

eAuthorization on **eClaimLink**

“Helping Patients Get The Services
they Need Faster”

Question and Answer Session

Tuesday 28th March 2017



Agenda

1. Session Objectives
2. The eClaimLink Taskforce and Regulation
3. Questions & Answers
4. Next Steps



1. Session Objective

- ✓ As announced at the launch event in December 2016, guidelines will be reviewed quarterly with input from the **Stakeholders' Consultations and Inputs Group (SCIG)**. This group was formed and includes a representative from all Hospitals and Groups and also some Clinics and centers.
 - ✓ Written feedback was requested from **ALL Payers and the SCIG members**
 - ✓ Approximately 70 feedback questions were received, collated, grouped and discussed over several session.
 - ✓ The output of these sessions was the **Question and Answer document** that will be published on eClaimLink and discussed in more details today.
- ✓ **OBJECTIVE:** To address all submitted queries and concerns from both Payers and Providers



2. The eClaimLink Taskforce and Regulation

- ✓ In order to support the regulation and implementation of eAuthorization and other eClaimLink initiatives, **The eClaimLink Taskforce** was formed.
- ✓ This taskforce consists of:
 - ✓ Members of HFD (representing the interests of other DHA Departments)
 - ✓ Dimensions Healthcare
 - ✓ Payers:
 - ✓ Oman Insurance – Dr. Yaser Sabsabi - Vice President, Head Of Preauthorization for Medical and Life claims
 - ✓ Neuron – Dr Faisal Gilani – Manager, Provider Network Operations & Relations
- ✓ **OBJECTIVE:** 1. Guideline and regulation review 2. Planning of developments 3. fine tuning of the system 4. Incorporation of market & user input that is unique to the Dubai market and its needs.

3. Questions & Answers

Panel Members

Mihtab Osman, DHA Health Funding Department

Sabine Karam, Dimensions Healthcare

Dr. Yaser Sabsabi, Oman Insurance

Dr Faisal Gilani, Neuron TPA



1. The in-patient field which is used to enter the price estimate does not reflect the full cost of the request and price is based on CPT code, which does not reflect the total price. How can we add for additional items used?

A new set of generic codes has been introduced to incorporate estimated price:

1. **Drug:** 9999-999999-9999
2. **Consumables:** A4649, A9999

2. How can a Payer request for more information from a Provider to clarify the rejection/denial reason for both Providers and insurers?

A new denial/rejection code “**AUTH-012 Request for information**” has been added to be utilized when more information is required. The PriorAuthorization result will be “Pending” at this point to avoid using “Yes or No” until the details are completed from the Provider’s side.



3. How can a Payer track an authorization that is amended? Can we use the same transaction number? Will transaction number change?

At this stage of implementation, we want to avoid causing too much change to Payers systems as different payers will have different systems and number formats. We are however considering utilizing a standard format that will enable the user to see the amended original request

4. Is it possible to submit the eligibility request at DHPO and receive information regarding the member's benefits?

This is a future development for eligibility. At this stage in the eAuthorization initiative implementation, basic information is shared with Providers. Once Payer and Provider participation is at a satisfactory level, DHA will phase out developments to expand the level of information shared and this will be unified across all Payers and in line with Premium regulation.



5. Can the size of the uploaded document be increased to more than 5MB per encounter to accommodate more complex in-patient cases?

We can investigate the feasibility, however we will need to have a samples transactions that have a larger size than 5mb in order to investigate and review and recommend possible solutions.

6. Observation is not in a standard format and there are many variations sent by Providers related to universal dental and other types. Will these be standardized?

Following this query, the observations in eClaimLink were reviewed and the list standardized.

The new list will be published soon.



7. We still receive NON-STANDARD codes in eClaims submission and internal codes are submitted ,however NON-STANDARD codes do not exist in eAuthorization to retrieve the exact items. How will we adjust for this?

The use of Non-standard-codes was prohibited and outlined in *General Circular 2 of 2016* and therefore the use of internal codes in eAuthorization is prohibited as well.

Providers must use the agreed standard CPT coded price list.

Some use of internal codes is permitted for packages and bundles and also in cases where the CPT code is not present in the current 2012 version of CPT utilized in eClaimLink.



8. Can we attach scanned copies of claims to provide history to avoid irrelevant investigations on cases?

Yes. There is a facility to add an attachment, however this is not always necessary.

If a Payer requires more information, a new denial/rejection code “**AUTH-012 Request for information**” has been added for authorization to be utilized when more information is required. The observation field can be utilized to submit the requested additional information depending on the type and format.

All available observation types and details can be found on the eClaimLink on the following pathway:

[eClaimLink > DHD > Documentation > EDSC Releases: **eClaimLink EDSC Release V5 2014-04-20**].



9. Is it possible to have the patients' mobile number to communicate with them and validate the request?

The policy holder mobile phone number should already be available with the Payer during the registration/insuring of the member.

We do not expect Payers to do such validation before responding back to the Provider as this will cause delays and increased TAT.

This should be carried out at a later time and date for audit purposes if a Payer wishes to confirm that the service authorized was in fact rendered.



10. What is the process for revoking a pre-approved case? Can a Payer revoke or amend the status? Likewise, can a Provider issue a cancellation of the request once approved?

Currently the Provider can cancel through the system, through generating another PriorRequest with AuthorizationType = Cancellation.

Payers are only permitted to update a PriorRequest status from Denied to Approved.

The opposite (Approved to Denied) is not permitted.

This topic will be revisited in Q2, to discuss the ability to create a process/transaction/workflow that enables Payers to initiate a PriorAuthorization cancellation request.



11. Does the system allow eClaims to be submitted without eAuthorization reference?

Yes. eAuthorization reference is not mandatory in the eClaim schema as not all services require authorization. The requirement for an eAuthorization is dependent on the terms of the individual's policy and so must be addressed on a case-by-case basis.

12. Is there a free text field for the Payer and the Provider to add comments?

Yes. There are several fields that can be used to provide additional information related to the PriorRequest and the PriorAuthorization:

1. Provider can submit additional information within the PriorRequest using the observation field.
2. Payers can submit additional information within the PriorAuthorization using both the comments and observation fields.

Detailed description and XML schema format of the observation field is available on [eClaimLink > DHD > Documentation > EDSC Releases: **eClaimLink EDSC Release V5 2014-04-20**].



13. There is no option in the system to re-approve the approved/partially approved cases, if the validity date of approval is exceeded. What do we do in such scenarios?

If the PriorAuthorization is expired, it is recommended that the Provider sends another PriorRequest where the Payer can generate another PriorAuthorization containing a new expiry date.

14. Is there an option to extend the inpatient approval case?

In the case of requesting a patient stay at the hospital, the Provider and Payer have several options:

1. Provider can edit the existing approval with the new details and submit it to DHPO, and the Payer will send another PriorAuthorization to approve the revised request.
2. Payer and Provider agree that if the change is within a given range, the Provider does not need to submit a new PriorRequest and can just send the full details during the ClaimSubmission.



15. In case of any query from the Payer side, there is currently no option to query the Provider and we have to reject the full case with remarks.

A new denial/rejection code “**AUTH-012 Request for information**” has been added for authorization to be utilized when more information is required.



16. Clinicians should be mapped in Payer In-house systems, otherwise the system will reject such cases. All our network providers are already notified about this

Payers should rely on eClaimLink validation for Provider and Physician licenses as the system is directly integrated to the licensing source, which is DHA Health Regulation Departments Sheryan System. This is updated at midnight every night so eClaimLink is more accurate than any manually updated list in a Payers system.

Payers that still want to build another layer of validation will be able to daily download the lists published on the [eClaimLink > DHD > Codes & Lists]

Exceptional cases may appear when a clinician license is expired, renewed but not updated on the system yet. If the claim is submitted the next day it should be resolved.



17. Can providers see the ID payer (Payer Approval Reference Number)?

Yes

18. Some Provider authorization requests are being sent with Zero as net activity amount or quantity. What do we do in such cases?

A Payer may do the following:

1. Refer to the existing tariff
2. Use the new denial/rejection code “**AUTH-012 Request for information**” that has been added to be utilized when more information is required.

19. When will Emirates ID be activated in e-Authorization?

This is already available on the eAuthorizaton system.

For those using the online portal, use the EID in the location of the memberID and submit the request.



20. Can DHA provide us with a list of Clinicians along with their accurate eClaimLink license numbers, along with the Providers they belong to along with their specialty?

The updated list of licensed clinicians is available to download from [eClaimLink > DHD > Codes & Lists].

Additional details such as specialty and primary facility are under investigation to be released by the DHA Health Regulation Department.

21. In the future would there be an option for add-on fields to the basic schema as per the requirements of the Payer?

All changes to schema should be suggested with justification to HFD and will undergo assessment.



22. When a procedure is approved on e-authorization portal , being under the TAT of 30 min , would the payer then hold the right to review and edit the CPT requested for this procedure? And retrospectively subject to file audit for verification of claimed services?

There is no restriction on the guideline for the TAT and the Payer reserves the right to audit and verify at a later date.

23. Would there be an option to edit the CPT requested by the Provider, from the Payer's end , when responding on a request?

No. Payers are not allowed to update the transaction details. If an update is needed, the Payer may send a PriorAuthorization with a rejection to the existing transaction with comments, and the Provider will be required to send a new PriorRequest for the updated transaction.



24. There is no denial/rejection codes for certain rejections like "Supporting document not submitted" available. What do we do in such scenarios?

A new denial/rejection code "**AUTH-012 Request for information**" has been added for authorization to be utilized when additional information is required.

25. DHPO currently cancels the existing request and creates a new request when provider resubmits a request. The new request does not have any link with the original request creating confusion to the user. Can Idpayer should be updated for the new request as a link to the original request?

This is as per the current published guideline.

This topic will be revisited in Q2 as it requires further discussion and investigation.



26. Can a web service should be made available to get the timestamp for the following?

- 1. If the prior-authorization has reached the post office**
- 2. Whether the Provider has downloaded the request**

This service currently exists and you can use the system on the DHPO.

The web services can be found on the [eClaimLink > DHD > Documentation > **DHPO WebService Specification 2015-02-04** “GetNewPriorAuthorizationTransactions”].

The user can also check the transactions through the eClaimLink > DHPO > Transactions > PriorRequest & PriorAuthorization Transactions.

27. Is there a feature for re-uploading the request to DHPO?

A Provider will not be allowed to upload another transaction without a response, except if the type is cancellation.



28. If a healthcare provider is licensed in the Northern Emirates and is using DHPO/eClaimLink to submit claims, are they bound by all the DHA rules with regards to the usage of eClaimLink (i.e. eAuthorization, ePrescription etc.)?

eClaimLink is a system provided by DHA to advance the health insurance market and unify operations and provide users with efficient processes for claim submission and other initiatives. All initiatives are mandated for Dubai Providers and any Northern Emirates Provider using the system will be subject to the same guidelines.

29. When will the eligibility check display co-payments and deductibles, and benefits such as maternity and dental?

The implementation of the benefit and unification will be addressed during premium regulation. This project requires input and commitment from Payers in order to succeed in the least amount of time as possible. Technically eClaimLink can provide this information however the benefit information must be provided by Payers in the agreed format.



30. We are confused as to which portals to use for eAuthorization as many Payers and TPA use their own portal for eAuthorization and don't use DHPO.

All transactions to acquire eligibility and eAuthorizations must go through the DHPO. Providers may utilize the Payer portal as long as the transaction workflow, standard codes and mandatory fields are fully compliant with the DHA's mandates.

Additional information, for eligibility that is not mandated by the DHA can be shared with the Providers or members through external portals deployed by each Payer separately.

31. We have some diagnostic tests requires scheduled appointments and need to set the validity of approvals should be more than 1 day. Is this possible?

The validity is currently based on the agreement between the Payer and the Provider. DHA can set validity if necessary, however there is no intention to over regulate and allow for the market to decide at this stage.



32. We are facing many delays due to Payers failing to assign appropriate denial codes which will help to re upload the authorization request accurately. How can we overcome this?

This can be managed through some guidelines on rejection and denial reasons. Payers are expected to select appropriate denial codes.

A additional denial code “**AUTH-012 Request for information**” has been added and updated status to avoid unnecessary rejections due to additional information being required.

The observation field should be used to communicate specifics if required.

33. What is the contingency plan in case of a system downtime?

The contingency plan is the same as the PBM transactions. Users are expected to go to the manual process, incase of Payer/Provider or DHPO downtime, where all the transactions need to be uploaded again.



34. Why can't the start date and end date be mandated since it is variable for each Payer?

The validity period is based on the agreement between the payer and the provider.

DHA can mandate these fields if deemed necessary upon assessment later on in the implementation.

35. With regards to Authorization status, Approved status – despite the approved status on the specific field, rejection of service are often encountered in the detailed description and vice versa. How can we overcome this?

Each payer system treats the authorization result differently so we recommend that Providers always look at the activity level results.



36. Can Payers be requested to give details of denials, query, benefit limits or approvals for multiple sessions (physiotherapy ,injections)?

Payers can provide further details about the denials, benefit limits and any other additional information through the comments field in the PriorAuthorization transaction.

DHA can mandate these details if deemed necessary upon assessment later on in the implementation.

37. At the ACTIVITY LEVEL can Payers furnish all relevant fields such as: Approved status, Approved quantity, Approved amount, Co payment ? And as a specific dental request - The universal tooth numbering system entered in the observation field is not reflecting on Payer system.

This will be mandated by DHA. Payers already populate the Payment amount. Then the provider system can deduct from the requested amount and deduce with the patient share. Examples of technical issues faced need to be reported to eClaim support.



38. Why there is no provision for taking approval for vaccination on the eAuthorization portal?

All specific medication can be requested using eAuthorization, if for example this item is to be administered in an IP setting or during an OP visit.

For all medication to be used by the patient after the visit or discharge these must be requested initially by the physician using eRx and then by a pharmacist, as per the eRX cycle.

39. Currently, there are multiple Payer and receivers IDs for a single entity. Why can't we have only active and updated list at the eAuthorization portal?

This is valid and will not be updated. An updated list of all Payer and TPA IDs is available to download from eClaimLink and cannot be restricted due to the ongoing contracting between Payers and TPA's. We envisage that during the coming stages of implementation and the launch of premium regulation, this information will be provided by the Payer.



40. We are recently facing issues with certain Insurance Companies/TPA's, requesting Emirates ID as the insurance card. As per current DHPO system, there is no option to proceed with eligibility verification without member insurance card number and payer name.

Real time eligibility check will determine whether a patients plan or policy is active and whether it is accepted at a particular facility. DHPO currently accommodates both fields, and the emirates ID can be used in both fields in such cases in order to replace the MemberID.

41. In the transactions list on the eClaimLink portal, is it possible to have an option to search for the approvals using the patient name?

Name is not available. The unique identifier for the member is MemberID.

This request will be taken into consideration as an enhancement and may be implemented if assessed as a priority.



42. In the activity section of eAuthorization, is it applicable to change gross amount to net amount instead?

In both PriorRequest and PriorAuthorization the activity has an element to carry the Net Amount.

43. All patients, whose insurance plan is the Essential Benefits Plan must visit a GP and obtain a referral prior to going to see a specialty Physician and some policies require approval for specialist consultation. There is no provision to mention the referral doctors & clinic name in eAuth module and there is no provision in eAuth to enter referral details.

The eReferral mandate is on a procedure level and not on the transaction level. There is no eAuthorization transaction to check for a member referral.



44. We have noticed that some Payers are unable to view the approval details which we have sent through DHPO. What do we do in such cases?

Any technical issues faced need to be reported to eClaimLink support as soon as they happen, along with providing the needed details to be able to trace the issue. Examples need to be provided with screenshots when possible. This will allow the support team to actively resolve or feedback on how this can be resolved.

45. What happens if Payers direct Providers to use their portals for eAuthorization and not via DHPO?

Payers and Providers may utilize any utility/portal to complete the eligibility transactions as long as they use a system or portal that is compliant with the DHA rules and regulations. However, for all eAuthorization requests both Providers and Payers are required by mandate to integrate to DHPO, if they have an EMR system or be ready to use the free, online tool on eClaimLink.



46. What happens when a Payer uses “Auto- Authorization ” ?

Instances where this is encountered should be fed back to eClaimLink support. As this initiative is new, feedback is required in order for HFD and Dimensions to access if any specific guidelines or regulations are required.

Auto approval is not enforced by the DHA and is not recommended to be used by Payers.

4. Next Steps



- This presentation and Question and Answer document will be uploaded to eClaimLink
- Additional guidelines will be added to the existing eAuthorization guidelines currently available on eClaimLink
- HFD will continue to monitor use of the eAuthorization system and compliance to guidelines
- The eClaimLink Taskforce members and topics will be expanded to address all eClaimLink related feedback, development topics and timelines for implementation



For further communication related to this topic:

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