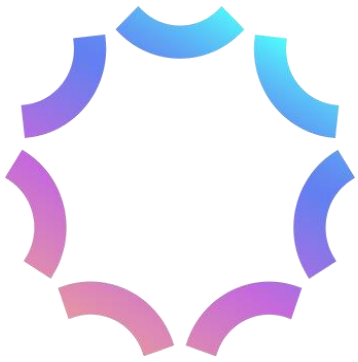
nphies



nphies Billing Cycle Guidelines

Version 1.3

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SECTION 1.0 ABBREVIATIONS

Abbreviation	Description
NPHIES	National Platform for Health Information Exchange Services
CHI	Council of Health Insurance
CHI BS	Council of Health Insurance Billing System
HIC	Health Insurance Company
HCP	HealthCare Provider
TPA	Third Party Administrator
TAT	Turn-around time

SECTION 2.0 DOCUMENT RELEASE NOTE

REVISION HISTORY			
Document Version Number	**Date of Release**	**Details of Changes**	**Section No.(s)**
1.0	15-May-21	Created the first version to be published.	All Sections applicable
1.1	19-June-21	Updated to align with the latest BRVR & Profile changes	All Sections applicable
1.2	06-Jul-21	Updated to align with the latest regulations	Section 4
1.3	9-Sep-21	Section (5.1) – Page12: 1. PatientPaid changed to patientShare to be aligned with the profiles document. Section (5.2) – Page 14: 2. Category code values changed to be small letters. 3. Category code values (deductible, rejected and unallocDeduct) were removed, as advised these are not used in the Saudi market. 4. Adding the Tax filed to the calculation in the given response example. Section (5.3) – Page 16: 5. Adding the 3 PaymentReconciliation.detail fields to the table.	Section 5

SECTION 3.0 IDENTIFYING EXISTING MARKET AGREEMENTS

This section outlines how the nphies platform allows an HCP to report both TPA and the contracted HIC within nphies health insurance transactions, so the transactions can be routed and processed by the TPA without losing the financial accountability of the actual insurer.

In doing this nphies, provides CHI a view of the KSA market landscape, existing relationships, and behavior of individual market participants.

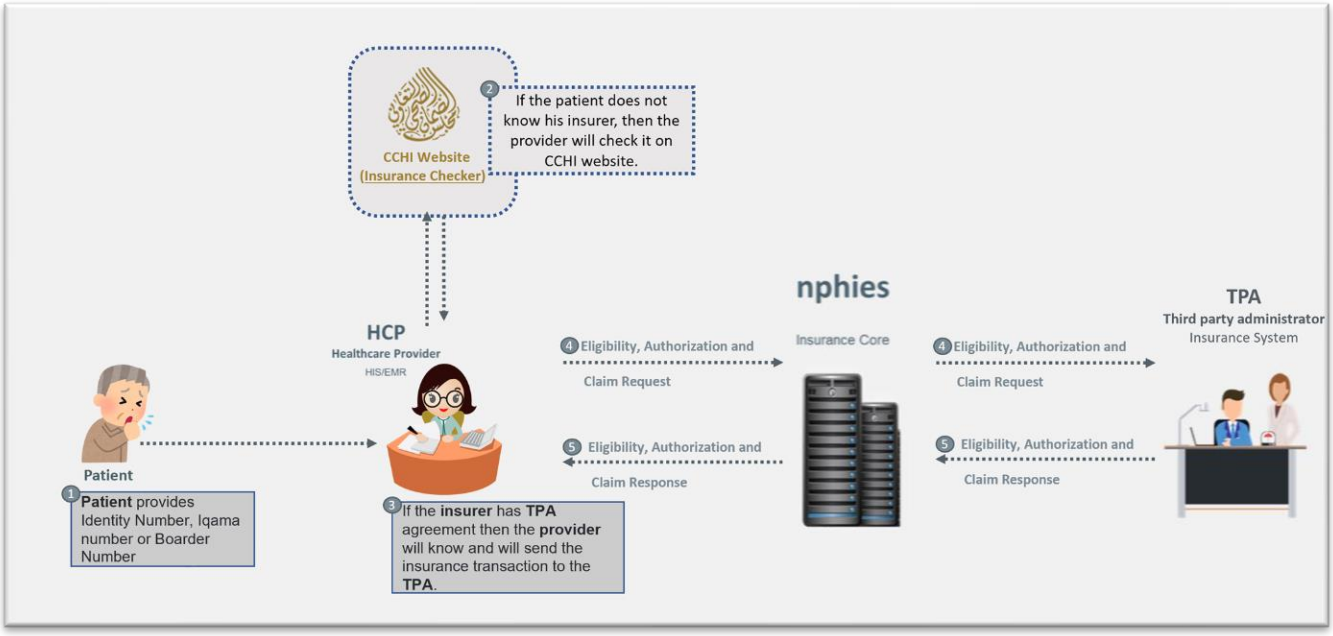
3.1 Identification of TPA involvement in the transaction flow

It is common practice for HICs to contract with licensed TPAs to manage the insurance transaction adjudication and HCPs queries within a specified network coverage based on predefined terms and condition, for a specific contracted admin fee.

Within the nphies platform, each HCP, TPA and HIC is assigned a unique identifier which is recognized and accepted by the platform. The lists of HIC, TPA and HIC unique ID can be downloaded from the nphies Community Portal following the path:

https://cportal.nphies.sa > HD > Codes list > Essential List

The diagram below depicts the transaction flow and interaction between the patient, HCP and TPA:



3.2 Reporting Guidelines

The nphies platform and Profiles structure covers all related business scenarios, allowing HCPs to submit transactions to TPAs directly by following the below reporting guidelines:

3.2.1 The HCP should enter the TPA ID in the **MessageHeader.destination.receiver**

- This field exists within the *nphies Profiles* > *MessageHeader* (Request) for all nphies transaction types, as follows:

Field Name	Description	Type	Value
MessageHeader.destination.receiver	The receiver's organization license issued by the CHI and maintained in the registry.	Reference Organization - Payer (Resource)	**TPA's ID****

3.2.2 Within the receiver organization reference, the HCP should specify that the **Organization.type** value as **pay**= TPA, not **ins**= Insurance Company, as follows

Field Name	Description	Type	Value
Organization.type	The kind(s) of organization that this is.	CodeableConcept	TPA = pay*

For more information regarding the predefined list of acceptable values for each profile field, please refer to the Codeable concept document which can be downloaded from the nphies Community Portal following the path:

https://cportal.nphies.sa > HD > Documentation > Technical Standards > nphies Codeable Concept

3.2.3 The HCP should enter the Insurance company ID in the CoverageEligibilityRequest.insurer or Claim.insurer depending on the transaction type, as follows:

Trans. Type	Field Name	Description	Type	Value
Eligibility	**CoverageEligibilityRequest.insurer**	Coverage issuer. A reference to the payer organization license issued by the CHI and maintained in the terminology server.	Reference (organization)	HIC's ID**
Authorization	**Claim.insurer**	The Insurer who is target of the request.	Reference (Organization)	HIC's ID**
Claims	**Claim.insurer**	The Insurer who is target of the request.	Reference (Organization)	HIC's ID**

3.2.4 Within the Insurer organization reference, the provider should specify that the **Organization.type** value as **INS**= Insurance Company, Not **Pay**= TPA, as follows:

Path	Description	Min	Max	Type	Value
Organization.type	The kind(s) of organization that this is.	1	1	CodeableConcept	**ins**= Insurer*

SECTION 4.0 NPHIES BILLING CYCLE AND REGULATIONS

This section aims to explain the how the nphies workflows translate into business processes.

Depicted below are the business processes that collectively form the nphies Billing Process. Each business process is explained in further detail and the CHI mandated regulatory business rules for each are also and referenced.

4.1 Patient Encounter Process

The patient encounter process starts from patient eligibility and ends with the rendering of the medical service and the end of the patient journey.

4.1.1 Applicable Mandated Regulatory Business Rules

Rule Ref	Source (Reference)	Regulatory Business Rules (Mandates)
1	**Document:** Implementing Regulation of the Cooperative Health Insurance Law_ Page (34), Article 90, Point (3). Annex No. (2): Standards of Treatment Cost Approval.	The service provider shall file a request **[**Prior authorization request**]** to bear the cost of providing treatment to beneficiaries to the insurance company **not later than 15 minutes** from the time the attending physician completes the request, subject to criteria for requesting approval to bear treatment costs attached to this Regulation (Annex 2).
2	**Document:** Implementing Regulation of the Cooperative Health Insurance Law_ Page (35), Article 90, Point (4).	Article 94 Insurance companies shall reply to service providers' request to provide treatment to beneficiaries not later **than 60 minutes** from the time of receiving such request; in case of denial, grounds shall be provided. Treatment is deemed to be approved if the insurer fails to respond within the 60 minute time frame.
3	Document: Implementing Regulation of the Cooperative Health Insurance Law_ Page (35), Article 90, Point (5).	Service providers shall reply to enquiries and remarks sent by the insurance company, if any, regarding the request for approval not later than **30 minutes** from the time of receiving such request.

4.1.2 *Patient Encounter Journey*

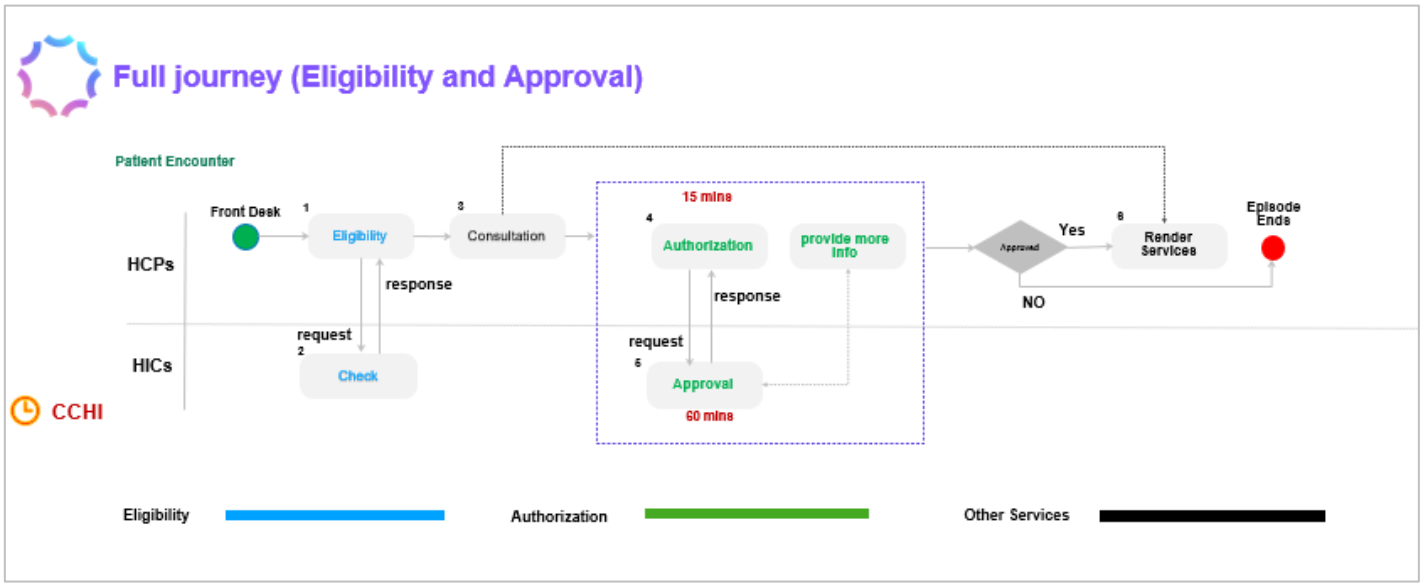
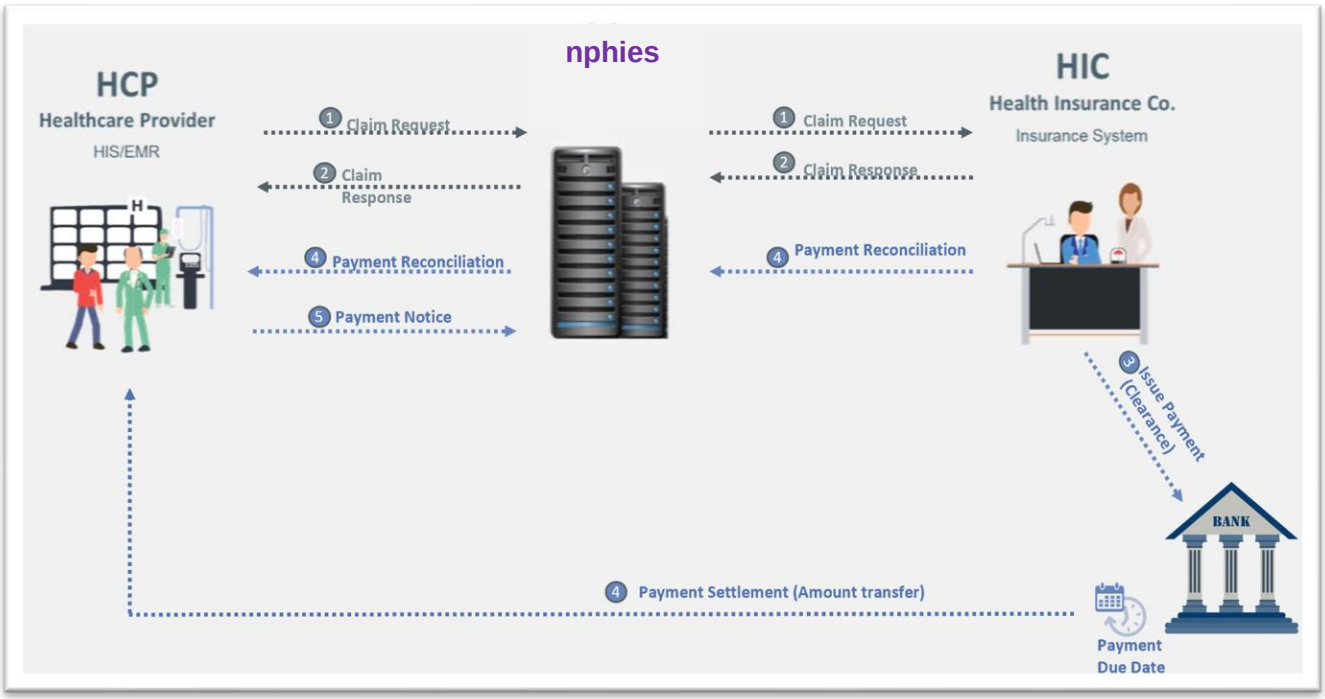


Figure 1 Part 1-3 of encounter journey

4.2 Claims Cycle (Full journey)

The basic claim submission and response cycle scenario consists of a single claim submission by the HCP and a single claim response from the HIC/TPA.

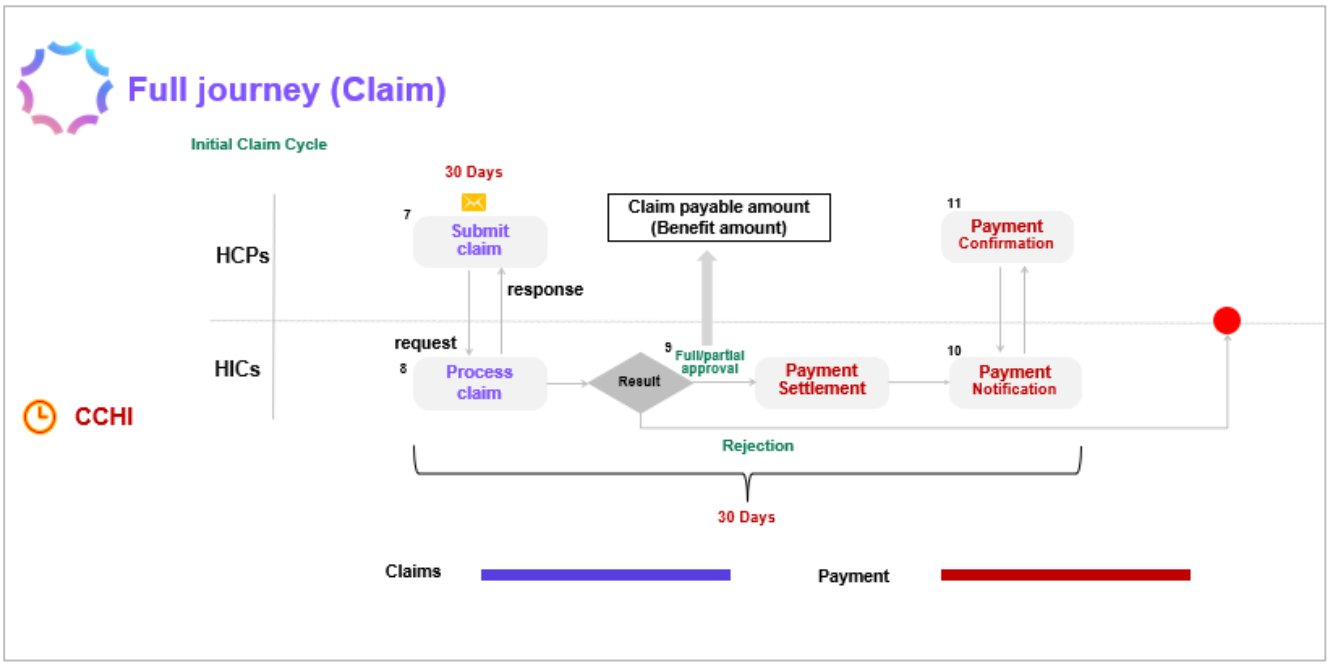
4.2.1 *Workflow*



4.2.2 *Applicable Mandated Regulatory Business Rules*

Rule Ref	Source (Reference)	Regulatory Business Rules (Mandates)
1	**Document:** Article number (90) from the implementing regulations of the cooperative health insurance law clause 7.	The service provider shall file claims to the insurance company or TPA directly or through RCM within a period not exceeding **30 days** from rendering the service unless a longer period is directly or indirectly approved by the insurance company or is due to an acceptable justification.
2	**Document:** Article number (90) from the implementing regulations of the cooperative health insurance law clause 8,	The insurance company or TPA shall settle (pay) completed and accepted claims of the service providers within a period not exceeding **30 days** from the date of receiving such claims. Including partially accepted claims.
3	**Document:** Enabling Provisions Notice pursuant to the implementation of the National Platform for Health Information Exchange Services - Policy Directive Number 3	nphies fee structure is 2% of the individual claim amount, which consists of the following: -Payer share 1% of the individual claim amount. -Provider share 1% of the individual claim amount. **Further Details highlighted in section 4.2.3*

4.2.3 *Claim Cycle Full Journey*

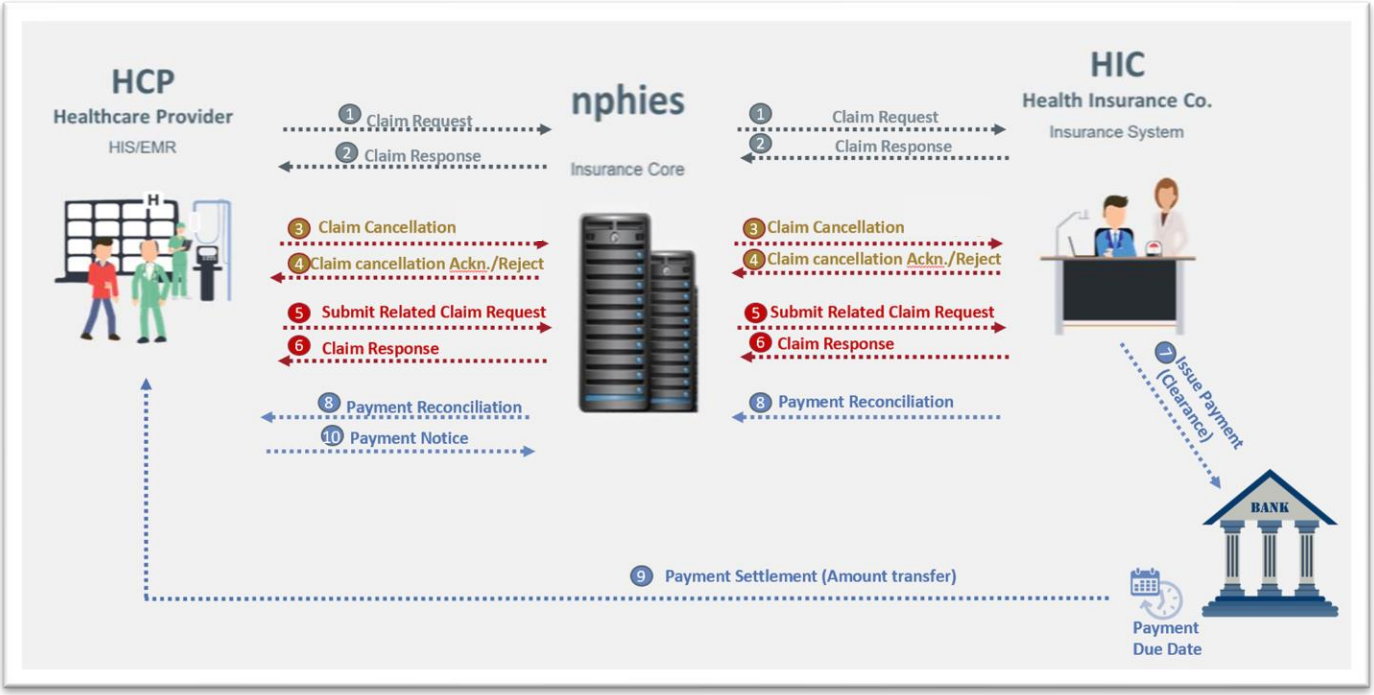


Notes	
1	There are no revisions from the HCP side to claims once submitted, Changes require a **cancellation** and submission of a new claim.
2	HIC may request further information as part of the adjudication process, the information should be provided by the HCP in the same TAT window (**30 Days**).
3	The nphies fees are calculated on the pre-tax amount that the insurer decided to pay in the **claim response** for each completely adjudicated claim.
All the above TATs are inclusive of further potential communication between payers & providers for clarification or supporting documents.	

4.3 Claim Re-Submission Cycle

The nphies platform allows the HCP to replace a claim by cancelling the initial claim and sending another claim, which also contains the initial claim identifier. This will allow the TPA/HIC to link the 2 claims in their system.

4.3.1 Workflow



The related claims fields in the new claim request supports providing the information on the initial claim:

Path	Description	Min	Max	Type
Claim.related	Other claims which are related to this claim such as prior submissions or claims for related services or for the same event.	0	*	BackboneElement
Claim.related.claim	Reference to a related claim.	**1**	**1**	Reference (Claim)
Claim.related.relationship	A code to convey how the claims are related.	**1**	**1**	CodeableConcept

4.3.2 Applicable Mandated Regulatory Business Rules

Rule #	Source (Reference)	Regulatory Business Rules (Mandates)
1	**Document:** Article number (90) from the implementing regulations of the cooperative health insurance law clause 13.	The HCP should review the rejected claims and submit supportive/additional documents for re-adjudication with turnaround time (TAT) not exceeding **15 days** from receiving the initial claim response.
2	**Document:** Article number (90) from the implementing regulations of the cooperative health insurance law clause 14,	The HIC should review and settle the payment for the claims submitted for re-adjudication with additional information with processing TAT not exceeding **15 days** of receiving the latest claim submission.

4.3.3 Claims Re-Submission Cycle

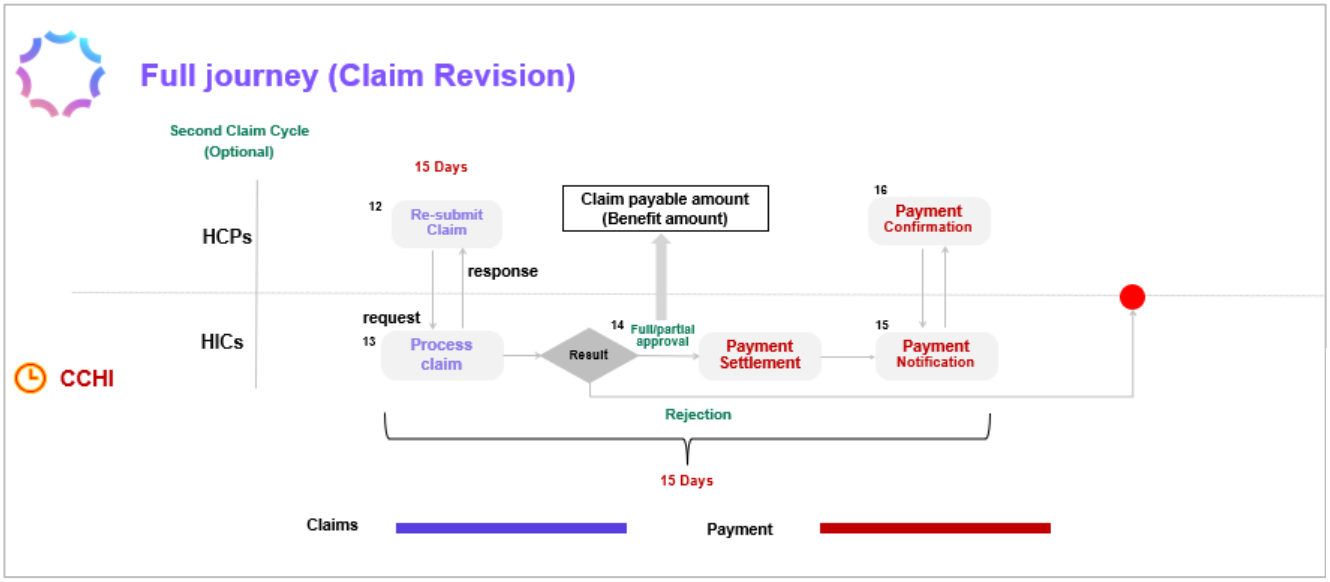


Figure 3 Part 3-3 of encounter journey

SECTION 5.0 FINANCIAL FIELDS WITHIN NPHIES TRANSACTIONS

5.1 Financial Fields in the "Claim Request" Transaction

The below table summarize all the financial fields on item level in the claim/Authorization request transaction which should be entered by the HCP.

Claim Request Field	Min	Field Definition
Claim.item.quantity	1	Identifies the number of units (quantity) for a specific item, it can be the number of services rendered or products dispensed.
Claim.item.unitPrice	1	The basic price for the requested/claimed single item based on the payer provider agreement.
Claim.item.factor	0	It reflects the payer-provider contracted rates for the claimed item: 1. Discount: refers to the proportion discounted from that amount. Or 2. Multiplier rates = refers to a factor that, when applied, amplifies that amount.
Claim.item.net	1	Refers to the total amount of the charges included for the Claim item. The prices on which **item.net** should reflect the unit price times the requested/claimed quantity including the patient charge and tax. ***Claim.item.net = ((unit*quantity) *factor) + tax***
Claim.item.extension . patientShare	1	This is the amount the HCP collected from the patient typically for patient co-payments.
Claim.item .extension.tax	0	Tax amount – this is the applicable tax rate multiplied by the **item.net**

5.1.1 VAT (tax) calculation

The VAT (tax) which is ultimately payable for a claim will depend on a number of factors, such as: the tax rates for the various services provided; the citizenship of the patient; and the amount of the claim payable by the patient after consideration by all of the patient's insurers. It is not always possible for providers to accurately estimate the amounts which will be paid by insurers, and the applicable VAT collectable given that duplicate services may be rejected and that patients may consume benefit limits.

Therefore, providers shall include in the Tax (VAT) calculations all possible VAT collectable, which will be the correct amount of VAT to be collected if the patient is not a Saudi citizen, regardless of how much their insurers pay, and if insurers pay for all of the claimed service charges even if the patient is a Saudi citizen. The only situation when the VAT expressed on the claim will differ from the actual VAT to be remitted to the government will be when a Saudi citizen pays for some portion of the claim in which case the provider will need to adjust the VAT to reduce it by the VAT exemption amount for the patient portion of the claim when they remit VAT to the government.

On the claim/Authorization request, there is one field to report the total claimed amount:

Claim Request Field	Min	Field Definition
Claim.total	1	The total value of all the items in the claim, sum of the items net amounts.

The below example illustrates the claims billing calculations for two items that have the same market price but different payer-provider agreement rates, different patient share and different claimed quantity within the same transaction:

Financial Field	Item 1	Item 2
Claim.item.quantity **	**1**	**2**
Claim.item.unitPrice **	**100 SAR**	**100 SAR**
Claim.item.factor	**1 (no discount)**	**.8 (20% discount)**
Tax rate: (for example only)	**15%**	**15%**
Tax calculated on:	((100*1) *1) = 100	((100*2) *.8) = 160
Claim.item.extension.tax	**15 SAR**	**24 SAR**
Claim.item.extension. patientShare (typically their copay)	**10 SAR**	**5 SAR**
Claim.item.net **	((100*1) *1) +15=**115 SAR**	((100*2) *.8) +24=**184 SAR**
Claim. Total (115+184) = 299		

* Required element in the claim
* Required element in the authorization
Fields shown in **bold** may or shall be included in the actual claim or authorization

***Note**: Authorizations will not include tax and are expressed net of the expected patient share, while claims will be based on the 100% service charge, that is they include the tax and are inclusive of the expected patient share*.

5.2 Financial Fields in the "Claim Response" Transaction

The below table summarize how all the claim item level financial fields in the claim request transaction should be entered by the HCP.

Claim Request Field	Min	Field Definition
ClaimResponse.item.adjudication	**1:N**	This Backbone Element contains all the below listed fields which summarize the financial adjudication and calculation output by the payer.
ClaimResponse.item.adjudication.category*	**1**	A value indicates the information type of the adjudication record which allows the payer to report the breakdown calculations for the claimed item. *
ClaimResponse.item.adjudication.reason	**0**	A field which supports the understanding of the adjudication result and explaining variance from expected amount, this field includes a list of the adjudication denial codes. (For more information please refer to the codeable concept file)
ClaimResponse.item.adjudication.amount	**0**	Monetary amount associated with the category.
ClaimResponse.item.adjudication.value	**0**	A non-monetary value used when the category provides a quantity or percentage value.
Claim Request Field	**Min**	**Field Definition**
ClaimResponse.total	**0:N**	Categorized monetary totals for the adjudication, Backbone element contains 2 fields which allow the payer to report the total adjudication amounts on claim/Authorization level.

ClaimResponse.total.category*	1	A code to indicate the information type of this adjudication record. Information types may include: the value submitted, maximum values or percentages allowed or payable under the plan, amounts that the patient is responsible for in aggregate or pertaining to this item, amounts paid by other coverages, and the benefit payable for this item. *
ClaimResponse.total.amount	1	Monetary total amount associated with the category.

*The below table summarizes the acceptable list of values for the "ClaimResponse.item.adjudication.category" and "ClaimResponse.total.category":

Category codes	Display	Field Definition	MDS
submitted	Submitted Amount	The total submitted amount for the claim or group or line item which should be equal to the claim.item.net (in the claim request)	Billed amount
copay	Patient Co-Payment	Patient Co-Payment	
eligible	Eligible Amount	The amount of charge which the payer is accepting to consider for adjudication. Usually based on the agreed price with the HCP, after applying the discount if any.	Allowed Amount
tax	Tax	The amount of tax	
benefit	Benefit Amount	Amount payable under the coverage, the exact payable amount by the payer.	Paid Amount
patientShare	Patient share	Amount to be paid by the patient: ***patientShare = submitted amount – benefit amount***	Patient Paid Amount
approved-quantity	Approved Quantity	The quantity approved by the payer for certain item	

The example below illustrates the claims billing calculations for two items in claim response with different adjudication amounts:

Adjudication Category Codes	Item 1	Item 2
(submitted quantity)	1	2
approved-quantity **	**1**	**1**
submitted	**115 SAR**	**184 SAR**
(submitted tax)	15 SAR	24 SAR
(submitted pre-tax)	(100-5) = 100 SAR	(16-8) = 160 SAR
eligible	**100 SAR**	**80 SAR (only 1 approved)**
copay	**20 SAR**	**10 SAR**
(eligible after copay)	(100-20) = 80 SAR	(80-10) = 70 SAR
(remaining benefit limit)	800.50 SAR	55 SAR
(benefit pre-tax)	Minimum (80, 800.50) = 80 SAR	Minimum (70,55) = 55 SAR
tax * (on the benefit)	**(80 * 15%) = 12 SAR**	**(55 * 15%) = 8.25 SAR**
benefit **	**(80+12) = 92 SAR**	**(55+8.25) = 63.25 SAR**
patientShare (includes tax)	**(115-92) = 23 SAR**	**(184-63.25) = 120.75 SAR**
ClaimResponse Payable by the Insurer (92+63.25) = 155.25		

* Required element in the claim response
* Required element in the authorization response
Category codes shown in **bold** may or shall be included in the actual response

5.3 Nphies fees calculation from the Claim Response

Nphies Fees calculation	Item 1	Item 2
Benefit amount pre-tax	**80 SAR**	**55 SAR**
Market rate (2%)	**2%**	**2%**
fees excluding TAX	**(80 * 2%) = 1.6 SAR**	**(55 * 2%) = 1.1 SAR**
TAX (VAT)	**(1.6 * 15%) = 0.24**	**(1.1 * 15%) = 0.16**
Total fees amount including TAX	**(1.6 + 0.24) = 1.84 SAR**	**(1.1 + 0.16) = 1.26 SAR**
Total Nphies fees (1.84+1.26) = 3.1 SAR		

The providers and the payers will each pay 1%, the payer will pay the full 2% then will deduct 1% as the provider portion from the payment amount.

5.4 Financial Fields in the “Payment Reconciliation” Transaction

Payment Reconciliation Field	Description	Field use
PaymentReconciliation .paymentAmount	= Sum of (PaymentReconciliation .detail.amount) within the same Payment reconciliation	Total payment amount as indicated on the financial instrument; the amount that is being paid in the whole payment reconciliation transaction.
PaymentReconciliation .detail.amount	= ClaimResponse.total.amount – nphies fee extension.amount – other fees extension.amount	The monetary amount allocated from the total payment to the payable; the amount that paid at claim level within the payment reconciliation transaction, less the nphies fees and other fees such as charges for early payment.
PaymentReconciliation.detail fields:		
PaymentReconciliation.detail. extension.component-payment		The payment amount (benefit) from the Claim (positive if payment, negative for cancelled claims which were previously paid)
PaymentReconciliation.detail. extension.component-early-fee		The early payment fee amount for the Claim (negative if payment, positive for cancelled claims which were previously paid)
PaymentReconciliation.detail. extension.component-nphies-fee		The nphies fee amount for the Claim (negative if payment, positive for cancelled claims which were previously paid)