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

(3) Standard. The code set specified at 45 CFR 162.1002(c)(3) for the indicated procedures or other actions taken.

(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).


(4) Standard. The code set specified at 45 CFR 162.1002(c)(3) for the indicated procedures or other actions taken.

(c) Laboratory tests—(1) 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).

(2) Standard. Logical Observation Identifiers Names and Codes (LOINC®) Database version 2.40, a universal code system for identifying laboratory and clinical observations produced by the Regenstrief Institute, Inc. (incorporated by reference in §170.299).

(3) 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—(1) Standard. Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.
§ 170.210 Standards for health information technology to protect electronic health information created, maintained, and exchanged.

The Secretary adopts the following standards to protect electronic health information created, maintained, and exchanged:


(b) Record actions related to electronic health information. The date, time, patient identification, and user identification must be recorded when electronic health information is created, modified, accessed, or deleted; and an indication of which action(s) occurred and by whom must also be recorded.

(c) Verification that electronic health information has not been altered in transit. A hashing algorithm with a security strength equal to or greater than SHA-1 (Secure Hash Algorithm (SHA-1) as specified by the National Institute of Standards and Technology (NIST) in FIPS PUB 180-4 (March 2012)) must be used to verify that electronic health information has not been altered.

(d) Record treatment, payment, and health care operations disclosures. The date, time, patient identification, user identification, and a description of the disclosure must be recorded for disclosures for treatment, payment, and health care operations, as these terms are defined at 45 CFR 164.501.

(e) Record actions related to electronic health information, audit log status, and encryption of end-user devices. (1)(i) The audit log must record the information specified in sections 7.2 through 7.4, 7.6, and 7.7 of the standard specified at §170.210(h) when EHR technology is in use.

(ii) The date and time must be recorded in accordance with the standard specified at §170.210(g).