دائـــــرة الـصـــحـــة
DEPARTMENT OF HEALTH

JAWDA DATA CERTIFICATION (JDC) CERTIFICATION RULES

FOR HEALTHCARE PROVIDERS

Consolidated Methodology Part II

(ANNEXURE & APPENDICES)

September - 2026



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TABLE OF CONTENTS

1 GENERAL 6
2 APPLICATION AND PLANNING FOR CERTIFICATION 7
2.1 Contract formation 7
2.2 Audit Planning 9
2.3 Audit Sample Type for Claims Review 11
2.4 Sampling Method for Claims Review 11
2.5 Sampling for KPI Validation: 12
2.6 Random Sample Sharing for Claims Review: 12
3 PERFORMANCE OF AUDITS 12
3.1 General 12
3.2 Audit Process: 13
3.3 Audit Evidence Collection 13
3.4 Confidentiality 14
4 CERTIFICATION REQUIREMENTS AND GUIDELINES FOR CRITERIA 14
4.1 JAWDA Data Certification 14
4.2 Claims Review Process (Billing, Coding and Compliance) 14
4.3 Clinical Coding Process Review 19
4.4 Process Review for: “KPI” Quality Indicators (Obsolete September 1, 2026) 22
4.5 KPI Validation for Collection and Submission of Jawda Quality Indicators 22
5 DENTAL SERVICES 26
5.1 Audit Verification Points: 26
6 AUDIT ON SELF-PAY /MEDICAL TOURISM/ PROFORMA SERVICES 27
6.1 Audit Verification Points: 28
7 REPORT 29
7.1 Audit Report Format 30
8 NON-CONFORMITIES AND CORRECTIVE ACTIONS 31
9 WEIGHTS AND SCORING 32
10 DECISION MAKING 32
10.1 Passing Grade System for JAWDA Data Certification 32
11 RE-AUDITS 33
12 INTERIM AUDIT PROCESS 34
13 LISTING AND DE-LISTING 35
13.1 Impact of De-listing (Gap in Listing) 36
14 MAINTAINING VALIDITY OF THE CERTIFICATE 37

14.1 Management of Certificates 37
15 MODIFICATION OF CERTIFICATION AND COMMUNICATION OF CHANGES 37
16 CONDITIONS AT WHICH THE AUDIT PROCESS WILL STOP 37
17 CONDITIONS AT WHICH THE CERTIFICATION PROCESS MAY BE SUSPENDED 38
18 SUSPENSION, REINSTATEMENT AND WITHDRAWAL OF CERTIFICATION 38
19 RENUNCIATION OF CERTIFICATION 39
20 NEW FACILITY LISTING AND EXTENSION OF LISTING 39
21 COMPLAINTS/APPEAL MANAGEMENT 40
APPENDIX 43
APPENDIX-I 44
APPENDIX-II 48
APPENDIX-III 52

ANNEXURE

CERTIFICATION RULES

for

JAWDA Data Certification for Healthcare Providers -

Methodology Part -II

1 GENERAL

These rules constitute the integration of the Contract between the certification body (TASNEEF) and Healthcare Facilities. These Rules are an integral part of the Methodology to achieve the JAWDA Data Certification. In this perspective, the rules describe to identify criteria that Facilities can or must apply for the JAWDA Data Certification related to the DoH JDC Methodology 2019 and how facilities can apply to obtain, retain, renew and use this certification, as well as its possible suspension and revocation.

1.1. Certification is in accordance with DoH JDC Methodology (dated January 2019) to facilities where the Management System must be recognized as conforming. The Criteria of the certification are represented from the Methodology and other requirements of the reference standards or guidelines described in this document.

1.2. Certification is open to all Healthcare facilities in Abu Dhabi belonging to the following categories and encounters:

- Hospitals
- Medical Centers, Clinics, Home care Centers, Telemedicine, Long Term Care Centers /Rehabilitation Centers facilities/Dental Centers and all facilities offering Self-Pay Services, Excluding Pharmacies, Optical shops, School Clinics and exclusive diagnostic laboratories, Dental Laboratories, Orthotics and Prosthetics.

TASNEEF is entitled to refuse requests for certification by facilities whose activities have been subject to restriction, suspension or proscription by a public authority.

When TASNEEF declines an application, the reasons shall be communicated to DoH and the facility CFO/CEO/COO or delegated authority, including the representative for audit.

1.3. This document also provides guidelines to the Criteria applicable to the certification process because the JAWDA Data Certification is oriented to apply a complete third-party concept audit.

Quality means the ability to satisfy the requirements of regulatory, moral, material, social and economic nature, translated into stated requirements.

The quality of the health service (intended as the ability to satisfy the associated needs) is the result of a:

- a series of scientific, technical and technological, organizational, procedural, relational and communicational elements in which a determining role is carried on by the human variables (health operators and service customers – in this concept is patients) that strongly interact in the realization processes, even more than in other activities, also essentially based on human relations, such as education

The elements to be considered in quality in health and associated achievement services are therefore numerous and complex, for example, through:

1.4. adequate organization of the structure and suitable management of the primary and supporting services, which are reflected, though not strictly, in the ISO 9000 and other international standards and accreditation systems;

- adequate definition of the "technical" content of the services provided (service specifications), which corresponds to a series of specialized standard references of which medical-scientific documentation and diagnostic-therapeutic protocols are particularly important;
- qualification of assigned personnel (basic training, applicative knowledge, human skills and ethical behaviour), which is related to the mechanisms of recruitment, selection, and training;
- medical-scientific reference documentation (Protocols, Procedures or Instructions, etc.) that are used to support the records.

1.5. The JAWDA Data Certificate issued pertains exclusively to a single healthcare facility identified by its DoH license number.

2 APPLICATION AND PLANNING FOR CERTIFICATION

Facilities wishing to obtain certification for their JAWDA must provide TASNEEF with their main facility data and site location by filling in all parts of the "APPLICATION FORM" on TASNEEF website at www.tasneefba.ae/jdc to initiate the Certification process

Facilities applying for the first time apply for certification through the online application, and notifications are received in the ba.jdc@tasneef.ae e-mail.

- Name of the Facility
- DoH License No.
- Facility Settings
- Contact Details
- Other mandatory fields

This information should be provided by an authorized representative of the applicant organization and shall be the point of contact for the entire certification process.

- For the re-certification, apply by downloading the registration form online and send the ba.jdc@tasneef.ae e-mail and /or to the admins. The facility must confirm the schedule and share the facility location and contact details, along with a location map and landmark.
- All the requests should be accompanied by a copy of DoH license.
- All correspondence will be sent to the registered emails only, and changes must be notified to TRBA
- Facilities whose schedules are not published in the annual planner should contact TRBA immediately to request a schedule. As per DOH, the JDC audit is mandatory for all facilities.
- Change of facility management/ownership or location will not change the audit schedules or JDC requirements for audit unless there is a change in license number.

2.1 Contract formation

i. TASNEEF will open a file with the provided information, and a contract with fixed prices approved by DoH will be sent to the provider per the type of facility and applicable tier system based on volume of claims submission, which is provided by DoH, and then the contract will be sent to the authorized representative for certification. The Pricing Tariff list is published on the TRBA webpage.
ii. Details of Tier information are as provided in Appendix-I Tables of the Tier system.
iii. For a new facility audit, at least one of the applicable settings should meet 120 claims, and the remaining settings can have a minimum tier sample to proceed for initial audit.
iv. All the Licensed facilities with Facility type as Provision of Health Services, are applicable for contract category as (Tier HC) Home Healthcare. Facilities with a subtype of a license is Medical Center but authorized as a Homecare service provider are also applicable for the Tier HC contract.
v. All the facilities with Facility Type as Rehabilitation center are applicable for Contract Category-Medical Center (Tier-M) provided they do not have home health and long-term care services.
vi. Facilities with a License of facility subtype as Rehabilitation Hospital shall be applicable for contract as Tier-RH.

vii. If a facility has a mix of settings, if a facility operates across multiple settings such as outpatient, daycare, home care, etc., the selection of the contract tier type will be applied based on the higher tariff. For example, if a facility has settings as outpatient and home care, the contract shall be considered for home care. If a facility has outpatient, daycare and home care, the contract shall be for home care.

viii. Home care facilities that do not submit claims daily are not required to wait until the audit to meet the minimum sample size of 120 claims. Instead, claims submitted over one month that meet the minimum required sample size under the Tier system will be sufficient to proceed with the audit.

ix. If a facility has outpatient and inpatient claims, the contract shall be issued as a Center, however, there will be additional charges to cover the cost of additional man-days required for the audit of Inpatient claims.

x. For Self-Pay, the Tier system is applicable only if submission is made for a minimum of 6 months; otherwise, contract with a flat rate for Self-Pay will be applicable. This is to promote as an incentive for continuous submission compliance for Self-Pay activities.

xi. The audit process for proforma payers (services which are not paid either by patients or insurance companies) is the same as the self-pay audit process. Self-pay tier system and prices are applicable for Proforma services as well. For the purpose of this certification, Self-Pay and Proforma are considered to follow the same audit process.

xii. In addition to the Tier system, Centers with applicability to KPI submissions will be charged additionally to cover the man-days.

xiii. Facility shall be in the scope of audit until the license is shown as active on the DoH website, till the day of the audit. Similarly, if a speciality or setting is cancelled by the time of audit, the audit will still be conducted on the submitted claims. This can be excluded only if there are not enough claims to be audited.

xiv. Facility with scope of service as Proforma services shall be considered for audit according to the Self-pay audit process.

xv. The facility that handles general, dental, and self-pay claims can proceed with the audit when the general claims have accumulated a sufficient volume, even if there is no minimum tier sample available for dental, as is the case with self-pay claims.

xvi. If a facility has additional service as Long-Term Care, there will be an additional charge to cover the cost of additional man-days required for the audit of LTC claims.

xvii. New facilities must proactively request an audit instead of waiting for notification from TASNEEF.

xviii. If insurance services apply to the facility but the facility has few or no insurance claims, yet there are more than 200 self-pay claims available, the recertification audit will be conducted based on the available/submitted claims to avoid a listing gap for the facility.

xix. Self-pay facilities with Dental and Dermatology specialties shall nominate physicians from both specialties.

xx. If the audit man-days are minimized due to facility-related reasons such as unavailability of data, data corruption, or lack of backups, the audit price will remain unchanged.

Acceptance of the contract is made by sending TASNEEF the specific form signed and attached to the contract, and any other document for which certification is requested.

On receipt of the signed contract for certification and the relevant annexes as applicable and having ensured they are complete, TASNEEF will send the facility a written acceptance of its application and will proceed to generate the invoice along with other additional steps for the audit process.

The agreement signed between TASNEEF and the facility includes:

1) Certification fee
2) Information on the fee for Follow-up Audits if applicable to the facility, as mentioned in the contract and as per the applicable General Terms and Conditions
3) A single consolidated package price applicable as per the Tariff published on TRBA website. The tariff selection is done based on the Tier of General claims and the applicability of dental and Self-pay services in scope.
4) Facilities which are exclusive dental Centers without general medical services will follow the tier system of Dental and tariff accordingly.
5) The self-pay tier system and Tariff are applicable to facilities only with exclusive self-pay services.
6) Facilities with only Dental and or Self Pay will be applicable for contracts related to specific services
7) After the satisfactory completion of the initial audit and after validation by TASNEEF, a Certificate of Conformity with the reference standard, if it meets the criteria, will be issued.
8) Contract information for Re-audits as applicable per methodology

2.2 Audit Planning

i. The application for certification should be initiated by the facility at least two months prior to the scheduled audit date of the listing expiry published on Shafafiya.
ii. The facility is required to share the list of Coders with their certification and other department personnel details in the scope of the audit process and interviews at least 3 weeks prior to the audit schedule.
iii. If facility management changes, but still bears the same DoH License Number, the facility will still proceed with the JDC audit, with claim samples to be taken from the previous 12-13 months and not from the date of management change.
iv. Any rescheduling request should be sent at least 1-2 months before with a documented reason for the request. In the absence of relevant documentation supporting the reason, the schedule will not change, and the audit will proceed with the actual schedule.
v. Only one rescheduling request can be accommodated for any emergency reasons with supporting documentation, and the new schedule can be provided as per the availability of the audit slot.
vi. Schedules for KPI audit will be as per the claims schedule; however, if it is delayed for specific reasons, it will be communicated by TRBA with the earliest possible schedule without causing any listing impacts due to the delay.
vii. Any request for rescheduling within one month of the scheduled date will incur additional charges.
viii. The assigned schedule may be cancelled if the application is not received at least 2 weeks before the given schedule.
ix. An audit plan will be communicated to the facility within a week before the audit schedule.
x. In case of delay in application by facilities, the above timeline may be affected, and the audit plan shall be sent only after receiving the required information.
xi. Facilities with electronic medical records should be kept ready and sent to TRBA, the process of mapping the Claim ID to the related medical records.
xii. Facilities having electronic medical records, the auditor should be given access to the visit information as required for the audit and need not print the copies for auditor evaluation.
xiii. Facilities with paper medical records should arrange the total medical records related to claims provided for audit within the first hour of audit start.
xiv. The auditing team may decide to perform any audit on-site or desktop/remotely.

xv. Facilities maintaining both electronic and paper medical records should present the full documentation to the auditor at the start of the audit, and it is the facility's responsibility to ensure a mechanism is in place to indicate the presence of any additional paper medical documentation. Extracting additional pieces of paper documentation during the audit cannot be accepted for evaluation.

xvi. Facilities with the same audit representative for both Claims review and KPI review may request to schedule the audit on different days.

xvii. Facilities that have multiple Key Performance Indicators (KPIs) and a single audit representative may opt to schedule the audit on different days for each KPI.

xviii. Facilities that have resumed operations after a temporary closure/license issue must submit their JDC application within 7 working days from the date of resuming operations. This requirement applies to all facilities, regardless of sufficient claims, to ensure eligibility for an audit or to extend the listing (EOL) for an additional six months.

xix. The audit will be scheduled 30 to 45 days before the certificate expiration date, and the schedule will be published on the JDC website. (Link)

xx. Claims and KPI audits will be scheduled for different durations based on their applicability. Accordingly, the annual planner will reflect the date for the claims audit, while the KPI audit will be scheduled based on the applicable days.

NOTE 1: Any delay in the application resulting in missing the schedule will not be the responsibility of TRBA. Upon request, TRBA may arrange for another schedule depending on the availability; however, it will not guarantee the continuity of the listing. The resulting gaps in listing will be the sole responsibility of the facilities.

NOTE 2: A maximum of 3 changes will be allowed for the nominees for the interview, and no changes shall be considered 1 week prior to the audit date. Any changes resulting from emergency conditions shall be considered when provided with supporting evidence to file in our records for such emergency conditions.

NOTE 3: In case of absence of nominees for interviews after confirmation of the schedule, it shall be considered as zero for scoring.

2.2.1 Special Requirements for Multi-Site Facilities

If a provider operates more than one facility, each facility must undergo the certification process individually. TRBA prefers to proceed with individual contracts to avoid major changes in the contract and Tier. However, if the facility still prefers a group contract, it can be issued, but the clause of change in the tier system may change the price in the contract. Nevertheless, audit activities will be performed for each facility anyway, and the policies can be verified once there is an update.

Note: *In case of a centralized system, the auditor will verify if all facilities are following the same methods and procedures and the awareness and adherence of centralized policies and processes are verified for each facility.*

2.3 Audit Sample Type for Claims Review

Random samples will span across each major encounter type as applicable to the provider's settings, to enable meaningful coverage of sample distribution for audit. The random sample does not contain any identifiable patient information.

Encounter Type	Setting
1	Outpatient
2	Emergency Room
3	Inpatient
4	Inpatient Bed + Emergency room
5	Day case
10	Teleconsultation
12	Home care

Example: A hospital that provides care in Outpatient, Inpatient, Emergency room, Day case and Homecare settings, five individual sets of claim samples will be audited.

2.4 Sampling Method for Claims Review

A random sample of Dental and Self-Pay services will be audited if applicable.

i. The audit sample will include claims available from the past 12-13 months from the audit date for certification or re-certification
ii. Random sample size is as per the Tier system mentioned in the tables in Appendix I
iii. Each facility Tier information is provided by DoH based on the volume of claims submitted to KEH during the past 12-13 months.
iv. Sampling is done using a scientific formula based on international best practices of accreditation.
v. The sample count indicated for each tier represents the sum of samples from all applicable encounter types/settings.
vi. In case of an insufficient number of claims in one specific setting, the difference in claim sample count will be selected from another setting.
vii. Random sample contains a percentage of claims selected based on the specific quality criteria provided by DoH.
viii. Random sample for Dental and self-pay services will be based on the specific applicable tiers.
ix. Claims samples will be randomly selected by the DoH KEH tool based on the tier system and may not be equally distributed across all months.

2.5 Sampling for KPI Validation:

For the KPI validation, the audit will consider the typical third-party approach, which means sampling could occur; however, sampling will cover all the applicable KPIs. This shall also include, but not be limited to, disease-specific coding rules, i.e. cancer, severity, cesarean, neonatal, complications etc. Sampling of KPIs for Data validation can be done considering the high-risk indicators.

2.6 Random Sample Sharing for Claims Review:

- Random sample shall be shared only on the day of audit.
- Healthcare providers shall keep ready the process of mapping the medical records to the claim IDs to avoid any delays in providing relevant medical records for audit.
- Claims directly accessible by claim ID in the health information systems, without any need for mapping to medical records, need not be shared with the facility. However, the facility will receive the list of evaluated claims with the identified findings as an Annexure to the formal report.
- Random samples shall be shared one day before only for claims of Inpatient, Homecare, and Long-Term Care if the facility has no Electronic Medical Record.
- The claims sample size for re-audits will be Tier-1 of the applicable setting.
- Claims samples from the previous year after the issue of the final report will be considered for re-certification.
- Claims samples from after the issue of the final report of the recent audit will be considered for re-audits.

NOTE 1: Any delay impacting the audit schedule can result in an incomplete audit and can impact the scoring, and TRBA cannot be held responsible for such an impact, if any. All the medical records relevant to the list of claims should be made available at the start of the audit at 9:00 AM. Any unreasonable delays shall impact the score, and any delays causing the auditors to extend the audit time (including evidence collection) may incur additional charges.

3 PERFORMANCE OF AUDITS

3.1 General

An “Audit Plan” is drawn up for each audit, which is sent to the customer facility in good time.

The audit has the following objectives:

a) Determination of the conformity of the client’s management systems, or part of it, with audit criteria.
b) Evaluation of the ability of the management system to ensure the client organization meets applicable and contractual requirements.
c) As applicable, identification of areas for potential improvement of the management system.

The Audit Plan indicates the tasks assigned for the audit. Specifically, for each facility covering the applicable domains:

a) The structure, policy, processes, records and related documents of the applicable Management system must be examined and checked.
b) It must be established whether these satisfy the requirements applicable to the scope of certification.
c) It must be established whether the processes and documented information are drawn up, implemented and kept efficiently, to nurture trust in the Facility's management system.

d) Every inconsistency between the organization or facility's policy, objectives, goals and the result obtained must be reported to the facility (authorized representative) to allow for appropriate action.
e) Collecting audit evidence.
f) Communication with the Head of the Facility/ Representative, along with the nominees mentioned on the audit plan, is seen to be required for opening and closing meetings to ensure a clear understanding of the audit objective, process, identified findings and required corrective actions.
g) Presence of Top management for the closing meeting is important to show commitment to continual quality improvement of organization and to understand the areas of improvement and actions.

3.2 Audit Process:

The audit process will be conducted as per the audit plan, starting with the opening meeting, simultaneous request for evidence and closing meeting.

3.3 Audit Evidence Collection

i. Evidence of documentation and identified deviations will be collected, as agreed in the Provider Healthcare Facility - TASNEEF contract. The evidence will be retained for a maximum of 2 years in accordance with this
ii. All the documents reviewed in electronic format will be directly collected as evidence by the auditors themselves. It shall be the responsibility of the facility to hand over all the other required documentation and requested evidence before the auditor leaves the facility on the scheduled day and time. The facility cannot extend the hours of the auditor to collect the evidence.
iii. Failure to provide the requested evidence within the time shall be considered as non-compliance with certification requirements, and any documentation provided for any reason after the timeline cannot be accepted. Consequently, the audit and/or certification process may be discontinued, as the audit would no longer be effective in achieving its intended objectives and maintaining the integrity of the certification process.
iv. The Health Information Systems should have the capability to electronically print/save the required visit documents as audit evidence. Not having the option or such a feature to provide evidence shall be considered as no evidence provided, and the auditor's findings, documented with specific reference, remain valid.
v. It is highly recommended to provide evidence in electronic format to save paper and time.
vi. Physical copies of evidence will not be accepted from facilities that use Electronic Medical Records.
vii. The evidence can be masked with confidential patient information, retaining other required details of the visit and other pertinent information.
viii. It is the responsibility to provide all the requested evidence of policies and claim-related documentation during the audit. Required evidence, if found absent during the reporting phase, will be finalized based on the findings collected by auditors during the audit and cannot be negated by facilities.
ix. Protected health information of the patient will be handled as per the required standards of privacy and security.
x. In the case of a multi-day audit, the requested evidence must be provided on the same day and will not be carried out to the next day. Any documentation submitted after the specified timeline, for any reason, will not be accepted.
xi. All relevant evidence must be provided during the audit. Any evidence submitted after the audit, even if it relates to the claims or process, will not be accepted during the report process.
xii. Any evidence related to findings that auditors request, but the facility fails to provide during the audit, will be marked as an error. No justifications or evidence will be accepted after the audit.
xiii. If the facility fails to present the required evidence during the audit and submits it after the audit, it will not be accepted, even if the evidence is valid.

NOTE 1: It shall be the responsibility of the facility to acquire all the required approvals before the audit day, as per the release of information, to provide all the requested evidence on the day of the audit without causing any hindrance to the audit process. Failure to provide evidence on the same day shall be considered a breach in compliance with the audit requirement and cannot be disputed.

NOTE 2: Any evidence missed from the list requested by the auditors will be the sole responsibility of the facility and shall be considered as no available documentation during our further reviews, and providers cannot comment or disagree on the claims for which evidence is missing or not provided.

3.4 Confidentiality

i. TASNEEF-RINA Business Assurance management is responsible for all information obtained or created during the performance of certification activities at all levels of our structure, including committees and external bodies or individuals acting on our behalf. Information about the client should be treated as confidential, consistent with the certification body's policy.

ii. All the acts (documents, letters, communications, etc.) relating to the system/Process assertion certification activities shall be regarded as confidential.

iii. Access to and consultation of documents relating to the certificate/statement are reserved for the purposes involved in the certification process and for the organization in question.

4 CERTIFICATION REQUIREMENTS AND GUIDELINES FOR CRITERIA

4.1 JAWDA Data Certification

DoH defines two key elements of quality in healthcare: Reliability and Excellence.

To obtain JAWDA Data Certification, the facility must:

- Have established a Management System and kept it active in total conformity with the requirements of the DoH JDC Methodology.
- The management system is considered to be fully operative when processes, Verification Points and documented information are established for the required domains of certification as per below:
- Claims review (Applicable for all facilities, including Dental, Self-Pay & Medical Tourism)
- Clinical Coding Process Review (Applicable for all facilities including Dental and Self-Pay)
- "KPI" Data Validation (Applicable to facilities that submit KPIs to DOH)

4.2 Claims Review Process (Billing, Coding and Compliance)

Claims Review is one of the components of the JAWDA Data Certification. Claims review is a validation process to review clinical documentation against the submission of reported clinical coded data by all healthcare providers.

Claims review does not exclude the activities billed with zero charges and cannot consider any exceptions for such reasons.

JAWDA Data Certification will endeavor to strengthen the trust between payers and providers and to DoH 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 DoH 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 DoH

4.2.1 Claims Review

TASNEEF will receive an audit sample as per the applicable Tier system through the DoH portal for each type of setting identified within the facility scope.

i. As part evaluation of the Clinical Coding and Data Process, TASNEEF Auditors should be provided with complete access to data and documentation. 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.
ii. A claim not identified during the audit or identified as a missing record after confirmation with the audit representative will be considered as having zero accuracy and completeness scores and should be documented. Any documents provided after audit day shall not be accepted as documentation for review.
iii. Missing chief complaint on the visit documentation will be considered as "0" score, as a claim is not billable without a chief complaint. However, a chief complaint can be considered if written in continuation as part of the history of the presenting illness.
iv. TASNEEF will then complete the audit in accordance with this methodology and collect audit evidence.
v. All healthcare providers should agree to provide all the requested claims information, though previously audited by TRBA, considering it as an ad-hoc audit that can happen occasionally. This may involve the same sample or a different sample, or a mix of claims or any other verification as required.
vi. The scoring against each criterion will be applied as per this Methodology and the inclusive Error Scoring Tables in Appendix III
vii. Claims review will be done applying the audit concepts and claims scoring criteria of this methodology.
viii. Errors related to deficient documentation of services and procedures have specific categories in the error scoring tables. These are considered completeness errors. It may be considered an accuracy error for the future.
ix. A claim can have both accuracy and completeness aspects applicable to the same service or condition.

x. The E&M Guidelines: The provider must state the E/M guidelines being followed, 1995 or 1997 (other than Outpatient). The use of both guidelines is not allowed. (The E/M documentation cannot be a mixed template of 1995 and 1997/ Cannot mix body areas and body systems).
xi. Outpatient Evaluation & Management should be verified with the 2021 guidelines.
xii. Failed facilities / New facilities should code the actual E/M as per the documentation with "Zero" billing, though base level E/M is reported as per payer instructions.
xiii. According to DOH instructions, all facilities are required to code two Evaluation and Management (E&M) codes: 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.
xiv. Evaluation and Management (E&M) codes (New and Established) will be verified based on the facility group classification according to the DOH instructions, rather than the individual facility license.
xv. Diagnosis pertaining to the visit and supporting documentation shall be present in the current document. Supporting documentation from previous visits cannot be considered for coded conditions.
xvi. The narrative diagnoses or final impression diagnoses, dental progress notes, and intraoral and extraoral findings should be documented in the physician's own clinical words.
xvii. The diagnoses documented under the final impression or narrative diagnosis must be supported by the clinical documentation within the encounter, including the chief complaint (CC), history of present illness (HPI), past, family, and social history (PFSH), review of system (ROS), physical examination, oral examination findings, radiology findings, or any other relevant documentation sections, excluding the final impression section. Missing the same supporting documentation for the reported diagnosis will be considered an accuracy error with a score deduction.
xviii. The Narrative Diagnosis must be documented separately and will not be considered from the physical examination or dental oral examination, even if the content is the same.
xix. If any issue was fixed after the audit finding was raised during the audit by the auditor cannot be considered for the current audit.
xx. Incorrect Encounter Start Type and Encounter End Type will be classified as accuracy errors. This rule is effective for claims with service rendered starting January 2025.
xxi. 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. Any documentation provided that is not in alignment with this requirement will not be considered and will be marked as no supporting documentation during the claims review.
xxii. Score will be deducted only once for the same error repeated in Claims with the same prior authorization number from the payer, for long-term care claims like home care claims.
xxiii. Submitting additional codes that are unnecessary for the claim and to DOH due to technical errors will be classified as miscellaneous billing errors and will result in a deduction from the accuracy score.

4.2.2 Classification of Errors for Claims Review:

Errors are classified as coding-related, documentation-related, and Billing-related.

Coding related:

- Any errors related to the general and chapter-specific guidelines of diagnosis coding.
- Errors related to procedure guidelines in coding.
- Documentation is more specific to code for a higher specificity.
- Evaluation and management services are either missing, coded at high or low levels or coded with incorrect category
- Incorrect diagnosis or procedures coded to the available documentation.
- Missing relevant or secondary diagnosis, additional diagnosis.

- Coding signs and symptoms, incorrect sequencing of diagnosis.
- Missing additional procedure codes.
- Coding possible, probable or questionable diagnosis.
- Minor procedure included in E&M or E&M included in surgical procedure.
- Missing medical necessity for the procedures ordered.
- Chief complaint(s) not related to the primary diagnosis.
- Lack of Narrative diagnosis in physician's own words.

Documentation related:

- Any diagnosis or procedures are documented insufficiently.
- Incomplete report or missing report.
- Documentation of problem(s) pertinent physician examination as normal.
- Documentation of an extensive physical examination than required as per the complaints.
- Copy and paste of the same documentation.
- Lack of more specific documentation when required to specify
- Lack of mentioning relationships of conditions as cause and effect, or late effect or complication or resolved or Due to.
- Any other abnormal clinical documentation.

Billing/Claiming related:

- Missing Per Diem codes
- Missing consent forms
- Incorrect DRG
- Incorrect Per Diem or Service Codes.
- Missing number of units of service codes.
- Missing anaesthesia units.
- Claim submitted to the incorrect setting as an encounter type
- Follow up within seven days of the same complaint.

4.2.3 Claims Review Audit Verification Points and Scoring Criteria:

Claim level audit on random samples as per the guidelines mentioned in the methodology. The audit will focus on claiming aspects as Documentation, Coding, Billing and Submissions and shall provide scoring as:

a) Accuracy (ICD-10-CM, CPT 4th Edition for all services (including Radiology), USC&LS Codes (as per applicable year of code sets), DOH Service Codes, DOH telemedicine codes, DOH Mandatory Tariff List of Codes)
b) Completeness (ICD-10-CM, CPT 4th Edition for all services, USC&LS Codes (as per applicable year of code sets), DOH Service Codes, DOH telemedicine codes, DOH Mandatory Tariff List of Codes)

Claims review will output an Accuracy Score by assignment and reporting of only the codes and data that are clearly and consistently supported by the health record documentation and in accordance with applicable code set and abstraction conventions, rules, and guidelines.

Accuracy

Claims reviews will also identify clinical coding submission or improper documentation practices intended to inappropriately increase reimbursement from payers or influence payer adjudication rules, or deviate from the guidelines, or not accurately reflect the services provided.

Completeness

Analysis contributes to recommendations on claims coding practices and does not affect the passing criteria. It includes missing additional diagnoses and insufficient documentation that would have provided more detail on the condition or status of the patient, but would not have had an impact on the unusually high outcome of reimbursement from the payer for the services provided.

Completeness scoring will help determine and/or recommend improvements with regard to the reporting of clinical coding and/or deficiencies in physician documentation.

i. Accuracy and Completeness will be scored against the set of criteria, as supplied by the Error Scoring Tables of this methodology in Appendix III.
ii. Coding based on incomplete documentation, resulting in errors, is scored as accuracy.
iii. Incompleteness of documentation by itself will be considered as completeness errors for tracking and education.
iv. Completeness errors are limited to the details mentioned in the scoring tables.
v. The error scoring tables for outpatients are also applicable to Day case and Emergency.
vi. These scored errors have been rated by Diagnosis and by Procedures as Major, Moderate or Minor.
vii. Each record will start with 100 points for accuracy and 100 points for Completeness, and the presence of any errors will result in the deduction of the set number of points
viii. There can be no more than one error scored per code or one error per error-category in one claim for accuracy scoring.
ix. Score will be deducted only once for the same error repeated in Claims under the same authorization of home health care.
x. All Completeness errors will be scored for each error irrespective of error category, unlike in Accuracy.
xi. The facility will be allowed to review the individual errors after sending the formal report, and in case there is a difference of opinion in claims review where there is a possibility of different coding outcomes based on a standard guideline or reference, it can be brought to the notice of the reviewer with a clear, relevant standard reference. Only the comments with justification referring to any circular from DoH or published guidelines, or standard coding guidelines, will be considered for review and response. It is to the sole discretion of the third-party audit body to decide, based on the applicability, to consider the references provided.
xii. All grey areas in coding which are not addressed in the coding manual or adjudication rules, DoH standards, or coding guidelines should be mentioned in the internal coding practice policy and procedures of that facility.
xiii. In case of no clear references available to both parties on the grey areas of coding concepts, the facility should have a documented policy and a consistent implementation of such aspects in the facility to consider for the benefit assignment. Otherwise, the conclusions made by the audit team shall remain applicable, and the facility cannot be rewarded with score benefit.
xiv. Only the coding accuracy score shall impact the passing criteria.

xv. A coding completeness score for the facility does not have any impact on passing criteria and will be utilized and recorded as a tool to track education requirements or coding process gaps for corrective actions for future follow-up reviews.

xvi. Complete absence of claims during audit shall be considered for scoring as “zero”.

xvii. Report available only with diagnosis/prescriptions, but without documentation of Chief Complaint/Review of Systems/Physical Examination is also considered a score of zero.

xviii. The scoring on each claim is as per the error categories mentioned in detail as per the tables of Error Scoring Table 1 to Table 8: Appendix-III

xix. Once each medical record has been scored, scoring weights equivalent to the ratio of claims distribution per each setting will be applied, and an overall claims review score is generated. (E.g. Inpatients-DRG, Day-case, Outpatient clinics, Emergency and Home Care).

xx. Claims from dental and self-pay will also generate the scoring weights per claims ratio to the total claims.

xxi. The extent of documentation review is determined by the auditors. Facility co-operation is obligatory

xxii. Medical tourism claims sample will be included within the self-pay claims tier system

xxiii. Services rendered under a one DoH license, but a Claim submitted under another DoH license will be considered an error. Lack of supporting documentation for the whole visit will be scored as “0”

xxiv. Any technical issues, errors, or mistakes cannot be exempted from scoring zero

xxv. Claims submitted to DoH for services rendered out of jurisdiction will be considered as an error, and the whole claim will be scored as “0”.

xxvi. Documentation supporting the established final Diagnosis should be available in the medical record.

xxvii. Verification of consent forms and Left Against Medical Advice (LAMA) forms in accordance with the Department of Health (DOH) guidelines.

xxviii. Verification of patient signatures on all relevant documents.

xxix. Claims in which the billed physician differs from the actual service performer shall be classified as noncompliant and assigned a “zero” score.

xxx. Verification of performing physician signatures on diagnostic reports.

xxxi. Diagnosis-Related Groups (DRGs) are included as part of the audit review scope.

xxxii. It is the facility’s responsibility to provide all the required documentation requested by the auditor for the audit. Anything that cannot be verified due to the unavailability of the necessary documentation/process will be marked as “Not Verified” and will result in a zero score for the respective field.

4.3 Clinical Coding Process Review

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.

Coding processes will be audited at the facility to assess the establishment of policies based on standard and regulatory requirements of DOH Coding manual and normative references mentioned in this document, and adherence to it. The Clinical Coding Process review is an integrated process evaluation for General, Dental and Self-Pay services. However, all the applicable verification points will be evaluated for all applicable services.

The facility should be able to demonstrate the process being implemented for each service line (General, Dental, Self-Pay).

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

4.3.1 Audit Verification Points and Scoring Criteria:

i. Process flow chart reflects the entire claims cycle. It can be a single flow map or multiple to reflect different processes. However, there shall be at least one high-level flow map reflecting all the functions and interactions, and the details can be verified in the respective function flow maps.
ii. Updated and in-force policies as stated with reference to Chapter 8 from the Methodology standard
iii. Evidence of the physician coder query process reflects the start, course and end points of the query process meeting the requirements of the query as per the DOH code of ethics.
iv. Documents meeting the requirements of active Certifications and continuous education
v. In case of outsourced services, the outsourced party shall be responsible for submitting all the required documents related to their scope of work relating to methodology requirements; however, the final responsibility lies with the facility
vi. Evidence establishing an internal quality control process that can be requested by the auditor from any quarter of the year.
vii. Evidence of coder interaction with related departments when applicable (Pre-authorization, Resubmissions)
viii. Interviews conducted to verify the adherence to policies and effectiveness of the process shall be documented; however, the observations identified during the interview process are related to appreciative quality or perceptive quality and cannot be a matter of debate
ix. Any additional evidence required to represent compliance with requirements can be requested by auditors; hence, evidence is not limited to documents as stated above
x. Sample verification of coding and documentation practices mentioned as requirements in methodology chapter 8. All the documents shall be legible and complete with the facility name, date and required authentications
xi. Any process being followed shall have documentation, and a lack of such evidence or records shall be considered as non-conformity and receive a score deduction
xii. All the finalized nominees to be available as per the audit plan;
xiii. If the physician is unavailable for the interview (e.g., due to resignation, absence, or any other reason), the physician interview component shall be marked as **"**Not Verified" and will receive a "zero" score for the respective field. In addition, 5 points shall be deducted from the overall score due to the inability to verify the timeliness of documentation
xiv. Each aspect of the clinical coding process review will be verified as applicable and in relevance with Dental and Self-Pay processes.
xv. The self-pay submission process will be verified with the respective team.
xvi. DOH mandates facilities to maintain Electronic Medical Records, and this adherence will be assessed during the process review. Non-compliance will be indicated if complete Paper Medical Records are found in place of complete Electronic Medical Records.
xvii. Facilities should submit to TASNEEF an action plan for resolving any major deficiencies identified during the review. If requirements are not met by the next scheduled audit, DoH will be notified for further action. Impact rating of non-conformities will affect certification.

xxxiii. **Timeliness:** Missing medical records locking time in hours within their policy for the timeliness of documentation completion. If documentation locking is beyond the claim submission period, then it will be finding.

xxxiv. The audit log and timeliness implementation will also be evaluated from the claims review, in addition to the existing process review. The implementation of these two requirements should be complied with and be evident from the process as well as the claims review. A 5-point score deduction will be applied, even if any gaps are identified from the claims review, though the process review indicates adherence to the criteria or vice versa. Adherence to the criteria should be evident during the process review as well as the claims review.

xxxv. All time-based codes will be verified against the documented start and end times; total time spent alone will not be accepted.

xxxvi. During the clinical coding process review, if Major non-conformities are identified for any of the below, it will result in a deduction of five points (5.00) score from over all claims review score:

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 (Audit Log should be demonstrated by the IT in front of the auditor)
d) Non-Physician staff having create/add/modify/delete access to Physician documentations
e) Any other finding affecting the privacy, confidentiality, or information security of patient electronic as well as Paper Medical Records

Scoring of Clinical Coding Process Review:

- Deficiencies identified during the reviews of coding processes, policies and non-conformity of adherence by relevant staff will be rated based on their impact, affecting the score.
- Observations made regarding the awareness of process and coding references cannot be contested, as it is an unbiased, appreciable evaluation.
- Clinical Coding Process Review nonconformities or deficiencies will have an impact rating as Major and Minor, which will affect certification
- No separate score is generated for the dental and self-pay Coding process review.
- Clinical Coding Process Review score is a consolidated score generated from a comprehensive evaluation of applicable aspects for general, dental and self-pay services, as applicable to the scope of the facility.
- Claims process flow and effectiveness: (15 points)
  - Coding Process Flow Chart/Map (5 points)
  - Comparison of the Flow map to the implemented process (2 points)
  - Effectiveness of the mentioned processes of functions (8 points)
- Training and orientation (10 points)
- Policies and Practices review (40 points)
  - Healthcare Documentation Policy and Practice review (16 points)
  - Medical Records Policy and Practice Review (Interview) (12 points)
  - Clinical coding Practices and Policy Review (12 points)
- Coder Credentials verification/Coding training (5 points)
- Process Compliance verification (30 points)
  - Coder Observation (4 points)
  - Physician Interviews (18 points)
  - Claims Process (Insurance – Pre-authorization, Billing, Submission, Denial management) function Interview (5 points)
  - Medical Tourism Submission & Process (Claims related) (3 points)

Note: Certified Coder Requirement

One of the following criteria must be met for the JAWDA Data Certification audit:

- have a Certified Coder with active status of AAPC or AHIMA (or) evidence of contracted outsourcing for coding services, and the coder credentials of the coder representing the facility for the scope of service from the outsourced company

  And/or

- Action plan and evidence of progress to train and certify a coder within the facility in a specific time (maximum 1 year)
- Certified coder is not a requirement for facilities with exclusive dental services; however, training on coding guidelines for reporting ICD should be evident.

4.4 Process Review for: "KPI" Quality Indicators (Obsolete September 1, 2026)

No KPI process review will be conducted for the following areas during KPI audits:

a) KPI Process for Planning, Support, and Operations
b) KPI Process for Quality Governance and Improvement

Although no formal process review will be conducted, any significant process deviations identified during the validation review will be recorded as non-scoring *Major Nonconformities*.

Patient Safety Taxonomy process will be verified at all facilities. Each facility must have a defined process in place for instances when there is no data to be submitted.

4.5 KPI Validation for Collection and Submission of Jawda Quality Indicators

The vision 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.

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

KPI validation is a method to verify if the information collected from the Hospitals for DOH Quality Performance KPI Profile program has objective evidence to confirm that the requirements which define the intended use have been met.

4.5.1 Jawda KPI Data Review **(New Scoring Methodology applicable from September 1, 2026)**

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 DoH Shafafiya following coder review.
- Indicators that were not reviewed due to missing required information will be classified as **"Not Verified"** and will incur a score deduction.

- The facility shall provide the final data validation sheet indicating all the included & excluded data.
- KPI scores generated for health facilities that were audited for the first time, as well as for newly introduced indicators published by DOH, shall not be included in the JDC final score. This approach aims to promote awareness and understanding of the audit process and newly implemented speciality KPIs.
- New indicators (non-scoring indicators) will be audited in addition to the scoring indicators for the hospitals.
- The latest data will be used for the initial KPI audits and for new KPI profiles, published by DOH. However, this latest data will be considered only after the submission period has ended including grace period if any.
- The KPI audit shall be conducted for all facilities to which the KPI is applicable, even if zero data is submitted.
- Facilities that achieved a grade of "C" or "D" (<90 score) in the KPI audit are required to resubmit the corrected data to DOH within **30 days** of receiving the final audit report, based on the audit findings. However, this resubmitted data will not be considered for re-audit purposes for failed facilities.
- During the audit, if it is found that the facility has not submitted any applicable KPIs, it will be considered a major finding, and a score deduction will be applied to the respective indicators.
- Any KPI specialty that has reported zero data for four quarters consecutively will not be considered for the audit. However, as per DoH instructions, these specialties will still be reviewed under the non-scoring category.

Note: Initial KPI audits and newly introduced KPI indicators will be considered non-scoring during the first year and will not be included in the JDC audit score.

4.5.2 KPI Data Validation Process

KPI Data validation will be followed by the defined sampling method with acceptable error based on the volume of the data submitted.

The sampling method and acceptable error criteria are uniformly applicable to all facilities undergoing KPI audits.

Indicator Data Category (Submitted Denominator volume)	Sample Size	Acceptable Error Count
>10000	20 Samples	2
5001 - 10000	15 Samples	2
1001-5000	10 Samples	2
6 - 1000	6 to 8 Samples	1
5 or below	5 Samples	0

Note 1: The sample size may be smaller than the defined number depending on the audit progress, but it will not exceed the specified maximum limit. Sample size is not applicable for missing population.

Note 2: For hospitals, the audit indicators will be reviewed as specified in Methodology. For non-hospital facilities, all applicable indicators within the relevant profiles will be included in the audit.

Indicator Selection:

Hospital indicator selection will be based on the facility size as follows:

- **1H to 3H hospitals:** 20 indicators with 3-day audit.
- **4H to 6H hospitals:** 30 indicators with 5-day audit.
- **All applicable KPIs with all indicators** will be included in the audit for the facilities other than hospitals.

- Indicator selection will follow the criteria outlined in the table above.
- Non-scoring indicators will be included as additional indicators alongside the confirmed indicators for hospitals.
- The sampling method does not apply to the non-scoring indicators.
- If the required number of indicators according to the applicable percentage is insufficient to meet the respective category, the remaining indicators will be replaced from the highest data category according to the number of samples.

  For example, if the category with more than 10,000 data lacks sufficient indicators, the shortfall shall be compensated by allocating additional indicators to the category with the highest number of indicators, in proportion to the required sample size.

- Indicator replacement will be based on the required number of samples rather than the exact number of indicators.
- All indicators across all applicable KPIs will be reviewed for non-hospital facilities.
- If the selected quarter shows 0/0 submissions due to no patients, data from an alternative quarter with available submissions will be selected.
- If 0/0 data indicator is selected for the audit, then minimum of 5 sample will be reviewed to validate the accuracy of the submitted data.
- **Sampling techniques** shall be applied during the audit, based on the auditor's analysis of the data.

Note: The same sample will not be considered for the same definition indicators.

4.5.3 Audit Verification Points, Scoring Criteria and Error Counting:

Audit Verification Points: Jawda KPIs from all the sub-domains will be verified as per the applicability of KPI profiles and per the facility type.

Below are the verification components that will be reviewed during the audit, but not limited to:

a) Numerator
b) Inclusions Numerator (when applicable)
c) Exclusions Numerator (when applicable)
d) Denominator
e) Inclusions Denominator (when applicable)
f) Exclusions Denominator (when applicable)
g) Traceable data elements and Regeneration of the Data (RCM Data)

All relevant KPI indicators are validated for the accuracy of the submitted data against the applicable KPI criteria and the reliability of the submitted data.

Scoring Criteria and Error Counting:

Scoring components are as follows:

- Numerator (50 score)
- Denominator (50 score)

- KPI data validation carries a 50% weightage in the overall score.
- Each indicator is considered with a maximum of 100 points.
- KPI Data Validation is categorized for scoring as Met/Not met, resulting in score assignment.
- Met with full score and Not Met is zero score.
- The indicator score will not be deducted unless it exceeds the acceptable error count as specified in section 4.5.
- Multiple discrepancies identified within a single sample shall be counted as one finding for the respective indicator.
- KPI findings resulting from claims submitted after the KPI data submission deadline will not be considered as audit findings.
- Findings within the acceptable error limit will not result in any score deduction, and the indicator will be marked as **"Met".**
- Findings exceeding the acceptable error limit will result in the affected component of the indicator being marked as **"Not Met".**

Scoring Method Example 1:

- The indicator allows 2 acceptable errors.
- The first two findings will not result in any score deduction.

Upon the third finding:

- If the finding is related to the Denominator; the Denominator score will become zero; or

- If the finding is related to the Numerator, the Numerator score will become zero.
- The total indicator score will be 50, as only one component (Denominator or Numerator) is affected in this scenario.

Scoring Method Example 2:

- The indicator allows 2 acceptable errors.
- The first two findings will not result in any score deduction.

  Upon the next findings:
  - The third finding affects the Denominator, resulting in the Denominator score becoming zero.
  - The fourth finding affects the Numerator, resulting in the Numerator score becoming zero.
  - The total indicator score will become zero in this scenario, as both components are affected.

- The same scoring method applies to all indicators, including those with the same denominator definition.

5 DENTAL SERVICES

Clinical Coding Process Review will be conducted for facilities with exclusive dental services and shall generate an individual score of 100.

For facilities with dental services as an additional scope, clinical coding process review of dental will be conducted as an integrated process review.

5.1 Audit Verification Points:

A. Process review:

Includes verification of policies and processes for the following data points, as documented in chapters 4.2 and 4.3, applicable as relevant:

i. Medical records policies and adherence
ii. Documentation policies and adherence
iii. Coding and Claiming processes and practices, including consents and pre-authorizations
iv. Universal Dental Charting
v. Clinical Coding Process Review score is a comprehensive score from evaluation of process (general/ dental/ Self-pay) as applicable.
vi. Clinical Coding Process Review for Dental is integrated with general services unless the facility is an exclusively dental service provider.

B. Claims review:

i. There are no minimum required claims count to conduct an audit on dental claims for the first year or re-certification.
ii. A distinct random sample of dental claims shall be provided by DoH per the tier system of medical Centers if applicable.
iii. To verify the documentation, consents and approvals for the submitted claims as per the Canadian classification system
iv. Physician documentations are verified in detail to support the services provided, and assigned codes shall be thoroughly reviewed.
v. Verify all the information related to the claim, such as billed clinician, date of service, activity quantity, encounter type, Activity type, encounter start type, end type, etc.

vi. Dental claims submitted under a general setting, or vice versa, will be considered an accuracy error.
vii. All time-based codes verify with start and end times instead of total time spent.
viii. The relevant physician's license validity and the existence of privilege will be verified for each claim. (refer to Shafafiya DoH Clinician list / Internal Facility Privilege communicated to the Payer).
ix. Verification of consumables details.
x. Endodontic procedures billed with additional CPTs that are considered inclusive.
xi. Claims review score is a weighted score proportionate to the claim's ratio.
xii. A score shall be generated based on identified error scoring criteria for claims and the coding process.
xiii. The facilities with passing scores will be listed on Shafafiya with the scores achieved.
xiv. Re-audits shall be conducted for facilities where the total score achieved is less than 86%.

6 AUDIT ON SELF-PAY /MEDICAL TOURISM/ PROFORMA SERVICES

With reference to the Data Reporting requirements stated in the Healthcare Regulatory Policy Manual, Chapter 6, Data Management, all Healthcare Providers and Healthcare Payers must submit healthcare data to the DoH, as specified in the DOH Data Standards and Procedures.

a. Self-Pay Services:

i. All the healthcare facilities which are already in the scope of the JDC audit with medical/surgical claims shall also be in the scope of the audit.
ii. Audit on all Self-Pay services, Proforma services, and Medical Tourism claims is mandatory as applicable.
iii. All claims, including self-pay and non-insurance, must be submitted promptly and in compliance with the provisions of the Standard Provider Contract.
iv. Clinical Coding Process Review and Claims review will be conducted as per the exclusive.
v. Claims review sample for medical tourism will be selected from the overall Self-Pay Tier system count.
vi. Audit for Self-Pay services generates a score which is inclusive of the overall JDC score and shall be updated as listed on Shafafiya. Additionally, all the facility scores shall be reported to DoH for their further actions and proceedings, if any.
vii. Score weight is assigned as per the claim distribution ratio.
viii. Re-audits shall be conducted for facilities where the score achieved is less than 86%.

b. Proforma Invoice:

i. Facilities with exclusive self-pay/proforma services are applicable for the self-pay specific tier system (Tier-SP) and listing on Shafafiya.
ii. Facilities that have only Proforma claims shall be audited on claims and clinical coding process review following the rules applicable for Self-pay.
iii. If a facility provides proforma services, it should be coded and submitted in the Self-pay category. Otherwise, Self-pay submission scoring deductions shall be applied.
iv. The audit process for proforma payers (services which are not paid either by patients or insurance companies) is the same as the self-pay audit process and self-pay tier system, and prices are applicable.

A -5 score Deduction:

- A 5-point score will be deducted from the Self-Pay claims generated score if the self-pay submission is not done consistently or completely **from the previous JDC audit**.
- Facilities having insurance claim submissions but not compliant with Self-pay submissions to DoH shall have a

5-point deduction from the overall claims score, though the self-pay claims were not audited.

- Individual Self-pay facilities that do not have submissions of self-pay services to DoH, shall have a -5-point deduction on the total claims score generated from samples selected manually from the facility.

c. Medical Tourism:

i. The facility must provide demographics of Self-Pay patients to verify whether the patient qualifies as Self-Pay or medical tourism. Not providing the requested information to the auditor shall be considered as no relevant supporting documentation is presented, which may impact on the scoring based on audit conclusions.

ii. The facility must submit all required demographic details, including the payment field. These details must be provided for all Self-Pay and Medical Tourism samples to facilitate verification during the audit.

iii. Verification of the Medical Tourism process includes Policy and Flow chart.

iv. Submission of Medical Tourism claims is mandatory. A -5 score will be deducted from the Medical Tourism claims score if the facility has incomplete or inconsistent MT claim submissions. This requirement will be enforced starting from the 2026 audits, with the first audit cycle serving as an improvement opportunity for facilities for this score deduction.

6.1 Audit Verification Points:

Claims review: All applicable guidelines of JDC criteria for claims review are applicable

- There is no minimum required claims count to conduct an audit on self-pay claims for the first year or until further change.
- A distinct random sample of self-pay claims shall be provided by DoH per the self-pay tier system.
- To verify the documentation, patient consent and bills of the rendered services to the submitted claims information.
- Physician documentations are verified in detail to support the services provided, and assigned codes shall be thoroughly reviewed as per applicable coding guidelines.
- A score shall be generated based on identified error scoring criteria for claims and coding process; however, the facilities shall be recorded on the Shafafiya certified facilities list with the scores achieved, and results shall be notified to DoH for required actions or decisions.
- Facilities that have other general and or dental services in addition to self-pay will generate an overall JDC score where the clinical coding process review score is a comprehensive score from evaluation of process (general, dental, Self-pay) as applicable, and the Claims review score is weighted proportionate to the claim's ratio.

All costs related to the audit on any Self-pay services will be charged to the facility.

Process review: Clinical Coding Process Review for self-pay is integrated with general services unless the facility is the exclusive provider of self-pay services. All applicable guidelines of JDC criteria for Clinical Coding Process review are applicable

Clinical Coding Process review shall be conducted on the medical records, Data collection, recording, documentation, Coding and billing and Claim submission process as documented in chapter 4.2 and 4.3, applicable as relevant.

7 REPORT

All the audit activities (Reviews, Validations and Process Reviews, for Claims and KPIs) will be performed according to the plan with facilities as per the audit plan.

Upon the completion of the audit of the Facility, a copy of the written report will be delivered by the Technical Specialist of TRBA to the authorized persons for the facility, for understanding and acknowledgement of the report and required action plans within 5 calendar days of the formal report received.

Formal and final reports will be shared only with registered email addresses. It is the facility's responsibility to disseminate the reports internally to all relevant team members and to respond to the formal report within 5 calendar days.

The formal report with acknowledgement should be endorsed by the CEO or CFO, or the COO delegated authority of the facility and should be submitted to TRBA for final decision.

The Formal endorsed report will be for the review of the Certification Controller and for the final decision from TRBA in collaboration with DoH.

Findings may be modified during the formal audit report review and/or the final audit report review based on the applicable guidelines/JDC methodology and the evidence provided during the audit.

The original audit report is owned by the certification body.

The facility may indicate any reservations or comments concerning the findings by the TRBA auditors in the relevant space in the audit report. Only concerns with references to standard guidelines (Regional or International) from Claims review criteria-General/ Clinical Coding Process Review- Criteria or DoH (DOH) circulars shall be reviewed, and the conclusion shall be communicated in the final report. Comments regarding the absence of such references are not deemed to provide any response.

Considering the audit as a Third-party concept, the comments from the facility cannot be seen as a dispute or an ongoing discussion. TRBA reserves the right to decide after careful consideration of valid comments from healthcare facilities.

The final report will be issued prior to listing expiry, and facilities with late applications or delayed audit process will receive the final report within 30-40 working days from the date of the audit completion.

Any delay in reporting from TRBA from the specified timeline, TRBA shall inform the facility and ensure that there will be no negative impacts on the listing resulting from delays.

There cannot be any scope for reviews or revisions after the issue of the final report.

The Final report will include:

- Scoring for claims review
- Scoring for Process Review – Clinical Coding
- Scoring for KPI data validation (applicable as per JAWDA program)
- Improvement areas

In the event of several major non-conformities, the certification process requires an extra visit for process review; this follow-up audit must be performed within two months to check the effectiveness of the proposed corrective actions.

All costs relating to any follow-up audit deriving from shortcomings in the Management System will be charged to the facility.

7.1 Audit Report Format

The Final report includes:

1. Overall report summary as PDF or Word with JAWDA Data Certification - Final Score and Grade, Annex-A with Facility Comments and Corrective Action Plan, Annex-B with Scoring Details of claims review score, Process review score and KPI data validation score.
2. The Process Review Details in the Final report include:
    a. Gaps or deficiencies identified in the process
    b. Coding Policies review
    c. Coder certification validation and observation
    d. Summary of Claims Review Findings
    e. Identified non-conformities of compliance to policies and process flow by relevant personnel.
    f. Improvement Areas: based on process, policies and compliance check
    g. All extenuating circumstances, if any, that have been verified and validated by TASNEEF

3. Claims review details of the Formal Report must include:
    a. A Cover page from DoH with Facility Name. license and Audit Type.
    b. Each additional Data sheet(s) for each setting as Inpatient, Outpatient, Emergency, Day-case/ Homecare or Telemedicine /Dental/Self-Pay with:
        i. The full list of all claims/encounters audited
        ii. Claim ID
        iii. Date(s) of encounter
        iv. All CPT codes and descriptors, including E&M codes if applicable, except ancillary services (i.e., Laboratory and Pathology) and Green Rain Drug Codes.
        v. All ICD-10-CM codes and descriptors indicating the Diagnosis type as principal and secondary codes, etc.
        vi. Details of error, corrections, with codes, descriptor, Auditor Comments, error categories and scores on each claim reviewed, Reference Criteria, Coding and/or Documentation error classification, Additional comments, if any
        vii. Scores following the specified scoring methods and points with totals for each department
    c. KPI Validation findings- Data validation for the verified KPIs will be reflected as scores.

The facility should respond to TASNEEF through e-mail with a definitive action plan to resolve the identified non-conformities in process, within 5 calendar days after receiving the formal audit report. Any delay in sending the

corrective action plan may delay the final audit report and result. Such delays resulting in any gap in listing or any other impacts shall not be the responsibility of TRBA.

Note 1: Additional Error Classification: To help overall reflection of concerned areas for improvement and to understand how each error is contributing to the score, identified coding errors will be additionally classified as Coding errors and/or Documentation based errors.

8 NON-CONFORMITIES AND CORRECTIVE ACTIONS

Each aspect of the mentioned domains for audit shall be verified for conformance to the requirements of applicable standards.

Clinical Coding Process Review will be verified for conformance, and the report shall clearly indicate the non-conformities.

Claims Review will be verified for conformance to the relevant criteria, and non-conformance is recorded with score deduction according to the scoring Tables published in Appendix-III

KPI Data Validation shall be verified for the conformance of submitted data to the accuracy required as per the DoH KPI profile. Nonconformities for KPI Data Validation shall be recorded with a score deduction.

Conformity: - Has objective evidence of conformity to standard requirements. Non-Conformance is categorized into Major and Minor.

Major Non-Conformity: A fundamental or important issue that requires action as soon as possible, without which a process may result in an unproductive or ineffective outcome.

Minor Non-Conformity: An issue, the resolution of which would improve overall effectiveness/efficiencies of the process.

All the Major Non-Conformities must be rectified with a corrective action plan. Minor non-conformities can be verified for the root cause and rectified.

Corrective Action: Corrective actions are steps that are taken to eliminate the causes of existing nonconformities in order to prevent recurrence

Corrective Action Plan: A corrective action plan is a step-by-step schedule for addressing a process gap or area of non-compliance. It should clearly describe the identified non-conformity, determine the root cause, specify the corrective action to be taken, assign responsibility for implementation, and state the expected completion date.

As per the International standards and best practices, a target date for corrective actions to be implemented is set to be within a maximum of 90 days.

The Leadership of the organization should understand, acknowledge and assume the responsibility to monitor the corrective actions and ensure conformance.

After analyzing the reasons for any major or minor observations indicated in the above report, the Facility must, within the data indicated on the report, inform TASNEEF of its proposals for handling the observations, as well as the corrective action required, and the dates envisaged for its implementation.

Any disagreements documented in the corrective action plan are not considered as a corrective action; a proper corrective action is required to be submitted, and thus, does not meet the requirement of effective completion of the audit process.

- A minor non-conformity in the previous audit is identified as Major if the corrective action plan is not implemented.
- The auditing team may decide to perform any audit on-site or desktop/remote.
- The facility can apply for re-audit after 60 days (from the day of audit/result) by submitting the proof of corrective actions

9 WEIGHTS AND SCORING

i. Scoring weights equivalent to the ratio of claims distribution per each setting will be applied, and an overall claims review score is generated. (E.g. Inpatients-DRG, Day-case, Outpatient clinics, Emergency and Home Care).
ii. The final score will be weighted per the facility type, domains and services.
iii. Examples of Domain weightages and Scoring Details can be seen in the tables as shown in Appendix II. The passing scores for claims review, process review of clinical coding, and KPI data validation will be communicated annually from DoH.
iv. The current passing score is 86% as an overall accuracy score.
v. Clinical Coding Process Review is a comprehensive process review covering general, dental and self-pay services that generates an integrated score out of 100.
vi. Claims review scores of General, Dental and Self-Pay are weighted scores per the claims' ratio.

10 DECISION MAKING

TRBA reviews the submitted Formal Audit Report, referring to the collected evidence and issues a final report with Final Audit Score details and acknowledges the corrective action plans. TRBA reserves the right to reject the corrective action plans if supposed to meet the requirements of corrective actions and any disagreements on auditor findings. The facility can request more details to understand the non-conformity and provide the corrective action plan.

The facilities will be graded based on the scores achieved, and the certification validity is based on the grades obtained.

10.1 Passing Grade System for JAWDA Data Certification

Grades and validity based on accuracy scores

Accuracy Score	Grade	Validity
96-100	"A"	18 months
90-95	"B"	12 months
86-89	"C"	9 months
<86	"D"-Failed	Re-Audit

- The passing grade for all facilities is determined based on the Final Score, which represents a comprehensive evaluation including the individual Claims Review, Clinical Coding Process Review for facilities without KPIs and non-scoring KPIs, and KPI Data Validation for facilities where KPIs are applicable.
- The facility should score an overall Accuracy Score of a minimum of 86% in total, as per the weights explained in Table of Appendix-II.
- The validity of certification is based on the grades linked to the scoring achieved.
- There will be a bonus validity for high scores and reduced validity for lower passing scores.

11 RE-AUDITS

The facilities that could not meet the passing criteria will not be published on the Shafafiya Certified Facilities list.

i. Facilities will fall under re-audit if they achieve a total score of less than 86%.
ii. Re-audit will be done only for the problem area, where the score of the individual domain is less than 86%.
iii. If a facility has scored less than 86% in process review and scored more than 86% in claims review and KPI, then re-audit shall be conducted only on Process review after 1 month from the date of the audit result. The gap in listing will be approximately a month.
iv. As the process review is comprehensive, all the major & minor non-conformities will be reviewed during the re-audit, irrespective of general/dental/self-pay.
v. The score of General/Dental/Self-Pay (including Medical Tourism &Proforma claims), any of the claims review is less than 86, a re-audit will be conducted only on those service claims.
vi. If the facility has passed in process review and KPI but scored less than 86% in claims review, then the re-audit shall be conducted only on claims review “after 2 months” from the date of the audit result. The gap in listing will be approximately 2 months.
vii. If a facility has failed in both process and claims review and passed in KPI, a re-audit shall be conducted on both the problem areas “after 2 months” from the audit result date. The gap in listing will be approximately 2 months.
viii. The claims sample will be as per the least tier sample of applicable facility type
ix. Claims Sample is selected from the period after the issue of the final report.
x. Prices for Re-audit are separate for Process review, claims review and KPI and are fixed per facility type.
xi. The facility should ensure the relevant personnel are trained in the recommended areas of improvement.
xii. Revised policies and processes per the standard requirements of clinical coding to proceed for a re-audit.
xiii. Facility can apply for re-audit as per above mentioned timeline by submitting the proof of corrective actions or a letter of request stating readiness for re-audit (in case of re-audit, only for claims review).
xiv. Facility should respond to TASNEEF through e-mail with a definitive action plan to resolve the identified deviations in process, within 5 calendar days after receiving the formal audit report.

xv. In case of a facility failed only in KPI Data validation, a re-audit will be conducted only "after 2 months" from the date of audit results (even though new KPI Data is available) to accommodate and ensure corrective actions are implemented in the new submissions.

xvi. If a facility has multiple KPIs and achieves a total KPI score of less than 86, then the re-audit shall be conducted only for the individual KPI(s) that scored below 86.

xvii. If the facility failed KPI Data Validation and a 5-point score deduction was applied for major process non-conformities in the previous audit, a re-audit shall be conducted on both KPI Data Validation and the identified major process non-conformities.

xviii. If the facility failed due to the 5-score deduction and passed in all applicable domains, then a re-audit shall be conducted in the process that resulted in the 5-score deduction.

xix. If the facility fails in KPI Data validation, the re-audit will be conducted on the new subsequent quarter's data submitted after the issuance of the final audit report.

xx. Listing after passing in Re-Audit will be done after adding the scores of other passed domains, and the grade shall be assigned based on the overall score.

xxi. Facilities that failed in a re-audit shall be subject to a complete audit with all applicable domains in scope.

xxii. If facilities do not undergo the re-audit within six months, they will be required to undergo a complete audit.

Conditional Listing:

i. If new KPI data is not available for the re-audit, conditional listing shall commence two months after the date of the audit results.

ii. If new KPI Data is not available even after two months, then the facility will be provided with 9 months of conditional listing. Once new data is available, a re-audit shall be conducted. A backdated conditional listing will be provided if the facility achieves a passing score; if it fails in re-audit, back-dated de-listing will be done.

iii. There will not be any temporary listing for re-audit other than "Conditional listing" for KPI data validation.

iv. Conditional listing will not be granted if the re-audit is delayed due to reasons attributable to the facility.

v. It will be provided only if new KPI data is not available for the re-audit, in accordance with the contractual agreement. However, once the new KPI data is submitted, if the facility is not ready for the audit for any reason, the conditional listing will be delisted from Shafafiya, as it was granted solely for the unavailability of KPI data purposes.

12 INTERIM AUDIT PROCESS

- Currently Interim Audits are applicable for only 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 number of indicators selected for the interim audit will be the same as selected for the initial audit. However, Indicators for the audit will be differ.
- All audit processes will remain consistent with the same applied during the Initial Audit.
- The Interim Audit shall be scheduled once the required claims and KPI data are available.
- Audit man-days and audit price are applied based on the applicable tier for the Interim Audit.
- Each facility shall be permitted a single opportunity to participate in the Interim Audit.
- The final audit report shall be issued at the earliest possible time upon completion of the Interim Audit.
- Next renewal audit will proceed with the new claims & KPI Data.

Shafafiya Listing for Interim Audit Results

- Upon completion of the Interim Audit, the updated results will be published on Shafafiya.
- If the facility passes the Interim Audit, the score will be updated, and the listing status will remain as per the previous listing. Recertification will be conducted in line with the original expiry date of the Initial Audit listing.
- If the facility does not pass the Interim Audit, it will be completely D-listed from the Shafafiya list.

  The facility will benefit from the Interim Audit results until the expiry of the Initial Audit listing period.

Listing on Shafafiya will be as follows:

Listing Type	DOH License	Facility Name	Audit Date	Previous Listing Valid Till	JDC Effective Date	Expiry Date	Score	Grade
Initial Audit Listing	MF1234	Hospital A	6-Oct-2025	21-Nov-2025	22-Nov-2025	23-Aug-2026	89.86	C
Interim Audit Listing	MF1234	Hospital A	6-Oct-2025	21-Nov-2025	22-Nov-2025	23-Aug-2026	97.00	A

13 LISTING AND DE-LISTING

- The issuing of certifications and recommendations is the sole responsibility of TASNEEF based on facts. TASNEEF will provide the information to DoH to be published in the listing as they see fit.
- Facilities with the Certification Effective Date is date of publication on the Certified Facilities List on https://www.DoH.gov.ae/en/Shafafiya/dictionary
- The Certification Expiry Date is based on the grades obtained.

- This issue of Certification shall be forwarded to DoH, as applicable, and will be within 30-40 working days of receipt of the completed audit by TASNEEF, as applicable per the general terms and conditions of annexure for this methodology. The reflection of the results on the DoH website is subject to the date of upload of updated listings by DoH.
- It is the responsibility of the healthcare facilities and Payers to review the published list to ascertain pertinent information on scores and/or coding certification validity.
- It is also the responsibility of healthcare facilities to apply for renewal certification 2 months before the certification listing expiry.
- If the Audit fails to meet the scoring criteria, after being reviewed by TASNEEF, the re-audit criteria is as per Chapter 11 of this methodology.
- The list of certified facilities will consist of three parts:
- New facilities listing (see TRBA website for New Facility listing guidance and process)
- JAWDA Data Certified Facilities from 2018 to date
- TASNEEF retains the right to revoke certification of a facility based on substantive evidence that the audit of this facility was not representative of actual coding practice. There must be evidence of improper conduct, which may include, but is not limited to:
- Evidence of documentation manipulation
- Evidence of bribery or collusion

13.1 Impact of De-listing (Gap in Listing)

- Facilities shall understand that the gap in the listing resulted from the unsuccessful outcome of JDC audits might have an impact on the reimbursements from the payers or may have an impact on their participation in the Health Insurance scheme, without mentioning the level of impact.
- Any gaps resulting in the listing of the facility due to late applications, missing audit schedules, or any other delays or reasons caused by the facility will not be the responsibility of TRBA.
- Delay in sending the corrective action plans, resulting in a gap in listing, is the sole responsibility of the health care facility.
- Request for early schedules or schedules nearing the existing expiry of listing may not be accomplished or provided due to the unavailability of calendar schedules. Gaps resulting from such delays are the sole responsibility of the health care facility.
- Listing will be granted from the date of the audit for facilities without prior certification listing (including new facilities, re-audits, and those with a listing gap).
- New facilities proceeding for early audit schedules shall be listed as JDC certified from the date of audit, though they have a valid listing for another few months. Such listing of a new facility shall overlap with the JDC certification listing.
- Facilities who have got certification previous year, but unable to proceed with certification due to less claims shall still proceed with certification to maintain continuity of listing provided they have a minimum sample of 30, putting into consideration that the facility may make up for more claims in the later part of the year and shall not incur gap in listing, unless the facility chooses to proceed with the listing gap, such action implies understanding of implications of liabilities resulting from claims process.

14 MAINTAINING VALIDITY OF THE CERTIFICATE

The facility must ensure its System continues to comply with the Methodologies and other applicable reference standards or regulatory documents. The facility must record any complaints/claims and the relative corrective action implemented, and must make these records available, together with the corrective action taken to address the identified deviations.

TASNEEF also reserves the right to conduct additional audits based on the impact of deviations identified in the processes. TASNEEF further reserves the right to conduct and charge for re-audits of facilities that fail the audit.

- May conduct a follow-up audit to confirm that the major deviations identified during the initial audit have been corrected by the facility as per the action plan. The action plan should be sent by the facility to TASNEEF, giving the details of the action for corrections within a week after the initial audit.
- TASNEEF shall conduct a Re-audit on failed facilities as required on Process or Claims review. Re-audit on Clinical Coding Process review is to verify the corrected Processes as per the action plan within a two-month duration after the audit.

If the facility refuses without a justified reason, TASNEEF may decide to suspend/withdraw certification.

14.1 Management of Certificates

1. The validity of the certificate is based on the score achieved by the facility.
2. The validity of the certificate could be subject to the results of the subsequent audits.
3. The validity of the certificate may be suspended, withdrawn or relinquished

15 MODIFICATION OF CERTIFICATION AND COMMUNICATION OF CHANGES

1. The facility must promptly inform TASNEEF of any changes in factors that may affect the capacity of the Management System to continue to satisfy the requirements of JAWDA Data Certification.
2. These requirements concern, for example, modifications to the legal, commercial, facility or ownership status.
3. TASNEEF reserves the right to perform additional audits on the facility if the modifications communicated are considered particularly significant in regard to maintaining the conformity of the Management System with the requirements of the reference standard and of these rules or to review the economic conditions for the possible modification of the contract.
4. TASNEEF promptly informs the facility whenever any changes in the methodology, reference standards or certification rules are published.

16 CONDITIONS AT WHICH THE AUDIT PROCESS WILL STOP

1. When required evidence is not provided on time (within the end of the audit time) as per the schedule for the audited function, it leads to a loss of audit time; consequently audit process will be useless and ineffective
2. When the auditor faces difficulties in getting and collecting the relevant evidence at the time of audit (i.e. collection will be later after the audit), this might lead to improper conclusions of audit findings.

3. When the planned nominated personnel are not available, and the one provided is not competent to provide the required evidence or to demonstrate a responsible attitude, consequently audit process will be useless.
4. Absence of authorized person from the top management who is authorized to facilitate the audit process with the competency and authorization levels that help him to understand, respond, discuss, agree and sign the concluded findings during the whole audit process (i.e. from planning till audit report and certificates submission)
5. Any case that might be classified by the lead auditor as losing the professional objective of the audit process and providing unprofessional services, like:

    i. Unavailable agreed resources with the client, like a proper, adequate and comfortable room space for the auditors, access to review the required medical records or documentation
    ii. Unavailability of required employees for the audit per the agreed plan communicated with the client, especially when no concern is received from the client side after plan communications
    iii. Any interaction from an unrepresented auditee which will not serve the purpose of the audit and may adversely affect the auditor's ability to conclude proper and professional conclusions.
6. If, due to emergencies, TRBA auditors couldn't join the audit as per the planned arrangements client will be informed to set another audit plan.
7. Cases from 1 to 5- Client will be charged for the compensated new planned time to complete the audit process.
8. Case no. 6- TRBA will reschedule audit time compensation before certification expiry date.

17 CONDITIONS AT WHICH THE CERTIFICATION PROCESS MAY BE SUSPENDED

1. In cases when the audited facility cannot provide evidence before the completion of the audit time.
2. In cases when TRBA will reject the facility's proposed corrective actions not result in an effective solution for identified non-conformities.
3. In case of not sending the corrective actions plan within the 5 Calendar days of sending the formal report.
4. The audit will be immediately terminated and reported to DOH for further action if the auditee attempts to coerce, bribe, or influence the auditors to engage in or disregard any form of malpractice.

18 SUSPENSION, REINSTATEMENT AND WITHDRAWAL OF CERTIFICATION

The validity of the certificate of conformity may be suspended as indicated in "GENERAL TERMS AND CONDITIONS" and in the following specific cases:

- if the Facility refuses to allow the scheduled audits to be performed at the required frequencies;
- if observations are found in the management system which have not been corrected within the time limits established by TASNEEF
- if the facility does not observe the deadlines established for the communication of corrective actions, the following observations/observations indicated on the audit report;
- for evidence that the facility does not guarantee the respect of the laws and regulations applicable to the supplied services or activity
- if any justified and serious claims received by TASNEEF are confirmed.

The facility may also make a justified request to suspend certification, normally for not more than six months and in no case after the date of expiry of the certificate.

This suspension will be notified in writing, stating the conditions for reinstating certification and the date by which the new conditions are to be complied with.

Revocation of the certificate of conformity may be decided in the following specific cases:

- if the facility does not accept the economic conditions established by TASNEEF due to a modification in the contract tariff, approved with DoH
- for every other major reason, at TASNEEF 's discretion, such as the proven incapacity of the system to pursue its objectives of complying with legislative, contractual requirements.

Withdrawal of the Certificate of Conformity is notified in writing to the Facility and made public on DoH website

Any facility which, following revocation of its Certificate, wishes to be re-certified must submit a new application and follow the entire procedure all over again.

19 RENUNCIATION OF CERTIFICATION

A certified facility may send formal communication of renunciation of certification to TASNEEF in case of business termination before the expiry of the certificate.

Upon receipt of this communication, TASNEEF starts the procedure for invalidating the Certificate. Within one month of the date of the communication, TASNEEF updates the validity status of the certificate.

20 NEW FACILITY LISTING AND EXTENSION OF LISTING

New Facilities Listing:

a. Any new facility, including Dental Centers and Self-Pay, must apply for “New Facility Listing” within 6 months of obtaining their DOH license.
b. Facilities which have been operating for over 6 months after obtaining DOH license should present a letter of explanation for the delay in the request.
c. Every request for New Facility Listing should be accompanied by the following documents:
    i. A copy of the valid DOH facility license
    ii. The Facility’s CODING Process Flow Chart or policy
    iii. A letter stating all the above, as well as a summary description of the coding process flow in this facility
    iv. Proof of Coder (internal or outsourced, as applicable) current certification and/or experience (proof that the certification is current and valid)
    v. Proof of current Continuing Education of the coder. If applicable, a copy of the coding outsourcing service contract with companies.
d. Once the documents are reviewed and if these meet the criteria as specified in this Methodology, the facility will be listed in Shafafiya with a validity of 6 months.
e. All Listed New Facilities should be able to proceed with JAWDA Data Certification process once the facility has submitted a minimum of 120 claims in the total scope. For Hospitals, the facility shall apply for an audit after submitting a minimum of 120 claims for each setting or completing six months of claim submission,

irrespective of the number of claims count per settings, whichever is earlier. If by the date of expiry of the initial listing, the facility does not have a sufficient number of claims, it can apply for extension as described below.

f. If a facility is not new and submitted some claims previously or years ago, the facility should provide a reason why the facility could not maintain the certification continuously or the reason for the gap years.
g. The reason will be reviewed by DoH and/or TASNEEF, and a final decision on listing under exemption will be given.
h. A new or extension of listing will not be provided if the facility has already served patients but has not submitted the claims.

Extension of New Facility listing

a. After 6 months of new listing, if the facility is unable to start the claiming process or cannot meet the criteria of 120 claims for each facility setting to proceed for certification, an extension request should be sent to TRBA executives assigned to your facility.
b. The facility should provide a justification letter for the request for extension in the listing.
c. The justification will be reviewed by TASNEEF, and after confirmation from DOH that there are insufficient claims, the extension will be issued in the list of Certified – New Facilities list.
d. The duration of the extension period may vary from 3- 6 months based on the submitted claims count. New facilities proceeding for early audit schedules shall be listed as JDC certified from the date of audit, regardless of the remaining months of the current listing. Such listing of a new facility or extension of listing shall overlap with the JDC certification listing.
e. Not more than 2 extensions of 6 months' validity will be provided. The facility should be audited prior to the expiry of the extension listing if the facility claims submission count meets the required sample, and need not necessarily meet 120 claims.
f. Any case where the facility has not initiated any claims submission should submit the supporting documentation as justification for the request for further extension as a special case.
g. Facilities may apply for an extension if they are unable to undergo the renewal audit due to insufficient claims (e.g., temporary closure).
h. An extension of the listing will not be granted if the facility opts out of the audit for reasons such as temporary closure or other similar circumstances, even if sufficient claims are available for the audit.

21 COMPLAINTS / APPEAL MANAGEMENT

Appeal process:

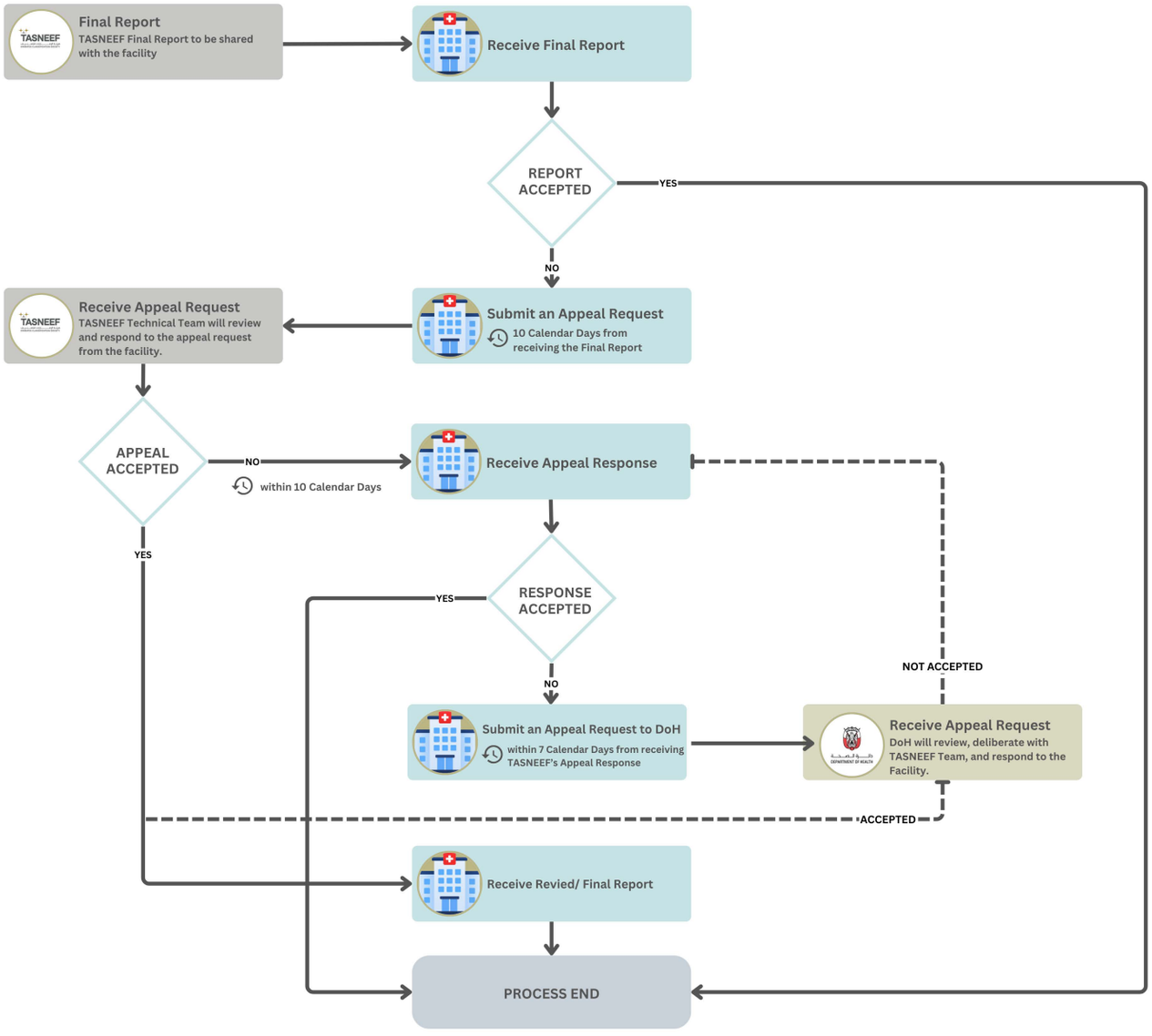
1. All the evaluations shall be done as per the methodology criteria and normative references.
2. If the facility is requesting further analysis on JDC evaluations and committee decision, even after final report results and response, an appeal request can be sent to TASNEEF at **ba.jdc@tasneef.ae**
3. The appeal request shall include the facility license, region, head of the facility details and the Audit representative details, along with the details of audit concerns with supporting documents and references.
   a. Appeals should be submitted within **10 calendar days** from the date of receipt of the final report and must include all details of the disagreements previously raised during the formal report acknowledgement that were not accepted by TASNEEF, along with the relevant supporting documentation and applicable reference guidelines.

New evidence or information that was not available to TASNEEF at the time of the audit/report review cannot be accepted as part of the appeal

b. Any new disagreements or concerns which were not raised during the formal report stage cannot be accepted for review during the appeal stage.
c. An opinion or personal interpretation or internal practice of an entity that is not supported by any standards (DoH standards take priority) cannot be the basis for considering arbitration, and the request cannot be processed further, and no additional appeals can be made or forwarded to DoH.
d. TASNEEF will respond to the facility **within 10 calendar** days of receiving the facility's appeal. If any finding is agreed upon for revision, TASNEEF will issue an updated final report, including the revised scoring and grade, where applicable.

4. Concerns or aspects pending the DoH decision will follow the evaluation and conclusion of TASNEEF till the matter is addressed and decided.
5. No appeals can be raised, overriding the methodology criteria and guidelines.
6. To ensure the efficiency of the appeal process and maintain the position of the certification body, every appeal request will be evaluated to verify the eligibility criteria to accept or deny the appeal request. If not meeting the criteria, the appeal will not be processed.
7. Where the facility remains dissatisfied following TASNEEF's appeal response, it may request clarification or regulatory review from DoH at **jawda@doh.gov.ae** for their clarification **within 7 calendar days** from the TASNEEF response.
8. Pursuant to standard protocols, any escalation of an appeal to the DOH must be preceded by the TASNEEF appeal process.
9. DOH will respond to the facility **within 10 days** of receiving the facility's appeal to DOH. If any finding is agreed upon for revision, TASNEEF will issue an updated final report, including the revised scoring and grade, where applicable based on the agreed findings by DOH.
10. The facility will receive a response from DOH based on their review of the submitted concerns and supporting information/documentation.
11. The evaluation and certification outcomes issued by TASNEEF shall remain effective until the Department of Health (DoH) issues a final determination.
12. The submission of an appeal does not suspend, alter, or invalidate the active certification results unless an official revision is issued through the formal appeal process.

Appeal Process Flow



APPENDIX

Appendix-I – The Tier System

Appendix-II- Scoring Weights & Examples

Appendix-III- Scoring Tables

APPENDIX-I

The Tier System

The Tier System

The Tier system is classified based on the annual volume of claims submissions. Tiers are classified by facility types as Tier H for Hospitals, Tier M for Centers/ Clinics, Tier D for exclusive Dental Centers (Services), Tier HC for Home Health Care Centers, Tier RH for Rehabilitation Hospitals (Long Term Care Centers) and Tier SP for exclusive Self-Pay services.

Table 1

	Tier	Billing Volume/Year	Claim Sample
Medical Centers	Tier 6-M	>=150,001	95
	Tier 5-M	100,001 to 150,000	75
	Tier 4-M	50,001 to 100,000	60
	Tier 3-M	25,001 to 50,000	41
	Tier 2-M	10,001 to 25,000	30
	Tier 1-M	<=10,000	24

Table 2

	Tier	Billing Volume/Year	Claim Sample
Home Health care	Tier 3-HC	>= 26,001	30
	Tier 2-HC	15,001 to 26,000	25
	Tier 1-HC	<=15,000	20

Table 3

	Tier	Billing Volume/Year	Claim Sample
Hospitals	Tier 6-H	>=700,001	221
	Tier 5-H	400,001 to 700,000	185
	Tier 4-H	200,001 to 400,000	140
	Tier 3-H	100,001 to 200,000	102
	Tier 2-H	50,001 to 100,000	70
	Tier 1-H	<=50,000	60

Table 4

	Tier	Billing Volume/Year	Claim Sample
Rehabilitation Hospitals	Tier 4-RH	>=50,001	35
	Tier 3-RH	25,001 to 50,000	30
	Tier 2-RH	10,001 to 25,000	25
	Tier 1-RH	<=10,000	20

Table 5

	Tier	**Billing Volume/Year**	**Claim Sample**
Dental	Tier 4-D	>=50,001	30
	Tier 3-D	30,001 to 50,000	26
	Tier 2-D	15,001 to 30,000	23
	Tier 1-D	<=15,000	20

Table 6

	Tier	**Billing Volume/Year**	**Claim Sample**
Self-Pay	Tier 4-SP	>=5,001	20
	Tier 3-SP	1,001 to 5,000	18
	Tier 2-SP	201 to 1,000	15
	Tier 1-SP	1 to 200	10
	Tier SP	No Submission- <1	10

Self-Pay Hospital - Table 7

	Tier	Billing Volume/Year	Claim Sample
SP-HOSPITAL	Tier 2-HSP	>= 20,001	60
	Tier 1-HSP	<=20,000	40

Self-Pay Home Health Care - Table 8

	Tier	Billing Volume/Year	Claim Sample
SP-HHC	Tier 2-HCSP	>= 10,001	20
	Tier 1-HCSP	<=10,000	10

APPENDIX-II

Scoring Weights & Examples

Scoring Weights and Examples

The Final JAWDA Data Certification Score will be a comprehensive score obtained as per the assigned scoring weights for each domain - Claims Review Score, Clinical Coding Process Review Score, and KPI Data Validation score.

The Summary of scoring weights per the facility type is as shown below:

Table 1- Summary of scoring weights – Facilities with KPI applicable

Facilities with KPI applicable	
Scope	**Weight**
Claims Review Score	40
Clinical Coding Process Review Score	10
KPI Data Validation Score	50

Facilities with KPI applicable								
Domain	Domain details	Claim Count (24+10)	Claim distribution ratio	Score-Each Setting	Score as per claim ratio	Domain weights	4.2.3 Claims Review Audit Verification Points	Final Score
Claims Review Each Setting 100	Home Health Care - 100	16	49%	95	46.55			
	Out Patient - 100	8	23%	93	21.39			
	Self-Pay (Routine) - 100	7	20%	95	19.00			
	Self-Pay (Medical Tourism)- 100	3	9%	93	8.37			
					94.37		0	
Claims Review Score - 100					94.37	40%		37.75
Clinical Coding Process Review (General+Self-pay)	Process flow Map / effectiveness - 15				15.00			
	Clinical Coding/Documentation Polices & Practices - 40				38.00			
	Coder Credentials - 05				5.00			
	Orientation/Training - 10				10.00			
	Policies Adherence - 30				25.00			
Clinical Coding Process Review Score - 100					93.00	10%		9.30
KPI Data Validation Score - 100					92.00	50%		46.00
FINAL JAWDA DATA CERTIFICATION SCORE								93.05

Table 2- Summary of scoring weights – Facilities without KPI

Facilities with No KPI applicable	
Scope	**Weight**
Claims Review Score	80
Clinical Coding Process Review Score	20

Facilities with No KPI applicable								
Domain	Domain details	Claim Count (24+10)	Claim distribution ratio	Score-Each Setting	Score as per claim ratio	Domain weights	4.2.3 Claims Review Audit Verification Points	Final Score
Claims Review Each Setting 100	Home Health Care - 100	16	49%	95	46.55			
	Out Patient - 100	8	23%	93	21.39			
	Self-Pay (Routine) - 100	7	20%	95	19.00			
	Self-Pay (Medical Tourism)- 100	3	9%	93	8.37			
					94.37		0	
Claims Review Score - 100					94.37	80%		75.50
Clinical Coding Process Review (General+Self-pay)	Process flow Map / effectiveness - 15				15.00			
	Clinical Coding/Documentation Polices & Practices - 40				38.00			
	Coder Credentials - 05				5.00			
	Orientation/Training - 10				10.00			
	Policies Adherence - 30				25.00			
Clinical Coding Process Review Score - 100					93.00	20%		18.60
FINAL JAWDA DATA CERTIFICATION SCORE								94.10

Table 3- Summary of scoring weights – Facilities with KPI applicable but KPI Data not submitted

Facilities with KPI applicable but KPI Data not submitted	
Scope	**Weight**
Claims Review Score	40
Clinical Coding Process Review Score	10
KPI Data Validation Score	0

Facilities with KPI applicable but KPI Data not submitted								
Domain	Domain details	Claim Count (24+10)	Claim distribution ratio	Score-Each Setting	Score as per claim ratio	Domain weights	4.2.3 Claims Review Audit Verification Points	Final Score
Claims Review Each Setting 100	Home Health Care - 100	16	49%	95	46.55			
	Out Patient - 100	8	23%	93	21.39			
	Self-Pay (Routine) - 100	7	20%	95	19.00			
	Self-Pay (Medical Tourism)- 100	3	9%	93	8.37			
					94.37		0	
Claims Review Score - 100					**94.37**	**40%**		**37.75**
Clinical Coding Process Review (General+Self-pay)	Process flow Map / effectiveness - 15				15.00			
	Clinical Coding/Documentation Polices & Practices - 40				38.00			
	Coder Credentials - 05				5.00			
	Orientation/Training - 10				10.00			
	Policies Adherence - 30				25.00			
Clinical Coding Process Review Score - 100					**93.00**	**10%**		**9.30**
KPI Data Validation Score - 100					0	50%		0
FINAL JAWDA DATA CERTIFICATION SCORE								47.05

APPENDIX-III

Scoring Tables

Tables of Error Scoring for Claims Review

Table 1: Error Scoring: Inpatient /Long Term Care (LTC) – Accuracy

ERROR SCORING TABLE FOR INPATIENT / LTC - ACCURACY ERRORS			
Category-Score		**Accuracy Error**	**Example and Explanation**
1. Major Encounter type error-10 - BILLING RELATED			
Major	10	Claim uploaded to the wrong Encounter Type.	Claimed codes are uploaded to the incorrect encounter type.
2. Major – Billing Related			
Major	100	Missing the Patient Signature or Patient details	Any required document that was missing the patient's signature
		Mismatching the billed physician and service performer	Any mismatch between the billed physicians and the actual service performer.
		No Medical Record	Missing a complete Medical Record for the audit sample
Major	20	Incorrect Diagnosis-Related Groups (DRGs)	Facility billed High/Low DRG OR Incorrect DRG reported
		Missing required forms	Missing Consent form for the relevant treatment Missing LAMA form signed by the patient or relative
		Incorrect Consumable details	If any details of used consumables—such as dates, signatures of ordering versus using physicians, or other The relevant information is incorrect.
3. Moderate Billing Error Categories - 10			

Moderate	10	Claim with incorrect Encounter Start or End Type.	Claimed codes are with incorrect encounter start or end type.
Moderate	10	Other Billing Errors	Claim submitted with incorrect Quantities (Less or More) of any code; Physician authentication is missing from the relevant documentation
4. Minor Billing Related - 05			
Minor	5	Other miscellaneous errors.	Claim submitted with any incorrect date CPT 36415 was billed without performing within the facility or CPT 36415 Venipuncture is not eligible to report as per guidelines
Minor	5	Missing Demographic details	The Medical Tourism claim is missing Payment or patient details in demographics.
5. Moderate Per-Diem code error- 05			
Moderate	5	Missing/ Incorrect - Per-Diem codes or service codes	Missed to bill appropriate Per-Diem codes/service codes OR Billed Per-Diem codes/service codes are incorrect for the service provided
		Per-Diem codes or service codes added without documentation	Billed Per-Diem codes/service codes added without supportive documentation; (17-23 added without recovery room service)
E&M AND PROCEDURE ACCURACY ERROR – CODING RELATED			
6. Major Procedure Error - 20			
Major	20	Surgical procedure coded without documentation.	"31623 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings" is coded when there is no

			documentation to substantiate brushing. Also, coding an add-on code without a relevant primary procedure code.
Major	20	Incorrect surgical procedure code.	The claimed code does not match what is documented “EGD diagnostic procedure done without specimen collection but coded EGD with biopsy”.
Major	20	Missed the code surgical procedure code.	Surgical (Minor or Major) Procedure is not coded when it is performed.
7. Major Evaluation and Management Error-15			
Major	15	E & M code missing, high or in the wrong category; or coded without documentation or coded with insufficient documentation	• Missed to code E&M code or E & M code does not meet the documentation criteria. • Inpatient E & M codes are mandatory on all records, assigned according to guidelines and rules, as of 1st January 2014. If they are missing, in the wrong category, or are higher than warranted by documentation, it shall be scored as an error (Please, see LTC below for clarity) • If LTC or a subtype must be claimed according to the LTC Standard and use the applicable service codes. There is an error if an additional Inpatient E & M is assigned – (LTC and subtypes must be claimed through the inpatient encounter type.) • If Rehab (or LTC) is claimed by DRG as an inpatient stay, then the scoring rules for Inpatient apply.

8. Moderate Procedure Error-10			
Moderate	10	Non-surgical procedure/medicine codes are coded without documentation, / Incorrect CPT code.	Ex: Non-surgical procedure/services like radiology, immunization, injection, IV, respiratory services, ECG, etc., are coded without documentation / Coded wrong CPT.
Moderate	10	Missed / Incorrect Cosmetic Procedure OR Coded Cosmetic Procedure without documentation	Missed coding the performed Cosmetic procedure OR The Coded Cosmetic procedure does not meet the documentation requirements OR Cosmetic procedure coded without supporting documentation.
Moderate	10	Missed / Incorrect Modifier usage	If a modifier is missed or used incorrectly, it will come under this error category
Moderate	10	Missing non-surgical procedure codes	Non-surgical procedure/service codes like IM, IV, CTG, ECG, Anaesthesia codes, etc., are not coded when they are documented.
9. Minor Procedure Error-5			
Minor	05	Procedures do not have corresponding diagnosis code documentation;	Turbinectomy Procedure performed, but there is no corresponding documentation and diagnosis to support the procedure performed.
Minor	05	Unbundling of CPT codes.	Any CPT code that is bundled into another procedure should not be billed together.

DIAGNOSIS ACCURACY ERROR – CODING RELATED			
10. Major Diagnosis Error-20			
Major	20	Diagnosis coded without documentation or coding sign & symptom INSTEAD of the diagnosis. OR Coded Final Impression or diagnosis has no supporting visit notes justification as per DoH JDC Methodology 4.2.1(iv)	Code is given without any supporting documentation OR Coded sign or symptom, and not the documented diagnosis, such as a PDx- R30.0 Dysuria coded when documentation shows a PDx- N39.0: Urinary tract infection NOS. OR The code is not as per the documentation.
Major	20	Incorrect selection of principal diagnosis.	The “Incorrect selection of Principal Dx.” - refers to a sequencing issue, not a documentation issue. Both codes must be present, and the wrong one is selected as the principal diagnosis, but the correct code must be listed.
Major	20	Missing relevant principal diagnosis.	The claim is not coded with the principal diagnosis of the actual reason for patient admission.
Major	20	The claimed code does not match the documentation, / Incorrect diagnosis codes.	Coded diagnosis is not accurate based on the available documentation. Ex: Documented as GBS +ve and coded as O98.81X without current infection affecting the pregnancy. If the codes assigned are not within the correct Category, then it would be a Major Error of “Claimed code doesn't match/Incorrect diagnosis code". [Ex: Documented as Acute appendicitis (K35.80) but coded as Chronic appendicitis (K36)]

11. Moderate diagnosis error-10			
Moderate	10	Missing a relevant secondary diagnosis specific to this encounter or specific to the performed procedure.	Missing required and/or pertinent secondary diagnosis which is relevant to this encounter, including Chapter 21 codes. (i.e. 'history of' codes, BMI, Smoking, place of occurrence, activity etc.,)– Examples: Patient has coronary artery disease and a history of CABG not coded; Or Patient morbidly obese and the BMI is not coded. If the manifestation code is assigned without an underlying condition, or if relevant Chapter 21 codes are not assigned. And, all complications and comorbidities (CC) or Major Complications and Comorbidities (MCC).
Moderate	10	Error of specificity in the diagnosis code.	The "Error of specificity in diagnosis code" refers to coding within the correct Category or Subcategory, but not coding to the specificity available in the documentation. (Ex: Acute Bronchitis due to RSV coded as Acute Bronchitis unspecified-J20.9 instead of J20.5);
Moderate	10	Procedure orders do not have a corresponding diagnosis code.	Order for ECG; however, there is no diagnosis documentation to justify the reason for the order.
12. Minor Diagnosis Error - 05			
Minor	05	Coding Signs & Symptoms/condition is integral to Diagnosis additionally.	Coding additionally (not instead of) Signs & Symptoms that are associated routinely with a disease process, unless otherwise instructed by the classification - Ex: "K27.7 Chronic peptic ulcer of unspecified site without mention of hemorrhage or perforation, with obstruction" is the Principal diagnosis, and a secondary symptom code is added "R10.13 Dyspepsia. OR

			Documented as osteoarthritis in the knee and coded both ICD's M17.9 & M19.90. Against coding guidelines.

DOCUMENTATION ACCURACY ERROR – DOCUMENTATION RELATED			
13. Moderate Documentation Error-10			
Moderate	10	Missing Narrative Diagnoses	Missed narrating the complete diagnoses in the clinical final impression by the physician.

Table 2: Error Scoring: Inpatient/LTC – Completeness

SCORING TABLE FOR INPATIENT/LTC – COMPLETENESS ERROR			
Category-Score		**Completeness Error**	**Example and Explanation**
DIAGNOSIS AND PROCEDURE ERRORS			
1. Major Diagnosis Error-15			
Major	15	Does not code “Possible, Probable etc.”	Coding Guidelines specify that in an Inpatient setting, the documentation of “possible’’, ‘’probable’’, “?”, etc. are to be coded.
2. Moderate Diagnosis Error -10			
Moderate	10	Missing additional diagnosis.	Missed assigning additional code, according to coding rules and guidelines and available documentation.
3. Major E&M Error-20			
Major	20	Low E&M Inpatient;	E & M are mandatory to be coded on every claim. If the E & M is lower than the available documentation.
DOCUMENTATION ERRORS			
4. Major Documentation Error-20			
Major	20	Missing documentation or insufficient documentation to code the initial or subsequent day evaluation and Management	No or Insufficient documentation to code the lowest level E/M; example 99221
Major	20	Missing documentation details for Procedures/ Operative reports	Physiotherapy- Details of modalities, site of application of modality, time start and end, authentication etc., Procedures: Aseptic precautions, Technique/approach of procedure, detailed

			procedure notes, closure technique, hemostasis, risks encountered, if any, post-procedural complications, if any. Injection: Site, route, strength, dose, time, initials Operative note: Date of procedure, Physicians, Type of Anesthesia, Pre-op and Post Op Diagnosis, Technique of procedure, detailed procedure note, closure technique, hemostasis, risks encountered if any, post procedural complications if any.
5. Moderate Service Documentation Error-10			
Moderate	10	Radiology/Diagnostic reports have no documentation of indication for test, technique or approach of procedure/views of radiological examination;	Indication for X-ray: Cough Technique or approach: PA view No. of Views: Single Findings: Impression: Pneumonic consolidation

Table 3: Error Scoring: Outpatient/ER/Day case – Accuracy

ERROR SCORING TABLE FOR OP, ER, DAY CASE – ACCURACY ERRORS			
Category - Score		**Accuracy Error**	**Example and Explanation**
1. Major Encounter type error (Billing Related Error)			
Major	10	Claim uploaded to the wrong Encounter Type.	Claimed codes are uploaded to the incorrect encounter type.
Major	100	Missed the Patient Signature or Patient details	Any required document that was missing the patient's signature.
		Mismatching of the billed physician and service performer	Any mismatch between the billed physicians and the actual service performer.
		The claim date is before the service was provided	When claims were submitted before the actual date of the service was provided.
		Missing Medical Record	Missing a complete Medical Record for the audit sample
Major	20	Incorrect Diagnosis-Related Groups (DRGs)	Facility billed the incorrect DRG
		Missing Required Forms	Missing Consent form for the relevant treatment OR Missing LAMA form signed by the patient or relative
		Incorrect Consumable details	If any details of used consumables—such as dates, signatures of ordering versus using physicians, or other relevant information—are incorrect.
2. Moderate Billing Related Error - 10			
Moderate	10	Claim with incorrect Encounter Start or End Type.	Claimed codes are with incorrect encounter start or end type.

Moderate	10	Other Billing Errors	Claim submitted with incorrect Quantities (Less or More) of any code. Physician authentication is missing on the relevant documentation
3. Minor Billing Related Error - 05			
Minor	05	Missing / Incorrect Per-Diem or Service Code;	Missed to bill appropriate Per-Diem codes whenever applicable. OR Billed Per-Diem code is incorrect for the care provided (i.e., Medical or surgical) and hours of stay. OR Coded Per-Diem / Service code codes with no supporting documentation
Minor	05	Other miscellaneous billing errors.	Incorrect Date of service on the claim CPT 36415 billed without performing within the facility; Or CPT 36415 Venipuncture is not eligible to report as per adjudication guidelines Missed reporting CPT 36415 when it was required.
Minor	05	Missing Demographic details	The Medical Tourism claim is missing Payment OR patient details in demographics.
E&M / PROCEDURE ERROR - ACCURACY			
4. Major Evaluation and Management Error-20			
Major	20	E&M code missing, high and/or in the wrong category; or coded without documentation or insufficient documentation;	Missed E&M code (Follow-up E&M) or E & M code does not meet the documentation criteria.

5. Major Procedure Error-20			
Major	20	Surgical/Diagnostic procedure coded without documentation.	"31623 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings" is coded when there is no documentation to substantiate brushing.
Major	20	Incorrect surgical procedure code/Claimed code does not match what is documented	The claimed code does not match what is documented "31622 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed" is on the record and documentation, and 31623 is coded. This can be either first-listed or secondary.
6. Moderate Procedure Error-10			
Moderate	10	Missed assigning the surgical procedure code.	Procedure not coded when it is performed. Eg. Documented as a Simple Repair leg, but missed the code CPT 12001
Moderate	10	E&M code is inclusive in the procedure code, or the procedure is inclusive in E&M.	Encounter only for injection, hence E&M should not be billed separately without physician intervention. Follow coding guidelines for "distinct &/or separate service. Example: A distinct E & M is coded in addition to the initial cast application. Wound dressing inclusive of E/M
Moderate	10	Non-surgical procedure/medicine procedure coded without documentation, / Coded with an incorrect / Missing CPT code.	Ex: Non-surgical procedure/services like radiology, immunization, injection, IV, respiratory services, ECG, etc., are coded without documentation / Coded wrong CPT. Eg. Local anesthesia is billed with general anesthesia/Conscious sedation code; Non-surgical procedure/service codes like IM, IV, CTG, ECG, Anaesthesia codes, etc., are not coded when they are documented.

Moderate	10	Missed / Incorrect Modifier usage	If a modifier is missed or an incorrect modifier is reported
Moderate	10	Missed / Incorrect Cosmetic Procedure OR Coded Cosmetic Procedure without documentation	Missed coding the performed Cosmetic procedure / The Coded Cosmetic procedure is not meeting the documentation requirements OR Cosmetic procedure coded without supporting documentation.
7. Minor Procedure Error - 05			
Minor	05	Unbundling of CPT codes. Minor procedure is integral to the other procedure.	Any CPT code that is bundled into another procedure should not be billed together.
Minor	05	Procedures do not have corresponding diagnosis code documentation.	Turbinectomy Procedure performed, but there is no corresponding documentation and diagnosis to support the procedure performed.
DIAGNOSIS ACCURACY ERROR – CODING RELATED			
8. Major Diagnosis Error-15			
Major	15	Diagnosis coded without documentation or coding signs & symptoms INSTEAD of the diagnosis. OR Coded Final Impression or diagnosis has no supporting visit notes justification as per DoH JDC Methodology 4.2.1(iv)	Diagnosis coded without documentation in the claim OR Documentation does not support the billed code. OR Code is a documented sign or symptom and not the documented diagnosis, such as a PDx- R30.0 Dysuria coded when documentation shows a PDx- N39.0: Urinary tract infection NOS.
Major	15	The claimed code does not match the documentation / Incorrect diagnosis codes.	The code which is on the Claim does not match what is documented and/or coded.

Major	15	Coding Possible, Probable, suggestive, likely or questionable diagnosis.	Coding Guidelines specify that in an Outpatient setting, the documentation of "possible'', ''probable'', "?" etc. are not to be coded.
9. Moderate Diagnosis Error-10			
Moderate	10	Missing relevant primary or secondary diagnosis specific to this encounter.	Missing required and/or pertinent secondary diagnosis which is relevant to this encounter, including Chapter 21 codes. (i.e., 'history of' codes, BMI, Smoking, place of occurrence, activity etc.,)– Examples are; Patient has coronary artery disease and a history of CABG not coded, Or Patient morbidly obese and BMI are not coded. Also, if the manifestation code is assigned without an underlying condition. Or the relevant Chapter 21 codes are not assigned.
Moderate	10	Coded condition is integral in another condition or Code (specific or non-specific, or other)	Documented as osteoarthritis in the knee and coded both ICD's M17.9 & M19.90. Against coding guidelines.
Moderate	10	Error of specificity in the diagnosis code.	The "Error of specificity in diagnosis code" refers to coding within the correct Category or Subcategory, but not coding to the specificity available in the documentation. (Ex: Acute Bronchitis due to RSV coded as Acute Bronchitis unspecified-J20.9 instead of J20.5); If the codes assigned are not within the correct Category, then it would be a Major Error of "Claimed code doesn't match/Incorrect diagnosis code". [Ex: Documented as Acute appendicitis (K35.80) but coded as Chronic appendicitis (K36)]
Moderate	10	Procedures or Prescription orders do not have a corresponding diagnosis code/Diagnosis Documentation	Principal diagnosis – J45.909 Unspecified Asthma Principal procedure - 36660 Catheterization, umbilical artery, newborn, for diagnosis/therapy.

Moderate	10	The primary or Principal diagnosis coded is not relevant to the chief complaint or doesn't have any relationship with the chief complaint.	Ex: Patient came with epigastric pain, but the primary diagnosis was coded as osteoarthritis of the knee. This is not to be confused with a sequencing error. In this case, there will not be any final diagnosis related to the chief complaint in secondary, tertiary or other positions. Ex: Chief complaint: Cough, joint tenderness documented in PE, Final diagnosis is osteoarthritis
10. Minor Diagnosis Error - 05			
Minor	05	Incorrect sequencing of diagnosis.	This is strictly a sequencing issue, not a documentation issue. Both/all codes are present; however, the wrong code is selected as the principal diagnosis. If another code (incorrect) is listed, then it would be a Major Error of “Diagnosis coded without documentation”.
Minor	05	Coding Signs & Symptoms to support for Prescriptions and labs, or Coding Signs & Symptoms integral to Diagnosis additionally	Coding additionally (not instead of) Signs & Symptoms that are associated routinely with a disease process, unless otherwise instructed by the classification - Example: “K27.7 Chronic peptic ulcer of unspecified site without mention of hemorrhage or perforation, with obstruction” is the Principal diagnosis and a secondary symptom code is added “R10.13 Dyspepsia.
DOCUMENTATION ACCURACY ERROR – DOCUMENTATION RELATED			
11. Moderate Documentation Error-10			
Moderate	10	Missing Narrative Diagnoses	Missed narrating the complete diagnoses in the clinical final impression by the physician.

Table 4: Error Scoring: Coding Error List Outpatient/ER/Day Case – Completeness

SCORING TABLE FOR OP, ER, DAY CASE – COMPLETENESS ERRORS			
Category-Score		**Completeness Error**	**Example and Explanation**
DIAGNOSIS AND PROCEDURE ERRORS			
1. Major Diagnosis Error - 10			
Major	10	Missing additional diagnoses code(s);	Missed assigning additional code, according to coding rules and guidelines and available documentation.
CLINICAL DOCUMENTATION ERRORS			
3. Major Documentation Errors - 15			
Major	15	Missing documentation details for Procedures	Physiotherapy- Details of modalities, site of application of modality, time start and end, authentication etc., Procedures: Aseptic precautions, Technique/approach of procedure, detailed procedure notes, closure technique, hemostasis, risks encountered, if any, post-procedural complications if any. Injection: Site, route, strength, dose, start/end times, initials Operative note: Date of procedure, Physicians, Type of Anesthesia, Pre-op and Post Op Diagnosis, Technique of procedure, detailed procedure note, closure technique, hemostasis, risks encountered if any, post procedural complications if any.
4. Moderate Documentation Errors - 10			

Moderate	10	Systems Review and Physical Examination is contrary to documented and coded conditions.	Diagnosed with Acute Tonsillitis, ENT examination shows normal;
Moderate	10	Relevant system examination is missing in the document.	Dermatitis as Final Diagnosis, examination of Skin/Integumentary system is completely missing.
Moderate	10	Extensive template documentation of physical examination and review of systems. Not updated as per the relevance to the visit conditions.	Documentation of 12 systems for dermatitis
Moderate	10	Radiology/Diagnostic reports have no documentation of indication for test, technique or approach of procedure/views of radiological examination	Indication for X-ray: Cough Technique or approach: PA view No. of Views: Single Findings: Impression: Pneumonic consolidation

Table 5 Error Scoring: Home Health Care – Accuracy

SCORING TABLE FOR HOME CARE – ACCURACY ERRORS			
Category-Score		**Accuracy Error**	**Example and Explanation**
1. Major Encounter Type -10 (Billing Related)			
Major	10	Claim uploaded to the wrong Encounter Type	Claimed codes are uploaded to the incorrect encounter type
Major	100	Missed the Patient Signature or Patient details	Any required document that was missing the patient's signature.
		Mismatching of the billed physician and service performer	Any mismatch between the billed physicians and the actual service performer.
		The claim date is before the service was provided	When claims were submitted before the actual date of the service was provided.
		No Medical Record	Missing a complete Medical Record for the audit sample
Major	20	Missing Required Forms	Missing Consent form for the relevant treatment OR Missing LAMA form signed by the patient or relative
	20	Incorrect/Missing Per-Diem code	The billed Per-Diem code is incorrect for the care provided OR The Per-Diem code is missing
2. Moderate Billing Related Error - 10			
Moderate	10	Claim with incorrect Encounter Start or End Type.	Claimed codes are with incorrect encounter start or end type.
Moderate	10	Other Billing Errors	Claim submitted with incorrect Quantities (Less or More) of any code. Physician authentication is missing on the relevant documentation

2. Minor Billing Related Error - 5			
Minor	05	Other miscellaneous billing errors.	Claim submitted with any incorrect date
Minor	05	Missing Demographic details	The Medical Tourism claim is missing Payment OR patient details in demographics.
PROCEDURES ACCURACY ERRORS			
2. Major Procedure Error - 20			
Major	20	Procedure coded without documentation	"99507 Home visit for care and maintenance of catheter" is coded when there is no documentation to substantiate PEG tube care. "98960 Education & Training for Patient self-management" is coded when there is no documentation to substantiate timing.
3. Major Home Care Evaluation & Management Error - 15			
Major	15	E&M level high and/or in wrong category	E & M code does not meet the documentation criteria.
4. Moderate Procedure Error for Physiotherapy Evaluation-10			
Moderate	10	Physiotherapy evaluation/services coded without documentation	"97002 Physical therapy re-evaluation" is coded when there is no documentation to substantiate Physiotherapy assessment" "97110 coded without documentation" Missing Start & End time for physiotherapy services
5. Moderate Procedure Error -10			

Moderate	10	Incorrect procedure code	The claimed code does not match what is documented. "Documented as Subcutaneous insulin injection but coded for IM injection 99506 procedure code" etc.,
Moderate	10	Missing non-surgical procedure codes	Non-surgical procedure/service codes like IM, IV, CTG, ECG, Anaesthesia codes, etc., are not coded when they are documented.
6. Minor Procedure Error -05			
Minor	5	Unbundling of CPT codes.	Any CPT code that is bundled into another procedure should not be billed together.
DIAGNOSIS ACCURACY ERRORS			
7. Major Diagnosis Error - 15			
Major	15	Diagnosis coded without documentation. OR Coded Final Impression or diagnosis has no supporting visit notes justification as per DoH JDC Methodology 4.2.1(iv)	Coded diagnosis is not per the documentation. Coded diagnosis is not per the documentation.
Major	15	The claimed code does not match the documentation.	The code which is on the Claim does not match what is documented and/or coded.
Major	15	Coding Possible, Probable or questionable diagnosis (see Coding Guidelines) Coding Possible, Probable or questionable diagnosis (see Coding Guidelines)	Coding Guidelines specify that in the outpatient setting, the documentation of "possible'', ''probable'', "?", etc. are not to be coded.
8. Moderate Diagnosis Error-10			

Moderate	10	Coding Signs & Symptoms integral to Diagnosis, additionally OR Coded condition is integral to another condition.	Coding additionally (not instead of) Signs & Symptoms that are associated routinely with a disease process, unless otherwise instructed by the classification - Example: "K27.7 Chronic peptic ulcer of unspecified site without mention of haemorrhage or perforation, with obstruction" is the Principal diagnosis, and a secondary symptom code is added "R10.13 Dyspepsia Diagnosis Hemiplegia is integral to condition hemiplegia due to CVA. Diagnosis unspecific Hyperlipidemia is integral to mixed hyperlipidemia.
Moderate	10	Error of specificity in the diagnosis code	The "Error of specificity in diagnosis code" refers to coding within the correct Category or Subcategory, but not coding to the specificity available in the documentation. If the codes assigned are not within the correct Category/Sub category, then it would be a Major Error of "Diagnosis coded without documentation". The example would be the documentation showing the site as the toe, and the code assigned is the foot when greater specificity is available.
Moderate	10	Missing a relevant diagnosis specific to this encounter	Missing required and/or pertinent secondary diagnosis which is relevant to this encounter, including Chapter 21 codes. (i.e., 'history of' codes, BMI, Smoking, place of occurrence, activity,)– Examples are: Patient has coronary artery disease and a history of CABG not coded, or Patient is morbidly obese, and BMI are not coded. Also, if the manifestation code is assigned without an underlying condition. Or the relevant Chapter 21 codes are not assigned.

9. Minor Diagnosis Error-5			
Minor	05	Incorrect Selection of Primary Diagnosis	Ensure that the diagnosis is the one most related to the patient's current plan of care, is the chief reason home care is needed, and is the most acute condition requiring the most intensive skilled services (if more than one diagnosis is treated concurrently).
Minor	05	Acute conditions are not codable; Resolved and/or History conditions are not codable	An acute diagnosis currently not on medication cannot be coded in a home care set-up. Resolved diagnosis cannot be coded in the home care set-up. Ex-Cannot code the history of CVA when the patient is still having hemiplegia due to the late effect of CVA. Documented as laryngeal carcinoma, status post laryngectomy, hence cannot code the diagnosis malignant neoplasm of larynx.
Minor	05	Incorrect sequencing of diagnosis	This is strictly a sequencing issue, not a documentation issue. Both/all codes are present; however, the wrong code is selected as the principal diagnosis. If another code (incorrect) is listed, then it would be a Major Error of "Diagnosis coded without documentation".
DOCUMENTATION ACCURACY ERROR – DOCUMENTATION RELATED			
10. Moderate Documentation Error-10			
Moderate	10	Missing Narrative Diagnoses	Missed narrating the complete diagnoses in the clinical final impression by the physician.

Table 6: Error Scoring: Home Health Care – Completeness

SCORING TABLE FOR HOME CARE – COMPLETENESS ERRORS			
Category-Score		**Completeness Error**	**Example and Explanation**
1. Major Procedure Error - 20			
Major	20	Missing Procedure Codes	Documentation shows that a procedure is performed, and the code is not assigned.
2. Major E&M Error - 10			
Major	10	Coding Low E & M / Missing E & M	Missed coding E&M when the evaluation is performed
3. Moderate Procedure Home Physiotherapy - 10			
Moderate	10	Physiotherapy was coded with insufficient documentation.	Insufficient documentation may be: Missing detailed documentation of each physiotherapy modality.
4. Moderate Procedure Home Nurse visits - 10			
Moderate	10	Nursing procedure coded from insufficient documentation.	Insufficient documentation found for the claim code may be: Missing detailed documentation of each Home visit service. Missing detailed documentation of the pattern of care (Nursing duration, etc..)
5. Minor Physiotherapy Evaluation - 5			

Minor	5	Missing Physiotherapy Evaluation or re-evaluation code	Documentation shows physiotherapy assessment is performed but the code is not assigned.
DIAGNOSIS COMPLETENESS ERRORS			
6. Major Diagnosis Error - 10			
Major	10	Missing additional diagnoses code(s)	Missed assigning additional code, according to coding rules and guidelines and available documentation.
DOCUMENTATION COMPLETENESS ERRORS			
7. Moderate Documentation Error - 10			
Moderate	10	Systems Review and Physical Examination is contrary to documented and coded conditions.	Diagnosed with Pressure Ulcer, Integumentary examination shows normal;
8. Minor Documentation Error - 5			
Minor	5	A relevant system examination is missing in the document.	Dermatitis as Final Diagnosis, examination of the skin/Integumentary system is completely missing.

Table 7: Error Scoring: Dental Setting – Accuracy

SCORING TABLE FOR DENTAL CARE – ACCURACY ERRORS			
Category - Score		**Accuracy**	**Example and/ or Explanation**
1. Major Encounter Type -10			
Major	100	Missed the Patient Signature or Patient details	Any required document that was missing the patient's signature.
		Mismatching of the billed physician and service performer	Any mismatch between the billed physicians and the actual service performer.
		The claim date is before the service was provided	When claims were submitted before the actual date of the service was provided.
		Missing Medical Record	Missing a complete Medical Record for the audit sample
Major	10	Claim uploaded to the wrong Encounter Type	Claimed codes are uploaded to the incorrect encounter type
		Claim uploaded with the wrong activity type.	Claimed codes are uploaded with the incorrect activity type
		Other miscellaneous billing errors, or incorrect or missing per-diem/service codes	Incorrect Date of service on the claim, Or Incorrect units of Additional or add-on non-surgical procedure codes
2. **Major Billing Type - 20**			
		Physician's License Expired The physician is not licensed	The Service provided physician's DOH license has expired. The service-provided physician does not have a DOH license.

Major	20	Billed the incorrect physician	The physician who was billed is not the same physician who provided the service to the patient.
		Mismatched the Patient visit time	The patient's visit time does not align with the time-based services provided on the same day.
		Incorrect Consumable details	If any details of used consumables—such as dates, signatures of ordering versus using physicians, or other relevant information—are incorrect.
		Missing Required Forms	Missing Consent form for the relevant treatment OR Missing LAMA form signed by the patient or relative
3. **Moderate Billing Type - 10**			
Moderate	10	Invalid Physician License	The physician does not have the required privilege to perform the service
		Other Billing Errors	Claim submitted with incorrect Quantities (Less or More) of any code. Physician authentication is missing on the relevant documentation
4. **Minor Billing Type - 05**			
Minor	05	Missing Demographic details	The Medical Tourism claim is missing Payment or patient details in demographics.
		Other miscellaneous billing errors.	Claim submitted with any incorrect post date
PROCEDURES ACCURACY ERRORS			
5. Major Procedure Error – 20			
Major	20	Procedure coded without documentation	''21111 Restorations, Amalgam, Non-Bonded, Primary Teeth, one surface is coded'' when there is no documentation to support any restoration.

			No or insufficient information on time documentation for each time-based procedure;
6. Major Procedure Error - 10			
Major	10	Billed Unbundled Procedure	Endodontic procedures are billed with additional CPTs that are considered inclusive.
		Billed E/M code	Incorrectly billed E/M in a dental claim
7. Major Dental Care Examination Error - 25			
Major	25	Examination without documentation / Incorrect Examination Code	''01201 Examination and Diagnosis, Limited, Oral, New Patient'' is coded'' when there is no documentation to support any examination OR an Incorrect Dental Examination Code is coded to the available documentation.
8. Moderate Procedure Error -10			
Moderate	10	Incorrect procedure code / Claimed Procedure does not match what is documented / Incorrect tooth Number/Missing Tooth Number;	The Procedure code or tooth number for the procedure, which is on the Claim does not match what is documented and/or coded. Missed documenting the Tooth number;
Moderate	10	An additional procedure/Minor procedure code which is inclusive in the Examination code;	A related minor procedure or examination is included in a major procedure or examination performed on the same visit.
DIAGNOSIS ACCURACY ERRORS			
9. Major Diagnosis Error – 20			
Major	20	Diagnosis coded without documentation or coding sign symptom INSTEAD of the diagnosis;	Code is not per the documentation, e.g. documentation does not support the code. OR Code is a documented sign or symptom and not the

			documented diagnosis, such as a PDx- K08.89: Tooth pain coded when documentation shows a PDx- K04.7: Dental Abscess
Major	20	The claimed code does not match the documentation;	The code which is on the Claim does not match what is documented and/or coded.
Major	20	Coding Possible, rule out, Suspected, Probable or questionable diagnosis;	Coding Guidelines specify that in an Outpatient setting, the documentation of "possible'', ''probable'', "?" etc. are not to be coded. Not Applicable in an inpatient setting.
10. Moderate Diagnosis Error-10			
Moderate	10	Dental Procedures do not have a corresponding diagnosis code;	Any dental procedure code which is not supported by a related dental diagnosis.
Moderate	10	Missing relevant primary/secondary diagnosis specific to this encounter;	Missing required and/or pertinent secondary diagnosis which is relevant to this encounter. Examples are; Patient Encounter is for dental examination and cleaning with abnormal findings; abnormal findings were not coded. Also, if the manifestation code is assigned without an underlying condition.
Moderate	10	Coding Signs & Symptoms integral to Diagnosis, additionally;	Coding additionally (not instead of) Signs & Symptoms that are associated routinely with a disease process, unless otherwise instructed by the classification. Example: "K04.7, Periapical abscess without sinus'' is the Principal diagnosis, and a secondary symptom code is added "K08.89 Toothache.
Moderate	10	Error of specificity in diagnosis code;	The "Error of specificity in diagnosis code" refers to coding within the correct Category or Subcategory but not coding to the specificity or Incorrect specificity as per the availability in the documentation. The

			example would be the documentation showing the dental caries into pulp and unspecified dental caries, when greater specificity is available.
11. Minor Diagnosis Error – 5			
Minor	05	Incorrect sequencing of diagnosis;	This is strictly a sequencing issue, not a documentation issue. Both/all codes are present; however, the wrong code is selected as principal diagnosis.

DOCUMENTATION ACCURACY ERROR – DOCUMENTATION RELATED			
12. Moderate Documentation Error-10			
Moderate	10	Missing Narrative Diagnoses	Missed narrating the complete diagnoses in the clinical final impression by the physician.

Table 8: Error Scoring: Dental Setting – Completeness

SCORING TABLE FOR DENTAL CARE – COMPLETENESS ERRORS			
Category-Score		**Accuracy**	**Example and/or Explanation**
PROCEDURE AND EXAMINATION ERROR			
1. Major Procedure Error - 20			
Major	20	Missing Dental Procedure Code;	Documentation shows a procedure is performed, which is significant and separate from other procedure codes and the code is not assigned.
2. Major Examination Error - 20			
Major	20	Missing Dental Examination;	Documentation shows a dental examination was performed, which is significant and separate from other procedure codes and the code is not assigned.
DOCUMENTATION COMPLETENESS ERROR			
3. Major Documentation Error - 15			
Major	15	Missing documentation details for Procedures;	Procedures: Aseptic precautions, Technique/approach of procedure, detailed procedure note, hemostasis, risks encountered, if any, post-procedural complications, if any, Timing documentation for time-based codes
Major	15	Missing documentation details for Examinations Or Relevant dental examination is missing, or the documented examination contradicts the coded conditions	Examinations: Dental completeness of documentation like (Chief complaint, dental examination, intra-oral and or extra oral & its types (primary, mixed, permanent dentition not based on age criteria), charting, dental history, past medical history, allergy, pre-& post instructions, treatment plan, follow-ups, prescription etc.)

			Follow-up visit – Chief complaint should correlate with the staged procedure/Reason for visit; (e.g. – RCT) Plaque & Gingivitis as Final Diagnosis, examination of the Intraoral is completely missing. Diagnosed with Periapical Abscess, Gingivitis. Dental Intraoral examination shows normal;
4. Moderate Documentation Errors - 10			
Moderate	10	Missing additional diagnoses	There is no complete and full code assignment(s), according to coding rules and guidelines and available documentation
Moderate	10	Radiology/Diagnostic reports have no documentation of indication for test, technique or approach of procedure/views of radiological examination & Interpretation of the X-ray;	Indication for X-ray: Caries/Pulpitis Technique or approach: Periapical view No. of Views: Single Findings: Impression: Dental caries penetrating the pulp Missed documenting the interpretation in the Dental clinical visit; Histopathology/Test/Analysis documentation;