Additional Upfront Filters

1. Late Submissions Validation

Rule Explanation

Validate date of service against submission date to be within mandated no. of days.
This is only for Out-Patient claim.

Expected Error Message

“Time limit for submission has expired”

Example

Month of service date is Aug-24, if claim submission is 01/10/2024, claim will be rejected.

2. Age Rule

Rule Explanation

System will validate the service against the age of the member to check if valid based on member age.

Expected Error Message

“Age not matching with the type of service (specify here the actual service rejected) provided”

Example

- PSA (Prostatic Specific Antigen) Total/Free, not allowed for Age Less Than 5

3. ICD Codes

Rule Explanation

There are certain ICD codes which are diagnostic in nature or inactive which should not be attached to a claim.

Expected Error Message

- “(Mention the Principal ICD Code}) is not valid as primary diagnosis”
- “(Mention the ICD Code) is inactive ICD 10 AM 10ED Code”

Example

ICD code: B91 (Sequelae of poliomyelitis) will be rejected as: Unacceptable Primary Diagnosis

4. Maternity Lab Service Protocol

Rule Explanation

Laboratory services during pregnancy period that should be done only once for the same provider from the initial visit till delivery.

Expected Error Message

“Billed laboratory service [mention the lab service description and Nphies code] should not be repeated during a pregnancy period till delivery”

Example

HIV, once per provider per maternity routine till end of pregnancy.

5. Total Claim Amount vs PA Amount

Rule Explanation

Check the claim total amount (for those items that require approval) exceeds the total of all line items of the attached preauths.

Expected Error Message

“Total claim amount had exceeded the approved amount in preauthorization; {mention the service/s} requires preauthorization”

Example

If claim total amount is 1,500 but the preauthorazied amount is 1,000.

6. Validation on ID No and Membership No.

Rule Explanation

The submitted ID No. (National or Iqama) and Membership No. should be identical as per Bupa record.

Expected Error Message

“Bupa membership no. is not matching with the ID No. submitted”

Example

Submitted Membership No. is for member "A“ while ID No. is for member "B“.

7. Dental Services Quantity

Rule Explanation

All dental services that require tooth number in submission should be billed separately as single line-item with quantity 1.

Expected Error Message

“Dental Service {mention the specific billed dental service} quantity should not be greater than 1”

Example

Tooth Extraction line-item with quantity more than 1.

8. Invalid Clinical Data

Rule Explanation

The presented Chief Complaint is not valid that warrants as claim.

Expected Error Message

“Chief Complaint submitted is invalid”

Example

If the Chief Complaint "Patient not seen by me" , "No show “.

9. Hearing Aid Max Quantity 2

Rule Explanation

Billed hearing aid should not exceed quantity 2 within one policy period.

Expected Error Message

“Billed quantity of hearing aid device has exceeded the allowed limit”

Example

Hearing aid maximum quantity 2 per contract

10. Document attachment

Rule Explanation

No attachment made to the submitted claim which instead of checking the claim manually, this will be done upfront.

Expected Error Message

“No document attached to the claim”

Example

Invoice/s and investigations results /reports are not attached to the claim request.

11. Duplicate items

Rule Explanation

Specific items should not be billed again within the same claim request.

Expected Error Message

“Duplicate / repeated billing of ’*Service Description*’”

Example

Ferosac Inj 20Mg-Ml Amp billed as duplicate for the same claim.

12. Medications / tests not part of pre-authorized request

Rule Explanation

Any billed item under dental or above preauthorization limit where it is not included on the attached preauthorization.

Expected Error Message

“’*Service Description*’ not part of pre-authorized request”
”

Example

Filling was billed in a claim but the attached preauthorization has no approved filling service.

13. Not part of routine ANC

Rule Explanation

Pre-defined lab investigations are already known as part of routine ANC and any service not included in the list should not be billed under such type of claim.

Expected Error Message

“’*Service Description/s*’ not part of recommended routine care / profile”

Example

FREE T4 is billed under a maternity claim.

14. Filling is part of RCT

Rule Explanation

Filling will be rejected if billed together with RCT in the same date and not preauthorized.

Expected Error Message

“Filling is part of RCT”

Example

Filling is part of of billed RCT.

15. The Scaling has already been done

Rule Explanation

The number scaling is pre-defined under member’s Table of Benefits and should be billed only not beyond this.

Expected Error Message

“The scaling has already been done”

Example

The scaling has already been done.

16. Panoramic X-ray is done

Rule Explanation

Panoramic x-ray should not be done and billed more than once in one contract period for the same provider.

Expected Error Message

“The panoramic x-ray has already been done within a period of one (1) year 260028292 on treatment date 07 April, 2024”

Example

Panoramic x-ray is done.

Current Filters Adjustments

1. Sub-limit Logic Update

Rule Adjustment

To validate the claim amount with the approved amount in Preauthorization

Reason

System was checking the amount during claim submission while PA amount is higher than the remaining, and it is not accurate

2. Match Claim’s Item with Attached PA Items

Rule Adjustment

items in the claim to be matching the item/s of the attached Pre-Auth based on the submitted service code or Nphies code in both places. The system will check all the items in all episodes.
If failed, return this error message: “Attached approval ID is not related to the claim”

Reason

To close the gap in the current logic. Provider can attach a PA No. for the same member within the validity period while it’s not related to the claim

3. Preauthorization Status (Line-Item)

Rule Adjustment

The status of line-item in preauthorization ID will be validated instead of the status of the episose.

Reason

There are items already rejected in preauthorization but still submitted in claims. Additionally, already approved items from previous episode but rejected in the succeeding episode.


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THANK YOU