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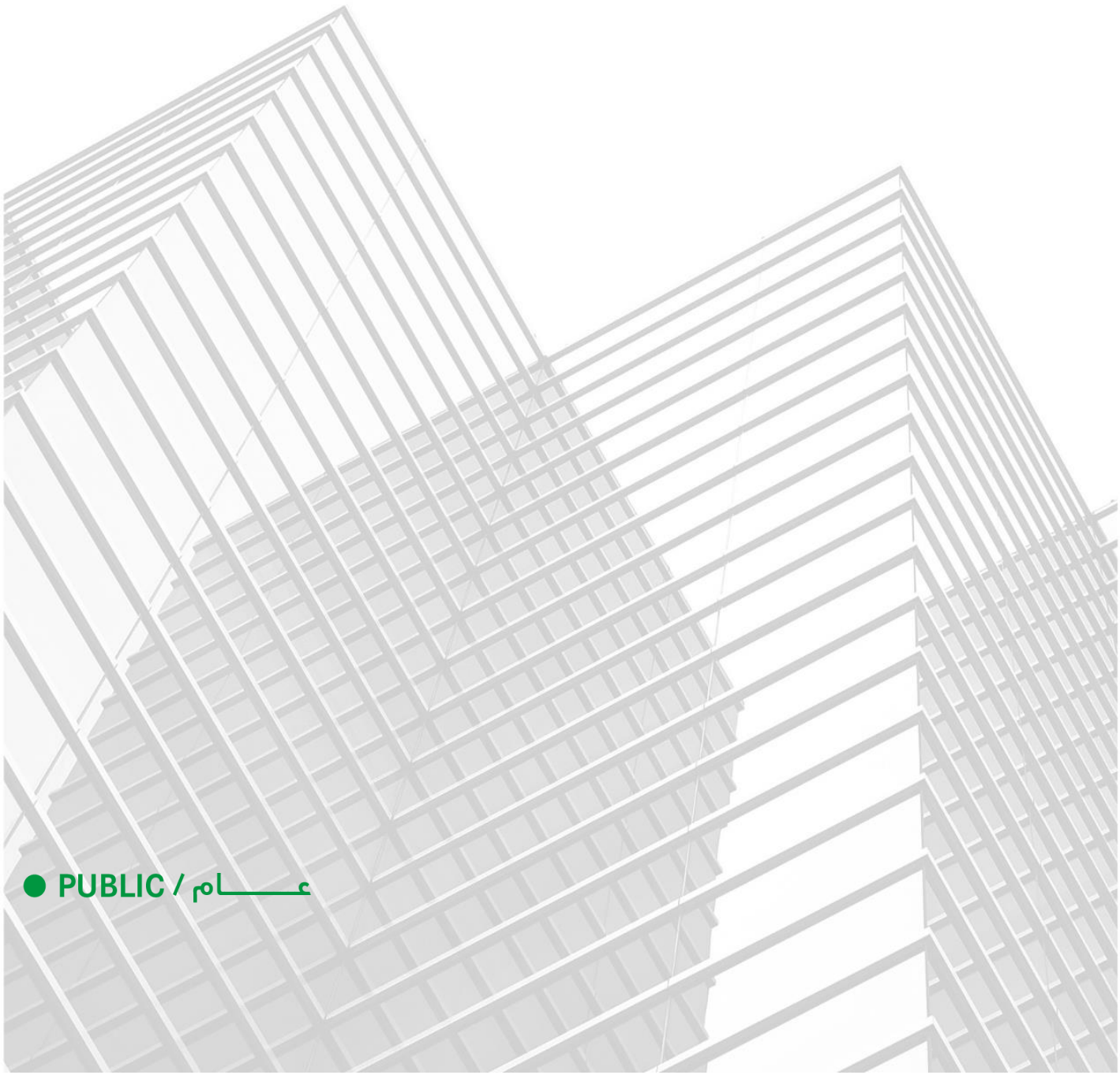
DEPARTMENT OF HEALTH

Standard for the Principles and Procedures Governing the Recovery of Payment for Healthcare Services under the Health Insurance Scheme



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1. Definitions and Abbreviations

No.	Term / Abbreviation	Definition
1.1	Claims Reconciliation	A process used to compare the amount supposed to be paid and amount actually paid to claimants (healthcare providers).
1.2	Healthcare Insurance Abuse (Abuse)	Insured Person or Healthcare Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Payer or in the reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. In contrast to Health Insurance Fraud, Abuse is not criminal in intent.
1.3	Health Insurance Fraud (Fraud)	Means an intentional act of deception by any person which has as its purpose the objective of: (i) obtaining a (financial or other) benefit or advantage related to the operation of the Health Insurance Scheme; or (ii) causing or exposing another person to a (financial or other) loss or disadvantage related to the operation of the Health Insurance Scheme, whether that act in fact achieves its intended purpose or not.
1.4	Health Insurance Misuse (Misuse)	Means an incorrect diagnoses as well as medical errors and other sources of avoidable complications (such as infections that patients acquire during a hospital stay).
1.5	Standard Provider Contract (SPC)	Standard Contract governing the Contractual Relation between Healthcare Service Providers, Health Insurance Companies and TPA.
1.6	Third Party Administrators	A health insurance claims' administrator company licensed by DOH to operate in the field of health insurance.

2. Standard Purpose

2.1 This Standard defines the principles and procedures governing the recovery, of payment- by Payers- for claims under the health insurance scheme in Abu Dhabi. The Standard sets out the:

2.1.1 reasons for recovery, the recovery process, and the obligations of both Payers and Providers as they pertain to recovery;

2.1.2 interactions with DOH and its regulations concerning decisions for recovery of payment for claims; and

2.1.3 rules for the recovery of payment for claims process.

3. Standard Scope

3.1 This Standard is applicable to all Healthcare Payers (Payers), Third Party Administrators (TPAs), Healthcare Providers (Providers) and Health Insurance Stakeholders in the Emirate of Abu Dhabi working under the Health Insurance Scheme, Law, and its implementing regulation, and must be read in conjunction with the following DOH regulatory documents:

3.1.1 Healthcare Insurers Manual[1]

3.1.2 The Standard Provider Contract governing the contractual relationship between Healthcare Service Providers, Health Insurance Companies and Third Party Administrators[2,3]

3.1.3 The DOH Health Insurance Claims Adjudication Standard and Claims Adjudication Rules [4].

3.1.4 The DOH Standard for Medical Billing Services[5].

3.1.5 DOH issued Health Insurance Circulars pertaining to claims management and processing [6].

4. Standard Requirements and Specifications

4.1 Reasons for Recovery of Payment for Claims

4.1.1 The followings constitute – without limitation - grounds for seeking recovery by the Payers of payment of claims:

- 4.1.1.1 Results of audit or billing and payment review of provider claims for reimbursement for services (audits may be conducted by the payer/TPA and/or their appropriately commissioned and authorized third party auditors, see Appendix 1);
  - 4.1.1.1.1 Fraud, misuse and abuse.
  - 4.1.1.1.2 Claims reconciliation.
  - 4.1.1.1.3 Voluntary reporting of errors & mistakes by Providers.
  - 4.1.1.1.4 Mutually agreed and accepted Edits.
  - 4.1.1.1.5 Duplicate payments & over payments.
  - 4.1.1.1.6 Coding errors.
  - 4.1.1.1.7 Other unintentional errors.
  - 4.1.1.1.8 Coordination of benefits.
  - 4.1.1.1.9 DOH Arbitration award.
  - 4.1.1.1.10 DOH Violation Decision
  - 4.1.1.1.11 Court Ruling.

4.1.2 Results of DOH's appointed auditors / TPA's audit or billing and payments review of provider claims related to Government Funded Programs that are proven it was paid unlawfully or wrongly paid and/or results of review of trend and services utilization analysis of the provider's behavior related to these programs were the provider has proven by the trend comparison to its peers that they have committed overutilization, or excessive services.

4.1.3 Recovery of the public funds for the public interest identified by DOH or an appointed auditor by a competent Authority.

4.1.4 Recovery of payment of claims based on the health insurance law & its implementing regulation, as amended from time to time.

4.1.5 Payers may require recovery of a payment for claims identified in accordance with Section 4.1 and the requirements of this Standard, and Providers must comply with these requests for recovery in accordance with this Standard.

4.2 Processes Governing the Recovery of Payment of Claims

4.2.1 Audit process

- 4.2.1.1 When conducting audits, Payers and TPA must ensure that they:
- 4.2.1.2 Use industry best practice standards to audit paid claims.
- 4.2.1.3 Staff assigned to conduct audits must demonstrate that they have the relevant qualifications to perform such audits and ensure staff are formally authorized by the employing payer as being responsible to perform audits, and that evidence of certification and formal authority is documented and provided to DOH upon its request.
- 4.2.1.4 Commission only reputable third-party audit firms specializing in the field, if they decide to outsource claims reimbursement audits, and that third-party auditors must be required to sign a Non-Disclosure Agreement to protect the confidentiality and privacy of information in accordance with DOH requirements for data management.
- 4.2.1.5 Notification of intention to audit,
  - 4.2.1.5.1 There shall be no prior notification to the provider of the intention to audit, if the audit is:
    - 4.2.1.5.1.1 Initiated by the DOH, or
    - 4.2.1.5.1.2 The Department of Health has approved in writing conducting the audit by the Payers/TPA without Prior Notification, after submitting acceptable justification for such.
- 4.2.1.6 In all other cases, Notification of intention to audit is issued in writing at least three [3] working days prior to audit. The notification will NOT specify the claims to be audited so as to prevent modification of files to be audited.
- 4.2.1.7 Upon auditor arrival Providers must meet the following obligations during/prior to the audit process:
  - 4.2.1.7.1 To grant immediate access to premises, staff, and requisite documents/files to auditors to perform the audit.
  - 4.2.1.7.2 To grant auditors immediate access to all requested Medical and Billing records with specific codes, specific patients and/or specific doctors.

4.2.1.7.3 Obtain and provide auditors with signed beneficiary/patient consent.

4.2.1.7.4 Where the Provider fails to obtain consent (either due to refusal of and/or lack of response from beneficiary/patient), they are obliged to notify the Payer/TPA of such failure.

4.2.1.7.5 The provider must provide evidence that all efforts have been made to secure consent in accordance with the DOH Standard for Consent.

4.2.1.7.6 To respond in detail, case-by-case, to audit report issued by

4.2.1.7.7 Payer/TPAs (audit report) within twenty working days from the date of receiving the audit report; Failure to respond to the audit report within twenty working days results in automatic acceptance of the audit results by the Provider.

4.2.1.7.8 The Auditors shall have the right to access records that are related to paid claims and to take or be provided with copies of related documentation.

4.2.1.7.9 Payers/TPS have the following obligations:

4.2.1.7.9.1 To ensure that only duly authorized auditors audit a Provider.

4.2.1.7.9.2 Provide exit interview to summarize the audit; and

4.2.1.7.9.3 Provide audit report with results within thirty working days of audit (the exit interview date).

4.2.1.7.10 Billing and Payment Review Process:

4.2.1.7.10.1 Payer/TPA may conduct an internal review of paid claims submitted by Providers and Payments connected to these claims in order to identify any potential irregularities:

4.2.1.7.10.2 Payer/TPA shall communicate any irregularities identified during the review to Providers (Billing and Payment Review Report). The report sent to Providers must detail why the claim is being contested with supporting Documentation.

4.2.1.7.10.3 The Provider must respond in detail, on a case-by-case basis, with supporting records as needed, to the Billing and Payment Review Report within twenty [20] working days from the date of receiving the Billing and Payment Review Report; and

4.2.1.7.10.4 Failure to respond to Billing and Payment Review Report within twenty working days results in automatic acceptance of review results by the Provider.

4.3 Disputes

4.3.1 A disagreement by the provider concerning an Audit Report or Billing and Payment Review Report must be addressed between the Payer and Provider via formal correspondence (e-mail, letter, or a physical/virtual meeting) to discuss the audited cases or billing payment irregularities, the disagreement, and to agree on actions to resolve the disagreement within fifteen working days following the receipt of the Providers notification of disagreement.

4.3.2 In case of agreement, recovery will be due within fifteen working days. following the receipt of the Providers notification of agreement.

4.3.3 In case of unresolved disagreements, dispute must be referred to the DOH arbitration process for arbitration by the Provider within ten working days of expiration of the fifteen working days period noted in section 4.3.1 by submitting the complaint at https://bpmweb.doh.gov.ae/UserManagement/MainPage.html. Once filed, the arbitration reference number must be provided to the Payer. Failure to provide the reference number within the ten working days as noted above will result in automatic acceptance of the original results by the Provider.

4.3.4 DOH arbitration award will be final and binding on both parties for all disputes.

4.4 Reconciliation

4.4.1 As per the Standard Provider Contract, Payers/TPA and Providers must reconcile their accounts at least once annually using the available template with the Standard Provider Contract.

4.4.2 For agreed reconciliation signed by both parties (Payer/TPA and Provider), recovery of claims may be pursued for services rendered during the reconciled period for reasons provided for under 4.1 of this standard, namely: Reasons for Recovery of Payment for Claims.

4.5 Overpayment

4.5.1 In the event of any overpayment, duplicate payment or other payment in excess of that to which the Provider is entitled for Covered Services to the beneficiary/patient, the Payer/TPA may:

4.5.1.1 Recover the amounts by way of offset; or

4.5.1.2 Reclaim from current and/or future payments after identifying remittance advice(s) on which the overpayment was made to the Provider. Such recovery must only take place after either party (Payer or Provider) has been notified with supporting evidence prior to recharge (refer to the Standard Provider Contract, clause 4.2.d).

4.6 Voluntary Reporting of Claims Errors and Mistakes by Providers

4.6.1 Providers must report erroneous claims independent of any audit or reconciliation process; and

4.6.2 Reporting of errors and/or mistakes assumes agreement by the provider for the payer to initiate recovery of payment for claims.

4.7 Edits

4.7.1 The Claims Adjudication Standard establishes the concept of Simple Edits and Rules to be shared with Providers; only Edits and Rules shared with Providers before the start of a relevant reconciliation period can be used as the basis for recovery; and

4.7.2 Claims Adjudication Edits must not be applied retrospectively to claims before sharing and agreeing the Edits.

4.8 Fraud and Abuse

4.8.1 Payers/TPA must have in place measures to prevent, detect and re-capture improper payments. Where identified, these improper payments must be reported and rectified in accordance with the requirements of this Standard.

4.8.2 Statistical evidence, data analysis, whistle blowing, and/or mystery shopping may be used to investigate further audits to validate suspicion of fraud and/or abuse.

4.8.3 Mandatory reporting is required of all cases of suspected Fraud and/or Abuse to DOH according to DOH Policy on Health Insurance Fraud and Abuse (Chapter VI, Healthcare Insurance Policy Manual, Version 1.0).

4.8.4 Until final ruling by either DOH (abuse) and/or courts (fraud), the Payer may:

4.8.4.1 Suspend payment, in the amount equivalent to claims suspected of and/or reported as Fraud, Abuse and/or Misuse as per the Standard Provider Contract (3.9.(d) for unpaid claims.

4.8.4.2 Withhold payment in the amount equivalent to paid claims suspected of and/or reported as fraud and/or abuse from the provider against general accounts payable with the Payer as per the Standard Provider Contract (3.9.(2) d); and

4.8.4.3 After confirmation of fraud (by the courts), abuse and/or misuse by DOH, the Payer/TPA may unilaterally terminate the contract with the Provider immediately and where appropriate withhold funds.

4.9 **Other Court Rulings as a Result of Legal Disputes**

4.9.1 Any other ruling by the relevant courts concerning a dispute between Payers and

4.9.2 Providers relating to overpayment may lead to a recovery of overpaid amounts.

4.9.3 Rulings must be implemented in accordance with the reporting requirements of the recovered amounts.

4.10**Recovery period and other limits**

4.10.1 A Payer must not seek recovery of payment for claims after the reconciliation date of final settlement, except for cases as per 4.1 Reasons for Recovery of Payment for Claims);

4.10.2 In case of convicted fraud, judgment by the court and/or applicable criminal law shall override specific stipulations in this standard; and

4.10.3 Any finding(s) must not be extrapolated to any other claim not specifically audited.

4.10.4 except in cases voluntarily agreed upon by the Payer/TPA and Provider, where a pattern may have been detected (e.g., of unbundling errors) and that may result in further audits either by Payer or a Payer-initiated full coding certification re-audit.

4.11Recovery Process

4.11.1 Recovery of payment for claims may be initiated after:

4.11.2 Failure of the Provider to grant access to medical records as per section 6.

4.11.3 Ruling of fraud and/or abuse (confiscation of withheld amounts) or any other court ruling or DOH decision.

4.11.4 Ruling of the DOH arbitration process.

4.11.5 Acceptance of Audit Report and Billing and Payment Review Report results, coding error and/or duplicates by Provider and/or any other unintentional error by Provider.

4.11.6 The Payer must remit finally adjusted claim in accordance with DOH Data Standard, a requirement that applies universally to all cases of recovery independent of the original reason for recovery.

4.11.7 Failure to comply with the reporting requirement of recovered amounts may result in penalties applied by DOH in accordance with data reporting requirements as set out in the health insurance law, its bylaw and its regulation and the Healthcare Insurers Policy Manual Version 1.0.

4.11.8 In cases not provided for under this Standard the terms and conditions of the Standard Provider Contract (SPC) apply in relation to recovery by Payer.

5. Enforcement and Sanctions

Healthcare providers, payers and third-party administrators must comply with the terms and requirements of this Standard, the Standard Provider Contract, DOH Standard for Medical Billing Services, and the DOH Data Standards and Procedures. DOH may impose sanctions in relation to any breach of requirements under this standard in accordance with the Health Insurance Scheme Implementing Regulation and the Schedule of Violations and penalties issued under the DOH's Chairman Resolution as amended from time to time.

6. Relevant Reference Documents

No.	Reference Date	Reference Name	Relation Explanation / Coding / Publication Links
1	25-10-2023	Healthcare Insurers Manual	https://www.doh.gov.ae/-/media/09AEC8C5B6D34AA88DE110F63641B863.ashx
2	25-10-2023	Standard Provider Contract (SPC)	The Standard Provider Contract governing the contractual relationship between Healthcare Service Providers, Health Insurance Companies and Third Party Administrators - issued pursuant to DOH Circular No 133 year 2020, and its updates. https://www.doh.gov.ae/-/media/4491C88CFBCB4A75A6E777CC1ECCA3E3.ashx https://www.doh.gov.ae/-/media/15EE5C06FF2C411FA260F227EBB195C9.ashx
3	25-10-2023	Health insurance law no. 23/2005 & its by-laws	https://www.doh.gov.ae/-/media/AFAD86A6E3FF447DA030ED194F31CFB6.ashx
4	14-11-2023	DOH Health Insurance Claims Adjudication Standard and Claims Adjudication Rules	https://www.doh.gov.ae/-/media/AE9135D3019B4DDA83240F910D56BC79.ashx
5	14-11-2023	The DOH Standard for Medical Billing Services	https://www.doh.gov.ae/en/resources/standards
6	14-11-2023	DOH issued Health Insurance Circulars	https://www.doh.gov.ae/en/resources/Circulars

7. Appendices

Appendix 1 - Reasons for Recovery of Payment for Claims

Recovery Process Flow Chart