use of nullFlavor unless the requirement is on an attribute or the use of nullFlavor is explicitly precluded.

The subject of a conformance verb (keyword) in a top-level constraint is the template itself; in nested constraints, the subject is the element in the containing constraint."

National standards required fields are listed below. **Please note this is not the final list.**

NAACCR ID	Data Element	Opt	Template ID
2110	Date Case Report Exported	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
2230	Patient Last Name	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
2270	Patient Name Suffix	**SHOULD**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
2240	Patient First Name	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
2250	Patient Middle Name	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
2390	Patient Maiden Name	**SHOULD**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
2280	Patient Name Alias	**SHOULD**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
2350, 1810, 1820, 1830	Patient Address (Street Address, City, State, ZIP Code, Country)	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
	Address History	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
	Address Use	**SHOULD**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
	Patient Telephone	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
220	Patient Sex/Gender	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
240	Patient Date of Birth	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
2300	Patient Medical Record Number	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
2320	Patient Social Security Number	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
160, 161,162, 163, 164	sdtc:race (raceCode extension)	**MAY**	2.16.840.1.113883.10.20.22.1.1 [HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, Release 1]
190	Patient Ethnicity	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
250	Patient Birth Place	**SHALL**	1.3.6.1.4.1.19376.1.7.3.1.1.14.1
1502	Patient Marital Status	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
2460, 2470, 2480, 2490, 2500	Physician Name	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
2465, 2475, 2485, 2495, 2505	Physician ID (NPI)	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
	Physician Address (Street Address, City, State, Zip Code, Country)	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
	Physician Specialty	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
540	Provider Organization ID	**SHALL**	2.16.840.1.113883.10.20.3 [General Header Constraints for CDA R2]
2410	Provider Referred From	**SHOULD**	1.3.6.1.4.1.19376.1.4.1.3.1 [Encompassing Encounter]
2415, 2460, 2470, 2480, 2490, 2500	Provider Referred From ID (NPI)	**SHOULD**	1.3.6.1.4.1.19376.1.4.1.3.1 [Encompassing Encounter]
	Coded Social History Section	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.3.16.1
	Social History Narrative	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.3.16.1
270	Occupation	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.13.4 [Social History Observation]

NAACCR ID	Data Element	Opt	Template ID
280	Industry	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.13.4 [Social History Observation]
	Smoking Status	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.13.4 [Social History Observation]
	Payers Section	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7
630	Payer Type	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.17 [Coverage Entry]
	Cancer Diagnosis Section	**SHALL**	1.3.6.1.4.1.19376.1.7.3.1.3.14.1
	Cancer Diagnosis Entry	**SHALL**	1.3.6.1.4.1.19376.1.7.3.1.4.14.1
390	Diagnosis Date	**SHALL**	1.3.6.1.4.1.19376.1.7.3.1.4.14.1 [Cancer Diagnosis Entry]
523	Behavior	**SHALL**	1.3.6.1.4.1.19376.1.7.3.1.4.14.1 [Cancer Diagnosis Entry]
490	Diagnostic confirmation	**SHALL**	1.3.6.1.4.1.19376.1.7.3.1.4.14.1 [Cancer Diagnosis Entry]
400	Primary Site	**SHALL**	1.3.6.1.4.1.19376.1.7.3.1.4.14.1 [Cancer Diagnosis Entry]
410	Laterality	**SHALL**	1.3.6.1.4.1.19376.1.7.3.1.4.14.1 [Cancer Diagnosis Entry]
	TNM Clinical Stage Entry	**SHOULD**	1.3.6.1.4.1.19376.1.7.3.1.4.14.2 [TNM Stage Observation]
	Stage Group Narrative	**SHALL**	1.3.6.1.4.1.19376.1.7.3.1.4.14.2 [TNM Stage Observation]
970	TNM Clinical Stage Group	**SHALL**	1.3.6.1.4.1.19376.1.7.3.1.4.14.2 [TNM Stage Observation]
980	TNM Clinical Stage Descriptor	**SHALL**	1.3.6.1.4.1.19376.1.7.3.1.4.14.2 [TNM Stage Observation]
1060	TNM Edition Number	**SHALL**	1.3.6.1.4.1.19376.1.7.3.1.4.14.2 [TNM Stage Observation]
990	Provider who recorded stage information	**SHALL**	1.3.6.1.4.1.19376.1.7.3.1.4.14.2 [TNM Stage Observation]
940	TNM Clinical T	**SHALL**	1.3.6.1.4.1.19376.1.7.3.1.4.14.2 [TNM Stage Observation]
950	TNM Clinical N	**SHALL**	1.3.6.1.4.1.19376.1.7.3.1.4.14.2 [TNM Stage Observation]
960	TNM Clinical M	**SHALL**	1.3.6.1.4.1.19376.1.7.3.1.4.14.2 [TNM Stage Observation]
	Active Problems Section	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.3.6
	Start and Stop date of problem	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.3.6
3110–3164	Problem Code	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.5.2 [Problem Concern Entry]
	Progress Note Section	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.7

NAACCR ID	Data Element	Opt	Template ID
	Progress Notes Narrative	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.7
	Coded Results Section	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.3.28
	Procedure Entry	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.19
	Procedure Type	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.19
	Procedure DateTime	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.19
	Result Value	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.13 [Simple Observation]
	Result Text	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.13 [Simple Observation]
	Result DateTime	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.13 [Simple Observation]
	Facility	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.13 [Simple Observation]
	Facility ID	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.13 [Simple Observation]
	Procedures Section	**SHALL**	2.16.840.1.113883.10.20.1.12
	Procedure Activity Entry	**SHALL**	2.16.840.1.113883.10.20.1.29
670, 690	Procedure Type	**SHALL**	2.16.840.1.113883.10.20.1.29
	Body Site of procedure	**SHALL**	2.16.840.1.113883.10.20.1.29
1200, 1210	Procedure DateTime	**SHALL**	2.16.840.1.113883.10.20.1.29
	Medications Section	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.3.19
700, 710, 720	Medications Entry (Chemotherapy, Hormone Therapy, Immunotherapy)	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.7 [Medications]
1220, 1230, 1240	Start Date	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.7 [Medications]
	Stop Date	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.7 [Medications]
	Frequency	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.7 [Medications]
	Route	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.7 [Medications]
	Dose	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.7 [Medications]
	Site	**MAY**	1.3.6.1.4.1.19376.1.5.3.1.4.7 [Medications]
	Rate	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.7 [Medications]
	Consumable	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.7
	Product Entry	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.7.2
	Medication Brand Name	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.7.2 [Product Entry]
	Strength	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.7.2 [Product Entry]
	Coded product name	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.7.2 [Product Entry]

NAACCR ID	Data Element	Opt	Template ID
	Medications Administered Section (medications that are administered during the encounter) Chemotherapy, Hormone Therapy, Immunotherapy	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.3.21
700, 710, 720	Medications Entry (Chemotherapy, Hormone Therapy, Immunotherapy)	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.7 [Medications]
1220, 1230, 1240	Medication Start Date	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.7 [Medications]
	Medication Stop Date	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.7 [Medications]
	Administration Timing (Frequency)	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.7 [Medications]
	Route	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.7 [Medications]
	Dose	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.7 [Medications]
	Site of medication administration	**MAY**	1.3.6.1.4.1.19376.1.5.3.1.4.7 [Medications]
	Rate	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.7 [Medications]
	Consumable	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.7
	Product Entry	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.7.2
	Product	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.7.2 [Medications]
	Strength	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.7.2 [Product Entry]
	Code	**SHOULD**	1.3.6.1.4.1.19376.1.5.3.1.4.7.2 [Product Entry]
	Care Plan Section	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.3.31
	Observation Requests	**MAY**	1.3.6.1.4.1.19376.1.5.3.1.1.20.3.1
	Medication Entry	**MAY**	1.3.6.1.4.1.19376.1.5.3.1.4.7
	Immunization Entry	**MAY**	1.3.6.1.4.1.19376.1.5.3.1.4.12
	Procedure Entry	**MAY**	1.3.6.1.4.1.19376.1.5.3.1.4.19
	Encounters Entry	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.14
2420, 2425, 2460, 2470, 2480, 2490, 2500	Provider Referred To	**SHALL**	1.3.6.1.4.1.19376.1.5.3.1.4.14 [Encounters]