Preliminary ARRA IFR Stage 1 – Eligible Provider Test Step FAQs

Module	Question	Answer
General Questions	There are references to Table 2A. Where can I find this table?	Table 2A can be found in the Interim Final Rule.
	Can I just certify against one of the modules listed in the Eligible Provider test script, or do I also have to complete the Security module?	All Eligible Provider applicants must, at a minimum, comply with the Security requirements defined in the Interim Final Rule. These requirements can be found on the modular Security test script.
CPOE	Do we have to show all of the types of orders listed for this module?	In order to demonstrate compliance with this module, your system must be able to record, store, retrieve and manage all 4 of the types of orders bulleted: Medications, Laboratory, Radiology/Imaging and Provider Referrals. Please note that in order to comply with this module, you must satisfy the juror that your system can record, store, retrieve and manage these types of orders.
Drug Decision Support	What do we need in order to demonstrate formulary checking?	The Interim Final Rule requires that all certified EHR technology has the ability to conduct formulary checking electronically using appropriate NCPDP messaging. This requires the Formulary/Eligibility Checking certificate from SureScripts in addition to the NewRx and Rx Renewal certificate.
	What is meant by “responses to alerts”? Is this the reason the user provides when the interaction alert appears?	The report that is produced should show all alert descriptions, both passive and active, that appeared to providers, the provider ID or name, and their response to the alert (i.e., ignore, override, cancel action, etc. and the explanation they provide for taking such action). Please see the CCHIT Glossary of Terms and review the definition for the word 'alerts' for additional information.

Module	Question	Answer
	What is an example of an age-based alert?	An example of an age-specific alert would be an indication that appears when a child is too young to take a certain drug.
	We are confused because CPOE is listed as an alert. How do alerts occur based on CPOE?	CCHIT agrees that listing CPOE is confusing and we are unsure of why it is listed. Further clarification from the federal government is needed on this item.
	What is an example of being able to modify CDS rules?	Modifying the severity at which alerts are displayed to providers would be an example of modifying a CDS rule.
	Should the system track alerts that occur at the time of prescribing new medications and when modifying existing medications?	The report that is produced should show all alerts (alert description) that appeared to providers, the provider ID or name, and their response to the alert (i.e., ignore, override, cancel action, etc. and the explanation they provide for taking such action).Our understanding is that this would be for all alerts, whether at the time of prescribing new medications or changing existing ones.
	We use the rules provided by FirstDataBank and allow certain users to control the FDB rules which include categories of “Adult drug dosing”, “drug to drug” and “drug to allergy”. We allow the categories to be turned ‘on/off’ individually and when ‘ON’ allow the ability to determine the severity level of alert to display. Does this satisfy the requirement?	What you’ve described should satisfy this requirement since you are allowing the categories to be modified by an administrative user. If you are seeking modular certification, we would ask that you first show the jurors how categories can be turned on/off and then how you can change the severity level of warnings that display to individual providers. This would incorporate the requirements to deactivate, modify and add rules as required by the standard. We recognize that you will not actually be able to change FDB’s database itself.

Module	Question	Answer
	How can we test the system's ability to "add" CDS rules, when this is controlled at the drug database level, not at the EHR level?	CCHIT agrees that this typically cannot be demonstrated at the EHR level. For that reason, we will simply ask you to demonstrate how you can deactivate and modify the CDS rules, and will not ask you to demonstrate how you would add a CDS rule.
Problem List	Does this require an ICD-9 or SNOMED-CT code for the indication of 'no active problems'? If so, do you have a suggestion on which code should be used?	To our knowledge, there is not an ICD-9 or SNOMED-CT code that covers a patient having no problems. CCHIT's interpretation of this would be for the system to maintain a coded problem list should the patient have problems to track. If no problems are present, the system would have the ability to record in structured data that there are none. You won't be REQUIRED to demonstrate that you can collect "no active problems" as long as you can demonstrate that you can collect any diagnosis and associated code from either ICD-9 or SNOMED.
	Do I just have to show the problem list for one office visit, or should it be over multiple visits?	The system must have the capability to display and view a patient's problem list using data that has been previously entered into the EHR, including the capability to display the problem list spanning multiple visits.

Module	Question	Answer
ePrescribing	How will this be tested?	We will expect you to be able to send an electronic prescription to our CCHIT Test Pharmacy via the SureScripts staging environment. The details to set this up are included in the modular Eligible Provider test script. You will need to work with SureScripts to be sure you are ready for this test and to conduct a practice prescription ahead of time. Because we have live inspections ongoing, we ask that you notify us of the date you plan to practice and we will let you know if that is acceptable. Once we receive your practice prescriptions, we will email them back to you so that you can confirm that they went through the SureScripts staging environment correctly.
Medication List	Do we have to use the scenario provided in the Procedure column of the test script?	The scenario provided in the Procedure column of the test script is an example only. Applicants are welcome to create their own scenario for this module. The juror inspecting the applicant's product must be satisfied that all requirements listed in the criterion are successfully demonstrated.
Medication Allergy List	Do we have to use the scenario provided in the Procedure column of the test script?	The scenario provided in the Procedure column of the test script is an example only. Applicants are welcome to create their own scenario for this module. The juror inspecting the applicant's product must be satisfied that all requirements listed in the criterion are successfully demonstrated.

Module	Question	Answer
Demographics	Can we enter this information prior to the inspection, and then just display the information to the juror during the inspection?	This item requires your system to record, modify, and retrieve all 6 of the demographic items: preferred language, insurance type, gender, race, ethnicity and date of birth. You should not populate this information prior to the inspection. The juror will need to see that you can actually record these demographics. You will then show how the demographics can be saved, and then how the information can be retrieved. However, any demographic data element that is not listed here can be added prior to the day of the inspection (e.g. patient's name and address).
	Is there a list of preferred languages you would expect to see? For race and ethnicity the Criteria and Reference cites the federal Census Bureau guidelines. For language there is no such citation. However, the Census Bureau does in fact have data about languages. There are approximately 550. That data can be manipulated to narrow it down to the 20 most commonly used in the US. A list of 550 v. 20 impacts the design decisions we would make (a drop down list v. a search field). Making the incorrect choice will cause us to waste development time making corrections once the criteria are finalized.	For this requirement, you will just need to demonstrate that you can accommodate the languages selected by the client site. For the inspection, you can simply pick examples to demonstrate compliance.

Module	Question	Answer
	This criterion refers to recording race AND ethnicity. In the research we did on the Census Bureau requirements, it said that Race and Ethnicity could be recorded separately or that they could be recorded together in one field. Can we enter these in one discrete data field, or do they need to be entered as separate discrete data fields?	The terms race and ethnicity in the criterion appear individually, separated by a comma, rather than together as race/ethnicity. The reporting requirements for providers in the NPRM also seem to suggest that recording these two data elements separately would be required. The definitions and recommendations from the Census Bureau have not been mentioned in the Interim Final Rule as a reference for the collection of this data, therefore, the requirement for certification of EHR technology will require the recording of the data in 2 separate data fields.
Vital Signs	Do we have to use the scenario provided in the Procedure column of the test script when entering the vital signs?	The scenario provided in the Procedure column of the test script is an example only. Applicants are welcome to create their own scenario for this module. The juror inspecting the applicant's product must be satisfied that all requirements listed in the criterion are successfully demonstrated.
	Can we manually calculate the BMI based on the patient's height and weight?	For this requirement, your system must be able to calculate and display a patient's body mass index. Manual calculation of the BMI is not permitted. However, if you need to enter information such as the patient's height, weight, or age before the BMI can be calculated, that would be permissible.
	Our EHR technology is not specific to pediatrics. Do we still need to plot and display growth charts based on height, weight, and BMI?	Growth charts are now required to be displayed by all certified EHR technology under the Interim Final Rule. This means that even applicants whose EHR technology is not specific to children must be able to demonstrate this element.

Module	Question	Answer
	Our EHR product captures, displays and graphs a patient's height, weight, and BMI as well as IBW, BSA and other values at both the encounter level and across the patient's historical medical record level. What we do not currently do is electronically plot this against a growth chart. Is this a matter of just displaying a standard growth chart alongside the patient's graphed values or are they requiring the patient's graph to actually be super-imposed on top of a standard chart? There are CDC Growth Charts of 2000 based on BMI, stature, height, weight, etc. but also the more detailed WHO growth charts that are age, race, and sex specific. Do we need to incorporate all variables or just a standard set of Growth Charts one for Height/Weight and another for BMI male and female?	The government's criteria is not specific, so if you were able to demonstrate your collected values for height, for example, on one line and the weight norms for the age and gender on another for comparison this would be acceptable. Growth charts need to be able to compare the patient values with the statistical norms for the provider to help them decide if there might be a problem (so we should see both lines on the same chart). The criteria the government published did not specify if it had to be CDC data, but we suspect that is what most applicants will use. We will be flexible in our interpretation since the criteria seem to allow that.
	For Step I.01, we provide users the ability to mark delete incorrect vital sign records and then they would re-add them with the correct values. This is how they can modify values that might have been entered incorrectly. Will this be acceptable or do we have to actually show the previous value on some edit page where the user changes it and then saves it?	The Interim Final Rule is not prescriptive about what constitutes a modification, therefore, deleting an incorrect vital and re-entering the correct value would be acceptable. Your system must be able to track all corrections and addendums to a patient record in the audit log detail, so the deletion of this erroneous data should be captured as well as the entry of the updated value along with the user ID, date and time.
Smoking Status	Do we have to use the scenario provided in the Procedure column of the test script?	The scenario provided in the Procedure column of the test script is an example only. Applicants are welcome to create their own scenario for this module. The juror inspecting the applicant's product must be satisfied that all requirements listed in the criterion are successfully demonstrated.

Module	Question	Answer
	Can we add the smoking status choices in the Patient Demographic area of our system?	The Interim Final Rule is not prescriptive about where in the certified EHR the smoking status is maintained, as long as it is available. You would want to consider your end user's functionality needs in deciding where to place this. Patient History may also be an appropriate place to record this information.
	For Step J.01, does the text have to say exactly 'Current Smoker', 'Former Smoker', and 'Never Smoked'. We have our Current Tobacco Use measure that has options for 'Yes', 'No' and 'Former'. Will those terms be acceptable since they map to the same items?	Your system must, at a minimum, have the exact options of Current Smoker, Former Smoker, and Never Smoked since these are the requirements from the Interim Final Rule published by the federal government on January 13th, 2010. Since these are government criteria, CCHIT cannot change the requirements and our jurors will be scoring to the exact stated values. You may have other values in addition to these values; however, at a minimum the jurors must see these values.
Lab Test Results	Do the results have to be stored as discrete data?	The Interim Final Rules states "import the lab test results as structured data" – but that does imply storing the results data as discrete elements within the database. CCHIT feels that the intent is to bring the results in as discrete data, not just intact messages or files.
	Do we have to show the capability with multiple labs like Quest and Labcorp or is one lab okay?	For the Lab Results component, you should create your own lab file (from a single lab is fine) and show how you can electronically incorporate lab results received in a file into a specific patient record in discrete data fields.

Module	Question	Answer
	How will this be tested?	For this module, you must create your own lab file prior to the inspection. On the day of the inspection, you will show the juror how you can incorporate those lab results into a specific patient record as discrete data fields. The juror does not need to watch the interface transaction, but does need to see the lab values within the patient record as discrete data. You must also show all of the required CLIA required test report items when displaying the lab file.
	What is the list of CLIA required test report items?	(c) The test report must indicate the following: (1) For positive patient identification, either the patient's name and identification number, or a unique patient identifier and identification number. (2) The name and address of the laboratory location where the test was performed. (3) The test report date. (4) The test performed. (5) Specimen source, when appropriate. (6) The test result and, if applicable, the units of measurement or interpretation, or both. (7) Any information regarding the condition and disposition of specimens that do not meet the laboratory's criteria for acceptability.

Module	Question	Answer
	Where can we find the entire document referenced, 42 CFR 493.1291(c)(1) through (7).6?	http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=6aae569f4d56e206a8c65baf15efb00c&rgn=div8&view=text&node=42:5.0.1.1.9.11.28.57&idno=42
	The CLIA specs require the patient's name and identification number OR unique patient identifier and identification number. What constitutes an "identification number"? Will any other number that helps uniquely identify the patient suffice (e.g. phone number, SSN, date of birth, etc.)?	There is no specific requirement in the CFR as to what the ID must be. You may demonstrate whatever the system uses as the patient ID (e.g. medical record number).
Patient Lists	Do we have to use the scenario provided in the Procedure column of the test script?	The scenario provided in the Procedure column of the test script is an example only. Applicants are welcome to create their own scenario for this module. The juror inspecting the applicant's product must be satisfied that all requirements listed in the criterion are successfully demonstrated.
	Our report module provides the user the option to select which columns to display. They can then export the results and can use Excel to sort on the various items they selected. Is it acceptable that the sort is available through Excel?	Yes, this would meet the intent of the criterion.
Quality Reporting	Can we create the report(s) ahead of time?	You may create any of the reports required for this module ahead of time. On the day of the inspection, be prepared to show the juror the criteria you used to create the report, and then run the report. The juror may ask for verification that the patient listed actually meets the report criteria, so be prepared to show that as well.
	Where can we find greater detail regarding all of the CMS quality measures proposed under ARRA?	Some of these proposed quality measures can be found in the NPRM, and others can be found through the National Quality Forum (NQF).

Module	Question	Answer
Patient Reminders	Do we have to use the scenario provided in the Procedure column of the test script?	The scenario provided in the Procedure column of the test script is an example only. Applicants are welcome to create their own scenario for this module. The juror inspecting the applicant's product must be satisfied that all requirements listed in the criterion are successfully demonstrated.
	The communication preferences we have available for patients include secure messaging, email, messaging to a PHR, and electronic fax. Are these acceptable?	All of the communication preferences you have listed are acceptable, except for electronic fax. Electronic fax is not considered to meet this requirement.
Clinical Decision Support	Do we have to use the scenario provided in the Procedure column of the test script?	The scenario provided in the Procedure column of the test script is an example only. Applicants are welcome to create their own scenario for this module. The juror inspecting the applicant's product must be satisfied that all requirements listed in the criterion are successfully demonstrated.
	The IFR says that 5 CDS rules need to be implemented that use demographic data, specific patient diagnoses, conditions, diagnostic test rules, and/or patient medication lists. Does this mean that the system should have the ability to perform CDS against all 5 of the elements, or any of the 5 as long as 5 different CDS rules are shown?	CCHIT's interpretation is that the system must perform clinical decision support against the 5 listed elements. The 5 elements do not have to all be included in a single CDS Rule. For example, if you could show one Rule that uses demographic data, patient diagnoses/conditions and diagnostic test results, and then show a second CDS Rule that uses patient medications, you would have covered all 5 required elements. You can show as many CDS rules as necessary to demonstrate that you can include the 5 elements.
	Is the expectation that CDS rules will be for multiple of the 5 elements at once? For example, all female (demographic) diabetics (diagnosis) with A1C > 8 (result) who take an oral hypoglycemic (med)?	The CDS rules could certainly be built to accommodate multiple elements, but this is not required. You can show as many individual CDS rules as necessary to demonstrate that you can include the 5 elements.

Module	Question	Answer
	User response and tracking of that response is already captured in the Drug Decision Support module. How does this response and tracking differ?	The same type of tracking required for the Drug Decision Support module would be applicable here. Examples of these are wellness or disease management reminders or alerts (different than drug reminders and alerts). You may combine all alerts into one comprehensive report to meet the requirements (drug and health maintenance alerts together).
	How specifically does Drug Decision Support differ from Clinical Decision Support?	The difference is that the Drug Decision Support module covers drug-drug and drug-allergy contraindication checking, while the Clinical Decision Support module would cover other alerts such as alerting a provider that a lab test should be ordered based on the patient's diagnosis.
	How do clinical decision support rules differ from disease management/preventive/wellness guidelines? Is this just a difference in terminology?	Disease management/preventive/wellness guidelines represent a comprehensive documented plan for specific patients or populations based on recognized standards for well or chronic care. A Clinical Decision Support rule is established by setting up specific parameters within the EHR.

Module	Question	Answer
	Criterion IFR.EP.O.2 refers to "evidence grade". What is the evidence grade?	This website http://www.gradeworkinggroup.org/ states "a common, sensible and transparent approach to grading quality of evidence and strength of recommendations". The IFR criterion says "IFR.EP.O.2 Automatically and electronically generate and indicate (e.g., pop-up message or sound) in real-time, alerts and care suggestions based upon clinical decision support rules and evidence grade." Our interpretation is that they mean that a process to review and grade the quality of medical evidence to support the care suggestions and alerts has occurred. In other words, it has been vetted by an organization or organizations, and is supported by medical evidence. We believe that is the intent of the words "based upon ……..evidence grade".
	For criterion IFR.EP.O.1, we use red, green and yellow stoplight status icons for showing the user alerts based on standard and patient specific goal values for various measures. These are obviously not a pop-up or sound (the examples given in the criteria reference) so we wanted to be sure our use of a status icon will meet the criteria of showing an alert to the user.	There is no requirement that the alert specifically be a pop-up message or a sound. Instead, these are just examples of how your system might handle alerts. What you have described requiring the stoplight colors would also be sufficient for this step. On the day of your inspection, we would ask that you let the jurors know the meaning of each of the colors so they are clear on how your system handles alerts.

Module	Question	Answer
Insurance Eligibility	How will this be tested?	CCHIT does not have an eligibility database that the applicant can query during the inspection so we ask that applicants establish a connection with any insurance carrier and use the patient of their choice to demonstrate this functionality. The applicant may submit an electronic query to the carrier and should receive a return message from the carrier indicating the coverage for the patient to demonstrate compliance. It is permissible for the return message to be blank. Alternatively, you could generate a compliant 270 transaction followed by a demonstration of how the system would process an inbound 271 response. The transaction would not have to be based on a "live" request or response, and establishing a connection to an external party would not be required.
	Can we demonstrate compliance by only showing the patient's pharmacy benefit coverage?	This item relates to overall insurance eligibility for the patient and is not limited to prescription coverage through a PBM. To meet the requirements for this step you would simply have to show that you are able to electronically send a message to a carrier (you can even show the raw data file that you would send) and tell us what format the document has been created in and what steps are required to transmit it. If you can connect to an actual carrier for your test and send a real inquiry and either get confirmation of successful transmission or a reply all the better, but that is not required.

Module	Question	Answer
Electronic Claims Submission	The CCHIT Gap Analysis document indicates that this item is only required for applicants who "opted out". What does this mean?	This was an optional item on the Preliminary ARRA 2011 test scripts, so if the vendor chose not to perform it during their certification test (opt out), they will need to come back and demonstrate it before they are IFR Stage I certified. This is a required Interim Final Rule (IFR) standard for any vendor who wants to become IFR Stage I certified as a complete EHR.
	How will this be tested?	For this module, you must show the juror the process used in your system to compile the electronic claim document, show the raw data document (e.g. HL7) to the juror and then describe the process for the transmission.
	The CCHIT Gap Analysis document indicates that this item is only required for applicants who "opted out". What does this mean?	This was an optional item on the Preliminary ARRA 2011 test scripts, so if the vendor chose not to perform it during their certification test (opt out), they will need to come back and demonstrate it before they are IFR Stage I certified. This is a required Interim Final Rule (IFR) standard for any vendor who wants to become IFR Stage I certified as a complete EHR.

Module	Question	Answer
Patient Electronic Copy of Health Information	How will this be tested?	This component requires proof that you can export an electronic copy of the patient's diagnostic test results, medication list, allergy list, immunizations, and procedures. In this case, the patient may have requested an electronic copy and there is no portal to allow them to directly access it so you would have to demonstrate how you would produce the copy for them and provide it to them or push it out to them. You should do the following: 1. Demonstrate the creation of a copy of a patient record to include diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures. 2. Show a print preview of the file. If a print preview is not available, the applicant may email the file to the CCHIT Proctor. 3. Demonstrate and describe the process to provide the documentation to the patient on electronic media or through other electronic means. Transported patient information must meet the standards required in Table 2A, Row 1 of the Interim Final Rule to be valid.
	Will creating any e-copy of patient health related information be sufficient, or is there a need to show specific documents?	The e-copy of the PHI must include at a minimum their diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures. Anything extra is allowable but not required. Transported patient information must meet the standards required in Table 2A, Row 1 of the Interim Final Rule to be valid.

Module	Question	Answer
	Does this have to be one file or can it be separate files? For example, we have our Patient Face Sheet, our Vaccine Administration Record, and our Lab Results print-out that we will print to meet this step. Also, for the medication and allergy lists, do the RxNorm codes have to actually show in the document print preview? I read in the FAQ document I believe that it has a reference to a Table where it indicates what standards must be used. But this is a print preview for the patient not the exchange of clinical information so I wanted to check on if the codes have to be shown.	This step is not prescriptive on whether the summary is one file or multiple files, so either way you choose to demonstrate this would be acceptable. The RxNorm codes do not need to display in the print preview of the file. To verify that the medication table in use by the system comes from a source that includes cross indexing to RxNorm, we would ask that you identify your drug database supplier. The drug database should be one of those listed on the National Library of Medicine complete list of RxNorm compliant databases.
Patient Electronic Access to Health Information	Is patient portal access mandatory, or can we simply provide the access via CD or USB drive?	Online access must be demonstrated. Providing the PHI on a USB drive or CD would not be acceptable. Examples of online access would be a patient portal, setting up patient access to an FTP site, or pushing the information to the patient PHR housed on a publicly available personal health record database and ensuring that the resulting record is stored in a human readable form and the data types are differentiated and clearly identifiable (medications, allergies, procedures, etc.).
	Do we have to use the scenario provided in the Procedure column of the test script?	The scenario provided in the Procedure column of the test script is an example only. Applicants are welcome to create their own scenario for this module. The juror inspecting the applicant's product must be satisfied that all requirements listed in the criterion are successfully demonstrated.
Patient Clinical Summary	Our EHR technology does not track procedures. Do we have to include that in the summary?	The IFR criterion requires that the patient clinical summary include, at a minimum, diagnostic test results, medication list, medication allergy list, procedures, problem list and immunizations. In order to demonstrate compliance with this item, the clinical summary created by your system must include all of these items.

Module	Question	Answer
	We plan to show our generated note which allows the user to include the patient's clinical summary items and the items done during the specific office visit/encounter. For immunizations though, our note shows the ones during the visit and then we have a separate Vaccine Administration Record (VAR) form that we can print. Is it acceptable that we will have two files, one for the note and one for the patient's VAR form?	It would be acceptable to create multiple files to include the patient's full immunization record. However, the requirement is only that the immunizations from the current visit are provided, so it would also be acceptable to limit the immunizations to those administered during this encounter.

Module	Question	Answer
Exchange Clinical Information	How will this be tested?	You must attest to the standard you will use to create the file on the Modular IFR Stage 1 Application form: **Exchange Clinical Information (Please check one):** o HL7 CDA R2 CCD Level 2 o ASTM CCR The demonstration of this during your inspection will be a two-step process. 1. On the day of the inspection, create a file using the standard specified on your application. You will then email this file to CCHIT and it will be validated using the NIST validation tool to ensure it contains no XML errors. CCHIT will then manually review it to ensure the proper coded terminologies have been used correctly. The NIST Validator can be found at http://xreg2.nist.gov/cda-validation/validation.html. 2. On the day of your inspection, the CCHIT Proctor will send you 2 files: 1 for CCD and 1 for CCR. You will then demonstrate that you can open both files in human readable format. If this requires you to load the file into a specific patient's chart, that would be acceptable. Conversely, you could also apply a style sheet to show these files to the juror.

Module	Question	Answer
	Do we only need to receive the document, attach it to the patient's chart and then display in human readable format OR do we have to update the information in the patient's chart with the information received?	You must be able to receive and display in human readable format both a CCD and a CCR. There is no requirement that the clinical summary must update the discrete data fields in the patient's health record. However, you should be able to attach the file (as a simple document) to the patient's chart for accessing at a later time. You must also be able to create either a CCD or a CCR (not both) containing the required elements and it must be validated as meeting all the standards in Table 2A, Row 1.
	Can we use Laika to validate our CCD or CCR file during our practice sessions?	Laika will not be used for the Preliminary ARRA testing. You must use the NIST Validator, which can be found at http://xreg2.nist.gov/cda-validation/validation.html.
Medication Reconciliation	How will this be tested?	The reconciliation must include the comparison and merging of two separate medication lists into a single medication list that can be displayed electronically in real-time. The two separate lists are not specified, so it would be up to your team to determine the content and context of the lists. For example, the system might compare the patient's current or home medications, with any medications that have been prescribed during this encounter. In order for the comparison to take place, you may need to enter the patient's home/current medications prior to the inspection. Once the system highlights the differences, you would then make a disposition decision based on that information (e.g. discontinue a medication or change the dosing of a medication). Finally, you would show the merging of the two lists into one. During the demonstration, you could also do things like drag and drop from one list to the other, or select items to add to the current medication list off another list and then see that they now appear on the current med list, etc.

Module	Question	Answer
	Our system gives users the option to compare current medications and today's changes in medications, and electronically reconcile the medications. Does this meet the criteria?	The reconciliation must include the comparison and merging of two separate medication lists into a single medication list that can be displayed electronically in real-time. The two separate lists are not specified, so this would be up to you to determine the content and context of the lists.
	When our users prescribe medications, we give them an option to add the medication to the patient's current medication list. This option is selected by default. When they save the prescriptions, we do a check against their current medication list for those items. If the system finds a possible duplicate/match (looking at both the specific drug as well as the higher level medication level), the system displays a screen where the user can Archive the current medication record or they can choose not to add the new prescription medication (i.e. if the same record exists on the medication list but it has a comment that the user wants to keep). So if the patient's medication list has Lipitor 20mg and they are prescribing Lipitor 30 mg, the system will display the possible duplicate because it sees the medication higher level is the same even though the drugs are not exactly the same). So we are taking what the user prescribed during the encounter and comparing it to the patient's current medication list for the user. We feel this will meet the criterion based on what we read but we wanted to check.	This criterion was developed by the federal government and published in the Interim Final Rule on January 13th, 2010. CCHIT cannot change these criteria and we must evaluate your product against the criteria as described in the test step. This criterion requires the comparison of "two or more medication lists". Since your description of your system functionality does not indicate that two or more "lists" can be successfully demonstrated for comparison to each other, we cannot agree that your system may be compliant.

Module	Question	Answer
Immunization Registries	How will this be tested?	We will require you to attest to the standard you will use to create the file on the Modular IFR Stage 1 Application form: **Immunization Registries (Please check one):** o HL7 v2.3.1 o HL7 v2.5.1 During the inspection, we will ask you to compile the report for the juror and then submit the raw data file to the CCHIT Proctor. CCHIT will validate that the file conforms to standard you attested to on your application. You must also describe the process you would use to transmit this file to an immunization registry.
	Our state does not have an immunization registry; therefore we do not have anyone to accept our electronic submission of immunization data. Would we still need to demonstrate this ability?	To become certified in this component you would need to: a. Self-Attest on your Application form which standard you use for the files that are created. b. Submit the file to CCHIT for validation that it was created using the standard attested to on your application. c. Describe the process you would use to transmit the data file to the immunization registry. In other words, you do not have to demonstrate that you are actually sending immunization files to a registry, just that you have the capability to do so should your state begin to accept these files in the future.

Module	Question	Answer
	The CCHIT Gap Analysis document indicates that this item is only required for applicants who "opted out". What does this mean?	This was an optional item on the Preliminary ARRA 2011 test scripts, so if the vendor chose not to perform it during their certification test (opt out), they will need to come back and demonstrate it before they are IFR Stage I certified. This is a required Interim Final Rule (IFR) standard for any vendor who wants to become IFR Stage I certified as a complete EHR.
	Does this file need to be at the patient level or at the practice level? For instance, one file for each patient versus one file for each individual immunization versus one file for each practice containing all immunization data for a specific time period.	The Interim Final Rule is not prescriptive on whether this file is created at the patient-level or at the practice-level, therefore, CCHIT will allow either.
	Does CCHIT have a tool we can use to validate that these files are in the correct format before our inspection?	CCHIT will use a commercially available product to validate that the message was created using the standard you specify (HL7 2.3.1 or 2.5.1). You should be able to find some products to assist you with your own validation of these files prior to your inspection by searching for 'HL7 message editor' on the Internet. CCHIT does not recommend or endorse one product over another.
Reportable Lab Submission	How will this be tested?	Reportable Lab Submission is not applicable to the Eligible Provider domain. No testing will be done on this functionality.

Module	Question	Answer
Electronic Syndromic Surveillance	How will this be tested?	We will require you to attest to the standard you will use to create the file on the Modular IFR Stage 1 Application form: • HL7 v2.3.1 • HL7 v2.5.1 During the inspection, we will ask you to compile the report for the juror and then submit the raw data file to the CCHIT Proctor. CCHIT will validate that the file conforms to standard you attested to on your application. You must also describe the process you would use to transmit this file to a public health agency.
	Our state does not accept syndromic surveillance data in this way; therefore we do not have anyone to accept our electronic syndromic surveillance data. Would we still need to demonstrate this ability?	To become certified in this Meaningful Use component you would need to: a. Self-Attest on your Application form which standard you use for the files that are created. b. Submit the file to CCHIT for validation that it confirms to the standard attested to on your application. c. Describe the process you would use to transmit the data file. In other words, you do not have to demonstrate that you are actually sending syndromic surveillance data electronically, just that you have the capability to do so should your state begin to accept these files in the future.

Module	Question	Answer
	The CCHIT Gap Analysis document indicates that this item is only required for applicants who "opted out". What does this mean?	This was an optional item on the Preliminary ARRA 2011 test scripts, so if the vendor chose not to perform it during their certification test (opt out), they will need to come back and demonstrate it before they are IFR Stage I certified. This is a required Interim Final Rule (IFR) standard for any vendor who wants to become IFR Stage I certified as a complete EHR.
	Do we have to send a single, HL7 file with multiple patients on it? That is not how our HL7 interface is set up. We send files for individual patients. We can report on all patients with a diagnosis of influenza, it is just not the format of our interface to send a file like that. Is it ok instead to send individual files?	Since the Interim Final Rule is not specific about this, we will allow single patient transmissions.
	Does CCHIT have a tool we can use to validate that these files are in the correct format before our inspection?	CCHIT will use a commercially available product to validate that the message was created using the standard you specify (HL7 2.3.1 or 2.5.1). You should be able to find some products to assist you with your own validation of these files prior to your inspection by searching for 'HL7 message editor' on the Internet. CCHIT does not recommend or endorse one product over another.