Health Authority – Abu Dhabi		هـيئـــة الصحة - أبوظبي
Title*:* HAAD Health Insurance Claims Adjudication Standard **Reference**: HSF/CA/1.0		**Issue Date**: December 2010 **Version**: 1.0

1. Purpose

1.1. This standard establishes and mandates the Claims Adjudication Process and Rules for health insurance reimbursement in the emirate of Abu Dhabi.

2. Scope

2.1. This Standard applies to all Payers and Providers (together: "Healthcare Entities") approved by HAAD to participate in the Health insurance scheme of Abu Dhabi.

3. Enforcement and Sanctions

3.1. Healthcare entities must comply with the terms and requirements of this Standard, the HAAD Standard Contract and HAAD Data Standards and Procedures. HAAD may impose sanctions in relation to any breach of duties under this standard in accordance with the [HAAD Policy on Inspections, Complaints, Appeals & Sanctions].

4. Standard 1: Definitions

4.1. **Claims adjudication** is the determination of the payers financial responsibility, after the member's insurance benefits are applied to a medical claim, beyond those set out in the Standard Provider Contract. A determination may be for a full or partial settlement or dismissal of the entire claim.

4.2. An **Edit** for a code(s) is a set of rules generally automated, which screens for improper coding and/or treatment that might lead to inappropriate payment of medical claims. HAAD distinguishes two types of Edits, as follows:

4.2.1. Simple Edits: Rules that are based on specific clinical information on a ***single*** claim (including integrity of diagnosis, activity, observations and demographics of the member) evaluated against available clinical guidelines. Moreover, simple edits lead to consistently identical adjudication decision, irrespective which item would be added to the bill; example, maternity treatments for men are never covered irrespective of any information, whereas reconstructive surgery can be covered in case of trauma.

4.2.2. Complex Edits: Rules based on specific clinical information on 1) ***multiple*** claims clinical history of the member, facility, or clinician; 2) detecting relevant patterns; example, approving payment for a surgical follow up for patients having a history of surgical trauma or 3) rules on single claims that do not fall under the definition in 4.2.1.

4.3. **Adjudication guideline** is a document with the aim of guiding decisions taken to adjudicate a claim. Adjudication guidelines are applied by Payers during their adjudication process, and must be published or accessible by contracted providers through website or providers' portals, and be governed by the Standard Contract requirements. Where access is provided via website or providers' portal, published guidelines must be version numbered, dated, and traceable and be linked to the relevant contractual period.

5. Standard 2: Claims Adjudication Process

5.1. Payers must have a documented claims adjudication process which comprises the development, application and review of Edits Adjudication Guidelines and Audits.

5.2. The claims adjudication process must apply the HAAD Claims Adjudication Rules established by this Standard (**Appendix 1,** also available on the HAAD website).

5.3. Simple Edits are required to be shared electronically with HAAD and contracted providers on an ongoing basis. To respect the commercial confidentiality of these edits vis-a-vis other payers/providers, HAAD undertakes not to share these Edits with other payers/providers in their native form.

5.4. Payers must provide a reason for the denial of any submitted claim via remittance advice using the proper denial code on any partially or fully denied claim, as per www.haad.ae/datadictionary.

5.5. By December 31st, 2011. Payers, adjudicating medical claims, must have access to at least one internationally certified coder "Expert", as per the recognition guidelines of the Clinical Coding Steering Committee. After this date, HAAD may, at its sole discretion, enforce this requirement and monitor compliance with it accordingly.

5.6. Where differences on correct coding arise between healthcare entities, the Payers are required to prove involvement of their Expert(s) in the specific case to the provider upon request.

5.7. Healthcare entities are expected to undertake reasonable steps to resolve differences on correct coding amongst themselves. Where disagreement on correct coding persists despite reasonable attempts at resolution, the provider may submit the dispute for binding and non-appealable resolution to HAAD Clinical Coding Arbitration Sub-committee, a subcommittee of the HAAD Clinical Coding Steering Committee, for resolution.

5.8. Other non-coding related disputes can be escalated through the formal Complaints Procedure at HAAD.

6. Standard 3: Process for reviewing Adjudication Rules

6.1. HAAD may periodically call for submissions from Healthcare Entities for new additions and/or revisions to the Claims Adjudication Rules. Calls for submissions will be publicized via the HAAD website. HAAD may, on a best effort basis, also write to all relevant stakeholders directly inviting such submissions.

6.2. All submissions must be made electronically to hobaid@haad.ae. Only complete submissions will be accepted by HAAD. Submissions can be strengthened by attaching supporting evidence for the proposed Rules/Rule revisions.

6.3. HAAD, at its sole discretion, approves Claims Adjudication Rules for inclusion on the List of Claims Adjudication Rules established by this Standard (Appendix 1).

APPENDIX 1
HAAD HEALTH INSURANCE CLAIMS ADJUDICATION RULES*

ACTIVITY	RULE
1. Sharing of Edits and Guidelines	1. Simple Edits are required to be shared electronically with HAAD and contracted providers on an ongoing basis. To respect the commercial confidentiality of these edits vis-a-vis other payers/providers, HAAD undertakes not to share these Edits with other Payers/Providers in their native form.
2. Consistency of Adjudication	2.1. If a Provider can show inconsistency in claim adjudication decision for identical claims — within a quarter within the past 12 months — and consultation with the payer does not result in corrective measure or an appropriate reason for this denial, the provider is entitled for the higher of the two payments, or whatever the total number of claims within the year quarter at which such practice was reported. 2.2. Such a payment in each direction shall be applicable only after a validation from the Clinical Coding Arbitration Sub-committee, a subcommittee of the HAAD Clinical Coding Steering Committee for all cases identified and on a forward basis). NB – This rule might be overridden for certain plans (insurance schemes) and in the events of exemptions, exceptions and Exgratia.
3. Prior Authorisation	3.1. Denial due to lack of prior authorization only if the Schedule of Benefits in the Insurance Plan requires such prior authorization for the service(s) performed. 3.2. In case of incorrect denial on the basis of lack of prior authorization by the payer the provider is entitled for the payment in its entirety plus the entire time elapsed from first submission of the claim to settlement minus the payment period of 45 days will be treated as late payment per the standard payer contract, and reimbursed by the payer as such. 3.3. A prior authorization that has been incorrectly downgraded by the payer without justification from what was originally requested will be considered abusive; and dealt with in accordance with the HAAD health Insurance Fraud & Abuse Policy. The provider has the right to the payment for the higher procedure for all such claims. 3.4. If the payer's response to a prior authorization request by a provider is underspecified and incomplete they will be interpreted in the provider's favour and will be considered approved.
4. Plan Changes	4.1. The payer will, on a best effort basis, inform the provider of any updates and/or changes of a material impact on the claims adjudication process (example, changes in co-pays) within [5] working days of signing the policy and – if possible – ahead of executing the policy in the market.
5. Application of Coding Rules	5.1. All non-resolvable disputes over correct coding must be decided by HAAD Clinical Coding Arbitration Sub-committee, a subcommittee of the HAAD Clinical Coding Steering Committee. 5.2. If HAAD Clinical Arbitration Sub-committee decides that the Payer has misinterpreted or misapplied codes, and consequently incorrectly adjusted payments, the entire time elapsed from first submission of the claim to settlement minus the payment period of 45 days will be considered as late payment and reimbursed by the payer in accordance with the Standard Provider Contract related provisions.

* As Adjudication Rules are not Diagnosis Related Groupings (DRG) specific, and until the DRG system is fully implemented for all health insurance products by 31 December 2011, DRG related edits will be treated as complex edits.