(ONC Update) Planned Procedure Form Element

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The Planned Procedure form element allows healthcare providers to document planned procedures in a structured format that maintains SNOMED codification. This feature is part of the ONC HTI-1 certification updates to support USCDI v3 Health Status Assessments.

Overview | **Adding a Planned Procedure** | **Search & Select a Planned Procedure** | **Auto-Populate Code Attachment** | **Customize Note Section** | **Documenting** | **CCDA Output**

Related articles

- ONC Update: Clinical Form Management & Clinical Note
- ONC HTI-1 Updates: USCDI v3

Overview

The Planned Procedure element enables providers to:
- Document upcoming or scheduled procedures
- Capture procedure information in a standardized format
- Ensure SNOMED-based codification for interoperability
- Include planned procedure data in CCDA exports

Adding Planned Procedure in Clinical Form Management

Steps to Add the Element

1. Navigate to **Clinical Form Management**

2. Open or create a form

3. Select **Clinical Field** from the form elements

4. Choose **Planned Procedure** as the observation type

5. Configure the procedure parameters

Search & Select a Planned Procedure

A single-select search field labeled "**Procedure**" enables users to search for planned procedures.

Supported Value Sets

Users can search for a planned procedure within the following coding systems:
- **LOINC** - Logical Observation Identifiers Names and Codes
- **SNOMED** - Systematized Nomenclature of Medicine

- **CPT** - Current Procedural Terminology
- **ICD-10** - International Classification of Diseases
- **HCPCS** - Healthcare Common Procedure Coding System
- **Social Determinant of Health value set** - SDOH-related procedures and services

Search Results Include:

- **Procedure Name (description)** - The descriptive name of the procedure
- **SNOMED code** - The standardized SNOMED identifier

Auto-Populate Code Attachment

Upon selecting a procedure, the system automatically handles code attachment:

Automatic Population

- The **SNOMED code** is automatically populated in the Code attachment section
- This code is **not editable** to maintain data integrity

Manual Code Addition

Users can add other associated codes manually, including:
- CPT codes
- HCPCS codes
- ICD-10 codes
- Custom codes

SNOMED codes remain automatically populated and cannot be edited.

Customize Note Section

The Customized Note section maintains its current functionality:
- Editable by the user
- Allows customization of how the planned procedure appears in documentation
- Supports practice-specific documentation preferences

Documenting Planned Procedure in Clinical Note

Steps to Document

1. Add the Planned Procedure form to the Clinical note

2. Use the **date picker field** to enter the planned date or relevant timeframe

3. Complete any additional required fields

The date picker allows you to specify when the procedure is scheduled or expected to occur.

CCDA Output

The planned procedure data is properly formatted for CCDA export:

Compliance Mapping

- Displayed correctly in the CCDA PDF generator
- Maps back to **Planned Procedure Narrative LOINC Value: LOINC 59772-4**
- Ensures interoperability with other healthcare systems
- Supports continuity of care and care coordination

Data Structure

The data follows HL7 standards for planned procedures, ensuring:
- Proper XML structure in CCDA documents
- Compatibility with receiving systems
- Accurate representation of planned care activities