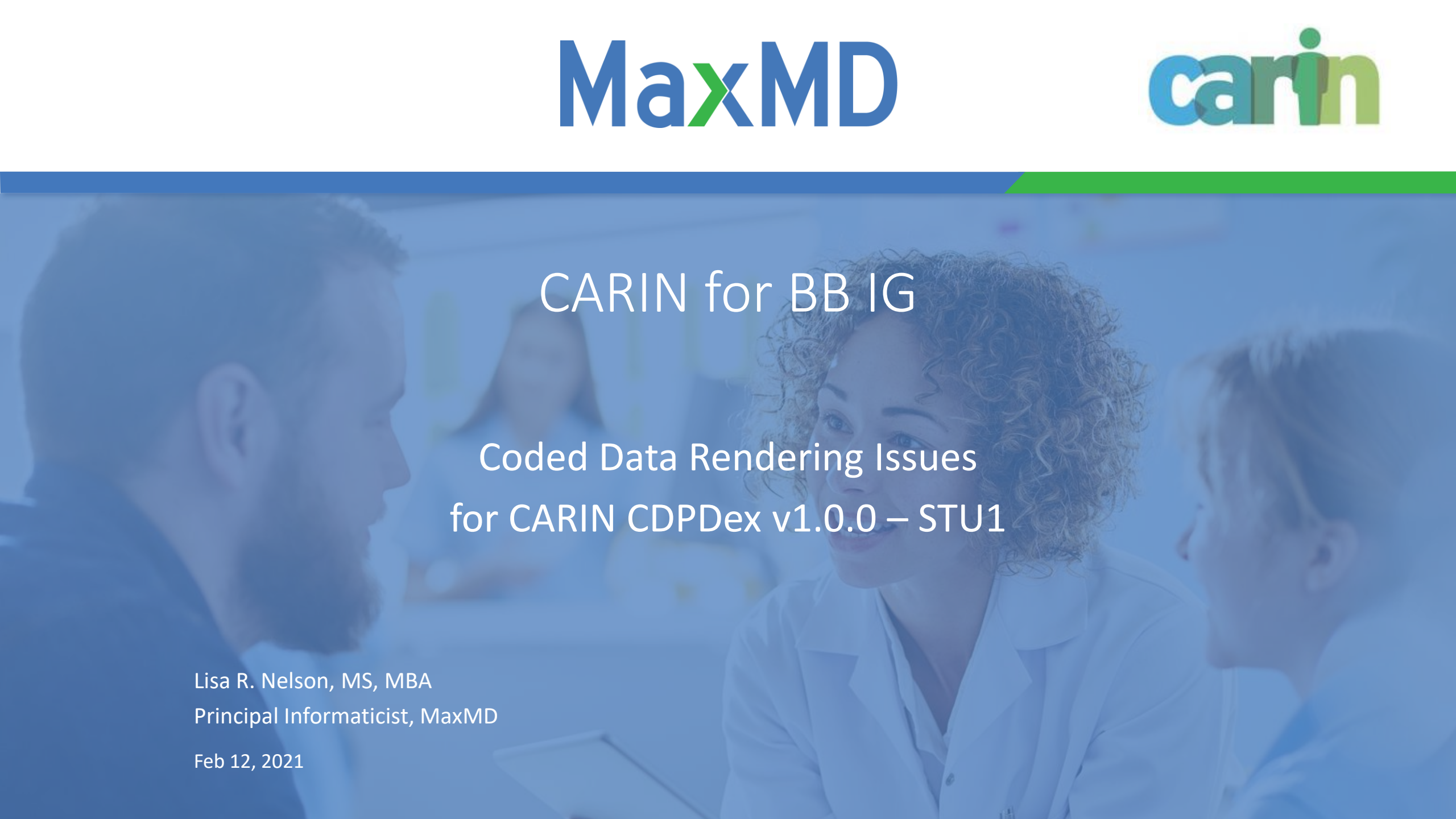

CARIN for BB IG

Coded Data Rendering Issues for CARIN CDPDex v1.0.0 – STU1

Lisa R. Nelson, MS, MBA
Principal Informaticist, MaxMD

Feb 12, 2021

Rendering Problems

1. Display and text issues for codeableConcepts
2. Code and text mismatches
3. Incomplete/inaccurate pharmacy product/service information
4. Little resemblance to actual EOB documents

Display and text issues for the codeableConcept

diagnosis

sequence: 1

diagnosis: I21.4

type: The single medical diagnosis that is most relevant to the patient's chief complaint or need for treatment.

```
"diagnosis": [
  {
    "sequence": 1,
    "diagnosisCodeableConcept": {
      "coding": [
        {
          "system": "http://hl7.org/fhir/sid/icd-10-cm",
          "code": "I21.4"
        }
      ]
    },
    "type": [
      {
        "coding": [
          {
            "system": "http://terminology.hl7.org/CodeSystem/ex-diagnosistype",
            "code": "principal",
            "display": "Principal Diagnosis"
          }
        ],
        "text": "The single medical diagnosis that is most relevant to the patient's chief complaint or need for treatment."
      }
    ]
  },
```

Missing display, missing text.

Questioning the definition of principal diagnosis.

Questionable relationship between display and text.

Code and text mismatched

Generated Narrative

identifier: Unique Claim ID: AW12341234123412341234123413

status: active

type: Outpatient Institution

use: claim

```
"type": {
  "coding": [
    {
      "system": "http://terminology.hl7.org/CodeSystem/claim-type",
      "code": "professional"
    }
  ],
  "text": "Outpatient Institution"
},
```

Code and text mismatched.

Incomplete/inaccurate Pharmacy information

productOrService: 100 CAPSULE in 1 BOTTLE (0777-3105-02)

adjudication

category: Submitted Amount

Amounts

Incomplete or inaccurate medication information.

```
"item": [
    {
        "sequence": 1,
        "productOrService": {
            "coding": [
                {
                    "system": "http://hl7.org/fhir/sid/ndc",
                    "code": "0777-3105-02",
                    "display": "100 CAPSULE in 1 BOTTLE (0777-3105-02)"
                }
            ]
        },
```

item

productOrService | S | 1..1 | CodeableConcept | Billing, service, product, or drug code
Binding: NDC or Compound (required)

Little resemblance to actual EOB documents

Generated Narrative

identifier: Indicates that the claim identifier is that assigned by a payer for a claim received from a provider or subscriber: InpatientEOBExample1

status: active

type: Institutional

use: claim

patient: Generated Summary: language: en-US; An identifier for the insured of an insurance policy (this insured always has a subscriber), usually assigned by the insurance carrier.: 88800933501; active; Member 01 Test : Phone: 5555555551, Phone: 5555555552, Phone: 5555555553, Phone: 5555555554, Phone: 5555555555, Phone: 5555555556, GXXX@XXXX.com, Fax: 5555555557; gender: male; birthDate: 1943-01-01; unknown

billablePeriod: 2017-05-23 --> 2017-05-23

created: Jun 1, 2017, 4:00:00 AM

insurer: UPMC Health Plan. Generated Summary: NAIC Code: 95216; active; Payer; name: UPMC Health Plan; Phone: 1-844-220-4785 TTY: 711, Phone: 1-866-406-8762

provider: Generated Summary: National Provider Identifier: 3334445550; active; name: Green Medical Group

Payees

- Type	Party
* Any benefit payable will be paid to the provider (Assignment of Benefit).	Generated Summary: National Provider Identifier: 4445556660; active; name: Blue Medical Group

outcome: complete

careTeam

sequence: 1

provider: Generated Summary: National Provider Identifier: 8889990000; active; Jack Brown

role: The attending physician

careTeam

sequence: 2

provider: Generated Summary: National Provider Identifier: 8889990000; active; Jack Brown

role: The referring physician

259DBPSTMN0020001-04665-02 20180915-015079 UHC01R 0000001825742725O0 29598400 09/15/18-CO-N-M--N-N

UnitedHealthcare
P.O. Box 30567
Salt Lake City, UT 84130-0567

Telephone: 1-877-816-3596

Explanation of Benefits Statement (EOB)

NELSON, MARK
40 HAPPY VALLEY RD
WESTERLY RI 02891-3516

This is not a bill. Do not pay.
This is to notify you that we processed your claim

Member/Patient Information

Sheet:	Page 3 of 12
Date:	09/15/2018
Member/Patient:	NELSON, MARK
Relationship:	Subscriber
Member ID:	94719287000
Subscriber:	NELSON, MARK
Group ID:	11739380

PAYMENT HAS BEEN MADE TO YOUR PROVIDER

Claims Summary

(Detailed claim information is located on the following pages)

$241.00	**Amount Billed** This is the total amount that your provider billed for the services that were provided to you.
$181.00	**Allowed Amount** The amount charged by your dental provider that is eligible for payment by you or your dental plan.
$108.00	**Your Plan Paid** This is the portion of the amount billed that was paid by your plan.
$73.00	**Your Responsibility to your Dental Provider** The portion of the amount billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, co-pay, coinsurance and / or non covered charges.

20180915-015079 UHC01R 0000001825742725O0 29598400 09/15/18-CO-N-M--N-N

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Salt Lake City, UT 84130-0567

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Claim Detail *for* NELSON, MARK

Provider: ARROWHEAD DENTAL ASSOCIATES (In Network) **Patient Account Number: 0020049010471347P** **Claim Number: 182574272500**

Date(s) of Service	Procedure Code & Description	Tooth #	Notes*	Amount Billed	Allowed Amount	Your Plan Paid	Your Itemized Responsibility to Provider**			Total Amount You Owe the Provider
							Deductible	Co-Pay	Co-Insurance	
09/13/18	D2392 - resin-based composite - two surfaces, posterior	05	K69	$241.00	$181.00	$108.00	$0.00	$0.00	$27.00	$73.00
Claim Subtotal:				$241.00	$181.00	$108.00	$0.00	$0.00	$27.00	$73.00

Notes*

K69 Patient responsible for difference in cost between service rendered and the fee for the service on which the plan benefit is based.

Plan underwritten by UnitedHealthcare Insurance Company

Please refer to your benefit plan documents for information regarding eligibility, frequency of benefits and claims information.

	Amount Billed	Allowed Amount	Your Plan Paid	Your Itemized Responsibility to Provider**			Total Amount You Owe the Provider
				Deductible	Co-pay	Co-Insurance	
Claim Total:	$241.00	$181.00	$108.00	$0.00	$0.00	$27.00	$73.00

**This total does not reflect any payments / copays you may have made at the time of service. Please wait for a provider bill before making a payment.

Use this EOB statement as a reference or retain as needed

20180915-015079 UHC01R 0000001825742725O0 29598400 09/15/18-CO-N-M--N-N

UnitedHealthcare
P.O. Box 30567
Salt Lake City, UT 84130-0567

Telephone: 1-877-816-3596

Your Account Summary

NELSON, MARK
Annual Benefit Limit: $2,000.00

	INDIVIDUAL		FAMILY	
Relationship: Subscriber	Applied Year to Date	Remaining Balance	Applied Year to Date	Remaining Balance
Account Summary Details				
Annual Deductible	$50.00	$0.00		
Annual Deductible			$50.00	$100.00
Lifetime Limit - Ortho		$1,000.00		

(1) The balances in Your Account Summary may change if claim adjustments are processed
(2) The total deductible amount applicable for the plan year will NOT exceed the highest listed deductible for either In-Network or Out-of-Network services
(3) The total benefit payable by the plan will NOT exceed the highest listed maximum amount for either In-Network or Out-of-Network services

Use this EOB statement as a reference or retain as needed

Contact Information

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