Policy Directive pursuant to the Health Insurance Law (No 11 of 2013) of the Emirate of Dubai

eClaimLink Policy Directive Number 01 of 2019 (PD 01/2019)

Subject of this Policy Directive	**Claims Audit and Recovery in the Emirate of Dubai**
Applicability of this Policy Directive	This Standard is applicable to all Healthcare Payers (Payers), Third Party Administrators (TPAs), Healthcare Providers (Providers) and Health Insurance Stakeholders in the Emirate of Dubai. This policy is integrated with other regulations, standards and circulars in Emirate of Dubai relevant to the Health Insurance Law (No 11 of 2013) of the Emirate of Dubai.
Purpose of this Policy Directive	The Policy Directive serves to regulate: 1. Audit processes 2. Recovery reasons 3. Process for recovery 4. The obligations of Auditors – DHIC, Payers and Providers 5. Regulatory requirements between DHIC Auditors, Payers and Providers
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This document replaces	Not applicable
This document has been replaced by	Not applicable
Effective date of this Policy Directive	Immediately
Grace period for compliance	None

1 Preamble

1.1 This Policy Directive provides an overview of the Recovery and Claims Audit practices, standards and procedures defined by Dubai Health Insurance Corporation (DHIC) in the Emirate of Dubai;

1.2 The policy establishes basic framework and offers a guide on the responsibilities of all parties engaged in the process of Recovery and Claims Audit;

1.3 The objective is to reduce improper payments by standardizing guidelines for all stakeholders to ensure all Claim Audits are performed efficiently and effectively, thereby promoting the accuracy and integrity of Providers' charges;

1.4 This Policy Directive applies to audits carried out either by the Dubai Health Insurance Corporation (DHIC), by Payers or by TPAs on behalf of payers

2 Glossary

2.1 Audit log

A historical record kept by Dubai Health Insurance Corporation (DHIC) or Payer that records the audit experience related to a particular party.

2.2 Claim

Any document that represents a Provider's request for payment from a Payer or TPA.

2.3 Claims Audit

A process to determine whether data in a Provider's health record, and/or appropriate and referenced medical policies, protocols and standards, document or support services listed on a Provider's claim.

2.4 Healthcare Insurance Abuse (Abuse)

Insured Person or Healthcare Provider practices that are inconsistent with accepted sound fiscal, business, or medical practices, and result in an unnecessary cost or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Abuse may include, but is not limited to:

2.4.1 Misusing codes on a claim;
2.4.2 Charging excessively for services or supplies;
2.4.3 Billing for services that were not medically necessary.
2.4.4 Improper payment for services

2.5 Health Insurance Fraud (Fraud)

False or misleading information is provided to Payers in an attempt to have them pay unauthorized benefits to the policy holder, another party, or the entity providing services. This violation can be committed by the insured individual or the Provider of health services. Health Insurance Fraud is an intentional act of deception by Healthcare Providers or Patients. Fraud may include, but is not limited to:

2.5.1 Facilitating the ineligible insured members to obtain health care services;
2.5.2 Billing for services, procedures and/or supplies that were never ordered or rendered;
2.5.3 Providing services or supplies to a patient that are not needed based on the patient's medical history
2.5.4 Charging for more expensive services than those actually provided;
2.5.5 Misrepresenting non–covered treatments as a medical necessity;
2.5.6 Falsifying a patient's diagnosis to justify tests, surgeries, or other procedures;
2.5.7 Billing each step of a single procedure as if it were a separate procedure;
2.5.8 Charging a patient more than the co–pay agreed to under the insurer's terms.

2.6 Health Insurance Waste (Waste)

Includes an incorrect diagnoses as well as medical errors and other sources of avoidable complications (such as infections that patients acquire during a hospital stay), or the overutilization of services or other activities that lead to unnecessary costs to healthcare payers

2.7 Health record

A compilation of data supporting and describing an individual's health care encounter including data on diagnoses, treatment, and outcomes

2.8 Over-Billing

The volume of services indicated on a claim exceeds the total volume identified in a Provider's health record documentation. Common reasons for overbilling are: billing for excessive or non-covered services, duplicate submission and subsequent payment of the same service or claim, billing for excluded or medically unnecessary services, billing for services that were furnished in a setting that was not appropriate to the patient's medical needs and condition.

2.9 Recovery of Payment

The return, in full or in part, of one or many payments made by healthcare payers in respect of a claim or claims.

2.10 Unbilled charges

Services that are documented but were never claimed originally

2.11 Under-Billing

The volume of services indicated on a claim is less than the volume identified in a Provider's health record documentation.

3 Reasons for Recovery of Payment for Claims

3.1 Dubai Health Insurance Corporation (DHIC) has specified the following reasons for seeking recovery of payment for claims;

3.1.1 On-site audits for Provider;
3.1.2 Identified Fraud, waste and abuse as per the above definitions;
3.1.3 Voluntary reporting of errors by Providers;
3.1.4 Coding errors;

3.1.5 Other unintentional errors;
3.1.6 Court ruling;
3.1.7 Duplicate billing/services;
3.1.8 Multiple billings of services by more than one physician within a group;
3.1.9 Overbilling

3.2 Payers/TPAs and Providers must adhere to the recovery process detailed in this Policy for cases where recovery of payment is sought, based on appropriate documentation.

3.3 Payers/TPAs must report any documented cases of Fraud, waste or abuse to Dubai Health Insurance Corporation (DHIC) through Health Insurance Compliance and Investigation Log (HICAL) that can be accessible via www.ISAHD.ae for corrective measures and legal sanctions as may be applicable.

4 Audit Process

4.1 Confidentiality and Authorizations

4.1.1 All parties to a Claims Audit must comply with United Arab Emirates Privacy Rules as regards to confidentiality of patient information;

4.1.2 All stakeholders conducting or involved with Claims Audit must maintain policies and procedures ensuring the confidentiality of patient protected health information (PHI) in their control and the proper disposal of this information, and must be able to provide relevant documentation on said policies and procedures to the DHIC if requested to do so;

4.1.3 In circumstances where authorization from a patient is required, the patient authorization must include the following information:

4.1.3.1 Patient's full name, address, and date of birth;
4.1.3.2 Purpose for releasing/obtaining the information;
4.1.3.3 Date the consent was signed;
4.1.3.4 Signature of patient or legal representative;

4.2 Qualifications of Auditors and Audit Coordinators

4.2.1 All individuals performing Claims Audit as well as persons functioning as Provider audit coordinators should have appropriate knowledge, experience, and/or expertise in a number of areas of healthcare including, but not limited to the following areas:

4.2.1.1 Structure of the health record as well as other forms of medical/clinical documentation;
4.2.1.2 Auditing and coding certificates accepted by Dubai Health Insurance Corporation (DHIC)
4.2.1.3 United Arab Emirates regulations concerning the use, disclosure, and confidentiality of all patient records.
4.2.1.4 Medical Practice and Standards

For the avoidance of doubt, an individual is not required to have appropriate knowledge on all areas. However, Payers/TPAs are required to ensure that sufficient number of individuals are involved in Claims Audit to ensure that the appropriate knowledge, experience and expertise is encompassed in the Claims Audit team.

4.2.2 Audit personnel should be able to work with a variety of healthcare personnel and patients. They should always conduct themselves in an acceptable, professional manner and adhere to ethical standards, confidentiality requirements, and objectivity. They should completely document their findings and any issues encountered. All unsupported or unbilled charges, overbilling or overpayments, identified in the course of an audit must be documented in the audit report by the auditor.

4.3 Notification of Audit

4.3.1 Notification of intention to audit must be formally communicated by Payer/TPA at least five [5] working days prior to the intended audit commencement date;

4.3.2 Dubai Health Insurance Corporation is authorized to conduct unannounced audit visit without prior intimation to Payers, TPAs or eClaimlink licensed Providers

4.3.3 DHIC or Payers/TPAs are not required to specify, and Providers are not permitted to request, the specification of the claims to be audited so as to prevent amendment of files to be audited;

4.3.4 The Provider has the right to reschedule the audit date if another Payer/TPA is conducting Claims Audit on same date; in such cases Provider must make all efforts to re-schedule the audit at the soonest possible date, and in all circumstances should reschedule the audit no later than ten [10] working days from the initially communicated audit commencement date

4.3.5 All requests for audits should include the following information:

4.3.5.1 The intended purpose for the audit;

4.3.5.2 The name of the auditor/s;

4.3.5.3 The name of the designated single point of contact at the requesting entity (Dubai Health Insurance Corporation, Payer/TPA as applicable) for any Provider queries.

4.3.6 Auditors should conduct audits at a Provider's site. On-site audits encourage and promote mutual understanding of the records and afford both parties the opportunity to quickly and efficiently handle questions that may arise; follow- up audit activities may be carried out on an off-site basis subject to Dubai Health Insurance Corporation (DHIC) or Payer/TPA and Provider agreeing to off-site follow up audit during the on-site audit, with agreement documented by both parties

4.3.7 The-on-site Claims Audit process should not take more than five [5] working days to be completed;

4.3.8 Providers should supply the auditor(s) with any additional departmental documentation that could improve the efficiency of the audit and/or ultimately support the changes originally billed, if applicable;

4.3.9 Providers shall bear all printing cost relevant to on-site audit.

4.4 Provider Audit Coordinators

4.4.1 Providers should designate an individual to coordinate all Claims Audit activities. An audit coordinator should have the same qualifications as an auditor. The main responsibilities of an audit coordinator include;

4.4.1.1 Scheduling an audit (subject at all times to the requirements laid out in 4.3);

4.4.1.2 Ensuring that authorization for the release of health information has been obtained, if applicable (as per the requirements laid out in 4.1);

4.4.1.3 Verifying that the auditor is an authorized representative of Dubai Health Insurance Corporation (DHIC) or the Payer/TPA;

4.4.1.4 Gathering the necessary documents for the audit;

4.4.1.5 Coordinating auditor requests for information, space in which to conduct an audit, and access to records and Provider personnel, as necessary;

4.4.1.6 Orienting auditors to internal hospital audit procedures, Health record documentation and claims practice;

4.4.1.7 Acting as a liaison between the auditor and other hospital personnel to provide department interviews when requested;

4.4.1.8 Conducting an exit interview with the auditor to answer questions and review audit findings;

4.4.1.9 Reviewing the auditor's final written Claims Audit Report and following up on any charges still in dispute;

4.4.1.10 Arranging for recovery payment and follow-up with Dubai Health Insurance Corporation (DHIC) or Payer/TPA if necessary.

4.5 Claims Audit Process

4.5.1 In order to have a fair, efficient, and effective Claims Audit process, Providers, Payers/TPAs and Dubai Health Insurance Corporation (DHIC) auditors should adhere to the following practices:

4.5.1.1 Payers/TPAs or Dubai Health Insurance Corporation (DHIC) must conduct on-site exit interview with the Provider's audit coordinator after completion of the audit process to summarize the process and answer any inquiry by the Provider's audit coordinator.

4.5.1.2 A written Claims Audit Report must be part of each audit. The report sent to Providers must detail why recovery payments are sought with appropriate supporting documentation;

4.5.1.3 Payer/TPA shall communicate the Claims Audit Report detailing audit findings within twenty [20] working days after on-site exit interview.

4.5.1.4 Providers must respond to the Claims Audit Report within twenty [20] working days after receiving it, otherwise, the audit findings shall be considered final;

4.5.2 Where Providers dispute the audit findings in their response, the parties involved in the audit should agree to set and adhere to a timeframe for resolution of the dispute, and once an agreement has been reached as to the disputed audit findings and the documentation finalized, the audit process is considered final and closed;

4.5.2.1 Recoveries of payments cannot be initiated until after the audit process is final and closed;

4.5.2.2 During the audit, the process may identify ongoing problems with either the billing, access to medical records or documentation process. If chronic issues cannot be resolved through the audit process, Providers or Payers/TPAs should contact the Dubai Health Insurance Corporation (DHIC). The Dubai Health Insurance Corporation (DHIC) shall coordinate with Providers and Payers/TPAs to facilitate corrective action.

5 Retrospective Audit

5.1 Dubai Health Insurance Corporation (DHIC) may conduct an internal retrospective e-claims review to detect trends in overbilling / misuse or unnecessary services or coding errors. The following types of corrective actions can result from retrospective claims review:

5.1.1 Provider Education/Feedback

The Provider receives notification of appropriate claim procedures when DHIC detects problems.

5.1.2 Pre-payment Review

Providers with identified problems may be placed under Pre-payment review by the DHIC. Once Providers re-establish correct billing practices, and the same is verified by the DHIC, Pre-payment review ends.

5.1.3 Post-payment review

Dubai Health Insurance Corporation (DHIC) shall notify Payers to perform post-payment claim reviews most commonly by using statistically valid sampling. Sampling allows estimation of under billing or over billing (if one exists) without requesting all records on all claims from Providers. This reduces the administrative burden for Payers.

5.2 Payers shall communicate the Claims Audit Review Report to Dubai Health Insurance Corporation (DHIC), which must be supported by proper documentation and evidenced-based justification.

6 Self-Reporting of Claims Errors and Mistakes by Providers

6.1 Providers must report incorrect claims independent of any onsite or retrospective audit or reconciliation process. Once the Voluntary Reporting of Claims is reported, Payer/TPA has [15] working days to initiate recovery of payment for claims.

6.2 No recovery of claims by the Payer/TPA will be accepted after this period by the Payer in respect of claims reported by the Provider

7 Fraud and Abuse

7.1 It is the responsibility of Payers/TPAs to establish effective measures to detect, report and prevent Fraud and Abuse cases. Payers/TPAs must report any Fraud cases to Dubai Health Insurance Corporation (DHIC) for investigations and corrective measurement;

7.2 Dubai Health Insurance Corporation (DHIC) is the only authorized entity to agree the referral of Fraud cases to courts. Payers/TPAs therefore may not refer Fraud cases to the Dubai courts without the agreement of the Dubai Health Insurance Corporation (DHIC). However, Payers/TPAs are permitted to withhold payments to Provider, in the amount equivalent to the amount of claims suspected of and/or reported as being fraudulent;

7.3 After confirmation of fraud (by the courts), Payer may unilaterally terminate the contract with the Provider immediately and where appropriate withhold funds. In addition, to the Fraud sanctions that set out by Dubai Health Insurance Corporation (DHIC), Payer has full right to recover the payment from the Provider within [15] days from the Provider.

8 Recovery Process

8.1 Recovery of payment can not be obtained by Payer after the reconciliation date, except for cases as per section 3; including convicted fraud, judgment by the court and/or applicable criminal law in United Arab Emirates.

8.2 Recovery of payment for claims may be initiated after any of the following:

8.2.1 Acceptance of Claims Audit Report results by the Provider;

8.2.2 Ruling of fraud and/or abuse or any other court ruling or Dubai Health Insurance Corporation (DHIC) decision;

8.3 Recovery is to be initiated through the eClaimLink system.

8.3.1 Payers/TPAs must submit remittance advice with one of the following denial reasons:

8.3.1.1 PRCE-003 - Recovery of Payment

Recovery of payment following Provider audit conducted by a Payer/TPA and finalization of the audit process detailed in this Policy Directive

8.3.1.2 PRCE-012 - Recovery of Payment – DHIC Authorized

Recovery of payment following Provider audit conducted by Dubai Health Insurance Corporation (DHIC) and communicated to the relevant Payer/TPA

8.4 This Policy Directive will not apply retrospectively.

9 Recovery of Payment

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

9.1.1 Recover the amounts by way of offset from current and/or future payments after identifying remittance advice(s) on which the overpayment was made to the Provider. Such recovery must only take place after the Provider has been notified with supporting evidence.

9.1.2 In the absence of current and/or future payment, Providers must provide reimbursement by cheque or electronic transfer to the Payer/TPA

10 Reconciliation

10.1 As per the eClaimLink archiving policy, Payers/TPAs and Providers must reconcile their accounts before the existing archiving of claims, 24 months from the submission date;

10.2 In all cases, Payers/TPAs and Providers must adhere to Dubai Health Insurance Corporation mandated timelines for completion of reconciliation processes;

10.3 For agreed reconciliation signed by both parties (Payer/TPA and Provider), no recovery of claims may be pursued for services rendered during the reconciled period for reasons other than Court or Dubai Health Insurance Corporation (DHIC) ruling or for claims amounts identified through the Audit process as arising from fraud, waste or abuse.