



# **QRDA Category I Conformance Statement Resource – CY 2019 eCQM Reporting**

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Updated  
December 2019

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# Release Notes

- **November 2016** – Initial posting of this resource for the CY 2016 reporting period
- **February 2017** – Updated posting of this resource
- **November 2017** – Updated this resource for use during the CY 2017 reporting period
- **October 2018** – Updated this resource for use during the CY 2018 reporting period
- **November 2019** – Updated this resource for use during the CY 2019 reporting period

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# QRDA Category I Conformance Statement Resource Overview

As of Calendar Year 2019, Quality Reporting Document Architecture (QRDA) Category I files are submitted by Eligible Hospitals (EHs) and Critical Access Hospitals (CAHs) to fulfill a portion of the mandatory electronic Clinical Quality Measure (eCQM) reporting requirements for the Centers for Medicare & Medicaid Services (CMS) Hospital Inpatient Quality Reporting (IQR) and/or Promoting Interoperability Program.

When test or production files are submitted for processing to the CMS data receiving system within the *QualityNet Secure Portal*, errors are identified with a conformance statement, or system requirement. These statements are referred to with a CONF number. CONF numbers are generated to tell the data submitter why the file was rejected and unable to be processed.

There are two types of conformance statements with different formats for the CONF number: the CMS CONF numbers and Health Level Seven (HL7) Clinical Document Architecture (CDA) QRDA Category I CONF numbers. The Conformance Statement Resource was developed to assist data submitters to resolve file upload errors by providing additional explanations and reference material to support successful submission.

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# Two Types of QRDA Category I Conformance Statements

## CMS CONF Number

- Format: CMS\_xxxx  
Example: CMS\_0010
- Format: xxxx\_yyyy\_C01  
Example: 1198-5300\_C01
- Reference material: Visit the eCQI Resource Center [CMS QRDA IG publication page](#), which includes the 2019 IG.

## HL7 CDA CONF Number

- HL7 CDA QRDA errors  
format: CONF:xxxx\_yyyy  
Example: CONF:3343-16598
- Reference material: Visit the HL7 website to obtain the [HL7 CDA® R2 IG: QRDA I STU Release 5](#).

**NOTE:** The HL7 website may require a HL7 account in order to download the Implementation Guide (IG).

# How to Use this QRDA Category I Conformance Statement Resource

The next page provides a table of commonly occurring CONF statements associated with the submission of QRDA Category I files for CY 2019 eCQM reporting. To obtain details on specific conformance or error messages:

1. Select the CONF number (highlighted as a blue link on the next page) to view the error description, the meaning of the error message, and details on how to resolve the error.
2. Choose **Select a new CONF number** at the bottom of the page to return to the CONF number table.
3. Selecting **End** at the bottom right hand corner of the page navigates to a list of resources.

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# Select a CONF Number From the List Below

## **CMS Conformance Numbers**

[CONF: CMS 0006](#) – Data Validation: Missing or Multiple CMS EHR IDs  
[CONF: CMS 0008](#) – Data Validation: Improper Extension for CMS EHR ID  
[CONF: CMS 0009](#) – Patient Identification Number Requirement  
[CONF: CMS 0026](#) – Improper Extension for intendedRecipient ID  
[CONF: CMS 0035](#) – CCN length  
[CONF: CMS 0060](#) – Encounter Performed Discharge Date Null  
[CONF: CMS 0061](#) – Encounter Performed Discharge Date Error  
[CONF: CMS 0062](#) – Encounter Performed Admission Date  
[CONF: CMS 0063](#) – Encounter Performed Discharge Date  
[CONF: CMS 0066](#) – CCN cannot be validated  
[CONF: CMS 0067](#) – Submitter Not Authorized to Submit  
[CONF: CMS 0068](#) – Dummy CCN  
[CONF: CMS 0071](#) – Data Validation: Not Well-Formed QRDA XML  
[CONF: CMS 0072](#) – QRDA Document Format Error  
[CONF: CMS 0073](#) – QRDA Document Format Error  
[CONF: CMS 0074](#) – Version Specific Measure Identifier  
[CONF: CMS 0075](#) – Admission Date [Effective Time / low value]  
[CONF: CMS 0076](#) – Discharge Date [Effective Time / high value]  
[CONF: CMS 0079](#) – Reporting Period Effective Date Range  
[CONF: CMS 0082](#) – Certification ID Year/Version Requirement  
[CONF: CMS 0083](#) – CMS EHR Certification ID Format Error  
[CONF: CMS 0110](#) – Datatype PQ Requirement  
[CONF: CMS 0115](#) – Data Validation: NPI Should Have 10 Digits  
[CONF: CMS 0117](#) – Data Validation: NPI Should Have Correct Checksum  
[CONF: CMS 0121](#) – Inconsistent Use of UTC Offset  
[CONF: 1198-5300 C01](#) – Birth Time Precise to the Day  
[CONF: 3343-14430 C01](#) – Missing Patient Characteristic Payer

## **HL7 CDA Conformance Numbers**

[CONF: 67-12978](#) – Measure Section QDM Entry  
[CONF: 67-13193](#) – eMeasure Reference QDM  
[CONF: 81-7291](#) – Patient Contact Information Street Address Line  
[CONF: 81-7292](#) – Patient Contact Information City  
[CONF: 81-9371](#) – Conformant Patient Name  
[CONF: 81-9372](#) – Cannot Contain Name Parts  
[CONF: 1198-5271](#) – Patient Contact Information US Realm Address  
[CONF: 1198-5280](#) – Patient Contact Information Telecom  
[CONF: 1198-5524](#) – Missing Custodian Organization Name  
[CONF: 1198-6394](#) – Administrative Gender Code  
[CONF: 1198-14838](#) – Service Event – Low Effective Time  
[CONF: 3343-27571](#) – Birth Time Precise to the Day  
[CONF: 3343-13372](#) – Missing or Multiple participantRole Elements  
[CONF: 3343-14431](#) – Missing Patient Characteristic Payer  
[CONF: 3343-27343](#) – Intervention Order Requires Author  
[CONF: 3343-27745](#) – Medication Order Requires Author

[End](#)

# CONF: CMS\_0006

## Data Validation: Missing or Multiple CMS EHR Certification ID (1 of 2)

**ERROR:** This id SHALL contain exactly one [1..1]  
@root="2.16.840.1.113883.3.2074.1" CMS EHR Certification  
Identification Number (CONF:CMS\_0006).

The Certified Health IT Product List (CHPL) is the authoritative and comprehensive listing of Health IT certified through the ONC Health IT Certification Program. A CMS EHR Certification ID is a number generated by the CHPL and used for reporting to CMS.

A CMS EHR Certification ID is a string made up of 15 alphanumeric characters and is used as the value of an "extension" attribute on an <id> element with a "root" attribute of "2.16.840.1.113883.3.2074.1"

This <id> element is contained in the <participant>/<associatedEntity> element of the root QRDA document element and is a required element of this associated entity. One and only one <id> with root="2.16.840.1.113883.3.2074.1" is allowed.



# CONF: CMS\_0006

## Data Validation: Missing or Multiple CMS EHR Certification ID (2 of 2)

### Proper root ClinicalDocument with CMS EHR Certification ID

```
<ClinicalDocument xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
  xsi:schemaLocation="urn:hl7-org:v3 ../Schema/CDA/infrastructure/cda/CDA_SDTc.xsd"
  xmlns="urn:hl7-org:v3" xmlns:voc="urn:hl7-org:v3/voc" xmlns:sdtc="urn:hl7-org:sdtc">
  <templateId root="2.16.840.1.113883.10.20.22.1.1" extension="2015-08-01"/>
  <templateId root="2.16.840.1.113883.10.20.24.1.1" extension="2017-08-01"/>
  <templateId root="2.16.840.1.113883.10.20.24.1.2" extension="2017-08-01"/>
  <templateId root="2.16.840.1.113883.10.20.24.1.3" extension="2018-02-01"/>
  ...
  <informationRecipient> ... </informationRecipient>
  ...
  <participant typeCode="DEV">
    <associatedEntity classCode="RGPR">
      <!-- CMS EHR Certification ID -->
      <id root="2.16.840.1.113883.3.2074.1" extension="0015EML275MCA49"/>
    </associatedEntity>
  </participant>
  <documentationOf> ... </documentationOf>
  <component>
    <structuredBody> ... </structuredBody>
  </component>
  ...
</ClinicalDocument>
```

# CONF: CMS\_0008

## Data Validation: Improper Extension for CMS EHR Certification ID (1 of 2)

**ERROR:** This id SHALL contain exactly one [1..1]  
@extension (CONF:CMS\_0008).

The Certified Health IT Product List (CHPL) is the authoritative and comprehensive listing of Health IT certified through the ONC Health IT Certification Program. A CMS EHR Certification Identification Number is a number generated by the CHPL and used for reporting to CMS.

A CMS EHR Certification ID is a string made up of 15 alphanumeric characters and is used as the value of an "**extension**" attribute on an <id> element with a "root" attribute of "2.16.840.1.113883.3.2074.1"

This <id> element is contained in the <participant>/<associatedEntity> element of the root QRDA document element and is a required element of this associated entity. One and only one <id> with root="2.16.840.1.113883.3.2074.1" is allowed.

# CONF: CMS\_0008

## Data Validation: Improper Extension for CMS EHR Certification ID (2 of 2)

### Proper root ClinicalDocument with CMS EHR Certification ID

```
<ClinicalDocument xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
  xsi:schemaLocation="urn:hl7-org:v3 ../Schema/CDA/infrastructure/cda/CDA_SDTC.xsd"
  xmlns="urn:hl7-org:v3" xmlns:voc="urn:hl7-org:v3/voc" xmlns:sdtc="urn:hl7-org:sdtc">
  <templateId root="2.16.840.1.113883.10.20.22.1.1" extension="2015-08-01"/>
  <templateId root="2.16.840.1.113883.10.20.24.1.1" extension="2017-08-01"/>
  <templateId root="2.16.840.1.113883.10.20.24.1.2" extension="2017-08-01"/>
  <templateId root="2.16.840.1.113883.10.20.24.1.3" extension="2018-02-01"/>
  ...
  <informationRecipient> ... </informationRecipient>
  <participant typeCode="DEV">
    <associatedEntity classCode="RGPR">
      <!-- CMS EHR Certification ID -->
      <id root="2.16.840.1.113883.3.2074.1" extension="0015EML275MCA49"/>
    </associatedEntity>
  </participant>
  <documentationOf> ... </documentationOf>
  <component>
    <structuredBody> ... </structuredBody>
  </component>
  ...
</ClinicalDocument>
```

# CONF: CMS\_0009, CMS\_0053 & CMS\_0103

## Patient Identification Number Requirement (1 of 2)

**ERROR:** This patientRole SHALL contain exactly one [1..1] id (CONF:CMS\_0009) such that it SHALL contain exactly one [1..1] @root (CONF:CMS\_0053). SHALL contain exactly one [1..1] @extension (CONF:CMS\_0103).

**Meaning:** Patient Identification Number is required in a QRDA I file for HQR submissions.

# CONF: CMS\_0009, CMS\_0053 & CMS\_0103

## Patient Identification Number Requirement (2 of 2)

### How to Fix:

A Patient Identification Number is an id contained in the <recordTarget>/<patientRole> element other than the id elements for HICN and MBI.

The value of "root" attribute of the id element for Patient Identification Number may vary for different hospitals and can not be the same OIDs for HICN (2.16.840.1.113883.4.572) and MBI (2.16.840.1.113883.4.927)

The value of "extension" attribute of this <id> element contains the Patient Identification Number.

```
<ClinicalDocument ...>
...
<recordTarget>
  <patientRole>
    <!-- Patient Identification Number -->
    <id root="Patient_Identification_Number_root"
extension="Patient_Identification_Number_goes_here"/>
    <!-- Medicare HIC Number/HICN -->
    <id root="2.16.840.1.113883.4.572"
extension="HICN_goes_here"/>
    <!-- Medicare Beneficiary Identifier -->
    <id root="2.16.840.1.113883.4.927"
extension="MBI_goes_here"/>
    ...
  </patientRole>
</recordTarget>
...
```

# CONF: CMS\_0026

## Improper Extension for intendedRecipient ID (1 of 2)

**ERROR:** This id SHALL contain exactly one [1..1] @extension, which SHALL be selected from ValueSet QRDA I CMS Program Name urn:oid:2.16.840.1.113883.3.249.14.103 STATIC 2018-02-01 (CONF:CMS\_0026).

Every QRDA document must have an <informationRecipient>, which must have an <intendedRecipient> with one <id>. The <id> element must have an "extension" attribute. The value of that attribute must be one of the values found in the QRDA I CMS Program Name value set (urn:oid: 2.16.840.1.113883.3.249.14.103)

### Proper Information Recipient Example

```
<ClinicalDocument xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
  xsi:schemaLocation="urn:hl7-org:v3 ../Schema/CDA/infrastructure/cda/CDA_SDTC.xsd"
  xmlns="urn:hl7-org:v3" xmlns:voc="urn:hl7-org:v3/voc" xmlns:sdtc="urn:hl7-org:sdtc">
  <!-- QRDA Category I Report - CMS (V5) -->
  ...
  <informationRecipient>
    <intendedRecipient>
      <id root="2.16.840.1.113883.3.249.7" extension="HQR_PI"/>
    </intendedRecipient>
  </informationRecipient>
  ...
</ClinicalDocument>
```

# CONF: CMS\_0026

## Improper Extension for intendedRecipient ID (2 of 2)

### Allowed QRDA I CMS Program Name Values for CY2019

Program Name Value	Print Name
HQR_PI	Hospital Quality Reporting for the Promoting Interoperability Program
HQR_IQR	Hospital Quality Reporting for the Inpatient Quality Reporting Program
HQR_PI_IQR	Hospital Quality Reporting for the Promoting Interoperability Program and the IQR Program
HQR_IQR_VOL	Hospital Quality Reporting for Inpatient Quality Reporting Program voluntary submissions
CDAC_HQR_EHR	CDAC_HQR_EHR

# CONF: CMS\_0035 & CONF: CMS\_0066

## CMS Certification Number (CCN)

CONF #	Validation Performed	Meaning	Solution
CMS_0035	CCN <b>SHALL</b> be six to ten characters in length	CCNs submitted that have five or fewer characters or 11 or more characters will not pass validation.	Review CCN included in QRDA file to ensure accuracy.
CMS_0066	CCN (NULL) cannot be validated	CCN passes Schematron format check but the value does not appear in HQR lookup of valid CCNs. This message will appear if CCN is Null.	Review QRDA File to ensure: <ul style="list-style-type: none"><li>• CCN is included and is accurate</li><li>• Verify where the @root="2.16.840.1.113883.4.336" is present, that the CCN extension is also present</li></ul>



# CONF: CMS\_0060

## Encounter Performed Discharge Date Null (1 of 2)

**ERROR:** The system SHALL reject QRDA I files if the Encounter Performed Discharge Date is null.

Example: Null discharge date

```
<effectiveTime>  
  <!-- Attribute: Admission Datetime-->  
  <low value="20190329090000"/>  
  <!-- Attribute: Discharge Datetime with an empty value -->  
  <high value=""/>  
</effectiveTime>
```

# CONF: CMS\_0060

## Encounter Performed Discharge Date Null (2 of 2)

### Example of correct discharge datetime:

```
<!-- "Encounter Performed: Inpatient Encounter" using Encounter Inpatient SNOMEDCT Value Set  
(2.16.840.1.113883.3.666.5.307) -->  
<entry typeCode="DRIV">  
  <act classCode="ACT" moodCode="EVN">  
    <!-- Encounter Performed Act (V2) -->  
    <templateId root="2.16.840.1.113883.10.20.24.3.133" extension="2017-08-01"/>  
    <id root="72b0c35b-18dd-4058-887f-c945be0439b3"/>  
    <code code="ENC" displayName="Encounter" codeSystem="2.16.840.1.113883.5.6" codeSystemName="ActClass"/>  
    <entryRelationship typeCode="SUBJ">  
      <encounter classCode="ENC" moodCode="EVN">  
        <!-- Conforms to C-CDA R2.1 Encounter Activity (V3) -->  
        <templateId root="2.16.840.1.113883.10.20.22.4.49" extension="2015-08-01"/>  
        <!-- Encounter Performed (V4) -->  
        <templateId root="2.16.840.1.113883.10.20.24.3.23" extension="2017-08-01"/>  
        <id root="dccf424e-18dd-4058-887f-a8151eaaa55"/>  
        <code code="32485007" displayName="Hospital admission (procedure)"  
          codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMEDCT"/>  
        <text>Encounter, Performed: Inpatient Encounter</text>  
        <statusCode code="completed" />  
        <effectiveTime>  
          <!-- QDM Attribute: Admission Datetime -->  
          <low value="20190129090000"/>  
          <!-- QDM Attribute: Discharge Datetime -->  
          <high value="20190131100000"/>  
        </effectiveTime>  
      </encounter>  
    </entryRelationship>  
  </act>  
</entry>
```

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# CONF: CMS\_0061

## Encounter Performed Discharge Date Error (1 of 2)

**ERROR:** The system SHALL reject QRDA I files if the Encounter Performed Discharge Date (effectiveTime/high value) is after the upload date (discharge date is in the future) (CONF: CMS\_0061).

Every Encounter Performed entry:

```
<templateId root="2.16.840.1.113883.10.20.24.3.23" extension="2017-08-01"/>
```

must have a single effectiveTime element. The <high> element of effectiveTime represents **discharge** date and time. The <high> element must have a single "value" attribute, the value of which represents the actual discharge date and time.

The QRDA I file will not be accepted if the discharge date (the value of effectiveTime/high/@value attribute) occurs after the date that the QRDA file is uploaded for submission.

# CONF: CMS\_0061

## Encounter Performed Discharge Date Error (2 of 2)

### Improper example:

QRDA I file is uploaded for submission on October 3<sup>rd</sup>, 2019.

Discharge date of Encounter Performed contained in the QRDA I file is after the file upload date.

```
<act classCode="ACT" moodCode="EVN">
  <!-- Encounter Performed Act (V2) -->
  <templateId root="2.16.840.1.113883.10.20.24.3.133" extension="2017-08-01"/>
  <id root="72b0c35b-18dd-4058-887f-c945be0439b3"/>
  <code code="ENC" displayName="Encounter" codeSystem="2.16.840.1.113883.5.6" codeSystemName="ActClass" />
  <entryRelationship typeCode="SUBJ">
    <encounter classCode="ENC" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.22.4.49" extension="2015-08-01"/>
      <!-- Encounter Performed (V4) templateId-->
      <templateId root="2.16.840.1.113883.10.20.24.3.23" extension="2017-08-01"/>
      ...
      <effectiveTime>
        <!-- QDM Attribute: admission datetime -->
        <low value="20190921090000"/>
        <!-- QDM Attribute: discharge datetime -->
        <high value="20191012103000"/>
      </effectiveTime>
    </encounter>
  </entryRelationship>
</act>
```

### How to fix:

The encounter performed discharge date cannot be after the QRDA I file upload date.

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# CONF: CMS\_0062

## Encounter Performed Admission Date (1 of 2)

**ERROR:** The system SHALL reject QRDA I files if the Encounter Performed Admission Date (effectiveTime/low value) is after the Encounter Performed Discharge Date (effectiveTime/high value).

### Meaning:

Possible conditions resulting in this error are:

- Encounter Performed Admission Date (effectiveTime/low value) is after the Encounter Performed Discharge Date (effectiveTime/high value)
- Admission Date or Discharge Date values are null or have an invalid format

# CONF: CMS\_0062

## Encounter Performed Admission Date (2 of 2)

Example of invalid admission date after the discharge date:

```
<low value="20190131090000"/> <!-- January 31 -->
<high value="20190129103000"/> <!-- January 29 -->
```

Example of valid admission and discharge dates:

```
<act classCode="ACT" moodCode="EVN">
  <!-- Encounter Performed Act (V2) -->
  <templateId root="2.16.840.1.113883.10.20.24.3.133" extension="2017-08-01"/>
  <id root="90b0c39e-18dd-4058-887f-c945be0490b7"/>
  <code code="ENC" displayName="Encounter" codeSystem="2.16.840.1.113883.5.6" codeSystemName="ActClass"/>
  <entryRelationship typeCode="SUBJ">
    <encounter classCode="ENC" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.22.4.49" extension="2015-08-01" />
      <!-- Encounter Performed (V4) -->
      <templateId root="2.16.840.1.113883.10.20.24.3.23" extension="2017-08-01" />
      <id root="9b84977d-e6f6-4f50-9897-a6e1c90ba201"/>
      <code code="32485007" displayName="Hospital admission (procedure)" codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMEDCT"/>
      <text>Encounter, Performed: Inpatient Encounter</text>
      <statusCode code="completed" />
      <effectiveTime>
        <!-- QDM Attribute: admission datetime -->
        <low value="20190129103000"/>
        <!-- QDM Attribute: discharge datetime -->
        <high value="20190131109000"/>
      </effectiveTime>
    </encounter>
  </entryRelationship>
</act>
```

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CONF number](#)

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# CONF: CMS\_0063

## Encounter Performed Discharge Dates (1 of 2)

---

**ERROR:** There are no Encounter Performed Discharge Dates within the reporting period found in the QRDA.

# CONF: CMS\_0063

## Encounter Performed Discharge Dates (2 of 2)

### Meaning:

There must be at least one encounter in the QRDA file that has its discharge date within the reporting period.

If there are other encounters reported that are outside the reporting period, the file will not be rejected as long as there is at least one encounter with the discharge date within the reporting period, as specified in the Reporting Parameters Section of the QRDA.

```
<entry typeCode="DRIV">
  <act classCode="ACT" moodCode="EVN">
    <!-- Reporting Parameters Act -->
    <templateId root="2.16.840.1.113883.10.20.17.3.8"/>
    <!-- Reporting Parameters Act - CMS-->
    <templateId root="2.16.840.1.113883.10.20.17.3.8.1" extension="2016-03-01"/>
    <id root="56op11cf-b01b-4527-a704-c098c16288yd"/>
    <code code="252116004" codeSystem="2.16.840.1.113883.6.96"
      displayName="Observation Parameters"/>
    <effectiveTime>
      <low value="20190401"/>
      <high value="20190630"/>
    </effectiveTime>
  </act>
</entry>
```

The relevant elements for reporting period are in the rectangle above, effectiveTime/low and effectiveTime/high.

This example is for CY2019Q2 of the reporting period, as shown in the table below.

CY 2019 Discharge Reporting Period		
Quarter	Discharge Start	Discharge End
CY2019Q1	1/1/2019	3/31/2019
CY2019Q2	4/1/2019	6/30/2019
CY2019Q3	7/1/2019	9/30/2019
CY2019Q4	10/1/2019	12/31/2019

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# CONF: CMS\_0067

## Submitter Not Authorized to Submit (1 of 2)

**ERROR:** Submitter (%s) is not authorized to submit for this provider ( %s) (CONF:CMS\_0067).

During the data validation process, validation found that the Submitter (vendor) has not been authorized to submit data on behalf of the hospital. The hospital's CCN provided in the QRDA file is used in database lookup.

# CONF: CMS\_0067

## Submitter Not Authorized to Submit (2 of 2)

Proper custodian element with CCN for QRDA Clinical Document

```
<ClinicalDocument>
...
  <custodian>
    <assignedCustodian>
      <representedCustodianOrganization>
        <!-- CMS Certification Number (CCN) -->
        <id root="2.16.840.1.113883.4.336" extension="800890"/>
        <name>Good Health Hospital</name>
        <telecom use="WP" value="tel:(555)555-1003"/>
        <addr use="WP">
          <streetAddressLine>21 North Ave</streetAddressLine>
          <city>Burlington</city>
          <state>MA</state>
          <postalCode>02368</postalCode>
          <country>US</country>
        </addr>
      </representedCustodianOrganization>
    </assignedCustodian>
  </custodian>
...
</ClinicalDocument>
```

The value 800890 used in the example above is an acceptable dummy CCN number. However, only vendors can use the dummy CCN (see CMS\_0068), and the dummy CCN can ONLY be used for test data submissions (see CMS\_0069).

# CONF: CMS\_0068

## Dummy CCN

**ERROR:** Provider is not allowed to use a dummy CCN number (800890) for submissions.

### Meaning:

The dummy CMS Certification Number (CCN) (shown below) can be used only by vendors and only for test data submissions.

```
<id root="2.16.840.1.113883.4.336" extension="800890"/>
```

# CONF: CMS\_0071

## Data Validation: Not Well-Formed QRDA XML (1 of 2)

**ERROR:** Data submitted is not a well formed QRDA XML (CONF:CMS\_0071).

All QRDA XML files must contain only properly formatted XML.

The occurrence of this error means that the document violates the syntax rule in the XML specification, e.g., missing start/end tag or prime elements missing or not properly nested or not properly written.

Additionally, a QRDA document must conform to a specific XML schema (CDA\_SDTC.xsd). See CMS\_0072.

# CONF: CMS\_0071

## Data Validation: Not Well-Formed QRDA XML (2 of 2)

### Some common XML syntax errors:

- **Missing root element.** All XML documents must have a single root element.  
In the case of QRDA documents, that root element is the <clinicalDocument></clinicalDocument> element.
- **XML is case-sensitive** – Following is rejected because <tel> and </Tel> do not match case:  
`<tel>513-744-7098</Tel>`
- **Missing End Tags** – Following is rejected because <street> has no end tag, and <postalCode> has a malformed closing tag:  
`<address>  
    <street>34 Fountain Square Plaza  
    <region>OH</region>  
    <postal-code>45202<postal-code>  
</address>`
- **Spaces in element names** - Following is rejected because of spaces in the addressbook element name:  
`<address book>...</address book>`
- **Attribute values missing quotes** - Following is rejected because value for attribute preferred is not in quotes:  
`<tel preferred=true>555-112-3344</tel>`

# CONF: CMS\_0072

## QRDA Document Format Error

**ERROR:** The document does not conform to QRDA document formats accepted by CMS.

### Meaning:

QRDA structure of the submitted file does not conform to the QRDA XML Schema (CDA\_SDTC.XSD) provided by HL7. The file does not pass the schema check. Validation continues on the file to identify any other errors.

Note: The CDA\_SDTC.XSD XML schema is available in the HL7 QRDA Category I standard zip file [HL7 CDA® R2 IG: QRDA I STU Release 5](#).

# CONF: CMS\_0073

## QRDA Document Format Error

**ERROR:** The document does not conform to QRDA document formats accepted by CMS.

### Meaning:

The QRDA must have **all four** required header template IDs and extensions by the 2019 CMS QRDA I IG and its base standard QRDA Category I, Standard for Trial Use (STU), Release 5 being sent to CMS:

```
<!-- US Realm Header (V3) -->
<templateId root="2.16.840.1.113883.10.20.22.1.1"
             extension="2015-08-01"/>

<!-- QRDA Category I Framework (V4) -->
<templateId root="2.16.840.1.113883.10.20.24.1.1"
             extension="2017-08-01"/>

<!-- QDM-Based QRDA (V5) -->
<templateId root="2.16.840.1.113883.10.20.24.1.2"
             extension="2017-08-01"/>

<!-- QRDA Category I Report - CMS (V5) -->
<templateId root="2.16.840.1.113883.10.20.24.1.3"
             extension="2018-02-01"/>
```

This error is also produced for an empty file or any non-XML file type (e.g., PDF). Processing stops immediately on these files.

# CONF: CMS\_0074

## Version Specific Measure Identifier (1 of 3)

**ERROR:** The Version Specific Measure Identifier is not valid for the current program year.

**Meaning:** Each measure in the QRDA must reference the version specific identifier. Only the 2019 Reporting Period Eligible Hospital / Critical Access Hospitals eCQMs will be accepted for the CY 2019 reporting year.



# CONF: CMS\_0074

## Version Specific Measure Identifier (2 of 3)

To locate the Version Specific Measure Identifier in the eCQM XML file:

- Use the **QualityMeasureDocument/id/@root** XPath for eCQM Version Specific Measure Identifier
- Submit ONLY the Version Specific Measure Identifier
- Remember that the Version Specific Measure Identifier is not case sensitive

# CONF: CMS\_0074

## Version Specific Measure Identifier (3 of 3)

Example Health Quality Measures Format (HQMF) XML snippet from CMS108v7:

```
<!-- Measure Details Section -->
<typeId extension="POQM_HD000001UV02" root="2.16.840.1.113883.1.3"/>
<templateId>
  <item extension="2017-08-01" root="2.16.840.1.113883.10.20.28.1.1"/>
</templateId>
<!-- Version specific measure identifier -->
<id root="40280382-6258-7581-0162-693c3d8a07c9"/>
<code code="57024-2" codeSystem="2.16.840.1.113883.6.1">
  <displayName value="Health Quality Measure Document"/>
</code>
<title value="Venous Thromboembolism Prophylaxis"/>
<text value="This measure assesses the number of patients who received VTE
prophylaxis or have documentation why no VTE prophylaxis was given the day of or
the day after hospital admission or surgery end date for surgeries that start the
day of or the day after hospital admission"/>
<statusCode code="COMPLETED"/>
<setId root="38b0b5ec-0f63-466f-8fe3-2cd20ddd1622"/>
<!-- Measure version that corresponds to file name -->
<versionNumber value="7.4.000"/>
```

# CONF: CMS\_0075 & CONF: CMS\_0076

## Admission/Discharge Dates [effectiveTime] (1 of 2)

CONF #	Validation Performed	Meaning	Solution
0075	Admission Date is not properly formatted.	Fails validation check for Encounter Performed Admission Date (effectiveTime / low value)	Confirm proper format of admission date.
0076	Discharge Date is not properly formatted.	Fails validation check for Encounter Performed Admission Date (effectiveTime / high value)	Confirm proper format of discharge date.

# CONF: CMS\_0075 & CONF: CMS\_0076

## Admission/Discharge Dates [effectiveTime] (2 of 2)

Proper format for dates: YYYYMMDDHHMMSSxUUUU		
YYYY	Year	Range 1900 to 9999
MM	Month	Range 01 to 12
DD	Day	Range 01 to 31 (note: true to month and leap years)
HH	Hour	Range 0 to 23
SS	Seconds	Range 0 to 59
X	Plus or minus sign	
UUUU	UTC Time Shift	-1300 thru +1400
<b>NOTE:</b> Use of the UTC Time Shift is optional, however if it is used, it must be present throughout the whole QRDA Category I file for the file to be accepted.		

# CONF: CMS\_0079

## Reporting Period Effective Date Range (1 of 3)

**ERROR:** Reporting Period Effective Date Range does not match one of the Program's calendar year Discharge Quarters.

**Meaning:** The Reporting Parameter Section effective date range must exactly match one of the HQR allowable calendar year discharge quarters.

# CONF: CMS\_0079

## Reporting Period Effective Date Range (2 of 3)

EffectiveTime with allowable low and high values:

```
<entry typeCode="DRIV">
  <act classCode="ACT" moodCode="EVN">
    <!-- Reporting Parameters Act -->
    <templateId root="2.16.840.1.113883.10.20.17.3.8"/>
    <!-- Reporting Parameters Act CMS-->
    <templateId root="2.16.840.1.113883.10.20.17.3.8.1"
      extension="2016-03-01"/>
    <code code="252116004" codeSystem="2.16.840.1.113883.6.96"
      displayName="Observation Parameters"/>
    <effectiveTime>
      <low value="20190101"/>
      <high value="20190331"/>
    </effectiveTime>
  </act>
</entry>
```

# CONF: CMS\_0079

## Reporting Period Effective Date Range (3 of 3)

Promoting Interoperability and Hospital IQR Program Submissions via Test and Production QRDA Category I Files				
	CY Discharge Quarters		Production and Test Data Submissions	
Quarter	Discharge Start	Discharge End	Start	End
CY2019Q1	1/1/2019	3/31/2019	9/12/2019	3/02/2020
CY2019Q2	4/1/2019	6/30/2019	9/12/2019	3/02/2020
CY2019Q3	7/1/2019	9/30/2019	9/12/2019	3/02/2020
CY2019Q4	10/1/2019	12/31/2019	9/12/2019	3/02/2020

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# CONF: CMS\_0082

## CMS EHR Certification ID Year/Version Requirement (1 of 2)

---

**ERROR:** CMS EHR Certification ID does not meet year/version criteria

**Meaning:** The EHR system needs to be certified to 2015 Edition.



# CONF: CMS\_0082

## CMS EHR Certification ID Year/Version Requirement (2 of 2)

### How to Fix:

The EHR products used must be certified to 2015.

Create CMS EHR Certification ID on the ONC Certified Health IT Product List website (<https://chpl.healthit.gov>) by selecting appropriate 2015 Edition products.

A CMS EHR Certification ID is a string made up of 15 alphanumeric characters and is used as the value of an "**extension**" attribute on an <id> element with a "root" attribute of "2.16.840.1.113883.3.2074.1"

```
<ClinicalDocument
xmlns:xsi="http://www.w3.org/2001/XMLSchema
-instance" ... >
...
<participant typeCode="DEV">
  <associatedEntity classCode="RGPR">
    <!-- CMS EHR Certification Number -->
    <id root="2.16.840.1.113883.3.2074.1"
extension="0015EML275MCA49"/>
  </associatedEntity>
</participant>
...
</ClinicalDocument>
```

# CONF: CMS\_0083

## CMS EHR Certification ID Format Error

**ERROR:** CMS EHR Certification ID format is not valid

### How to Fix:

Create CMS EHR Certification ID on the ONC Certified Health IT Product List website (<https://chpl.healthit.gov>) by selecting appropriate 2015 Edition products.

Make sure the CMS EHR Certification ID is a string made up of 15 alphanumeric characters and is used as the value of an "**extension**" attribute on an <id> element with a "root" attribute of "2.16.840.1.113883.3.2074.1"

```
<ClinicalDocument
xmlns:xsi="http://www.w3.org/2001/XMLSchema
a-instance" ... >

...
<participant typeCode="DEV">
  <associatedEntity classCode="RGPR">
    <!-- CMS EHR Certification Number -->
    <id root="2.16.840.1.113883.3.2074.1"
extension="0015EML275MCA49"/>
  </associatedEntity>
</participant>

...
</ClinicalDocument>
```

# CONF: CMS\_0110

## Datatype PQ Requirement

**ERROR:** Data types of PQ SHALL have either @value or @nullFlavor but SHALL NOT have both @value and @nullFlavor. If @value is present then @unit SHALL be present but @unit SHALL NOT be present if @value is not present.

**Meaning:** For value element with PQ datatype, only the following two options are considered valid:

1. Both a value and a unit are provided

```
<value xsi:type="PQ" value="90" unit="mmHg"/>
```

2. No value is provided, a nullFlavor with a valid nullFlavor code is provided instead

```
<value xsi:type="PQ" nullFlavor="NI"/>
```

# CONF: CMS\_0115

## Data Validation: NPI Should Have 10 Digits (1 of 2)

### **ERROR:** The NPI should have 10 digits.

The NPI, National Provider Identifier is a unique ID number issued to health care providers (in the U.S.) by CMS.

The NPI is a 10-digit number where the 10<sup>th</sup> digit is a checksum digit. There is no embedded intelligence (i.e. no information about the provider) in the NPI. NPI numbers are validated using the Luhn Algorithm.

The NPI is used as the value of an "extension" attribute in an <id> element, when the "root" attribute has value of "2.16.840.1.113883.4.6". In cases where no NPI is provided or available, an attribute of nullFlavor="NA" may be used.

NPI <id> elements are present in elements including assignedEntity, assignedAuthor, and participantRole.

# CONF: CMS\_0115

## Data Validation: NPI Should Have 10 Digits (2 of 2)

### Example using <id> with NPI provided:

```
<observation classCode="OBS" moodCode="EVN">
  ...
  <participant typeCode="IND">
    <participantRole >
      <!-- NPI -->
      <id root="2.16.840.1.113883.4.6" extension="1234567893" />
    ...
  </participantRole>
</participant>
</observation>
```

### Example using <id> with no NPI provided:

```
<documentationof>
  ...
  <performer typeCode="PRF">
    ...
    <assignedEntity>
      <!-- This is the provider NPI -->
      <!-- For HQR, NPI may not be applicable. Hospitals may submit nullFlavor here. -->
      <id root="2.16.840.1.113883.4.6" nullFlavor="NA" />
    ...
  </assignedEntity>
</performer>
  ...
</documentationof>
```

[Select a new  
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# CONF: CMS\_0117

## Data Validation: NPI Should Have Correct Checksum (1 of 2)

**ERROR:** The NPI should have a correct checksum, using the Luhn algorithm.

The NPI, National Provider Identifier is a unique ID number issued to health care providers (in the U.S.) by CMS

The NPI is a 10-digit number where the 10<sup>th</sup> digit is a checksum digit. There is no embedded intelligence (i.e. no information about the provider) in the NPI. NPI numbers are validated using the Luhn Algorithm.

See [https://en.wikipedia.org/wiki/Luhn\\_algorithm](https://en.wikipedia.org/wiki/Luhn_algorithm)

# CONF: CMS\_0117

## Data Validation: NPI Should Have Correct Checksum (2 of 2)

### Example using <id> with proper NPI provided

```
<observation classCode="OBS" moodCode="EVN">
...
  <participant typeCode="IND">
    <participantRole>
      <!-- NPI -->
      <id root="2.16.840.1.113883.4.6" extension="1234567893"/>
    ...
  </participantRole>
</participant>
</observation>
```

# CONF: CMS\_0121

## Inconsistent Use of UTC Offset (1 of 2)

**ERROR:** A Coordinated Universal Time (UTC time) offset should not be used anywhere in a QRDA Category I file or, if a UTC time offset is needed anywhere, then it must be specified everywhere a time field is provided.

There are several time elements in a QRDA document. Those that are specific beyond day and include the time value may also include a UTC offset to make it clear what time zone the action took place in. If you use the UTC offset anywhere in a QRDA document you should use it everywhere there is a time element other than birthTime as this may not be specific beyond day.

You are not required to use a UTC offset anywhere but if you do you must use it everywhere for time elements such as <time> or <effectiveTime>.



# CONF: CMS\_0121

## Inconsistent Use of UTC Offset (2 of 2)

### Example of time elements with UTC offset, highlighted:

```
<effectiveTime value="20190111061231-0500"/>

<time value="20190111061231-0500"/>

<effectiveTime>
  <low value="20191101123000+0600"/>
  <high value="20191106090300+0600"/>
</effectiveTime>

<time>
  <low value="20191101123000-0600"/>
  <high value="20191106090300-0600"/>
</time>
```

### Example of time elements without UTC offset:

```
<effectiveTime value="20190111061231"/>

<time value="20190111061231"/>

<effectiveTime>
  <low value="20191101123000"/>
  <high value="20191106090300"/>
</effectiveTime>

<time>
  <low value="20191101123000"/>
  <high value="20191106090300"/>
</time>
```

# CONF: 67-12978 & CONF: 67-13193

## eMeasure Reference QDM

The following conformance statements are associated with Measure Section Quality Data Model (QDM).

CONF #	Validation Performed	Meaning	Solution
67-12978	<b>SHALL</b> contain at least one [1..*] <b>entry</b>	At least one entry is required	Confirm entry is present in file
67-13193	Such entries <b>SHALL</b> contain exactly one [1..1] <b>eMeasure Reference QDM</b> (identifier: urn:oid:2.16.840.1.113883.10.20.24.3.97)	Such entries (referenced in 67-12978) must contain one eMeasure Reference QDM (which defines how a QDM eCQM should be referenced in QDM-Based QRDA)	Confirm the entry is a template with the templateId 2.16.840.1.113883.10.20.24.3.97

# Patient Contact Information

CONF #	Validation Performed	Meaning	Solution
1198-5271	This patientRole <b>SHALL</b> contain at least one [1..*] <b>US Realm Address</b> (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2)	No 'address' tag included in file	'Address' must be included in file to pass validation
81-7292	<b>SHALL</b> contain exactly one [1..1] <b>city</b>	No 'city' tag included in file	'City' must be included in file to pass validation
81-7291	<b>SHALL</b> contain at least one and not more than 4 [1..4] <b>streetAddressLine</b>	No 'streetAddressLine' tag included in file, or more than 4 included	'StreetAddressLine' must be included, and no more than 4 instances, in file to pass validation
1198-5280	This patientRole <b>SHALL</b> contain at least one [1..*] <b>telecom</b>	No 'telecom' tag included in file	'Telecom' must be included in file to pass validation

# CONF: 81-9371

## Conformant Person Name (1 of 2)

**ERROR:** The content of name SHALL be either a conformant Patient Name (PTN.US.FIELDED) or a string.

### Meaning:

The name data element must be provided either as a string or conformant to the structure defined by the Patient Name (PTN.US.FIELDED). For data elements that are defined using US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) data type such as:

ClinicalDocument/patient/name

ClinicalDocument/legalAuthenticator/assignedEntity/assigned Person/name

# CONF: 81-9371

## Conformant Person Name (2 of 2)

**Error:** This xml snippet contains partial name structure as defined by the US Realm Person Name (PN.US.FIELDDED) data type.

```
<name>
  <family>Doe</family>
</name>
```

### How to fix:

**Option 1 (preferred):** Provide the missing <given> element to meet the minimally required structure of name as defined by the US Realm Person Name (PN.US.FIELDDED) data type.

```
<name>
  <family>Doe</family>
  <given>John</given>
</name>
```

**Option 2:** Provide a string instead of a structured name.

```
<name>John Doe</name>
```

# CONF: 81-9372

## Cannot Contain Name Parts (1 of 2)

**ERROR:** The string SHALL NOT contain name parts.

### Meaning:

If a structured name is provided, the name data element must conform to the structure defined by the Patient Name (PTN.US.FIELDDED) for data elements that are defined using US Realm Person Name (PN.US.FIELDDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) data type such as

ClinicalDocument/patient/name

ClinicalDocument/legalAuthenticator/assignedEntity/assignedPerson/name

# CONF: 81-9372

## Cannot Contain Name Parts (2 of 2)

**Error:** This xml snippet contains partial name structure as defined by the US Realm Person Name (PN.US.FIELDDED) data type.

```
<name>  
  <family>Doe</family>  
</name>
```

**How to fix:** Provide the missing <given> element to meet the minimally required structure of name as defined by the US Realm Person Name (PN.US.FIELDDED) data type.

```
<name>  
  <family>Doe</family>  
  <given>John</given>  
</name>
```

# CONF: 1098-5300\_C01 & CONF: 3343-27571

## BirthTime Precise to the Day

### Two CONF# related to birthTime

CONF #	Validation Performed	Meaning
3343-27571	This patient SHALL contain exactly one [1..1] birthTime	Only one birthTime is allowed in a patient file
1198-5300_C01	SHALL be precise to day	The format of the birthTime must include the day

Note: For cases where information about newborn's time of birth needs to be captured birthTime may be precise to the minute.

Valid birthTime: 19430801

Invalid birthTime: 194308

Valid example from QRDA Category I: `<birthTime value="19460102"/>`



# CONF: 1198-6394

## Administrative Gender Code

**ERROR:** This patient SHALL contain exactly one [1..1] administrativeGenderCode, which shall be selected from Value Set Administrative Gender (HL7 V3) urn:2.16.840.1.113883.1.11.1 dynamic.

### NOTE:

This schematron rule about the administrative gender from the base IG was removed from the schematron file, because CMS IG overwrites this and requires the Office of the National Coordinator (ONC) Administrative Sex value set urn:oid: 2.16.840.1.113762.1.4.1.

# CONF: 3343-27745

## Medication Order (V4) Requires Author (1 of 2)

**ERROR:** SHALL contain exactly one [1..1] author.

### **Meaning:**

Author is a required element in Medication Order (V4). Author represents the clinician ordering the medication from a pharmacy for a patient.

# CONF: 3343-27745

## Medication Order (V4) Requires Author (2 of 2)

```
<!--QDM Datatype: Medication, Order -->
<entry>
  <substanceAdministration classCode="SBADM" moodCode="RQ0">
    <!-- Conforms to C-CDA R2.1 Planned Medication Activity (V2) -->
    <templateId root="2.16.840.1.113883.10.20.22.4.42" extension="2014-06-09"/>
    <!-- Medication Order (V4) -->
    <templateId root="2.16.840.1.113883.10.20.24.3.47" extension="2017-08-01"/>
    <id root="9a5f4d94-ccad-4d57-80ea-27737545c7bb"/>
    ...
    <author>
      <!-- Author -->
      <templateId root="2.16.840.1.113883.10.20.24.3.155" extension="2017-08-01"/>

      <time value="201904081130"/>
      <assignedAuthor>
        <id nullFlavor="NA"/>
      </assignedAuthor>
    </author>
  </substanceAdministration>
</entry>
```

# CONF: 1198-14838

## Service Event – Low Effective Time (1 of 2)

**ERROR:** This effectiveTime SHALL contain exactly one [1..1] low (CONF:1198-14838).

### Meaning:

This error message is regarding the **ClinicalDocument/documentationOf/serviceEvent/effectiveTime/low** xpath. For serviceEvent/effectiveTime, low is a required data element.

# CONF: 1198-14838

## Service Event – Low Effective Time (2 of 2)

**Error:** This xml snippet is missing the required effectiveTime/low

```
<serviceEvent>  
  <effectiveTime value="20190101"/>
```

**How to fix:** Provide the required effectiveTime/low

```
<serviceEvent>  
  <effectiveTime>  
    <low value="20190101"/>  
    <high value="20190331"/>  
  </effectiveTime>
```

# CONF: 3343-13372

## Missing or Multiple participantRole Elements (1 of 2)

**ERROR:** SHALL contain exactly one [1..1] participantRole (CONF:3343-13372).

A Facility Location (V2) subentry must contain exactly one participantRole. The class code attribute for the participantRole must be "SDLOC", and there must be one exactly one <code> element within the participantRole.

The participantRole should contain at least one <addr> and one <telecom> element, and may contain a playingEntity with a class code of "PLC".

# CONF: 3343-13372

## Missing or Multiple participantRole Elements (2 of 2)

### Proper example for Facility Location (V2) subentry:

```
<participant typeCode="LOC">
  <!-- Facility Location (V2) template -->
  <templateId root="2.16.840.1.113883.10.20.24.3.100" extension="2017-08-01"/>
  <time>
    <!-- QDM Attribute: LocationPeriod - startTime -->
    <low value="20190203"/>
    <!-- QDM Attribute: LocationPeriod - endTime -->
    <high value="20190206"/>
  </time>
  <participantRole classCode="SDLOC">
    <code code="309905000" codeSystem="2.16.840.1.113883.6.96"
      codeSystemName="SNOMED CT" displayName="Adult Intensive Care Unit" />
  </participantRole>
</participant>
```

# CONF: 1198-5524

## Missing Custodian Organization Name (1 of 2)

**ERROR:** This representedCustodianOrganization SHALL contain exactly one [1..1] name (CONF:1198-5524).

In the US Realm Header (V3) template you must define the custodian of the QRDA Document you are submitting. The custodian element represents the organization that is in charge of maintaining and is entrusted with the care of the document. There are several elements that are required to define the custodian one of which is the name of the organization.



# CONF: 1198-5524

## Missing Custodian Organization Name (2 of 2)

### Proper example for Custodian Organization Name:

```
<ClinicalDocument>
  <realmCode code="US"/>
  <typeId extension="POCD_HD000040" root="2.16.840.1.113883.1.3"/>
  <templateId root="2.16.840.1.113883.10.20.22.1.1" extension="2015-08-01"/>
  <templateId root="2.16.840.1.113883.10.20.24.1.1" extension="2017-08-01"/>
  <templateId root="2.16.840.1.113883.10.20.24.1.2" extension="2017-08-01"/>
  <templateId root="2.16.840.1.113883.10.20.24.1.3" extension="2018-02-01"/>
  ...
  <custodian>
    <assignedCustodian>
      <representedCustodianOrganization>
        <id root="2.16.840.1.113883.4.336" extension="800890"/>
        <name>Good Health Hospital</name>
        <telecom use="WP" value="tel:+1(555)555-1009"/>
        <addr use="WP">
          <streetAddressLine>1009 Healthcare Drive</streetAddressLine>
          <city>Portland</city>
          <state>OR</state>
          <postalCode>99123</postalCode>
          <country>US</country>
        </addr>
      </representedCustodianOrganization>
    </assignedCustodian>
  </custodian>
  ...
</ClinicalDocument>
```

# CONF: 3343-14430\_C01 & CONF: 3343-14431

## Missing Patient Characteristic Payer(1 of 2)

### ERROR:

SHALL contain at least one [1..\*] entry  
(CONF:3343-14430\_C01) such that it

SHALL contain exactly one [1..1] Patient Characteristic  
Payer (identifier: urn:oid:2.16.840.1.113883.10.20.24.3.55)  
(CONF:3343-14431).

The Patient Data Section QDM (V5) – CMS template must contain an entry with a Patient Characteristic Payer. This indicates the payer for the patient for the reported measure(s) and is a required supplemental data element for all measures.

# CONF: 3343-14430\_C01 & CONF: 3343-14431

## Missing Patient Characteristic Payer (2 of 2)

### Proper example for Patient Characteristic Payer:

```
<section>
  <!-- Patient Data Section QDM (V5) - CMS-->
  <templateId root="2.16.840.1.113883.10.20.17.2.4"/>
  <templateId root="2.16.840.1.113883.10.20.24.2.1" extension="2017-08-01"/>
  <templateId root="2.16.840.1.113883.10.20.24.2.1.1" extension="2018-02-01"/>
  ...
  <entry typeCode="DRIV">
    <observation classCode="OBS" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.24.3.55"/>
      <id root="4ddf1cc3-e325-472e-ad76-elledfcla00d" />
      <code code="48768-6" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Payment
Source"/>
      <statusCode code="completed"/>
      <effectiveTime>
        <low value="20190101"/>
        <high value="20191231"/>
      </effectiveTime>
      <value xsi:type="CD" code="1" codeSystem="2.16.840.1.113883.3.221.5"
        codeSystemName="Source of Payment Typology" displayName="Medicare"/>
    </observation>
  </entry>
  ...
</section>
```

# CONF: 3343-27343

## Intervention Order Requires Author (1 of 2)

**ERROR:** SHALL contain exactly one [1..1] Author (identifier:  
urn:oid:2.16.840.1.113883.10.20.24.3.155:2017-08-01)  
(CONF:3343-27343).

An Intervention Order (V4) act entry is a request by a physician or appropriately licensed care provider to an appropriate provider or facility to perform a service and/or other type of action necessary for care.

An example of this is an order for smoking cessation counseling or physical therapy.

The act's moodCode attribute is constrained to "RQO", therefore an author is required to represent the ordering clinician. An author time/date stamp is also required. This time element maps to a QDM time attribute and would be used in measure calculations.

# CONF: 3343-27343

## Intervention Order Requires Author (2 of 2)

### Proper example :

```
<act classCode="ACT" moodCode="RQ0">
  <!-- Conforms to C-CDA R2.1 Planned Act (V2) template -->
  <templateId root="2.16.840.1.113883.10.20.22.4.39" extension="2014-06-09"/>
  <!-- Intervention Order (V4) template -->
  <templateId root="2.16.840.1.113883.10.20.24.3.31" extension="2017-08-01"/>
  <id root="db734647-fc99-424c-a864-7e3cda82e703" />
  <!-- Intervention -->
  <code code="133918004" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMEDCT"
    displayName="Comfort measures (regime/therapy)"/>
  <statusCode code="active"/>
  <author>
    <!-- Author -->
    <templateId root="2.16.840.1.113883.10.20.24.3.155" extension="2017-08-01"/>
    <time value="201904081130"/>
    <assignedAuthor>
      <id nullFlavor="NA"/>
    </assignedAuthor>
  </author>
  ...
</act>
```

# Acronyms

<b>CAH</b>	Critical Access Hospital	<b>PI</b>	Promoting Interoperability
<b>CCN</b>	CMS Certification Number	<b>PY</b>	Payment Year
<b>CDA</b>	Clinical Document Architecture	<b>QDM</b>	Quality Data Model
<b>CONF</b>	Conformance	<b>QRDA</b>	Quality Reporting Document Architecture
<b>CY</b>	Calendar Year	<b>UTC</b>	Coordinated Universal Time
<b>eCQM</b>	electronic Clinical Quality Measure	<b>XML</b>	Extensible Markup Language
<b>EH</b>	Eligible Hospital		
<b>EHR</b>	Electronic Health Record		
<b>HIC/HICN</b>	Health Insurance Claim Number		
<b>HL7</b>	Health Level Seven		
<b>HQR</b>	Hospital Quality Reporting		
<b>IG</b>	Implementation Guide		
<b>IQR</b>	Hospital Inpatient Quality Reporting		
<b>LOINC</b>	Logical Observation Identifiers Names and Codes		
<b>MBI</b>	Medicare Beneficiary Identification Number		
<b>OID</b>	Object Identifier		

# Resources

**QualityNet Help Desk – QualityNet Secure Portal (reports, PSVA tool, data upload, troubleshooting file errors), Promoting Interoperability Program (objectives, attestation, policy)**

[Qnetsupport@hcqis.org](mailto:Qnetsupport@hcqis.org)

(866) 288-8912, 7 a.m. – 7 p.m. CT, Monday – Friday

**Hospital IQR Program and Policy – Hospital Inpatient Support Team**

<https://cms-ip.custhelp.com>

(866) 800-8765 or (844) 472-4477, 8 a.m. – 8 p.m. ET Monday – Friday (except federal holidays)

**The JIRA – Office of the National Coordinator (ONC) Project Tracking**

<https://oncprojecttracking.healthit.gov/>

Resource to submit questions and comments regarding:

- Issues identified with eCQM logic
- Clarification on specifications
- The 2019 CMS QRDA IG

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