Enabling Provisions Notice pursuant to the implementation of the UniPlat system

Technical Update Number 2 of 2020 (TU 02-2020)

Subject of this Technical Update	Types of UniPlat Financial Services transactions
Applicability of this Technical Update	This Technical Update applies to all health insurance market participants providing health insurance products, health insurance services or healthcare services in the Kingdom of Saudi Arabia
Purpose of this Technical Update	This Technical Update describes the types of transaction business processes and cycles between payers and providers that will be processed through the Financial Services solution
Publication date	18/06/2020
This document replaces	Not applicable
This document has been replaced by	Not applicable
Effective date of this Technical Update	18/06/2020
Grace period for compliance	

Objectives of this Technical Update

- To describe the various transaction business process cycles between payers and providers that will be processed through the Financial Services solution
- This document is not intended to be a detailed technical manual for developers but rather to provide an overview to payers and providers of the transaction business process cycles

Background

In the absence of a centralised electronic health insurance system health insurance transactions between payers and providers are largely email or paper-based requiring significant manual intervention with little standardisation in terminology or process. This results in inefficient, time consuming and labour-intensive processes

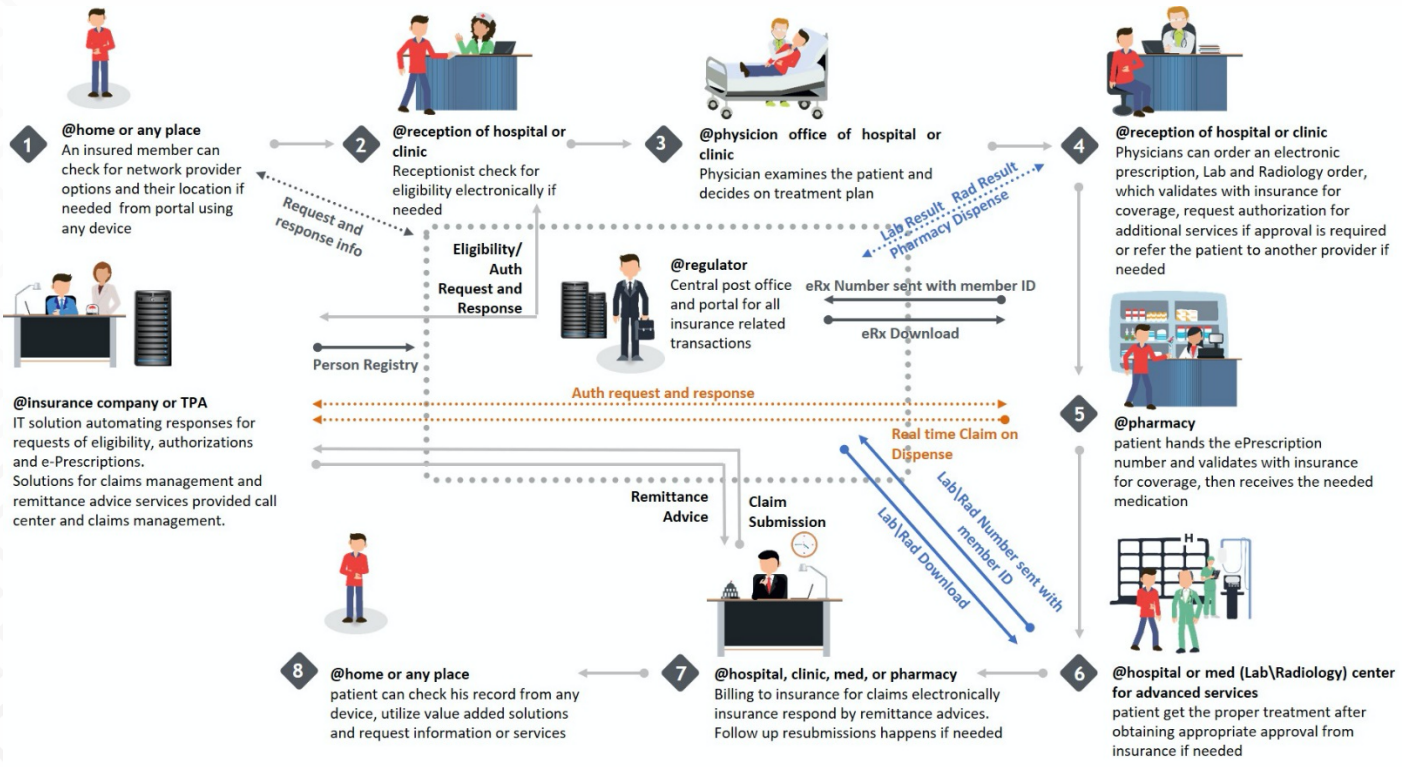
The current system also makes it difficult for health and insurance regulatory bodies to capture and analyse data for the purpose of understanding population health, identifying financial flows, identifying opportunities for preventive measures and generally achieving a more efficient healthcare financing system with improved patient outcomes and a reduction in errors, fraud, waste and abuse

The implementation of a set of automated, swift and heavily validated transactions through a central platform (the Financial Services solution) will help achieve the above objectives as well as produce cost savings for both payers and providers

The communication standard to be used for data exchange is HL7-FHIR. Fast Healthcare Interoperability Resources (FHIR) is a standard describing data formats and elements and an application programming interface (API) for exchanging electronic health records. The standard was created by the Health Level Seven (HL7) International healthcare standards organization

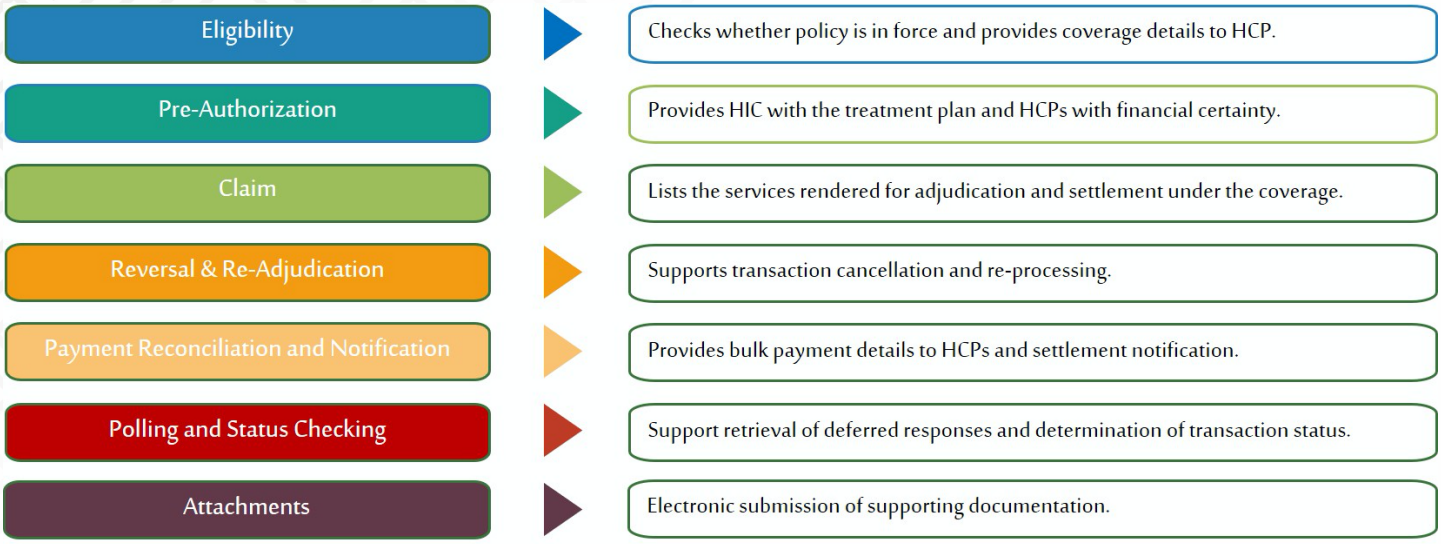
The overall view of transaction flows

The graphic below provides a high-level view of the types of transaction along the patient journey that will be processed through the Financial Services solution



Primary claims related transactions

The graphic below shows the types of transaction that will flow through the Financial Services solution

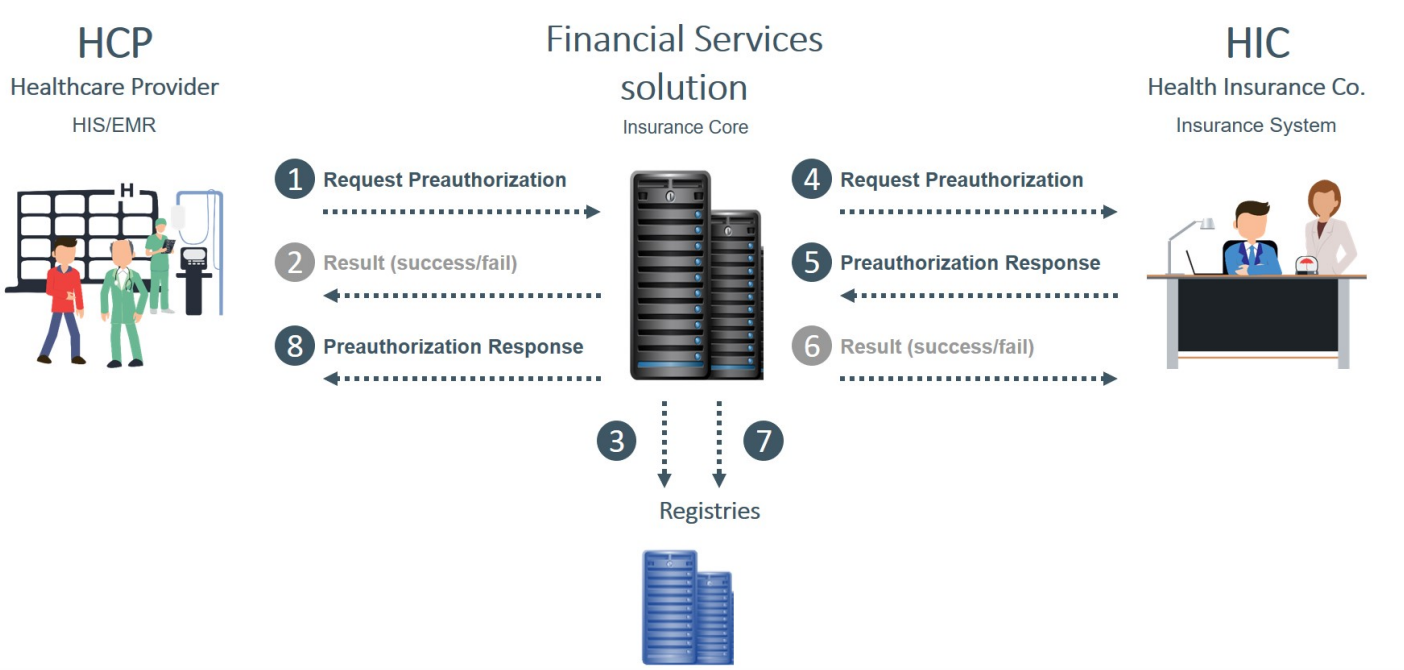


Some of the transactions that will be included in the automated business cycle processes are listed below. This is not an exhaustive list but includes the main transactions:

- Check eligibility cycle (provider checks patient eligibility for service requested and payer notifies provider of eligibility check result for service requested)
- Request pre-authorisation (provider requests pre-authorization of covered service and payer notifies provider of outcome of pre-authorisation request)
- Cancellation of pre-authorisation request (provider notifies payer to cancel pre-authorisation request and payer confirms cancellation of pre-authorisation request)
- Advanced pre-authorisation request
- Nullification of pre-authorisation request
- Process claim cycle (provider submits a claim to payer and payer responds)
- Re-adjudication of claim cycle (payer rejects claim and provider resubmits claim for re-adjudication and payer responds)
- Nullification of claim cycle
- Amendment of claim cycle (provider submits nullification request, submits a revised claim and payer responds)
- Revise claim cycle (payer notifies provider of revised claim/invoice)
- Inquire claim status cycle (provider requests status update and payer responds)
- Payment advice and confirmation cycle (payer notifies provider of payment in process and provider confirms payment received)
- Claim supporting documents request (payer requests upload of supporting documents and provider submits)

Sample transaction business cycle

The graphic below illustrates a typical transaction in terms of the process and cycle of request, validations and responses. Many of the processes shown are internal to the system and will not require user involvement



Non-claims related functionalities

There are a number of other transactions that will take place within the Financial Services solution platform as listed below:

- Validation of a Financial Services solution stakeholder (this will validate patients, payers, providers and healthcare professionals against registries held within the system which includes IDs and license records)
- Sending HCP network (payers will use this to send details of their healthcare provider networks to the data registry)
- Registration of an accredited enterprise through the UniPlat Community Portal. Financial Services solution stakeholders will be able to register as an accredited enterprise
- Manage enterprise (allows Financial Services solution stakeholders to amend and update their registration)
- Register and track feedback requests sent to the regulator
- Report and identify possible fraud and abuse

Expected timelines for implementation

A market assessment is being carried out to identify the readiness of payers and providers to "onboard" to the new platform. Details of this assessment survey can be found in Enabling Provision Notice PD 01-2020. Once the survey is completed, CCHI will announce dates for the commencement of onboarding.

For any Inquiries related to this provision, please send an e-mail to the following address: **Onboarding@cchi.gov.sa** *or contact the unified number:* **920004299**