Standards Notice pursuant to the Health Insurance Law (No 11 of 2013) of the Emirate of Dubai

eClaimLink Standards Notice 03 of 2019 (SN 03/2019)

Subject of this Standards Notice	**Claim Cycle Standardisation**
Applicability of this Standards Notice	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 Standards Notice 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 Standards Notice	This Standards Notice serves to announce the standardisation of the Claim cycle timelines and permissible frequency of submissions
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This document replaces	Not Applicable
This document has been replaced by	Not Applicable
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Effective date of this Standards Notice	1st October 2019

1 Preamble

The Standards Notice serves to:

1.1 This Standards Notice supersedes any existing contracted timelines;
1.2 Standardise the timeline for Claim submission and resubmission;
1.3 Standardise the maximum number of permitted Claim resubmissions permissible;
1.4 Standardise the timeline for Claim remittance and payment;
1.5 Outline the timeline for reconciliation and settlement of Claims submitted prior to 1st September 2019;
1.6 Reiterate existing policies and developments that are complementary to the instructions out lined in this Standards Notice , that must be considered;
1.7 Outline the compliance monitoring objectives of Dubai Health Insurance Corporation

2 Definitions

2.1 Resubmission

Following review and once Remittance Advice has been received; the Provider has three options for each Claim:

A. Accept: no action
B. Correct: resubmit using Claim.Resubmission transaction. The number and nature of corrections allowed can be specified in the Provider-Payer contract and this Standards Notice .

C. Internal Complaint: start Internal Grievance & Appeals process -- resubmit using Claim.Resubmission. There may be multiple cycles of Claim.Resubmission and Remittance.Advice outlined in this Standards Notice

D. Reconciliation: resubmit using Claim.Resubmission transaction once Claim is discussed and outcome is agreed by all Parties.

2.2 Reconciliation

2.2.1 Reconciliation refers to the process where disputed Claims are addressed and examined in detail to ascertain and identifying the correct amount to be paid and amount actually paid to a Healthcare Provider (Provider) before the Claim can be deemed reconciled and closed.

2.2.2 Healthcare Providers (Providers) and Healthcare Payers (Payers) or Third Party Administrators (TPAs) may carry out the reconciliation process at any time in the claim cycle post communication of first Remittance Advice, subject to agreement by both parties to enter into the same.

3 Standardisation of the Submission, Resubmission, Remittance and Payment Timelines

3.1 Dubai Health Insurance Corporation is continuously monitoring market compliance and performance to eClaimLink Policies, Guidelines as well as Business and Validation Rules.

3.2 Current market behavior will be used as a baseline to substantiate and support decision making and subsequent Policy updates aimed at standardizing submission, remittance and resubmission timelines.

3.3 This Standards Notice serves as a guide to set the timelines for claim submission, resubmission, remittance and payment, while also setting the maximum permissible resubmissions for each claim and penalty for delays.

3.4 As Government Programs are subject to separate parameters and agreements, the said penalties shall not apply to them.

3.5 Where existing contractually agreed timelines, between a Healthcare Payer (Payer) or Third Party Administrator (TPA) and Healthcare Provider (Provider), are more than those mandated in this Standards Notice, this Standards Notice supersedes the contracted timelines.

3.6 New contracts between a Healthcare Payer (Payer) or Third Party Administrator (TPA) and Healthcare Provider (Provider) must comply with this Standards Notice (SN).*Executive Council Resolution No 7 of 2016*

3.6.1 Failure to comply with the mandates of this Standards Notice will be considered a violation and may incur a fine or fines from those listed in the Resolution referenced above. In addition, failure to comply with the mandates of this Standards Notice may incur a sanction or sanctions from those available for application by the Dubai Health Insurance Corporation (DHIC).

3.7 Submission

3.7.1 The Healthcare Provider (Provider) undertakes to submit the eClaim to the Healthcare Payer (Payer) or Third Party Administrator (TPA) no later than **the 15th of the next month** following the service month.

3.7.2 In case of delay in submission, the Healthcare Payer (Payer) has the right to receive a 0.03% delay fee per calendar day from the Net Claimed amount due. These fees will be based on the original Net amount claimed and not on the amount that is eventually paid.

3.8 Resubmission

3.8.1 All disputed claims including rejected claims must be resubmitted to the Healthcare Payer (Payer) or Third Party Administrator (TPA) within ***Twenty One (21) calendar days*** from the date of receipt of payment or Remittance Advice (RA) with denial reason.

3.8.2 Healthcare Providers (Providers) will be permitted to resubmit a disputed claim a maximum of ***TWO (2) resubmissions***, inclusive of resubmission and reconciliation(2nd resubmission).

3.8.3 Healthcare Payers (Payers) or Third Party Administrators (TPAs) must make available to the Healthcare Providers (Providers) through remittance advice posting the denial reason for any partially or fully rejected amounts. See clause 6.1.3 for development that must be completed to fully satisfy this clause.

3.8.4 In case of delay in resubmission, the Healthcare Payer (Payer) has the right to receive a 0.03% delay fee per calendar day from the Net Claimed amount due. These fees will be based on the original Net amount claimed and not on the amount that is eventually paid.

3.8.5 The combined number of correction, internal complaint and reconciliation resubmissions specified in the Provider – Payer contract shall not exceed the maximum number of resubmissions specified in this Standards Notice.

3.9 Remittance & Payment

3.9.1 The Healthcare Payer (Payer) or Third Party Administrator (TPA) undertakes to make payment and post remittance advice on DHPO, with payment reference, for adjudicated claims within ***Forty-five (45) calendar days*** from the date of claim submission.

3.9.2 In the case of claims, which extend to resubmission, any subsequent remittance must be posted on DHPO and payment made within ***Thirty (30) calendar days*** from the date of claim resubmission.

3.9.3 In case of delay in payment, the Healthcare Provider (Provider) has the right to receive a 0.03% delay fee per calendar day from the Net Claimed amount due. These fees will be based on the original Net amount claimed and not on the amount that is eventually paid.

3.9.4 *PD 03-2019 Settlement of Payment for Emergency Services*

3.9.4.1 Remittance and payment timelines for emergency claims as per the above referenced Standards Notice must be made within 7 days of claim submission. Failure to do so will result in the Payer incurring the relevant fine detailed in 3.7.2.2. below

3.9.4.2

Executive Council Resolution No. (7) of 2016 states at Table No.2, item 19:	
عدم قيام شركة التأمين بسداد الخدمات الصحية المقدمة في الحالات الطارئة من منسأة صحية غير مدرجة لديها ضمن شبكة مقدمي الخدمات الصحية خلال (7) أيام عمل من تاريخ تقديمها.	(5000) درهم إضافة الى سداد تكلفة العلاج

3.9.5 Healthcare Payers (Payers) and Third Party Administrators (TPAs) must ensure that Remittance Advice (RA) with complete and accurate payment reference is posted on DHPO for each Claim.

3.9.6 It is mandatory for Healthcare Payers (Payers) and Third Party Administrators (TPAs) to provide all relevant denial codes accurately, as per the codes stated and published on eClaimLink, referenced in clause 6.1.2.

3.9.7 The above are to be strictly adhered to, as failure to do so will lead to penalties and/or possible suspension or revocation of license status.

3.9.8 Healthcare Payers (Payers) are also required to adhere to these timelines where a Third Party Administrator (TPA) has been contracted to administer their claims.

3.10 Reconciliation

3.10.1 The Reconciliation (2nd resubmission) is only permitted for claims that have undergone discussion and reconciliation by all Parties.

3.10.2 Any claims that are deemed reconciled by all Parties must be resubmitted by the Healthcare Provider (Provider) and tagged as a new resubmission type: ***Reconciliation***, as per the updated Business and validation Rules available to download using the following pathway*: eClaimLink > DHD > Documentation*.

3.10.3 Healthcare Payers (Payers)/Third Party Administrators (TPAs) and Healthcare Providers (Providers) must agree to schedule reconciliation a minimum of ***Two (2) times*** annually.

3.10.4 The resubmission timeline stated in section 3.8 should not be applied to this Second (2nd) resubmission.

3.10.5 The existing eClaimLink Policy for Claim archiving must be noted by all Parties, as the maximum validity for a claim is restricted to 24 months from Claim submission date. See clause 6.1.1 for further details.

4 Impact of this Standards Notice on Claim Cycle Length

4.1 For a claim that adheres to all timeframes stipulated in the Standard Notice (SN), the maximum permissible cycle length will be ***141 days*** as depicted in *Diagram 1*.

4.2 The timeframe and frequency for reconciliation to settle disputed claims must satisfy clause 3.10.3.

4.3 Example Scenario:

4.3.1 A patient is discharged from Hospital X on 27th April. Hospital X submitted this IP claim before 15th of May to TPA Z. TPA Z processed this claim and sent remittance advice (RA) with denial code and explanation added as a comment at claim level. TPA Z also made partial payment with payment reference, in order for Hospital X to track payment. Hospital X decided to contest this partial payment and resubmitted the claim with correction in 10 calendar days of receiving the RA. TPA Z responded in 25 calendar days (after receiving the resubmitted claim) with the final RA.

Submission	The Healthcare Provider (Provider) undertakes to submit the eClaim to the Healthcare Payer (Payer) or Third Party Administrator (TPA) no later **the 15th of the next month** following the service month.
1st Remittance Advice	The Healthcare Payer (Payer) or Third Party Administrator (TPA) undertakes to make payment for adjudicated claims within **Forty-five (45) calendar days** from date of claim submission.
1st Resubmission	All disputed claims including rejected claims should be resubmitted to the Healthcare Payer (Payer) or Third Party Administrator (TPA) within **Twenty one (21) calendar days** from the date of receipt of payment or Remittance Advice (RA) with denial reason..
2nd Remittance Advice	The Healthcare Payer (Payer) or Third Party Administrator (TPA) undertakes to make payment for adjudicated claims within **Thirty (30) calendar days** from date of claim resubmission.
RECONCILIATION	
2nd Resubmission	All disputed claims including rejected claims should be resubmitted to the Healthcare Payer (Payer) or Third Party Administrator (TPA) within **Twenty one (21) calendar days** from the date of reconciliation.
3rd Remittance Advice	The Healthcare Payer (Payer) or Third Party Administrator (TPA) undertakes to make payment for adjudicated claims within **Thirty (30) calendar days** from date of claim resubmission.

Diagram 1

5 Reconciliation and Settlement of Claims

5.1 Healthcare Payers (Payers) and Third Party Administrators (TPAs) and Healthcare Providers (Providers) are collectively responsible for closing all active claims with submission date prior to 1st July 2018.

5.2 Any submissions as of 1st October 2019 must adhere to the timelines stipulated in this Standards Notice and claims must be strictly settled within the timelines stated in this Standard Notice (SN).

5.3 Dubai Health Insurance Corporation (DHIC) will monitor resubmissions of type “Reconciliation” for evaluation of market behaviour.

6 Existing Policies and Developments

6.1 The following policies and developments have been implemented to complement a shared objective of creating an efficient and timely Claim cycle.

6.1.1 **Claim Archiving**

6.1.1.1 *eClaimLink Archiving Policy 2017-07-04*

6.1.1.2 As per the above mentioned policy, claims submitted prior to 1st January 2018 that are not settled by 1st January 2020 will be archived automatically and deemed settled and closed.

6.1.1.3 Any unsettled or disputed claims must be finalized prior to 1st January 2020. Post this date no requests to retrieve archived claims will be entertained.

6.1.2 **Expansion of Denial Code List**

6.1.2.1 *GC 06-2018 Denial Code Updates*

6.1.2.2 Increased denial codes and development or comments at Claim level to encourage clear communication and efficiency between Payers, TPAs and Providers.

6.1.2.3 Improper use or misuse of denial codes should be reported to DHIC via email (ISAHD@dha.gov.ae) immediately, where cases will be investigated with full anonymity.

6.1.2.4 Full denial code list can be found using this pathway: *eClaimLink > DHD > Codes & Lists > Denial.*

6.1.3 **Schema Development**

6.1.3.1 *GC 04-2019 Addition of Comment Field to the Remittance.Advice Schema*

6.1.3.2 A new comment field has been added on the Remittance.Advice schema that will allow Payers and TPAs to share additional information with Providers at the Claim level.

6.1.3.3 This field is mandatory for all claims where there is a full or partial denial and is in line with Dubai Health Insurance Corporations objective to improve the quality of information shared during the claim cycle to reduce the cycle length and improve overall efficiency process.

For any questions, please write to ISAHD@dha.gov.ae