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DEPARTMENT OF HEALTH

JAWDA DATA CERTIFICATION (JDC) FOR HEALTHCARE PROVIDERS

Part-8 (2025)

Technical Clarifications to Methodology 2019, 2020, 2021, 2022, 2023 & 2024

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, Part-5 Part-6 and Part-7 of JDC methodology 2019, 2020, 2021, 2022, 2023 & 2024. ***If any statement is conflicting between Part-8 and Part 1, 2, then the requirements specified in Part-8 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

2.2 Applicability:

As per DOH requirements, apart from previous JDC Methodology applicability the below are included in the audit scope.

i. New KPI profiles, that are published by DoH.

8. DOCUMENTATION REQUIREMENTS AND IMPLEMENTATION

8.2 Claims Review Records Implementation Requirements

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

i. 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.
ii. All relevant Evaluation and Management (E&M) documentation must be available in the patient's current visit record.
iii. The review of E&M coding will be conducted according to the AMA guidelines, which will be superseded by DOH updates, if any, and as applicable.
iv. Accurate Encounter Start Type and Encounter End Type have to be followed.
v. 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.

8.3 Clinical Coding Process Review Implementation Requirements

8.3.2 Clinical Coding Process Review Aspects

i. The audit log and the timeliness of documentation will be verified by randomly selecting any of the physicians, who may not have been nominated. The facility must provide a list of the physicians present on the audit day to ensure their documentation is verified.

ii. System requirements that do not meet the JDC Methodology criteria due to technical issues will still be included in the audit and will be considered as non-conformities.

8.4 JAWDA KPI Process Review Implementation Requirements

Most of the time the source of KPI data is derived from patient records. To enhance data validation, complete Revenue Cycle Management claims data - including both insurance and self-pay—from all applicable settings - must be provided during the validation process. This data should include submitted ICD, CPT, and service codes, along with all required patient's information.

Note: KPI score generated for the initial KPI audit or any new specialty KPI profiles introduced by DOH, shall not be included in the JDC final Score. This is to facilitate awareness of the audit process and new specialty KPI. This applies to all facilities undergoing their first KPI audit or any newly introduced KPIs.

8..4.3 Verification Points

viii. KPI Report: follow the updated points.

a) Statistics reports generated from the health information system are reliable / requested RCM Data Provided Submitted data is valid and reliable
b) Report prepared in an organized document
c) Names of the approval panel, designations, date of signature, signatures
d) Review and Approval of CEO or Head of Facility before submission to DoH

8.5 KPI Data Validation Implementation Requirements

If a facility reports as 'N/A' (Not Applicable) for any Jawda indicator that is relevant and applicable to their services, a score of zero will be assigned to that indicator based on the eligible population identified during the audit. When uncertain about the applicability of an indicator, facilities should consult with the DOH for clarification.

If the selected quarter of KPI data lacks patient entries and shows a submission of 0/0, data from any other quarters containing rational numbers will be selected.

9 AD-HOC KPI AUDITS

Ad-Hoc KPI audit reports and scores will be reported to only DoH by their instructions.

Technical Clarifications to Part-2 of JDC Methodology

2 APPLICATION AND PLANNING FOR CERTIFICATION

2.1 Contract formation

i. If a facility operates across multiple settings such as outpatient, daycare, homecare, etc., selection of the contract tier type will be applied based on the higher tariff.

ii. If insurance services are applicable to the facility but the facility has few or no insurance claims, yet there are more than 200 self-pay claims available, the audit will be conducted based on the available/submitted claims.

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

2.2 Audit Planning

i. All licensed facilities must ensure the initiation of the JAWDA Data Certification application, regardless of whether the license is new or previously certified. This applies to all audit types, including re-audits.

ii. 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.

iii. 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)

2.3 Audit Sample Type for Claims Review

The Encounter Types below are added to the scope of the audit.

Encounter Type	Setting
10	Teleconsultation
4	Inpatient Bed + Emergency room

3 PERFORMANCE OF AUDITS

3.3 Audit Evidence Collection

i. 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.

ii. Physical copies of evidence will not be accepted from facilities that use Electronic Medical Records.

iii. 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.

4 CERTIFICATION REQUIREMENTS AND GUIDELINES FOR CRITERIA

4.2 Claims Review

4.2.1 Claims Review

- 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.
- 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.
- The review of E&M coding will be conducted according to the AMA E&M Coding Guidelines, which will be superseded by DOH updates, if any, and, as applicable.
- 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.
- 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.
- 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 homecare claims.
- 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.

4.2.3 Claims Review Audit Verification Points and Scoring Criteria:

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 claims review.

4.3 Clinical Coding Process Review

4.3.1 Audit Verification Points and Scoring Criteria:

i. 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 attached to the actual patient documentation, either by scanning or electronically integrating it into the record.

ii. Self-pay facilities with Dental and Dermatology specialties shall nominate physicians from both specialties for the audit.

4.4 Process Review for: "KPI" Quality Indicators

4.4.1 Audit Verification Points and Scoring Criteria:

KPI Process for Planning, Support and Operations (50 Points)

viii. KPI Report: follow the updated points.

a) Statistics reports generated from the health information system are reliable / requested RCM Data Provided (2 points)
b) Submitted data valid and reliable (2 points)
c) Report prepared in an organized document (1 point)
d) Names of the approval panel, designations, date of signature, signatures (1 point)
e) Review and Approval of CEO or Head of Facility prior to submission to DoH (1 point)

Note: The validity and reliability of the submitted data will be determined based on the KPI Data Validation score. If a facility fails to achieve the passing score of 86.00, it will be considered a Major Non-Conformity.

4.5 KPI Validation for Collection and Submission of Jawda

i. If a facility reports as 'N/A' (Not Applicable) for any Jawda indicator that is relevant and applicable to their services, a score of zero will be assigned to that indicator based on the eligible population identified during the audit. When uncertain about the applicability of an indicator, facilities should consult with the DOH for clarification.

ii. If the selected quarter of KPI data lacks patient entries and shows a submission of 0/0, data from any other quarters containing rational numbers will be selected.

5 DENTAL SERVICES

5.1 Audit Verification Points:

B. Claims review:

In addition to the documentation review for the dental services rendered, the following aspects will be reviewed during the claims review. The facility must cooperate and provide the necessary information for this review:

i. Dental claims submitted under a general setting, or vice versa, will be considered an accuracy error.

ii. The relevant physician's license validity will be verified for each claim.

iii. Time-based codes will be checked for time eligibility.

iv. 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.

6 AUDITS ON SELF-PAY SERVICES/PROFORMA SERVICES

6.1 Audit Verification Points: Claims review

- 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 audit.

6.2 Medical Tourism

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

7 REPORT

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.

17 CONDITIONS AT WHICH AUDIT PROCESS WILL STOP

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.

20 NEW FACILITIES LISTING AND EXTENSION OF LISTING

A new or extension of listing will not be provided if the facility has already served patients but has not submitted the claims.

APPENDIX-I

Additional Tier Systems

Self-Pay Hospital - Table 6

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

Self-Pay Home Health Care - Table 7

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

APPENDIX-III

Scoring Tables

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	E&M is included in the procedure /Service code Or The procedure / Service code is included 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. The non-surgical cleansing of a wound will be considered bundled in the E&M code.
5. 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.

Table 5 Error Scoring: Home Health Care – Accuracy

SCORING TABLE FOR HOME CARE – ACCURACY ERRORS			
Category-Score		Accuracy Error	Example and Explanation
1. Major Per-Diem Code Error - 20			
Major	20	Incorrect / Missing Per-Diem coded	The billed Per-Diem code is incorrect for the care provided OR The billed Per-Diem code is missing

Table 8 Error Scoring: Home Health Care – Accuracy

SCORING TABLE FOR DENTAL – ACCURACY ERRORS			
Category-Score		Accuracy Error	Example and Explanation
1. Major Billing Type - 20			
Major	20	Physician's License is Expired OR The physician is not Licensed	The Service provided physician's DOH license is expired. OR The service-provided physician does not have DOH-license.
Major	20	Billed incorrect physician	The physician who was billed is not the same physician who has provided the service to the patient.
Major	20	Mismatched the Patient visit time	The patient's visit time does not align with the time-based services provided on the same day.
1. Major Encounter Type -10			
Major	10	Claim uploaded to wrong Encounter Type Or Claim uploaded with wrong activity type.	Claimed codes are uploaded to incorrect encounter type Claimed codes are uploaded with incorrect activity type