Feedback, DaVinci 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.**

**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).**

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.
   2. 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.
   3. Suggest using the term, ‘Request AEOB using GFEs’ instead of ‘Get’ to align with other flows in the IG.
   4. Suggested the outline of the FHIR-X12 Translator be dashed to convey it is optional
   5. 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.
2. Background
   1. 3.1 Recommend adding this IG’s relationship to the CARIN IG for Blue Button®
   2. 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).
3. 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.

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

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.

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.

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.

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.
  2. Why is PlanNet required? The law does not require validation of the providers contact information.
  3. 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.

**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?
  2. 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?
  3. 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?
  4. ‘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?
  5. What is the difference between the AEOBResponseID and the ID Generator?
  6. 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’?

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.
2. 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.
3. **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 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?

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.

7.3 Terms and Concepts

1. What is a Best Faith Estimate?
2. Why is ‘Discounted Cash Price’ included --- Individuals who pay cash are not covered under the No Surprise Billing
3. Co-insurance is defined which is one of several patient cost sharing data elements… add definitions for Co-Pay and Deductible
4. 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’?
  2. Define separate profiles for Institutional and Professional / Non-Clinician
  3. 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.
  4. Define a Practitioner Resource

8.0.2 Structures: Extension Definitions

1. Why is CompouindDrugLinkingNumber defined?
2. Update the estimatedDateOfService to include a reference to dates of admission
3. Why is ExpirationDate defined?
4. 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
5. What is an InterTransIdentifier?
6. What is the difference between an EstimatedDateOfService and a Proposed Date of Service
7. Delete extension ProductOrServiceBillingCode. Use Claim.item.productOrService
8. Delete extension ProductOrServiceOtherCharge. Use Claim.item.unitPrice
9. Delete extension Provider Contracting Rate – the payer has the provider’s contracted amount in their records
10. Delete extension Provider Contracting Status as the payer will make that determination as they adjudicate the claim
11. Delete extension ProviderGrouperMethodology … it’s not required for the payer to process the Advanced EOB Request.

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
  2. 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.

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.