GOVERNMENT OF DUBAI

DUBAI HEALTH AUTHORITY

Dubai Health Insurance

Adjudication Manual

Version 1.0

(For Inpatient Use)

Dubai Health Authority

Dubai Health Insurance Corporation

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1. Introduction

1.1 Purpose of the Dubai Health Insurance Adjudication Manual

The objective of this manual is to provide guidance to claims processing officers to adjudicate claims correctly and consistently in accordance to standardized adjudication rules.

2. Adjudication Rules

2.1 Pre-authorization and Final Submission of DRG Code

- Providers are to submit an initial DRG code Insurers for pre-approval.
- Providers are to update the pre-authorization DRG code within 48 hours of patient discharge before submitting the claim to the payer.
- Payers are to respond back within 48 hours post receipt of the revised DRG code.
- Payers are not to reject any justifiable revision of DRG code at time of claim submission.

Note:

Discharge date/time is a mandated field with effect from 1 September 2020. It is part of the claim submission schema indicated as "EncounterEnd". Please click on the following link for details: https://www.eclaimlink.ae/dhd/encounterend.html

2.2 Splitting of DRG Payments Between Two Payers Due to Change of Insurer During a Patient Episode

The following formulas applies:

- Total DRG Payment = Base Rate x Relative Weight (including Outlier and Add-On Payments)

- Total DRG Payment Per Day = Total DRG Payment / Total LOS
- Insurer A Payment = Total DRG Payment Per Day x LOS (Insurer A) x Negotiation Factor (Insurer A)
- Insurer B Payment = Total DRG Payment Per Day x LOS (Insurer B) x Negotiation Factor (Insurer B)

2.3 Billing DRGs for Transfer Cases (Not Within the Same Hospital Group)

When a patient is transferred from hospital A to hospital B, Hospital A submits a DRG claim that is paid per diem where the first hospital day is paid at 100% and subsequent days paid at 50% capped at the DRG inlier payment. Hospital B submits a full DRG claim for the episode in Hospital B.

2.4 Discharge Medication in DRG Payments

DRG payments includes discharge medication of up to 7 days maximum calculated from the date of discharge.

2.5 Applying Mark-up on Price of Consumables and Drugs for High Cost Add-on Payments

Hospital mark ups are not permitted when submitting claims with add-on payments. Hospitals are requested to submit the invoice directly from the supplier.

2.6 Surgical Kits in High Cost Add-on Payments

Individual items in surgical kits will need to be separated and each individual item will need to meet the add-on payment criterion in order to be eligible for additional payments.

2.7 Insurance Policy Excluded Services and DRG Billing

Hospital services that were provided but are not covered in the insurance policy should not be reported as part of the DRG submission. Services not covered in the insurance policy should be settled between patient and hospital.

2.8 Suites and VIP Room Charges

DRGs provides a standardized payment for the services provided. Room charges are already incurred in the base rate calculations. Any additional room charges will be settled between the patient and the hospital. Hospitals, at their discretion, may offer a better rooms without charging the patient.

2.9 Patient Hoteling

Patient should be clinically and administratively discharged upon the completion of patient care. If the patient decides to continue to stay in the hospital, the patient should be billed separately from the DRG payments.

2.10 Billing Methodology for Paying Community-Based and Visiting Surgeons

Clinicians' bills should be reported as part of the DRG claim submission by the hospital. Clinicians will not be billed separately from the DRG claim submission.

2.11 Billing Methodology for "Send Out" Services

Send out services are those cases where to patient is accompanied by the hospital to another facility to receive service. Payments for send out services should be arranged internally between hospital and the facility. The send out service will not be part of the DRG claim from the hospital.