

(a) *Patient summary record—(1) Standard.* Health Level Seven Clinical Document Architecture (CDA) Release 2, Continuity of Care Document (CCD) (incorporated by reference in § 170.299). *Implementation specifications.* The Healthcare Information Technology Standards Panel (HITSP) Summary Documents Using HL7 CCD Component HITSP/C32 (incorporated by reference in § 170.299).

(2) *Standard.* ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369 (incorporated by reference in § 170.299).

(b) *Electronic prescribing. (1) Standard.* The National Council for the Prescription Drug Programs (NCPDP) Prescriber/Pharmacist Interface SCRIPT standard, Implementation Guide, Version 8, Release 1 (Version 8.1) October 2005 (incorporated by reference in § 170.299)

(2) *Standard.* NCPDP SCRIPT Standard, Implementation Guide, Version 10.6 (incorporated by reference in § 170.299).

(c) *Electronic submission of lab results to public health agencies. Standard.* HL7 2.5.1 (incorporated by reference in § 170.299). *Implementation specifications.* HL7 Version 2.5.1 Implementation Guide: Electronic Laboratory Reporting to Public Health, Release 1 (US Realm) (incorporated by reference in § 170.299).

(d) *Electronic submission to public health agencies for surveillance or reporting. (1) Standard.* HL7 2.3.1 (incorporated by reference in § 170.299).

(2) *Standard.* HL7 2.5.1 (incorporated by reference in § 170.299).

(e) *Electronic submission to immunization registries. (1) Standard.* HL7 2.3.1 (incorporated by reference in § 170.299). *Implementation specifications.* Implementation Guide for Immunization Data Transactions using Version 2.3.1 of the Health Level Seven (HL7) Standard Protocol Implementation Guide Version 2.2 (incorporated by reference in § 170.299).

(2) *Standard.* HL7 2.5.1 (incorporated by reference in § 170.299). *Implementation specifications.* HL7 2.5.1 Implementation Guide for Immunization Messaging Release 1.0 (incorporated by reference in § 170.299).

(f) *Quality reporting. Standard.* The CMS Physician Quality Reporting Initiative (PQRI) 2009 Registry XML Specification (incorporated by reference in § 170.299). *Implementation specifications.* Physician Quality Reporting Initiative Measure Specifications Manual for Claims and Registry (incorporated by reference in § 170.299).

[75 FR 44649, July 28, 2010, as amended at 75 FR 62690, Oct. 13, 2010]

#### § 170.207 Vocabulary standards for representing electronic health information.

The Secretary adopts the following code sets, terminology, and nomenclature as the vocabulary standards for the purpose of representing electronic health information:

(a) *Problems—(1) Standard.* The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions.

(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).

(b) *Procedures—(1) Standard.* The code set specified at 45 CFR 162.1002(a)(2).

(2) *Standard.* The code set specified at 45 CFR 162.1002(a)(5).

(c) *Laboratory test results. Standard.* Logical Observation Identifiers Names and Codes (LOINC®) version 2.27, when such codes were received within an electronic transaction from a laboratory (incorporated by reference in § 170.299).

(d) *Medications. Standard.* Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.

(e) *Immunizations. Standard.* HL7 Standard Code Set CVX—Vaccines Administered, July 30, 2009 version (incorporated by reference in § 170.299).

(f) *Race and Ethnicity. Standard.* The Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, Statistical Policy Directive No. 15, October 30, 1997 (available at <http://www.whitehouse.gov/omb/rewrite/fedreg/ombdir15.html>).