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DEPARTMENT OF HEALTH

JAWDA DATA CERTIFICATION (JDC) FOR HEALTHCARE PROVIDERS

Part-7 (2024)

Technical Clarifications to Methodology 2019, 2020, 2021, 2022 & 2023

December 01

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TABLE OF CONTENTS

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, Part-5 and Part-6 of JDC methodology 2019, 2020, 2021, 2022 & 2023. ***If any statement is conflicting between Part-7 and Part 1, 2, then the requirements specified in Part-7 shall prevail.***

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 are 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 all applicable facilities.

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)

Diagnosis and supporting documentation specific to the visit shall be present in the visit specific documents. Supporting documentation from previous visits cannot be considered for coded conditions.

8.3.2 Clinical Coding Process Review Aspects

C. Health Care Medical Record Documentation policies:

During the clinical coding process review, Major non-conformities identified for the below will impact claims review scores as an underlying cause that may potentially affect the claims documentations or accuracies:

I. **Timeliness:**
   - The facility shall indicate the time in hours format within their policy for the timeliness of documentation completion.
   - Documentation locking time should not be beyond the claim submission period. All documentation shall be completed and locked prior to claim submission.

8.4 JAWDA KPI Process Review Implementation Requirements

Sources of KPI data are usually patient records as an alternate source of data to compare during the validation process, therefore, submitted ICD and CPT codes for the reported quarter KPI data (without system logic) shall be provided during the audit as per the auditor's request.

8.5 KPI Data Validation Implementation Requirements

If a facility marks 'N/A' i.e., Not Applicable for any specific indicator that is actually relevant and applicable to their services, it will result in a score of zero for that indicator. When in doubt about an indicator's applicability, facilities should confirm with the DOH.

8.5.2 Verification Points

Amended the verification points from previous methodologies as below:

a) Count/Numerator including Inclusions (when applicable)
b) Exclusions Numerator (when applicable)
c) Count/Denominator including Inclusions (when applicable)
d) Exclusions Denominator (when applicable)

Scoring for indicators shall be based on their respective applicable verification points.

Technical Clarifications to Part-2 of JDC Methodology

2 APPLICATION AND PLANNING FOR CERTIFICATION

2.1 Contract formation

I. 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.
II. New facilities must proactively request an audit instead of waiting for notification from TASNEEF.
III. Facilities with the same audit representative for both Claims review and KPI review may request to schedule the audit on different days.
IV. 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.

2.6 Random Sample Sharing for Claims Review:

I. Samples for homecare services will be shared for claims submitted for services that span multiple days only.
II. 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.

3 PERFORMANCE OF AUDITS

3.3 Audit Evidence Collection

i. In the case of a multi-day audit, the requested evidence must be provided on the same day and will not be carried over to the next day. Any documentation submitted after the specified timeline, for any reason, will not be accepted.

4. CERTIFICATION REQUIREMENTS AND GUIDELINES FOR CRITERIA

4.2 Claims Review

4.2.1 Claims Review

- 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.

- Narrative Diagnosis, Final impression & dental progress notes should be in physician's own words, missing the same is considered as an accuracy error with score deduction.

4.2.3 Claims Review Audit Verification Points and Scoring Criteria:

Timeliness:

During the clinical coding process review, if Major non-conformities are identified for the below, it will result in the deduction of a five-point (5.00) score from the overall claims review score:

a. Missing medical records locking time in hours within their policy for the timeliness of documentation completion.
b. Documentation locking is beyond the claim submission period.

4.3 Clinical Coding Process Review

4.3.1 Audit Verification Points and Scoring Criteria:

I. DOH mandates facilities to maintain Electronic Medical Records, and this adherence will be assessed during the process review. Non-compliance will be indicated if Paper Medical Records are found in place of Electronic Medical Records.

4.4 Process Review for "KPI" Quality Indicators

- If one or more KPI specialties are applicable, a merged process review shall be conducted by a single auditor for the medical centers.

4.5 KPI Validation for Collection and Submission of Jawda

- For the current audit, data from any quarter following the previously audited data can be selected.
- The number of indicators to be audited depends on the size of the hospital in accordance with DoH instruction to TASNEEF.
- The selection of specific indicators for audit is in accordance with DOH instructions, based on the applicable specialties and services.
- If the data submitted is "0" for four quarters, those indicators will be excluded from the audit.
- If a facility marks 'N/A' for an indicator relevant to their services, it will result in a score of zero for that indicator. When there is an ambiguity about an indicator's applicability, the facility should confirm with the DOH.
- Technical errors or system or tool malfunctions and typographical errors resulting in incorrect data submissions or
  submissions with mismatched documentation details will still be part of the audit and verified as per the Methodology.
- System Logic should be provided at the auditor's request.

4.5.1 Audit Verification Points and Scoring Criteria:

Jawda KPIs from all the sub-domains will be verified as per the applicability of KPI profiles and the facility type.
The different verification points, as applicable, are but not limited to the calculation of:

- Numerator with inclusion
- Numerator Exclusions (as applicable)
- Denominator with inclusion
- Denominator Exclusions (as applicable)

Each indicator is considered with a maximum of 100 points which is equally distributed across all applicable.

verification points as mentioned in 4.5.1.

Example 1:

QI001: Total score points assigned -100,

- Count/Numerator-50.00 points.
- Count/Denominator-50.00 points

• **Example 2:**

QI005: Total score points assigned -100

- Numerator: 25 points
- Numerator exclusion: 25 points
- Denominator: 25 points
- Denominator exclusion: 25 points

Note: When indicators with the same denominator definitions in the profile do not match the submitted data due to the same cause, there will be a complete score deduction for the initial indicator and a partial score deduction for the repeated indicators.

6 AUDITS ON SELF-PAY SERVICES/PROFORMA SERVICES

6.1 Audit Verification Points: Claims review

- 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.

7 REPORT

- Findings may be revised during the formal audit report review and/or the final audit report review, based on the guidelines/JDC Methodology and evidence provided during the audit.

APPENDIX-II

Scoring Weights & Examples

Scoring Weights and Examples

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

Table 1- Summary of scoring weights

Facilities with Applicable KPI but no KPI data submission	
Scope	**Weight**
Claims Review Score	40
Clinical Coding Process Review Score	10
KPI Process Review Score	0
KPI Data Validation Score	0

Example1: Updated details of scoring for the KPI applicable facilities not submitted are 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**	10%		**0**
KPI Data Validation Score - 100					0	40%		**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 Documentation Error-10			
Moderate	10	Missing Narrative Diagnoses	Missed to narrate the complete diagnoses in the clinical final impression by the physician;

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 Documentation Error-10			
Moderate	10	Missing Narrative Diagnoses	Missed to narrate the complete diagnoses in the clinical final impression by the physician;

Table 6 Error Scoring: Home Health Care – Accuracy

SCORING TABLE FOR HOME CARE – COMPLETENESS ERRORS			
Category-Score		Accuracy Error	Example and Explanation
4. Moderate Documentation Error-10			
Moderate	10	Missing Narrative Diagnoses	Missed to narrate the complete diagnoses in the clinical final impression by the physician.

Table 8 Error Scoring: Home Health Care – Accuracy

SCORING TABLE FOR DENTAL – COMPLETENESS ERRORS			
Category-Score		Accuracy Error	Example and Explanation
4. Moderate Documentation Error-10			
Moderate	10	Missing Narrative Diagnoses	Missed to narrate the complete diagnoses in the dental examination or final impression by the physician.