Addendum 06 to DOH Claims & Adjudication Rules

Version

V2025

Including the Mandatory Tariff Pricelist Application Rules.

Department of Health

1. Purpose of this Document.

The purpose of this addendum is to update Section 4.4 IR-DRG to introduce the rules in calculating the reimbursement for inpatient claims with discharge disposition of Left Against Medical Advice

2. Rule effective Date:

01 November 2025

3. Claims and Adjudication Rules

4.4 IR-DRGs

4.4.1 General IR-DRG Rules

- IR-DRGs are mandated for all inpatient encounters, for all products.
- The DRG Relative Weights, incorporated into the most updated Mandatory tariff, apply solely to the current version of IR DRG. Therefore, they should not be utilized with any previous versions of the grouper.
- DoH Standard establishing the Diagnosis Related Groupings System is available at DoH website www.doh.gov.ae, Policies and Circulars Section: Reference HSF/DRG/1.0, Approval Date Jun/2010.[1]
- In the IR-DRG system, payment is fully inclusive of all procedures, services, consumables, and devices utilized during service delivery by the provider in a single inpatient encounter.
- For e-claim submission under the IR-DRG prospective payment system:
  - All activities (services and procedures) shall be reported using the "Fee for Service" claiming methodology, as explained in section 4.2.
  - Activity.Net must be set to "zero" value for all Activities except for the IR-DRG code, and service code 99 for the outlier payment.
  - Inpatient encounters, must have observations as defined in Routine reporting requirements published on https://www.doh.gov.ae/en/Shafafiya/reporting under Standards / Reporting requirements / Routine reporting / Reference = "ActivityCost".[2]
  - For inpatient encounters, all Activities with "zero" value in the Activity.Net, and NOT claimed to insurance must have observations as defined in Routine reporting requirements published on https://www.doh.gov.ae/en/Shafafiya/reporting under Standards / Reporting requirements / Routine reporting / Reference = "DRG-NotCovered."[3]
- Member Share (Co-pays and deductibles) are not affected by the DRG payment system and should be

[1] Reference: Circular 48: Schedule for Implementation of Payment System Updates.
[2] Providers can start including the observations in the e-claim on voluntary basis prior to Oct 15th, however all healthcare entities are mandated to utilize the observation for billing and payment purposes as of Oct 15th 2012.
[3] Providers can start including the observations in the e-claim on voluntary basis prior to Oct 15th, however all healthcare entities are mandated to utilize the observation for billing and payment purposes as of Oct 15th 2012.

collected as normal.

- IR-DRGs are dependent on principal diagnosis and procedures performed; IR-DRG severity might be affected by the secondary diagnosis.
- In the event of several procedures being performed in the same encounter, the principal procedure shall be select based on the following hierarchy:
  - Select the procedure(s) contained in the IR-DRG(s) with the lowest PCAT value for the IR-DRG type.
  - If there is more than one procedure contained in the IR-DRG(s) with the lowest PCAT value, select the procedure contained in the IR-DRG with the same MDC as the MDC of the principal diagnosis.
  - If more than one of the procedures contained in the IR-DRGs with the lowest PCAT value have the same MDC as the principal diagnosis (or if none of them do), select the procedure that is contained in the IR-DRG that is listed first in the ordered list of IR-DRGs contained in the Procedure Hierarchy.
  - The PCATs (procedure category) within each IR-DRG type are ordered in terms of relative resource consumption, with a lower PCAT value indicating higher resource consumption.
- Adjudication of claims payable using the IR-DRGs prospective payment system shall be in compliance with the Claims Adjudication and Pre-Authorization rules set in section 5 of this document, and DoH Adjudication Standard. With the following DRG specific adjudication rule:
  - If the principal diagnosis is not covered condition under the insurance plan, Insurance companies shall have the right to deny the entire claim.
  - If the principal procedure is not covered, insurance companies could exclude the Service, procedure or item, and pay using the recalculated DRG.
  - Secondary diagnosis coding shall follow the following published rules. Accordingly:
    - Secondary diagnosis(es) if related to an uncovered condition but has a bearing on the current hospital stay shall not be excluded from the DRG payment.
    - Providers shall refrain from coding a secondary diagnosis (es) that refer to an earlier episode that has no bearing on the current hospital stay, unless for chronic conditions and co-morbidities.
    - Diagnosis (es) not supported by coded services shall NOT be excluded by the Insurance companies during adjudication, as such diagnosis(es) might have an influence on the length of hospital stay, or increased nursing care and/or monitoring. However, if these diagnoses are identified as inaccurately coded during an audit, they may be subject to recovery.

4.4.2 Payment Calculations

Price For Basic Product, the Base Rate is AED 8,500; the Gap is AED 25,000 and the Marginal is 60%.

For all other products, Base Rate, Gap and Marginal must be negotiated in accordance with the terms of the Standard Provider Contract.

- Payers are liable to pay the complete DRG Base payment unless the case is eligible for outlier payment or qualifies for the split DRG payment rules.

4.4.2.1 Base Payment

- The Final Mandatory Tariff lists the relative weights. The exact base payment can be calculated by multiplying the base rate [x]by the relative weight of the DRG (rounded off to 4 decimals) and rounded off to the full AED

(no decimals) using the following formula:

Base payment = Base Rate * Relative Weight + (HCPCS) Add-on Payment

4.4.2.2 Outlier Payment

- Outlier payment acts as a "stop-loss" measure to protect providers from incurring losses while managing complex cases and is calculated as follows for Non-Mental Health Inpatient DRGs:

Outlier payment = (Cost – (Base Payment + Gap)) * Marginal.

- Cost for outlier will be established by using the Mandatory Tariff prices regardless of the product, and the cost of the HCPCS as previously defined.
- Services that can be excluded from the DRG / DRG outlier payment shall be limited to:
  - Claiming Errors and duplicate charges, using simple and complex edits as defined in the DoH adjudication standard.
  - "Medically impossible" charges: services that couldn't have been provided due to:
    - Patient gender restriction.
    - Patient age restriction.
    - Patient previous medical history.
  - Not-covered item under the insurance plan.
- For Mental Health Inpatient DRGs, the outlier is applicable for cases where the actual length of stay is greater than the High Trim for the DRG and is calculated as follows:

Outlier payment = (Actual LOS – High Trim) x (DRG RW/DRG ALOS) x Base Rate

  - Separate authorization requests shall be submitted for cases requiring outlier payment within 24 hours of the case exceeding the HTLOS.
  - The actual LOS used for the above formula should be rounded off to 2 decimal places.
  - The Activity.Net for Mental Health DRGs outlier payment shall be reported using SRVC Code 99-02.
  - Please refer to Appendix A for the list of DRGs eligible for the length of stay outlier.

4.4.2.3 Adjustor for Children and Adolescent Mental Health Services (CAHMS)

- The total payment for patients less than 18 years of age shall be increased by 50% of the total claim amount.
- The Activity.Net for the CAHMS adjustor payment shall be reported using SRVC code 99-03.
- Please refer to Appendix A for the list of DRGs eligible for the CAHMS adjustor.

4.4.2.4 Payment Calculation for Left Against Medical Advice

- Claims with EncounterEndType = 2 = Discharged against advice shall be reimbursed using the daily relative weight of the corresponding DRG of the encounter.
- The calculated payment shall not exceed the DRG allowed amount that would have been paid for the claim based on the billed activity lines and diagnosis.
- The payment shall be calculated using the following formula:

LAMA Payment = Actual LOS * (DRG RW/DRG ALOS) * Base Rate

- The actual LOS used for the above formula should be rounded off to 2 decimal places.
- The Activity.Net for the LAMA payment based on the above formula shall be reported using SRVCE Code 99-01.
- The specific DRG into which the case falls based on the reported activity lines and diagnosis shall be reported as activity line with Activity.Net set to "zero" value.
- Claims with EncounterEndType = 3 = Discharged absent without leave shall be reported with the Activity.Net set to "zero" value for all activities including the DRG.
- Reporting of Activity.Net for outlier and add-on payments shall not be applicable for EncounterEndType = 2 and EncounterEndType = 3.

4.4.2.5 Split of DRG payment for encounters involving more than one payer

Rules included in this section shall apply in the event of:

1. Inpatient encounters extending beyond the policy's expiry date and more than one payer is involved in reimbursement for a single inpatient encounter. Reimbursement for such encounter shall be per the following rules;
   a. Medical Cases (IM):
      - Irrespective of the Length of Stay (LOS) of the encounter, Payer 1 will be responsible for the total DRG Payment
   b. Surgical Cases (IP):
      - If the surgery leading to the surgical DRG, was performed within the Payer 1 coverage period and no subsequent surgeries took place post Member's Insurance Policy Expiry Date; Payer 1 will be responsible for the Total DRG Payment.
      - If the surgery leading to the surgical DRG, was performed after the Member's Insurance Policy Expiry Date, the payment split of such encounter shall be determined as follows;

Payer 1 Responsibility	Total DRG Payment*(X/Y)+ (((1-X/Y))* Total DRG Payment)*30%)
Payer 2 Responsibility	Total DRG Payment- Payer 1 Responsibility

      - Total DRG payment = DRG base payment + Outlier

        X = No: of days covered by Payor 1

Y = Total no: of days of the encounter (admission)

2. Newborn inpatient encounter that extends beyond one month coverage period through the mother's insurance
   - The cost of the Newborn treatment is to be billed separately from the mother's bill but using the mother's insurance coverage.
   - Claiming for the mother treatment will be using the mother's insurance details and mother member ID.
   - Claiming for the newborn treatment will be using the mother's insurance details; insurance carrier and insurance benefits, BUT using the newborn's unique member ID. Newborn's member IDs (temporary or permanent) are to be made available by the payers in a reasonable timeframe from the time the request for the member ID is initiated, by the healthcare provider.