Test Report document for Patient Problem List

Tested By	**ViCarePlus Team, www.vicareplus.com**
Tested On	**10/12/2010**
Total number of testcases	**9**
Number of testcases passed	**9**
Number of bugs	**0**
FINAL RULE:	
§170.302 (c) Maintain up-to-date problem list. Enable a user to electronically record, modify, and retrieve a patient's problem list for longitudinal care in accordance with:(1) The standard specified in §170.207(a)(1); or (2) At a minimum, the version of the standard specified in §170.207(a)(2).	

170.207(a) Problems	Regulatory Referenced Standard
(1) Standard. The code set specified at 45 CFR 162.1002(a)(1). (2)(2) Standard. International Health Terminology Standards Development Organization (IHTSDO) Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) July 2009 version (incorporated by reference in §170.299).	**45 CFR 162.1002 Medical data code sets The Secretary adopts the following code set maintaining organization's code sets as the standard medical data code sets: (a) International Classification of Diseases, 9th Edition, Clinical Modification, (ICD-9- CM), Volumes 1 and 2 (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following conditions: (1) Diseases.**

NIST SUPPLIED TEST DATA

TD170.302.c – 1: Record Problems – Ambulatory Setting Using ICD-9 Codes 1)Cerebrovascular Accident, ICD-9 Code: V12.54, Status: Active,Date Diagnosed: May 22, 2010)2)Recurrent Urinary Tract Infection, ICD-9 Code: V13.02, Status: Active,Date Diagnosed:June 24, 2010 3)Chronic Obstructive Pulmonary Disease, ICD-9 Code: 496.0, Status: Active,Date Diagnosed: April 4, 2010 4)Essential Hypertension, ICD-9 Code: 401.9, Status: Active,Date Diagnosed: March 30, 2010 **TD170.302.c – 2: Modify Problems – Ambulatory Setting** 1)Change the Status of Urinary Tract Infection from Active to Resolved,Date Modified: August 29, 2010 2)Change the Status of EssentialHypertension From Active to Inactive, Date Modified: August 29, 2010 **TD170.302.c – 3a: Retrieve Problems – Ambulatory Setting Active Problems only Using ICD-9 Codes** 1)Cerebrovascular Accident, ICD-9 Code: V12.54, Status: Active,Date Diagnosed:May 22, 2010 2)Chronic Obstructive Pulmonary Disease, ICD-9 Code: 496.0, Status: Active,Date Diagnosed:April 4,20103) **TD170.302.c – 3b: Retrieve Problem History – Ambulatory Setting List of all Problems including active, inactive and resolved Using ICD-9 Codes** 1) Cerebrovascular Accident, ICD-9 Code: V12.54, Status: Active Date Diagnosed:May 22 2010 2)Recurrent Urinary Tract Infection, ICD-9 Code: V13.02, Status: Resolved ,Date Diagnosed:June 24,2010 Date Modified:August 29, 20103) Chronic Obstructive Pulmonary Disease, ICD-9 Code: 496.0, Status: Active,Date Diagnosed: April 4, 2010 4) Essential Hypertension, ICD-9 Code: 401.9, Status: Inactive. Date Diagnosed: March 30,2010 Date Modified:August 29, 2010

Test Case ID	Test Cases Checked	Output	Status
DTR170.302.c – 1: Electronically Record Patient Problem List in an Ambulatory Setting			
PL_01	Select a patient such that ,the patient's previous problem history are recorded. Create a new encounter and Click the 'ADD' button in Patient/Client->Visits->Create visits,to add problem	The her function for adding problems is identified.	**PASS**
PL_02	Identify which vocabulary standard is implemented in the EHR for recording patient problems (ICD-9 or SNOMED CT) by clicking in the Diagnosis Code input field	ICD 9 code is used	**PASS**
PL_03	Use the NIST supplied data TD170.302.c – 1,enter the title in 'Title' field,ICD9 code by clicking in the 'Diagnosis Code' field and status in 'Outcome' .Save the details	All the details were added correctly,without any omission	**PASS**
PL_04	Check whether the the patient problem list data entered during the test are associated with one of the required standard terminologies (ICD-9, SNOMED CT). Validation methods include, but are not limited to: verifying that the appropriate vocabulary code is displayed along with the patient problem description when the user is recording patient problems; or verifying that the EHR includes the capability to cross-reference (map) the user-displayed problem descriptions to the appropriate vocabulary codes; or verifying that the patient problem list data stored in the EHR contains the appropriate vocabulary codes	The code for the problem is added using ICD-9 and the codes contains the appropriate vocabulary codes	**PASS**
DTR170.302.c – 2: Electronically Modify Patient Problem List in an Ambulatory Setting			
PL_05	Select the patient for whom the problems were added during DTR170.302.c -1 and click 'Edit' button in Medical Problems' section in the patient's demographics page	All the medical problems including those added during DTR170.302.c -1 are listed with date	**PASS**
PL_06	Click on the problem created during DTR170.302.c -1	Page for editing the medical problems appear	**PASS**
PL_07	Using the data from TD170.302.c – 2 modify the problem details	The data can be modified correctly without any omission	**PASS**
DTR170.302.c – 3: Electronically Retrieve Patient Problem List and Problem List History in an Ambulatory Setting			
PL_08	Click the 'Edit' button' in "Medical Problems' section of the patient demographics.	The patient's problem history is listed	**PASS**
PL_09	Check whether the problems entered during DTR170.302.c -1 and modified during DTR170.302.c -2 are listed according to TD170.302.c – 3a and TD170.302.c – 3b:	The patient problem history data and the correct values from the standard terminology display correctly and without omission	**PASS**