The feedback is based on the Da Vinci PCT Implementation Guide as of 11/8. It includes open items from BCBSA’s feedback as of 9/28/2021 and MITRE feedback dated 10/8.

[in reviewing the IG on 11/11… it looks like today’s version has reverted back to a version prior to 11/8; for example, content previously in the data flow on 11/8 is not there on 11/11]

# IG Home

## Section 1.1 – Overview: (<https://build.fhir.org/ig/HL7/davinci-pct/index.html#overview> )

* 1. **9/28 BCBSA**: 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.

[10/8 MITRE] 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?

**11/8 BCBSA:** Suggest the following wording replace the first two paragraphs of the Overview:

[The Consolidated Appropriations Act, 2021 (CAA) (H.R. 133)](https://www.congress.gov/bill/116th-congress/house-bill/133) was signed into law on Dec. 27, 2020. Combined with funding for COVID-19 relief, it provides protections for patients from surprise medical bills and several other health-related provisions.

It requires individual and group health plans to provide an Advanced EOB (AEOB) for scheduled services at least three days in advance to give patients transparency into which providers are expected to provide treatment, the network status of providers, good faith estimates of cost, cost-sharing and progress towards meeting deductibles and out-of-pocket maximums, whether a service is subject to medical management and relevant disclaimers.

The AEOB requirement is triggered upon notification from the provider of the scheduled service or request of the patient to provide a notification of the good faith estimate of the expected charges, billing and diagnostic codes for furnishing their services, including services reasonably expected to be provided by another health care provider.

This IG will address the use case whereby a good faith estimate is provided by the scheduling provider, triggering a good faith estimate of the amount the payer is responsible for paying for items and services; i.e., the Advanced EOB.

To ensure compliance, implementers should reference the CAA and associated regulations.

* 1. **11/8 BCBSA:** The second paragraph of the overview states: ‘The goal of this IG is to support the request for cost information for specific services and items from the payer and return them in near real-time to allow effective decision making by the patient in consultation with the ‘ordering’ provider.’ To stay aligned with the requirements of the CAA, modify the paragraph to read: ‘The goal of this IG is to support the request by the scheduling provider for cost information for specific services and items from the payer. The payer may elect to provide an AEOB to a patient’s third party app. The IG supports the payer providing the AEOB to the patient via FHIR as an optional delivery method. Additionally, the IG supports the payer optionally providing the scheduling provider a copy of the AEOB.
	2. **11/8 BCBSA:** Modify the fifth paragraph to read ‘As this is a FHIR based use case and X12 is not required, X12 data elements required for claims submission will only be used to inform the data elements in the PCT APIs. In other words, the implementer is not required to use X12 as there is not an HIPAA mandate to do so.

**AEOB Interaction Diagram Steps (High Level View)**

* 1. **9/28 BCBSA**: 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.

[10/8 MITRE] 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.

**11/8 BCBSA:** This has not been updated to be clearer.

If the coordination of the scheduling providers with other providers is not in scope for this IG, how will this be solved?

* 1. Diagram Revisions:

**11/8 BCBSA:** The term ‘payer’s intermediary’ is inaccurate. The payer or the provider may have the relationship with the intermediary. Some payers do not contract with a clearinghouse; others do. Providers can either contract with a Practice Management system who has the relationship with the clearinghouse or in some cases contracts directly with the clearinghouse through their Practice Management software.

The Optional FHIR-X12 translation box could be removed. If an Intermediary is used by the payer, it would be an agent of the payer. The IG doesn’t call out provider agents. Using agents is an implementation decision of the provider and the payer.

If the decision is to keep the reference to an X12 intermediary, make the diagram more generic:

Remove the gray box; update ‘Payer’s Intermediary’ to be ‘Payer / Provider’s Intermediary’.

It conveys that if the payer decides to provide the provider an AEOB, it would go through the intermediary, which is not a requirement.

Change ‘gfe-submit response (FHIR)’ in data flow #2 to dash to depict that it is optional.

The version dated 11/11 shows the patient accessing the AEOB through the intermediary. This is inaccurate. Modify the diagram accordingly. The lines should be dotted to show that the payer to patient AEOB FHIR transaction is optional. The description of 11/8 showed that the patient may receive the EOBs via payer’s portal or mail. This needs to be re-added.

Add a note to diagram flow #5 to reflect #5’s verbiage above the diagram to note that the FHIR transaction is optional ***[in reviewing the IG on 11/11… it looks like today’s version has reverted back to a version prior to 11/8 as on 11/11, #5 flow and verbiage is not there]***

[BCBSA 9/28] Add that the payer provides the data to a 3rd party app who provides it to the patient.

 [MITRE] Good suggestion, we can add that.

-- **11/8 BCBSA:** As of 11/8 it was not added.

## Section 3.3: US Core (<https://build.fhir.org/ig/HL7/davinci-pct/underlying_technologies.html#us-core>)

1. **11/8 BCBSA:** RE ‘Provider billing and payer claims adjudication systems SHALL use the specification defined by US Core in exchanging information with payers. Implementers should be familiar with this specification’, Before the SHALL add: ‘for those resources defined by US Core’. At the end add: ‘Claim Resources are not defined by US Core’

# PCT Specification

## Relationship to other IGs

1. **11/8 BCBSA:** PCT Specification –> Relationship to Other IGs takes one to a subtopic, 4.1.6, that speaks to US Core, which is Section 3.3. Consolidate the two sections
2. **9/28 BCBSA:** Recommend adding this IG’s relationship to the CARIN IG for Blue Button®

[10/8 MITRE] Other than the current use of the some CARIN value sets what is the relationship CARIN IG for Blue Button®?

**11/8 BCBSA:**

-- For those data elements common to PCT and CARIN, we would expect to see the same mapping of the PCT data elements to the CARIN profiles and data elements

-- Unless the use cases call for different Value Sets, we would expect both to be the same

-- We advocate that the PCT AEOB leverage the CARIN IG; reference feedback in section 2.1.2.

-- Search parameters would be defined as applicable to each use case

1. **9/28 BCBSA:** 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).

[10/8 MITRE} Good suggestion, I think we can add this to the TODO list.

 -- **11/8 BCBSA:** as of 11/8, it’s not in the IG

## Section 2 Use Cases and Overview

**11/8 BCBSA:** (the red ribbon drop down shows Overview and Use Cases – they should be the same <https://build.fhir.org/ig/HL7/davinci-pct/use_cases.html#use-cases-and-overview>

### Section 2.1.1 <https://build.fhir.org/ig/HL7/davinci-pct/use_cases.html#submit-aeob-request-to-payer> **11/8 BCBSA:** Make the same changes described in Section 1.1 – Overview

### Section 2.1.2 <https://build.fhir.org/ig/HL7/davinci-pct/use_cases.html#get-completed-aeob-from-payer>.

**11/8 BCBSA:**

Why is the PCT IG defining a new profile / API for the AEOB? If it is implemented by payers and 3rd party developers, it will require them to write new code separate from the EOBs they developed for the Patient Access API. Couldn’t the CARIN BB IG be adapted to provide the AEOB? At first glance, it would require 1) requiring the value ‘predetermination’ EOB.use, 2) defining extensions to allow verbiage for out-of-network providers, whether a service is subject to medical management and relevant disclaimers of estimates with invariants that they are to be used when the value of EOB.use is ‘predetermination’ 3) reviewing the cardinality of the CARIN IG to determine if different cardinalities should be defined for the Advanced EOB.

### Section 2.1.3 Example <https://build.fhir.org/ig/HL7/davinci-pct/use_cases.html#example>

**11/8 BCBSA:**

“#4: The next day, Eve calls the radiology facility (Office of Dr. Christine Curie, NPI - 1234567893) to schedule her brain MRI, CPT 70551 and provide her coverage information, which she plans to use” – the scenario speaks to the radiology facility; however the example speaks to a professional – change the example to be a facility.

Modify #7 as follows: The ABC’s Radiology Office Administrator enters the services and coverage information, initiates the process with other potential providers to generate the Good Faith Estimate (GFE) for the expected charges with the expected billing and diagnostic codes ~~costs and services~~.

Modify #9 as follows: The payer receives the GFE. Within one business day the payer adjudicates it ~~to determine patient costs~~ and sends the Good Faith Estimates of cost, cost-sharing and progress towards meeting deductibles and out-of-pocket maximums, as well as whether a service is subject to medical management and relevant disclaimers of estimates as an AEOB ~~(including the GFE)~~ securely to Eve.

Modify #12 as follows: Optionally, Eve or ~~any interested party~~ an authorized user could use their 3rd party app to query for the AEOB using the Bundle.identifier and auth token if the payer supports the API.

## Section 2.2 Terms and Concepts <https://build.fhir.org/ig/HL7/davinci-pct/use_cases.html#terms-and-concepts>

**11/8 BCBSA:**

1. Modify the definition of the Advanced EOB Proposed Definition as follows: [The Consolidated Appropriations Act](https://www.congress.gov/bill/116th-congress/house-bill/133) includes provisions whereby health plans, based on charges, billing and diagnostic codes provided by the provider(s), provide an Advanced EOB for scheduled services to give patients transparency into which providers are expected to provide treatment, the network status of providers, good faith estimates of cost, cost-sharing and progress towards meeting deductibles and out-of-pocket maximums, as well as whether a service is subject to medical management and relevant disclaimers of estimates; for example a disclaimer that the information provided in the notification is only an estimate based on the items and services reasonably expected, at the time of scheduling and is subject to change. To ensure compliance, Implementers should reference the CAA and associated regulations.
2. Add the following to the definition after the word ‘pandemic’: Title I (the No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021 establishes new protections from surprise billing and excessive cost sharing for consumers receiving health care items/services.
3. Where is the Charge Description Master, the comprehensive list of a hospital’s items billable to a payer, in the data flow of the IG?
4. Add the following to the definition for Collection of Services after ‘gathering the’: Good Faith Estimate for the expected charges, billing and diagnostic codes for multiple providers. Delete the ‘Note: this may span across Providers (NPIs)’
5. Delete De-identified minimum negotiated charge, De-identified maximum negotiated charge and Fee schedules… they’re not relevant to the use case.

## Section 4. Formal Specification <https://build.fhir.org/ig/HL7/davinci-pct/formal_specification.html>

### Section 4.1.3 Systems <https://build.fhir.org/ig/HL7/davinci-pct/formal_specification.html#systems>

**11/8 BCBSA:**

1. Change ‘Payer Intermediary etc.’ to read ‘**Intermediary:** The payer or the provider may have the relationship with the intermediary. Some payers do not contract with a clearinghouse; others do. Providers can either contract with a Practice Management system who has the relationship with the clearinghouse or in some cases contracts directly with the clearinghouse through their Practice Management software.’

## Section 5. Terminology Licensure <https://build.fhir.org/ig/HL7/davinci-pct/terminology_licensure.html#terminology-licensure>

### Section 5.1.2 Licensed Industry Standard Code Systems <https://build.fhir.org/ig/HL7/davinci-pct/terminology_licensure.html#licensed-industry-standard-code-systems>

**11/8 BCBSA:**

1. Delete NCPDP. Retail Pharmacy is not included in the CAA scope.

## Section 1.2 Downloads <https://build.fhir.org/ig/HL7/davinci-pct/index.html#downloads>

**11/8 BCBSA:**

1. This section is accessed from two pages, IG Home and from PCT Specification … is that intended?