

Business Rules

1 Activity

- 1.1 Process for claiming unlisted procedures:
- Report the specific “unlisted” procedure code from the chapter in CPT that it belongs to (i.e., don't use the service code for undefined services)
 - Charge the pre-agreed price for this code. If no specific charge has been pre-agreed, then use the charge of the most closely related procedure, and describe this procedure in an Observation (Type=Text,Code=ClosestUnlistedProcedure,Value=Text description of procedure);
 - Disagreements on price can be resolved through the remittance/resubmission process
 - For the avoidance of doubt, the process of claiming for unlisted procedures does not alter the benefits coverage for members
- 1.2 In a DRG claim, the Provider reports all activities, but charges only the DRG that payment is sought for. Activity.Code and Activity.Net of the DRG activity should correspond to the DRG calculated based on activities that are covered by insurance, while everything else can be deduced from the claim. To ensure clarity for the Payer, activities that are not claimed to insurance must have the following observation: Observation.Type = 'Flags', Observation.Code = 'Exclude from DRG grouping'. (DSP decision 209)

2 Encounter

- 2.1 Encounter.End and Encounter.EndType are mandatory for encounter types 3 and 4.

3 Observation

- 3.1 Tooth number Observation is mandatory for all relevant Dental Claims with Activity.Start after 28 February 2010
- 3.2 The Payer may require the following codes to have a .pdf file attachment for further information and clarification, if a Provider wishes to challenge the following Denial/Adjustment codes:
- Auth-003: PriorAuthorizationNumber is invalid
 - Auth-004: Service(s) is (are) performed outside authorization validity date
 - In addition, the Provider may attach a .pdf file to any or all codes at his own discretion.

4 Resubmission

- 4.1 Once a Remittance.Advice has been received, the provider has four options for each claim:
- A) Accept -- no action
- B) Correct -- resubmit using Claim.Resubmission transaction. The number and nature of corrections allowed can be specified in the Provider-Payer contract
- C) Start Internal Grievance+Appeals process -- resubmit using Claim.Resubmission. There may be multiple cycles of Claim.Resubmission and Remittance.Advice. After every Remittance.Advice which does not resolve a difference of opinion, the Provider may choose to go to external review as per the Standards and Procedures Guidance. In such a case, no further Claim.Resubmission is allowed.

- 4.2 Resubmission.Type='Legacy' to be used only for drugs that were dispensed after June 1, 2008 but before a drug code is published. Legacy claims of this sort can only be made within 60 days of publishing the drug code. The rules for a Legacy resubmission are analogous to an internal complaint.
- 4.3 Corrections require resubmission of the entire claim while internal complaints should only resubmit contested activity
- 4.4 Providers can only submit a 'complaint' about claims they deem to have submitted 100% accurately, otherwise it has to be classified as a 'correction'
- 4.5 Claim amounts for a resubmission: for an internal complaint, this means the contested amounts; for a correction it means the corrected amounts
- 4.6 Claim.ID needs to remain identical throughout all iterations of Claim.Submission (resubmissions) and Remittance.Advice
- 4.7 Once a claim has been submitted, it cannot be resubmitted until a Remittance.Advice has been received.
- 4.8 Any resubmission of a ClaimSubmission requires the Resubmission element. Claim.Submission without Resubmission element can in general only be used once for a particular claim. Any subsequent submissions are simply invalid.
- 4.9 Claim-level comments should be made in Resubmission.Comments, but this element may remain empty.
- 4.10 Any Activity-level comments should be made as an Observation of Type 'Text', Code 'Resubmission', with the Value being the comment text, and ValueType left empty.
- 4.11 Claim.Submission without Resubmission element can in general only be used once for a particular claim. Any subsequent submissions are simply invalid.
- 4.12 Claim.Submission can be resubmitted if it turns out that the Post Office has no record of the Claim
- 4.13 All disputed claims and corrections should be resubmitted to the Payer within 45 calendar days from the date of related RemittanceAdvice transaction.
- 4.14 Activities in 'internal complaint' type resubmissions must have the same Activity.ID as in the original submission, in all other types of resubmissions Activity.ID must be unique across for the same Claim.ID (DSP decision 190)
- 4.15 For a correction, Provider's ActivityIDs must all be different from those submitted originally. This allows take-backs to be identified unambiguously, and allows simple tracking of the payment terms of the corrected claim. Take-backs do not affect payment terms/fine calculations for the corrected claim. (DSP decision 207)
- 4.16 Provider can send correction for existing PriorRequest transaction using the following logic:
 - Correction is sent in case user finds out something is wrong with the original request and he wants to resubmit full request again after receiving related PriorAuthorization.
 - For ePrescriptions (**Authorization.Type=Prescription**) Correction is not allowed. Original prescription need to be cancelled and new ePrescription issued (see business rule 5.8). (DSP decision 219)
- 4.17 Payer can deny PriorRequest transaction fully or deny only some activities. Payer can also authorize activity with lower PaymentAmount than requested by clinician. Provider can disagree and send complaint PriorRequest transaction again. The following business rules apply:
 - Complaint is sent only for those activities that are denied by payer or activities that got different Activity.Net authorized than requested.

- The following complaints are not allowed:
 - If complaint PriorRequest contains activity that is approved by payer
 - If complaint PriorRequest contains activity with the same Activity.Net that is already approved by payer
 - If complaint PriorRequest contains activity that is already dispensed
 - Complaint about the limit
- Complaint must only contain activities available in the original PriorRequest
- Complaint is allowed even if prescription has dispensed activities if they are not part of complaint PriorRequest

(DSP decision 219)

5 Transactions

- 5.1 If validation of a transaction results in an error, it is invalid in full. The entire transaction can be resubmitted once all errors are corrected.
- 5.2 For transaction pairs the receiver of the first transaction must be the sender of the second transaction, e.g., if a TPA receives a ClaimSubmission from a provider, then that TPA (not the insurer) must send the RemittanceAdvice to the provider.
- 5.3 Providers must be able to add all activities (whether associated with charges or not) on a Claim, while payers must refrain from adding any content into transactions that isn't directly related to remitting Claims at hand
- 5.4 Payers to submit RemittanceAdvice on the day of any remittance
- 5.5 Single remittance advice per claim: each claim with all its activities must be remitted in full in any remittance advice that is present. It is not to be split or separated over more than one remittance advice. Exception: take-backs for corrections or post-audit may be submitted in a separate transaction (All take-backs related to a single claim still need to occur in the same transaction, though). Note that for internal complaints, only the contested activity/ies need to be remitted. (DSP decision 207)
- 5.6 In all transactions MemberID must be reported exactly as printed on the member's card (from TransactionDate >= 1 Jan 2011).
- 5.7 Interim billing per calendar month is allowed for Long Term Care claims when patient's stay at the facility has exceeded 30 days of continuous inpatient care. Such a claim would have Encounter.StartType 7=Continuing Encounter or Encounter.EndType 6=Not discharged. (DSP decision 204)
- 5.8 Provider can cancel previously submitted PriorRequest transaction using PriorRequest with Authorization.Type=Cancellation. Cancellation is sent in case user finds out something is so wrong that entire PriorRequest must be stopped, which particularly applies to ePrescriptions (see business rule 4.16). (DSP decision 219)

6 PriorRequest with Authorization.Type=Prescription

6.1 Provider submits a PriorRequest with Authorization.Type = Prescription

- Prescribing physician submits electronic Prescription. As on paper, such a Prescription is valid for maximum of 60 days unless otherwise defined.
- Payers must specify a process in case a provider, for provider-specific reasons cannot connect to the Post Office or the Post Office is unavailable
- Splitting of prescriptions into multiple PriorRequests on grounds not clinically indicated will be treated as Abuse. Transition arrangements apply to certain providers.
- **ReceiverID** should be the PayerID – Insurer or TPA
- Authorization.Type is ‘Prescription’
- **Authorization.ID** must be globally unique and start with SenderID
- **Activity.Type** Drugs are generally prescribed using their generic name [Activity.Type=10], while Brands are allowed only for drugs included in the ‘Dispense as prescribed’ list of drugs published by HAAD [ActivityType=5]. In addition, it is possible to prescribe medical devices and consumables [ActivityType=4].
- Each prescribed item has a unique **ActivityID**
- Each Drug has associated **Observations**:

Description	Type	Code	Value	ValueType	Mandatory
Patient weight	LOINC	3141-9	Float	Kg	No
Dose/Strength	Text	Dose	Float	Mg, mcg, ml	Yes
Dosage Form	Text	DosageForm	Text- see codes		Yes
Route	Text	Route	Text- see codes		Yes
Instruction	Text	Instruction	Text		No
Duration: the duration of the quantity to be dispensed at one time, excluding any refills Example: Duration = 1 month, Refills = 2 means that the drug is prescribed for three months	Text	Duration	Float	minutes, hours, days, weeks, months	Yes
Frequency: the number of times the medication is prescribed to be administered during the period identified by ValueType	Text	Frequency	Integer	See allowed Frequency ValueTypes	Yes
Refills: the number of times a drug may be refilled. In general, it is expected that most Prescriptions will have 0 Refills It is the prescribing Doctor’s prerogative to specify refills There are regulations that limit duration of a prescription and/or the number of refills An insurance company will in general not pay for durations that go beyond the coverage period of their insured members	Text	Refills	Integer		Yes

6.2 Payer submits a PriorAuthorization response to a PriorRequest with Authorization.Type=Prescription

- A PriorRequest not responded to within 1 minute is considered finally authorised by the Payer.

The following exemptions apply:

- During the transition phase, the time limit is 10 minutes. It is expected that a Payer will respond to at least 85% of PriorRequests within 5 minutes for any given Provider. These time limits will be periodically reviewed and adjusted downwards by a technical working group that reports to the Data Standards Panel.
- If the PriorRequest has a non-empty Instruction observation the time limit is 15 minutes
- Responses to Complaints and Corrections are exempt from above time requirements. HAAD may at a later stage introduce performance expectations, e.g., >90% of all complaints are dealt with in under 30 minutes.
- Payers and providers are expected to agree a protocol to follow, should related systems not be available.
- The PriorAuthorization represents the Payer's information at that time, and does not represent a warranty for the future.
 - For instance, if the authorization indicates a remaining sub-limit (prior to this prescription) of AED 1000, this must be true at that time. It does not guarantee that AED 1000 will still be available when that Prescription is dispensed and claimed, say 14 days later -- perhaps some other prescriptions have been claimed in the interim for instance.
- A payer may comment on a Prescription at multiple levels
 - **Authorization.Response** is empty, i.e., there is no aggregate Yes or No response
 - **Activity.DenialCode** must be used, if the payer will adjust/deny an Activity. Absence of a denial code, indicates acceptance in principle.
 - **Authorization.Comments** is used to highlight drug interactions
 - An applicable financial limit for a member must be provided in the **Authorization.Limit** element. If the field is left empty, no limit applies.
 - It is good practice for the Payer to provide a list of all possible drugs (individual Activity) consistent with a particular generic drug name in a PriorAuthorization, however this is not required. The list of Proposed brands will be linked to the respective generic using the Activity.ID, for example, if the approved generic has Activity.ID = 2, proposed brands will get Activity.ID 2-B1, 2-B2, etc.
 - The following non-mandatory **Observations** may be added

Description	Definition	Type	Code	Value	ValueType
Dispense date	The date after which the drug can be dispensed	Text	DispenseDate	Date	Date
Payer comments	Additional information per activity, if needed	Text	PayerComments	Text	Comments

6.3 Pharmacy obtains prescription

- A pharmacy may either receive a paper prescription from a patient (or guardian of the patient) or use the web service GetDrugs to download an electronic prescription. GetDrugs
- downloads all prescribed, but not dispensed drugs for a specific patient, together with any Payer Authorizations. These shall be grouped by prescription in order to refer to authorization when submitting eClaim.
- may only be used by licensed Pharmacies
- may only be used if the patient (or guardian of the patient) is present. Once Authentication with the EmiratesID card is available, this may serve as proof of the interaction

7 PriorRequest with Authorization.Type=Authorization

7.1 Pharmacy may submit a PriorRequest with Authorization.Type=Authorization

- A pharmacy has the right to submit a PriorRequest with AuthorizationType='Authorization', and a payer may for certain plans also require submission of a PriorRequest with AuthorizationType='Authorization'
- **Authorization.Type** must be 'Authorization'
- **Authorization.ID** must be identical to Authorization.ID on ePrescription. If not available, then Authorization.ID must be globally unique and start with SenderID.
- **Activity.Type** must be 4 or 5 – branded drugs or consumables only
- **Activity.ID** should match the Activity.ID provided by the Prescribing Physician in the original PriorRequest Prescription
- **Activity.Start** indicates the date at which the member is expected to start consuming the drug [already in the definition of the ActivityStart] if it is PRN, it is today's date
- Requested Activities can be Corrected/Cancelled by the Sender as long as it is not yet dispensed
- If a pharmacist/prescribing physician realizes a mistake, (s)he may submit a correction, for which analogous rules apply as for Claims, i.e., by sending a PriorRequest with Resubmission.Type = 'Correction'
- If a Provider is unhappy with the Payer's response, (s)he must submit a complaint, for which analogous rules apply as for Claims, i.e., by sending a PriorRequest with Resubmission.Type = 'internal complaint'. The long-term intention is for complaints to be handled solely via PriorRequests and PriorAuthorizations, but Payers may offer the pharmacist/prescribing physician the additional (not alternative) complementary option to call the Payer before or after submitting the complaint

7.2 A Payer submits a PriorAuthorization response to a PriorRequest with Authorization.Type=Authorization

- The time lines for automatic approval are the same as set out in 6.2.
- A Payer must comment on each Activity submitted by the provider
- For each approved Activity Payer must return **Activity.PatientShare** and **Activity.PaymentAmount**
- For each denied Activity Payer must return **Activity.DenialID**. **Authorization.DenialID** must be empty
- A PriorAuthorization guarantees payment as per prior agreements between payers and providers

7.3 Pharmacy dispenses drugs and submits ClaimSubmission

- A pharmacy is not required to or may not be able to fill the entire prescription. The remaining part of the prescription may be filled later at the same Pharmacy or a different one.
- Drugs prescribed but not approved by the payer may be dispensed, if the patient decides to self-pay, and would show on the ClaimSubmission with a Net Amount of 0.
- Any drugs claimed will automatically be removed from the prescription server, and will no longer be available via GetDrugs. To enable this, **Activity.PriorAuthorizationID** must equal Authorization.ID on ePrescription.
- Once dispensed, a pharmacy should claim immediately. The pharmacy is liable for any risks that arise from late claiming. In particular, if a drug dispensed but not yet claimed is downloaded via GetDrugs by a different pharmacy in the interim, then the original pharmacy may fail to be reimbursed by the Payer.

8 PriorAuthorization

- 8.1 The Price-type denial/adjustment codes are not used in PriorAuthorization. Payer communicates approved amounts using PriorAuthorization.Activity.PaymentAmount and PriorAuthorization.Activity.PatientShare. (Effective 1 Jan 13, DSP decision 236)
- 8.2 In a Prior Authorization for a DRG, Providers and Payers exchange full (6-digit) DRG codes, however, according to HAAD DRG Standard the Provider requests and Payer authorisations apply only to the base DRG (the first 5 digits of the DRG code).

9 PersonRegister

- 9.1 In PersonRegisters Payers report actual member's Emirates ID number whenever available. For contracts renewed on or after 1 Oct 2012, for members over 15 years of age Payers must report members' actual Emirates ID numbers in the EmiratesIDNumber element of the PersonRegister transaction - default values are not allowed. (Effective 1 May 2013, DSP decision 243)
- 9.2 Payers must submit PersonRegisters for all changes to Membership within 24 hours of the change, including addition, modification as well as expiry.
- 9.3 Payers need to obtain members' personal details using Unified ID or Emirates ID number of each member from the PersonProfile web service as described at:

www.haad.ae/shafafiya/dictionary >> [Web Services](#) >> [PersonProfile](#)

- 9.4 Payers must ensure consistency of Member's personal data submitted in PersonRegisters with details received from PersonProfile web service. Payers are encouraged to use these data in their internal systems.