دائـــــرة الـصـــحـــة
DEPARTMENT OF HEALTH

JAWDA DATA CERTIFICATION (JDC) FOR HEALTHCARE PROVIDERS

Consolidated Methodology Part I (Standard)

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Address:

Tel.

Fax.

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1 INTRODUCTION

For the purpose of this document, the Department of Health () and Health Authority of Abu Dhabi (DOH) are synonymous and refer to the same regulatory entity, and TASNEEF and TRBA are synonymous in representing the Certification body

The consolidation of documents includes Parts 1 to 9.1 of the JDC methodology from 2019 to 2026. Any new updates issued by the shall be applicable in addition to these guidelines, effective from the date of publication by the .

A Half-yearly update can be made if further clarifications are seen as necessary to be published based on the updates received from the regulatory authorities. Any such updates or clarifications that impact the course of action from Part 2 will be applicable, effective from the date of receipt of such clarification.

The Department of Health () is the regulatory body of the Healthcare Sector in the Emirate of Abu Dhabi and ensures excellence in healthcare for the community by monitoring the health status of the population. is mandated:

- To achieve the highest standards in health curative, preventative and medical services and health insurance in the Emirate.
- To lay down the strategies, policies and plans, including future projects and extensions for the health sector in the Emirate, and to follow up on their implementation
- To apply the laws, rules, regulations and policies which are issued as they are related to its purposes and responsibilities, in addition to what is issued by the respective international and regional organizations in line with the development of the health sector.
- To follow up and monitor the operation of the health sectors for achieving exemplary provision of health, curative, preventive and medicinal services and health insurance.

 defines the strategy for the health system, monitors and analyses the health status of the population and performance of the system. In addition, shapes the regulatory framework for the health system, inspects against regulations, enforces standards, and encourages adoption of world–class best practices and performance targets by all healthcare service providers in the Emirate of Abu Dhabi.

Patient safety, clinical effectiveness and patient experience are recognized as the main pillars of quality in healthcare, which is governed through the JAWDA framework that was established in 2014. In Abu Dhabi, the measurement of patient safety, clinical effectiveness, accessibility and patient experience data is intended to identify strengths and weaknesses of healthcare delivery, drive quality improvement, inform regulation and promote patient choice. In addition to data on harm avoidance, success rates for treatments and medical services accessibility, providers will be assessed on aspects of care such as dignity and respect, compassion and involvement in care decisions through patient satisfaction surveys. A set of standardized performance indicators is included in the JAWDA framework to fulfil the aforementioned objectives.

High-quality coded clinical data is essential when developing a reliable and effective data repository for statistical health data analysis with a vision for high-quality health care.

Clinical Coding is the process of translating the written or electronic medical documentation of a patient's diagnosis and services performed for an episode of care into a meaningful representation of numeric or alphanumeric codes. To record this information, healthcare providers, like hospitals and clinics in Abu Dhabi, use all applicable -approved code sets related to Clinical documentation and Coding for Data reporting requirements.

Patient safety is 'the discipline in the health care sector that applies safety science methods toward the goal of achieving a trustworthy system of health care delivery'. Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of and maximizes recovery from adverse events.

Clinical effectiveness is "the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients. The process involves a framework of informing, changing and monitoring practice. Clinical effectiveness is about doing the right thing at the right time for the right patient and is concerned with demonstrating improvements in quality and performance that can be summarized by:

- The right thing (evidence-based practice requires that decisions about health care are based on the best available, current, valid and reliable evidence)
- In the right way (developing a workforce that is skilled and competent to deliver the care required)
- At the right time (accessible services providing treatment when the patient needs them)
- In the right place (location of treatment/services).
- With the right outcome (clinical effectiveness/maximizing health gain)

Accessibility is "ensuring that the population of Abu Dhabi has access to quality medical services that will lead to achieving desired outcomes and enhancing patient experience". This is measured through a set of waiting time indicators within the quality framework to guide healthcare future strategies and improvements.

The Health System of the Emirate of Abu Dhabi is comprehensive, encompassing the full spectrum of health services, and it is accessible to all residents of Abu Dhabi. The system is driven towards excellence through a continuous outcome 'improvement' culture and monitoring achievement of specified indicators. Providers of health services are independent, predominantly private and follow the highest international quality standards. The system is financed through mandatory health insurance.

In doing so, will:

- Drive structure, process and outcome improvements across the health sector
- Improve quality governance and leadership
- Put people first and champion their rights
- Focus on quality and act swiftly to eliminate poor quality of care
- Work with stakeholders and apply fair processes.
- Gather information and utilize knowledge and expertise to improve care.

Link the care to payment in a way that results in continuous improvement and maximize the value of the care provided in Abu Dhabi.

From that vision, the current methodology was developed for standardization of healthcare quality practice and data sources through two primary disciplines. The first one addresses the requirements of coding & claims process requirements, and the second one addresses the JAWDA key performance indicator requirements for provided services in terms of timeliness of care, patient safety and clinical effectiveness.

1.1 About JDC Methodology:

The methodology has been developed in collaboration with policies, laws and standards to standardize the practice of the two healthcare workstreams disciplines, coding & claims process and JAWDA key performance indicator process for all the healthcare facilities as per the applicability.

The methodology structure follows the Plan Do Check Act technique for quality improvement and is based on the concept of the process approach to enhance any kind of performance. Any discipline might be added later in the scope of the methodology.

What is the process approach and PDCA style of implementation?

The application of a system of processes within a facility, together with the identification and interactions of these processes and their management to produce the desired outcome, can be referred to as the “process approach”.

An advantage of the process approach is the ongoing control that it provides over the linkage between the individual processes and the system of processes, as well as over their combination and interaction.

When used within a JDC, such an approach emphasizes the importance of;

a) understanding and meeting requirements,
b) the need to consider processes in terms of added value
c) obtaining results of process performance and effectiveness, and
d) continual improvement of processes based on objective measurement

In addition, the methodology known as “Plan-Do-Check-Act” (PDCA) can be applied to all processes. PDCA can be briefly described as follows.

Plan: establish the objectives and processes necessary to deliver results in accordance with regulatory requirements.

Do: implement the processes.

Check: monitor and measure process outputs against objectives and requirements and report the results.

Act: take actions to continually improve process performance.

1.2 Objective

The objective of JAWDA Data Certification is to improve the quality of clinical data documentation for the purposes of regulatory monitoring and control, reimbursement, research, analysis, and statistics and to meet the global standards, thereby contributing towards achieving Abu Dhabi’s Vision, in delivering high-quality services in the healthcare sector.

In addition, JAWDA Data Certification will strengthen the trust between payers and providers by:

- Enhancing the quality and the governance of health data by improving coding standards and data processing.
- Creating a shared understanding of the facility's coding quality
- Giving the payers confidence that a facility is coding and submitting accurately to and other entities
- Enhance the governance, processes and validation of quality key performance indicators, data collection and reporting.
- Providing healthcare providers with recommendations on the areas of improvement of quality of coding, collection and submission of clinical data within the scope of JDC.

This document is an update of the "Policy Manuals" that were published in 2012. The Manuals were drafted in collaboration with Abu Dhabi and international healthcare experts, including the Joint Commission International ('JCI'), other health regulators, local and international legal advisors (Al Tamimi and Wragge and Co.), and delegates from Abu Dhabi and international Providers, Professionals and Insurers. The 2012 Manuals followed a structured consultation process comprising the formation of a permanent DoH Policy Advisory and Consultative Panel and formal sector-wide consultation (8-12 weeks). The current document has been updated in light of the new relevant regulations published since 2012.

2 METHODOLOGY SCOPE

2.1 General:

What requirements does the methodology address?

The Department of Health () ensures excellence in healthcare for the community by monitoring the health status of the population.

JAWDA Data Certification methodology is a set of requirements that determine how clinical coding practices, Quality key performance indicators, and Quality governance aspects are planned, implemented, maintained and continually improved to build confidence between all key stakeholders through granting a certificate of compliance to this methodology's requirements.

2.2 Applicability:

JDC Methodology is applicable to all healthcare facilities that are regulated by the Department of Health, Abu Dhabi, U.A.E. Below are the audit scopes of JDC methodology.

Audit scope for JAWDA Data Certification consists of three domains for audit:

- Claims Review (Applicable for all licensed healthcare facilities, including Dental, Self-Pay and Medical Tourism)
- Clinical Coding Process Review (Applicable for all licensed healthcare facilities, including Dental and Self-Pay)
- JAWDA KPI Data Validation (KPIs submitted by the facilities to DoH)

Note 1: Exclusive Diagnostic centers, Laboratories, School clinics, optical centers, and pharmacies. Company clinics and university clinics are included.

Note 2: Exclusivity mentioned in Note 1 means operating without any physician consultation or therapies

Note 3: Dental centers and self-pay, including medical tourism, services are under the current scope of methodology.

Note 4: KPI Data validation applies to all healthcare providers submitting JAWDA KPIs to DoH.

3 NORMATIVE REFERENCES

Requirements stated in this methodology are considered mandatory for all healthcare facilities determined in the scope of applicability. Other reference requirements which are complementary to this methodology are also considered applicable.

- JAWDA Data Certification Methodology 2019 (Standard and Annexure - Certification Rules)
- CPT 4th Edition procedure
- ICD-10-CM Official Guidelines for Coding and Reporting
- Coding Manual for Hospitals & Other Healthcare Institutions, published by Health Authority- Abu Dhabi
- Claims and Adjudication Rules Version 2012 and Version 2025 and all related Addendums
- American Medical Association (AMA)
- American Hospital Association (AHA) Coding Clinics
- USC & LS Codes and ICD-10 CM guidelines for Dental
- DoH Health Insurance Claims Adjudication Standard
- DoH Standard for Medical Billing Services in the Emirate of Abu Dhabi
- DoH Standard for Provision of Long-Term Care in healthcare facilities in the Emirate of Abu Dhabi and Appendices
- Standard for Provision of Home Healthcare Services in the Emirate of Abu Dhabi, Version 1.4 , Version 2 and Appendices
- DoH Service Standards for Post-Acute Rehabilitation Services in the Emirate of Abu Dhabi
- DoH Standards for Tele-consultation in the Emirate of Abu Dhabi
- DoH Mandatory Tariff List of Codes
- Medical Record, Health Information Retention and Disposal Policy
- American Hospital Association’s Coding Clinic
- CPT Assistants
- Marshfield Clinic Tool or Trailblazer tool for E/M
- Merck’s Manual Professional Version
- Dorland’s Medical Dictionary
- Stedman’s Medical Dictionary
- Center for Medicare & Medicaid Services (CMS) manual system
- Medlineplus.gov (Normative references)
- Mayo Clinic (Normative references)
- DoH provider’s policy Manual
- DoH Regulator Policy Manual

- DoH Healthcare Professional Policy Manual
- All the relevant standards published by , and not limited to the above-mentioned
- WHO Medical record standards
- Electronic Code of Federal Regulations, Part 11
- American Health Information Management System (AHIMA)- Body of Knowledge
- ASTM E1869-04(2014) Standard Guide for Confidentiality, Privacy, Access, and Data Security Principles for Health Information, Including Electronic Health Records
- ASTM E2017 - 99(2010) Standard Guide for Amendments to Health Information
- ISO 9001:2015(paragraphs 7.2, 7.5, 8.0 in relation to the validation concept, 9.0, 10.0)
- DoH reference Quality Performance KPI Profile - Dec. 2015
- DoH reference. Per Circular CEO 38/ 12
- DoH Policy for Quality and Patient Safety (Document Ref No: Policy/Quality and Patient Safety/V1.0)
- Data Standard - DOH Fourth Revision 14 April 2014, according to DSP decision 265
- Shafafiya and related references, such as in the Data Dictionary on the website
- ISO 27001 – IT Security Management System
- JAWDA Quality Performance Guidelines for Healthcare facilities (latest version as applicable)
- All applicable KPI Profiles.

3.1 Terms and definitions

Activity: With reference to claims, an Activity is a clinical service, intervention, medication or material provided to the Patient on orders of a responsible clinician, such as drugs, consultations, investigations and surgical procedures. Some types of activities are used to describe multiple different services, such as room and board, per diems, consumables, DRGs, etc.

Audit: A systematic, independent, objective identification of conformity to the standards.

An *audit* is a systematic evidence-gathering process. *Audit* must be independent, and evidence must be evaluated objectively to determine the extent to which agreed criteria are fulfilled. There are three types of audits: first-party, second-party, and third-party

First-party audits are internal audits, while second- and third-party audits are external audits. Organizations use first-party audits to audit themselves. First-party audits are used to provide input for management review and for other internal purposes. They're also used to declare that an organization meets specified requirements (this is called a self-declaration)

Second-party audits are external audits. They're usually done by customers or by others on their behalf. However, they can also be done by regulators or any other external party that has an interest in an organization

Third-party audits are external audits as well. However, they're performed by independent organizations such as registrars (certification bodies) or regulators

Audit criteria: *Audit criteria* are used as a reference point and include policies, requirements, and other forms of documented information. They are compared against audit evidence to determine how well they are being met. Audit evidence is used to determine how well policies are being implemented and how well requirements are being followed

Audit evidence: *Audit evidence* includes records, factual statements, and other verifiable information that is related to the audit criteria being used. Audit criteria include policies, requirements, and other documented information

Audit findings: *Audit findings* result from a process that evaluates audit evidence and compares it against audit criteria. *Audit findings* can show that audit criteria are being met (conformity) or that they are not being met (nonconformity). They can also identify best practices or improvement opportunities

Audit observations for KPI: Audit observations identify a lack or gap in the process/ output that cannot be referenced to JDC methodology or JAWDA KPI Profiles. No score deduction will be applied for findings remarked as Observations. Score deduction is applied in full for major non-conformity and partially for minor non-conformity

Audit program: An *audit program* refers to a set of one or more audits that are planned and carried out within a specific time frame and are intended to achieve a specific audit purpose

Adjudication – Claims judgment process for settlement

Ancillary Services – Laboratory, Pathology services as per the scope of this methodology

Billing-related error– Category of an error which resulted from incorrect assignment of billing guidelines like encounter type, date of service etc.,

Characteristic: A *characteristic* is a distinctive feature or property of something. Characteristics can be inherent or assigned and can be qualitative or quantitative. An inherent characteristic exists in something or is a permanent feature of something, while an assigned characteristic is a feature that is attributed or attached to something

Claim(s) - A claim is an original request for payment for health services provided to a single Patient. Claims are generally linked to patients who are covered by health insurance. For the purposes of this guidance, any invoices made out to non-insured Patients should also be considered as Claims.

Coding-related error– Coding-related error: An error resulting from the incorrect selection, assignment, sequencing, or application of an applicable diagnosis, procedure, service, drug, dental, or other approved code, including ICD-10-CM, CPT, HCPCS, and any other code set adopted by DoH for the relevant service and transaction.

Co-morbidity (diagnosis) – Co-morbidities are conditions that exist at the same time as the principal condition in the same patient (for example, hypertension is a co-morbidity of ischemic heart disease or diabetes), e.g. one or more coexisting medical conditions or disease processes co-occurring with a primary disease or disorder

Complication (diagnosis) – In coding, a complication generally refers to a misadventure of a medical or surgical procedure or intervention, an adverse outcome from clinical intervention. In medicine, an additional problem that arises following a procedure, treatment or illness is secondary to it. A complication complicates the situation

Competence: *Competence* means being able to apply knowledge and skill to achieve intended results. *Being competent* means having the knowledge and skills that you need and knowing how to apply it. Being competent means that you're qualified to do the job

Complaint: *A Complaint* refers to an expression of dissatisfaction with a product or service and is filed by a customer and received by an organization. Whenever a customer lodges a complaint, a response is either explicitly or implicitly required

Conformity: *Conformity* is the "fulfilment of a requirement". *To conform* means to meet or comply with requirements, and a requirement is a need, expectation, or obligation. There are many types of requirements, including customer requirements, quality requirements, quality management requirements, management requirements, product requirements, service requirements, contractual requirements, statutory requirements, and regulatory requirements

Continual improvement: *Continual improvement* is a set of recurring activities that are carried out in order to enhance performance. Continual improvements can be achieved by carrying out audits, self-assessments, and management reviews. Continual improvements can also be realized by collecting data, analyzing information, setting objectives, and implementing corrective and preventive actions

Correction: A *correction* is any action that is taken to eliminate nonconformity.

However, corrections do not address root causes. When applied to products, corrections can include reworking products, reprocessing them, regrading them, assigning them to a different use, or simply destroying them

Corrective action: Corrective actions are steps that are taken to eliminate the causes of existing nonconformities in order to prevent recurrence. The corrective action process tries to make sure that existing nonconformities and potentially undesirable situations don't happen again

Data: The term *data* is defined as any facts about an object

Data Collection: For the purpose of JDC methodology, it is defined as the process of collecting variables of data required for reporting as per the definitions of JAWDA KPIs.

Data Validation: For the purpose of JDC methodology, "Data validation could be defined as a process which ensures the correspondence of the final data meets the required quality characteristics of data variables as per the definitions of JAWDA KPIs**."**

Date of Expiry – The expiry date listed on the Certified Facility List on

https://www.DoH.gov.ae/en/Shafafiya/dictionary

Day case – Licensed Setting where the patient is medically expected to remain confined for 6-12 hrs. for treatment, primarily surgical interventions performed in Ambulatory Surgery Centers (ASCs) or Hospitals that are licensed/sublicensed, equipped and operated.

Delisting - Removal of the facility's certification status from Shafafiya following the discontinuation of its listing.

Denial – A payer's determination not to reimburse all or part of a claim or claim line after adjudication, based on the member's benefits, applicable rules, contractual requirements, or supporting documentation. A denial is distinct from a technical rejection that prevents a transaction from being accepted for processing.

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Department – Within the Audit Methodology, a department is either Inpatient Encounters, Outpatient Encounters (inclusive of Day case/ Telemedicine and/or Homecare), or Emergency Department Encounters

Determination: *To determine* means to find or to identify the value of a characteristic

Documentation-related error– An error resulted due to incomplete, inaccurate or unspecific physician documentation to support the services rendered

Effectiveness: *Effectiveness* refers to the degree to which a planned effect is achieved. Planned activities are effective if these activities are actually carried out, and planned results are effective if these results are actually achieved

Encounter Type – Place of service codes used on the claims, they specify the entity where the service was rendered, e.g., emergency

Evidence – Supporting Documentation or record of information for audit findings.

Facility - A healthcare establishment holding a valid license issued by the Department of Health – Abu Dhabi to provide healthcare services at a specified location and within an approved scope of services.

Facility setting – The healthcare setting in which an encounter occurs, such as outpatient, emergency, inpatient, day case, home healthcare, telemedicine, assisted living, mobile unit, or ambulance, as applicable to the facility's license and the approved Shafafiya encounter-type values.

Improvement: *Improvement* is a set of activities that organizations carry out in order to enhance performance (get better results). Improvement can be achieved by means of a single activity or by means of a recurring set of activities

JAWDA - has launched and initiated JAWDA-Abu Dhabi Healthcare Quality Index Indicators. JAWDA is the Arabic word for Quality. The indicators are aimed at improving the quality of the healthcare services provided to nationals and residents in the Emirate of Abu Dhabi and beyond, if agreed. The guidance sets out the definitions, parameters and frequency by which JAWDA Quality indicators will be measured and submitted to and will ensure Healthcare Providers provide safe, effective and high-quality services

JAWDA Sampling Tool – application for claims random sample generation from Knowledge engine for Health (KEH)

Shafafiya is the DoH platform and standards framework for the secure exchange of healthcare information among authorized healthcare entities in Abu Dhabi. Facilities shall use the current Shafafiya data dictionary, schemas, transaction specifications, validation rules and release-management requirements applicable to their transactions. Technical architecture descriptions that are not necessary to establish a compliance requirement shall be maintained in controlled technical documentation rather than in this Methodology.

Management: The term *management* refers to all the activities that are used to coordinate, direct, and control organizations. These activities include developing policies, setting objectives, and establishing processes to achieve these objectives. In this context, term management does not refer to people. It refers to what managers do

Measurement: *Measurement* is a process that is used to determine value. In most cases this value will be a quantity

Medical Necessity – defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care

Monitoring: To *monitor* means to determine the status of an activity, process, or system at different stages or at different times. In order to determine status, you need to supervise and continually check and critically observe the activity, process, or system that is being monitored

Nonconformity: *Nonconformity* is a nonfulfillment or failure to meet a requirement. A requirement is a need, expectation, or obligation. It can be stated or implied by an organization or interested parties

Objective audit evidence: *Objective audit evidence* is information that is verifiable and generally consists of records and other statements of fact that are relevant to the audit criteria being used

Objective evidence: *Objective evidence* is data that shows or proves that something exists or is true. *Objective evidence* can be collected by performing observations, measurements, tests, or using other suitable methods

Performance: The term *performance* refers to a *measurable result*. It refers to the measurable results that activities, processes, products, services, systems and organizations can achieve. Whenever they *perform well,* it means that acceptable results are being achieved, and whenever they *perform poorly*, unacceptable results are achieved

Performance indicator: A *performance indicator* (metric) is a characteristic that is used to measure customer satisfaction and how well outputs are realized

Policy: A *policy* is a general commitment, direction, or intention and is formally stated by top management. A *quality policy statement* should express top management's commitment to the implementation and improvement of its quality management system and should allow managers to set quality objectives

Pre-Authorization – Prior approval for services by insurance provider or payer

Present on Admission (POA) - Present on admission is defined as the conditions present at the time the order for inpatient admission occurs. The POA indicator is intended to differentiate conditions present at the time of admission from those conditions that develop during the inpatient admission

Principal Diagnosis - Inpatients:

The condition established after study to be chiefly responsible for occasioning the admission of the patient to the healthcare facility. Coding of uncertain diagnoses at discharge shall follow the applicable inpatient coding rules in the current DoH Coding Manual and ICD-10-CM Official Guidelines for Coding and Reporting.

Primary Diagnosis - Outpatients:

Report first the diagnosis, condition, problem or other reason chiefly responsible for the services provided during the encounter, to the highest level of certainty known for that encounter. Do not code diagnoses documented as probable, suspected, questionable or rule out in the outpatient setting; instead, code the signs, symptoms, abnormal findings or other reason for the visit, as applicable under the current DoH Coding Manual and ICD-10-CM Official Guidelines.

Process: A *process* is a set of activities that are interrelated or that interact with one another. *Processes* use resources to transform input into outputs. Processes are interconnected because the output from one process often becomes the input for another process.

While *processes* usually transform inputs into outputs, this is not always the case. Sometimes inputs become outputs without transformation

Organizational processes should be planned and carried out under controlled conditions. An effective process is one that realizes planned activities and achieves planned results

Process approach: The *process approach* is a management strategy. When managers use a *process approach*, it means that they manage and control the processes that make up their organization, the interaction between these processes, and the inputs and outputs that tie these processes together

Process-based quality management system: A *process-based quality management system* uses a process approach to manage and control how its quality policy is implemented and how its quality objectives are achieved. A *process-based QMS* is a network of interrelated and interconnected processes

Each process uses resources to transform inputs into outputs. Since the output of one process becomes the input of another process, processes interact and are interrelated by means of such input-output relationships. These process interactions create a single integrated process-based QMS

Provider: A healthcare facility or healthcare professional licensed or otherwise authorized by the Department of Health to provide healthcare services within the scope of the applicable license or authorization.

Reference: DoH regulatory usage and the scope language in *Edited Consolidated JDC Methodology Part_1*.

Quality: The adjective *quality* applies to objects and refers to the degree to which a set of inherent characteristics fulfils a set of requirements. An *object* is any entity that is either conceivable or perceivable, and an inherent characteristic is a feature that exists in an object

The *quality of an object* can be determined by comparing a set of inherent characteristics against a set of requirements. If those characteristics meet all requirements, high or excellent quality is achieved, but if those characteristics do not meet all requirements, a low or poor level of quality is achieved. So the quality of an object depends on a set of characteristics and a set of requirements, and how well the former complies with the latter

Quality management: *Quality management* includes all the activities that organizations use to direct, control, and coordinate quality. These activities include formulating a quality policy and setting quality objectives. They also include quality planning, quality control, quality assurance, and quality improvement

Quality management system: A *quality management system (QMS)* is a set of interrelated or interacting elements that organizations use to formulate quality policies and quality objectives and to establish the processes that are needed to ensure that policies are followed and objectives are achieved. These elements include structures, programs, practices, procedures, plans, rules, roles, responsibilities, relationships, contracts, agreements, documents, records, methods, tools, techniques, technologies, and resources

Re-audit – Audit conducted after a failure in the initial audit.

Recertification - Renewal of previously achieved JAWDA Data Certification as per the applicable criteria. The schedule of recertification will be determined by the certification body (TRBA). Facilities shall apply 2 months prior to the schedule to enable the activities to be completed prior to expiry of certification and to avoid any discontinuity in the listing.

Resubmission – A subsequent submission of a previously submitted claim or claim line, linked to the original transaction and made for correction, reconsideration, or other permitted processing in accordance with the applicable DoH transaction and adjudication requirements

Revoking of Certification - Removal of certification status due to an unfavourable outcome of re-audit or when a facility is subject to restriction, suspension or proscription by a public authority

Regulatory requirement: A *regulatory requirement* is an obligation that is specified by an authority which gets its mandate from a legislative body

Requirement: A *requirement* is a need, expectation, or obligation. It can be stated or implied by an organization, its customers, or other interested parties. A specified requirement is one that has been stated (in a document for example), whereas an implied requirement is a need, expectation, or obligation that is common practice or customary There are many types of requirements. Some of these include customer requirements, quality requirements, quality management requirements, management requirements, product requirements, service requirements, contractual requirements, statutory requirements, and regulatory requirements

Review: A *review* is an activity. Its purpose is to figure out how well the thing being reviewed is capable of achieving established objectives. *Reviews* ask the following question: Is the subject (or object) of the review a suitable, adequate, effective, and efficient way of achieving established objectives

There are many kinds of reviews. Some of these include management reviews, design and development reviews, customer requirement reviews, nonconformity reviews, and peer reviews

Risk: *Risk* is the *"effect of uncertainty on an expected result",* and an *effect* is a positive or negative deviation from what is expected. The following two paragraphs will explain what this means. This definition recognizes that all of us operate in an uncertain world. Whenever we try to achieve something, there's always the chance that things will not go according to plan. Sometimes we get positive results, and sometimes we get negative results, and occasionally we get both. Because of this, we need to reduce uncertainty as much as possible. *Uncertainty* (or lack of certainty) is a state or condition that involves a deficiency of information and leads to inadequate or incomplete knowledge or understanding. In the context of risk management, uncertainty exists whenever the knowledge or understanding of an event, consequence, or likelihood is inadequate or incomplete. While this definition argues that risk can be positive as well as negative, a note acknowledges that "*the term risk is sometimes used when there is only the possibility of negative consequences*".

Secondary Diagnosis - Inpatients: All conditions that co-exist at the time of admission, including chronic conditions, or develop subsequently, which affect the treatment received and/or the length of stay - that affect patient care in terms of requiring: Clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay,

increased nursing care and/or monitoring; excluding diagnoses that refer to an earlier episode that have no bearing on the current hospital stay

Secondary Diagnosis - Outpatients: A co-existing condition, including a chronic condition, that exists at the time of the encounter and requires or affects patient management. Conditions that do not affect the current encounter shall not be reported as secondary diagnoses

Traceability: *Traceability* is the ability to identify and trace the history, distribution, location, and application of products, parts, materials, and services.

Validation: *Validation* is a process. It uses objective evidence to confirm that the requirements which define an intended use or application have been met. Whenever all requirements have been met, a *validated status* is established. *Validation* can be carried out under realistic use conditions or within a simulated use environment. There are several ways to confirm that the requirements which define an intended use or application have been met. For example, you could do tests, you could carry out alternative calculations, or you could examine documents before you issue them

Verification: *Verification* is a process. It uses objective evidence to confirm that specified requirements have been met. Whenever specified requirements have been met, a verified status is achieved. There are many ways to verify that requirements have been met. For example, you could inspect something, you could do tests, you could carry out alternative calculations, or you could examine documents before you issue them

3.2 Abbreviations

AAPC	-	American Academy of Professional Coders
Ad-Hoc	-	Not Planned
AHA	-	American Hospital Association
AHIMA	-	American Health Information Management Association
AMA	-	American Medical Association
ASC	-	Ambulatory Surgery Center
ASTM	-	American Society for Testing and Materials
BMI	-	Body Mass Index
CDA	-	Canadian Dental Association
CEU	–	Continuing Education Unit
CEO	-	Chief Executive Officer
COO	-	Chief Operations Officer
CFO	-	Chief Financial Officer
CMS	-	Centers for Medicare and Medicaid Services
CPT	–	Current Procedural Terminology
DSP	-	Data Standards panel

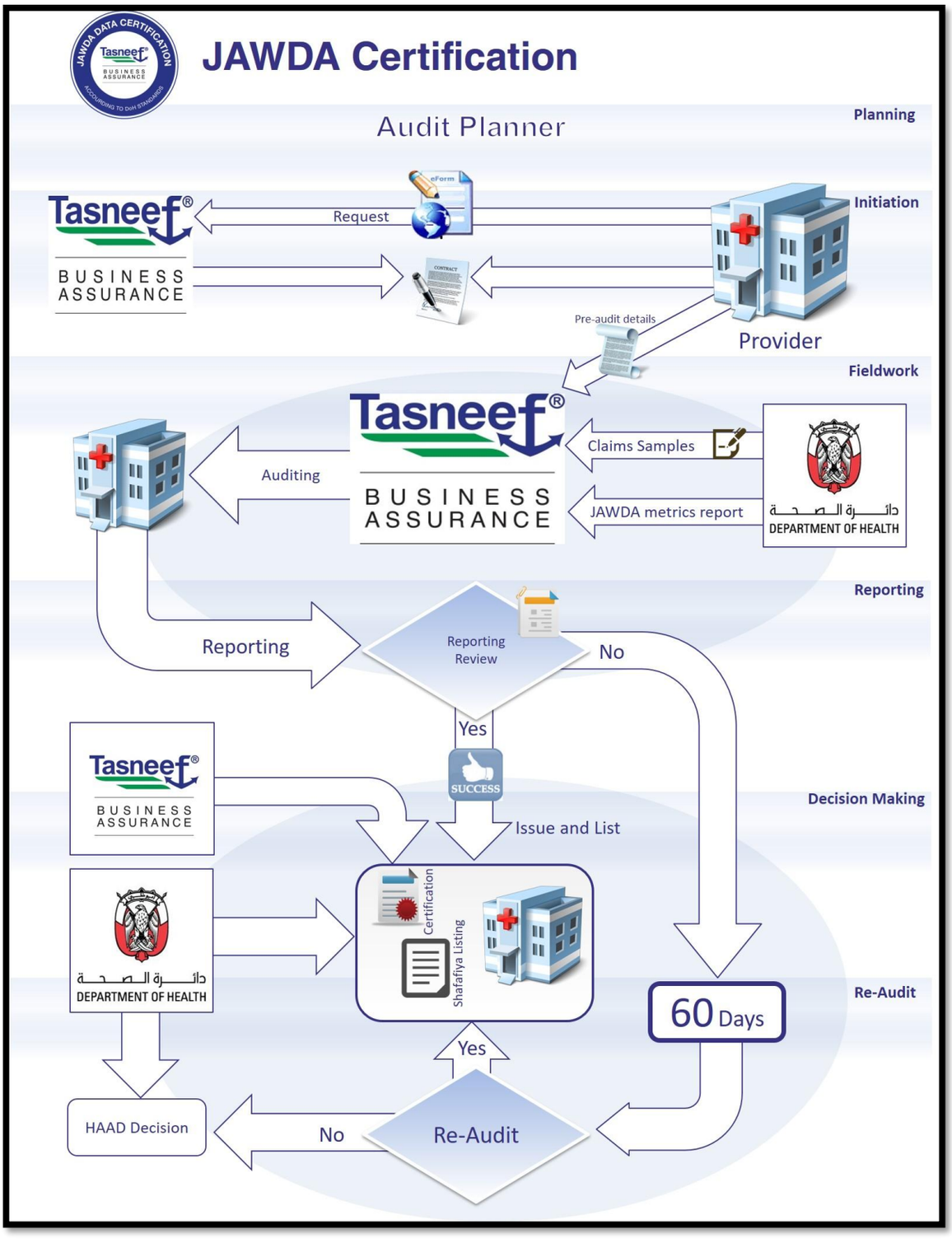
DTA	-	Decision to Admit
DoH	-	Department of Health – Abu Dhabi
DRG	–	Diagnosis-Related Groups
EKG	-	Electrocardiogram
E/M (E & M)	–	Evaluation and Management
EMR	–	Electronic Medical Record
EHR	-	Electronic Health Record
ER	-	Emergency Room / Emergency Department
DOH	–	Health Authority Abu Dhabi
HIPAA	-	Health Information Portability and Accountability Act, 1996
HIS	–	Health Information System
ICD 10-CM	-	International Classification of Diseases, Tenth Revision, Clinical Modification
IP	-	Inpatient
ISO	-	International Organization for Standardization
JDC	-	JAWDA Data Certification
KEH	-	Knowledge Engine for Health
KPI	-	Key Performance Indicators
LTC	-	Long Term Care
MDM	–	Medical Decision Making
NICU	-	Neonatal Intensive Care Unit
PICU	-	Pediatric Intensive Care Unit
NOPP	-	Nature of Presenting Problem
OP	-	Outpatient
OTC	-	Over the Counter
PDCA	-	Plan-Do-Check-Act
POA	-	Present on Admission
PMR	-	Paper Medical Records
SOP	-	Standard Operating Procedure
SPC	–	Standard Provider Contract
TRBA	-	TASNEEF-RINA Business Assurance
USC&LS	-	Unified System of Codes and List of Services (rules as established by the Canadian Dental Association)
WHO	-	World Health Organization

4 CERTIFICATION BODY

Aiming at continuous improvement of quality care, patient safety and data quality in the Emirate of Abu Dhabi, the Department of Health (Health Authority Abu Dhabi) has signed a service level agreement with TASNEEF through its subsidiary TASNEEF-RINA Business Assurance (TRBA).TASNEEF is the only external certifying body to conduct JAWDA Data Certification compliance audits, and to issue certificates, to healthcare providers as described in this methodology; however, reserve the right to conduct its own assessment and auditing using internal resources if needed

Per the Notice as of 25th August 2016, which is published on the website, "TASNEEF-RINA Business Assurance (TRBA) is authorized to issue "Clinical Coding Certifications" (CCC) defined in "DOH Periodical No. 45 – Health Insurance DOH Circular-45" as of 11 July 2011 which is now known as JAWDA Data Certification (JDC) as per the reference of circular DG-02-2018." Any new circular or notice from having any influence, impact or relation to JDC applies to this methodology.

JAWDA Data Certification-Audit Process



5 GENERAL REQUIREMENTS

1. The facility shall establish a documented JDC management system addressing all the mentioned requirements.
2. The Facility shall determine the processes that are necessary for coding, claiming, quality governance, and key performance indicators mandated by the Department of Health - Abu Dhabi
3. Determine the interaction and sequences of the processes
4. Determine criteria and methods needed to ensure that both the operation and control of these processes are effective
5. Ensure the availability of resources and information necessary to support the operation and monitoring of these processes
6. Monitor, measure where applicable, and analyse these processes
7. Implement actions necessary to achieve planned results and continual improvement of these processes

Where coding, billing or claims functions are outsourced, the healthcare facility remains accountable for compliance with applicable DoH requirements. The facility shall perform due diligence before appointment, define responsibilities and access rights contractually, monitor performance and data quality, retain audit rights, ensure confidentiality and security, verify compliance with applicable licensing requirements, and implement corrective action where deficiencies are identified.

5.1 Facility Authorized Compliance Representative

Each Facility is required to have a designated Point of Contact regarding:

- Coding Updates
- JDC Certification-related activities
- Ensure adherence to DOH Code of Ethics as mentioned in DOH Coding Manual. Please refer to the Normative references.
- In-house compliance monitoring, Documentation, Coding training workshops etc.,
- Discuss with CEO/Top Management to keep informed about the compliance status and concerns
- Initiate or take actions with the approval of CEO/Top Management when internal compliance has been threatened.
- All activities related to Quality & Monitoring are to be routed through the CEO.
- JAWDA Quality Performance KPI Profile (if applicable)
- Audit Evidence collection
- Audit coordination
- Leadership, Delegate or Representative to attend opening and closing meetings to ensure commitment to required corrective actions.

6 LEADERSHIP

Facility Top Management shall demonstrate relevant commitment to comply with the requirements of the JDC methodology and regulations by the following:

a) Promoting the culture of quality, patient safety and proper performance of clinical coding & claims and JAWDA key performance indicators in compliance with regulations and requirements regardless of any other implications
b) Encouraging staff to participate in quality programs and fostering a no-blame and just culture to empower staff to report on errors.
c) Ensuring the necessary control measures in the implementation based on the risk assessment of the interactions between different functions' interests.
d) Ensuring the availability of resources for the implementation of the requirements of JDC, as well as any other regulations.
e) Defining and approving clearly the roles & responsibilities, authorities, scope of work and objectives of the involved personnel individually or collectively regarding quality aspects, medical records, data governance and risk management.
f) Commitment for the corrective actions required coming from the non-conformities raised by Third Party audits and or external parties and or regulatory bodies.
g) Ensuring policies for internal communications to the relevant personnel to promote effective communication, such as easy reporting, safe communication without blaming, concerns, escalation, resolving conflicts, feedback and lessons learnt for Quality and patient safety concerns
h) Appointment of Leads required for the implementation, coordination, monitoring and reporting to top management about the facility performance of JDC. The responsibilities of Nominated leads should include, but not be limited to, the following:
    - Coding Updates
    - Coding Certification-related activities
    - Ensure adherence to DOH Code of Ethics as mentioned in DOH Coding Manual. Please refer to the Normative references
    - In-house coding monitoring, Documentation, and coding training workshops
    - Discuss with top management to keep informed about the compliance status and concerns
    - Initiate or take corrective actions with the approval of top management when internal compliance has been threatened.
    - All activities related to quality & monitoring to be routed through the top management

7 PLANNING

The Facility shall plan to develop, implement, maintain, and continually improve the clinical coding& claims and JAWDA KPI processes for all the applicable, considering the following:

a) The facility shall establish, develop, document, implement, and regularly review and update Risk management
b) Program policy determining the criteria required to assess different kinds of risks, which may include, but are not limited to, operational, clinical, financial, safety, and environmental risks, with their relevant control measures
c) Assessment of clinical coding & claims and KPI process, the current practice taking into consideration the Facility's internal and external issues, and regulatory requirements.
d) Identify the Gaps between current practice and requirements
e) Identifying the relevant control measures to reduce the identified gaps to the most accepted tolerable level, and regularly reviewing their suitability
f) Plan for control measures required for monitoring and measurements of different processes' performance

g) The facility shall develop a documented quality program that includes, but is not limited to, the requirements, Facility vision, mission, values, quality model, quality and patient safety framework, responsibilities and accountability's structure.
h) The Facility shall develop a KPI profile defining different aspects like definitions, calculations, inclusion criteria, exclusion criteria, data source, way of collection, involved staff roles & responsibilities, validation roles & Responsibilities and the champion for the performance necessary actions within the different functions
i) Plan targeted objectives for all relevant functions and individual level for the coding & claims process to improve the performance of the current practice.
j) Plan targeted objectives for all functions and individual level for the JAWDA KPI process to achieve the targeted value as well as to improve the current practice performance.
k) Plan to provide, and maintain required competencies consistent with identified roles, responsibilities and regulatory requirements.
l) Ensuring the proper implementation between different functions in the process interaction design that leads to the fulfilment of the planned arrangements.
m) The facility shall establish, develop, document, and implement an Emergency preparedness policy that determines required resources, roles& responsibilities, competencies for different scenarios of potential IT system downtime. The planned arrangements shall be reviewed at planned intervals to assess the readiness's suitability to different identified scenarios, recording the strengths and weaknesses of the implemented drills and addressing the required corrective actions

8 Documentation Requirements and Implementation

(Performance and Operational Controls of Process Execution)

DoH defines reliability and excellence as two key elements of healthcare quality.

Reliability:

- The systematic reduction in errors or untoward events defined in Standards
- Monitoring through self-checking or audits and inspections by or by bodies on its behalf.

Excellence:

- The continuous improvement, beyond minimum Standards, of clinical care delivery, customer satisfaction and cost-effectiveness.
- Underpinned by the routine collection, analysis and use of health data for routine clinical audit by Providers (and Departments) and Professionals.
- Driven towards continuous improvement through a clear "pay for quality" incentive system with the intention of improving clinical data quality, thereby improving the quality of patient care.

To obtain JAWDA Data Certification, the facility must:

- Having established a Management System and keeping it active in total conformity with the requirements of the JDC Methodology 2019.

- The management system is considered to be fully operative when processes, verification points and documented information are established.

8.1 General

All the documentation as seen necessary per the regulatory requirements, References, Regulations and developed policies that are seen by the Facility are necessary for the planning and implementation of the JDC scope or facility requirements.

8.1.1 General Documents and Records Controls

A documented procedure shall be established to define the controls needed

a) to approve documents for adequacy before issue,
b) to review and update as necessary and re-approve documents,
c) to ensure that changes and the current revision status of documents are identified,
d) to ensure that relevant versions of applicable documents are available at points of use,
e) to ensure that documents remain legible and readily identifiable,
f) to ensure that documents of external origin determined by the Facility to be necessary for the planning and operation of the JDC are identified and their distribution controlled
g) to prevent the unintended use of obsolete documents, and to apply suitable identification to them if they are retained for any purpose.

Records established to provide evidence of conformity to requirements and of the effective operation of the JDC shall be controlled.

The Facility shall establish a documented procedure to define the controls needed for the identification, storage, protection, retrieval, retention and disposition of records.

Records shall remain legible, readily identifiable and retrievable.

The Facility shall plan and carry out service provision under controlled conditions, taking into consideration the output of the planning stage and the records coming from the implementation of Process documents.

Controlled conditions shall include, as applicable,

a) the availability of information that describes the implementation requirements that might include, and not limited to, (Policies, checklists, instructions, References, Regulations, Guidelines)
b) the availability of developed treatment protocols, as necessary,
c) the use of suitable resources
d) the availability and use of monitoring and measuring tools,
e) the implementation of monitoring, measurement and validation of data
f) the availability of adequate and maintained equipment or applications ensuring the proper implementation of the process
g) Accessibility of updated information or processes required for effective implementation of the process

JAWDA Data Certification documentation and records requirements for the following domains of certification are to be considered:

- Claims Review (Applicable for all licensed healthcare facilities)
- Clinical Coding Process Review (Applicable for all licensed healthcare facilities)
- "KPI" Data Validation (Applicable for all facilities relevant to Quality Indicators Data Submission)

8.2 Claims Review Records Implementation requirements:

JAWDA Data Certification will endeavour to strengthen the trust between payers and providers and to by:

- Creating a shared understanding of the facility's coding and physician documentation quality
- Giving the payers confidence that a facility is coding and documenting accurately
- Providing the facility with areas for improvement in the quality of coding processes
- Provides with confidence that the submitted codes on claims that also form the basis for KPI are accurate.

This involves the comparison of actual coding practices against agreed, documented standards with the intention of improving clinical coding data quality, thereby improving the quality of patient care. The purpose of the claim review is to measure the medical record:

- to verify documented services provided to the patient,
- to verify the documented information describing the course of the patient's condition and treatment, and
- to verify the validity of billable services as per applicable guidelines
- to verify the quality of data being reported to

Claims Review is one of the domains of the JAWDA Data Certification. Claims review is a validation process to review physician documentation against the submission of reported clinical coded data by all healthcare providers. Below is the reference to clauses from DOH Policy Manuals.

With Reference to DOH Provider Policy Manual Chapter V. General Duties, Governance, and Change of Control, PART A, 45 Claims, Each Healthcare Provider must ensure that any claim (DOH Healthcare Insurers Policy Manual and specified requirements thereof), (DOH Standard Provider Contract), (DOH Coding Manual), for payment which is submitted by it to a Health Insurer in respect of treatment provided at a Facility which it operates

- 45.1.1 relates only to treatment actually provided
- 45.1.2 is accurate in all other respects.
- 45.2 Each Healthcare Provider must ensure that it complies at all times with all regulatory requirements relating to insurance fraud, abuse, misuse and mistakes and errors (Chapter VI: DOH Healthcare Insurers Policy Manual).

With reference to Data Reporting requirements as stated in Healthcare Regulatory Policy Manual Chapter 6 Data Management, all Healthcare Providers and Healthcare Payers must submit healthcare data to DOH, as specified in the DOH Data Standards and Procedures, within the following three broad sources and reporting systems mentioned below from the Data Standards published by DOH

- 67.1.1 routine transactions
- 67.1.2 public health notifications regarding
    a) vital statistics
    b) notifiable diseases
    c) injury and poison surveillance, and
    d) others for which DOH may provide custom online interfaces.
- 67.1.3 additional healthcare data which may be requested by DOH in accordance with its mandate as Abu Dhabi Health Regulator.
- 67.4 Healthcare Providers and Healthcare Payers must submit to DOH healthcare data that are accurate, complete, in the format, by the means, and within the timeframe specified by DOH.

All the facilities providing healthcare services to patients without claiming insurance, either paid for by the patient out of pocket or other.

8.2.1 Applicability

Claims Review will be applicable for all the claims generated from medical, surgical, Home Health Care, Long Term Care, Rehabilitation, Telehealth, Dental, Self-Pay and Medical Tourism services specific to ICD-10 CM diagnosis and CPT 4th Edition procedure codes, E/M codes for all applicable visits, All applicable Service codes, DRG when applicable, USC&LS Codes for Dental, as well as DOH Telemedicine Service Codes.

- Drug Codes provided for prescriptions will not be considered in scope. (i.e. Green Rain).
- In addition, codes for supplies and other ancillary services (Laboratory and Pathology) will not be part of the audit; however, the diagnosis codes supporting the ancillary services will be checked for supporting documentation of medical necessity. Physicians should clearly document the intention and justification for lab orders or prescriptions.
- The codes for consumables, including high-cost consumables, other ancillary services, and prescriptions, will be verified for claims eligible for add-on payments and outlier payments to validate that the relevant add-on payment and outlier service codes have been submitted correctly in accordance with the Claims and Adjudication Rules.
- The consumable invoice copies will also be reviewed to verify the details of the consumables used, including the date of ordering, signatures of the ordering and using physicians, and other relevant information.
- CPT codes or any codes billed with zero charges are still considered as part of the audit, and will be verified for the relevant documentation
- E&M, as reported according to the available documentation, falls within the scope of the audit.
- Technical errors or malfunctions and typographical errors resulting in incorrect claim submissions or submissions with mismatched documentation details will still be part of the audit and verified as per the standard criteria.

NOTE 1: Any diagnosis submitted to support a prescription, or diagnostic investigation shall be documented in the patient's medical record and shall accurately reflect the clinician's assessment at the time of the encounter. Where the diagnosis has not been confirmed, it shall be clearly documented as a **working, provisional, suspected, or rule-out diagnosis**. For outpatient submissions, uncertain diagnoses shall not be reported as confirmed diagnoses; the applicable signs, symptoms, abnormal findings, or reason for the service shall be submitted in accordance with the approved coding and submission requirements.

Also, replace **"schema of submission"** with **"applicable claim submission fields"** or **"electronic claim submission"**, unless *Schema* is the exact technical field name used in Shafafiya.

8.2.2 Claims Review Aspects

The same criteria of documentation and claims are applicable for Self-Pay. However, the billing or adjudication rules for Self-Pay services may not be completely applicable.

Aspects specific to claims review are mentioned below:

a) The audit focus is on clinician documentation and accurate application of code assignments on the claims, irrespective of billed charges.
b) All Clinical judgments should have corresponding medical necessity documentation in the medical record to conclude on such a diagnosis.
c) In addition to coding the incorrect level of E/M or the incorrect category of E/M compared to documentation, the other possible E & M errors also include the following:
    - No E&M code assigned in Outpatient, Day Case/Emergency, where relevant.
    - No E&M code assigned in Inpatient, when documentation met.
d) recommends the use of the 1995 or 1997 Guidelines for Evaluation and Management (E/M) codes for settings other than outpatient services. Facilities should specify the E/M guidelines followed within their coding practice policy. Accordingly, auditors will evaluate the E/M codes submitted by the facility against the documented guidelines specified in the facility's coding practice policy.
e) The facility must state one guideline or another, as the use of a combination of these two guidelines is not acceptable. If a facility has transitioned from using one guideline to another, it should be stated at the time of application for audit, accompanied by a declaration letter.
f) 2021 Guidelines for Evaluation and Management codes be utilized for Outpatient visits.
g) Evaluation and Management (E&M) codes (New and Established) should be billed based on the facility group classification according to the instructions, rather than the individual facility license (Oct 2024).
h) As per the ICD guidelines, symptoms that are routinely or usually associated with the condition are considered integral to the disease or condition. This cannot be an exception unless the physician clearly documents that the symptom is not considered integral to such a condition and provides the reason for further investigations and differential conditions suspected to be the cause of such a symptom (excluding from the current condition). The references for symptoms can be Merck's Manual, Dorland's Dictionary, listed as references in the coding manual. Additionally, coders can refer to Medlineplus.gov from the National Library of Medicine and or Mayo Clinic.

i) Any specific details of coding where there is no one specific guideline, the facility can choose to adopt any of the best standard practices guidelines; however, shall be documented clearly in the clinical coding policies of the facility regarding the adopted guideline and its implementation shall be clearly stated. Missing details of the specific guideline, applicability and implementation shall be considered as no policy.
j) All grey areas in coding, which are not addressed in the coding manual or adjudication rules, or standards, or coding guidelines, should be mentioned in the internal coding practice policy and procedures of that facility. A specific aspect in coding is considered a grey area only when the regulator and certification body have agreed on it as such.
k) Any special circumstances specific to a facility can be notified with sufficient documentation and evidence to forward the request to the concerned authority for a decision. The exceptional circumstance should be considered as an exception by the concerned regulatory authority and shall not be a decision by the facility.
l) As part evaluation of the Clinical Coding and Data Process, the facility should be able to provide complete access to required data and documentation as per the contract with TASNEEF. The facility shall provide auditors with access to all the requested information regarding the claims and processes, not limited to any single visit or document. If required, auditors can review the documentation of previous visits to form thorough conclusions required for complete evaluations. Evaluation is not restricted to the sample claims information provided only.
m) Occasionally, all healthcare providers agree to provide all the requested claims information, though previously audited by TRBA, considering it as an ad-hoc audit. This may involve the same sample, a different sample or a mix of claims or any other verification as requested by the regulatory authority.
n) Any issues in claims resulting from errors in claims submission will be marked as a billing error in addition to all other applicable errors as per applicable guidelines and documentation.
o) A claim received in the audit sample will be evaluated based on the Claim date and documentation available. All the codes that do not have supporting documentation specific to the claim date will be considered as coded without documentation, in addition to a billing error.
p) Diagnosis and supporting documentation specific to the visit shall be present in the visit-specific documents. Supporting documentation from previous visits cannot be considered for coded conditions.
q) According to instructions, all facilities are required to report two Evaluation and Management (E&M) codes from Oct 2024 for GP & Specialists; one with a value for billing purposes and another with a zero value, based on the documentation. The E&M code with zero value, as documented, falls under the scope of the JDC audit. Based on the audit findings, a score deduction will be applied.
r) All relevant Evaluation and Management (E&M) documentation must be available in the patient's current visit record. The review of E&M coding will be conducted according to the AMA guidelines, which will be superseded by updates, if any, and as applicable.
s) Entries added as an addendum to a health record to provide additional information in conjunction with a previous entry must be completed as soon as possible to represent the most accurate patient health information. Addendum entries shall always indicate the signature update with time and date, and must be available within the actual patient visit documentation of the EMR, either by electronically integrating into the record or by scanning.
t) Accurate Encounter Start Type and Encounter End Types must be followed in accordance with the values and definitions specified in the Common Types Schema.
u) Facility should maintain the start and end times for all time-based codes.
v) Consent forms for all applicable patients should be maintained as required by the Department of Health () Guidelines.
w) Ensure that LAMA (Left Against Medical Advice) forms are duly signed by the patient or their authorized relative.

x) Ensure that diagnostic test reports are duly signed by the performing physicians involved.
y) Repetition of audit findings will be notified to the for their actions.
z) Representative from the registration desk of a healthcare facility to be involved in the audit as part of the Medical Tourism process evaluation.

8.2.3 Verification Points

The facility shall always make available the medical records required for claims review. All the documents or reports generated from each visit should be compiled and are an integral part of the patient's medical record. All such information should be linked to the patient's file or medical record and should be readily available. The required documents are listed as applicable below, but not limited to:

- Patient Visit information forms / Visit note
- Physician Assessment or evaluation, or consultation records
- Consultation evaluation Records
- Nursing assessment Nursing Documentation Records
- Procedures Notes records/operative notes records
- Physician Assessments prior to admission
- Physician Query Forms
- All other relevant documents like consent forms etc.
- Medication administration records
- Referral summary notes/records
- Laboratories and radiology orders and results records
- Insurance approval/Pre-authorization documents
- Medical Reports
- Pathology notes
- Patient Consent forms and records
- Therapy assessments and notes
- Counselling and education notes
- BMI assessment forms
- Speciality-specific procedure forms
- Anesthesia records
- Physician Progress Notes
- Discharge summary
- Face-to-face forms
- Medication/ Prescription order forms
- Infusion/Hydration/Nebulization forms
- Input / Output monitoring forms
- Vital signs monitoring forms
- NICU/PICU Report
- Obstetrics/Delivery Report
- ER Consultation or ER physician assessment sheet
- Initial assessment with History and Physical examination

- Subsequent Assessment forms and or progress notes
- Discharge Summary of Referring Physician (Home Care/LTC)
- Referral Notes/face-to-face form from the treating Physician (Home Care/LTC)
- In-house Physician evaluation form (Home Care/LTC)
- Daily Activity forms (Home Care/LTC)
- Nursing care plan (Home Care)
- Insurance approval documentation records
- Therapy assessments and notes records
- Counselling and education Records
- Nursing assessment records
- Progress notes are records by nursing staff
- Any reports from EKG, Doppler or any other medical evaluation reports

8.3 Clinical Coding Process Review Implementation Requirements

With reference to DOH Professional Policy Manual, Chapter 45.2, Each Healthcare Professional must communicate fully with all Patients and keep them informed about the nature and purpose of all tests and treatment and communicate promptly and fully all results and the clinical implications of such results.

With Reference to DOH Provider Policy Manual Chapter V. General Duties, Governance, and Change of Control, PART B, 48 Policies -

- 48.4 The policies and procedures must be revised by the Provider to ensure that they remain accurate and up to date at all times.
- 48.5 A copy of the policies and procedures must be available to and readily accessible by all staff at each Facility to which they relate.
- 48.6 Each Provider must ensure that its policies and procedures are complied with.

With reference to DOH Provider Policy Manual Chapter VII Standards of Care, Patient Assessment and Records, each Healthcare Provider must maintain a record for each of its Patients (a Patient Record).

- 96.2 A Patient Record shall document
- 96.2.1- the health history of the Patient
- 96.2.2- the patient consents to the health intervention, services to be provided and likely access to the Record for the purposes of health insurance coverage
- 96.2.3 - the date, any referrals and the findings of each assessment or physical examination of him which is carried out at any of the Provider's Facilities
- 96.2.4 - the treatment provided to him at any of those Facilities, and
- 96.2.5 - where the Patient is treated at an Inpatient Facility
- 96.2.5.1 - a clinical summary of his condition and plan of care at the time of his discharge from the Facility, and
- 96.2.5.2-Adverse incidents affecting the patient in the course of treatment at the inpatient Facility.
- 96.3 - A Patient Record must be written in the English language.
- 96.4 - The Provider must ensure that each Patient Record is readily available to all those of its staff who are responsible for the treatment of the Patient.

Coding processes will be audited at the facility to assess the establishment of policies based on standard and regulatory requirements of DOH Coding manual, Criteria and normative references mentioned in this document, and adherence to it.

Properly trained hospital staff must be involved at the appropriate phases to ensure accuracy of information reported on each claim.

8.3.1 Applicability

Clinical Coding Process Review will be applicable for all the departments involved in the claim and coding cycle, starting from registration to completion of the claim cycle.

8.3.2 Clinical Coding Process Review Aspects

Successful processes should be understood and followed by all involved. The facility will be rated on the facility's understanding and adherence to its process. The process of adherence check is to understand the deficiencies in the Management System.

The facility shall document the coding processes in a suitable form relevant to the complexity of the process and size of the facility, ensuring the following:

A. **Organizational Claims and Coding Process Flow chart:** Reflecting the process flow of activities involved in the Claim process of the subject facility, addressing the following:
    a. Completeness of documentation by querying the physician
    b. Accuracy of the coding, determining the controls
    c. Interaction of the coder with other functions of the claims cycle

B. **Clinical Coding Practice policies(s):** The updated and authorized coding policy addressing the practices of clinical coding at the facility. The policy should be able to state all the guidance, standard coding and claiming references to be reviewed and followed for an effective and accurate coding process. The specific scenarios where there is no clear stated guideline available from authentic sources or regulatory, the facility can adopt to include a suitable international best practice in the policy to be put into practice. The policy(s) should be able to address the following, but not limited to:
    a. Accessibility of updated Coding references
    b. List of Standard Coding References
    c. Ethical Coding Assignment
    d. Effective Coder-Physician query process
    e. Coding for Pre-Authorization and Resubmissions
    f. Dental Coding, claiming, Pre-authorizations
    g. Self-Pay specific coding and Claim process

C. Health Care Medical Record Documentation policies:

A patient's health record plays five unique roles: (1) It represents that patient's health history, (2) It provides a method for clinical communication and care planning, (3) It serves as the legal document describing the healthcare services provided. (4) It is a source of data for clinical, health services, and outcomes research. (5) It serves as a major resource for healthcare practitioner education. The facility shall put in place the policies and processes of medical records documentation, ensuring the following, and shall be able to present the relevant records for review as necessary for JDC process:

i. **Timeliness:** Timelines of documentation completion and the encouragement to enter all details at the time of rendering service. Completion of addendums within timelines.
   - **A.** The facility shall clearly indicate the time in hours within its policy for the timeliness of documentation completion.
   - **B.** Documentation locking time should not be beyond the claim submission period. All documentation shall be completed and locked prior to claim submission.

ii. **Completeness and relevancy:** Maintaining the medical records and ensuring that they are completely and accurately documented, readily accessible, and systematically organized. State the system of E/M guidelines to use, and the template of documentation reflects the stated guidelines format. Completeness of medical record, which shall expand to include all generated records from different functions, documentation establishing medical necessity of the performed services, and describe the basis and assumptions upon which the medical decision is taken by addressing the clinical significance of abnormal test results, the description shall be written in a narrative manner instead of mere code selection. In all established E/M visits, the mandatory key component should include Medical Decision Making. Established patient visit documentation has equal requirements as of new patient. Distinguish clearly the differential diagnostic conditions from the Final or confirmed diagnosis. Extent of Documentation Examples not limited to: (No. of views of X-ray, ultrasound techniques, detailed report of findings and conclusion, contrast documentation, physician authentication of orders, physician confirmation of ancillary report results, start and stop times, documentations of technique, site, type of anesthesia, course of procedure, observations if any, complications or risks if any, closure technique, hemostasis status and patient instructions, details of counseling and education along with the specific times, Chief complaint, applicable histories, Review of systems, relevant Physical examination, orders with justifications, obtained or reviewed results or records, treatment, management plan, education if required, referral if required, and so on further as required per the best practices of international documentation and medical standards.

iii. **Medical Necessity documentation:** Medical necessity is defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. Medical necessity is best supported in MDM documentation. Address the clinical significance of abnormal test results
   1. Support the intensity of patient evaluation and treatment
   2. Describe the thought processes and complexity of medical decision-making.
   3. Include all diagnostic and therapeutic procedures, treatments, and tests ordered and performed, in addition to the results.

iv. **Quality of Documentation:** Processes to establish the integrity of documentation by creating controls to avoid cloning, copy/paste, template documentations practices, documenting related and relevant information to the current visit reason, and all the information that affects the care plan and management of patient health.

v. **Confidentiality of Patient Health Information** (Paper and Electronic Medical Records)

D. Documentation rules: During the clinical coding process review, Major non-conformities identified for any of the below will impact claims review scores as an underlying cause affecting the claims documentation:

a) Access to medical records after closure/ locking time
b) Date and time of the computer are editable
c) Audit log is not available for the claim requested, reflecting that any modifications or updates are on the audit log status

d) Non-Physician staff have created/add/modify/delete access to Physician documentation.
e) Any other finding affecting the privacy, confidentiality, or information security of patient electronic as well as Paper Medical Records.

- The audit log and the timeliness of documentation will be verified by randomly selecting any of the physicians, who may not have been nominated. The facility must provide a list of the physicians present on the audit day to ensure their documentation is verified.
- System requirements that do not meet the JDC Methodology criteria due to technical issues will still be included in the audit and will be considered as non-conformities.
- The confidentiality of physician documentation and the timeliness of individual documentation should be maintained by all relevant staff, including nurses, technicians, MRD personnel, insurance staff, medical coders, and other concerned team members. No staff member should have access to the documentation of other clinical staff.

E. **Medical Records Keeping Policy:** The facility shall put in place the policies and processes of record-keeping principles and controls for both electronic and paper-generated records, ensuring the following:
The facility shall state in the policy regarding the type of medical records such as paper, electronic or hybrid.
   a. Paper Medical Records (PMR)
      i. Clearly and permanently identify any amendment, correction or delayed entry as such (PMR)
      ii. Clearly indicate the date and author of any amendment, correction or delayed entry, and (PMR)
      iii. Do not delete, but instead clearly identify all original content (PMR)
      iv. Protect the integrity of documentation
   b. Electronic Health Records (EHR):
      i. Distinctly identify any amendment, correction or delayed entry (EHR)
      ii. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record. (EHR)
      iii. Security: As per the Data Standards Fourth revision 14 April 2014, according to Data Standards Panel decision 265, published by DOH and per other applicable regulatory standards

         1.1 to protect electronic health information created, maintained, and exchanged, encryption and decryption of electronic health information

         2.1 Controls determined related to modification authority, deletion, approval authority, and audit log for record history

   The scope of verification is limited to data creation, generation, implementation, reporting, security, accessibility, availability, readiness of information, audit trail system, access controls, backup and data retention, and Data integrity.
   There is no published UAE official guidance regarding records management. In the absence of any official specific technical guidance, as a minimum, entities need to implement systems and processes that meet currently recognized industry best practices for electronic information recordkeeping.

F. Training Policies:
   a. Training policies for new hire orientation on the regulatory () policies and standards, Coding and documentation requirements, training manuals and or SOPs for orientation of Internal applications involved in the activities of handling and generating health data. Documents or forms, or plans for supporting the continuous education of involved personnel, as and when required.

b. Competencies Maintenance: Continuous education and competencies maintenance documents for involved personnel in the coding & claims process shall be evident, not limited to nominees of the process interview

NOTE 1: One of the required competencies in coding & claims process is a mandatory Certified Coder with an active status of AAPC or AHIMA, or:

Evidence of contracted outsourcing for coding services.

Action plan to train and certify a coder within the facility within a specific time (maximum 1 year)

NOTE 2: Certified coder is not a requirement for facilities with exclusive dental services; however, training on coding guidelines for reporting ICD should be evident.

8.3.3 Verification Points

JDC methodology documentation requirements for Clinical Coding Process review include developing, implementing and updating of processes, policies relevant to clinical coding, claim process and data submission, but not limited to the following:

a) Organizational flow chart reflecting the claims and coding process being followed in the facility
b) Policies review - such as Coding Practice Policies
c) Healthcare Medical Record Documentation policies
d) Medical records keeping policy
e) Training and orientation policy
f) Record of Coder certification validation based on submitted proofs (Coder Credentials and Continuous education validation)
g) Adherence and Implementation of policies through respective departments
h) Verify the effective implementation of the quality control process
i) Verify the effectiveness of the query process and timely response
j) Verify the effectiveness of coding certified personnel interaction or involvement for pre-authorizations and the resubmission process
k) Verify the understanding and adherence to healthcare documentation and medical records policies and requirements as per the applicable criteria
l) Understanding and adherence to coding standards and coding practice policies
m) Verify the accessibility and demonstrated awareness of coding references.
n) Accuracy of the coding, determining the controls for the availability of relevant Documentation, and updated references and regulations at the point of use
o) Verify the adherence of training policy and processes
p) Review understanding of ethical practices for coding
q) Gaps or deficiencies in the data creation, transformation, generation, submission and resubmission process
r) Review of control and modification of documents
s) Verify the awareness of the claim cycle process and coding requirements by each function or department involved

8.4 KPI Data Validation Implementation Requirements

The vision of for the Health System in Abu Dhabi is to provide access to high-quality healthcare services to all. To achieve the vision, a common language was developed and a standardized way of exchanging data.

KPI validation is to ensure that KPI's definitions are followed as stated in guidelines.

As healthcare moves forward with initiatives such as quality-driven reimbursement and clinical quality measure reporting, both organizations and physicians must justify patient care and demonstrate quality outcomes.

The healthcare provider shall establish, implement, maintain and continually improve a Data Verification and Validation management system, including the processes needed and their interactions, in accordance with the requirements of this Standard.

Data verification is a way of making sure the user does not make a mistake when inputting data (An example of this includes double entry of data, such as when creating a password or email, to prevent incorrect data input).

Data validation is about checking the input data to ensure it conforms to the data requirements of the system to avoid data errors (Example: *Data range check/inclusion/exclusion*).

8.4.1 Applicability

i. JAWDA Program for all applicable Indicators and Metrics.
ii. Relevant to all facilities involved in submitting KPIs to DoH .

8.4.2 Verification Points

i. The different verification points, as applicable, are but not limited to the calculation of the following variables:
   - Numerator
   - Inclusions Numerator
   - Exclusions Numerator
   - Denominator
   - Inclusions Denominator
   - Exclusions Denominator
   - Traceable data elements and Regeneration of the report

ii. The KPI values included in the management approved KPI Report shall be identical to the values uploaded on the JAWDA system.
iii. If a facility reports as 'N/A' (Not Applicable) for any JAWDA indicator that is relevant and applicable to their services, a score of zero will be assigned to that indicator based on the eligible population identified during the audit. When uncertain about the applicability of an indicator, facilities should consult with them for clarification.
iv. If the selected quarter of KPI data lacks patient entries and shows a submission of 0/0, data from any other quarters containing rational numbers will be selected.

v. Most of the time, the source of KPI data is derived from patient records. To enhance data validation, it is essential to include complete Revenue Cycle Management (RCM) or claims data. Therefore, healthcare facilities are required to provide the following data during KPI audits to ensure effective KPI data validation:
   - RCM data, clinical coding data, or claims data, as specified in the KPI profile requirements. The data should include, but not be limited to, diagnoses, procedures, service line items, physician name and speciality, patient date of birth, age, and gender.
   - Final diagnosis codes must be accurately reflected in the claims submitted to Shafafiya following coder review.

vi. Facilities are responsible for notifying the Department of Health () about the KPIs applicable to them and must ensure that the submission portal for these KPIs is requested to be opened prior to or within the designated submission period to submit the same.

vii. Facilities that achieved a grade of “C” or “D” (<90 score) in the KPI audit are required to resubmit the corrected data within 30 days to DoH based on the KPI audit findings.

9 MONITORING, MEASUREMENT & CONTINUAL IMPROVEMENT

The organization shall evaluate the performance of the JDC management system and its effectiveness. The organization shall retain appropriate documented information as evidence of the evaluations.

9.1 Patient and customer satisfaction

The facility should monitor customers' and patients’ perceptions of the degree to which their needs and expectations have been fulfilled. The facility shall determine the methods for obtaining, monitoring and reviewing this information.

9.2 Internal Audit Program

At planned intervals, the facility shall conduct internal audits at least annually to evaluate if the JDC management system is implemented, maintained and is effective.

The organization shall:

a) implement an internal audit program, including the frequency, responsibilities, JDC criteria, and reporting and retaining evidence and documented information of the audit results and follow-up
b) conduct audits by impartial auditors
c) appropriate reporting to the relevant management
d) follow up on correction and corrective actions

9.3 Review of the Performance

9.3.1 General

Top management shall review the facility’s management system to ensure its alignment with the JDC requirements.

The facility shall retain documented information as evidence of the results of management reviews. The overall review should be performed and documented annually.

9.3.2 Review Agenda

The management shall review the performance of the facility’s JDC system, taking into consideration:

a. Follow up from previous review and any JDC audit aspect related
b. changes in the organization or from external aspects that may affect the JDC system
c. information on:
    1) feedback from relevant interested parties such as
    2) the extent to which the objectives of JDC have been met
    3) status of nonconformities and corrective actions
    4) audit results from internal and external parties, such as the certification body
    5) any other verification points as per 10.3.5
d. risks affecting JDC requirements, trends in quality indicators

9.3.3 Outputs of the review

The outputs shall include action plans related to:

a) improvements
b) verification and evaluation of system quality verification points in JDC Processes
c) assignment of responsibilities.

9.3.4 Periodical Management reviews

Regular reviews should be reported, documented and retained quarterly on the facility performance of JDC processes by a pre-defined agenda, an attendees list, including who follows previous meetings, an action plan with clear responsibilities and timeframe.

Regular reviews could be partial management review meetings or other top management meetings with a fixed agenda, inputs and outputs on planned intervals.

At least one review has to be performed after JDC audits, and any changes to JDC methodology and/or policies related to the scope of JDC.

9.3.5 Verification Points

Verification points could be internal review and validation of data before pre-authorization and submission, regular verification of completeness of medical records, completeness of documentation, checklists, and different kinds of registers

NOTE. Audits could be Internal Audits, Peer evaluations, retrospective/prospective Audits, and second and third-party audits. Competencies and independence are important to consider.

Resulted implementation Records to be maintained, like but not limited to the following:

- Different committees signed and approved minutes of meetings
- Management review signed and approved minutes of meetings
- Audit records
- Corrective actions record
- Analysis studies records
- Incident investigation records

9.4 Improvement

9.4.1 General

The facility shall implement any necessary actions to meet JDC requirements and continuously improve the related system.

9.4.2 Nonconformity and corrective action as an opportunity for Improvement

Nonconformities are also opportunities for improvement. The facility shall reply to a non-conformity from internal or external parties, such as the certification body, by:

1) corrective actions
2) analyzing the nonconformity and determining the causes
3) Update risk registers if necessary

The facility shall document and retain information on:

a) analysis of the non-conformities
b) corrective actions

9.5 The Improvement Cycle

The facility shall verify the results of any audits, internal or external, any customer or patient feedback and any study or trend made available from any parties, including the review of the performance from the management, to determine the opportunity to improve the JDC system.

10 INTERIM AUDIT PROCESS (Applicable to Hospitals)

- The Interim Audit is a voluntary audit offered to facilities that have successfully passed the JDC Audit and wish to improve their audit score and grade.
- Hospitals must submit their application for the Interim Audit within one month from the issuance of the Initial Audit final report.
- TASNEEF shall initiate the contracting process within 15 days of receiving the application
- The Interim Audit shall be conducted no earlier than three months after the issuance of the Initial Audit Final Report.
- The Interim Audit shall encompass all four domains using the same Methodology applied during the Initial Audit. Facilities must provide all required documentation and evidence in accordance with the Initial Audit requirements.
- The Coding Process Review shall assess records and claims generated between the Initial Audit Final Report date and the Interim Audit commencement date.
- Claims sample shall be selected from the claims submitted during the period between the Initial and Interim Audits.
- Facility tier classification shall be determined based on the volume of claims submitted between the Initial and Interim Audits.
- KPI Data Validation shall be conducted using the most recently submitted quarter KPI dataset available at the time of the Interim Audit.
- The Interim Audit shall apply the same scoring and grading structure as per Methodology.
- The final audit report shall be issued at the earliest possible time upon completion of the Interim Audit.