The eClaimLink Taskforce

Date of Meeting	Start Time	Finish Time	Meeting Location
Wednesday 31st January 2018	9:00 am	11:00pm	Health Funding Department – Society of Engineers Hall 1 - Ground Floor

Agenda

1. Prescriber compliance – enforcement of the eRx cycle & mandate of eRx Reference Number

- eRx Reference number is not mandatory for prescriptions from Providers Outside of Dubai (OOD)
- Enhancements to be added to the eClaimLink eRx Pharmacy system to allow Payers to reject Prior requests with missing eRx reference number
- This will be mandated for prescriptions written by Dubai Providers for insured patients and to be enforced across Dubai Providers.

Update

- New denial code created– Missing eRx Reference Number
- Announcement to market 1st February 2018, including responsibility matrix for involved parties.
- Effective 1st April 2018
- 2 month preparatory period

Agenda

2. Pharmacist edit restrictions

- Diagnosis cannot be changed once an eRx reference number is used to populate a Prior request.
- Without an eRx reference number the pharmacist must enter diagnosis
- Modification of the medication is allowed, as per stock and availability
- Restrictions to be reviewed for pharmacists ability to edit an ePrescription in line with MOH guidelines
- Will be fully resolved once the eRx reference number is mandated

Update

- DHA Pharmacy services has applied for an update to the MOH Law on dispensing, in the interim we will working with PSD to apply the restrictions which will be eventually applied in the Law.
- Discussion on applying Generic only prescribing is also ongoing **– Feedback required for next meeting**

Feedback

2. Pharmacist edit restrictions

- eRx Number at the Physician Level does not ensure approvals for the Medications. Payer checks are minimal in the Physician cycle.

This is true. Payer checks must be minimal as at physician level we check only what is required by the GP, and financial checks should not affect whether the GP prescribes the medication he patient needs or not. The patient can still pay cash for necessary medication that is not covered.

- ERx Diagnosis edit option that is used by pharmacist should not be discontinued because some payer system does not take into account the symptoms that linked to a particular Diagnosis like URTI (decongestants –nasal spray or cough syrups do not get approved).Once the Payer systems are upgraded then this option can be discontinued because the patient will suffer the most in this revised cycle and this sick patient will have to continue going back to the physician for such correction .The Aim of ERx was to enhance patient experience and reduce the waiting time at pharmacy –this will completely get lost

This links to the use of billing guidelines where the market should be using coding guidelines. This will be addressed by the Coding Committee.

Agenda

3. Addition of emergency notification function to comply with market requirement of notifications within 24hrs

- The 24 hour notice period for inpatient emergency care commonly stated in Payer Standard Polices and Schedule of Benefits, whereby inpatient treatment received without prior approval from the insurance company, including cases of medical emergency which were not notified within 24 hours from the date of admission is considered an exclusion.
- A separate notification function is not required as eAuth using encounter type EMERGENCY is sufficient.
- Payers must be ready to receive eAuthorizations from non-network Providers

Update

- DSL code available – 61.08 – Consultation by a physician at Emergency Room
- Announcement to market 1st February 2018, including responsibility matrix for involved parties.
- Effective 1st April 2018
- 2 month preparatory period

Agenda

4. Creating a cost estimate for an Authorization accurately

- Discussed internally, and agreed that the estimate is just an approximate figure
- Payers will need to set in place a process and create a confidence interval subject to the data they have on previous claims
- Adding more generic codes is not advised
- Providers must request for an updated Authorization, if there is an extension of stay or others services required

Update

- This needs to be discussed in greater detail with the task force members **– Feedback required for next meeting**

Feedback

4. Creating a cost estimate for an Authorization accurately

- Cost Estimate amount does not match the correct estimate requiring PDF & Doc attachments. Also not possible for provider to enter each approval Lab or Radio item in Pre-auth level like a claim. (N&A)
- Need in cost estimate the Estimated IP Lab Investigations, Estimated IP Radio Investigations, and Estimated IP Consumable. Any Investigations or Consumable individual unit cost greater than AED1000 or AED2000 have to be entered as a separate entry. (N&A)

Would it not cause more communication between Parties if there are undisclosed items yet large monetary amounts requested? It is still our suggestion that costly investigations or consumables must be added, however a market agreed percentage be added as a buffer.

Inaccurate cost estimate should not be a denial reason if sufficient balance is available within the policy, also if the services provided are medically necessary.

Agenda

5. eAuthorizations from non-network providers via eClaimLink

- Concerns raised that eAuth requests sent via eClaimLink are not picked up by Payers.
- Many situations where a non-network provider will need to send an authorization request so Payers need to check that their systems can pick up eAuth posted to DHPO regardless of whether they are network or non network.

Update

- Announcement to market 1st February 2018, including responsibility matrix for involved parties.
- Effective 1st April 2018
- 2 month preparatory period

Agenda

6. Unification of Payer response to eEligibility and eAuthorization

- Current schema and functionality does not provide added value to users and must be reviewed to meet the needs of Providers and allow for efficient exchange of information.

Update

- Planning has begun to study the functionality available across the market and we are looking to unify the responses which differ from Payer to Payer.
- To be announced during Q2

7. Revision of the approvals and Transaction ID's

- Resubmission element for eAuthorization has been requested similar to eClaims.

Update

- Functionality already available for integrated Providers.

Feedback

6. Unification of Payer response to eEligibility and eAuthorization

- Eclaim Link needs to be upgraded to be a comprehensive portal which will provide complete information regarding eligibility, copayment / Deductible , Benefits which will eliminate the need for specific Payer portals thus making the registration process easier and quicker. (AHD)

We fully agree and have put in place a team to work on this project.

- This project must be time bound for realization and implementation. (AHD)

A timeline has been set and the market will have 3 months notice to make adjustments to their integration to eClaimLink. we will then have a test period of 1 month before mandating the shift from Payer portals to eClaimLink. We will also announce all changes to integration for other projects at the same time to the market.

- In e Auth the decimal point is going up to 13 for approved amount & 15 digits for patient share. (N&A)

Dimensions Healthcare will look into this and make the required adjustments.

- Emirates ID verifier to ascertain the correct TPA is not there. E.g. Payer A is having TPA x TPA y & TPA Z. When we check EID card in the DHPO we only get Payer A name & then we have to go to TPA x, TPA y & TPA z website to find out which one. (N&A)

This will be resolved.

Agenda

8. eAuthorization – request for information status update

- The Status on eAuths when the denial code is - reguest for information should be as pending, not denied.
- Examples required for review by technical support team

9. Denial Codes

- Denial codes need to be updated

Update

- Feedback needs to be discussed with Task Force members and then reviewed internally.

Feedback

9. Denial Codes

- Most Payers use below 2 codes which does not provide clarity or exact reason to providers to resubmit the claims. This project must be time bound for realization and implementation. (AHD)
  - **CLAI-012 -Submission not compliant with contractual agreement between provider & payer** - Should be amended as CPT not appropriate or specific for the diagnosis.
  - **MNEC-004 - Service is not clinically indicated based on good clinical practice, without additional supporting diagnoses/activities** - Should be amended as More medical information is required to process the claim resubmit with documents. (AHD)
- Documents required (only available at Auth level with Auth012)Possibility of common documents being listed: Reports/Discharge Summary/Invoices. (Aafiya)
- Resubmission denied- Initial denial stands valid. (Aafiya)
- GP Referral required and not obtained. (Aafiya)
- RTA not covered. (Aafiya)

For some of these suggestions, the benefits and further explanation is required.

Agenda

10. Resubmission cap for claims

- We are considering setting a market limit of 2 resubmissions for each claim followed by reconciliation.
- Each claim will have 1 claim ID and a max of 2 submission ID's, plus an additional submission if adjustment is required.
- No limit for non-network providers will result in extended cycles and delayed reconciliation.

Update

- Each claim will have 1 claim ID, 1 submission and a max of 2 resubmission ID's, with the final resubmission being a the result of reconciliation.
- Announcement to market 1st February 2018, including responsibility matrix for involved parties.
- Effective 1st April 2018
- 2 month preparatory period

Agenda

11. eAuthorization TAT

- eAuthorization TAT to be enforced and we propose the below TAT for approvals
- OP – within 6 hours; IP – within 24 hours
- Provision for extending the validity of the approvals
- Provision for sending reminders for delay in reply from payer's on eAuth requests

Update

- Initial TAT to be OP – within 6 hours; IP – within 24 hours
- Announcement to market 1st February 2018, including responsibility matrix for involved parties.
- Effective 1st April 2018
- eAuth TAT reports will be published mid April 2018 for Q1 2018 and continue quarterly. 1 report per payer and one general report for Providers.

Feedback

11. eAuthorization TAT

- Validity of E Authorizations should be extended to 30 days/until the expiry of the policy whichever comes earlier. AHD

This has always been a Payer/Provider agreed validity period. Extended validity periods may cause issues especially where cancelation is required.

Pro’s and cons need to be discussed.

Agenda

12. Signs and Symptoms
• Signs & symptoms are required by some Payers to allow claim clearance even if Diagnosis is established. • This is not in line with International Coding Guidelines
Update • This will be discussed during the next Coding Committee Meeting

Feedback

12. Signs and Symptoms

- We suggest for outpatient claims the R chapter codes of ICD should be allowed to be used for outpatient services as this will convey more detailed information to the payer and thus help in adjudicating the claim properly. (AHD)

Dimensions Team: Are you aware of the background as to why R chapter codes are not used in ICD?