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DEPARTMENT OF HEALTH

JAWDA DATA CERTIFICATION (JDC) FOR HEALTHCARE PROVIDERS

Part-6 (2023)

Technical Clarifications to Methodology 2019, 2020, 2021 & 2022

December 01

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Technical Clarifications to Part-1 *of* JDC Methodology

1 INTRODUCTION

The purpose of this document is to provide clarifications on specific aspects of Part-1, Part-2, Part-3, Part-4 and Part-5 of JDC methodology 2019, 2020, 2021 & 2022.

A Half-yearly update can be made if further clarifications are seen necessary to be published based on the updates received from the regulatory authorities. Any such updates or clarifications that is impacting the course of actions from part-2 will be applicable effective from the date of such clarification received.

2 METHODOLOGY SCOPE

The scope of JDC Methodology 2020 remains the same however, as new KPI profiles are published by DoH, such KPIs will be under the audit scope, and accordingly KPI Domain may be applicable also to centers.

8. Documentation Requirements and Implementation

8.2 Claims Review Records Implementation requirements

(Performance and Operational Controls of Processes Execution)

8.2.2 Claims Review Aspects (All other points mentioned in previous Methodologies remain valid)

A representative from the registration desk of a healthcare facility to be involved in the audit as part of the Medical Tourism process evaluation.

8.3.2 Clinical Coding Process Review Aspects

C. Health Care Medical Record Documentation policies:

I. **Timeliness:** Timelines of documentation completion is encouraged to enter all details at the time of rendering service. Completion of addendums shall be completed as per the facilities policy.

The facility shall clearly indicate the time in hours within their policy for the timeliness of documentation completion.

8.4 JAWDA KPI Process Review Implementation Requirements

Most of the times, sources of KPI data are patient records, as an alternate source of data to compare for the validation process, ICD and CPT codes for the submitted data shall be readily provided

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Technical Clarifications to Part-2

JDC Methodology

2 APPLICATION AND PLANNING FOR CERTIFICATION

2.1 Contract formation

i. For a new facility audit at least one of applicable settings should meet 120 claims and remaining settings can have minimum tier sample to proceed for initial audit.
ii. The facility can proceed with the audit though they do not have a minimum tier sample in Self-Pay setting.
iii. Facility with scope of service as Proforma services shall be considered for audit according to Self-pay audit process.
iv. 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.

4. CERTIFICATION REQUIREMENTS AND GUIDELINES FOR CRITERIA

4.2 Claims Review

4.2.1 Claims Review

- 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.
- New / Established E/M should be coded based on the Facility's License not based on the Group of facilities.

4.2.3 Claims Review Audit Verification Points and Scoring Criteria:

a. Audit Log should be demonstrated by the IT in front of the auditor.
b. If any issue was fixed after the audit finding raised during the audit by the auditor cannot be considered for the current audit.

4.3 Clinical Coding Process Review

4.3.1 Audit Verification Points and Scoring Criteria:

Scoring of Clinical Coding Process Review:

- 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)
  - Relevant representative for Medical Tourism (Claims related) (3 points)

4.4 Process Review for "KPI" Quality Indicators

- Facilities with JAWDA KPI as applicable, but not submitted for 2 consecutive quarters shall be scored with "zero" for KPI domains.

6 AUDITS ON SELF-PAY SERVICES/PROFORMA SERVICES

6.1 Audit Verification Points: Claims review

- 5 points score will be deducted from Self-Pay claims generated score if self-pay submission is not done consistently for the last 8 months or incomplete claim submission.
- Facility should submit Self-pay claims consistently at least on monthly basis (e.g. Jan claims in Feb and Feb claims in March).
- Facilities having insurance claim submissions but not compliant with Self-pay submissions to DoH, shall have 5- a points deduction from the overall claims score.
- Facilities that have only Proforma claims, shall be audited on claims and clinical coding process review following the rules applicable for Self-pay.

11 RE-AUDITS

- Facilities that failed in a re-audit shall be applicable for a complete audit with all applicable domains in scope.
- In case of 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.
- 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, else, will be de-listed from Shafafiya.
- If the new KPI data is not available for the re-audit, a conditional listing shall start from 2 months after the date of audit results.
- If the facility failed in KPI Data Validation and 5 scores are deducted for Audit Log, then a re-audit shall be conducted on KPI Data Validation and Audit Log process.
- If the facility failed due to the 5-score deduction and passed in all applicable domains, then a re-audit shall be conducted on the process that resulted in 5 score deduction.

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APPENDIX-II

Scoring Weights & Examples

Scoring Weights and Examples

The Summary of scoring weights for the facilities KPI applicable but not submitted KPIs as shown below:

Table 1- Summary of scoring weights

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

Example1: Details of scoring for the KPI applicable facilities not submitted will be as shown in the below table

HOME HEALTH CARE - DETAILED SCORING								
Domain	**Domain details**	**Claim Count (25+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	17	49%	95	46.14			
	Out Patient - 100	8	23%	93	21.26			
	Self-Pay (Routine) - 100	7	20%	95	19.00			
	Self-Pay (Medical Tourism)- 100	3	9%	93	7.97			
					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 Process Review	Planning, Support and Operations 50				0			
	Quality Governance & Improvement 50				0			
KPI Process Review Score - 100					**0**	40%		**0**
KPI Data Validation Score - 100					**0**	10%		**0**
FINAL JAWDA DATA CERTIFICATION SCORE								**47.05**

APPENDIX-III

Scoring Tables

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
4. Moderate Procedure Error-10			
Moderate	10	Missed / Incorrect Cosmetic Procedure Or Coded Cosmetic Procedure without documentation	Missed to code the performed Cosmetic procedure Or The Coded Cosmetic procedure is not meeting with the documentation Or Cosmetic procedure coded without supporting documentation.

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
4. Moderate Procedure Error-10			
Moderate	10	Missed / Incorrect Cosmetic Procedure Or Coded Cosmetic Procedure without documentation	Missed to code the performed Cosmetic procedure Or The Coded Cosmetic procedure is not meeting with the documentation Or Cosmetic procedure coded without supporting documentation.

Table 6 Error Scoring: Home Health Care – Accuracy

SCORING TABLE FOR HOME CARE – COMPLETENESS ERRORS			
Category-Score		Accuracy Error	Example and Explanation
5. Moderate Procedure Error -10			
Moderate	10	Missing documentation details for Procedures	Nursing procedure details missing Physiotherapy- Details of modalities, site of application of modality, time start and end, authentication etc.,