HAAD Claims & Adjudication Rules

Version

V2011-Q2

Including the Mandatory Tariff Pricelist Application Rules.

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HEALTH AUTHORITY

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Table of Contents Page

1 -Purpose & Scope 3
1.1 -Purpose of this document 3
1.2 -Scope 3
2 -Implementation of Updates and Revision..... 3
2.1 -Effective Date 3
2.2- Updates and Revisions 3
2.3-Implementation Rules 5
2.3.1- Prices Implementation 5
2.3.2- Codes Implementation 6
3- Codes Definitions 6
3.1- Service Codes 7
4- Mandatory Tariff Pricelist 15
4.1- Purpose and use..... 15
4.2- Mandatory Tariff Application Rules..... 15
5- Claiming Methodologies..... 16
5.1- Fee For Service..... 16
5.1.1-Fee for Service – Evaluation and Management (E&M) Codes..... 17
5.1.1.1- E&M Services not separately Reimbursable..... 18
5.1.1.2- Claiming for Outpatient Consultations..... 18
5.1.2- Fee for Service- Anesthesia..... 19
5.1.3- Contrast and Radiopharmaceutical Materials..... 20
5.2- Perdiems..... 20
5.3- IR-DRGs..... 22
5.3.1- Payments Calculations..... 23
6- Adjudication Rules..... 25
6.1.1- List of Simple Edits..... 25

1. Purpose and Scope

1.1. Purpose of this Document.

- 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. Notwithstanding, contents of this document shall not be viewed or utilized in isolation from: (1) Circulars and Standards published on HAAD's website, (2) HAAD's Data Standard, (3) Clinical Coding Steering Committee (CCSC) decision, (4) Standard Providers Contract (SPC) provision and /or (5) the DRG Advisory Panel decisions. 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, 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 to the benefit of the insured.

1.2. Scope

- In contrast to the previous versions (i.e. the Basic Product Pricelist) and Rules for Claiming under the Basic Product Pricelist, this version provides comprehensive and exhaustive rules for inpatient, outpatient and ambulatory encounters.
- 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 HAAD to participate in the health insurance scheme.

2. Implementation of Updates and Revisions:

2.1. Effective Date:

- Prices listed in the Mandatory Tariff pricelist version **V2011-Q2**, and the rules included herein shall be made in effect as of **May 1, 2011**.

2.2. Updates and Revisions

- This version of the Mandatory Tariff shall be made effective on the date stated in section 2.1.
- Future updates (including schedule, intervals and public consultation process) of the Mandatory Tariff and HAAD Claims and Adjudication Rules updates, shall be implemented as per the following schedule:

- There shall be one major annual update to the Mandatory Tariff Pricelist and HAAD Claims & Adjudication Rules. The major update shall aim to:
  i. Incorporate standard codes: CPT, HCPCS addition, deletion or description update released by AMA and CMS. And / or non-standard codes: Service Codes, released by HAAD Health System Financing (HSF) Dept.
  ii. Wide-scale services and products prices update based on the revised CPT codes RVUs, Demand and Supply, Market Trends and other Economic Factors.
  iii. Update the Claims & Adjudication Rules to align with the strategic objectives, latest claiming and adjudication practices and governance.
  iv. Include updates in this revision which shall be published subsequent to CCSC review and approval of changes in the standard codes, IR-DRG grouper software, and DSP revision and approval of the changes to the Data Standard, if required.
  v. The annual update which shall be published for consultation in the first week of October of each year. However the changes shall be made effective as of the date stated in section 2.1, which (for future updates) shall be inclusive of the one month consultation and two months review and implementation period by healthcare entities: Providers and Payers.

- There might be up to three additional quarterly updates to the Mandatory Tariff Pricelist and HAAD Claims & Adjudication Rules, which shall include but not be limited to:
  i. Update of the IR-DRG weights, following the recommendations of the IR-DRG Advisory Panel.
  ii. Limited-scale Services and Products prices update to accommodate changes in the Demand and Supply, Market Trends and other Economic Factors.
  iii. Update of the Claims & Adjudication Rules to coincide with the latest claiming and adjudication practices and governance.
  iv. Addition of prices for un-priced codes.
  v. Addition of Non-standard Codes.
  vi. If required, the quarterly updates shall be published for consultation on the first week of: of January, April and July of each year. Otherwise, last quarter pricelist and rules shall remain in effect until the next quarter updates is published.
- The new releases of the Mandatory Tariff and HAAD Claims & Adjudication Rules shall be:
  i. Published on HAAD website for one month public consultation period.
  ii. Comments shall be submitted in writing to HAAD at the following e-mail address <GPPB@haad.ae>. Submissions need to be specific, and should be supported with price cost analysis and relevant supportive materials and evidence.

iii. After the end of the consultation period, the pricelist and the accompanying rules shall be published on HAAD website as official and final.

iv. Healthcare entities: Providers and Payers shall be given two calendar months to adopt the changes using the implementation rules explained in section.

2.3. Implementation Rules

2.3.1. Prices Implementation

- The tariff for products and services that are subject to the Mandatory Tariff (the Basic Product) shall follow prices listed in the Mandatory Tariff pricelist version **V2011-Q2**, and the rules included herein as of **May 1st 2011**.
- The tariff for products and services that are not subject to the Mandatory Tariff (Other Products than the Basic Product), shall be set by the parties at a rate between 1 and 3 times the HAAD Mandatory Tariff as set in the Standard Provider Contract.
- Tariffs agreed between the Parties shall be as set out in Appendix V of the Standard Provider Contract and shall be based on the Mandatory Tariff in effect at the time of agreement signature. However, Parties might opt to set the reimbursement rates using one of the following options:
  i. ***Variable Rates:*** using the Mandatory Tariff in effect, with or without multiplier; in such case, the reimbursement rates shall be subject to the periodic price updates (Increase / Decrease) published by HAAD, while the multiplier will remain as negotiated.
  ii. ***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; in such case, prices will remain unchanged throughout the contractual period despite any update to the Mandatory Tariff HAAD publish. Appendix V must indicate the Mandatory Tariff version used (e.g. V2011-Q2), or the list of the services and its respective price*.

  * Note: this rule is not permissible for the DRG codes.

- Any Party shall notify, in writing, the other Party if it wishes to review any tariff at least 60 calendar days prior to 31 December of each year. In such case the Parties shall negotiate an alternative tariff in good faith. Otherwise, if no negotiation was initiated, at the time of renewal, prices will follow the Mandatory Tariff in effect while the multiplier will remain constant.

2.3.2. 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 / 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 the Code Expiry Date. Healthcare entities: providers and payers, shall not have the choice to use the retired codes after the expiry date.

3. Codes' Definitions:

- Coding of healthcare products and services shall be in accordance with:
  - "HAAD Coding Manual for Hospitals and Other Healthcare Institutions" available at HAAD website https://www.shafafiya.org/dictionary/webframe.html, / Standards/ Coding Manual corner which includes:
    - ICD-9-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,
  - Drug Codes rules as set by HAAD Pharma/ Medicines and Medical Products Department, including MOH registered drugs.
  - The Coding Rules as established by HAAD for the non-standard "Service Codes" as listed in section 3.1. and
- All standard codes are defined and available for download from https://www.shafafiya.org/dictionary/webframe.html / Codes corner. HAAD has Emirate-wide licenses for all standard codes sets.
- Non-standard codes are defined by HAAD Health System Financing Department 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 HAAD Data Standards and Procedures are defined in https://www.shafafiya.org/dictionary/webframe.html / Standards / Data Standard corner.

3.1. Service Codes

- Service Codes are Abu Dhabi specific codes defined by HAAD Health System Financing Department and added to describe activity that is not unambiguously represented in other existing standard codes set.
- Following is the conclusive list of the HAAD Service Codes, along with the codes long description. A tabular set of these codes is also found at HAAD website https://www.shafafiya.org/dictionary/Codes/Codes.xls

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 patients 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 patients 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 who requires a short stay program for patients 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 requires a short stay program for patients 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	Observation/Treatment room - Hourly Rate	Hourly rate for the bed / room occupied by registered patient for less than 6 hours and equipped with one or more beds; in a patient care unit which is designated for: i. Observation services prior to inpatient admission, transfer or surgery. ii. For treatments or procedures requiring special equipment, such as removing sutures, draining a hematoma, packing a wound, or performing an examination.

Code	Code Short Description	Code Long Description
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 observation services post-surgery or post anesthesia.
17-24	Observation Room - Daily Rate	Daily rate for the bed / room occupied by registered patient for less than 6 hours (whether or not the patient remains in the facility past midnight) and equipped with one or more beds; in a patient care unit which is designated for extended observation or treatment.
17-25	Day Stay (Day care) Room - Daily Rate	Daily rate for the bed / room occupied by registered patient for 6 to 12 hours (whether or not the patient remains in the facility past midnight) and equipped with one or more beds and designated for Ambulatory or Outpatient surgical or medical care.

Code	Code Short Description	Code Long Description

2. Per-diems

Unless otherwise specified, Service Codes under the Per-Diems section are:

- Inclusive of the room charge, all care equipment and systems specific to the special room type, all items which do not have a valid CPT or code, Evaluation and Management, Nursing and Medical Supervision charges, all therapies (including respiratory therapy, all physiotherapy, nutritional therapy etc), drugs*, diagnostic test**, anesthetist charges, and medical supplies(HCPCS)*, recovery room, treatment room. And
- Exclusive of surgeon fees, expensive drugs*, MRI, CAT Scans and PET Scans and expensive supplies (HCPCS)*.
- For NICU, PICU, ICU, SCU and SCBU exclusive of radiology tests, laboratory tests and all drugs.

** Note: See the Per-Diem specific claiming rules for expensive drugs and supplies claiming.*
***Routine diagnostic tests not inclusive of MRI, CAT Scans, and PET Scans.*

2.1 Room and Board

Code	Code Short Description	Code Long Description
1	Ward or Shared Room - Daily Rate (Day 1 to 3)	Daily all inclusive (as defined above) 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 above) 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 above) 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 above) 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 above) 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 above) 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 are as defined in accommodation section, Service code *28*.
8	NICU - Daily Rate (Day 22 and more)	Daily all inclusive (as defined above) 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 above) 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 above) 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 above) 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 above) 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 above) 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 above) 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 above) 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 above) 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 above) 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 above) 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 above) 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 above) 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 above) 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 above) 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 above) 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 above) 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 above) 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 above) rate of hospital/nursing home confinement of registered patient who fall under the category of simple cases as defined by the HAAD Long Term Care Standard.
17-14	Long Term Stay (Intermediate Cases)	Daily all inclusive (as defined above) rate of hospital/nursing home confinement of registered patient who fall under the category of Intermediate cases as defined by the HAAD Long Term Care Standard.
17-15	Long Term Stay (Intensive Cases)	Daily all inclusive (as defined above) rate of hospital/nursing home confinement of registered patient who fall under the category of Intensive cases as defined by the HAAD Long Term Care Standard.
17-16	Long Term Stay (Severe Cases)	Daily all inclusive (as defined above) rate of hospital/nursing home confinement of registered patient who fall under the category of Severe cases as defined by the HAAD Long Term Care Standard.
2.6 Observation, Day Stay and other rooms		
15	Perdiem - Treatment or Observation Room - NOT inclusive of Laboratory and Radiology	Daily all inclusive (as defined above) rate for out-Patient observation services provided for assessed, examined, monitored, or treated of a registered patient for: - Less than 6 hours. - In any part of the hospital. - Regardless of the hour of admission, and even if the patient remains in the facility past midnight. And - Not inclusive of any Laboratory and Radiology charge.
16	Perdiem - Day Stay (Day Care) Room - NOT inclusive of Laboratory and Radiology	Daily all inclusive (as defined above) rate for out-Patient observation services provided for assessed, examined, monitored, or treated of a registered patient for: - 6 to 12 hours. - In any part of the hospital. - Regardless of the hour of admission, and even if the patient remains in the facility past midnight. And - Incurs a stay of room and board, regardless or the room type. - Not inclusive of any Laboratory and Radiology charge.
24	Per diem -Observation	Daily all inclusive (as defined above) rate for out-Patient observation services provided for assessed, examined, monitored, or treated of a registered patient for: - Less than 6 hours. - In any part of the hospital. - Regardless of the hour of admission, and even if the patient remains in the facility past midnight.
25	Per Diem- Day care / Day Stay	Daily all inclusive (as defined above) rate for out-Patient observation services provided for assessed, examined, monitored, or treated of a registered patient for: - 6 to 12 hours. - In any part of the hospital. - 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. Which shall include: - Initial and Routine patient assessment prior to, during or after in-center dialysis treatment. - Performance of hemodialysis. - Patient education and support concerning renal disease, dialysis treatment,

		diet, lifestyle and social aspects. - Equipment required for the performance of the Hemodialysis. - All disposable products and supplies required for the performance of the Hemodialysis. - Medical supervision of the dialysis by qualified physician. - Pharmaceuticals which are required in the performance of the dialysis treatment. - All routine investigation tests required for hemodialysis.
14-02	Per Diem- Automated Peritoneal Dialysis (APD).	Daily all inclusive rate for out-patient Automated Peritoneal Dialysis in a dialysis center provided for a registered patient. Which shall include: - Initial and Routine patient assessment prior to, during or after in-center dialysis treatment - Performance of Automated Peritoneal Dialysis. - Patient training for self-administration of Continuous Ambulatory Peritoneal Dialysis, as well as education and support concerning renal disease, dialysis treatment, diet, lifestyle and social aspects - Equipment required for the performance of the Automated Peritoneal Dialysis treatment. - All disposable products and supplies required for the performance of the Automated Peritoneal Dialysis. - Medical supervision of the dialysis by qualified physician. - Pharmaceuticals which are required in the performance of the Automated Peritoneal Dialysis treatment. - All routine investigation tests required for Automated Peritoneal Dialysis.
14-03	Per Diem- Continuous Ambulatory Peritoneal Dialysis (CAPD).	Daily all inclusive rate for out-patient Continuous Ambulatory Peritoneal Dialysis in a dialysis center provided for a registered patient. Which shall include: - Initial and Routine patient assessment prior to, during or after in-center dialysis treatment - Performance of Automated Peritoneal Dialysis. - Patient training 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 - Medical supervision of the dialysis by qualified physician. - Pharmaceuticals which are required in the performance of the Continuous Ambulatory Peritoneal Dialysis treatment. - All routine investigation tests required for Continuous Ambulatory Peritoneal Dialysis.
3. Consultations		
9	Consultation GP	Consultation by a General Physician For the evaluation and management of a new or established patient which includes, at a minimum, a problem focused history, problem focused examination and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.
9.1	Consultation GP – Follow up	Free follow-up consultation of the same diagnosis within 7 days of initial consultation by a General Practitioner.
10	Consultation Specialist	Consultation by a Specialist Physician For the evaluation and management of

		a new or established patient which includes, at a minimum, a problem focused history, problem focused examination and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
10.1	Consultation Specialist – Follow up	Free follow-up consultation of the same diagnosis within 7 days of initial consultation by a Specialist.
11	Consultation Consultant	Office consultation by a Consultant Physician For the evaluation and management of a new or established patient which includes, at a minimum, a problem focused history, problem focused examination and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
11.1	Consultation Consultant – Follow up	Free follow-up consultation of the same diagnosis within 7 days of initial consultation by a Consultant.
21	Home visit - G.P consultation	Retired
22	Home visit - Specialist consultation	Retired
23	Home visit - Consultant consultation	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, Ventouse, 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 a person accommodating i) an insured ii) a critically ill patient of any 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.	
99	Outlier Payment	Outlier Payment. See IR-DRG Standard at www.haad.ae

4. Mandatory Tariff Pricelist

4.1. Purpose and Use

- 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.

4.2. Mandatory Tariff Application Rules

- The Mandatory Tariff is the exhaustive pricelist for the Basic Product Plan.
- Mandatory prices are set by HAAD for the Basic Product and are non-negotiable between providers and payers.
- For all other Products; the Mandatory Tariff defines the price floor and cap where prices must fall within 1 to 3 times, respectively, of the price set in the Mandatory Tariff Pricelist.
- The process of claiming shall not alter the benefits coverage for members, hence in the absence of defined code for: Drugs, Supplies, Products or Services, the closest “Unlisted” code shall be utilized; Description of the Drugs, Supplies, Products or Services must be included in the Observation field using the following values (Type=Text, Code=Closest Drugs, Supplies, Products or Services Code, Value=Text description of procedure)- reference *Data Standards and Procedures*.
- For Un-priced or Unlisted Code, healthcare entities: providers and payers, must negotiate a reimbursement rate per service before concluding providing the service. If no specific

charge is pre-negotiated, provider must bill using the price of the most closely related Drugs, Supplies, Products, Procedure or Services- reference *Data Standards and Procedures*.

- HCPCs codes prices or negotiated rates are inclusive of the device / item costs, handling cost and provider mark-up.

5. Claiming Methodologies

- **Outpatient encounters;** claiming for outpatient encounters shall follow the Fee for Service (FFS) methodology, as defined in section 5.1. FFS methodology is permissible for outpatient encounters in 2011 and shall remain unchanged in 2012.
- **Inpatient encounters;** healthcare entities: providers and payers have the option to negotiate the reimbursement inpatient encounters using one of three methods;
  1) Fee for Service (FFS) methodology, as defined in section 5.1.
  2) Perdiem with CPT, HCPCS, CDA and Drug Codes, as defined in section 5.2. or
  3) IR- DRG, as defined in the section 5.3.

  With exception of Basic Product, the use of any and all of those methodologies shall be permitted up to Dec 31st 2011. However, on Jan 1st 2012 IR-DRG shall become the only acceptable method of payment for inpatient encounters in the Emirate of Abu Dhabi.

- **Ambulatory Services encounters**; providers and payers have the option to negotiate the reimbursement inpatient encounters using one of the following methods;
  1) Fee for Service (FFS) methodology, as defined in section 5.1. Or
  2) Perdiem (selected codes) with CPT, HCPCS, CDA and Drug Codes, as defined in section 5.2.

  With exception of Basic Product, the use of any and all of those methodologies shall be permitted in year 2011 and 2012. However HAAD, 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. Healthcare entities: Providers and Payers shall be provided with sufficient time to review and adapt to the selected system, would the decision is made to have the prospective payment system in effect, as the only or "one of" the acceptable method of payment in the near future.

5.1. Fee for Service

- "Fee for Service" models allow for services performed being separately billed and paid for using the available codes sets approved by CCSC and HAAD.
- Under the Fee for Service (FFS) methodology, all services must be coded and billed separately, using HAAD approved codes (CPTs, HCPCS, Drug codes …etc) and as defined by CCSC and /or HAAD: CCSC (Standard Codes), HAAD (Service Codes and Drugs codes). As such, 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 defined, distinctive and unambiguous 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, one related E/M encounter on the date immediately prior to or on the date of 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.

- For Basic Product members, Fee for Service use will be limited to outpatient services and where there is no designated Ambulatory Code or Claiming Rule to the contrary.
- Following codes sets can be used for Fee for Service claiming
  - **Service Codes:** Limited to the following codes sets:
  - Set 1 - Accommodation
    - 1.1. Room and Board
    - 1.2 Special Care
    - 1.3 Nursery
    - 1.4 Intensive Care
    - 1.5 Other rooms
  - Set 3 - Consultations
  - Set 4 - Operating Room Services
  - Set 5 - Other Services
  - **CPT codes:** All approved and active CPT codes.
  - **Anesthesia codes:** All approved and active anesthesia CPT codes.
  - **HCPCS:** All approved and active HCPCS codes.
  - **Drug Codes:** Drug Codes as set by HAAD Pharma/ Medicines and Medical Products Department, including MOH registered drugs.
  - **Dental codes:** All approved and active USC&LS codes.

5.1.1. Fee for Service - Evaluation and Management (E/M) Codes:

- E/M Codes are mandatory for all Outpatient services including Homecare and Preventive Services since September 1, 2010. For details refer to the Health insurance circular 33 at HAAD website: *www.haad.ae*.

- Until June 30th 2011, Providers not yet Coding Certified must continue to bill based on the three Service Codes 9, 10 and 11. Nonetheless, Providers are required to use E&M codes as a prerequisite for reimbursement, but keep charges at a value of zero.
- On and after July 1st 2011, Providers not yet Coding Certified will be claiming using the lowest level (level 1) of the applicable E&M codes type (Outpatient: New patient, Established Patient, Emergency …etc), Nonetheless, Providers are required to use proper E&M codes as a prerequisite for reimbursement, but keep charges at a value of zero.
- Providers already certified (Coding Certified providers are listed at http://www.shafafiya.org/dictionary/) must bill at the preliminary E/M prices as published on our website.
- For certified providers, a "follow up within one week" shall be billed using Evaluation and Management of an established patient codes 99211 to 99215 at "0" value. And until certification, follow up within one week must continue to be billed using Service Codes 9.1, 10. 1 and 11.1 plus appropriate established E/M codes at "0" value.
- Codes 99341 to 99350 and codes 99381 to 99404 can be used without passing the initial audit, however must be passed in all subsequent audits.
- Codes 99201-99215 and codes 99341 to 99350 can be used by both physicians and authorized Clinicians.

5.1.1.1. E & M Services Not Separately Reimbursable

- The following CPT-4 codes for E & M services are not separately reimbursable if billed by the same provider, same of similar chief complaint, for the same recipient and same date - or within the subsequent week- of service. In such cases, for the following code combinations, reimbursement will be made only for the higher paying of the codes billed.
  1. New patient, office or other outpatient visit (99201 – 99205) and another new patient, office or other outpatient visit (99201 –99205).
  2. Established patient, office outpatient visit (99211 –99215) occurring within 7 days from the initial New patient, office or other outpatient visit (99201 – 99205).
  3. New or established patient, subsequent hospital care (99231 –99233) and new or established patient, initial inpatient consultation (992551 – 99255). Applicable only for the same date of service.
  4. New or established patient, initial hospital care (99221 – 99223) and new or established patient, subsequent hospital care (99231 – 99233). Applicable only for the same date of service.

5.1.1.2. Claiming for Outpatient Consultation (99241 – 99245).

- There might be restriction on the payment of a medically necessary consultation, unless the following requirements are met:
  1. The service must meet the requirements criteria as set out in the Clinical Coding Steering Committee's Coding Manual.

ii. The consultant documents both a request for a consultation from an appropriate source and the need for consultation (i.e., the reason for the service) in the patient's medical record. This also must appear in the requesting physician's plan of care, which is in the patient's medical record.

iii. The consultant provides a written report of his or her findings and recommendations, which shall be provided to the referring physician. Those findings and recommendations should be available in the consultation report.

iv. The following do not meet the criteria for consultation services:
   - Standing orders in the medical record; no order for a consultation; and no written report of a consultation.
   - Transfer of care. When a physician asks another physician to take over responsibility for managing the patient's complete care, it is considered a transfer of care. Coding should be for the appropriate level of new or established E&M code, but not a consultation code.

5.1.2. Fee for Service - Anesthesia Codes,

- This claiming guide provides you with the claiming criteria for anesthesia services provided by HAAD licensed physicians.
- For the Basic product, and other product if claiming using IR-DRG, Anesthesia codes are used for cost reporting and outlier calculation.
- Following are the types of anesthesia eligible for separate claiming
  i. Inhalation
  ii. Regional, including:
     - Spinal (low spinal, saddle block)
     - epidural (caudal)
     - Nerves block (retro-bulbar, brachial plexus block, etc.)
     - Field block
  iii. Intravenous
  iv. 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
  - Local anesthesia
  - Standby anesthesia (99360)

- 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 = EAD 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 and be reported using the appropriate CPT code as defined by CCSC.

5.1.3. 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 CPT/HCPCS description; Or codes in which clinical review determined contrast or radiopharmaceutical materials were required in order to perform the service.
- HAAD Drug codes shall be used for billing Contrast and Radiopharmaceuticals Materials.

5.2. Per Diem

- Codes used for Per Diem claiming are:
  - 2.1 Room and Board
  - 2.2 Intensive Care.
  - 2.3 Nursery

- 2.4 Special Care
- 2.5 Long Term Stay
- 2.6 Observation, Day Stay and other rooms
- 2.7 Dialysis

- Per diem is a daily all inclusive rate, which includes:
  - Room and Board Charge, care equipment and systems specific to the special room type.
  - All items which do not have a CPT or HCPCs code on the covered basic product pricelist.
  - 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.
  - Cost of single drug that doesn't exceeds AED 1000 in accumulative cost during the entire length of stay. Rule is not applicable to Long term Care.
  - Cost of all drugs for Long term Care.
  - Approved Single HCPCS, Products and Medical supplies not costing in excess of AED 1,500. Rule is not applicable to Long Term Care.
  - Cost of all HCPCS (for consumables, Products or medical devices) for Long Term Care.

- Per diems are exclusive of:
  - Surgeon fees,
  - Cost of single drug that exceeds AED 1,000 in accumulative cost during the entire length of stay. Rule is not applicable to Long Term Care.
  - Approved Single HCPCS (for consumables, Products or medical devices) costing in excess of AED 1,500. Rule is not applicable to Long Term Care.
  - MRI, CAT Scans and PET Scans tests.
- NICU, PICU, ICU, SCU and SCBU are exclusive of radiology tests, laboratory tests and all drugs.
- Code 15 "Per diem -Observation "and 16 "Per Diem- Day care / Day Stay", are not inclusive of Laboratory and Radiology.
- For Basic Product members or providers claiming using IR-DRG system, per diem usage shall be limited to:

  - **Outpatient / Ambulatory services (Day Care/Day Stay)**:
    - Service code 25 is mandatory for the Basic Product.

- For other products, Daycare Per Diems can be billed using Service codes 16 and 25.

  (For full description of these codes refer to the section on Per Diems and Service Codes Descriptions in this document).

- **Observations:**
  - Service code 24 is mandatory for the Basic Product.
  - For other products, Observations can be billed using Service codes 15 and 24.

    (For full description of these codes please refer to the sections on Per Diems and Service Codes Descriptions in this document).
- **Long Term Care (LTC):**
  - LTC must be billed as Per diems using Service codes 17-13, 17-14, 17-15 and 17-16.
  - LTC Service Codes must be used in accordance to the HAAD Standard for Provision of Long-Term Care.

    (For reference see the Long Term Care Standard at www.haad.ae).
- **Inpatient Dental Care**:
  - Dental services are not covered for the Basic Product members, except in case of emergency.
  - Emergency inpatient dental services must be billed as Fee-for-Service.
- **Transferred Cases:**
  - For Transfer patients between facilities (inter-hospital transfers) for the purpose of managing Acute Medical Condition. Transfer Case definition doesn't apply to patient transferred to facilities or inter-hospital for Long Term Care, as defined in HAAD Standard for Provision of Long-Term Care.
  - For Basic Product, or other product if IR-DRG prospective payment system is used, transferred inpatient cases:
    - Transferring facility should bill and receive payment for Per Diem, using the designated Service Codes: However all services will be coded and billed at at "0" value for reporting purposes.
    - The receiving facility shall receive payment IR-DRG payment. Please refer to section 5.3 for details of IR-DRG claiming methodology.
  - For transferred patient encounters, data elements must be reported in accordance with the rules defined in HAAD Data Standard for transferred cases. These include but are not limited to: EncounterStartType, EncounterTransferSource, EncounterTransferDestination, and EncounterEndType.

5.3. IR-DRGs:

- IR-DRGs are effective and mandated for the Basic Product for all Inpatient encounters with Encounter Start date on or after 1 August, 2010. For all other products IR-DRGs will be mandated and effective upon voluntary adoption of the IR-DRG system or by January 1 2012 - which ever falls first.
- HAAD Standard establishing the Diagnosis Related Groupings System is available at HAAD website www.haad.ae , Policies and Circulars Section: Reference HSF/DRG/1.0, Approval Date Jun/2010.
- In the IR-DRG system, payment is fully inclusive of all procedures, services, consumables and devices utilized during services 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 5.1. The Activity.Net must be set to “zero” value for all Activities with the exception of the IR-DRG code, and service code 99 for the outlier payment.
- 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 primary diagnosis and primary procedure; IR-DRG severity might be affected by the secondary diagnosis.
- 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 6 of this document, and HAAD Adjudication Standard published in December 2010. With the following DRG specific adjudication rule:
  - If the principle diagnosis is not covered condition under the insurance plan, Insurance Companies shall have the right to deny the entire claim.
  - If the principle procedure is not covered. Insurance companies could exclude the Service, procedure or item, and pay using the recalculate DRG.
  - Secondary diagnosis coding shall follow CCSC published rules. Accordingly:
    - Secondary diagnosis(es) if relates to uncovered condition but has 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 and have 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 influence on the length of hospital stay, or increased nursing care and/or monitoring. However, can be flagged for audit, and be subject to recovery if confirmed to be wrongly coded by the medical record audit.
    - Confirmed Coding errors shall be reported to CCSC for arbitration review and potential audit certificate cancellation of the frequent violators.

5.3.1. Payment Calculations

- For Basic Product, the **Base Rate is AED 8,500; the Gap is AED 50,000 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.
- Unless the Split of DRGs payment rule applies, payers are liable for the complete DRG Base Payment only, unless the case hits the outlier:

i. Base Payment

- The Mandatory Tariff lists the relative weights. The exact base payment can be calculated by multiplying the base rate [x], the relative weight of the DRG (in 4 decimals) and rounded off to the full AED (no decimals) using the following formula:

Base payment = Base Rate x Relative Weight.

ii. Outlier Payment:

- Outlier payment acts as a "stop-loss" measure to protect providers from incurring losses while managing complex cases and calculated as follows:

Outlier payment = (Cost Base Payment – Gap) x 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 HAAD 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.

iii. Split of DRGs payment for encounters involving more than one payer.

- Rules included in this section shall apply in the event of:
  - Inpatient encounter that extends beyond the expiry date of the policy, or New-born in-patient encounter that extends beyond one month coverage period through the mother's insurance, and where more than one payer is involved in reimbursement of the cost of a single inpatient encounter. And
  - Reimbursement of cost of the members' treatment is in accordance with the IR-DRG payment system.

- Single Admission is considered a single encounter thus shall be reimbursed as single DRG payment for the entire stay, irrespective of number of day's coverage limitation.
- For Newborn cases:
  - 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.
- Reimbursement for such encounter shall be in accordance with the following rules;
  - **Medical Cases (IM);** irrespective of the Length of Stay (LOS). Payer 1 will be responsible for the total DRG Payment

  - **Surgical Cases (IP) ;**
    - If the surgery was performed within the Payer 1 coverage period and no subsequent surgeries taken place post Member's Insurance Policy Expiry Date; Payer 1 will be responsible for the Total DRG Payment.
    - If the surgery 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 = Number of Days covered by the Payer 1   Y = Total number of day of the Encounter (Admission)

6. Adjudication and Pre-authorizations Rules

- HAAD 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 HAAD to participate in the Health insurance scheme of Abu Dhabi.

- HAAD Health Insurance Adjudication Standard is available at HAAD website www.haad.ae , Policies and Circulars Section: Reference HSF/CA/1.0, Approval Date Dec/2010.

6.1.1. List of Simple Edits.

- Simple Edits are required to be shared electronically with HAAD and contracted providers on an ongoing basis. To respect the commercial confidentiality of these edits vis-a-vis other payers, HAAD undertakes not to share these Edits with other Payers/Providers in their native attributed form.
- As Adjudication Rules are not Diagnosis Related Groupings (DRG) specific, and until the DRG system is fully implemented for all health insurance products by 31 December 2011, DRG related edits will be treated as complex edits.
- Following is the listing of the most commonly used simple edits used in the Emirate of Abu Dhabi

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