DoH CLAIMS & ADJUDICATION RULES

Including the Mandatory Tariff Pricelist Application Rules.

دائـــــرة الـصـــحـــة

DEPARTMENT OF HEALTH

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Revision History

Version	Date	Comments
v25.0	01/01/2025	• Updated adjudication rules to reflect changes since the last version, including the transition to the 2021 codeset. • All addendums published since the last version and valid were incorporated. • This document applies to claims with "Encounter.Start" date of 1st January 2025 onward

1 Purpose and Scope

1.1 Document Purpose and Scope

Rules included in this document are built on the "Rules for Claiming under the Basic Product Pricelist" which was part of the previous Basic Product Pricelist (former description of the Mandatory Tariff file). Hence content of this document shall supersede any and all rules previous versions might have included.

This document complements the Mandatory Tariff pricelist; explaining its content and sets the claiming rules of its use for all encounters. Notwithstanding, the contents of this document shall not be viewed or utilized in isolation from:

1. Circulars and Standards published on DoH's website,
2. DoH's Data Standard,
3. Standard Providers Contract (SPC) provision and /or

In the event of any conflict between the content of this document and the Law and Rules and the aforementioned governance; the Law and Rules and the governance shall take precedence.

Also, the content of this document and the Mandatory Tariff Pricelist shall not cancel, limit, or contradict with any mandatory benefit defined as a minimum coverage by the Abu Dhabi health insurance law, and shall be interpreted within the context of law and the benefit of the insured.

The Mandatory Tariff pricelist and the rules included herein are applicable to all health insurance products regulated by the health insurance scheme.

It also applies to healthcare entities, providers and payers approved by DoH to participate in the health insurance scheme.

1.2 Mandatory Tariff Pricelist Purpose and Scope

- The Mandatory Tariff is the exhaustive pricelist for the Basic Product Plan.
- Mandatory prices correspond to the Gross Amount due to the healthcare providers for services performed for insured patients; Patients will need to pay a Patient Share while the payer is to pay the remaining Net Amount.
- The process of claiming shall not alter the benefits coverage for members, hence in the absence of a defined code for services, the closest unlisted code can be used for claiming services. An observation must be reported in the eClaim as defined in Routine reporting requirements published on Reporting - Shafafiya | Department of Health Abu Dhabi Reference = "UnlistedCodes".

1.3 Updates and Revisions

Future updates of the Mandatory Tariff and DoH Claims and Adjudication Rules will be published in the Shafafiya website https://www.doh.gov.ae/en/Shafafiya

The updates of the Mandatory Tariff & the Claims and Adjudication rule major update shall aim to:

- Incorporate standard codes: ICD-10-CM, CPT, CDA, HCPCS addition, deletion or description update released by AMA and CMS. And / or non-standard codes: Service Codes, released by DoH Healthcare Payer Sector.
- Wide-scale services and products prices update based on the revised CPT codes RVUs, Demand and Supply, Market Trends and other Economic Factors.

- Update the Claims & Adjudication Rules to align with the strategic objectives, latest claiming and adjudication practices and governance.

There might be **additional LIMITED/PERIODICAL updates** to the Mandatory Tariff Pricelist and / or DoH Claims & Adjudication Rules. The updates, or periodical addendums, shall be limited to:

- Update of the 3M™ International Refined Diagnosis Related Groups (IR-DRG) weights.
- Incorporate standard codes addition, deletion or description changes and / or non-standard codes; without affecting the unchanged codes prices.
- Limited-scale price update or pricing un-priced codes of supply, product or service, to accommodate changes in the market trends or other economic factors.
- Update of the Claims & Adjudication Rules.

Next limited/periodical updates schedule shall be established based on the recommendations by DoH in the future for this purpose. At all times, the last published pricelist and rules shall remain in effect.

2 Implementation Rules

2.1 Rules implementation

The rules included herein shall be utilized for billing, adjudication and reimbursement purposes for claims with "Encounter.Start" date of 1st January 2025 onward;

Where no rule existed in prior versions of the Claims and Adjudication rules, and only in the event both Providers and Payers mutually agree, rules included herein can be retroactively implemented.

2.2 Code Implementation

- New Codes (update status = <N>) shall be available for encounter with "Encounter.Start" equal or greater than the Code effective Date. Healthcare entities: providers and payers, shall have the choice to include or not include the new Codes in their contractual agreement that is in effect.
- Retired Codes (Update Status = <E>) shall be permitted to be used for encounters with "Encounter.Start" less or equal to the Code Expiry Date. Healthcare entities: providers and payers, shall not have the choice to use the retired codes after the expiry date.

2.3 Rates Implementation

2.3.1 Multipliers Ranges

For priced services and for all inpatient DRGs,

- For the Basic Product, the prices, DRG weights and IR DRG Base Rate listed in the most updated Mandatory Tariff version shall be implemented
- For the other Products, subject to section 2.4.2 of this document, services' prices shall be set by the parties between 1 and 3 times of the DoH Mandatory Tariff and the Basic Product DRG Base Rate. However, the DRG weight, shall be used as published and in effect on the agreement effective or renewal date.

For unpriced or unlisted code, healthcare entities:

- For all products, and unless otherwise stated, providers and payers must negotiate a reimbursement rate per service before concluding providing the service.
- If no specific charge is pre-negotiated, the provider must bill using the price of the most closely related drug, supply, product, procedure or service

2.3.2 Multipliers Application Rules

Medication/Drugs, blood and blood Products are not subject to 1 to 3 times the Mandatory Tariff range. Discount application on the Medication and Drugs shall follow DoH circular 20, dated March 12th 2009 and Ministry of Health circular number 89, and UAE FEDERAL LAW NO: 4, 1983. Dated 2004 on the retail; however remain subject to the free market dynamics and the provisions of the contractual arrangement between the healthcare entities.

For all services and codes, providers and payers are permitted to negotiate multipliers per service category (Laboratory, Radiology, etc.), or CPT codes range as outlined in section 6.2.2, but are not allowed to negotiate individual prices per service code. Multiplier must fall within the range of 1 to 3 times the Mandatory Tariff, and be in compliance with the following rules:

2.3.2.1 DRGs

- A single DRG Base Rate, per provider branch or all branches, and Insurance company single product, bundle of products, or all products.
- In the presence of TPA: A single DRG Base Rate, per provider branch or all branches, and the represented individual or all Insurance companies per single product, bundle of products, or all products.

2.3.2.2 CPTs

- Single multiplier for all CPT codes per Provider branch or all branches and Insurance company single product, bundle of products, or all products; In the presence of TPA: per Individual or all represented Insurance companies.
- Single multiplier per CPT range, as defined in section 6.2.2 of this document, per provider branch or all branches and Insurance company single Product, the bundle of products, or all products. In the presence of TPA: Individual or all represented Insurance companies.

2.3.2.3 Anesthesia codes

- Single Base Rate for all Anesthesia codes (00100-01999; 99100-99140), per provider branch or all branches, and Insurance company single product, and the bundle of products, or all products. In the presence of TPA: per Individual or all represented insurance companies.

2.3.3 Rate Update Implementation Options

Tariffs agreed between the Parties shall be as set out in the relevant appendix in the Standard Provider Contract using one of the following options:

- **Variable Rates:**
  - Using the price of the Mandatory Tariff in effect at the time of agreement with or without multiplier,
  - The reimbursement rates shall be subject to the periodic price updates (Increase / Decrease) published by DoH, while the multiplier will remain as negotiated.
  - The Government Subsidized Basic Product reimbursement rates shall always be set as Variable Rates, with a multiplier of 1.

- **Fixed Rates:**
  - Using the price of the Mandatory Tariff in effect at the time of agreement with or without multiplier, OR defined price per products or services; subject to price implementation rules.
  - The reimbursement rates shall not be subject to the periodic price updates (Increase / Decrease) published by DoH; and such, prices will remain unchanged throughout the contractual period despite any update to the Mandatory Tariff DoH published.
  - For this option to be utilized, the relevant Appendix in the SPC shall clearly state the Mandatory Tariff version in use, e.g. V2012.

At the time of renewal, and in the event that no negotiation was initiated, prices and DRG weights will follow the Mandatory Tariff in effect, while the multiplier and the DRG Base Rate shall remain constant.

2.4 Pay for Quality

For other products than Basic Products, Insurance companies and Providers can agree to include Pay for Quality indicators in Appendix (IV) of their agreement. Examples of types of indicators in Pay for Quality program:

1. **Clinical Outcome Quality Indicators**
   - Emergency Department visit to Admission ratio.
   - Hospital Acquired Diseases.
   - 30-day readmission
2. **Administrative / Process Quality indicators**
   - Rejection Rate.
   - Resubmission Rate.
3. **Customer Satisfaction.**
   - Patient Satisfaction rate.

If mutually agreed to be included in the contractual agreement, the Pay for Quality program must be compliant with the following requirement:

2.4.1 Parameters for P4Q Indicators

- *Must have a Meaningful Use.*
- ***Must have verifiable measurement,*** through external and independent source agreed by both parties or centrally available via the Health Authority.
- ***Cost / Revenue neutral to the insurance companies,*** whereby providers can obtain additional payment or reduction /refund of payment based on their performance against the performance of other providers offering the same service, but the net effect at the aggregate level must be cost/revenue neutral to the payer.
- Providers can offset reductions under one indicator by the good performance on other indicators; ***the net augmentation/reduction (additional payment or refund) shall be calculated against all the underlying indicators for which the provider was eligible***.
- Where possible, the principle of ***"one indicator for all categories"*** shall be applied. However P4Q indicators should align with the respective characteristics of the provider's category. E.g. readmission rates will only be measured in hospitals**.**

2.4.2 Application of Pay for Quality

- **Scoring.** P4Q indicators should be subject to scoring mechanisms irrespective of the size of the facility.
- **Eligibility.** Each indicator will have individual criteria for eligibility; i.e., "Overall patient satisfaction score" will be applicable only to hospitals that participated in the DoH patient survey.
- **Scope.** The outcomes supplement/reduction will be applicable to all invoices included in the encounter type pre-selected and has an "Encounter.Start" date within the agreed upon review period.

3 Code Definitions

3.1 Standard Codes

- Coding of healthcare products and services shall be in accordance with:
  - "DoH Coding Manual for Hospitals and Other Healthcare Institutions" available at DoH website Standards - Shafafiya | Department of Health Abu Dhabi, which includes:
    - ICD-10-CM (International Classification of Diseases, 9th revision) coding conventions,
    - CPT-4 (Current Procedural Terminology),
    - HCPCS (Healthcare Common Procedure Coding System),
  - IR-DRG codes rules as Defined by 3M,
  - Dental Codes (USC&LS) rules as established by the Canadian Dental Association, Unified System of Codes and List of Services,
  - DoH Drug Codes rules as set by DoH Pharma/ Medicines and Medical Products Department, including MOH registered drugs.
  - The Coding Rules as established by DoH for the non-standard "Service Codes" as listed in section 3.2 and section 6.2.1 of this document. and
- All standard codes are defined and available for download from https://www.doh.gov.ae/en/Shafafiya/prices under Prices/Mandatory Tariff. DoH has Emirate-wide licenses for all standard code sets.
- Non-standard codes are defined by DoH Healthcare Payer Sector to describe activity that is not unambiguously represented by an existing standard code.
- Selection and sequencing of diagnoses, service codes, procedures codes, dental codes or DRGs must meet the definitions of required data sets for applicable healthcare settings. Data Elements and DoH Data Standards and Procedures are defined in https://www.doh.gov.ae/en/Shafafiya/standards under Coding Manual.

3.2 Service Codes

Service Codes are Abu Dhabi specific codes defined by DoH Healthcare Payer Sector and added to describe an activity that is not unambiguously represented in other existing standard codes set.

The conclusive list of the DoH Service Codes, along with the codes long description, is set in section 6.2.1 of this document. A tabular set of the Service Codes is also found in the most updated version of the Mandatory Tariff.

4 Claiming Methodologies

4.1 Methodology per Encounter Type

4.1.1 Inpatient encounters

1. ***Inpatient***: Is a beneficiary registered and admitted to a hospital for bed occupancy for purposes of receiving healthcare services and is medically expected to remain confined overnight and for a period in excess of 12 consecutive hours.
2. Reimbursement of Inpatient encounters can follow one of the following methods;
    a. Fee for Service (FFS) methodology, as defined in section 4.2. Or
    b. Per diem (selected codes) with CPT, HCPCS, CDA and Drug Codes, as defined in section 4.3. Or
    c. Inpatient DRGs.
3. On January 1st 2013, IR-DRG will become the only acceptable method of claiming for inpatient encounters in the Emirate of Abu Dhabi for inpatient encounters; refer to circular 49 for implementation date.

4.1.2 Ambulatory Surgical Procedures or Same Day Surgery

1. Surgical interventions performed in Ambulatory Surgery Centers (ASCs) or Hospitals that are licensed/sublicensed, equipped, and operated primarily for the purpose of performing surgical procedures, and the beneficiary is medically expected to remain confined for 6 to 12 hours in a Day Care / Day Stay section of the facility, even if the patient remains in the facility past midnight.
2. Reimbursement of Ambulatory Service encounters can follow one of the following methods;
    a. Fee for Service (FFS) methodology, as defined in section 4.2. Or
    b. Per diem (selected codes) with CPT, HCPCS, CDA, and Drug Codes, as defined in section 4.3. Or
    c. Ambulatory DRGs.
3. For the Basic Product, Ambulatory Services shall be billed using the per diems methodology - as defined in Section 4.3. For all other products, the use of any or all of the above methodologies shall be permitted.
4. DoH, at its own discretion, might decide to activate the ambulatory section (in part or in full) of the DRG system or introduce a new prospective payment system that is analogous to the DRG system for the Ambulatory Services, following stakeholders' consultation and sufficient implementation time.

4.1.3 Outpatient encounters

Outpatient: is a beneficiary who has not been admitted *at that encounter* in the healthcare facility as an inpatient or ambulatory case, but is seen for diagnostic, therapeutic or observation services. Reimbursement of outpatient encounters can follow one of the following methods;

- Fee for Service (FFS) methodology, as defined in section 4.2. Or
- Per diem (selected codes) with CPT, HCPCS, CDA and Drug Codes, as defined in section 4.3.

All related services (excluding PBM claim) provided during the same day of an outpatient / emergency visit under the care of the same physician should be billed in a single claim.

Pre-anesthesia check-up visit for an inpatient surgery is not billed separately; it is included in the inpatient DRG.

4.2 Fee for Service

- "Fee for Service" model allows for services rendered to be separately billed and reimbursed, using the

available codes sets approved by DoH.

- For Basic Product members, payment using Fee for Service (FFS) will be limited to services rendered in outpatient and "ambulatory surgical" settings; for the services that are not included in the Per diem Codes definition, or have no claiming rule that restricts its reimbursement.
- HCPCs codes prices or negotiated rates are inclusive of the device / item costs, handling cost, and provider mark-up.
- In the absence of unbundling,[1] the Fee for Service (FFS) model allows for services to be coded and billed separately, subject to rules set by DoH or other acceptable coding references.
- Unless the code description or definition indicates the inclusion of other services, no code description or definition can be stretched by providers or payers to include other services that have distinctive and unambiguous defined codes.
- Following codes sets can be used for Fee for Service (FFS) claiming
  - **Service Codes:** Refer to section 6.2.1
  - **CPT codes (including anesthesia codes):** All CPT codes that are active and available for billing purposes.
  - **HCPCS:** All approved and active HCPCS codes.
  - **Dental codes:** All approved and active USC&LS codes.

4.2.1 Fee for Service - Special Claiming Rules

4.2.1.1 Evaluation and Management (E&M) Codes:

Department of Health Abu Dhabi mandates the use of Evaluation and Management codes for reimbursement of doctor's visits. Reimbursement of doctor visit, shall be in accordance with the following rules:

1. Facilities that have obtained JAWDA Data Certification will be included in the Shafafiya Certified Facilities List, along with their respective grades and the certification's validity period. These facilities can bill their Evaluation and Management (E&M) codes based on the DoH published criteria for reimbursing E&M, applying the rates stipulated in the mandatory tariff for Basic products and negotiated rates (ranging from 1 to 3 times the mandatory tariff) for other products.
2. Facilities without JAWDA Data Certification shall bill doctor's visits using the lowest level of the E&M code category, claiming the rate applicable for the lowest level of the respective E&M code category for the basic product. For all other products, they shall bill the negotiated rate for the lowest level of the respective E&M code category. Additionally, these facilities must report the correct E&M codes in a separate (additional) activity line with charges set at zero as a prerequisite for reimbursement.
3. Newly licensed facilities that do not have the required three months of billing history are exempt from the JAWDA Data certification requirement for the first six months from receipt of the first patient. These facilities, if they have a valid Process Flow Map and proof of certified and/or experienced coder(s) shall bill doctor's visits utilizing the E&M codes, applying the rates as specified in the mandatory tariff for Basic product and negotiated rates (1 to 3 times the mandatory tariff) for other products. However, if the JAWDA data Certification is not obtained by the end of the exemption period, the insurance companies have the right to reclaim any aggregate amount paid above the rate set for the uncertified providers.

[1] Unbundling: is the practice in which separate procedure codes are billed for procedures which are typically included as one code

4.2.1.2 Services Included in E & M Codes

- E&M codes may be used by all physicians and Clinicians;[2] subject to their scope of practice.
- Refer to the AMA coding guidelines and the DoH Coding Manual for proper selection of E&M level and services included in the E&M Codes.

4.2.1.3 E & M Services Not Separately Reimbursable

The following CPT-4 codes for E&M services are not separately reimbursable if billed for the same patient, for the same specialty[3] at the same facility or the same facility group[4] on the same date -or within the subsequent week- of service. In such cases, for the following combinations, reimbursement will be made only for the higher paying of the codes billed.

- New patient, office or other outpatient visit and another new patient, office or other outpatient visit.
- Established patient, office outpatient visit occurring within 7 days from the initial New/established patient, office or other outpatient visit.
- New or established patient, subsequent hospital care and new or established patient, initial inpatient consultation. Applicable only for the same date of service.
- New or established patient, initial hospital care and new or established patient, subsequent hospital care. Applicable only for the same date of service.
- Calculation of the "Follow up within one week" starts from and includes the day of visit (ActivityStart); and shall be billed using E&M code of an established patient codes 99211 to 99215 at "0" value.

4.2.1.4 Surgical CPT codes

- CPT Surgical Section codes represent the documented surgical procedure; however, by definition following services are always included in addition to the operation per se:
  - Local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia;
  - Subsequent to the decision for surgery, the same physician related E&M encounter on the date of the procedure (including history and physical);
  - Immediate postoperative care, including dictating operative notes, talking with the family and other physicians;
  - Writing orders;
  - Evaluating the patient in the post-operative recovery area;
  - Typical postoperative follow-up care.
- Surgical Codes do not include supplies and materials, Anesthesia, Operation Room charges or Recovery Room or any service not otherwise specified above.

4.2.1.5 Anesthesia Codes

This claiming guide provides you with the claiming criteria for anesthesia services provided by DoH-licensed physicians. For the Basic product and other products, if claiming using IR-DRG, Anesthesia codes are used for cost

[2] This refers to licensed healthcare professional as follows: 1. Registered school nurse 2. Registered nurse 3. Regaistered midwife 4. Optometrist 5. Podiatrists 7. Chiropractic Practitioner 8. Osteopathy practitioner

[3] Specialty refers to the "category" column in the DOH published list of Clinician licenses at Dictionary - Shafafiya | Department of Health Abu Dhabi (doh.gov.ae).

[4] A Healthcare Facility Group is a group of DoH Licensed Healthcare facilities that are under the same ownership(s) or under the same direct management and oversight of a headquarters.

reporting and outlier calculation. Following are the types of anesthesia eligible for separate claiming

- Inhalation
- Regional, including:
  - Spinal (low spinal, saddle block)
  - Epidural (caudal)
  - Nerves block (retro-bulbar, brachial plexus block, etc.)
  - Field block
- Intravenous
- Rectal

The following types of anesthesia services are not eligible for separate reimbursement:

- Anesthesia provided in conjunction with non-covered services
- Administration of anesthesia by the surgeon or assistant surgeon
- Moderate sedation
- Local anesthesia
- Standby anesthesia

Anesthesia time starts when the physician or anesthetist begins to prepare the patient for anesthesia care in the operating room or equivalent area and ends when the anesthesiologist is no longer in personal attendance, i.e., when the patient may be safely placed under postoperative supervision.

- Payment for the administration of anesthesia is based on the base unit value assigned to the procedure code, plus time units, multiplied by Base Rate.
  - **Base unit:** values have been assigned to each anesthesia procedure code and reflect the difficulty of the anesthesia service, including the usual preoperative and postoperative care and evaluation.
  - **Time Units:** Anesthesia time involves the continuous actual presence of the anesthesiologist. Time units are determined on the basis of one time unit for each 15 minutes of anesthesia, and provider's reports the total anesthesia time in minutes on the claim.

    Note: Time units are not recognized for code 01996 (daily management of epidural or sub-arachnoid drug administration).
- **Base Rate:** the fee schedule anesthesia conversion factor; 1 Unit = AED 66.
- Example of anesthesia reimbursement calculation:
  - Surgery Repair of Cleft Palate, Anesthesia time = 2 hours.
    - Code 00102 (Anesthesia Repair of Cleft Palate) base units = 6.
    - Time units = 8 = (120 anesthesia minutes /15 minutes Time Conversion)
    - Base Rate = AED 66 = (Mandatory Tariff X 1)
  - Total Reimbursement of Anesthesia = (6+8)*66 = AED 924.
- **Anesthesia for Multiple Surgical Procedures:** Payment can be made for anesthesia associated with multiple surgical procedures. Reimbursement is determined by the base unit of the anesthesia procedure with the highest base unit value and the total time units for the total operative session. Claiming should report the anesthesia procedure code with the highest base unit value and indicate the total time for all procedures.

- **Aborted Anesthesia Procedure:** When surgery is aborted after general anesthesia induction has taken place, payment may be made based on three base units plus time. Anesthesia must be reported using unlisted Procedure code 01999, in addition to the relevant anesthesia code. Refer to section 1.2 for claiming unlisted services.

4.2.1.6 Contrast and Radiopharmaceuticals Materials

When an imaging or therapeutic nuclear medicine procedure is performed, separate reimbursement for Radiopharmaceutical materials shall be permitted if reported on the same date of service with a CPT code that requires Contrast or Radiopharmaceutical materials.

The Imaging codes eligible for separate contrast reimbursement are those that have mention of "with contrast" within their code description; Or codes in which clinical review determined contrast or radiopharmaceutical materials were required in order to perform the service.

HCPCS radiopharmaceutical codes ranging from A9500 to A9699 and A4641, A4642 shall be used for billing Contrast and Radiopharmaceuticals Materials

INR monitoring device & supplies: HCPCS code G 0429 should be used to bill Home INR monitoring device & supplies.

4.2.1.7 Venipuncture and Injection Procedures

Venipuncture (36415) is denied or paid based on the circumstances in which it is provided. Payment for venipuncture is only permitted when the analysis of the sample drawn is performed at an external laboratory outside the healthcare facility or healthcare facility group.

Neither an injection procedure (96372-96379) nor a venipuncture (36415) should be reported with any diagnostic procedure code that involves the use of an intravenous contrast medium (e.g., do not report venipuncture code 36415 with 74400 for intravenous urography). These are considered incidental to the primary procedure.

4.2.1.8 Blood and blood products

In pursuant of Decree # 154 for 2017 of the UAE cabinet, Blood and Blood Products prices are fixed, therefore are NOT subject to 1-3 times the Mandatory Tariff range for all products, but rather reimbursable at the rate set in the Mandatory Tariff pricelist.

Blood and Blood Products prices are inclusive of Blood Unit cost, Cross Match, Antibodies Screening and Administration and handling cost.

4.2.1.9 Ophthalmology / Diagnostic eye exams

Ophthalmologist has the choice to utilize the following E&M codes for eye care provided:

- 99202 - 99205 Office or other outpatient services New patient
- 99211 - 99215 Office or other outpatient services Established patient
- 99241 - 99245 office consultations
- 99281 - 99288 emergency department services
- 92002 - 92014 General ophthalmological services

The physician should select the code that represents the service needed based on the patents presenting problem. The documentation should reflect the examination billed, which shall be in compliance with the criteria set by the AMA Guidelines and the Coding Manual.

4.2.1.10 Wound Care

When service provided is only a non-surgical cleansing of a wound without sharp debridement, with or without the application of a surgical dressing, the appropriate Evaluation and Management (E&M) codes should be used.

The selection of the E&M service should be supported by the documentation of the appropriate components; and the non-surgical cleansing of a wound will be considered bundled in the E&M reimbursements, and has no entitlement for separate payment.

If performed in the "Follow up within one week" period, non-surgical cleansing of a wound without sharp debridement might be separately reimbursable using the appropriate service codes (51-01, 51-02 and 51-03); for the following services appropriate CPT codes must be used: wound debridement, dressing for burns, and dressing change under anesthesia.

4.2.1.11 Telemedicine Services

As per the new payment model for telemedicine services CPT codes provided in section 6.2.3 will be utilized for telemedicine services provided by healthcare facilities. Please refer to section 6.2.3 for detailed description of the codes.

1. The telemedicine services shall be reported using Encounter Type = 10 Tele-Medicine.
2. For Encounter Type = 10, It is mandatory to report the outcome of telemedicine services by using the appropriate code in the EncounterEndType as follows:

    8 = Tele-Medicine resulting in Emergency Management
    9 = Tele-Medicine resulting in Prescription
    10 = Tele-Medicine resulting in Referral
    11 = Tele-Medicine resulting in Follow up
    12 = Tele-Medicine resulting in Self Care

3. Report only one of the above EncounterEndType elements when more than one outcome applies. This can be the "most complex" or highest code order with EncounterEndType= 8 being the highest code order representing the most complex outcome or EncounterEndType 12 = "Tele-Medicine resulting in Self Care" being the least complex outcome.
4. Eligibility check is required for all telemedicine services.
5. Except for the tele-counseling services (CPT Code 99446–99448), all telemedicine services must be patient initiated. Calls initiated by the provider to discuss test results and pharmacological counselling are not billable.
6. The use of the codes for telemedicine services for new patients is restricted to Family Physicians, Psychiatrists, and General Practitioners. The remaining specialties may only offer telemedicine services for established patients. For Thiqa members, Pediatric and Obstetrics & Gynecology Physicians will also be eligible to use the codes for telemedicine services for new patients.
7. Multiple tele-consultation services provided on the same day by the same facility to the same patient will only be paid once.
8. The time-based codes (CPT codes 99441-99443, 98966–98968, 99091, 99446–99448, 90832-90834, 90836-90838) shall be reported and billed based on the total time spent during a telemedicine service. It is required for the performing clinician to document the start and end time of the service. The total time spent should not include any waiting time or time spent due to technical issues.
9. The CPT codes 90791 & 90792 are only billed for initial assessments - lasting more than 30 minutes - of an illness or suspected illness. It is required for the performing clinician to document the start and end time of the

service. The total time spent should not include any waiting time or time spent due to technical issues.

10. For tele-psychiatry (psychotherapy) encounters with consultation, the performing physician is required to:
    - Document only the time spent for the actual psychotherapy session. Time spent during the consultation shall be excluded from the calculation / reporting of the total time spent during the psychotherapy session.
    - The consultation element of these encounters will be coded using CPT codes 99441– 99443 based on the total time spent for the consultation and will be used for reporting purposes only, billed charge = Zero.
11. Telemedicine services are not separately reimbursable if billed by the same facility for the same diagnosis and same specialty for below circumstances:
    - The service ends with a decision to see the patient face-to-face within 7 days.
    - Provided within 7 days from the initial office visit or telemedicine service.
12. The rate set shall include all relevant materials used to provide the telemedicine encounter. No separate payment shall be made for any other material including but not limited to hardware/equipment/videotapes and transmissions.
13. Preauthorization is required for all covered services ordered/prescribed as a result of the telemedicine service such as DMEs, medications, etc. according to the member's schedule of benefits.
14. All telemedicine providers are not eligible to separately bill for venipuncture when laboratory services are ordered as a result of the telemedicine service.

4.2.1.12 IPC Teleconsultation Program

International Patient Care Teleconsultation services should be reported with services codes 01-11-01 to 01-11-04 (please refer to section 6.2.1 for a detailed description of the codes)

- A Medical Board Approval is to be attached to the patient's file in order to confirm the eligibility.
- The time-based codes should be reported and billed based on the total time spent during an IPC teleconsultation. It is required for the performing physician to document either the start/end time of the service or the total time spent for the service. The total time spent should not include any waiting time or time spent due to technical issues.
- For a multidisciplinary IPC teleconsultation, a minimum of 2 codes is expected to be reported. The service of the primary provider will be reported using service code 01-11-02 and services performed by each additional provider will be reported with service code 01-11-03. Service code 01-11-03 should never be reported as a stand-alone code.
- The IPC teleconsultation encounter shall be reported with EncounterType = 1 = No Bed + No emergency room

4.2.1.13 National Biobank services

- The service codes for biobank services are 54-01, 54-02, 54-03, 54-04. Please refer to section 6.2.1 for a complete description of these service codes.
- These service codes shall be reported using EncounterType = 1 No Bed + No emergency room.
- The samples/specimens collected and processed shall be stored in the National Biobank for a
- period stated as per rules and regulations.
- The rate set shall include all activities mentioned in the code descriptions as well as the kits and consumables used in sample/specimen collection.

4.2.1.14 Ambulance transportation

4.2.1.14.1 Emergency Ambulance Transportation

Definition: Emergency ambulance transportation involves the transport of a patient in an emergency medical condition. The emergency ambulance service transports patients to the nearest appropriate healthcare facility and provides advanced medical care at the scene of the accident or medical emergency and during transport. An emergency medical condition is defined according to DoH Standard for Emergency Departments And Urgent Care Centers. [5]

4.2.1.14.1.1 Emergency transportation from an accident scene or medical emergency location to the hospital

When a patient is transported from an accident scene or any other medical emergency location, Ambulance providers can claim emergency transport services using the appropriate ambulance HCPCS codes, based on the most updated Mandatory Tariff and the relevant ambulance encounter type.

Healthcare providers who offer emergency ambulance transport services to transfer their inpatients or outpatients to another facility for continued care can claim the service by reporting it using the appropriate emergency ambulance HCPCS codes, in accordance with the most updated Mandatory Tariff.

4.2.1.14.2 Non-emergency Ambulance transportation

Definition: Non-emergency ambulance transportation involves transporting a patient who requires medical care or monitoring during transit but does not face an emergency medical condition as defined by the DoH Standard for Emergency Departments And Urgent Care Centers. This service is typically used for patients who need to be transported to or from medical appointments, hospital discharges, or transfers between facilities when their condition prevents them from traveling by other means and meets the eligibility criteria for the non-emergency ambulance transfer. Refer to section 6.1.1 for the Ambulance transfer diagram.

4.2.1.14.2.1 Eligibility Criteria for non-emergency Ambulance transfer:

The patient's health condition during the ground transport is such that use of any other method of transportation is contraindicated. The patient being transported is bed confined before and after the ambulance transportation. “Bed-confined” means the patient must meet all of the following three criteria:

- Unable to get up from bed without assistance.
- Unable to ambulate.
- Unable to sit in a chair (including a wheelchair) and could be moved only by stretcher

4.2.1.14.2.2 Documentation

All relevant patient records must appropriately document the necessity for ambulance transport. This includes records from the healthcare provider which must clearly justify why other forms of transportation would be unsafe or inadequate.

4.2.1.14.2.3 Patient transport to home after discharge:

When a patient needs to be transferred back to home after treatment is completed, the transport should meet the medical necessity requirement for non-emergency ambulance transfer.

This ambulance transport should be reported using HCPCS code A0428.

4.2.1.14.2.4 Interfacility transfer for continuation of treatment: (refer to the transfer policy)

When a patient meeting the eligibility criteria for non-emergency ambulance transfer is being transferred from one

[5] DoH Standard For Emergency Departments And Urgent Care Centers

healthcare provider to another for the continuation of treatment, the transferring facility should report this outbound transportation in the per diem claim with the HCPCS code A0428 with zero amount. This applies to all interfacility transfers under any setting.

4.2.1.14.2.5 Transport from home to hospital and back

If a patient meeting the eligibility criteria for non-emergency ambulance transfer needs to be transported by ambulance to receive outpatient hospital services like dialysis, blood transfusion, etc., and back to his/her home, the patient needs to contact the treating facility.

This ambulance transport is reported using the HCPCS code A0428.

4.3 Per diem

Codes that are defined as Per diem are:

- Subcategory 2.1: Room and Board
- Subcategory 2.2: Intensive Care.
- Subcategory 2.3: Nursery
- Subcategory 2.4: Special Care
- Subcategory 2.5: Long Term Stay
- Subcategory 2.6: Observation, Day Stay and other rooms
- Subcategory 2.7: Dialysis

Unless otherwise specified, all per Diem are daily all-inclusive and shall be inclusive of:

- Room and Board Charge, care equipment, and systems specific to the special room type.
- Evaluation and Management.
- Routine Nursing and medical supervision charges.
- All therapies (including respiratory therapy, all physiotherapy, nutritional therapy etc).
- Radiology tests excluding MRI, CAT Scans, and PET Scans.
- Laboratory tests.
- Anesthetist and anesthesia charges.
- Operation Room.
- Recovery Room.
- Drug/pharmaceuticals:
    - For other than long-term care: cost of a single drug that doesn't exceed AED 1000 in accumulative cost during the entire length of stay.
    - For Long Term Care: all drugs regardless of their cost.
- Products or supplies:
    - For other than long term care: Please see Special Rules under section 4.3.2
    - For Long Term Care: all consumables, products, and supplies regardless of their cost.

- For the Basic Product: all items which do not have a valid and covered code in the Mandatory Tariff pricelist.
- NICU, PICU, ICU, SCU, and SCBU are inclusive of all the above but are exclusive of radiology tests, laboratory tests, and all drugs.
- When reporting using Per Diem, providers can claim only the rate designated for the corresponding per diem code and any excluded services.
- Regarding services included within the per diem code, providers are obligated to accurately report the appropriate codes as activity lines, while maintaining charges at a value of zero as a prerequisite for reimbursement.
- Encounters containing per diem codes must include observations as delineated in the Routine Reporting Requirements published on Reporting - Shafafiya | Department of Health Abu Dhabi

The mandatory use of the per diem service code for the Basic Product, shall be limited to:

- **Ambulatory Services (medical and surgical):** Codes 25-01 and 25-02 for the patient medically expected to remain confined for 6 to 12 hours.
- **Outpatient assessment, examination, monitoring, treatment or therapy purposes:** Service code 24 for patients medically expected to remain confined for less than 6 hours.
- **Long Term Care (LTC):** Codes 17-13, 17-14, 17-15 and 17-16 – as defined. LTC Service Codes must be used in accordance to the DoH Standard for Provision of Long-Term Care.[6]
- **Inpatient Dental Care:** Limited to emergency cases only. Using the appropriate code of per diems with Sub-Category 2.1. Dental services not included in the per diem, must be billed as Fee-for-Service.

4.3.1 Transferred Cases

A transfer between acute inpatient hospitals occurs when a patient is admitted to a hospital and is subsequently transferred to another for continued treatment. Transfer Case definition doesn't apply to patients transferred to facilities or inter-hospital for Long Term Care.

Payment for transferred cases shall be in accordance with the following rules:

- The transferring facility should bill and receive payment for Per diem, using the designated Service Codes.
- The receiving facility shall receive payment IR-DRG payment.[7]
- Payment to the transferring hospital shall not exceed the DRG allowed amount that would have been paid for the claim based on the billed activity lines and diagnosis.
- If a transfer case qualifies as an outlier, the Insurance Company shall apply outlier payment method to the billed activity lines and payment to the transferring hospital shall not exceed the total amount of equivalent DRG and the calculated outlier.

For transferred patient encounters, data elements must be reported in accordance with the rules defined in DoH Data Standard for transferred cases, which include but are not limited to: "EncounterStartType," "EncounterTransferSource," "EncounterTransferDestination," and "EncounterEndType."

[6] For reference see the Long Term Care Standard at www.doh.gov.ae
[7] Refer to IR-DRG claiming methodology, for details.

4.3.2 Special Rules on HCPCS for Per diems other than long term care

4.3.2.1 General Rules:

- Per diems other than long term care shall be eligible for separate reimbursement of medically indicated supplies and devices represented by HCPCS codes.
- To be eligible for a separate reimbursement, the approved HCPCS code should represent a single item costing more than AED 1,500 and only the amount in excess of AED 1,500 shall be reimbursed separately.
- If applicable, all items eligible for separate reimbursement shall require preauthorization as per the existing Schedule of Benefits.
- For pre-assembled kits, reporting and billing of the individual items within the kit using the appropriate HCPCS codes is required.
- Providers are required to report as an observation note the details of the items for which any of the HCPCS codes are used for, such as description of the item, manufacturer name, product name, and gross price.
- Providers are required to submit the invoice of items to be reimbursed separately at claim level.

4.3.2.2 Rules for A4649:

A4649 shall only be used when no HCPCS code exists to accurately describe the item eligible for reimbursement. If A4649 is used, the above general rules shall apply for reimbursement.

An item billed using A4649 should meet all below requirements:

- The item is determined to be medically justified for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part.
- The item is an integral and subordinate part of the service furnished, is used for one patient only, comes in contact with human tissue or is surgically implanted or inserted via introduction into the human body though a surgically created incision.
- The item is not a pre-assembled kit comprising of items with specific HCPCS code.

4.4 IR-DRGs

4.4.1 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.[8]
- 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

[8] Reference: Circular 48: Schedule for Implementation of Payment System Updates.

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".[9]
- 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."[10]

- Member Share (Co-pays and deductibles) are not affected by the DRG payment system and should be 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.

[9] 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.
[10] 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.

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:

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.

4.4.2.3 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.

4.5 Bundled Payment Methodology

4.5.1 ART Related services

A. Service codes 70-01, 70-02, 70-03, 70-04, 70-05, 70-06, 70-07, 70-08, 70-09, 70-10, 70-11 are used for bundled reimbursement for successful IVF cycle (please refer to section 6.2.1 for detailed description, inclusions and exclusions of these codes).

4.5.1.1 Benefit-Related Billing Rules

Number of genetic testing – one test per cycle as per the eligibility mentioned in the DOH Policy on THIQA Coverage for Assisted Reproductive Treatment and Services.

4.5.1.2 Pricing-Related Billing Rules

- The service codes are reported with EncounterType = 1 (No Bed + No emergency room).
- Pre-authorization - Required for all the above service codes at the start of the cycle.
- All activities (services and procedures) shall be reported using the Per diem claiming methodology, as explained in section 4.3. of the DOH Claims and Adjudication Rules document.
- Providers shall only claim the rate set for the respective IVF service code and any excluded services. For the services that are included in the service code providers are required to report the proper codes as activity line but keep charges at a value of zero as a prerequisite for reimbursement.
- Transfer in between providers – Patient have the right to change the provider if not satisfied. However, the transfer should be encouraged after the completion of an entire package rather than interrupting the cycle of the treatment under the same package and the provider will be reimbursed as incomplete cycle and paid for

the successfully completed step(s) as per the service code specified for each step of the ART bundle.

- Reimbursement for transfer of frozen embryos to another provider – Provider completing the embryo transfer will be paid for the respective package and the provider that initiated the IVF cycle will be reimbursed as incomplete cycle and paid for the successfully completed step(s) as per the service code specified for each step of the ART bundle.
- Missing services/benefits - Reporting activity items included in each bundle is a prerequisite for payment. The claim has to be submitted after completing the cycle to allow reporting all expected and performed services.
- Pre-authorization will be revised when the cycle is incomplete and the claim shall be submitted billed with service codes as defined in section 3.
- Reimbursement of Successful Embryo Thawing and Egg Thawing of an incomplete cycle, will be paid using the related CPT codes and should be medically reasonable and clearly documented for reimbursement.
- Bundle package of frozen embryo cycle (07-02) should have prerequisite of availability of frozen embryos.
- Bundle package of frozen egg cycle (07-04) should have prerequisite of stored eggs.
- Bundle packages (70-01, 70-02, 70-03, 70-04, and 70-05) cannot be billed together. Each bundle must be authorized as per the rules above.
- Bundle package (70-11) can be added to bundle package (70-03) – frozen Embryo cycle and package (70-05) – frozen egg cycle, if the bundle is requested 6 months from the initial stimulation.
- Please refer to the Appendix 1 Diagram1 for the pictorial representation of Bundle 1 to Bundle 5

B. Service codes 70-12, 70-13, 70-14, 70-15, 70-16 & 70-17 and CPT codes 55899,54505, 54500, 55899 & S4028 are to be used for ART related services outside the IVF bundles (please refer to section 6.2.1 for a detailed description of these codes).

- The above codes shall be reported using the appropriate Encounter Type as per clinical criteria.
- Pre-authorization is required for all codes mentioned within this adjudication.
- For the purpose of ART services, codes 55899, 54505, 54500 shall be reported with mandatory observation fields using the procedure name of the codes as indicated above. Missing mandatory observation fields or deviation from the procedure name shall result to non-payment of the service.
- For the purpose of ART services, codes 55899, 54505, 54500 and S4028 are not bundled codes and shall be reported and billed using the appropriate billing methodology for the procedures indicated above.
- Service codes 70-13, 70-15 and 70-17 are considered as add-on codes for each additional embryo and shall only be reported and billed after the maximum number of embryos required for the respective parent codes 70-12, 70-14, 70-16 (up to 5 embryos) are fulfilled.

4.5.2 Bone Marrow transplant

- Service codes 22-01 to 22-08 should be used to bill a value-based bundle for Bone marrow transplants. For a detailed description of service codes, please refer to section 6.2.1.
- The service codes for Bundle codes 22-01, 22-04, 22-05 and 22-08 are reported with Encounter type = 1.
- Bundle codes 22-02, 22-03, 22-06 and 22-07 are reported with Encounter type = 3.
- Pre-authorization – Required for all service codes and excluded medication mentioned within this adjudication at the start of the treatment.
- Providers shall only claim the rate set for the respective service code and any excluded services.

- For the services that are included in the service code providers are required to report the proper codes as activity line but keep charges at a value of zero as a prerequisite for reimbursement.
- Missing services/benefits – Reporting activity items included in each bundle is a prerequisite for payment. The claim has to be submitted after completing the bundle to allow reporting of all expected and performed services.

4.5.3 Comprehensive screening Codes:

The IFHAS packages for comprehensive screening should be reported using service codes 52-21 to 52-33. Please refer to section 6.2.1 for detailed description of the service codes. The screening program codes 52-21 to 52-33 must be only reported with Encounter Type 7 =Nationals Screening. Refer to the table at the end of this section for the list of appropriate screening codes for each age group and gender.

- An observation must be reported in the eClaim with the use of Codes 52-21 to 52-33 as defined in Routine Reporting Requirements published on https://www.doh.gov.ae/en/Shafafiya/reporting.
- For the services that are included in the service codes, providers are required to report the codes as activity line at claims level but keep charges at a value of zero as a prerequisite for reimbursement.
- All activities within each screening package are required in order to bill for a comprehensive screening package service code, missing activities due to medical reasons would be accepted for payment purposes based on proper documentation.
- Reimbursement for codes 52-21 to 52-33 shall not be allowed with CPTs 99202-99215, 99401– 99412, 96160 and 99381-99387; if billed by the same facility, for the same patient, same principal diagnosis (Comprehensive Screening) on the same date of service.
- “E&M Follow up within one week” rule shall not be applicable to service codes 52-21 to 52- 33. Hence, reimbursement shall be allowed for subsequent Evaluation and Management office visit, if deemed medically necessary.
- Coding and reimbursement of subsequent services (as below) shall be based on the medical necessity determined by the initial screening outcomes or services prescribed by DOH comprehensive screening program standard. Whereby;
    - Preventive medicine counseling CPT codes (99401 – 99412, 96160) shall be allowed for patients with established medium to high risk factors and/or further investigation or diagnostic services on any abnormal finding detected from the screening services.
    - In the absence of established risk factor or for subsequent encounter after counseling was commenced, and where abnormal finding were detected; such encounters shall be billed and reimbursed using the E&M codes as a medical condition and not a preventive service.
- In case of duplication of tests between IFHAS and other screening programs under Thiqa within a period of 90 days, the cost of that test will be subject to recovery.
- Eligibility of the above codes will be as per the DOH Comprehensive Screening Program standard.

Expected Screening map per age & gender

Package Description	Code	Male			Female		
		Age 18-39-Year-old	Age 40-64-Year-old	Age 65-75-Year-old	Age 18-39-Year-old	Age 40-64-Year-old	Age 65-75-Year-old
Comprehensive Screening Major Package for male & female (age 18-39 years)	52-21	52-21			52-21		
Comprehensive Screening Major Package for male & female (age 40-64 years)	52-22		52-22			52-22	
Comprehensive Screening Major Package for male & female (age 65-75 years)	52-23			52-23			52-23
Comprehensive Screening Minor Package for male & female (age 65-75 years)	52-24			52-24			52-24
Comprehensive Screening Oral Health Package for male & female (age 18-75 years)	52-25	52-25	52-25	52-25	52-25	52-25	52-25
Colon Cancer Screening male & female (age 40-75 years)	52-26		52-26	52-26		52-26	52-26
Cervical Cancer Screening for female (age 25-29 years)	52-27				52-27 /52-28*		
Cervical Cancer Screening for female (age 30-65 years)	52-28					52-28	
Lung Cancer Screening for (High Risk) male & female (age 55-75 years)	52-29		52-29**	52-29**		52-29**	52-29**
Standalone Screening Mammography for female eligible groups based on PCSP standard	52-30					52-30	52-30
Standalone Screening Fecal immunochemical test (FIT) for eligible groups based on PCSP standard	52-31		52-31	52-31		52-31	52-31
Standalone Screening Abdominal Aortic Aneurysm for eligible groups based on PCSP standard	52-32			52-32			
Standalone Screening DEXA scan for eligible groups based on PCSP standard	52-33			52-33			52-33

** Cervical Cancer Package according to age (25-29 yrs. for Srv. 52-27) , (30-65 yrs. for Srv. 52-28)*

*** High risk only (heavy smokers) at CCAD*

5 Adjudication and Pre-authorizations Rules

5.1 General Rules

- DoH Health Insurance Adjudication Standard has established and mandates the Claims Adjudication Process and Rules for health insurance reimbursement in the emirate of Abu Dhabi. And applies to all Payers and Providers (together: "Healthcare Entities") approved by DoH to participate in the Health insurance scheme of Abu Dhabi.
- DoH Health Insurance Adjudication Standard is available at DoH website www.doh.gov.ae, Policies and Circulars Section: Reference HSF/CA/1.0, Approval Date Dec/2010.

5.2 Medically Unlikely Edit (MUE)

- Medically Unlikely Edit (MUE), defines the maximum units of service that can be provided to a single beneficiary on a single date of service for a given HCPCS or CPT code, many of which are based on medical and anatomical limitations.
- The following table illustrates how MUEs are described. In this example, CPT 44970, laparoscopic surgical appendectomy, has an MUE of 1, indicating this service may only be billed for a single patient once on a single date of service.

CPT Code	Descriptor	MUE Edit (maximum frequency of delivery in a single day)
44970	laproscopic, surgical, appendectomy	1

- Not all HCPCS or CPT codes have an MUE, and thus, the publicly available MUEs may not necessarily be comprehensive.
- A table of MUEs is included as a supplemental list in addition to the Mandatory Tariff Pricelist / Tab MUE based

on the current code set version used.

- Insurance companies and Providers opt to utilize the MUE for determination of inappropriate utilization / adjudication purposes; in such case, a clear indication of utilization of MUE will have to be stated in the Provider Manual section of the Standard Provider Contract.

5.3 Abu Dhabi Insurers Simple Edits.

- Simple Edits are required to be shared electronically with DoH and contracted providers on an ongoing basis. To respect the commercial confidentiality of these edits vis-a-vis other payers, DoH undertakes not to share these Edits with other Payers/Providers in their native attributed form.
- Following is the listing of the most commonly used simple edits used in the Emirate of Abu Dhabi:

(Reserved for Future Use)

5.4 Modifiers

5.4.1 Modifier (25)

Description: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

- E&M services rendered on the same date of service by the same facility, same clinician as that of a minor procedure, for the same principle diagnosis / chief complaint shall not be reimbursed separately. However:
  - A significant and separately identifiable E&M service unrelated to the decision to perform the minor procedure shall be separately reimbursable by reporting the E&M service with Modifier 25 if provided by the same physician on the same day as the minor procedure or service.
  - The physician must appropriately and sufficiently document both the E&M service and the minor
  - procedure in the patient's medical record to support the claim for these services.
  - Modifier 25 shall only be appended to E&M services and may be applicable with multiple E&M services.
  - Modifier 25 shall be reported as an observation field as defined in Routine Reporting requirements published at www.doh.gov.ae/shafafiya/reporting.
- Modifier 25 is applicable with the procedures listed in "modifier 25 relevant CPTs" sheet in the Routine reporting requirements published at www.doh.gov.ae/shafafiya/reporting

5.4.2 Modifier (52)

Description: Reduced Services

- It is intended to be used in Abu Dhabi when billing E&M CPT codes for follow up E&M visits occurring between day 8 to 14 of the initial E&M visit. The first E&M visit during this period will be paid at 50% of the contractual price. Any subsequent E&M visit during the same period will be paid at "0" value.
- This rule is applicable to all E&M visits for the same patient, for the same specialty at the same facility or the same facility group.
- In case the patient visits a clinician of different specialty but with privileges for the specialty of initial E&M visit, this shall be adjudicated as a subsequent E&M visit to a physician of same specialty.
- Modifier 52 must be reported as an observation field to E&M CPT codes as defined in Routine Reporting requirements published at www.doh.gov.ae/shafafiya/reporting to be eligible for the 50% reimbursement.

- Below groups and conditions are excluded from the applications of day 8 to 14 day follow up rules:
  - E&M visits for pediatric patients under 18 years.
  - E&M visits for senior patients above 60 years.
  - E&M visits for People of Determination.
  - E&M visits related or following IFHAS, other preventive screenings, and vaccination services.
  - E&M visit for Psychiatric conditions as performed by Psychiatrist only.
  - E&M visit for Pregnancy and Maternity related conditions.
  - Emergency E&M visits.

5.4.3 Modifier (24)

Description: Unrelated Evaluation and Management Service by the Same Physician during a Postoperative Period.

Modifier 24 is intended to be used in Abu Dhabi as per below rules:

- modifier 24 may be used for 100% reimbursement of unrelated E&M visits provided for the same patient, for the same specialty, at the same facility or the same facility group occurring within day 1 to 14 follow up period.
- The following are eligible for a 100% E&M payment while occurring within day 1 to 14 follow up period:
  - The subsequent E&M visit cannot be reasonably related or detected as part of the initial E&M visit, documentation of evidence and justification should be provided to avail reimbursement.
  - Referral to a subspecialist consultant in the same specialty for a second opinion (99241 99245).
  - E&M visits occurring within day 8 to 14 follow up period of an initial Emergency E&M visit.
- Modifier 24 must be reported as an observation field to E&M CPT code as defined in Routine Reporting requirements published at www.doh.gov.ae/shafafiya/reporting to be eligible for 100% reimbursement.

5.4.4 Modifier (50)

Description: Bilateral Procedure.

- Modifier 50 for bilateral surgical procedures to be used with procedures that occur on identical, opposing structures (e.g., eyes, shoulder joints, breasts).
- Modifier 50 is applicable with the procedures listed in “modifier 50 relevant CPTs” sheet in the Routine reporting requirements published at www.doh.gov.ae/shafafiya/reporting.
- Modifier 50 must be reported as an observation field to applicable procedure CPT codes listed in Appendix 1 as defined in Routine Reporting requirements published at www.doh.gov.ae/shafafiya/reporting to avail the adjusted reimbursement.

  If a procedure is eligible for the 150 % adjusted reimbursement for bilateral procedures, the procedure should be reported with modifier 50 and one service unit.

5.5 Hospital-Acquired Conditions (HACs)

Adjudication rules of IR-DRG claims with reported Hospital Acquired Conditions (HACs) which are not Present On Admission (POA) following the current codeset.

5.5.1 List of HACs

1. Foreign Object Retained After Surgery

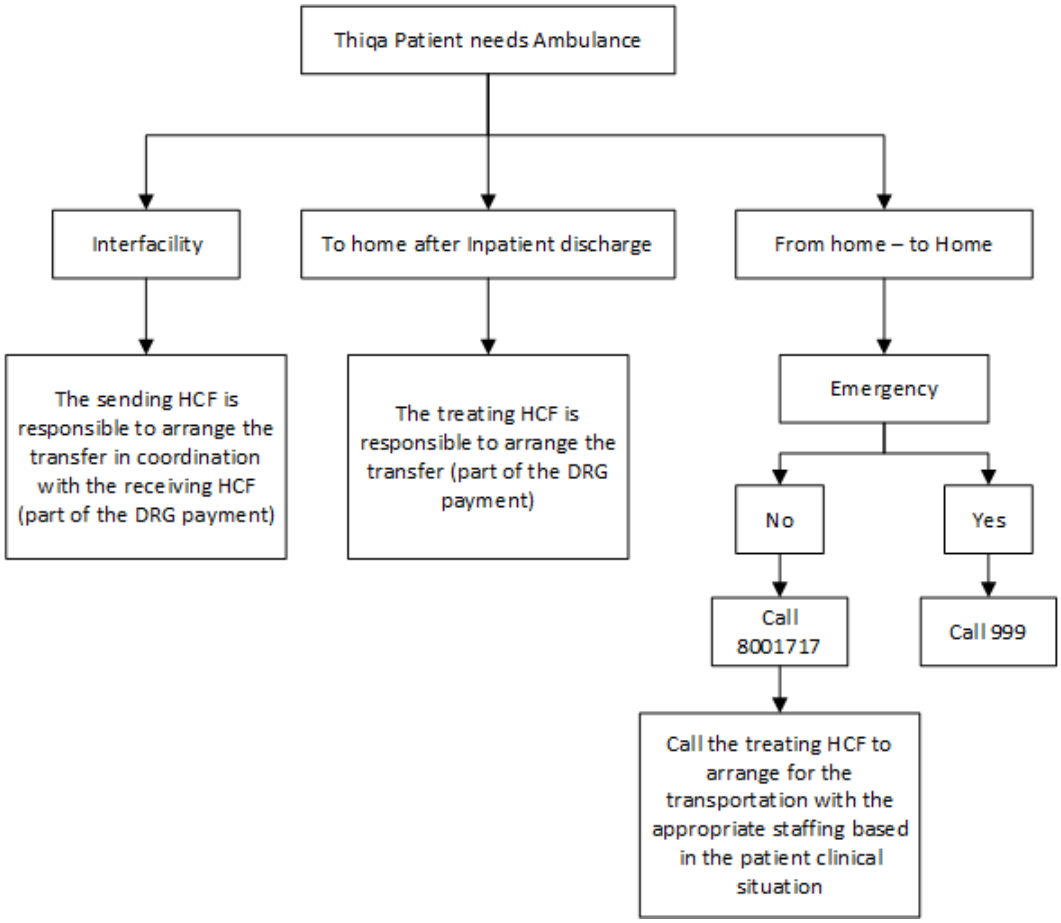
2. In-Hospital Fall and Trauma
3. Air Embolism
4. Blood Incompatibility
5. Stage III and IV Pressure Ulcers
6. Manifestations of Poor Glycemic Control
7. Catheter -Associated Urinary tract infection/UTI
8. Vascular Catheter-Associated Infection
9. SSI, Mediastinitis following Coronary Bypass Graft (CABG)
10. SSI following Bariatric Surgery for Obesity
11. SSI following Certain Orthopedic Procedures of Spine, Shoulder and Elbow
12. SSI following Cardiac Implantable Electronic Device (CIED) Procedures
13. DVT/PE following Total Knee or Hip Replacement
14. Iatrogenic Pneumothorax with Venous Catheterization
15. MRSA (Methicillin resistant Staphylococcus aureus)
16. Clostridium difficile (C.Diff)

- All diagnoses including the HACs shall be reported with the appropriate POA indicator in accordance with the Data Elements and as set out in the DoH Data Standards and Procedures (www.doh.gov.ae/shafafiya/dictionary). Please refer to section 6.2.4 for the full HAC list and POA (present on admission) Indicators.
- Providers shall not receive the higher payment for cases when one or a combination of the listed conditions is acquired during the hospitalization and has an impact on the IR-DRG severity.
- If IR-DRG severity level is affected by the listed HACs (higher severity), IR-DRG shall be grouped excluding HACs and claimed accordingly.
- Procedures related to the management of HACs shall be reported in the same claim as activity lines with Zero value but excluded from IR-DRG grouper calculation and payment.
- DRG outlier payment shall exclude activities (services, procedures, drugs, consumables etc.) related to the management of HACs.

6 Appendices

6.1 Appendix 1: Diagrams

6.1.1 Diagram 1 Ambulance transfer

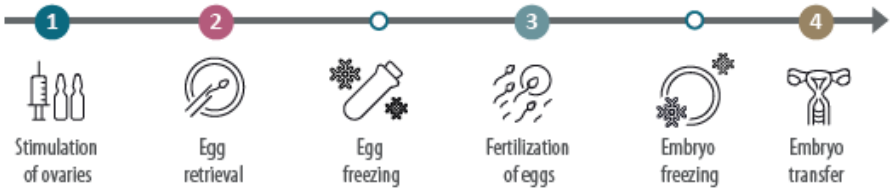


6.1.2 Diagram 2 DOH Claims & Adjudication Rules for bundle package for IVF services

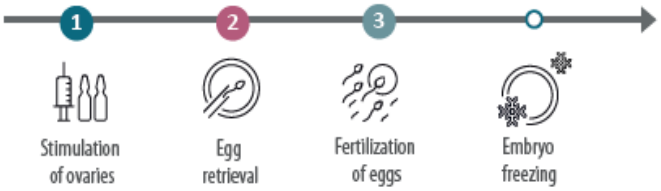
ANNEXURE – I

(DOH Claims & Adjudication Rules for bundle package for IVF services)

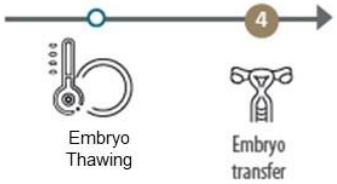
Bundle 1- Fresh Cycle



Bundle 2- Embryo Storage

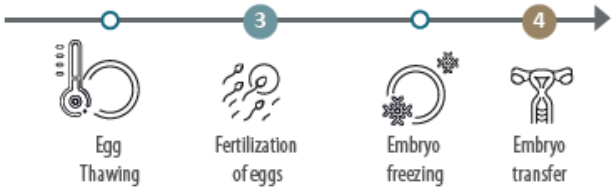


Bundle 3- Frozen Embryo Cycle



Bundle 4- Egg Storage

Bundle 5- Frozen Egg Cycle



6.2 Appendix 2: Tables

6.2.1 Table 1: Service Codes

Code	Code Short Description	Code Long Description
1. Accommodation		
Service Codes under the accommodation section are: Inclusive of room charge, routine nursing and medical supervision, care equipment and systems specific to a special room type, and all items which do not have a valid CPT or code. And Exclusive of Evaluation and Management, non-routine nursing and medical charges, operation room, all therapies (including respiratory therapy, all physiotherapy, nutritional therapy etc),drugs, diagnostic test, surgeon and anesthetist charges, and medical supplies unless specified otherwise.		
1.1 Room and Board		
17-01	Suite	Daily Room and Board charges for a single room (for the patient) plus one hall (for entertaining guests), each provided with a separate and fully accessible bathroom and inclusive of TV, fridge and seating's for visitors. Patient room is inclusive of a fully automated electric bed, adequate storage space for patient's personal belongings, special table for patient food, medical gases, vacuum, air and suction as well as other features associated with bedside and/or mobile charting, nurse server amenities, access to a private phone and medical specialty based comfort.
17-02	VIP Room	Daily Room and Board charges for a single room with a single fully accessible bathroom accompanied with exclusive measurements for minimal disturbances. Inclusive of a fully automated electric bed, adequate storage space for patient personal belongings, special table for patient food, medical gases, vacuum, air and suction as well as other features associated with bedside and/or mobile charting, nurse server amenities, access to a private phone, TV, fridge and saloon chairs for visitors.
17-03	First Class Room	Daily Room and Board charges for a single room with a single fully accessible bathroom accompanied with exclusive measurements for minimal disturbances. Inclusive of a fully automated electric bed, adequate storage space for patient personal belongings, special table for patient food, medical gases, vacuum, air and suction as well as other features associated with bedside and/or mobile charting, nurse server amenities, access to a private phone, TV, fridge and normal chairs seating arrangement for visitors.
17-04	Shared Room	Daily Room and Board charges for a single room with a single fully accessible bathroom and accommodating 2 single patient beds. Privacy of each bed area is maintained by a segregating screen or curtain and is inclusive of a fully automated electric bed, adequate storage space for the patient's personal belongings, special table for patient food, medical gases, vacuum, air and suction as well as other features associated with bedside and/or mobile charting, nurse server amenities and access to a private phone, TV fridge and seating arrangement for visitors.

17-05	Ward	Daily Room and Board charges for a single bed in a room accommodating three patients or more. Privacy of each bed area is maintained by a segregating screen or curtain and is inclusive of adequate storage space for the patient's personal belongings, special table for patient food, medical gases, vacuum, air and suction as well as other features associated with bedside and/or mobile charting, nurse server amenities and access to a private phone and seating arrangement for visitors.
17-06	Royal Suite	Daily Room and Board charges for a single room (for the patient) plus 1 or more rooms (for guests), provided with 2 or more separate bathrooms. Inclusive of all possible items for luxury and all possible measurements taken for privacy and exclusivity. Patient room is inclusive of a fully automated electric bed, adequate storage space for personal belongings, special table for patient food, medical gases, vacuum, air and suction as well as other features associated with bedside and/or mobile charting, nurse server amenities and access to a private phone.
17-10	Isolation Room	Daily Room and Board charges for a single bed in a room accommodating one patient or more. Fully equipped to prevent the spread of an infectious agent from an infected or colonized patient to susceptible persons. Inclusive of all of protective barriers and mechanical measurements taken for maintaining isolation.
17-08	Private Room Deluxe	Retired
17-09	Private Room Standard Suite	Retired
1.2.	Special Care	
29	Special Care Unit (SCU) or Adult Special-Care Unit (ASCU)	Daily Room and Board charges for the bed occupied by registered adult patient with a need for extra help but not critically ill.
30	Special Care Baby Unit (SCBU)	Daily Room and Board charges for the bed occupied by registered neonate patient (0 to 30 days of age) who is not premature or critically ill but with a need for extra help.
1.3.	Nursery	
32	Nursery - General Classification	Daily Room and Board charges for a registered healthy neonate (0 to 30 days of age), who incurs overnight stay for daily room and board in a hospital nursery.
1.4.	Intensive Care	
27	Intensive Care Unit (ICU)	Daily Room and Board charges for the bed occupied by a registered patient requiring intensive medical care in an Intensive care unit.
27-01	Coronary Care Unit (CCU)	Daily Room and Board charges for the bed occupied by a registered patient requiring intensive cardiac medical care in a coronary care unit.
28	Neonatal Intensive Care Unit (NICU)	Daily Room and Board charges for the bed occupied by registered premature and/or critically ill neonate patient (0 to 30 days) requiring intensive medical care in an Intensive care unit.
31	Pediatric intensive care Unit (PICU)	Daily Room and Board charges for the bed occupied by registered pediatric patient (1 month to 15 years of age) requiring intensive medical care in an Intensive care unit.
1.5	Other Rooms	
17-21	Emergency Room - Hourly Rate	Hourly rate for the bed / room occupied by registered patient in a hospital or clinic, staffed and equipped to provide emergency care to patient requiring immediate medical treatment.

17-22	Short Stay Room - Hourly Rate	Hourly rate for the bed / room occupied by registered patient who is medically expected to remain confined for less than 6 hours, and equipped with one or more beds; in a patient care unit for the purpose of : Assessment, examination, monitoring purposes. For treatments or therapy requiring special equipment, such as removing sutures, draining a hematoma, packing a wound, or performing an examination.
17-23	Recovery Room - Hourly Rate	Hourly rate for the bed / room occupied by registered patient equipped with one or more beds; in a patient care unit which is designated for monitoring post-surgery or post anesthesia patients.
17-24	Short Stay - Daily Rate	Daily rate for the bed / room occupied by registered patient for assessment, examination, monitoring, therapy or Non-invasivE&Minor procedure for a registered patient: Medically expected to remain confined for less than 6 hours; In a Day Care / Day Stay section of the facility, or a patient care unit equipped with one or more beds; Regardless of the hour of admission, and even if the patient remains in the facility past midnight.
17-25	Day Stay (Day care) - Daily Rate	Daily rate for the bed / room occupied by registered patient for assessment, examination, monitoring, therapy, procedure or surgery (major or minor) for a registered patient: Medically expected to remain confined for 6 to 12 hours; In a Day Care / Day Stay section of the facility, or a patient care unit equipped with one or more beds; Regardless of the hour of admission, and even if the patient remains in the facility past midnight.
2	Per-diems	
Refer to section 4.4 of the Claims and Adjudication Rules for the service included in the Per diem codes.		
2.1	Room and Board	
1	Ward or Shared Room - Daily Rate (Day 1 to 3)	Daily all inclusive (as defined in section 4.4) rate for three days or less of hospital confinement in Ward or Shared Room. Ward or Shared Room specifications are as defined accommodation section, Service code 17-04 and 17-05.
2	Ward or Shared Room - Daily Rate (Day 4 to 8)	Daily all inclusive (as defined in section 4.4) rate for four to eight days of hospital confinement in Ward or Shared Room. Ward or Shared Room specifications are as defined accommodation section, Service code 17-04 and 17-05.
3	Ward or Shared Room - Daily Rate (Day 8 and more)	Daily all inclusive (as defined in section 4.4) rate for eight or more days of hospital confinement in Ward or Shared Room. Ward or Shared Room specifications are as defined accommodation section, Service code 17-04 and 17-05.
3-01	Per Diem Room Rate difference - Daily Rate - Suite	Daily room rate difference between Ward or Shared Room, and Suite room. Situational code: only billable with Service Codes 1,2 and 3. Code is inclusive only of the Room and Board charge difference for a Suite Room, as defined in Accommodation section, Service code 17-01.
3-02	Per Diem Room Rate difference - Daily Rate - VIP Room	Daily room rate difference between Ward or Shared Room and VIP Room. Situational code: only billable with Service Codes 1,2 and 3. Code is inclusive only of the Room and Board charge difference for a VIP Room, as defined in Accommodation section, Service code 17-02.

3-03	Per Diem Room Rate difference - Daily Rate - First Class Room	Daily room rate difference between Ward or Shared Room and First Class Room. Situational code: only billable with Service Codes 1,2 and 3. Code is inclusive only of the Room and Board charge difference for a First Class Room, as defined in Accommodation section, Service code 17-03.
3-06	Per Diem Room Rate difference - Daily Rate - Royal Suite	Daily room rate difference between Ward or Shared Room and Royal Room. Situational code: only billable with Service Codes 1,2 and 3. Code is inclusive only of the Room and Board charge difference for a Royal Room, as defined in Accommodation section, Service code 17-06.
3-10	Per Diem Room Rate difference - Daily Rate - Isolation Room	Daily room rate difference between Ward or Shared Room and an Isolation Room. Situational code: only billable with Service Codes 1,2 and 3. Code is inclusive only of the Room and Board charge difference for a Royal Room, as defined in Accommodation section, Service code 17-10.
17-17	Per Diem - Category 17	Retired Code
17-18	Per Diem - Category 18	Retired Code
17-19	Per Diem - Category 19	Retired Code
17-20	Per Diem - Category 20	Retired Code
2.2	Intensive Care	
5	NICU - Daily Rate (Day 1 to 7)	Daily all inclusive (as defined in section 4.4) rate for day one to seven of hospital confinement of registered premature and/or critically ill neonate patient (0 to 30 days of age) in Neonatal Intensive Care Unit (NICU). NICU specifications are as defined in accommodation section, Service code *28*.
6	NICU - Daily Rate (Day 8 to 14)	Daily all inclusive (as defined in section 4.4) rate for day eight to fourteen of hospital confinement of registered premature and/or critically ill neonate patient (0 to 30 days of age) in Neonatal Intensive Care Unit (NICU). NICU specifications are as defined in accommodation section, Service code *28*.
7	NICU - Daily Rate (Day 15 to 21)	Daily all inclusive (as defined in section 4.4) rate for day fifteen to twenty one of hospital confinement of registered premature and/or critically ill neonate patient (0 to 30 days of age) in Neonatal Intensive Care Unit (NICU). NICU specifications accommodation section, Service code 28.
8	NICU - Daily Rate (Day 22 and more)	Daily all inclusive (as defined in section 4.4) rate for day twenty two to discharge of hospital confinement of registered premature and/or critically ill neonate patient (0 to 30 days of age) in Neonatal Intensive Care Unit (NICU). NICU specifications are as defined in accommodation section, Service code 28.
17-07	PICU - Daily Rate (Day 1 to 7)	Daily all inclusive (as defined in section 4.4) rate for day one to seven of hospital confinement of registered premature and/or critically ill pediatric patient (1 month to 15 years of age) in Special Pediatric Intensive Care Unit (PICU). PICU specifications are as defined in accommodation section, Service code 31.
17-07-01	PICU - Daily Rate (Day 8 to 14)	Daily all inclusive (as defined in section 4.4) rate for day eight to fourteen of hospital confinement of registered and critically ill pediatric patient (1 month to 15 years of age) in Special Pediatric Intensive Care Unit (PICU). PICU specifications are as defined in accommodation section, Service code 31.

17-07-02	PICU - Daily Rate (Day 15 to 21)	Daily all inclusive (as defined in section 4.4) rate for day fifteen to twenty one of hospital confinement of registered and critically ill pediatric patient (1 month to 15 years of age) in Special Pediatric Intensive Care Unit (NICU). NICU specifications are as defined in accommodation section, Service code 31.
17-07-03	PICU - Daily Rate (Day 22 and more)	Daily all inclusive (as defined in section 4.4) rate for day twenty two and more of hospital confinement of registered and critically ill pediatric patient (1 month to 15 years of age) in Special Pediatric Intensive Care Unit (PICU). PICU specifications are as defined in accommodation section, Service code 31.
4	ICU/CCU - Daily Rate (Day 1 to 7)	Daily all inclusive (as defined in section 4.4) rate for day one to seven of hospital confinement of registered and critically ill patient (more than 15 years of age) in Intensive Care Unit (ICU). ICU specifications are as defined in accommodation section, Service code 27.
4-01	ICU/CCU - Daily Rate (Day 8 to 14)	Daily all inclusive (as defined in section 4.4) rate for day eight to fourteen of hospital confinement of registered premature and/or critically ill patient (more than 15 years of age) in Intensive Care Unit (ICU). ICU specifications are as defined in accommodation section, Service code 27.
4-02	ICU/CCU - Daily Rate (Day 15 to 21)	Daily all inclusive (as defined in section 4.4) rate for day fifteen to twenty one of hospital confinement of registered and critically ill pediatric patient (more than 15 years of age) in Intensive Care Unit (ICU). ICU specifications are as defined in accommodation section, Service code 27.
4-03	ICU/CCU - Daily Rate (Day 22 and more)	Daily all inclusive (as defined in section 4.4) rate for day twenty two and more of hospital confinement of registered and critically ill pediatric patient (more than 15 years of age) in Intensive Care Unit (ICU). ICU specifications are as defined in accommodation section, Service code 27.
2.3 Nursery		
17-12	Newborn Nursery (Day 1 to 3)	Daily all inclusive (as defined in section 4.4) rate for day one and three of hospital confinement of registered healthy neonate patient (0 to 30 days of age) in a hospital nursery. Hospital nursery specifications are as defined in accommodation section, Service code 32.
17-12-01	Newborn Nursery (Day 4 to 8)	Daily all inclusive (as defined in section 4.4) rate for day four and eight of hospital confinement of registered healthy neonate patient (0 to 30 days of age) in a hospital nursery. Hospital nursery specifications are as defined in accommodation section, Service code 32.
17-12 -02	Newborn Nursery (Day 9 and more)	Daily all inclusive (as defined in section 4.4) rate for day nine and more of hospital confinement of registered healthy neonate patient (0 to 30 days of age) in a hospital nursery. Hospital nursery specifications are as defined in accommodation section, Service code 32.
2.4 Special Care		
18	SCU (Day 1 to 3)	Daily all inclusive (as defined in section 4.4) rate for day one and three of hospital confinement of registered adult patient who is not critically ill but is requiring of special medical attention in a Special Care Unit. Special Care Unit specifications are as defined in accommodation section, Service code 29.
18-01	SCU (Day 4 to 8)	Daily all inclusive (as defined in section 4.4) rate for day four and eight of hospital confinement of registered adult patient who is not critically ill but is requiring of special medical attention in a Special Care Unit. Special Care Unit specifications are as defined in accommodation section, Service code 29.

18-02	SCU (Day 9 and more)	Daily all inclusive (as defined in section 4.4) rate for day nine and more of hospital confinement of registered adult patient who is not critically ill but is requiring of special medical attention in a Special Care Unit. Special Care Unit specifications are as defined in accommodation section, Service code 29.
19	SCBU (Day 1 to 3)	Daily all inclusive (as defined in section 4.4) rate for day one and three of hospital confinement of registered neonate patient (0 to 30 days of age) who is not critically ill but is requiring of special medical attention in a Special Care Baby. Special Care Baby Unit specifications are as defined in accommodation section, Service code 30.
19-01	SCBU (Day 4 to 8)	Daily all inclusive (as defined in section 4.4) rate for day four and eight of hospital confinement of registered neonate patient (0 to 30 days of age) who is not critically ill but is requiring of special medical attention in a Special Care Baby. Special Care Baby Unit specifications are as defined in accommodation section, Service code 30.
19-02	SCBU (Day 9 and more)	Daily all inclusive (as defined in section 4.4) rate for day nine and more of hospital confinement of registered neonate patient (0 to 30 days of age) who is not critically ill but is requiring of special medical attention in a Special Care Baby. Special Care Baby Unit specifications are as defined in accommodation section, Service code 30.
2.5	Long Term Stay	
17-13	Long Term Stay (Simple Cases)	Daily all inclusive (as defined in section 4.4) rate of hospital/nursing home confinement of registered patient who fall under the category of simple cases as defined by the DoH Long Term Care Standard.
17-14	Long Term Stay (Intermediate Cases)	Daily all inclusive (as defined in section 4.4) rate of hospital/nursing home confinement of registered patient who fall under the category of Intermediate cases as defined by the DoH Long Term Care Standard.
17-15	Long Term Stay (Intensive Cases)	Daily all inclusive (as defined in section 4.4) rate of hospital/nursing home confinement of registered patient who fall under the category of Intensive cases as defined by the DoH Long Term Care Standard.
17-16	Long Term Stay (Severe Cases)	Daily all inclusive (as defined in section 4.4) rate of hospital/nursing home confinement of registered patient who fall under the category of Severe cases as defined by the DoH Long Term Care Standard.
2.6	Short Stay, Day Stay and other rooms	
15	Perdiem - Treatment or Observation Room - NOT inclusive of Laboratory and Radiology	Retired Code
16	Perdiem - Day Stay (Day Care) Room – NOT inclusive of Laboratory and Radiology	Retired Code
24	Perdiem - Short Stay	Daily all inclusive (as defined in section 4.4) rate for services provided for assessment, examination, monitoring, treatment or therapy purposes for a registered patient: Medically expected to remain confined for less than 6 hours; In a patient care unit equipped with one or more beds. Regardless of the hour of admission, and even if the patient remains in the facility past midnight.
25	Perdiem - Day Stay (Day care) - Inclusive.	Retired Code

25-01	Perdiem-Day Stay - Medical Case	Daily all inclusive (as defined in section 4.4) rate for assessment, examination, monitoring, therapy or Non-invasivE&Minor procedure for a registered patient: Medically expected to remain confined for 6 to 12 hours; In a Day Care / Day Stay section of the facility, or a patient care unit equipped with one or more beds; Regardless of the hour of admission, and even if the patient remains in the facility past midnight.
25-02	Perdiem-Day Stay - Surgical Case	Daily all inclusive (as defined in section 4.4) rate for assessment, examination, monitoring, therapy; including pre-, intra and post- operative care-provided in the same day- of major procedures or surgical interventions provided for a registered patient: Medically expected to remain confined for 6 to 12 hours;. In a Day Care / Day Stay section of the facility, or a patient care unit equipped with one or more beds. Regardless of the hour of admission, and even if the patient remains in the facility past midnight.
2.7 Dialysis		
14-01	Per Diem- Hemodialysis (HD).	Daily all inclusive rate for out-patient hemodialysis in a dialysis center provided for a registered patient. Inclusive of: • In-center initial and routine patient assessment by a clinician (doctor, nurse or qualified technician) prior to, during or after dialysis treatment. • Professional charge for performance of hemodialysis. • Patient and family education and support concerning renal disease, dialysis treatment, diet, lifestyle and social aspects. • Usage of equipment required for the performance of the Hemodialysis. • All disposable products and supplies required for the performance of the Hemodialysis. • Medical supervision (on-site or remote) of the dialysis by qualified physician • Pharmaceuticals routinely required in the performance of the dialysis treatment • Routine investigations and diagnostic tests recommended for patient on hemodialysis treatment.

14-02	Per Diem- Automated Peritoneal Dialysis (APD).	An all-inclusive monthly rate, triggered by an individual out-patient *"Automated Peritoneal Dialysis"* encounter, provided in a dialysis center for a registered patient. Inclusive of: • In-center initial and routine patient assessment by a clinician (doctor, nurse or qualified technician) prior to, during or after treatment, and/or Patient training, retraining and family education for self-administration of Automated Ambulatory Peritoneal Dialysis, as well as education and support concerning renal disease, dialysis treatment, diet, lifestyle and social aspects • Rental of equipment required for the performance of the Automated Peritoneal Dialysis, for a full month. • All disposable products and supplies required for the performance of the Automated Peritoneal Dialysis, for a full month. • Medical supervision (on-site or remote) of the dialysis by qualified clinicians. • Pharmaceuticals routinely required in the performance of the Automated Peritoneal Dialysis treatment, for a full month. • Routine investigations and diagnostic tests recommended for patient on Automated Peritoneal Dialysis treatment.
14-03	Per Diem-Continuous Ambulatory Peritoneal Dialysis (CAPD).	An all-inclusive monthly rate, triggered by an individual out-patient *"Continuous Ambulatory Peritoneal Dialysis"* encounter, provided in a dialysis center for a registered patient. Inclusive of: • In-center initial and routine patient assessment by a clinician (doctor, nurse or qualified technician) prior to, during or after treatment, and/or • Patient training, retraining and family education for self-administration of Continuous Ambulatory Peritoneal Dialysis, as well as education and support concerning renal disease, dialysis treatment, diet, lifestyle and social aspects • All disposable products and supplies required for the performance of the dialysis treatment, for a full month. • Medical supervision (on-site or remote) of the dialysis by qualified clinicians. • Pharmaceuticals routinely required in the performance of the Continuous Ambulatory Peritoneal Dialysis treatment, for a full month • Routine investigations and diagnostic tests recommended for patient on Continuous Ambulatory Peritoneal Dialysis treatment
3. Consultations		
9	Consultation GP	Code Retired
9.1	Consultation GP – Follow up	Code Retired
10	Consultation Specialist	Code Retired
10.1	Consultation Specialist – Follow up	Code Retired
11	Consultation Consultant	Code Retired
11.1	Consultation Consultant – Follow up	Code Retired
21	Home visit - G.P consultation	Code Retired
22	Home visit - Specialist consultation	Code Retired
23	Home visit - Consultant consultation	Code Retired

4.	Operating Room Services	
20	Operating Room Services – General Classification	Operating room inclusive of the Pre-medication room, Operating block, Anesthesia substance (consumables, gases etc), sterilization, respiratory and cardiac support, and emergency resuscitative devices, patient monitors, diagnostic tools, all consumables and drugs. Not inclusive of the anesthetist Doctor charge.
20-01	Operating Room - Minor Surgery	Operating room for a simple or minor procedure inclusive of the Pre-medication room, Operating block, Anesthesia substance (consumables, gases etc), sterilization, respiratory and cardiac support, and emergency resuscitative devices, patient monitors, diagnostic tools, all consumables, operation room's devices and drugs utilized in the operation room. Not inclusive of the anesthetist Doctor charge.
20-02	Operating Room - First Hour	Operating room for complex procedure or surgery, first hour rate. • Inclusive of the Pre-medication room, Operating block, Anesthesia substance (consumables, gases etc), sterilization, respiratory and cardiac support, and emergency resuscitative devices, patient monitors, diagnostic tools, all consumables, operation room's devices and drugs utilized in the operation room. • Not inclusive of the anesthetist Doctor charge.
20-03	Operating Room - Every Additional 1/2 hour	Operating room for complex procedure or surgery, every additional ½ hour. • Can only be billed with code 20.02. • Inclusive of the Pre-medication room, Operating block, Anesthesia substance (consumables, gases etc), sterilization, respiratory and cardiac support, and emergency resuscitative devices, patient monitors, diagnostic tools, all consumables, operation room's devices and drugs utilized in the operation room. • Not inclusive of the anesthetist Doctor charge.
20-04	Catheterization Lab	Catheterization Lab room for complex cardiac procedure or surgery. • Inclusive of the Pre-medication room, Operating block, Anesthesia substance (consumables, gases etc), sterilization, respiratory and cardiac support, and emergency resuscitative devices, patient monitors, diagnostic tools, all consumables, operation room's devices and drugs utilized in the operation room. • Not inclusive of the anesthetist Doctor charge.
20-05	Delivery Room	Hospital room equipped for childbirth; inclusive of all the birthing devices including but not limited to Fetal/Patient monitors, Forceps, Curettes, Surgical equipment, Sterilization, Emergency devices all consumables and drugs.
5.	Other Services	
17-11	Per Diem - Non-Medical Escort accommodation	Daily Rate. Accommodation stays in hospital or outside hospital (at reasonable and customary charges) for a single escort accompanying the patient outside Abu Dhabi. Exclusive of food and telephone charges. Charged per day. See Mandatory price list & Rules.
17-11-1	Per Diem - Medical Escort accommodation - Daily Rate	Daily Rate. Accommodation stays in hospital or outside hospital (at reasonable and customary charges) for a single medical professional accompanying the patient outside Abu Dhabi. Exclusive of food and telephone charges. Charged per day. See Mandatory price list & Rules.

17-11-2	Per Diem - International Assistance in case of Emergency	Daily Rate. Costs for providing emergency assistance during critical illness, & accident outside UAE. Including travel, security, medical assistance & local expertise in the country of treatment. See Mandatory price list & Rules.
12	Undefined services	Undefined service.
26	Per Diem - Companion Accommodation	Daily Rate. Per day room and board charges in hospital / treating facility for (1) a person accompanying a registered inpatient insured, of any age that is critically ill, or (2) parent accompanying a child under 10 years of age.
50-01	Comprehensive screening evaluation and management by clinician of an individual, including an age and gender appropriate history, questionnaire filling, examination, and ordering of laboratory/diagnostic procedures, new or established patient; 30-40 minutes.	
51-01	Non-surgical cleansing of a wound without debridement, with or without local anesthesia, with or without the application of a surgical dressing: 16 sq inches / 100 sq centimeters or less.	
51-02	Non-surgical cleansing of a wound without debridement, with or without local anesthesia, with or without the application of a surgical dressing: between 16 sq inches / 100 sq centimeters and 48 sq inches / 300 sq centimeters.	
51-03	Non-surgical cleansing of a wound without debridement, with or without local anesthesia, with or without the application of a surgical dressing: more than 48 sq inches / 300 sq centimeters.	
99	Outlier Payment	Outlier Payment for IR-DRG

Home Healthcare Services codes	
17-26-1	Per Diem- Bundled Base Payment of home care (Level 1- SIMPLE) A bundled payment that includes all • medical services and transportation • Supportive services: includes Physiotherapy, Speech Therapy, Occupational Therapy, Respiratory Therapy • bundled payment excludes medication, consumables and equipment which will be paid separately
17-26-2	Per Diem- Bundled Base Payment of home care (Level 2- Intermediate) A bundled payment that includes all • medical services and transportation • Supportive services: includes Physiotherapy, Speech Therapy, Occupational Therapy, Respiratory Therapy • bundled payment excludes medication, consumables and equipment which will be paid separately
17-26-3	Per Diem- Bundled Base Payment of home care (Level 3- Intensive) A bundled payment that includes all • medical services and transportation • Supportive services: includes Physiotherapy, Speech Therapy, Occupational Therapy, Respiratory Therapy • bundled payment excludes medication, consumables and equipment which will be paid separately
17-26-4	Per Diem- Bundled Base Payment of home care (Level 4- Complex) A bundled payment that includes all • medical services and transportation • Supportive services: includes Physiotherapy, Speech Therapy, Occupational Therapy, Respiratory Therapy • bundled payment excludes medication, consumables and equipment which will be paid separately
88	Outlier Payment "See Home care Standard version1.4 – Appendix 5”

Population At Risk Program Service code		
17-27-3	Tele consultation – Nurse assessment – Population at risk program to provide care at home	
Assisted Reproductive Therapy service codes		
Code	**Code Short Description**	**Code Long Description**
70-01	Bundled reimbursement for completed regular ART cycle	Completed fresh ART cycle is reimbursed on a bundled payment, including all services provided to the patient from ovarian stimulation to transfer of embryo(s). *Activities included* • All activities required for a complete ART cycle are included except for those mentioned in excluded activities column. *Activities excluded* • All take home medications. • Genetic tests (PGD, PGS Karyotyping). • Embryo storage beyond the first year.
70-02	Bundled reimbursement for embryo(s) storage	Storage of embryo(s) is reimbursed on a bundled payment, including all services provided to the patient from stimulation of ovaries, to freezing and storage of embryo up to 1 year. *Activities included* • All activities required for a complete ART cycle are included except for those mentioned in excluded activities column. *Activities excluded* • All take home medications. • Genetic tests (PGD, PGS Karyotyping). • Embryo storage beyond the first year.
70-03	Bundled reimbursement for completed ART cycle from frozen embryo(s)	Completed ART cycle is reimbursed on a bundled payment, including all services provided to the patient from thawing of embryo(s) to transfer of embryo. *Activities included* • All activities required for a complete ART cycle are included except for those mentioned in excluded activities column. *Activities excluded* • All take home medications. • Embryo storage beyond the first year.
70-04	Bundled reimbursement for egg(s) storage	Storage of egg(s) is reimbursed on a bundled payment, including all services provided to the patient from stimulation of ovaries to freezing and storage of egg(s) up to 1 year. *Activities included* • All activities required for a complete ART cycle are included except for those mentioned in excluded activities column. *Activities excluded* • All take home medications. • Embryo storage beyond the first year.

70-05	Bundled reimbursement for completed ART cycle from frozen egg(s)	Completed ART cycle is reimbursed on a bundled payment, including all services provided to the patient from thawing of egg(s) to transfer of embryo(s). *Activities included* • All activities required for a complete ART cycle are included except for those mentioned in excluded activities column. *Activities excluded* • All take home medications. • Genetic tests (PGD, PGS Karyotyping). • Embryo storage beyond the first year.
70-06	Stimulation of ovaries	Completed attempt of ovaries stimulation of an incomplete ART cycle. *Activities included* • All activities required are included except for taking home medication. *Activities excluded* • All take home medication.
70-07	Egg retrieval	Completed attempt of Egg retrieval of an incomplete ART cycle. *Activities included* • All activities required are included. *Activities excluded* • N/A
70-08	Egg freezing	Completed Egg freezing of an incomplete ART cycle. *Activities included* • All activities required are included. *Activities excluded* • N/A
70-09	Fertilization of eggs	Completed attempt of Fertilization of eggs of an incomplete ART cycle. *Activities included* • All the services are included except for Genetic tests PGD, PGS and karyotyping. *Activities excluded* • Genetic tests PGD, PGS and karyotyping.
70-10	Embryo freezing	Completed Embryo freezing of an incomplete ART cycle. *Activities included* • All the services are included except for Genetic tests PGD, PGS and karyotyping. *Activities excluded* • Genetic tests PGD, PGS and karyotyping.
70-11	Add-on Fertility Investigation	Special add-on investigation package to be added to bundle package 3 – frozen Embryo cycle and package 5 – frozen egg cycle, if the bundle is requested 6 months from the initial stimulation. *Activities included* • All activities required for preparing patient and for oocyte/ embryo thawing. *Activities excluded* • N/A
Assisted Reproductive therapy Services outside IVF bundle		
Code	**Code Short Description**	**Code Long Description**
70-12	Pre-implantation genetic testing for aneuploidy (PGT-A)	Pre-implantation genetic testing for aneuploidy (PGT-A), includes genetic consultation and counselling, embryo biopsy and all other necessary steps required to perform PGT-A test, for up to 5 embryos

70-13	PGT-A for each additional embryo	Pre-implantation genetic testing for aneuploidy (PGT-A) as an add-on for SRVC code 70-12, includes genetic consultation and counselling, embryo biopsy and all other necessary steps required to perform PGT-A test, for each additional embryo
70-14	Pre-implantation genetic testing for monogenic gene disorders (PGT-M)	Pre-implantation genetic testing for monogenic gene disorders (PGT-M) as an add- on for PGT-A (SRVC code 70-12), includes genetic consultation and counselling, review of the genetic testing report of parents from G42, custom test development (probe preparation) and all other necessary steps required to perform PGT-M test, for up to 5 embryos
70-15	PGT-M for each additional embryo	Pre-implantation genetic testing for monogenic gene disorders (PGT-M) as an add- on for SRVC code 70-14, includes genetic consultation and counselling, review of the genetic testing report of parents from G42, custom test development (probe preparation) and all other necessary steps required to perform PGT-M test, for each additional embryo
70-16	Pre-implantation genetic for structural chromosomal rearrangements (PGT-SR)	Pre-implantation genetic testing for structural chromosomal rearrangements (PGT-SR) as an add-on for PGT-A (SRVC code 70-12), includes genetic consultation and counselling, review of the genetic testing report of parents from G42, custom test development (probe preparation) and all other necessary steps required to perform PGT-SR test, for up to 5 embryos
70-17	PGT-SR for each additional embryo	Pre-implantation genetic testing for structural chromosomal rearrangements (PGT-SR) as an add-on for SRVC code 70-16, includes genetic consultation and counselling, review of the genetic testing report of parents from G42, custom test development (probe preparation) and all other necessary steps required to perform PGT-SR test, for each additional embryo

Code	**Code Description**	**Procedure Name**
55899	Unlisted procedure, male genital system	Microsurgical Testicular Sperm Extraction
54505	Biopsy of testis, incisional (separate procedure)	Testicular Sperm Extraction
54500	Biopsy of testis, needle (separate procedure)	Testicular Sperm Aspiration
55899	Unlisted procedure, male genital system	Percutaneous Epididymal Sperm Aspiration
S4028	Microsurgical epididymal sperm aspiration (mesa)	Microsurgical Epididymal Sperm Aspiration

Dental Capitation program service codes	
Code	**Code Description**
08-01	Dental Capitation package for children age 0 – 6 years for initial visit
08-02	Dental Capitation package for children age 0 – 6 years for minimum requirement of dental services for Quarter 1 to Quarter 3 from initiation (each quarter)
08-03	Dental Capitation package for children age 0 – 6 years for minimum requirement of dental services for Quarter 4 from initiation
08-04	Dental Capitation package for children age 7 – 12 years for initial visit
08-05	Dental Capitation package for children age 7 – 12 years for minimum requirement of dental services for Quarter 1 to Quarter 3 from initiation (each quarter)
08-06	Dental Capitation package for children age 7 – 12 years for minimum requirement of dental services for Quarter 4 from initiation
08-07	Dental Capitation package for children age 13 – 17 years for initial visit
08-08	Dental Capitation package for children age 13 – 17 years for minimum requirement of dental services for Quarter 1 to Quarter 3 from initiation (each quarter)
08-09	Dental Capitation package for children age 13 – 17 years for minimum requirement of dental services for Quarter 4 from initiation

Genetic testing for Premarital Screening			
Code	**Code Short Description**	**Code Long Description**	**Price**
53 –01	Genetic testing for Pre – Marital Screening, includes analysis and reporting of 569 genes	Genetic testing for Pre – Marital Screening, includes analysis and reporting of 569 genes: AAAS, ABCA4, ABCB11, ABCC6, ABCC8, ABCC9, ABCD4, ACAD9, ACADM, ACADS, ACADSB, ACADVL, ACAT1, ACOX1, ADA, ADAMTS2, ADAR, ADAT3, ADGRG1, ADGRG1 (GPR56), ADGRV1, ADK, AGA, AGL, AGPS, AGXT, AIRE, AK2, ALB, ALDH3A2, ALDH3A2 (FALDH), ALDH7A1, ALDOB, ALG6, ALMS1, ALOX12B, ALPL, AMT, AP1S1, AP3B1, APOB, ARG1, ARSA, ARSB, ASL, ASNS, ASPA, ASPM, ASS1, ATM, ATP13A2, ATP6V1B1, ATP7B, B3GAT3, BBS1, BBS10, BBS12, BBS2, BBS4, BBS7, BBS9, BCKDHA, BCKDHB, BCS1L, BLM, BRIP1, BSND, BTD, CA2, CA5A, CAD, CANT1, CAPN3, CASQ2, CBLIF (GIF), CBS, CC2D2A, CCDC103, CCDC39, CCDC40, CCDC65, CCN6 (WISP3), CCNO, CD3D, CD3E, CDH23, CDK5RAP2, CDKN2A, CEP290, CERKL, CFAP298 (C21ORF59), CFTR, CHAT, CHRNE, CIB2, CISD2, CLCNKB, CLDN14, CLN3, CLN5, CLN6, CLN8, CLPP, CLRN1, CNGA3, CNGB3, COA6, COL11A1, COL11A2, COL3A1, COL4A3, COL4A4, COL7A1, COLQ, COQ5, COQ6, COQ8A, CORO1A, COX6A1, CPS1, CPT1A, CPT2, CRB1, CRPPA, CSRP3, CTNS, CTSD, CTSF, CTSK, CUL7, CYP11B1, CYP11B2, CYP17A1, CYP1B1, CYP21A2, CYP27A1, CYP27B1, CYP2U1, DBT, DCLRE1C, DDC, DES, DGUOK, DHCR7, DHDDS, DHFR, DLD, DNAAF1, DNAAF11 (LRRC6), DNAAF2, DNAAF3, DNAAF4 (DYX1C1), DNAAF5, DNAH11, DNAH5, DNAI1, DNAI2, DNAJB13, DNAJC12, DNAL1, DNMT3B, DOCK8, DOK7, DPYD, DRC1, DSC2, DSG2, DSP, DUOX2, DUOXA2, DYSF, EDAR, EDN3, EDNRB, EIF2B5, ELN, ELP1, ENG, ERCC2, ESPN, ESRRB, ETFA, ETFB, ETFDH, ETHE1, EXOSC3, EYS, F10, F11, F12, F13A1, F13B, F2, F5, F7, FAH, FAM161A, FANCA, FANCC, FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, FBP1, FBXL4, FCGR3A, FGF3, FGFR3, FH, FKRP, FKTN, FOLR1, FOXE1, FTO, FUCA1, G6PC, G6PC1 (G6PC), GAA, GALC, GALE, GALK1, GALNS, GALNT3, GALT, GAMT, GAS8, GATM, GBA1 (GBA), GBE1, GCDH, GCH1, GCSH, GDF5, GFPT1, GGCX, GH1, GIPC3, GJB2, GJB6, GLB1, GLDC, GMPPA, GNE, GNPAT, GNPTAB, GNPTG, GNS, GORAB, GOT2, GP1BB, GP6, GP9, GPSM2, GRHPR, GRXCR1, GSS, GUCY2D, GUSB, GYS2, HADH, HADHA, HADHB, HAMP, HAX1, HBA1, HBA2, HBB, HBG2, HEPACAM, HEXA, HEXB, HGD, HGF, HGSNAT, HJV, HJV (HFE2), HLCS, HMGCL, HMGCS2, HOGA1, HPS1, HPS3, HPS4, HPS5, HPS6, HSD11B2, HSD17B3, HSD17B4, HSD3B2, HSD3B7, HYDIN, IDUA, IL2RA, IL7R, ILDR1, INPP5E, INPPL1, INS, ITGA2B, ITK, IVD, IYD, JAK3, JUP, KARS1 (KARS), KCNE1, KCNQ1, KCTD7, LAMA3, LAMB2, LAMB3, LAMC2, LARGE1, LARS2, LCA5, LDLR, LDLRAP1, LHCGR, LHX3, LIFR, LIPA, LMBRD1, LOXHD1, LPL, LRP2, LRPPRC, LRTOMT, LYST, MAN2B1, MARVELD2, MCCC1, MCCC2, MCIDAS, MCOLN1, MED17, MEFV, MEGF10, MFSD8, MIF (GIF), MKKS, MKS1, MLC1, MMAA, MMAB, MMACHC, MMADHC, MMUT (MUT), MOCS1, MOCS2, MPI, MPL, MPV17, MRAP, MRE11, MSRB3, MT3 (GIF), MTHFR, MTHFS, MTR, MTRR, MTTP, MUT, MYO15A, MYO6, MYO7A, NAGLU, NAGS, NBEAL2, NBN, NDUFAF6, NEB, NEK2, NPC1, NPC2, NPHP1, NPHS1, NPHS2, NSUN2, NTRK1, OAT, ODAD1 (CCDC114), ODAD2 (ARMC4), ODAD3 (CCDC151), ODAD4 (TTC25), OPA3, OTOA, OTOF, OTOG, OTOGL, P3H1 (LEPRE1), PAH, PC, PCCA, PCCB, PCDH15, PCSK1, PDHB, PDX1, PEPD, PET100, PEX1, PEX10, PEX12, PEX16, PEX2, PEX26, PEX6, PEX7, PFKM, PHGDH, PHKG2, PIK3CD, PJVK (DFNB59), PKHD1, PLA2G6, PLAU, PLOD1, PLPBP, PMM2, PNPLA6, PNPO, POLG, POMGNT1, POMT1, PPT1, PRF1, PROC, PROP1, PROS1, PSAP, PSAT1, PSPH, PTEN, PTPRC, PTS, PUS1, PYCR1, PYGL, PYGM, QDPR, RAB23, RAG1, RAG2, RAPSN, RARS2, RBP3, RDH12, RDX, RECQL4, RMRP , RNASEH2A, RNASEH2B, RNASEH2C, RPE65, RSPH1, RSPH3, RTEL1, S1PR2, SACS, SAMHD1, SARS1, SBDS, SCN1B, SCN4A, SCN5A, SCNN1A, SCNN1B, SCNN1G, SDHB, SDHD, SEPSECS, SERPINA1, SERPINC1, SGCA, SGCB, SGCG, SGSH, SLC12A3, SLC12A6, SLC17A5, SLC18A2, SLC22A5, SLC25A13, SLC25A15, SLC25A19, SLC25A20, SLC26A2, SLC26A3, SLC26A4, SLC2A1, SLC2A10, SLC2A9, SLC35A3, SLC37A4, SLC39A4, SLC4A11, SLC7A7, SLITRK6, SMN1*, SMPD1, SNAI2, SNAP29, SNX10, SPAG1, SPINK5, SPR, SRD5A3, ST3GAL5, STRC, SUMF1, SUOX, TALDO1, TAT, TBC1D24, TBX19, TCAP, TCIRG1, TCN2, TECPR2, TECTA, TFR2, TG, TGM1, TH, TMC1, TMEM138, TMEM216, TMIE, TMPRSS3, TNNI3, TPI1, TPK1, TPO, TPP1, TPRN, TRAPPC11, TRDN, TREX1, TRIM37, TRIOBP, TSEN2, TSEN34, TSEN54, TTC8, TTN, TTPA, UBR1, UGT1A1, UNC13D, UROS, USH1C, USH1G, USH2A, VPS13A, VPS13B, VPS13B (COH1), VPS53, VRK1, WHRN, WWOX, XPA, XPC, XYLT1, ZAP70, ZFYVE26, ZMYND10, ZNF513	NA

IPC Teleconsultation codes		
Code	**Code Short Description**	**Code Long Description**
01-11-01	Teleconsultation for International patient care (IPC) including medical doctor to medical doctor & patient, each 20 minutes	Teleconsultation for International patient care including consultation by a local medical doctor to international medical doctor & patient as initiated by the local teleconsultation team, each 20 minutes
01-11-02	Teleconsultation for International patient care (IPC), multidisciplinary team & patient, primary provider, each 20 minutes	Teleconsultation for International patient care including consultation by a multidisciplinary team to patient as initiated by the local teleconsultation team, primary local provider, each 20 minutes
01-11-03	Teleconsultation for International patient care (IPC), multidisciplinary team & patient, each additional provider, each 20 minutes	Teleconsultation for International patient care including consultation by a multidisciplinary team to patient as initiated by the local teleconsultation team, each additional local provider, each 20 minutes
01-11-04	Teleconsultation for International patient care (IPC), medical doctor to medical doctor	Teleconsultation for International patient care including consultation by a local medical doctor to an international medical doctor as initiated by the local teleconsultation team

Comprehensive screening Program Service codes IFHAS packages		
Code	**Short Code Description**	**Long Code Description**
52-21	Comprehensive Screening Major Package for male & female (age 18-39 years)	Comprehensive Screening Major Package for male & female (age 18-39 years) for consultation & Labs including the following services every 3 years: 99211, 96127, 36415, 82947, 83036, 80061, 82565
52-22	Comprehensive Screening Major Package for male & female (age 40-64 years)	Comprehensive Screening Major Package for male & female (age 40-64 years) for consultation & Labs including the following services every 3 years: 99211, 96127, 36415, 82947, 83036, 80061, 82565
52-23	Comprehensive Screening Major Package for male & female (age 65-75 years)	Comprehensive Screening Major Package for male & female (age 65-75 years) for consultation & Labs including the following services every 3 years: 99211, 96127, 36415, 82947, 83036, 80061, 82565
52-24	Comprehensive Screening Minor Package for male & female (age 65-75 years)	Comprehensive Screening Minor Package for male & female (age 65-75 years) for vision & hearing including the following services annually: 92551, 99173,
52-25	Comprehensive Screening Oral Health Package for male & female (age 18-75 years)	Comprehensive Screening Oral Health Package for male & female (age 18-75 years) for oral examination & oral hygiene **including the following services annually: 01103, 13211**
52-26	Colon Cancer Screening male & female (age 40-75 years)	Colon Cancer Screening Package for male and female (age 40-75 Years) including the following services every 10 years: 99211, G0105
52-27	Cervical Cancer Screening for female (age 25-29 years)	Cervical Cancer Screening Package for female (25-29 Years) including the following services every 3 years: 99211, 88142
52-28	Cervical Cancer Screening for female (age 30-65 years) for eligible groups based on PCSP standard	Cervical Cancer Screening Package for female (30-65 Years) including the following services every 5 years: 99211, 88142, 87623 or 87624 or 87625
52-29	Lung Cancer Screening for (High Risk) male & female (age 55-75 years)	Lung Cancer Screening Package for male & female (age 55-75 Years) for (high risk only, heavy smokers) including the following services annually: 99211, 71271
52-30	Standalone Screening Mammography for female for eligible groups based on PCSP standard	Standalone Screening Mammography for female every 2 years (77067) for eligible groups based on PCSP standard
52-31	Standalone Screening Fecal immunochemical test (FIT) for eligible groups based on PCSP standard	Standalone Screening Fecal immunochemical test (FIT) annually (82274) for eligible groups based on PCSP standard
52-32	Standalone Screening Abdominal Aortic Aneurysm for eligible groups based on PCSP standard	Standalone Screening Abdominal Aortic Aneurysm once in a lifetime (76706) for eligible groups based on PCSP standard

52-33	Standalone Screening DEXA scan for eligible groups based on PCSP standard	Standalone Screening DEXA scan every 3 years (77080) for eligible groups based on PCSP standard

Service codes for Bone marrow transplants		
Code	**Code Short Description**	**Code Long Description**
22-01	Bundled reimbursement for Bone Marrow Pre-transplantation work- up (Autologous)	The bundle reimbursement for Bone Marrow pre- transplantation work-up includes all procedures necessary for the pre-transplant work-up, extensive examination, Laboratory testing, Radiological and imaging analysis, Multidisciplinary team consultation. Excluded Services from this bundle payment are: • Medications plerixafor and defibrotide, or an equivalent, will be reimbursed in accordance with FDA label indication and require prior authorization. • Any additional cost pertaining to complications (excluding Potentially Preventable Complications of BMT transplant procedure). • List of CPT codes in **table 4 BMT CPT codes for Advanced Lab Tests/Services**, will be reimbursed outside the bundle based on medical necessity
22-02	Bundled reimbursement for Bone Marrow Preparation (Autologous)	The bundle reimbursement for Bone Marrow preparation includes all procedures necessary for the preparation, Evaluation and Management, laboratory testing and radiological analysis, Mobilization and Apheresis procedures and patient specific conditioning protocol. Excluded Activities: • Medications plerixafor and defibrotide, or an equivalent, will be reimbursed in accordance with FDA label indication and require prior authorization. • Any additional cost pertaining to complications (excluding Potentially Preventable Complications of BMT transplant procedure). • List of CPT codes in **table 4 BMT CPT codes for Advanced Lab Tests/Services**, will be reimbursed outside the bundle based on medical necessity
22-03	Bundled reimbursement for Bone Marrow Transplantation (Autologous)	The bundle reimbursement for Bone Marrow transplantation includes all inpatient procedures necessary for the Bone Marrow Transplantation to the day of discharge. Excluded Activities: • Medications plerixafor and defibrotide, or an equivalent, will be reimbursed in accordance with FDA label indication and require prior authorization. • Any additional cost pertaining to complications (excluding Potentially Preventable Complications of BMT transplant procedure). • List of CPT codes in **table 4 BMT CPT codes for Advanced Lab Tests/Services**, will be reimbursed outside the bundle based on medical necessity

22-04	Bundled reimbursement for Bone Marrow Post-transplantation follow-up (Autologous)	The bundle reimbursement for Bone Marrow post- transplant follow-up includes all procedures necessary for the Post-transplant follow-up (Per month from discharge date and up to four months), Evaluation and Management, laboratory testing and radiological analysis, medication up to 7 days, vaccination cost and cryopreservation for 6 months. Excluded Activities: • Medications plerixafor and defibrotide, or an equivalent, will be reimbursed in accordance with FDA label indication and require prior authorization. • Any additional cost pertaining to complications (excluding Potentially Preventable Complications of BMT transplant procedure). • List of CPT codes in **table 4 BMT CPT codes for Advanced Lab Tests/Services**, will be reimbursed outside the bundle based on medical necessity
22-05	Bundled reimbursement for Bone Marrow Pre-transplantation work-up (Allogenic)	The bundle reimbursement for Bone Marrow Pre-transplant work-up includes all procedures necessary for the pre-transplant work-up (Donor and recipient), extensive examination prior to transplantation, laboratory testing, radiological analysis, and multidisciplinary team consultation. Excluded Activities: • Medications plerixafor and defibrotide, or an equivalent, will be reimbursed in accordance with FDA label indication and require prior authorization. • Any additional cost pertaining to complications (excluding Potentially Preventable Complications of BMT transplant procedure). • List of CPT codes in **table 4 BMT CPT codes for Advanced Lab Tests/Services**, will be reimbursed outside the bundle based on medical necessity
22-06	Bundled reimbursement for Bone Marrow Preparation (Allogenic)	The bundle reimbursement for Bone Marrow preparation includes all procedures necessary for the preparation, Evaluation and Management, laboratory testing and radiological analysis, Mobilization and Apheresis procedures and patient specific conditioning protocol. Excluded Activities: • Medications plerixafor and defibrotide, or an equivalent, will be reimbursed in accordance with FDA label indication and require prior authorization. • Any additional cost pertaining to complications (excluding Potentially Preventable Complications of BMT transplant procedure). • List of CPT codes in **table 4 BMT CPT codes for Advanced Lab Tests/Services**, will be reimbursed outside the bundle based on medical necessity

22-07	Bundled reimbursement for Bone Marrow Transplantation (Allogenic)	The bundle reimbursement for Bone Marrow transplantation includes all inpatient procedures necessary for the Bone Marrow Transplantation to the day of discharge. Excluded Activities: • Medications plerixafor and defibrotide, or an equivalent, will be reimbursed in accordance with FDA label indication and require prior authorization. • Any additional cost pertaining to complications (excluding Potentially Preventable Complications of BMT transplant procedure). • List of CPT codes in **table 4 BMT CPT codes for Advanced Lab Tests/Services**, will be reimbursed outside the bundle based on medical necessity.
22-08	Bundled reimbursement for Bone Marrow Post-transplantation follow-up (Allogenic)	The bundle reimbursement for Bone Marrow post- transplant includes all procedures necessary for the Post-transplant follow-up (Per month from discharge date and up to four months from discharge date), Evaluation and Management, laboratory testing and radiological analysis, discharge medication up to 7 days, vaccination cost and cryopreservation for 6 months. Excluded Activities: • Medications plerixafor and defibrotide, or an equivalent, will be reimbursed in accordance with FDA label indication and require prior authorization • Any additional cost pertaining to complications (excluding Potentially Preventable Complications of BMT transplant procedure). • List of CPT codes in **table 4 BMT CPT codes for Advanced Lab Tests/Services**, will be reimbursed outside the bundle based on medical necessity.
National Biobank Service codes		
Code	**Code Short Description**	**Code Long Description**
54-01	Biobanking; Umbilical Cord Blood	Biobanking; sourced from Umbilical Cord Blood, includes collection, transportation, processing of the baby cord blood by checking stem cells (CD34) enumeration count, full blood count (CBC) and testing of the maternal samples for infectious diseases, HLA typing, cryopreservation and storage of the stem cells from the umbilical cord blood for future use
54-02	Biobanking; Body Fluids	Biobanking; sourced from Body Fluids, includes collection of different types of body fluids, transportation and long-term storage for future use, each sample
54-03	Biobanking; Human Tissue	Biobanking; sourced from Human Tissue, includes collection, transportation, processing of tissue using histopathological procedures and long-term storage of human tissue for future use, each sample
54-04	Biobanking; Human DNA	Biobanking; Human DNA, includes collection, transportation, extraction of DNA from blood and buccal samples and long- term storage for future use, each sample
Teleconsultation service codes for COVID-19 Home isolation program		
Code	**Description**	
17-27-1	Tele consultation – Consultant / specialist - Home isolation for asymptomatic COVID-19 patients or with mild symptoms out of healthcare facilities and provide care for them at home	
17-27-2	Tele consultation – Nurse assessment - Home isolation for asymptomatic COVID-19 patients or with mild symptoms out of healthcare facilities and provide care for them at home	
Home visit Service codes for COVID-19 Home Isolation/ quarantine programs		
Code	**Code Short Description**	**Code Long Description**

17-26-5	COVID-19 Home Isolation & Home quarantine programs Home visit	Home visit for a patient enrolled in COVID-19 Home Isolation & Home quarantine programs following the program criteria. Services included in the visit includes the following: • Nurse/Physician visit • Nurse/Physician assessment as per programs protocol set by ADPHC including visual assessment of stability, Vital signs: BP and HR, and Oxygen saturation (oximeter) • Trackers application / removal • Transportation and administration cost • Other services associated with the home isolation/ quarantine visit such as placing a poster, updating ESTIJABA platform. Frequency: As per HIP & HQP testing protocol.
Teleconsultation for COVID-19 Vaccine administration		
Code	**Code Short Description**	**Code Long Description**
01-10	Physician teleconsultation during Coronavirus disease (COVID-19) vaccine administration	Physician teleconsultation for a patient during (COVID-19) vaccine administration outside healthcare facilities (labor camps, malls, home visits, etc.).
Pfizer COVID-19 Vaccination		
Code	**Code Short Description**	**Code Long Description**
96	Nurse lead Pfizer COVID-19 Vaccine administration	Nurse lead Pfizer COVID-19 Vaccine administration including all vaccine administration activities such as vaccine preparation and logistics expenses
Ambulance service codes		
Code	**Short Code Description**	**Long Code Description**
55-01	Ambulance service, Non-Critical transport, (BLS)	Patient is clinically stable; however, the required service is not available at the current location, and transfer to another facility is needed. The average Response time: following DoH Scheme & guidelines. Clinicians/response team on Board: as per DoH guidelines. **Inter facility Ambulance Transportation, Round trip** This code represents the nonemergency transport of a patient in an basic life support ambulance and provision of a BLS assessment and BLS interventions by ambulance staff including the necessary supplies and services. Basic life support, or a BLS ambulance transport provides transport for a patient to travel from one location to another due to a medical condition. The patient's condition is usually stable and the patient requires basic life support services like administration of oxygen, wound management, splinting of broken bones and or bleeding control. The ambulance staffs are qualified emergency professional and the ambulance has specialized instruments. Use this code when the ambulance staff performs a basic life support assessment such as checking the patient's vital signs and they provide basic life support procedures during a patient transport for a nonemergency purpose. The ambulance staff uses minimal supplies. This code will not be covered if the ambulance transports the patient for a service that could have been provided safely and effectively at the point of origin, such as the patient's home.

55-02	Ambulance service, advanced life support, Critical transport, (ALS)	Patient is not clinically stable, requires immediate transfer. Response time: immediate up to 6 hours. Response Team: following DoH Scheme & guidelines **Inter facility Ambulance Transportation, Round trip** This code represents the nonemergency transport of a patient in an advanced life support, or ALS ambulance and provision of level one prehospital services such as an ALS assessment and or at least one ALS intervention by the ambulance staff including all the necessary supplies and services. Advanced life support, or an ALS ambulance typically provides transport for a patient to travel from one location to another due to an emergency medical condition. The patient is usually critical and requires advanced life support for sustaining life such as cardiac pacing, or defibrillation. The ambulance staffs are qualified emergency professional and the ambulance has specialized instruments. This code will not be covered if the ambulance transports the patient for a service that could have been provided safely and effectively at the point of origin, such as the patient's home.
55-03	Specialty Care Transport	For critically ill patient, who requires specialist team, (for example; bariatric overweight patient who requires special equipment for transfer/movement. Type III ambulance is usually used. Ex. Intubated patients, multiple infusions. Response time & Response team: as per to DoH guidelines. **Inter facility Ambulance Transportation, Round trip** This code represents the interfacility transportation of a critically ill (A patient with impairment of one or more vital organs systems leading to a life-threatening decline in condition) or injured patient by a ground ambulance, including the delivery of all medically necessary services and supplies.
55-04	Neonatal Transport Ambulance	Patient is clinically stable, but the medical condition is deteriorating. Example; Ambulance specifically designed for neonates Response time & Response team: as per DoH guidelines **Round trip** This code represents the transport of a neonate, typically defined as an infant less than a month old, using an ambulance as a mode of transport. patient is clinically stable, but the medical condition is deteriorating
55-05	Ground mileage, per Kilometer	**Inter facility Ambulance Transportation, Ground mileage, per Kilometer, Round trip**

56-01	Ambulance service, Non-Critical Transport, (BLS)	Patient is clinically stable; however, the transfer to health care entity is needed via an ambulance (for example: dialysis patient, radiation therapy patient). Response time & Response team: as per DoH Guidelines. **Home Transportation, Round trip** **The indications are same as 55-01**
56-02	Specialty care Transport	For critically ill patient, who requires specialist team, (for example; bariatric overweight patient who requires special equipment for transfer/movement. Type III ambulance is usually used. Ex. Intubated patients, multiple infusions. Response time & Response team: as per to DoH guidelines. **Home Transportation, Round trip** **The indications are same as 55-03**
56-03	Ground mileage, per Kilometer	**Home Transportation, Ground mileage, per Kilometer Round trip**

6.2.2 Table 2 : CPT Code Ranges

Note: refer back to section 2.4.2 "Multipliers Application Rules" for the use of the CPT Codes Ranges

Service Category	**Codes Range**	
	from	**to**
Evaluation And Management:	**99202 - 99499, 99091**	
Psychiatry	90785	90899
Dialysis	90935	90999
Gastroenterology	91010	91304
Ophthalmology	92002	92499
Special Otorhinolaryngologic Services	92502	92700
Cardiovascular	92920	93799
Noninvasive Vascular Diagnostic Studies	93880	93998
Pulmonary	94002	94799
Allergy & Clinical Immunology	95004	95199
Endocrinology	95249	95251
Neurology & Neuromuscular Procedures	95700	96020
Medical Genetics and Genetic Counseling Services	96040	
Central Nervous System Assessments/Tests	96105	96146
Health & Behaviour Assessment/Intervention	96156	96171
Hydration, Therapeutic, Prophylactic, injections & Infusions, and Chemotherapy and other Administration	96360	96549
Photodynamic Therapy	96567	96574

Special Dermatological Procedures	96900	96999
Physical Medicine & Rehabilitation	97010	97799
Medical Nutrition Therapy	97802	97804
Acupuncture	97810	97814
Osteopathic Manipulative Treatment	98925	98929
Chiropractic Manipulative Treatment	98940	98943
Education & Training For Patient Self-Management	98960	98962
Non-Face-to-Face Nonphysician Services	98966	98972
Special Services, Procedures And Reports	99000	99091
Qualifying Circumstances For Anesthesia	99100	99140
Moderate (Conscious) Sedation	99151	99157
Other Services & Procedures	99170	99199
Home Health Procedures/Services	99500	99602
Medication Therapy Management Services	99605	99607
Immunization Administration For Vaccines/Toxoids	90460	0072A
Biofeedback	90901	90913
Anaesthesia:	00100-01999; 99100-99140	
Surgery: 10004-69990		
General	10004	10012
Integumentary System	10030	19499
Musculoskeletal System	20100	29999
Respiratory System	30000	32999
Cardiovascular System	33016	37799
Hemic & Lymphatic Systems	38100	38999
Mediastinum & Diaphragm	39000	39599
Digestive System	40490	49999
Urinary System	50010	53899
Male Genital System	54000	55899
Reproductive System & Intersex	55920	55980
Female Genital System	56405	58999
Maternity Care & Delivery	59000	59899
Endocrine System	60000	60699
Nervous System	61000	64999
Eye & Ocular Adnexa	65091	68899
Auditory System	69000	69979
Operating microscope	69990	
Radiology: 70010-79999		
Diagnostic Imaging	70010	76499
Diagnostic Ultrasound	76506	76999
Radiologic Guidance	77001	77022
Breast Mammography	77046	77067
Bone/Joint Studies	77071	77086
Radiation Oncology	77261	77799
Nuclear Medicine	78012	79999
Pathology & Laboratory: 80047-0326U		
Organ Or Disease-Oriented Panels	80047	80081
Therapeutic Drug Assays	80143	80299
Drug Assay	80305-80377, 83992	
Evocative/Suppression Testing	80400	80439

Consultations (Clinical Pathology)	80500	80502
Urinalysis	81000	81099
Molecular pathology	81105	81479
Genomic Sequencing Procedures and Other Molecular Multianalyte Assays	81410	81471
Multianalyte Assays with Algorithmic Analyses	81490	81599
Chemistry	82009	84999
Hematology & Coagulation	85002	85999
Immunology	86000	86849
Transfusion Medicine	86850	86999
Microbiology	87003	87999
Anatomic Pathology (Postmortem)	88000	88099
Cytopathology	88104	88199
Cytogenetic Studies	88230	88299
Surgical Pathology	88300	88399
In Vivo (Transcutaneous) Lab Procedures	88720	88749
Other Procedures	89049	89240
Reproductive Medicine Procedures	89250	89398
Proprietary Laboratory Analyses	0001U	0326U

6.2.3 Table 3 : Telemedicine Services

The below CPT codes will be utilized for telemedicine services provided by All healthcare facilities:

All specialties (excluding Psychiatry/ Psychology)

Code	Code Description
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99091	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time
99446	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review

99447	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review
99448	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99441**	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442**	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
99443**	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
90833*	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90836*	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90838*	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90832	Psychotherapy, 30 minutes with patient
90834	Psychotherapy, 45 minutes with patient
90837	Psychotherapy, 60 minutes with patient

**To report with code 99441 - 99443, see details at point 4.2.1.11.10*
***For reporting purposes only in relation to details at point 4.2.1.11.10*

6.2.4 Table 4: BMT CPT codes for Advanced Lab Tests/Services

A. CPT codes for Advanced Lab Tests/Services		
Advanced Lab Tests/Services	**Code**	**Description**
FLOW CYTOMETRY IMMUNOPROFILE	88182	Flow cytometry, cell cycle or DNA analysis
	88184	Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker
	88185	Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)
	88187	Flow cytometry, interpretation; 2 to 8 markers
	88188	Flow cytometry, interpretation; 9 to 15 markers
	88189	Flow cytometry, interpretation; 16 or more markers
DURACLONE T REG	88184	Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker
	88185 x7	Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)
	88187	Flow cytometry, interpretation; 2 to 8 markers
MAXPAR DIRECT IMMUNO PROFILING ASSAY	88184	Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker
	88185 x29	Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)
	88189	Flow cytometry, interpretation; 16 or more markers
MINIMAL RESIDUAL DESEASE	Code will depend on target gene and methodology used.	
STEM CELL KIT	86367	Stem cells (ie, CD34), total count
TCR ALFA/BETA	86356 x2	Mononuclear cell antigen, quantitative (eg, flow cytometry), not otherwise specified, each antigen

CD 19 SELECTION	86152	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood);
	86153	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required
CD 34+ SELECTION	86152	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood);
	86153	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required
BUSULFAN TEST	80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3
CHIMERISM	81267	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection
	81268	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type
B. Paediatric BMT Services and codes		
Service Name	**Code**	**Description**
Whole Genome Sequencing for Recipient	81425	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis
Whole Genome Sequencing for Donor	81425	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis
Tests for donor-recipient compatibility apart from HLA Panel-Reactive Antibodies (PRA)	86830	Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); antibody identification by qualitative panel using complete HLA phenotypes, HLA Class I
	86831	Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); antibody identification by qualitative panel using complete HLA phenotypes, HLA Class II
Tests for donor-recipient compatibility apart from HLA Donor-Specific Antibodies (DSA)	86832	Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); semi-quantitative panel (eg, titer), HLA Class I
	86833	Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, Flow cytometry); semi-quantitative panel (eg, titer), HLA Class II
MRI T2* for Liver and Heart in patients with iron overload	74181	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)
	75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;
	76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation
RBC Genotyping in selected patients	81403	Molecular pathology procedure, Level 4 (refer to CPT code book for full description)
Caregiver's Stay	Service Code 26	Perdiem - Companion Accommodation Daily Rate. Per day room and board charges in hospital / treating facility for (1) a person accompanying a registered inpatient insured, of any age that is critically ill, or (2) parent accompanying a child under 10 years of age.

Table 5: DOH HAC list

Sl.No	Hospital Acquired Conditions (HAC)	Diagnosis Codes	Codes for Medical Procedures
1	Foreign Object Retained After Surgery	T81.500A, T81.501A, T81.502A, T81.503A, T81.504A, T81.505A, T81.506A, T81.507A, T81.508A, T81.509A, T81.510A, T81.511A, T81.512A, T81.513A, T81.514A, T81.515A, T81.516A, T81.517A, T81.518A, T81.519A, T81.520A, T81.521A, T81.522A, T81.523A, T81.524A, T81.525A, T81.526A, T81.527A, T81.528A, T81.529A, T81.530A, T81.531A, T81.532A, T81.533A, T81.534A, T81.535A, T81.536A, T81.537A, T81.538A, T81.539A, T81.590A, T81.591A, T81.592A, T81.593A, T81.594A, T81.595A, T81.596A, T81.597A, T81.598A, T81.599A, T81.60XA, T81.61XA, T81.69XA	All Medical and Surgical discharges
2	In-Hospital Fall and Trauma	Any injury caused by the following external cause codes during the hospital stay: W01.0XXA, W01.10XA, W01.110A, W01.111A, W01.118A, W01.119A, W01.190A, W01.198A, W04.XXXA, W05.0XXA, W06.XXXA, W07.XXXA, W08.XXXA, W17.89XA, W18.11XA, W18.12XA, W18.2XXA, W18.30XA, W18.31XA, W18.39XA	All Medical and Surgical discharges
3	Air Embolism	T80.0XXA	All Medical and Surgical discharges
4	Blood Incompatibility	T80.30XA, T80.310A, T80.311A, T80.319A, T80.39XA	All Medical and Surgical discharges
5	Stage III and IV Pressure Ulcers	L89.003, L89.004, L89.013, L89.014, L89.023, L89.024, L89.103, L89.104, L89.113, L89.114, L89.123, L89.124, L89.133, L89.134, L89.143, L89.144, L89.153, L89.154, L89.203, L89.204, L89.213, L89.214, L89.223, L89.224, L89.303, L89.304, L89.313, L89.314, L89.323, L89.324, L89.43, L89.44, L89.503, L89.504, L89.513, L89.514, L89.523, L89.524, L89.603, L89.604, L89.613, L89.614, L89.623, L89.624, L89.813, L89.814, L89.893, L89.894, L89.93, L89.94	All Medical and Surgical discharges

6	Manifestations of Poor Glycemic Control	E08.00, E08.01, E08.10, E08.11, E09.00, E09.01, E09.10, E09.11, E10.10, E10.11, E11.00, E11.01, E11.10, E11.11, E13.00, E13.01, E13.10, E13.11, E15	All Medical and Surgical discharges
7	Catheter - Associated Urinary tract infection/UTI	T83.510A, T83.511A, T83.512A, T83.518A	51701, 51702, 51703
8	Vascular Catheter-Associated Infection	T80.211A, T80.212A, T80.218A, T80.219A, T85.71XA, T85.735A	All Medical and Surgical discharges
9	SSI, Mediastinitis following Coronary Bypass Graft (CABG)	T82.7XXA, J98.51	33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33572, 35500, 35600, 92937, 92938, 92941, 92943
10	SSI following Bariatric Surgery for Obesity	K68.11, K95.01, K95.09, K95.81, K95.89, T81.40XA, T81.41XA, T81.42XA, T81.43XA, T81.44XA, T81.49XA	43631, 43632, 43633, 43644, 43645, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, 43999
11	SSI following Certain Orthopedic Procedures of Spine, Shoulder and Elbow	T81.40XA, T81.41XA, T81.42XA, T81.43XA, T81.44XA, T81.49XA, T84.60XA, T84.610A, T84.611A, T84.612A, T84.613A, T84.614A, T84.615A, T84.619A, T84.63XA, T84.69XA, T84.7XXA, K68.11	**Spine** 20930, 20931, 20932, 20933, 20934, 20936, 20937, 20938, 20939, 22010, 22015, 22206, 22207, 22208, 22210, 22212, 22214, 22216, 22220, 22222, 22224, 22226, 22505, 22818, 22819 **Elbow** 20605, 20606, 20802, 23930, 23931, 24065, 24066, 24071, 24073, 24075, 24076, 24077, 24079, 24155, 24200, 24201, 24220, 24310, 24320, 24330, 24331, 24340, 24370, 24371, 24586, 24587, 24600, 24605, 24615, 24620, 24635, 24800, 24802 **Shoulder** 20610, 20611, 23030, 23031, 23035, 23065, 23066, 23071, 23073, 23075, 23076, 23077, 23078, 23330, 23333, 23334, 23335, 23350, 23395, 23397, 23405, 23406, 23420, 23472, 23473, 23474, 23575, 23650, 23655, 23660, 23665, 23670, 23675, 23680, 23700, 23920, 23921, 23929, 24310, 24320, 29035, 29040, 29044, 29046, 29055, 29065, 29105, 29240, 29710, 29805, 29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29826, 29827, 29828
12	SSI following Cardiac Implantable Electronic Device (CIED) Procedures	K68.11, T81.40XA, T81.41XA, T81.42XA, T81.43XA, T81.44XA, T81.49XA, T82.6XXA, T82.7XXA	33206, 33207, 33208, 33210, 33211, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33221, 33222, 33223, 33224, 33225, 33226, 33227, 33228, 33229, 33230, 33231, 33233, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33243, 33244, 33249, 33262, 33263, 33264, 33270, 33271, 33272, 33273, 33274, 33275, 33285, 33286, 33289

13	DVT/PE following Total Knee or Hip Replacement	I26.93, I26.94, I26.99, I26.02, I26.09, I26.92, I82.401 , I82.402, I82.403, I82.409, I82.411, I82.412, I82.413, I82.419, I82.421, I82.422, I82.423, I82.429, I82.431, I82.432, I82.433, I82.439, I82.441, I82.442, I82.443, I82.449, I82.451, I82.452, I82.453, I82.459, I82.461, I82.462, I82.463, I82.469, I82.491, I82.492, I82.493, I82.499, I82.4Y1, I82.4Y2, I82.4Y3, I82.4Y9, I82.4Z1, I82.4Z2, I82.4Z3, I82.4Z9, I82.621, I82.622, I82.623, T81.72XA, T84.81XA, T84.86XA	27120, 27122, 27125, 27130, 27132, 27134, 27137, 27138, 27447, 27486, 27487, 27488
14	Iatrogenic Pneumothorax with Venous Catheterization	J95.811	36555, 36556, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36572, 36573, 36578, 36580, 36581, 36582, 36583, 36584, 36585, 36589, 36590, 36597
15	MRSA (Methicillin resistant Staphylococcus aureus)	A41.01, A41.02, A49.01, A49.02, B95.61, B95.62, J15.211, J15.212	All Medical and Surgical discharges
16	Clostridium difficile (C.Diff)	A04.71, A04.72, B96.7	All Medical and Surgical discharges

HAC Appendix 2: Present on Admission Indicator

POA Indicator	Description	Payment
Y	Diagnosis was present at time of inpatient admission.	Not Applicable. Payment is made for condition when a HAC is present.
N	Diagnosis was not present at time of inpatient admission.	Applicable. No payment is made for condition when a HAC is present.
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.	Applicable. No payment is made for condition when a HAC is present.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.	Not Applicable. Payment is made for condition when a HAC is present.
1	Diagnosis exempt from POA Indicator reporting.	Usually no effect on DRG or payment.