



دائرة الصحة
DEPARTMENT OF HEALTH

JAWDA DATA CERTIFICATION (JDC) FOR HEALTHCARE PROVIDERS

Part-9.1 (2026)

Technical Clarifications to Methodology 2019, 2020, 2021, 2022, 2023, 2024 & 2025

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TABLE OF CONTENTS

1	INTRODUCTION	5
2	METHODOLOGY SCOPE	5
8.	DOCUMENTATION REQUIREMENTS AND IMPLEMENTATION	5
8.2	Claims Review (Billing, Coding and Compliance) Records Implementation Requirements	5
8.3	Clinical Coding Process Review (changed to Clinical Coding and Billing Process Review) Implementation Requirements	6
8.4	JAWDA KPI Audit Review Requirements.....	6
9	AD-HOC KPI AUDITS	6
11	INTERIM AUDIT PROCESS (Applicable to Hospitals)	7
	Technical Clarifications to Part-2 of JDC Methodology	8
2	APPLICATION AND PLANNING FOR CERTIFICATION	9
2.1	Contract formation	9
2.2	Audit Planning.....	9
2.4	Sampling Method for Claims Review	9
3	PERFORMANCE OF AUDITS	9
3.3	Audit Evidence Collection	9
4	CERTIFICATION REQUIREMENTS AND GUIDELINES FOR CRITERIA.....	9
4.2	Claims Review Process (Billing, Coding and Compliance).....	9
4.3	Clinical Coding Process Review changed to Clinical Coding and Billing Process Review	10
4.4	Jawda KPI Data Review:	10
4.5	New KPI Data Validation Process (effective from September 1, 2026).....	11
5	DENTAL SERVICES.....	14
5.1	Audit Verification Points:.....	14
6	AUDITS ON SELF-PAY SERVICES/MEDICAL TOURISM	14
11	RE-AUDIT.....	14
14	LISTING AND DE-LISTING	14
20	NEW FACILITIES LISTING AND EXTENSION OF LISTING	15
22	INTERIM AUDIT PROCESS.....	15
	APPENDIX-II.....	17
	APPENDIX-III.....	19



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, Part-7 and Part-8 of JDC methodology 2019, 2020, 2021, 2022, 2023, 2024 & 2025. **If any statement conflicts between Part-9 and Part 1, 2, then the requirements specified in Part-9 shall prevail.**

Any new updates issued by the DOH shall be applicable in addition to these guidelines, effective from the date of publication by the DOH.

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

2 METHODOLOGY SCOPE

2.2 Applicability:

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

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

- Claims Review (Applicable for all licensed healthcare facilities, including Dental and Self-Pay)
- Clinical Coding Process Review (Applicable for all licensed healthcare facilities, including Dental, Self-Pay and Medical Tourism)
- Jawda KPI Data Validation (relevant to Quality Indicators Data Submission)

8. DOCUMENTATION REQUIREMENTS AND IMPLEMENTATION

8.2 Claims Review (Billing, Coding and Compliance) Records Implementation Requirements

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

- i. Evaluation and Management (E&M) codes (New and Established) should be billed based on the facility group classification according to the DOH instructions, rather than the individual facility license.
- ii. Facility should maintain the start and end times for all time-based codes.
- iii. Consent forms for all applicable patients should be maintained as required by the Department of Health (DOH) guidelines.

- iv. Ensure that LAMA (Left Against Medical Advice) forms are duly signed by the patient or their authorized relative.
- v. Ensure that diagnostic test reports are duly signed by the performing physicians involved.
- vi. Repetition of audit findings will be notified to the DoH for their actions.

8.3 Clinical Coding Process Review (changed to Clinical Coding and Billing Process Review) Implementation Requirements

8.3.2 Clinical Coding Process Review Aspects

The confidentiality of physician documentation and the timeliness of individual documentation should be maintained by all relevant staff, including nurses, technicians, MRD personnel, insurance staff, medical coders, and other concerned team members. No staff member should have access to the documentation of other clinical staff.

8.4 JAWDA KPI Audit Review Requirements

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.
- Facilities are responsible for notifying the Department of Health (DOH) about the KPIs applicable to them and must ensure that the submission portal for these KPIs is requested to be opened prior to or within the designated submission period to submit the same.
 - Facilities that achieved a grade of "C" or "D" in the KPI audit are required to resubmit the corrected data to DOH (within 2 to 4 weeks) based on the KPI audit findings.

9 AD-HOC KPI AUDITS

There will be no ad-hoc audits.

11 INTERIM AUDIT PROCESS (Applicable to Hospitals)

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

Technical Clarifications to Part-2 of JDC Methodology

2 APPLICATION AND PLANNING FOR CERTIFICATION

2.1 Contract formation

- i. 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.

2.2 Audit Planning

- i. 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.

2.4 Sampling Method for Claims Review

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.

3 PERFORMANCE OF AUDITS

3.3 Audit Evidence Collection

- i. 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.

4 CERTIFICATION REQUIREMENTS AND GUIDELINES FOR CRITERIA

4.2 Claims Review Process (Billing, Coding and Compliance)

4.2.1 Claims Review (All other points outlined in the previous methodologies remain valid. In case of any updates to specific points, the revised version will be followed)

- i. 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.
- ii. All time-based codes will be verified against the documented start and end times; total time spent alone will not be accepted.
- iii. Verification of consent forms and Left Against Medical Advice (LAMA) forms in accordance with the Department of Health (DOH) guidelines.
- iv. Verification of patient signatures on consent forms and all relevant documents.

- v. Claims in which the billed physician differs from the actual service performer shall be classified as non-compliant and assigned a “zero” score.
- vi. Verification of performing physician signatures on diagnostic reports.
- vii. Diagnosis-Related Groups (DRGs) are included as part of the audit review scope.
- viii. Verification of consumables details.
- ix. 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 will be marked as “Not Verified” and will result in a zero score for the respective field.

4.3 Clinical Coding Process Review changed to Clinical Coding and Billing Process Review

4.3.1 Audit Verification Points and Scoring Criteria:

- i. The confidentiality of physician documentation and the timeliness of individual documentation will be reviewed and verified for any relevant staff, including nurses, technicians, MRD personnel, insurance staff, medical coders, and other concerned personnel.

4.4 Jawda KPI Data Review:

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.
- 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.
 - 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” in the KPI audit are required to resubmit the corrected data to DOH (within 2 to 4 weeks) based on the KPI 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.

4.4.1 Audit Verification Points and Scoring Criteria:

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 New KPI Data Validation Process (effective from September 1, 2026)

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	100% Sample	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.

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.
 - Indicators will be selected from all KPI applicable to the respective facilities (non-hospital).
 - If the selected quarter shows 0/0 submissions due to no patients, data from an alternative quarter with available submissions will be selected.
 - **Sampling techniques** shall be applied during the audit, based on the auditor's analysis of the data.
 - The same sample will not be considered for the same definition indicators.

4.5.1 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 error.
- 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.

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

5 DENTAL SERVICES

5.1 Audit Verification Points:

B. Claims review: (in addition to 4.2.1)

- i. All time-based codes must be reported with start and end times instead of total time spent
- ii. Endodontic procedures billed with additional CPTs that are considered inclusive.
- iii. 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).
- iv. Verification of consumables details.

6 AUDITS ON SELF-PAY SERVICES/MEDICAL TOURISM

6.1 Medical Tourism

- 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.
- 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.
- Verification of Medical Tourism Policy and Flow chart.

11 RE-AUDIT

- 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.
- If the facility fails in Claims, the re-audit will be conducted on new claims that were submitted after the issuance of the final audit report.

14 LISTING AND DE-LISTING

- **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).
- **Conditional listing** - 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.

20 NEW FACILITIES LISTING AND EXTENSION OF LISTING

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.

22 INTERIM AUDIT PROCESS

- 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

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, as applicable.

Table 1- Summary of scoring weights for KPI applicable facilities

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

Scoring Table 1:

Facility with KPI								
Domain	Domain details	Claim Count	Claim distribution ratio	Score-Each Setting	Score as per claim ratio	Domain weights	4.2.3 Claims Review Audit Verification	Final Score
		180						
Claims Review Each Setting 100	OUTPATIENT	77	42.78%	92.27	39.47			
	INFAPIENT	21	11.67%	91.87	10.72			
	DAY CASE	21	11.67%	95	11.08			
	HOME CARE							
	EMERGENCY	21	11.67%	93.57	10.92			
	DENTAL-OP	20	11.11%	97	10.78			
	DENTAL-DC							
	SELF-PAY	14	7.78%	93	0.00			
	NO SELF-PAY SUBMISSIONS			0				
	SELF-PAY SCORE			91.5	7.12			
	MEDICAL TOURISM	6	3.33%	90	0.00			
	NO MT SUBMISSIONS			0				
	MT CLAIMS SCORE			90	3.00			
Claims Review Score - 100					93.08	40	0	37.23
Clinical Coding Process Review	Process flow Map / effectiveness -	15			15.00			
	Clinical Coding/Documentation Policies & Practices - AD				40.00			
	Coder Credentials -	05			5.00			
	Orientation/Training -	10			10.00			
	Policies Adherence -	20			30.00			
Clinical Coding Process Review Score - 100					98.00	10		9.80
KPI Data Validation Score - 100					95.00	50		47.50
FINAL JAWDA DATA CERTIFICATION SCORE								94.53

Table 2- Summary of scoring weights for facilities without KPI: There is no score change for facilities without KPI.

Facilities without KPI	
Scope	Weight
Claims Review Score	80
Clinical Coding Process Review Score	20

Scoring Table 2:

Facility without KPI								
Domain	Domain details	Claim Count	Claim distribution ratio	Score-Each Setting	Score as per claim ratio	Domain weights	4.2.3 Claims Review Audit Verification	Final Score
		117						
Claims Review Each Setting 100	OUTPATIENT	77	65.81%	92.27	60.72			
	DENTAL-OP	20	17.09%	97	16.58			
	SELF-PAY	14	11.97%	93	0.00			
	NO SELF-PAY SUBMISSIONS			0				
	SELF-PAY SCORE			91.5	10.95			
	MEDICAL TOURISM	6	5.13%	90	0.00			
	NO MT SUBMISSIONS			0				
	MT CLAIMS SCORE			90	4.62			
					92.87		0	
Claims Review Score - 100					92.87	80		74.30
Clinical Coding Process Review	Process flow Map / effectiveness - 15				15.00			
	Clinical Coding/Documentation Polices & f				40.00			
	Coder Credentials - 05				5.00			
	Orientation/Training - 10				10.00			
	Policies Adherence - 30				30.00			
Clinical Coding Process Review Score - 100					98.00	20		19.60
FINAL JAWDA DATA CERTIFICATION SCORE								93.90

APPENDIX-III

Scoring Tables

Table 1: Error Scoring: For all Settings– Accuracy including Dental

ERROR SCORING TABLE FOR ALL CASES – ACCURACY ERRORS			
Category - Score		Accuracy Error	Example and Explanation
Major – Billing Related			
Major	100	Mismatching Patient Signature or Patient details Mismatching of the billed physician and service performer	Any mismatch in the patient signature or patient details on supporting documents will result in the claim being scored as zero. Any mismatch between the billed physicians and the actual service performer.
Major	20	Incorrect Diagnosis-Related Groups (DRGs)	Facility billed High/Low DRG
Major	20	Missing required forms	Missing Consent form for the relevant treatment Missing LAMA form signed by the patient or relative
Major	20	Incorrect Consumable details	If any details of used consumables—such as dates, signatures of ordering versus using physicians, or other relevant information—are incorrect.
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



Minor Billing Related-5			
Minor	05	Other miscellaneous billing errors.	Claim submitted with any incorrect date
Minor	05	Missing / Incorrect Demographic details	The Medical Tourism claim is missing / incorrect Payment or patient details in demographics.
Moderate Procedure Error – 10			
Moderate	10	Missing non-surgical procedure codes	Non-surgical procedure/service codes like IM, IV, CTG, ECG, Anaesthesia codes, etc., are not coded when it is documented.

Table 2 Error Scoring: Dental – Accuracy

SCORING TABLE FOR DENTAL – ACCURACY ERRORS

Category-Score		Accuracy Error	Example and Explanation
1. Moderate Billing Type - 10			
Moderate	10	Invalid Physician License	The physician's license has expired; or The physician does not have the required privilege to perform the service
2. Major Procedure Code -10			
Major	10	Billed Unbundled Procedure	Endodontic procedures are billed with additional CPTs that are considered inclusive.
Major	10	Billed E/M code	Incorrectly billed E/M in a dental claim