Dear eClaimLink Users,

Reporting Guidelines for Inpatient Transactions (IP Encounters 3 & 4) During the Go-Live Implementation Phase of DRGs

Throughout the shadow billing phase, the DRG payment parameters were reported as financial observation values and collected to enable the payers and providers to compare the existing fee-for-service payments vs. the expected DRG payments.

During the go-live implementation phase, to facilitate the billing and payer adjudication process, each payment parameter must be reported separately on different activity lines.

Providers will be expected to make the following changes in the way that they report the financial attributes in their PriorRequests and ClaimSubmissions after the transition from fee-for-service to the DRG payment model:

Reporting of DRG Payment Parameters should now be done using separate activity lines as follows:

Activity Type	Activity Code	Used for Reporting of:
9 - DRG	DRG Code	DRG Inlier Payment
8 - DSL	99*	DRG Outlier Payment
8 - DSL	99.01*	DRG Transfer Payment
8 - DSL	98*	DRG Add-On Payment for High Cost Consumables
8 - DSL	98.01*	DRG Add-On Payment for High Cost Drugs

** New codes have been introduced on the Dubai Service List to be used in the reporting of DRG Payment Parameters.*

Inlier Payment (DRG Activity):
The DRG Activity claimed amount should no longer be reported as 0 but should reflect the contracted DRG inlier claim amount. Claim amount refers to the contracted amount after applying deductibles and co-payments.

Outlier Payment:
For inpatient cases where the cost exceeds the predetermined “threshold” amount, and an outlier payment applies, Providers can use DSL Code ‘**99**’ to report the DRG Outlier Payment.

Transfer Payment:
For Transfer cases, Providers can use DSL Code ‘**99.01**’ to report the DRG Transfer Payment.

High Cost Activities:

1. If there is a high cost consumable/drug, then the Provider should report the HCPCS/DDC code with ActivityNet=0.

2. In addition, for each high cost HCPCS/DDC Code, Provider must submit 2 Observations, together with each high cost HCPCS/DDC Activity:
    a. ***ActivityCost**– New financial observation to be used for reporting the actual cost value for each high cost activity
    b. **File Attachment** – PDF attachment of Invoice/Receipt, to be submitted as proof of the activity cost
    In case the above observation values are not reported for high cost activities, then the Payer should reject the activity using denial code "DRG-005 - Missing Observation (ActivityCost and/or File Attachment)"

3. After calculation of the high cost consumable/drug add-on payment, Provider must report the add-on payment with ActivityNet = Amount requested from the payer, using the Dubai Service List Codes:
    a. **98** – DRG Add-On Payment for High Cost Consumables
    b. **98.01** - DRG Add-On Payment for High Cost Drugs
    Please see sample provided below

Additional Important Guidelines:

1. Providers must accurately report the **Gross, Net and Patient Share** amounts on the claim level, depending on the tariff plan agreed with the payer. On the activity level, providers must use **ActivityNet** to report the amount requested from the Payer for each payment parameter.

2. **The claim-level reported financial amounts should reflect the DRG Payment where ClaimGross must equal DRG Total Payment.**

3. Providers must continue reporting the individual performed activities as per the current fee-for-service format, with the modification that the ActivityNet for all activities that are non-DRG Payment Parameters should be reported as 0, since the payment will no longer be collected based on the fee-for-service model. **If Providers fail to report all performed activities, then Payers should reject the claim using denial code "DRG004 – Missing Activities"**

4. All financial values are to be reported to the nearest hundredth decimal point.

Documentation:

1. The latest **Dubai Service List (DSL)** and **Denial Codes List** are available for download:
    - eClaimLink > DHD > Documentation > Codes and Lists > Dubai Service List

2. The latest **Observation reporting details** are available for download:
    - eClaimLink > DHD > Documentation > eClaimLink Observation Details Release 20200212

3. **Reporting Samples -** For your reference, you can download sample ClaimSubmission xml files on eCLaimLink > Documentation > **DRG Full Implementation** section:

- A sample submission containing a DRG activity and its associated attributes.
- A sample submission for a transfer case.

Please note that the provided samples are for demonstration purpose only and are not clinically valid.

4. All DRG Project Documents and Presentations are available on eClaimLink for download:
   - DHD > Documentation
     > DRG Full Implementation
     > DRG Shadow Billing Phases I & II (older documentation that were published during Phase I and II of shadow billing)

Timelines:

Providers and Payers must adopt these reporting guidelines by **01 April 2020**.

Denial Codes:

Denial Code	Description	Existing /New	Notes
PRCE-001	**Calculation Discrepancy**	Existing	Use for denying activity line if amount requested is incorrect. Can be used for DRG Inlier payment, outlier payment, transfer payment, add-on payment for high cost consumable/drug, and for activity Cost. Use in case the tallying of the DRG Activities Amount is incorrect.
DRG-001	**Incorrect DRG code**	New	
DRG-002	**Missing DRG code**	New	
DRG-003	**Incorrect Billing Regime**	New	Use in case provider submits fee for service billing/ does not follow the DRG Payment Model
DRG-004	**Missing Activities**	New	Use for denying the claim if not all performed activities are reported in the claim
COPY-002	**Incorrect Patient Share**	New	Use in case the provider reports an incorrect patient share amount
COPY-003	**Missing Patient Share**	New	Use in case the provider does not report the patient share amount on the claim
DRG-005	**Missing Observation (ActivityCost and/or File Attachment)**	New	Use to reject the activity if it is a high cost consumable or drug and is missing the required observations: ActivityCost and/or Invoice PDF attachment

- Payers should use one of the above denial codes in their remittance advice to indicate if something related to the DRG reporting is incorrect or missing.
- Providers should re-submit the claims with the corrected DRG-related values.
- In addition to the above, Payers can use any other valid denial code from the Denial Codes List, that could be applicable on a DRG claim or activity level.

Generic Claim Samples with Arbitrary Activity Codes and Values for Demonstration Purpose – not clinically valid

Claim						
ClaimGross	**ClaimNet**	**ClaimPatient Share**				
50000	**45000**	**5000**				
Diagnosis						
Type	**Code**	**DxInfoType**	**DxInfoCode**			
Primary	I25110	POA	Y			
Secondary	I10	POA	Y			
Secondary	E785	POA	Y			
Activities						
Activity ID	**Activity Type**	**Activity Code**	**ActivityQuantity**	**ActivityNet**	**Observation1**	**Observation2**
1	9 - DRG	051051	1	**27000**	Risk of Mortality 1	
2	8 - DSL	99 - Outlier	1	**9000**		
3	8 - DSL	*98 - Add-on HCPCS	1	**4500**		
4	8 - DSL	*98.01 - Add-0n Drug	1	**4500**		
5	8 – DSL	65	1	**0**		
6	8 – DSL	20	1	**0**		
7	3 - CPT	33533	1	**0**		
8	5 - DDC	0006-106601-0391	1	**0**		
9	4 - HCPCS	A4930	1	**0**		
10	4 - **HCPCS	A4649	1	**0**	ActivityCost* 10,000	File Attachment of Invoice
11	5 - **DDC	0013-101301-1131	1	**0**	ActivityCost* 10,000	File Attachment of Invoice

** Newly introduced activity and observation codes*
*** High cost HCPCS and DDC must be reported with the actual ActivityCost and Invoice File Attachment in the observations section*

In case of a transfer, the facility transferring the patient should claim for the transfer payment

- *The sample claim below has no relation to the sample claim provided above.*
- *Contains Arbitrary ActivityCodes and Values for Demonstration Purpose – not clinically valid.*

Claim						
ClaimGross	**ClaimNet**	**ClaimPatient Share**				
15000	**13500**	**1500**				
Diagnosis						
Type	**Code**	**DxInfoType**	**DxInfoCode**			
Primary	I25110	POA	Y			
Secondary	I10	POA	Y			
Secondary	E785	POA	Y			
Activities						
Activity ID	**Activity Type**	**Activity Code**	**ActivityQuantity**	**ActivityNet**	**Observation1**	**Observation2**
1	9 - DRG	051051	1	**0**	Risk of Mortality 1	
2	8 - DSL	*99.01 – Transfer**	1	**13500**		
3	3 - CPT	33533	1	**0**		
4	5 - DDC	0006-106601-0391	1	**0**		
5	4 - HCPCS	A4930	1	**0**		

** Newly introduced activity and observation codes*
*** The transfer payment to be reported should be a graduated per diem payment. The first hospital day will be paid the full per diem rate. Subsequent hospital days will be paid 50% of the per diem rate. In the ClaimSubmission, the provider should report one transfer payment by calculating the sum of per diem daily rates.*
Please see [DRG Full Implementation Presentation]() published on eClaimLink > DHD > Documentation page, for full details on the transfer payment guidelines.

Best Regards,

Information Desk Officer
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