Feedback, Da Vinci PCT Implementation Guide – reviewed 9/27/2021

**Several places in the IG convey that the AEOB from the payer to the provider is required. This is not required by the No Surprises Act. The workgroup agreed that this would be an optional feature but the IG does not reflect the optionality. We ultimately support this requirement, but feel it should be moved to a later phase. There are several open considerations that will need to be addressed (ex. what information can be shared with whom, is member approval needed, etc.) before this can be supported by payers.**

The PCT IG/RI will allow for an AEOB to be sent to anyone that this authorized.

Note: It is my understanding Da Vinci IGs do not just comply with current reg/laws but instead also try to solve healthcare industry problems that could one day become a reg/law.

We are happy to make this optional in the IG if Da Vinci and the community wants this.

**Vanessa/Viet/Da Vinci should this be optional?**

**We recommend that Advanced EOB Request follow claims submission standards. This will make it easier for providers and payers to understand the data. The standards call for separate formats for Institutional and Professional / Non-Clinician. In alignment with the standards, define an Institutional GFE (Advanced EOB Request) profile and a Professional / Non-Clinician profile. (To accommodate Value Set differences, CARIN defined separate profiles for Inpatient Institutional and Outpatient Institutional – Perhaps PCT could define one Institutional profile for both and define invariants to accommodate the varying Value Sets).**

We want to avoid creating multiple profiles for Institutional and Professional and others if we can use coding and value sets to differentiate the various profile usages.

1. Section 1.1 – Overview:
   1. Reference that the IG is written to support compliance with the No Surprises Act. Reference similar language in [Background CMS Patient Access and Interoperability Rules](https://build.fhir.org/ig/HL7/carin-bb/1_Background.html#cms-patient-access-and-interoperability-rules). It’s referenced in Terms and Concepts but needs more prominence as it’s the reason the IG is being defined.

Vanessa/Viet/Da Vinci, is this IG being balloted to support the No Surprises Act?

If yes, could you please the provide language/text for this?

* 1. The statement, ‘The composition of the collection of GFEs is currently not in scope for this IG’, is unclear. Does this mean the definition of the GFE is not in scope or the means by which the scheduling provider coordinates with other providers is not in scope?
     1. Although the workgroup has called out that the coordination of the scheduling provider with other providers is not in scope, for provider to payer continuity and a unified end to end solution, we recommended it be included in scope.

It means “the means by which the scheduling provider coordinates with other

providers is not in scope? I think we can work on making this more clear.

Also, I suspect the “composition of the collection of GFEs” might be in scope at another time using another work stream/IG. I will defer to Da Vinci here.

* 1. Suggest using the term, ‘Request AEOB using GFEs’ instead of ‘Get’ to align with other flows in the IG.

OK, yes this one had already been changed to reflect the flow of the IG. We will review it again.

* 1. Suggested the outline of the FHIR-X12 Translator be dashed to convey it is optional

OK, thanks will do! This graphic will be re-worked.

* 1. Clarify that use of FHIR by the payer in the communication to the patient is optional, the No Surprises Act does not require payers to provide the AEOB via an API. Add that the payer provides the data to a 3rd party app who provides it to the patient.

The PCT IG/RI will allow for an AEOB to be sent to anyone that this authorized.

Note: It is my understanding Da Vinci IGs do not just comply with current reg/laws but instead also try to solve healthcare industry problems that could one day become a reg/law.

We are happy to make this optional in the IG if Da Vinci and the community wants this.

**Vanessa/Viet/Da Vinci should this be optional?**

Add that the payer provides the data to a 3rd party app who provides it to the patient.

Good suggestion, we can add that.

1. Background
   1. 3.1 Recommend adding this IG’s relationship to the CARIN IG for Blue Button®

Other than the current use of the some CARIN value sets what is the relationship CARIN IG for Blue Button®?

* 1. Add a relationship diagram similar to the one in the [CARIN IG](https://build.fhir.org/ig/HL7/carin-bb/1_Background.html#us-core).

Good suggestion, I think we can add this to the TODO list.

1. Formal Specification

4.1.3

a. The definition of client systems isn’t accurate…the client system will be a provider’s Billing Management Software, not their electronic medical records.

We were aware of Billing Management Software being involved. We can add this.

Also, are you saying EHRs are not involved at **all** in this process by **all** providers?

b. The definition of payer systems should read ‘Payer systems adjudicate GFEs that have been submitted by a healthcare provider. The systems determine if a provider is in or out of network, verify patient eligibility, apply contracted amounts the provider’s network status needs to be confirmed, patient eligibility verified, and apply member cost sharing amounts

Sounds great, we can add this.

4.1.5 Re the note that the CARIN value sets are under discussion,

a. Industry standard value sets and code systems (i.e., CPT, HCPCS, DRG, etc.) should be the same as those defined by CARIN. They align with those defined by the HL7 Terminology Authority.

We agree for the most part and expect several value sets used by the PCT IG will be similar or the same as the ones uses in the CARIN IG. But since this is still being reviewed we cannot make this blanket statement at this time.

b. For those that are prefixed with C4BB, recommend conducting an assessment to determine if the GFE / AEOB use case calls for values that differ from CARIN.

Yes, this is already an ongoing task. Thanks

1. Underlying Technologies

6.3 US Core – remove sentence referencing clinical systems…the PCT use case calls for the use of provider billing and payer claims adjudication systems.

We can certainly add text to mention “provider billing” and “payer claims adjudication systems”.

Are you saying EHRs (clinical systems) are never used by any provider during a workflow like this?

1. Use Case

7.2

* 1. The role of the AEOBRequestTemplate is confusing based on the assumption that how providers create the GFE is out of scope.

OK, I see. We will do a better job to explain this.

* 1. Why is PlanNet required? The law does not require validation of the providers contact information.

Right it is not required. We can add text to make that clear.

* 1. When referencing a Provider ID (PID), recommend using NPI instead of Provider ID for specificity. Using NPI aligns with the use of claims submission standards and payers may use additional logic where needed to supplement use of NPI to reference specific providers.

Right, good point. We will make that change. I think we meant to make that change and missed it.

**Note that the No Surprises Act is silent on payers providing any status, validation or error messages back to the provider. Other than those required by FHIR, these should be optional services**

* 1. Re: ‘The Payer AEOB Processor returns the AEOBResponseID which is the unique identifier that can be used to check the status’ by what mechanism is the status checked?

This mechanism will be added to the IG soon.

* 1. Re: ‘a list of return addresses (e.g., email, text) specifying where to send notifications that the AEOB is ready as well as other status information.’ Why is email and text introduced? If this is a feature, shouldn’t they be FHIR transactions? Is it better to address the inbound information format as FHIR to clarify subsequent notifications?

We agree this area needs more work. We will review this.

* 1. RE: ‘The provider customizes the AEOBRequestTemplate by editing the template and adding the specific information for this patient, including the dates and location of the services’. This is unclear.. is the intent to provide the specific services for the patient, including services expected to be provided by other providers, to include the expected charges, billing codes and other diagnostic codes?

The AEOBRequestTemplate is not required to be conformant with this IG. But we can try to add more text/clarity here.

* 1. ‘in case of errors returns a list of errors to the provider along with the Bundle’ how will the errors be returned… via FHIR? If so isn’t that another FHIR transaction that should be defined? What Code System / Value Set will be used to convey the errors … CARC / RARC?

Yes, FHIR. This will be defined in a future IG update.

* 1. What is the difference between the AEOBResponseID and the ID Generator?

The ID Generator generates IDs. Note: The ID Generator is not required to be conformant with this IG. I think we can work on this language to make it more clear.

The AEOBResponseID is what is used during the asynchronous response from the payer system.

* 1. Re: ‘The payer begins processing the AEOBRequestBundle asynchronously and immediately …’  Asynchronously and immediately are contrasting terms… shouldn’t it say ‘AEOBRequestBundle asynchronously and upon completion’?

Yes, I think we can work on this language to make it more clear.

7.2.1

1. Re ‘The recipient (e.g., patient) is notified (e.g., via email or text)’ – the method by which a payer notifies a patient is defined by the communication preferences defined between the payer and the member.

Is this a question or a comment?

1. Conveying the AEOB to the patient via a FHIR API should be noted as optional and the work flow is contingent upon the payer opting to use the API.

“Conveying the AEOB to the patient via a FHIR API should be noted as optional” I think this makes sense. We can add this. Thanks

“the work flow is contingent upon the payer opting to use the API.” This seems somewhat obvious but I think we can add this.

1. **Payer communication of the AEOB to the provider is not required under the No Surprises Act.** Please note that 4.2.2 also calls out that it’s required.

The PCT IG/RI will allow for an AEOB to be sent to anyone that this authorized.

Note: It is my understanding Da Vinci IGs do not just comply with current reg/laws but instead also try to solve healthcare industry problems that could one day become a reg/law.

We are happy to make this optional in the IG if Da Vinci and the comminity wants this.

**Vanessa/Viet/Da Vinci should this be optional?**

The numbering doesn’t look quite right – shouldn’t ‘Get completed AEOB from payer’ be 7.3? or the header for 7.2 be a generic ‘Data Flow and System Actors’ with ‘Submit AEOB Request to Payer’ as 7.2.1?

We will review this and correct it as needed.

7.2.2 The list of System Actors is incomplete. Add provider IT systems / vendors and patients, etc. Add 3rd party apps between the payer and the patient.

We can add these.

7.3 Terms and Concepts

1. What is a Best Faith Estimate?

This has been removed.

1. Why is ‘Discounted Cash Price’ included --- Individuals who pay cash are not covered under the No Surprise Billing

Right, we don’t see the need for this. We can remove this.

1. Co-insurance is defined which is one of several patient cost sharing data elements… add definitions for Co-Pay and Deductible

We can add these.

1. Artifacts Summary

8.0.1 Structures: Resource Profiles

* 1. To align with the verbiage of the data flows, should ‘PCT Good Faith Estimate’ be renamed ‘PCT Advanced EOB Request’?

The GFE concept is clearly defined and widely referenced, and it is used to designate the data needed for exchanging between systems for generating the AEOB. Therefore, to have a profile created for and named after it makes good sense.

However, we are open to rename the profile after a formal review of the PCT IG and if there are further comments about renaming the profile.

* 1. Define separate profiles for Institutional and Professional / Non-Clinician

We want to avoid creating multiple profiles for Institutional and Professional and others if we can use coding and value sets to differentiate the various profile usages.

* 1. Delete the PCT RelatedPerson profile.The [RelatedPerson Resource](https://www.hl7.org/fhir/relatedperson.html) is defined to capture captures information about a person who accompanies a patient, for example, to the ER. Examples include a patient's relatives or friends, a neighbor bringing a patient to the hospital, a patient’s attorney or guardian. If the intent is to capture the subscriber identifier of the patient, it is defined as Coverage.subscriberid.

Will consider your suggestion and decide whether we need this profile or not.

* 1. Define a Practitioner Resource

Will create a PCT Practitioner profile.

8.0.2 Structures: Extension Definitions

1. Why is CompoundDrugLinkingNumber defined?

Mary Kay will answer and provide description/definition/comments for this data element

1. Update the estimatedDateOfService to include a reference to dates of admission

EstimatedDateOfService can have the type of Period to specify dates of admission.

1. Why is ExpirationDate defined?

The ExpirationDate is used to indicate that the AEOB is good until a certain date.

1. Suggest ‘coordinating provider’ be renamed to ‘scheduling provider’ to align with the verbiage in the law or add ‘coordinating provider’ to the terms and concepts defining it in relation to the scheduling provider

We want to keep ‘coordinating provider’ and will provide description to define it in relation to the scheduling provider.

1. What is an InterTransIdentifier?

Mary Kay will answer and provide description/definition/comments for this data element.

1. What is the difference between an EstimatedDateOfService and a Proposed Date of Service

The two terms mean the same thing. Will rename Proposed Date of Service to EstimatedDateOfService.

1. Delete extension ProductOrServiceBillingCode. Use Claim.item.productOrService

Will delete as suggested.

1. Delete extension ProductOrServiceOtherCharge. Use Claim.item.unitPrice

Will delete as suggested.

1. Delete extension Provider Contracting Rate – the payer has the provider’s contracted amount in their records

Will delete as suggested.

1. Delete extension Provider Contracting Status as the payer will make that determination as they adjudicate the claim

Will delete as suggested.

1. Delete extension ProviderGrouperMethodology … it’s not required for the payer to process the Advanced EOB Request.

This extension is added to the GFE profile in response to comments from the PCT community. We believe that this extension does provide a useful purpose.

8.0.3 Structures: Value Sets / 8.0.4 Structures: Code Systems

* 1. Delete PCT Coverage Copay type Value Set / Code System – it’s not required for the payer to adjudicate the Advanced EOB Request

We need the PCT Coverage Copay type Value Set to include new codes for defining the different copay situations for individual or family.

* 1. Delete PCT GFE Billing Code Value Set / Code System. The Value Sets that should be used for billing are the industry standard codes, i.e., CPT / HCPCS / ICD Diagnosis / ICD Procedure / DRG, etc.

We are still working on what value sets we want to create/use for the data elements. We will take your suggestion into consideration.

8.0.5 Example: Example Instances

8.40.1 Example Claim: PCT-Good-Faith-Estimate-1 – the example is incomplete as it doesn’t include the billing codes, diagnosis codes or charges.

The example is still under development.