إمارة أبوظبي
هيئته الصحة - أبوظبي
تمييز في الرعاية الصحية

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كتاب دوري رقم (13) ضمان صحي

الموضوع: أسس وقواعد تبادل البيانات الإلكترونية

يسرنا أن نبعث إليكم جميعاً بخلاص التحية والتقدير ونلتمص لكم حسن تعاونكم معنا لذا يخير ومصلحة وطننا الغالي.

تود إحاطة الجميع علمنا أنه قد تم إصدار أسس وقواعد تبادل البيانات الإلكترونية بين شركات الضمان الصحي وخدمات العلاج الطبي وشركات إدارة مطالبات الضمان الصحي، و التي يتوجب اتباعها حسب الملحق الذي يوضح هذه الأسس و القواعد بالتفصيل.

أملين من الجميع الالتزام بأحكام هذه الكتاب والعمل بموجبه وذلك لتعزيز وإتمام نجاح مشروع ضمان الصحي في إمارة أبوظبي.

وتفضلوا بقبول فائق الاحترام والتقدير

[ลาย توقيع]

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# 1 Introduction

The Vision for the Health System in Abu Dhabi is to provide access to high quality healthcare services to all. The Vision will be easier to achieve if all those delivering health care related services use a *common language* and have a *standardized way of exchanging data*. The common language and the standards should be self-sustaining, because they add value for participating healthcare entities. By definition they enable efficient electronic data exchange between healthcare organizations, facilitate discussions and create increased consistency and transparency.

This Guidance first defines a *common language* to describe all every day activities and processes in healthcare delivery (Chapters 2-3 as well as a data dictionary at www.haad.ae/DataDictionary). Next, the Guidance defines a *standardized way of exchanging data*, by bringing together all legal and information requirements to exchange data electronically, in particular health insurance claims (Chapter 4). Finally, the Guidance sets out key procedures required to build trust in electronic data exchanges and give healthcare participant additional protection and benefits (Chapters 5-9)

- Reliable confidentiality guarantees the trust of all healthcare participants (Chapter 5)
- Patients will gain transparency by requiring insurers to explain to them what health care services they have received (Chapter 6)
- Insurers will gain formal protection in cases of fraud and abuse (Chapter 7)
- Patients and Providers will gain formal protection through formalized procedures to deal with Payer Grievances and Appeals, for instance if payment and/or coverage is denied by a payer (Chapter 8)
- Healthcare organizations will gain representation and a formal mechanism to contribute to the further development of standards through a Data Standards Panel (Chapter 9)

## Implementation

This Guidance supersedes and replaces previous Standards Guidance issued on September 20 2007, and should be read in conjunction with the Knowledge Engine for Health [KEH] Electronic Partner Agreement (available on www.haad.ae/DataDictionary) which sets out reporting requirements by HAAD.

- The common language defined in the data dictionary is effective and applicable immediately.
- All code standards defined are effective and applicable immediately.
- All policies and procedures set out need to be in place by April 1 2008.
- Healthcare Providers are required to use purely electronic Claims transactions for all Claims related to Nationals enrolled with DAMAN under the thiqa plan, effective immediately. Exceptions to this rule have to be individually negotiated with HAAD.
- Healthcare Providers shall be in a position to require purely electronic Claims and Remittance transactions from 1 May 2008.
- Healthcare Insurers shall be in a position to require purely electronic Claims and Remittance transactions from 1 August 2008.
- Healthcare organisations with more than 20’000 annual encounters shall have implemented electronic data exchange by 31 December 2009.
2 Key concepts and definitions

Data dictionary

There is much value in having a common language to talk about healthcare amongst different stakeholders. The common language should be easy to understand yet accurate. The common language within the healthcare delivery system of Abu Dhabi is defined in a data dictionary, available on www.haad.ae/DataDictionary. All communications with HAAD need to use the common language defined in the data dictionary. Any electronic transactions between ePartners need to be mappable with the data dictionary. The data dictionary defines key concepts, such as a Person, as well as associated elements, e.g., Patient.FirstName and describes the relationships between concepts and elements.

Key concepts

Healthcare systems help individual Persons obtain better health. A person can be a Patient who has an Encounter with a Provider. The Provider then claims some or all of the charges from the Payer. The payer in turn collects insurance premiums (Financing) from its members, who are individual persons. The relationship between these key concepts is shown below.

Key concepts
When a patient has an encounter with a provider, the provider needs to know what was done with the patient – an **Activity** such as a lab test – to be able to charge for it. Activities may or may not lead to an **Observation**, such as the result of a lab test. The Activity and Observation concepts are both depicted in the Figure below, together with a summary of all the data elements within each concept.

### Key concepts and selected associated elements

- **Encounter**
  - An Encounter starts when a Patient is first brought under the care of a responsible healthcare professional and ends when the Patient stops being under the care of a responsible healthcare professional at the healthcare provider.

- **Activity**
  - Type
  - Code
  - Quantity
  - Net
  - Clinician

- **Observation**

### Encounter

An Encounter starts when a Patient is first brought under the care of a responsible healthcare professional and ends when the Patient stops being under the care of a responsible healthcare professional at the healthcare provider.

*Example 1* | A Patient has an accident at home and is driven by his family to the emergency room of a local hospital. After triage in the emergency room, the Patient is admitted to a ward and has surgery a few hours later. After five days the Patient is discharged home. The time period from
being registered in the emergency room until discharge from the hospital is considered to be one Encounter.

**Example 2** | A Patient has an out-patient consultation during which she undergoes a lab test and receives a prescription, which she collects on her way out of the hospital. Four days later she has an x-ray, and a further two days later a follow-up appointment with a doctor. The Patient has had three Encounters:

1. outpatient consultation + lab test + prescription
2. X-ray
3. follow-up appointment

**Example 3** | A Patient has an outpatient consultation, during which he receives a lab test, does an x-ray and receives a prescription, which he collects on the way out of the hospital. This Patient has only one Encounter: out-patient consultation + lab test + x-ray + prescription

**Claim**

A claim is an original request for payment for health services provided to a single Patient. A Claim is typically recorded on a claims form and supported by one or multiple invoices. Claims are generally linked to Patients who are covered by health insurance. For the purposes of this guidance, any invoices made out to non-insured Patients should also be considered as Claims.

**Activity**

A Claim may comprise one or many Claim items, often referred to as service lines. Analogously, an Encounter may comprise one or more items, e.g., only a visit to the emergency room (one item), or for example, a visit to the emergency room followed by an admission, lab test, diagnostics and prescriptions (five items).

An Activity is any Claim item or Encounter item.

- Generally a Claim item corresponds to an Encounter item, so every Claim item/Activity item is considered an Activity. This could be the case for example for a first outpatient consultation or a prescription, two separate activities.
- Some Encounter items however do not correspond with Claim items. For instance, individual surgical procedures are Encounter items, yet they may be claimed summarily as a DRG or flat fee (the Claim item). Both the surgical procedures as well as the DRG or flat fee are considered individual activities.
- Some Claim items don’t have corresponding Encounter items. In the example above, the DRG Claim item is a Claim item, but not an Encounter item.

**Example** | A Patient has elective surgery and receives a tailored drug cocktail, which is not covered by his primary insurance. For this one Encounter the hospital makes two Claims: one to the primary insurance which is billed as a DRG, and one to the supplementary insurance for the expensive drugs. The two Claims need to be reported in two separate records. The Encounter information on each record should include information on the procedures performed, even if they are not charged. On the first Claim the only charge relates to the DRG; on the second, the only charge relates to the drugs.
Each record should specify those chargeable activities which are related to the Claim.

Example | A Patient has an outpatient consultation and receives a prescription. If the provider makes two separate Claims for this one Encounter, this would result in two records, one covering the consultation and one covering the prescription. The record claiming the consultation would only have the consultation Activity, while the record claiming for the prescription would only comprise the prescription Activity.

Observation

An Observation is the result of an Encounter Activity such as a diagnostic test, lab work, etc. An Activity may have multiple Observations, but an Observation can only be the result of one Activity. In the simplest form for example, a blood pressure test (the Activity) results in a blood pressure reading (the Observation).

Laboratory observations, also known as findings, are essential analytical data elements for disease management, outcome analysis and other studies.
3 Code standards

A shared understanding of key concepts and elements, as described in the previous chapter, creates clarity. It does not necessarily, however, improve the efficiency of day-to-day interactions between healthcare stakeholders. For instance, a hospital needs to describe the drug prescribed to be reimbursed by the insurer. There are in principle many ways to describe this prescription, such as a hand-written note. This vagueness is highly inefficient and introduces many sources of error – spelling errors, as well as translation errors. There is a great benefit for all to have code standards for key elements.

Wherever possible and sensible, international code standards have been adopted. This avoids demanding local maintenance work on the standards, and allows comparisons with other geographies. The particular choice of code standards reflects the need to act in the best interests of the public and their stewards, including regulatory authorities, payers and providers. Where applicable the code standards have been reviewed and endorsed by relevant stakeholder groups, such as the Clinical Coding Steering committee.

All parties are required to use the latest HAAD-defined version of code sets. Emirate-wide licenses will be purchased for all code sets, where practicable, and will be available for download for use within the Emirate on www.haad.ae/DataDictionary.

Diagnosis

Standard

All diagnoses are to be coded using the International Classification of Diseases, 9th Revision, Clinical Modification, Sixth Edition, Volumes 1 and 2 (ICD-9CM). This standard has been recommended by the Clinical Coding Steering committee and has been consulted on previously. Recently, this standard has in addition received endorsement by the Emirates Insurance Association’s relevant sub-committee.

Categories of Use

All Clinical Encounters

- Hospital Inpatients
  - Diagnosis
  - Treatment
  - Management
  - Prevention
- Diseases
- Impairments
- Injuries
- Behavioral health disorders
- Other health problems and their manifestations
- Causes of injury, disease, impairment, or other health problem
Reference Publication


Sample

ICD-9 Codes to use when billing medical insurance for comprehensive (dilated) eye examination for diabetic patients.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1 Diabetes with Ophthalmic Manifestations</td>
<td>250.51</td>
</tr>
<tr>
<td>Type 2 Diabetes with Ophthalmic Manifestations</td>
<td>250.50</td>
</tr>
</tbody>
</table>

Special consideration – V-Codes

Standard

All health status determinations are to be coded using the International Classification of Diseases, 9th Revision, Clinical Modification, Sixth Edition, Volumes 1 and 2 (ICD-9CM).

ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury (V-Codes). The Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01.0 - V84.8) is provided to deal with occasions when circumstances other than a disease or injury (codes 001-999) are recorded as a diagnosis or problem.

Categories of Use

There are four primary circumstances for the use of V-Codes:

- A person who is not currently sick encounters the health services for some specific reason, such as to act as an organ donor, to receive prophylactic care, such as inoculations or health screenings, or to receive counseling on health related issues.
- A person with a resolving disease or injury, or a chronic, long-term condition requiring continuous care, encounters the healthcare system for specific aftercare of that disease or injury (e.g., dialysis for renal disease; chemotherapy for malignancy; cast change). A diagnosis/symptom code should be used whenever a current, acute, diagnosis is being treated or a sign or symptom is being studied.
- Circumstances or problems influence a person’s health status but are not in themselves a current illness or injury.
- Newborns, to indicate birth status

Sample

Sample ICD-9 V-Codes.

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9CM V-Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-term (current) drug use</td>
<td>V58.6</td>
</tr>
<tr>
<td>Asymptomatic postmenopausal status (age-related) (natural)</td>
<td>V49.81</td>
</tr>
<tr>
<td>Awaiting organ transplant status</td>
<td>V49.83</td>
</tr>
</tbody>
</table>
Medical services and procedures

Standard
All medical procedures performed within the Emirate, regardless of whether or not the procedure is billed to an insurance company or Third Party Administrator must be coded using the Current Procedural Terminology (CPT®) standard classification codes. The Clinical Coding Steering committee recommends the implementation of CPTs. This standard has also received preliminary endorsement by the Emirates Insurance Association’s relevant sub-committee.

Note | CPT codes will be used both in outpatient and inpatients settings, and completely replace legacy coding. This unification will provide for simpler coding standards and add flexibility to the payment system. This move will not slow down or prohibit the introduction of IR-DRGs, for instance, as it is compatible with CPTs. HAAD will work with and support those organizations that need to migrate from ICD9-CM procedure coding, to allow for a managed and orderly transition that does not unduly erode the skills base.

Categories of Use
• Physician services
• Clinical laboratory tests
• Diagnostic procedures
• Radiology procedures
• Behavioral health procedures
• Vision services
• Hearing services
• Occupational therapy services
• Transportation services (ambulance, air ambulance, etc.)

Reference Publication

Sample
CPT-4 Codes to use when billing medical insurance for comprehensive (dilated) eye examination for diabetic patients.

<table>
<thead>
<tr>
<th>CPT-4 Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patient- 92004</td>
<td>Type 1 Diabetes with</td>
</tr>
<tr>
<td>Established Patient- 92014</td>
<td>Ophthalmic Manifestations</td>
</tr>
<tr>
<td>New Patient- 92004</td>
<td>Type 2 Diabetes with</td>
</tr>
<tr>
<td>Established Patient- 92014</td>
<td>Ophthalmic Manifestations</td>
</tr>
</tbody>
</table>
Drugs

Standard

All drugs claimed or invoiced within the Emirate must be coded using classification codes consistent with the MoH’s National Drug Codes. This standard has received preliminary endorsement by the Emirates Insurance Association’s sub-committee.

Note | As and when regional drug codes, e.g., MoH drug codes become available, HAAD will consider actively transitioning to such broader standards. Should such a transition occur, HAAD would provide a mapping for all parties involved.

Categories of Use

- Retail Drug transactions

Sample

National Drug Codes to use when billing drugs to insurance companies and TPAs.

<table>
<thead>
<tr>
<th>NDC</th>
<th>PackName</th>
<th>Strength</th>
<th>Form</th>
<th>PackSize</th>
<th>PackPrice</th>
</tr>
</thead>
<tbody>
<tr>
<td>4692-5856-01-03</td>
<td>5-FLUOROURACIL &quot;EBEWE&quot; 250mg/5ml</td>
<td>50mg/ml</td>
<td>Infusion</td>
<td>5ml Ampoule x 5</td>
<td>36</td>
</tr>
<tr>
<td>4692-5856-01-01</td>
<td>5-FLUOROURACIL &quot;EBEWE&quot; 250mg/5ml</td>
<td>50mg/ml</td>
<td>Infusion</td>
<td>5ml Glass Vial</td>
<td>8</td>
</tr>
<tr>
<td>4692-5856-02-02</td>
<td>5-FLUOROURACIL &quot;EBEWE&quot; 500mg/10ml</td>
<td>50mg/ml</td>
<td>Infusion</td>
<td>10ml Ampoule x 5</td>
<td>53.5</td>
</tr>
<tr>
<td>4692-5856-02-01</td>
<td>5-FLUOROURACIL &quot;EBEWE&quot; 500mg/10ml</td>
<td>50mg/ml</td>
<td>Infusion</td>
<td>10ml Glass Vial</td>
<td>12.5</td>
</tr>
<tr>
<td>3493-4477-01-01</td>
<td>ABILIFY 10mg</td>
<td>10mg/tablet</td>
<td>Tablet</td>
<td>30's (10's Blister x 3)</td>
<td>709.5</td>
</tr>
<tr>
<td>3493-4477-02-01</td>
<td>ABILIFY 15mg</td>
<td>15mg/tablet</td>
<td>Tablet</td>
<td>30's (10's Blister x 3)</td>
<td>951.5</td>
</tr>
<tr>
<td>3493-4477-03-01</td>
<td>ABILIFY 20mg</td>
<td>20mg/tablet</td>
<td>Tablet</td>
<td>30's (10's Blister x 3)</td>
<td>1236.5</td>
</tr>
<tr>
<td>4205-5318-01-01</td>
<td>ACID CONCENTRATE FOR BICARBONATE HAEMODIALYSIS KSP-03</td>
<td>combination</td>
<td>Solution</td>
<td>5 Liter Can</td>
<td>34</td>
</tr>
</tbody>
</table>
Products and supplies

Standard

All products, supplies and services not covered under CPT® performed within the Emirate, regardless of whether or not the item is billed to an insurance company or Third Party Administrator are to be coded using the Healthcare Common Procedure Coding System (HCPCS) Level II code set. This standard has received preliminary endorsement by the Emirates Insurance Association’s relevant sub-committee.

Categories of Use

- Medical supplies
- Orthotic and prosthetic devices
- Durable medical equipment

Reference Publication

Centers for Medicare & Medicaid Services. *Healthcare Common Procedure Coding System (Level II)*.

Sample

HCPCS Level II Codes to use when billing products and supplies to insurance companies and TPAs.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Seq Num</th>
<th>RIC</th>
<th>Long Description</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4217</td>
<td>00100</td>
<td>3</td>
<td>STERILE WATER/SALINE, 500 ML</td>
<td>Sterile water/saline, 500 ml</td>
</tr>
<tr>
<td>A4252</td>
<td>00100</td>
<td>3</td>
<td>BLOOD KETONE TEST OR REAGENT STRIP, EACH</td>
<td>Blood ketone test or strip</td>
</tr>
<tr>
<td>E0754</td>
<td>00200</td>
<td>4</td>
<td>NEUROSTIMULATOR PULSE GENERATOR</td>
<td></td>
</tr>
</tbody>
</table>
Dental procedures

Standard
All dental procedures performed within the Emirate, regardless of whether or not the procedure is billed to an insurance company or Third Party Administrator, are to be coded using the Uniform System of Codes and List of Services (USC&LS). This standard has been recommended by the Abu Dhabi Dental Council. This standard has received preliminary endorsement by the Emirates Insurance Association’s relevant sub-committee.

Categories of Use
- Dental services

Reference Publication

Sample
USC&LS Code to use when billing a one surface restorative amalgam on a permanent molar to insurance companies and TPAs.

USC&LS Code: 21221
"2" 1221 represents the category "restorative"
2"1"221 represents the classification "amalgam restorations"
21"2"21 represents the sub-classification "amalgams permanent dentition"
212"2"1 represents the service title "permanent molars"
2122"1" represents the specific service "permanent molars one surface"
LOINC

Logical Observation Identifiers Names and Codes (LOINC®) are a universal standard for identifying laboratory observations. All units of measure are to be coded using the International System of Units (SI). This standard has been endorsed by the Laboratory Committee. All laboratory tests will need to be coded using LOINC codes. Reporting of LOINC codes is not yet mandatory.

Categories of Use

- Lab findings/observations

Reference Publication

The Regenstrief Institute, Inc. Logical Observation Identifiers Names and Codes June 2007, version 2.21. (LOINC®)

Sample

LOINC Codes to use when capturing observations.

<table>
<thead>
<tr>
<th>LOINC Code</th>
<th>Component</th>
<th>Property</th>
<th>Time</th>
<th>System</th>
<th>Scale</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>32561-3</td>
<td>Tuberculosis reaction wheal^1D post dose mammalian tuberculin ID</td>
<td>Len</td>
<td>Pt</td>
<td>Skin</td>
<td>Qn</td>
<td></td>
</tr>
<tr>
<td>717-9</td>
<td>Hemoglobin</td>
<td>ACnc</td>
<td>Pt</td>
<td>Bld</td>
<td>Ord</td>
<td></td>
</tr>
<tr>
<td>6711-6</td>
<td>Acetaminophen Ab.IgE</td>
<td>ACnc</td>
<td>Pt</td>
<td>Ser</td>
<td>Qn</td>
<td></td>
</tr>
</tbody>
</table>

Note | The Regenstrief Institute provides tools to assist in mapping LOINC® values to local codes.
Claim denials

Standard

Payers need to explain to providers if and why a claimed amount has been denied outright or adjusted in parts from the originally claimed sum.

Best practice suggests that denial codes should evolve over time and reflect the maturity of the payment system. It is therefore not advisable to directly copy denial code standards directly from other countries. Some denial codes are generic, and are used by most payers in most systems, while other denial codes are specific to individual insurance products.

A mandatory denial code standard has been developed that provides a welcome degree of standardization for providers, whilst retaining flexibility for payers to fine-tune denial codes to specific products.

The denial code standard will be reviewed and revised from time to time by the Data Standards Panel (see Chapter 9). The Data Standards Panel will explicitly allow individual insurers to add insurance-specific codes to the standard.

Categories of Use

- Claim-level denials
- Claim Service Line denials and adjustments

Reference Publication

The currently valid list of claim and service line denial codes can be found at www.haad.ae/DataDictionary
Diagnosis Related Grouping

Standard
All inpatient services/hospitalization will need to be coded using the International Refined Diagnosis-Related Grouping, at a future date. This standard is not mandatory at present.

Categories of Use
- All Inpatient/Hospitalization Encounters

Reference Publication
3M IR DRG Definitions Manual

Sample
Possible DRG Codes to use for a hospital stay based on a particular diagnosis.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9CM</th>
<th>Possible DRG</th>
<th>DRG Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia Due To Adenovirus</td>
<td>480.0</td>
<td>195</td>
<td>Simple pneumonia and pleurisy without complications and co morbidities or major complications and co morbidities</td>
</tr>
<tr>
<td>Spina Bifida, Unspecified Region, With Hydrocephalus, Arnold-Chiari syndrome, Type Two; Chiari malformation, Type Two; Any condition classifiable to 741.9 with any condition classifiable to 742.3</td>
<td>741.0</td>
<td>091</td>
<td>Other disorders of nervous system with major complications and comorbidities</td>
</tr>
</tbody>
</table>
Service codes

The overwhelming majority of currently billable activities is uniquely defined by a CPT, Drug or Dental code. There are cases, however, when a CPT, Drug or Dental code does not uniquely define what price should be charged. Examples of this include

- Per diem rates for medical inpatients, related to groups of diagnoses
- Per diem rates for surgical procedures, for extended lengths of stay
- Per diem surcharges for use of intensive care
- Generic codes for as yet undefined activities

HAAD will maintain a comprehensive list of such service codes, the use of which is mandatory. Payers need to request addition of their own specific services on to this list of service codes, if not already covered. Addition requests need to be made from Health System Financing. Payers will need to demonstrate that these services cannot be unambiguously represented by a CPT, Drug, Dental, HCPCS or existing Service code. The definitive list of service codes is available from www.haad.ae/DataDictionary and has the following illustrative structure

<table>
<thead>
<tr>
<th>Activity.Type</th>
<th>Activity.Code</th>
<th>Activity.Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 (Service)</td>
<td>001</td>
<td>Medical per diem category A</td>
</tr>
<tr>
<td>10 (Service)</td>
<td>002</td>
<td>Medical per diem category B</td>
</tr>
<tr>
<td>10 (Service)</td>
<td>003</td>
<td>Medical per diem category C</td>
</tr>
<tr>
<td>10 (Service)</td>
<td>004</td>
<td>Medical per diem category D</td>
</tr>
<tr>
<td>10 (Service)</td>
<td>005</td>
<td>Surgical per diem for extensions, category A</td>
</tr>
<tr>
<td>10 (Service)</td>
<td>006</td>
<td>Surgical per diem for extensions, category B</td>
</tr>
<tr>
<td>10 (Service)</td>
<td>007</td>
<td>Surgical per diem for extensions, category C</td>
</tr>
<tr>
<td>10 (Service)</td>
<td>008</td>
<td>Surgical per diem for extensions, category D</td>
</tr>
<tr>
<td>10 (Service)</td>
<td>009</td>
<td>ICU service surcharge</td>
</tr>
<tr>
<td>10 (Service)</td>
<td>010</td>
<td>Generic codes for as yet undefined services</td>
</tr>
</tbody>
</table>

Note / The codes are independent of the prices agreed between Payers and Providers. It may be the case that two insurers contract with the same provider using exactly the same codes, but do not reimburse the same rate for any single billable item.
Note | The price list agreed between a Payer and Provider can be represented in a table, which simplistically and illustratively could look as follows

<table>
<thead>
<tr>
<th>Activity.Type</th>
<th>Activity.Code</th>
<th>Activity.Description</th>
<th>Agreed Price</th>
<th>[Category]</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (CPT)</td>
<td>22.12</td>
<td>Toe nail extraction</td>
<td>200</td>
<td>Surgical A</td>
</tr>
<tr>
<td>1 (CPT)</td>
<td>24.56</td>
<td>Hernia procedure</td>
<td>500</td>
<td>Surgical C</td>
</tr>
<tr>
<td>...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 (Drug)</td>
<td>12-429-22-22</td>
<td>Lamisil 20 mg,</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 (Service)</td>
<td>001</td>
<td>Medical per diem category A</td>
<td>700</td>
<td></td>
</tr>
<tr>
<td>10 (Service)</td>
<td>002</td>
<td>Medical per diem category B</td>
<td>900</td>
<td></td>
</tr>
<tr>
<td>...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note | In the case of per diem rates for medical inpatients, every single diagnosis is related to a particular per diem category. For specificity, an additional table would need to be agreed, linking particular diagnoses to Medical per diem categories. This could be represented simplistically and illustratively as follows

<table>
<thead>
<tr>
<th>Diagnosis.Code</th>
<th>Related service code</th>
</tr>
</thead>
<tbody>
<tr>
<td>720.22</td>
<td>Medical per diem category A</td>
</tr>
<tr>
<td>740</td>
<td>Medical per diem category B</td>
</tr>
<tr>
<td>...</td>
<td>...</td>
</tr>
</tbody>
</table>

Note | There may be cases, when a Provider performs an activity, for which no appropriate code exists. In such cases, the following provisions apply, in the absence of an explicit agreement between Payer and Provider to the contrary. The Provider

- Identifies the activity code that is most closely related to the activity actually performed
- Reports this identified activity code on the Claim as an activity without a chargeable amount (Activity.Net is blank)
- Claims the activity “Generic code for as yet undefined services” (or equivalent) and charges the amount that would be charged for the most closely related activity to the activity actually performed.
Clinical terminology outlook

Classifications and terminologies

The most detailed healthcare information collected, such as in medical records, often goes far beyond what is captured by a coded diagnosis or activity. Observations, such as the interpretation of an x-ray, may be very rich and cannot readily be distilled into a single code. Rather than create an ever more detailed classification system to capture such information, it is considered best practice to use clinical terminologies, which describe rather than classify. A terminology is loosely analogous to an English dictionary, having ‘words’ or terms which can be composed into ‘sentences’.

SNOMED CT

SNOMED CT – Systematized nomenclature for Medicine – is likely the world’s biggest and best established clinical terminology, with over 300,000 terms and usage in several major countries, including the US and the UK. This standard is recommended, though not mandatory at present. SNOMED CT is maintained by the International Health Terminology Standards Development Organisation www.ihtsdo.org.

Note / SNOMED CT is often used in conjunction with LOINC codes in electronic transactions, where the LOINC code specifies the question, such as the specific type of lab test performed, while SNOMED CT can be used to generate the answer.

Note / If providers generate medical records on the basis of SNOMED CT, the corresponding CPT codes and ICD9-CM codes can be generated automatically and do not need to be coded separately. In addition, SNOMED CT terms don’t change, whereas classification system such as ICD do, often at significant transition cost for healthcare stakeholders. Coding in SNOMED CT avoids such costs.

Clinical record structure

Detailed clinical content, such as that generated by SNOMED CT or digital images, needs to be structured, before it can be analyzed effectively. This structuring is non-trivial. No generally accepted standard has yet emerged through which to share detailed clinical record.

Approaches range from highly structured granular messages (as used in the UK’s HL7 v3 implementation), through semi-structured messages (such as openEHR), through to flexibly structured content, such as the Clinical Document Architecture version 2.0. The latter has recently received more attention, and is the default candidate for a prospective candidate. In-depth consultation with stakeholders is needed, however, before such a standard would be defined. The current data dictionary is enabled to work with any of these options.
4 Electronic data exchange standards

Electronic data exchange needs to specify what is being exchanged, and how it is being exchanged. Electronic data exchange standards enable and facilitate processing of electronic claims, which is a hallmark of a healthy and efficient healthcare delivery system.

- Payers can reduce administrative costs by increasing the use of computer systems for storage, retrieval and processing of data, and increase data quality by reducing the possibility of human error when avoiding manual keying and rekeying of data.
- Providers increase revenues by submitting claims faster and being paid sooner than using paper; and reducing cost by processing claims electronically rather than on paper and manually.

Legal context

Law No. 23 of 2005 provides the framework in Abu Dhabi Emirate legislation for the setting-up and operation of the health insurance scheme.

Law No. 1 of 2007 creates Health Authority – Abu Dhabi, and sets out its objectives and competences as regulator in the health services field.

Recent UAE legislation on electronic exchanges (in particular Union (federal) Law 1/2006 on Electronic Transactions and Commerce) recognizes the role of international good practice and encourages electronic data submission between commercial parties such as payers and providers.

Union Law No. 1 of 2006 on Electronic Transactions and Commerce provides a comprehensive legal regime intended to give electronic records and transactions the same degree of legal validity as paper and other traditional modes of recording and transacting. It spearheads a culture change in information law, and its effects are already apparent in subsequent, more recent legislation in various fields, including public finance and insurance.

Within this context, the specific conditions to be met for electronic data exchange are:
- Compliance of all electronic transactions with HAAD’s data standards, code standards and electronic data exchange standards.
- An effective Electronic Partner Agreement (EPA) between Electronic Partners (ePartners).
What to exchange

Transactions are the units of communication between ePartners. For clarity and ease of use, transactions are grouped into related transaction sets. All allowed transactions are fully detailed in the data dictionary www.haad.ae/DataDictionary, and an overview is presented below. Transaction sets are reviewed and revised from time to time by the Data Standards Panel. The implementation of transaction sets is to the exclusion of paper documentation for routine processing. For the avoidance of doubt, this does not infringe any payer’s pre-existing right to access medical records as part of exception processing.

Generic messages [“GenericMessage”]

The generic message transactions allow ePartners to generically exchange information. They can be used like an instant messenger, like an email, or like a file transfer service, e.g., sending attachments.

Data submission to KEH [“KEH”]

The KEH transaction set is used for all data submissions to KEH [Knowledge Engine for Health], which is HAAD’s data warehouse. The KEH Electronic Partner Agreement (www.haad.ae/DataDictionary) defines who needs to submit what, when and how.

Eligibility Inquiry and Response [“Eligibility”]

This electronic transaction set can be used to inquire about the eligibility, coverage, co-payments, deductibles or benefits associated with a health plan, employer, plan sponsor, or Patient.

Prior Authorization Request and Response [“PriorAuthorization”]

The Prior authorization transaction set can be used to determine a Provider’s authorization from a Payer to perform selected services for a Patient. For insurance plans that require prior approval for selected services, this transaction set speeds the administrative process of requesting and obtaining preauthorization.

Claims Submission, Response and Status [“Claim”]

The Claim transaction set can be used to submit claims to Payers and for Payers to respond back to submitters with claim status. It indicates what services were rendered as well as the Provider, Patient and charges associated with those services. Claims status transactions can indicate denial in whole or in part, covered charges, current status within the Payer’s system (pended, paid, etc.), etc. It may become necessary to define separate transaction types within the claim set for various types of claims e.g. facility, professional, and pharmacy.

Payment and Remittance Advice [“Remittance”]

The Remittance transaction set can be used by the Payer to send the Provider information about claim adjudication and payment. It provides information at a detailed service line (Activity) level to enable the Provider to match the Payer’s adjudication decisions with the Provider’s original claim submission and specifies the reason for any adjustments, such as an increase in payment for interest due as result of late payment of a claim or a deduction from payment as result of a prior overpayment.
How to exchange

Just as a common language and coding standards are required to create clarity in what is being communicated, a communication standard or messaging format is necessary for how computer systems receive, process and respond to information electronically. A number of communication schemes tailored to healthcare are available. Health Level Seven version 3 currently offers a comprehensive and complete messaging standard based on modern modelling and development techniques. All routine electronic transactions between ePartners need to be Health Level 7 Version 3 compatible. The available electronic transactions are fully detailed in the data dictionary (www.haad.ae/DataDictionary)

Technical Note | HL7v3 messages are XML documents in which each item is “tagged” in the mark-up language syntax to provide context to the content. HL7v3 tags and attributes are defined in the HL7 Reference Information Model and by the HL7 Data Types. Each message requires a predefined structure that is set out in an XML schema or XSD. The schema defines the attributes, relative position, cardinality and descriptions of the data contained in each message. The HL7v3 Reference Information Model can be obtained via subscription from Health Level Seven at www.hl7.org. Health Level Seven offers many free tools to assist in implementing HL7v3 messaging and also provides referral information for many third-party commercial products and service providers at www.hl7.org.

Electronic Partner Agreement

Electronic communications between ePartners must be governed by an Electronic Partner Agreement (EPA). ePartners should strive to mutually agree terms of the EPA. In the absence of an explicit agreement between ePartners, the subsequent EPA provisions shall be enforceable as a default.

ePartners will

- Make electronic transactions using the mutual authentication SSL (Secure Socket Layer) protocol or, if not available, a couriered CD.
- Use electronic signatures based on the native SSL protocol or, if not available, use PGP (Pretty Good Privacy), based on the OpenPGP standard.
- Communicate, as a one-time event and using a couriered letter, the intent to sign electronically at least 14 days before attempting an authorized electronic interchange. The electronically signing party must provide the public key at least 14 days before attempting an authorized electronic interchange.
- Implement the Claim and Remittance transaction sets. An ePartner can enforce additions to specific transactions, if it can demonstrate to HAAD via the Data Standards Panel that this additional information is necessary and has historically been regularly used in internal electronic processing. For avoidance of doubt, this demonstration is not contingent on a majority recommendation by the Data Standards Panel.

HAAD will make available a default EPA.
5 Confidentiality

Confidentiality is a paramount concern for all partners involved in healthcare delivery in the Emirate of Abu Dhabi.

Confidential Health Information [CHI]

All information that can be used to identify a Patient or a commercial entity in a commercially sensitive context is considered Confidential Health Information (CHI). However, some data elements, when viewed independently, are not considered confidential. It is recognized that CHI classification can be based on a specific data element or combination of data elements from which identification can be ascertained.

Example 1 | Patient.ContactNumber is always considered CHI, while Encounter.Diagnosis<any> data by itself is not CHI.

Example 2 | Having Encounter.DiagnosisPrincipal with Encounter.PatientID makes diagnosis in this context CHI.

Protection Policies and Procedures

It is required that all partners develop, institute, educate staff and periodically update standard operating policies and procedures that protect CHI. The policies and procedures must be available for inspection and their use must be demonstrable upon request. HAAD will make available default policies and procedures.

Necessary and authorized access

Each party is required to ensure that only the minimum necessary personnel have access to CHI. Additionally, each party must have appropriate means to secure CHI and its use within its operations including when exchanging CHI with other partners. Each party must provide a means to authenticate authorized users.

Unauthorized access

Every party should strive to keep CHI from unauthorized access. HAAD must be notified, however, as soon as unauthorized access is detected. This notice must include what was disclosed, how it was obtained (means and methods), who gained unauthorized access if known, if the data has been subsequently unlawfully disclosed and the risk mitigation plan the party is now pursuing to prevent any further unauthorized access.

Confidentiality breaches can occur from external and internal sources. Each party must have a published sanction policy and ensure that it is effectively communicated to staff periodically. For external breaches appropriate law enforcement officials will be involved in the investigation and prosecution as necessary.
Storage of CHI

Each party is required to develop, maintain and implement policies and procedures for protecting CHI stored electronically or via paper. This is especially true for off-site storage in the case of paper records and backups, archives and live storage of electronic records. The storage policies and procedures apply irrespective of the purpose of storage, for instance whether CHI is stored on a CD for archiving or transmission purposes.

Transmission of CHI

Each party must protect CHI during the full lifecycle of transmissions, whether electronic or not. This includes preparation of data for transmission, transmitting data, and receiving transmitted data.

For the electronic transmission of CHI

- If the public internet is used for electronic data exchange, policies and procedures should cover the secure transmission of data, which includes encryption of data.
- If private secure point-to-point connections are used for electronic data exchange, policies and procedures should cover their provisioning and maintenance. Data encryption is recommended even when using secure private point-to-point connections.

Example | Each ePartner involved in electronic data exchange, should have policies and procedures to produce private and public encryption keys and provide a means for sharing public keys for decryption according to the standards in this Guidance, if the public internet is chosen as the means of connection.
6 Explanation of Benefits

Patients have a right to access information about the benefits they have received from their insurer, known as Explanation of Benefits. An Explanation of Benefits engages patients and helps them make more informed choices about their own healthcare.

A Health Insurer must provide an Explanation of Benefits to its members at least once a year. In addition, a member may request an Explanation of Benefits from their insurer. The Health Insurer must provide an Explanation of Benefits within seven working days after a request was made or a final determination of the claim was made, whichever is later. A member’s first request for an Explanation of Benefits for a specific claim is free of charge. Health Insurers are encouraged to define a standard Explanation of Benefits.

The Explanation of Benefits needs to use common language understood by patients and includes:

- Administrative information
  - Date of issuing Explanation of Benefits
  - Statement indicating that the Explanation of Benefits is not a bill
  - Identification of claim(s) included
  - Member information
  - Insurance Package summary details

- Clinical and financial information
  - Diagnoses
  - Service Dates
  - Service(s) Claimed, code and description
  - Amount charged by the Provider
  - Amount Paid by the Payer
  - For any amounts denied or rejected, a clear explanation why

Mental health services are to be excluded from any Explanation of Benefits.
7 Healthcare Fraud and Abuse

Definition

Healthcare insurance Fraud and Abuse is defined as the deliberate submittal of false claims to health insurers or Third Party Administrators acting on behalf of health insurers (collectively Payer). It is the intentional deception of a Payer by a healthcare provider (Provider), a Member acting independently or in collusion with a Provider, Payer employees, employer groups or others and can involve (among others):

- Provider billing for services, medicine and/or supplies not provided
- Provider deliberately performing medically unnecessary services, claiming they were medically necessary
- Provider billing with a reimbursement code for a complicated procedure rather than the simple procedure provided
- Clinic or hospital billing for services provided by an unlicensed Provider
- Durable medical equipment Provider billing for new equipment when used parts were utilized or billing for equipment that was never provided.
- Cross border billing - Provider billing for services provided elsewhere and not covered under the policy
- Obtaining coverage under false pretences such as using a family member or friends Health Insurance Card to obtain services the individual is not entitled to
- The solicitation or payment of bribes to secure medical services the individual is not entitled to
- Collusion on the part of any and all listed parties to implement a Fraud scheme that pays for services that the individual recipients are not entitled to or that may not even exist such as bogus billing schemes

Health insurance Fraud is a crime in the United Arab Emirates and if substantiated will be treated as such by the authorities and the respective law enforcement agencies.

Healthcare abuse is defined as Member or Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Payer, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. In contrast to healthcare Fraud, Abuse it is not criminal in intent

Reporting

The Payer conducts initial investigations internally. The Payer should be given access to the medical record provided that the Member gives consent. In addition, the Payer should contractually arrange with each Provider to allow for site-visit and spot checks in the context of Fraud and Abuse protection and can agree on contractual penalties should such access be denied. It is mandated that Payers investigate cases of suspected Fraud and Abuse internally first. In case of suspected Abuse, Payer and Provider should attempt to settle those cases amicably with Providers or Members. Only if there is continued disagreement, Payers can raise cases of suspected Abuse to an Arbitration Panel at HAAD. The Arbitration Panel will meet quarterly and the decision of the panel is binding to all parties and cannot be appealed. Once a case is developed sufficiently to substantiate alleged Fraud, the Payer is obliged to report the information to
HAAD in a standardized Suspected Health Insurance Fraud form (SIF form), available from www.haad.ae. A sample form is shown overleaf for illustration, but the online version should be used in practice.

Online reports of Fraud are retrieved and logged on a priority basis by HAAD. An email acknowledgement will follow receipt of the Payer’s SIF form if an email address is provided. The Payer may print a copy of the report which will include the Submission Verification Number at the time of submission. The customer service hotline at 800-800 provides further information and advice in cases of suspected Fraud and Abuse.

Confidentiality during process

Every reasonable effort will be made to protect the confidentiality of Payers, Members, and Providers reporting suspected Fraud and Abuse and to protect innocent persons and organizations against unsubstantiated allegations made in bad faith or with malice. As a safeguard against bad faith allegations that could seriously damage a company’s or an individual’s reputation the following rules should be kept by Payers reporting suspected Fraud and Abuse:

- Payers should not share information with each other due to the possibility that Payers could use the information inappropriately to discriminate against Providers
- The only Provider data that shall be released publicly are matters of public record such as criminal convictions, civil judgments, and negative license or certification actions

Once an investigation by HAAD has started, the Payer is required to fully cooperate and provide all related investigation materials requested. HAAD will also coordinate information gathering from other potential impacted Payers but will not share information among the Payers until a case is determined valid and one which will proceed to criminal and/or civil prosecution.
Suspected Insurance Fraud Form

Patient Information – If under legal age, please provide parent/guardian information

Name
Address
Contact Number
Email Address

Administrative Information
Submission Verification Number of Claim will be automatically generated from the website

Submission Date of Claim

Insurance Company Information
Insurance Company Name
Insurance Authorization Number
Third Party Administrator Name
Third Party Authorization Number

If a Suspected Insurance Fraud Form is being submitted by a Third Party Administrator on behalf of an insurance company, please fill out the followings
Contact Name
Contact Email
Contact Number

Healthcare Provider Information
Name
HAAD License Number
Healthcare provider, please specify, if more than one location
Contact Number

Suspected Insurance Fraud Details – Please tick the appropriate box

<table>
<thead>
<tr>
<th>Type of suspected fraud</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Provider – services not rendered</td>
</tr>
<tr>
<td>☐ Provider – performing unnecessary procedures</td>
</tr>
<tr>
<td>☐ Provider – used instead of new equipment</td>
</tr>
<tr>
<td>☐ Provider – billing performed elsewhere</td>
</tr>
<tr>
<td>☐ Provider – supplies not provided/substituted</td>
</tr>
<tr>
<td>☐ Provider – unlicensed provider claim</td>
</tr>
<tr>
<td>☐ Provider – billing other than performed</td>
</tr>
<tr>
<td>☐ Provider – unsubstantiated leave certificates</td>
</tr>
<tr>
<td>☐ Patient – obtaining services under false circumstances such as using a forged Health ID Card</td>
</tr>
</tbody>
</table>
8 Grievances & Appeals

Definitions

Grievances and Appeals are defined as customer complaints about a medical treatment or service being denied to or withheld from a Member by their respective Payer.

A treatment or service can be denied or withheld for clinical reasons and the related complaint is then defined as an **Appeal**. An Appeal can for instance be filed for:

- Denial of coverage based upon medical necessity, appropriateness of care, treatments deemed experimental or investigational in nature
- Denial of referral
- Benefit determined not to be covered under policy (e.g. prescription drugs, specific procedure(s)) which require review due to complications and/or unusual circumstances

A treatment or service can also be denied or withheld for administrative reasons and the related complaint is then called a **Grievance**. A Grievance can for instance be filed for:

- Lack of timely payment
- Eligibility denials
- Inappropriate application of co-payments and deductibles
- General Exclusions and Limitations

Members can file a Grievance or an Appeal following a structured process.

- First, a Member has to file a Grievance or Appeal with his health insurer “**Internal process**”. Every health insurer licensed in the Emirate of Abu Dhabi needs an internal Grievance & Appeals process with standard operating policies and procedures. These standard operating policies and procedures must be available for inspection and their use must be demonstrable upon request. The process must recognize both clinical appeals and administrative grievances.
- The Member can appeal a negative decision by the insurer by applying for an external review of his Grievance or Appeal by HAAD “**External process**”.
Internal Process

The following governing principles for the internal Grievances & Appeals process must be reflected in the health insurer’s standard operating policies and procedures:

- The insurer or Third Party Administrator acting on their behalf (collectively Payer) must make available to Members and Providers contact information for filing Grievances & Appeals that must include contact name or unit, contact email address and contact number.
- The Payer can establish a deadline for filing Grievances & Appeals which can be no less than 30 calendar days after the Member receives notice of the denial.
- Grievances & Appeals must be decided within 30 calendar days of the insurer’s receipt of the information needed to conduct the appeal, except for expedited clinical appeals as described below.
- For clinical cases only, an expedited appeal may be requested by the Member if the attending physician attests that a delay in providing the treatment or service poses an imminent or serious threat to the Member’s health. When requesting an expedited clinical appeal, a Physician Attestation Form (PAF) (available from HAAD) must be completed by the doctor and filed with the internal appeal application. These appeals must be responded to within 3 days of receipt of the completed appeal request.
- If the insurer rejects a Grievance or Appeal, the Member must be notified in writing of the decision. The notice must include the reasons for the decision including the clinical rationale for denial in a clinical case (Appeal) or a specific reference to the benefits summary made available to the Member/Provider illustrating the basis for denial/rejection in an administrative case (Grievance).

External application

A Member or Provider on behalf of the Member can seek an external appeal of a negative decision of the internal Grievances & Appeals process of the insurer with HAAD. To request an external appeal the Member or Provider must complete and deliver an application to HAAD within 30 calendar days of receiving written confirmation of the negative decision by the insurer on his internal Grievance or Appeal. The application for an external Grievance & Appeal must include:

- A completed "Request for External Appeal" form. This includes a medical release signed by the Member. A sample form is shown overleaf for illustration, but the online version should be used in practice. The form is available at www.haad.ae or can be obtained from HAAD’s customer service centre located at Health Authority Abu Dhabi Tower, Airport Road, contact number: 800-800
- Positive enrolment verification at date of service
  Example | A photocopy of the Member’s insurance card showing coverage dates
- A copy of the letter the insurer sent the Member and/or Provider with the negative decision of the internal Grievances & Appeals process by the insurer
- Proof that the service in question is a covered benefit / benefits summary from the insurer provided to the Member/ explanation of benefit sent to the Member if available.
- A filing fee of AED 100 (AED 0 for Abu Dhabi plan members), which is refundable if the decision is overturned.
- In the case of clinical appeals: An indication of whether the request should be expedited, and if yes, a Physician Attestation Form (PAF)
Request for External Appeal

Patient Information — If under legal age, please provide parent/guardian information

Name

Address

Contact Number

Email Address

Health insurance Company Information

Health insurance Company’s name:

Please state if patient is enrolled in the Abu Dhabi plan: □ Yes □ No

Brief Summary of Grievance or Appeal:

Please attach letter from insurer on denial of internal Grievance & Appeal process.

Appeal — Clinical Please state reason of your appeal claim by checking the appropriate box:

• Denial of coverage based upon medical necessity, appropriateness of care, treatments deemed experimental or investigational in nature: □ Yes □ No

• Denial of referral: □ Yes □ No

• Benefit determined not to be covered under policy, e.g. prescription drugs, specific procedure[s] which require review due to complications and/or unusual circumstances: □ Yes □ No

• Other:

Grievance—Administrative Please state reason of your grievance claim:

• Lack of timely payment: □ Yes □ No

• Eligibility denial: □ Yes □ No

• Inappropriate application of co-payments and deductibles: □ Yes □ No

• General exclusions and limitations: □ Yes □ No

• Other:

Fee received (to be filled out by HAAAD):

Expedited clinical appeal: □ Yes □ No If yes, please attach Physician Attestation Form.

Release Statement and Signature: I acknowledge that all of the information on this form is true to the best of my knowledge. I am insured with the above named insurer and have exhausted their internal Grievances & Appeals process. I hereby authorize my insurer, a Third Party Administrator acting on their behalf and my medical providers to release my medical records to HAAAD uniquely for the purpose of making a determination on my Grievance or Appeal.

Signature

Date
External review

For an external clinical appeal (Appeal), a preliminary review is conducted by HAAD to ensure eligibility for external review. If eligible, HAAD will coordinate with an independent review panel (IRP) on behalf of the Member, and will ensure that the IRP has the appropriate skills and credentials to perform the review.

- If the case is accepted for a full review, the Member/Provider and insurer will be notified of the IRP representative assigned to review the case.
- The insurer must send all relevant and requested medical and treatment records to the IRP representative within 15 calendar days of notice of the IRP representative. The representative may request additional information from the Member or Provider, who can independently submit information even if the representative has not requested specific information. A decision will be rendered by the IRP within 5 calendar days.
- Failure to provide requested information may result in a delayed decision or default decision against the delinquent party.

For an external administrative appeal (Grievance) a review will be conducted by HAAD. HAAD will make every reasonable effort to resolve the Grievance within 30 calendar days.

External decision

The Member/Provider and Payer will be notified in writing within 10 calendar days of a decision rendered by HAAD. The external review decision is final.

- If the Appeal is granted, the insurer will bear the full cost of the external clinical appeals process and filing fees will be returned to the Member.
- If the Appeal is denied, the Members will bear the full costs of the external medical review. Holders of the basic product (Abu Dhabi plan) will only be charged a fixed sum of AED 250.
- No extra costs will be charged in case of an external Grievance.

Expedited clinical appeal

A Member may request an expedited clinical appeal if the attending physician attests that a delay in providing the treatment or service poses an imminent or serious threat to the Member’s health. When requesting an expedited clinical appeal, the Physician Attestation Form (PAF) must be completed by the doctor and filed together with the external appeal application.

HAAD commits to the following principles for the Expedited Clinical Appeals process:
- An expedited clinical appeal will be decided by the reviewer within 2 calendar days of receipt of a completed application and supporting documentation.
- The Member / Provider and insurer will be notified immediately by telephone or fax of the IRP representative’s decision.
- Written notification will follow within 5 calendar days of rendering a decision.

Failure to provide requested information may result in a decision delay or default decision against the delinquent party.
Physician Attestation Form for Expedited Clinical Appeal

Physician Information

Name of attending physician completing this form______________________________
License number of physician _______________________________________________
License number of healthcare provider _______________________________________
Physician contact information ______________________________________________

Policy Holder Information

Patient name______________________________________________________________
Patient’s insurance plan and Identification Number ___________________________

Notice from HAAD if the patient has not yet received the services, and a delay in providing the health services would pose a serious threat to the health of the patient, as the patient’s attending physician, you may request the appeal to be expedited. If the appeal is expedited, HAAD must make a determination within 2 calendar days, instead of the standard 30 days, regardless of whether you provide all the necessary medical and treatment information. You must send any information to HAAD or the external medical reviewer appointed by HAAD immediately in order for it to be considered.

Acknowledgement of expediting clinical appeal:
Kindly confirm your appeal expedition, by ticking one of the following options:

☐ YES, this appeal must be expedited. I am aware that the external reviewer appointed by HAAD may need to contact me during non-business days and hours for medical information and that a decision will be made by the external appeal agent within 2 days of receiving this expedited appeal request, regardless of whether or not I provide medical information to the external reviewer.

During non-business days and hours I can be reached at __________________________

☐ NO, this appeal does not need to be expedited.

Attestation I attest that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

Attending Physician’s Name (Print) Signature and Date

_________________________________________ ________________________________
Reporting

Records must be kept by the insurer as to the type, frequency and outcomes of all Grievances & Appeals received and must include the following information:

- Patient Name
- Patient ID Number
- Provider Name
- Basis of Grievance or Appeal, (specify applicable exclusion / limitation)
- Date Received
- Date of Response
- Elapsed time from receipt to resolution (expressed in calendar days)
- Indication if an initial adverse determination is upheld or overturned
- If overturned, insurer must specify rationale for change from original determination

Example | Employer provided different/correct effective date of coverage

Payers must provide a log of all Grievances & Appeals in a format specified by HAAD together with the application for license renewal. All Grievances & Appeals are subject to audit by HAAD or a designated representative at any time.
9 Data Standards Panel

A Data Standards Panel will review and recommend to HAAD changes and additions to electronic data exchange standards, such as new or updated transactions and code standards. It falls within this remit to contribute to data strategy, opine on coding standards licensing and implementation, and advise on stakeholder communications. The Data Standards Panel

- Is composed of two provider representatives, three payer representatives, one representative each from the Laboratory Committee and the Clinical Coding Steering Committee and is chaired by the Head of Health Statistics at HAAD. The payer and provider representatives are to be nominated by relevant legitimate industry associations. If this cannot be done, HAAD will nominate representatives
- Meets every two months, and can be called with five days notice in case of urgent requests. It is anticipated that the Data Standards Panel will meet at least monthly in the early phases of implementation
- Requires pre-read at least five working days ahead of regular meetings and two working days for urgent meetings
- Is quorate if four Panel members in addition to the Chairperson attend
- Makes majority recommendations and makes minutes publicly available

Any licensed Provider or Payer can submit proposals to HAAD using the GenericMessage transaction with the subject “Data Standards Panel Proposal”. The proposal needs to include a succinct actionable recommendation, a paragraph on the context, and any supporting materials and evidence.