دائـــــرة الـصـــحـــة
DEPARTMENT OF HEALTH

JAWDA DATA CERTIFICATION (JDC) FOR HEALTHCARE PROVIDERS

Methodology 2019-Part I

(Standard)

December 18

DoH Address:

Tel.

Fax.

TABLE OF CONTENTS

1 INTRODUCTION

For the purpose of this document, Department of Health (DoH) and Health Authority of Abu Dhabi (HAAD) are synonymous and refer to the same regulatory entity and TASNEEF and TRBA are synonymous in representing the Certification body

The Department of Health (DoH) is the regulative body of the Healthcare Sector in the Emirate of Abu Dhabi and ensures excellence in Healthcare for the community by monitoring the health status of the population. DoH is mandated:

- To achieve the highest standards in health curative, preventative and medical services and health insurance in the Emirate.
- To lay down the strategies, policies and plans, including future projects and extensions for the health sector in the Emirate, and to follow-up their implementation
- To apply the laws, rules, regulations and policies which are issued as they are related to its purposes and responsibilities, in addition to what is issued by the respective international and regional organizations in line with the development of the health sector.
- To follow up and monitor the operation of the health sectors for achieving exemplary provision of health, curative, preventive and medicinal services and health insurance.

DoH defines the strategy for the health system, monitors and analyses the health status of the population and performance of the system. In addition, DoH shapes the regulatory framework for the health system, inspects against regulations, enforce standards, and encourages adoption of world – class best practices and performance targets by all healthcare service providers in the Emirate of Abu Dhabi.

Patient safety, clinical effectiveness and patient experience are recognized as the main pillars of quality in healthcare, which is governed through the Jawda framework that was established in 2014. In Abu Dhabi, the measurement of patient safety, clinical effectiveness, accessibility and patient experience data is intended to identify strengths and weaknesses of healthcare delivery, drive-quality improvement, inform regulation and promote patient choice. In addition to data on harm avoidance, success rates for treatments and medical services accessibility, providers will be assessed on aspects of care such as dignity and respect, compassion and involvement in care decisions through patient satisfaction surveys. A set of standardized performance indicators are included in the Jawda framework to fulfill the afore mentioned objectives.

High-quality coded clinical data is essential when developing reliable and effective data repository for statistical health data analysis with a vision for high quality of health care.

Clinical Coding is the process of translating the written or electronic medical documentation of a patient's diagnosis and services performed for an episode of care into a meaningful representation of numeric or alpha numeric codes. To record this information, healthcare providers, like hospitals and clinics in Abu Dhabi use all applicable DoH approved code sets related to Clinical documentation and Coding for Data reporting requirements.

Patient safety is 'the discipline in the health care sector that applies safety science methods toward the goal of achieving a trustworthy system of health care delivery'. Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of and maximizes recovery from, adverse events.

Clinical effectiveness is "the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients. The process involves a framework of informing, changing and monitoring practice" Clinical effectiveness is about doing the right thing at the right time for the right patient and is concerned with demonstrating improvements in quality and performance that can be summarized by:

- The right thing (evidence-based practice requires that decisions about health care are based on the best available, current, valid and reliable evidence)
- In the right way (developing a workforce that is skilled and competent to deliver the care required)
- At the right time (accessible services providing treatment when the patient needs them)
- In the right place (location of treatment/services).
- With the right outcome (clinical effectiveness/maximizing health gain)

Accessibility is "ensuring that the population of Abu Dhabi has access to quality medical services that will lead to achieving desired outcomes and enhancing patient experience". This is measured through a set of waiting time indicators within the quality framework to guide healthcare future strategies and improvements.

The Health System of the Emirate of Abu Dhabi is comprehensive, encompassing the full spectrum of health services and it is accessible to all residents of Abu Dhabi. The system is driven towards excellence through continuous outcome 'improvement' culture and monitoring achievement of specified indicators. Providers of health services are independent, predominately private and follow highest international quality standards. The system is financed through mandatory health insurance.

In doing so DoH will:

- Drive structure, process and outcome improvements across health sector
- Improve quality governance and leadership
- Put people first and champion their rights
- Focus on quality and act swiftly to eliminate poor quality of care
- Work with stakeholders and apply fair processes.
- Gather information and utilize knowledge and expertise to improve care.

Link the care to payment in a way that results in continuous improvement and maximize the value of the care provided in Abu Dhabi.

From that vision, the current methodology is developed for standardization of healthcare quality practice and data sources through two primary disciplines. The first one addressing the requirements of coding & claims process

requirements and the second one addresses the JAWDA key performance indicator requirements for provided services in terms of timeliness of care, patient safety and clinical effectiveness.

1.1 About JDC Methodology:

The methodology has been developed in collaboration with DoH policies, laws and standards to standardize the practice of the two healthcare workstreams disciplines coding & claims process and JAWDA key performance indicator process for all the healthcare facilities as per the applicability.

The methodology structure follows Plan Do Check Act technique for quality improvement and is based on the concept of process approach to enhance any kind of performance. Any discipline might be added later in the scope of the methodology.

What is process approach and PDCA style of implementation?

The application of a system of processes within a facility, together with the identification and interactions of these processes and their management to produce the desired outcome, can be referred to as the "process approach".

An advantage of the process approach is the ongoing control that it provides over the linkage between the individual processes and the system of processes, as well as over their combination and interaction.

When used within a JDC, such an approach emphasizes the importance of;

a) understanding and meeting requirements,
b) the need to consider processes in terms of added value
c) obtaining results of process performance and effectiveness, and
d) continual improvement of processes based on objective measurement

In addition, the methodology known as "Plan-Do-Check-Act" (PDCA) can be applied to all processes. PDCA can be briefly described as follows.

Plan: establish the objectives and processes necessary to deliver results in accordance with regulatory requirements.

Do: implement the processes.

Check: monitor and measure processes outputs against objectives and requirements and report the results.

Act: take actions to continually improve process performance.

1.2 Objective

The objective of JAWDA Data Certification is to improve the quality of clinical data documentation for the purposes of regulatory monitoring and control, reimbursement, research, analysis, and statistics and to meet the global standards, thereby contributing towards achieving Abu Dhabi's Vision, in delivering high quality services in the healthcare sector.

In addition, JAWDA Data Certification will strengthen the trust between payers and providers by:

- Enhancing the quality and the governance of health data by improving coding standards and data processing.
- Creating a shared understanding of the facility's coding quality
- Giving the payers confidence that a facility is coding and submitting accurately to DoH and other entities

- Enhance the governance, processes and validation of quality key performance indicators data collection and reporting.
- Providing healthcare providers with recommendations on the areas of improvement of quality of coding, collection and submission of clinical data within the scope of JDC.

This document is an update of the "Policy Manuals" that were published in 2012. The Manuals were drafted in collaboration with Abu Dhabi and international healthcare experts including the Joint Commission International ('JCI'), other health regulators, local and international legal advisors (Al Tamimi and Wragge and Co.), and delegates from Abu Dhabi and international Providers, Professionals and Insurers. The 2012 Manuals followed a structured consultation process comprising the formation of a permanent HAAD Policy Advisory and Consultative Panel and formal sector-wide consultation (8-12 weeks). The current document has been updated in light of the new relevant regulations published since 2012.

2 METHODOLOGY SCOPE

2.1 General:

What requirements does the methodology address?

The Department of Health (DoH) ensures excellence in Healthcare for the community by monitoring the health status of the population.

JAWDA Data Certification methodology is a set of requirements that determine how should clinical coding practices, Quality key performance indicators, and Quality governance aspects be planned, implemented, maintained and continually improved to build confidence between all key stakeholders through granting certificate of compliance to this methodology requirements.

2.2 Applicability:

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

Below are the audit scopes of JDC methodology 2019.

Audit scope for JAWDA Data Certification constitutes of four 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 and Self-Pay)
- Jawda KPI Data Validation (relevant to Quality Indicators Data Submission)
- Jawda KPI Process Review (relevant to Quality Indicators Data Submission)

Note 1: Exclusive Diagnostic centers, Laboratories, School clinics, optical centers, and pharmacies. Company clinics and university clinics are included.

Note 2: Exclusivity mentioned in Note 1 means operating without any physician consultation or therapies

Note3: Dental centers and self-pay, including medical tourism, services are under the current scope of methodology.

Note 4: KPI Domains are Applicable to all healthcare providers who are submitting Jawda KPIs to DOH.

3 NORMATIVE REFERENCES

Requirements stated in this methodology are considered mandatory for all healthcare facilities determined in the scope of applicability. Other reference requirements which are complementary to this methodology are also considered as applicable.

- DoH JAWDA Data Certification Methodology 2019 (Standard and Annexure - Certification Rules)
- CPT 4th Edition procedure
- ICD-10-CM Official Guidelines for Coding and Reporting
- Coding Manual for Hospitals & Other Healthcare Institutions, published by Health Authority- Abu Dhabi
- HAAD CLAIMS & ADJUDICATION RULES V2012 and all related Addendums
- American Medical Association (AMA)
- American Hospital Association (AHA) Coding Clinics
- USC & LS Codes and ICD-10 CM guidelines for Dental
- HAAD Health Insurance Claims Adjudication Standard
- HAAD Standard for Medical Billing Services in the Emirate of Abu Dhabi
- HAAD Standard for Provision of Long-Term Care in healthcare facilities in the Emirate of Abu Dhabi and Appendices
- HAAD Standard for Authorization of Homecare Health Services in the Emirate of Abu Dhabi Version 1.4 and Appendices
- HAAD Service Standards for Post-Acute Rehabilitation Services in the Emirate of Abu Dhabi
- HAAD Standards for Tele-consultation in the Emirate of Abu Dhabi
- Medical Record, Health Information Retention and Disposal Policy
- American Hospital Association’s Coding Clinic
- CPT Assistants
- Marshfield Clinic Tool or Trailblazer tool for E/M
- Merck’s Manual
- Dorland’s Medical Dictionary
- Stedman’s Medical Dictionary
- Centers for Medicare & Medicaid Services (CMS) manual system
- Medlineplus.gov (Normative references)
- Mayo clinic (Normative references)
- HAAD provider’s policy Manual
- HAAD Regulator Policy Manual
- HAAD Healthcare Professional Policy Manual
- All the relevant standards published by DoH and not limited to the above mentioned
- WHO Medical record standards
- Electronic Code of Federal Regulations, Part 11

- American Health Information Management System (AHIMA)- Body of Knowledge
- ASTM E1869-04(2014) Standard Guide for Confidentiality, Privacy, Access, and Data Security Principles for Health Information Including Electronic Health Records
- ASTM E2017 - 99(2010) Standard Guide for Amendments to Health Information
- ISO 9001:2015(paragraphs 7.2, 7.5, 8.0 in relation to the validation concept, 9.0, 10.0)
- Waiting time indicators from JAWDA program
- HAAD reference Quality Performance KPI Profile - Dec. 2015
- HAAD reference. Per Circular CEO 38/ 12
- HAAD Policy for Quality and Patient Safety (Document Ref No: Policy/Quality and Patient Safety/V1.0)
- Data Standard - HAAD Fourth Revision 14 April 2014 according to DSP decision 265
- Shafafiya and related references such as in Data Dictionary on DoH website
- ISO 27001 – IT Security Management System
- DoH Jawda Quality Performance Guidelines for Healthcare facilities (latest version as applicable)
- HAAD JAWDA Waiting Time (as applicable)

3.1 Terms and definitions

Activity: With reference to claims, an Activity is a clinical service, intervention, medication or material provided to the Patient on orders a responsible clinician, such as: drugs, consultations, investigations and surgical procedures. Some types of activities are used to describe multiple different services, such as room and board, per diems, consumables, DRGs, etc.

Audit: A systematic, independent objective identification of conformity to the standards.

An *audit* is a systematic evidence gathering process. *Audit* must be independent, and evidence must be evaluated objectively to determine the extent to which agreed criteria are fulfilled. There are three types of audits: first-party, second-party, and third-party

First-party audits are internal audits while second and third-party audits are external audits. Organizations use first party audits to audit themselves. First party audits are used to provide input for management review and for other internal purposes. They're also used to declare that an organization meets specified requirements (this is called a self-declaration)

Second party audits are external audits. They're usually done by customers or by others on their behalf. However, they can also be done by regulators or any other external party that has an interest in an organization

Third party audits are external audits as well. However, they're performed by independent organizations such as registrars (certification bodies) or regulators

Audit criteria: *Audit criteria* are used as a reference point and include policies, requirements, and other forms of documented information. They are compared against audit evidence to determine how well they are being met. Audit evidence is used to determine how well policies are being implemented and how well requirements are being followed

Audit evidence: *Audit evidence* includes records, factual statements, and other verifiable information that is related to the audit criteria being used. Audit criteria include policies, requirements, and other documented information

Audit findings: *Audit findings* result from a process that evaluates audit evidence and compares it against audit criteria. *Audit findings* can show that audit criteria are being met (conformity) or that they are not being met (nonconformity). They can also identify best practices or improvement opportunities

Audit program: An *audit program* refers to a set of one or more audits that are planned and carried out within a specific time frame and are intended to achieve a specific audit purpose

Adjudication – Claims judgment process for settlement

Ancillary Services – Laboratory, Pathology services as per the scope of this methodology

Billing-related error– Category of an error which resulted from incorrect assignment of billing guidelines like encounter type, date of service etc.,

Characteristic: A *characteristic* is a distinctive feature or property of something. Characteristics can be inherent or assigned and can be qualitative or quantitative. An inherent characteristic exists in something or is a permanent feature of something while an assigned characteristic is a feature that is attributed or attached to something

Claim(s) - A claim is an original request for payment for health services provided to a single Patient. Claims are generally linked to Patients who are covered by health insurance. For the purposes of this guidance, any invoices made out to non-insured Patients should also be considered as Claims.

Coding-related error– Category of an error which resulted from incorrect assignment of ICD and/or CPT codes or HCPCS

Co-morbidity (diagnosis) – Co-morbidities are conditions that exist at the same time as the principal condition in the same patient (for example hypertension is a co-morbidity of ischemic heart disease or diabetes), e.g. one or more coexisting medical conditions or disease processes co-occurring with a primary disease or disorder

Complication (diagnosis) – In coding, a complication generally refers to a misadventure of a medical or surgical procedure or intervention, an adverse outcome from clinical intervention. In medicine, an additional problem that arises following a procedure, treatment or illness and is secondary to it. A complication complicates the situation

Competence: *Competence* means being able to apply knowledge and skill to achieve intended results. *Being competent* means having the knowledge and skill that you need and knowing how to apply it. Being competent means that you're qualified to do the job

Complaint: *A Complaint* refers to an expression of dissatisfaction with a product or service and is filed by a customer and received by an organization. Whenever a customer lodges a complaint, a response is either explicitly or implicitly required

Conformity: *Conformity* is the "fulfillment of a requirement". *To conform* means to meet or comply with requirements and a requirement is a need, expectation, or obligation. There are many types of requirements including customer requirements, quality requirements, quality management requirements, management requirements, product requirements, service requirements, contractual requirements, statutory requirements, and regulatory requirements

Continual improvement: *Continual improvement* is a set of recurring activities that are carried out in order to enhance performance. Continual improvements can be achieved by carrying out audits, self-assessments, and management

reviews. Continual improvements can also be realized by collecting data, analyzing information, setting objectives, and implementing corrective and preventive actions

Correction: A *correction* is any action that is taken to eliminate a nonconformity. However, corrections do not address root causes. When applied to products, corrections can include reworking products, reprocessing them, regrading them, assigning them to a different use, or simply destroying them

Corrective action: Corrective actions are steps that are taken to eliminate the causes of existing nonconformities in order to prevent recurrence. The corrective action process tries to make sure that existing nonconformities and potentially undesirable situations don't happen again

Data: The term *data* is defined as any facts about an object

Data Collection: For the purpose of JDC methodology, it is defined as the process of collecting variables of data required for reporting as per the definitions of Jawda KPIs.

Data Validation: For the purpose of JDC methodology, "Data validation could be defined as a process which ensures the correspondence of the final data meets the required quality characteristics of data variables as per the definitions of Jawda KPIs**."**

Date of Expiry – The expiry date listed on the Certified Facility List on www.haad.ae/datadictionary

Day case – Licensed Setting where the patient is medically expected to remain confined for 6-12 hrs. for treatment, primarily surgical interventions performed in Ambulatory Surgery Centers (ASCs) or Hospitals that are licensed / sublicensed, equipped and operated.

Delisting - Removal of certification status due to expiry.

Denial – Claim rejected for payment.

Department – Within the Audit Methodology, a department is either Inpatient Encounters, Outpatient Encounters (inclusive of Day case/ Telemedicine and/or Homecare), or Emergency Department Encounters

Determination: *To determine* means to find or to identify the value of a characteristic

Documentation-related error– An error resulted due to incomplete, or inaccurate or unspecific physician documentation to support the services rendered

Effectiveness: *Effectiveness* refers to the degree to which a planned effect is achieved. Planned activities are effective if these activities are actually carried out and planned results are effective if these results are actually achieved

Encounter Type – Place of service codes used on the claims, they specify the entity where the service was rendered e.g., emergency

Evidence – Supporting Documentation or record of information for audit findings.

Facility - Each individually licensed health care provider where license is issued by Department of Health (DOH) previously known as HAAD

Facility setting – Each facility setting refers to the place of service like Outpatient, Emergency, Home Care, Inpatient, Day case (Day surgery) etc

Improvement: *Improvement* is a set of activities that organizations carry out in order to enhance performance (get better results). Improvement can be achieved by means of a single activity or by means of a recurring set of activities

JAWDA - DoH has launched and initiated JAWDA-Abu Dhabi Healthcare Quality Index Indicators. JAWDA is the Arabic word for Quality. The indicators are aimed at improving the quality of the healthcare services provided to nationals and residents in the Emirate of Abu Dhabi and beyond if agreed. The guidance sets out the definitions, parameters and frequency by which JAWDA Quality indicators will be measured and submitted to DoH and will ensure Healthcare Providers provide safe, effective and high-quality services

JAWDA Sampling Tool – DoH application for claims random sample generation from Knowledge engine for Health (KEH)

KEH - HAAD has developed Knowledge Engine for Health (KEH), a data warehouse for exchange and analysis of health data within Abu Dhabi Emirate. The front end of the data warehouse is information portal which serves as a communication gateway for the community. KEH portal provides information and data exchange services, such as the data dictionary, discussion fora such as wikis, a gateway and web services for exchanging transactions between healthcare providers and insurers. KEH data warehousing solution is built upon a MS SQL server 2005 database, using Integration services to load xml files and populate data tables, and Analysis services to maintain analytical data cubes.

Management: The term *management* refers to all the activities that are used to coordinate, direct, and control organizations. These activities include developing policies, setting objectives, and establishing processes to achieve these objectives. In this context, the term management does not refer to people. It refers to what managers do

Measurement: *Measurement* is a process that is used to determine a value. In most cases this value will be a quantity

Medical Necessity – defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care

Monitoring: To *monitor* means to determine the status of an activity, process, or system at different stages or at different times. In order to determine status, you need to supervise and to continually check and critically observe the activity, process, or system that is being monitored

Nonconformity: *Nonconformity* is a nonfulfillment or failure to meet a requirement. A requirement is a need, expectation, or obligation. It can be stated or implied by an organization or interested parties

Objective audit evidence: *Objective audit evidence* is information that is verifiable and generally consists of records and other statements of fact that are relevant to the audit criteria being used

Objective evidence: *Objective evidence* is data that shows or proves that something exists or is true. *Objective evidence* can be collected by performing observations, measurements, tests, or using other suitable methods

Performance: The term *performance* refers to a *measurable result*. It refers to the measurable results that activities, processes, products, services, systems and organizations are able to achieve. Whenever they *perform well* it means that acceptable results are being achieved and whenever they *perform poorly*, unacceptable results are achieved

Performance indicator: A *performance indicator* (metric) is a characteristic that is used to measure customer satisfaction and how well outputs are realized

Policy: A *policy* is a general commitment, direction, or intention and is formally stated by top management. A *quality policy statement* should express top management's commitment to the implementation and improvement of its quality management system and should allow managers to set quality objectives

Pre-Authorization – Prior approval for services by insurance provider or payer

Present on Admission (POA) - Present on admission is defined as the conditions present at the time the order for inpatient admission occurs. The POA indicator is intended to differentiate conditions present at the time of admission from those conditions that develop during the inpatient admission

Principal Diagnosis - Inpatients:

Condition established, after study, to be chiefly responsible for causing the admission of the patient to the healthcare facility including a suspected diagnosis or a probable diagnosis and is based on the patient's presenting history and physical and the physician's review of symptoms

Primary Diagnosis - Outpatients:

The condition or problem that is the reason the patient presented to healthcare and the clinician's assessment of these presenting symptoms/problems and corresponds to the tests or services provided; a symptom where the underlying causes has yet to be determined; the reason why the patient presented to for healthcare services

Provider - A doctor, hospital, healthcare professional or healthcare facility

Process: A *process* is a set of activities that are interrelated or that interact with one another. *Processes* use resources to transform inputs into outputs. Processes are interconnected because the output from one process often becomes the input for another process

While *processes* usually transform inputs into outputs, this is not always the case. Sometimes inputs become outputs without transformation

Organizational processes should be planned and carried out under controlled conditions. An effective process is one that realizes planned activities and achieves planned results

Process approach: The *process approach* is a management strategy. When managers use a *process approach*, it means that they manage and control the processes that make up their organization, the interaction between these processes, and the inputs and outputs that tie these processes together

Process-based quality management system: A *process-based quality management system* uses a process approach to manage and control how its quality policy is implemented and how its quality objectives are achieved. A *process-based QMS* is a network of interrelated and interconnected processes

Each process uses resources to transform inputs into outputs. Since the output of one process becomes the input of another process, processes interact and are interrelated by means of such input-output relationships. These process interactions create a single integrated process-based QMS

Quality: The adjective *quality* applies to objects and refers to the degree to which a set of inherent characteristics fulfills a set of requirements. An *object* is any entity that is either conceivable or perceivable and an inherent characteristic is a feature that exists in an object

The *quality of an object* can be determined by comparing a set of inherent characteristics against a set of requirements. If those characteristics meet all requirements, high or excellent quality is achieved but if those characteristics do not meet all requirements, a low or poor level of quality is achieved. So the quality of an object depends on a set of characteristics and a set of requirements and how well the former complies with the latter

Quality management: *Quality management* includes all the activities that organizations use to direct, control, and coordinate quality. These activities include formulating a quality policy and setting quality objectives. They also include quality planning, quality control, quality assurance, and quality improvement

Quality management system: A *quality management system (QMS)* is a set of interrelated or interacting elements that organizations use to formulate quality policies and quality objectives and to establish the processes that are needed to ensure that policies are followed and objectives are achieved. These elements include structures, programs, practices, procedures, plans, rules, roles, responsibilities, relationships, contracts, agreements, documents, records, methods, tools, techniques, technologies, and resources

Re-audit – Audit conducted after a failure in initial audit.

Recertification - Renewal of previously achieved JAWDA Data Certification as per the applicable criteria. The schedule of recertification will be determined by the certification body (TRBA). Facilities shall apply 2 months prior to the schedule to enable the activities to be completed prior to expiry of certification and to avoid any discontinuity in the listing.

Resubmission – Claim resubmitted to insurance for reimbursement

Revoking of Certification - Removal of certification status due to an unfavorable outcome of re-audit or when a facility subject to, restriction, suspension or proscription by a public authority

Regulatory requirement: A *regulatory requirement* is an obligation that is specified by an authority which gets its mandate from a legislative body

Requirement: A *requirement* is a need, expectation, or obligation. It can be stated or implied by an organization, its customers, or other interested parties. A specified requirement is one that has been stated (in a document for example), whereas an implied requirement is a need, expectation, or obligation that is common practice or customary There are many types of requirements. Some of these include customer requirements, quality requirements, quality management requirements, management requirements, product requirements, service requirements, contractual requirements, statutory requirements, and regulatory requirements

Review: A *review* is an activity. Its purpose is to figure out how well the thing being reviewed is capable of achieving established objectives. *Reviews* ask the following question: is the subject (or object) of the review a suitable, adequate, effective, and efficient way of achieving established objectives

There are many kinds of reviews. Some of these include management reviews, design and development reviews, customer requirement reviews, nonconformity reviews, and peer reviews

Risk: *Risk* is the *"effect of uncertainty on an expected result"* and an *effect* is a positive or negative deviation from what is expected. The following two paragraphs will explain what this means. This definition recognizes that all of us operate in an uncertain world. Whenever we try to achieve something, there's always the chance that things will not

go according to plan. Sometimes we get positive results and sometimes we get negative results and occasionally we get both. Because of this, we need to reduce uncertainty as much as possible. *Uncertainty* (or lack of certainty) is a state or condition that involves a deficiency of information and leads to inadequate or incomplete knowledge or understanding. In the context of risk management, uncertainty exists whenever the knowledge or understanding of an event, consequence, or likelihood is inadequate or incomplete. While this definition argues that risk can be positive as well as negative, a note acknowledges that "*the term risk is sometimes used when there is only the possibility of negative consequences*".

Secondary Diagnosis - Inpatients: All conditions that co-exist at the time of admission, including chronic conditions, or develop subsequently, which affect the treatment received and/or the length of stay - that affect patient care in terms of requiring: Clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and/or monitoring; excluding diagnoses that refer to an earlier episode that have no bearing on the current hospital stay

Secondary Diagnosis - Outpatients: All co-existing conditions, including chronic conditions that exist at the time of the encounter or visit and require or affect patient management; excluding diagnoses that have no bearing on the current encounter

Traceability: *Traceability* is the ability to identify and trace the history, distribution, location, and application of products, parts, materials, and services.

Validation: *Validation* is a process. It uses objective evidence to confirm that the requirements which define an intended use or application have been met. Whenever all requirements have been met, a *validated status* is established. *Validation* can be carried out under realistic use conditions or within a simulated use environment. There are several ways to confirm that the requirements which define an intended use or application have been met. For example, you could do tests, you could carry out alternative calculations, or you could examine documents before you issue them

Verification: *Verification* is a process. It uses objective evidence to confirm that specified requirements have been met. Whenever specified requirements have been met, a verified status is achieved. There are many ways to verify that requirements have been met. For example, you could inspect something, you could do tests, you could carry out alternative calculations, or you could examine documents before you issue them

3.2 Abbreviations

AAPC - American Academy of Professional Coders

Ad-Hoc - Not Planned

AHA - American Hospital Association

AHIMA - American Health Information Management Association

AMA -American Medical Association

ASC - Ambulatory Surgery Center

ASTM	-	American Society for Testing and Materials
BMI	-	Body Mass Index
CDA	-	Canadian Dental Association
CEU	–	Continuing Education Unit
CEO	-	Chief Executive Officer
COO	-	Chief Operations Officer
CFO	-	Chief Financial Officer
CMS	-	Centers for Medicare and Medicaid Services
CPT	–	Current Procedural Terminology
DSP	-	Data Standards panel
DTA	-	Decision to Admit
DoH	-	Department of Health
DRG	–	Diagnosis Related Groups
EKG	-	Electrocardiogram
E/M (E & M)	–	Evaluation and Management
EMR	–	Electronic Medical record
EHR	-	Electronic Health Record
ER	-	Emergency Room / Emergency Department
HAAD	–	Health Authority Abu Dhabi
HIPAA	-	Health Information Portability and Accountability Act, 1996
HIS	–	Health information System
ICD 10-CM	-	International Classification of Diseases Tenth Revision Clinical Modification
IP	-	Inpatient
ISO	-	International Organization for Standardization
JDC	-	JAWDA Data Certification
KEH	-	Knowledge Engine for Health
KPI	-	Key Performance Indicators
LTC	-	Long Term Care
MDM	–	Medical Decision Making
NICU	-	Neonatal Intensive Care Unit
PICU	-	Pediatric Intensive Care unit
NOPP	-	Nature of Presenting Problem
OP	-	Outpatient
OTC	-	Over the Counter
PDCA	-	Plan-Do-Check-Act
POA	-	Present on Admission

PMR - Paper Medical Records

SOP - Standard Operating Procedure

SPC – Standard Provider Contract

TRBA - TASNEEF-RINA Business Assurance

USC&LS- Unified System of Codes and List of Services (rules as established by the Canadian Dental Association)

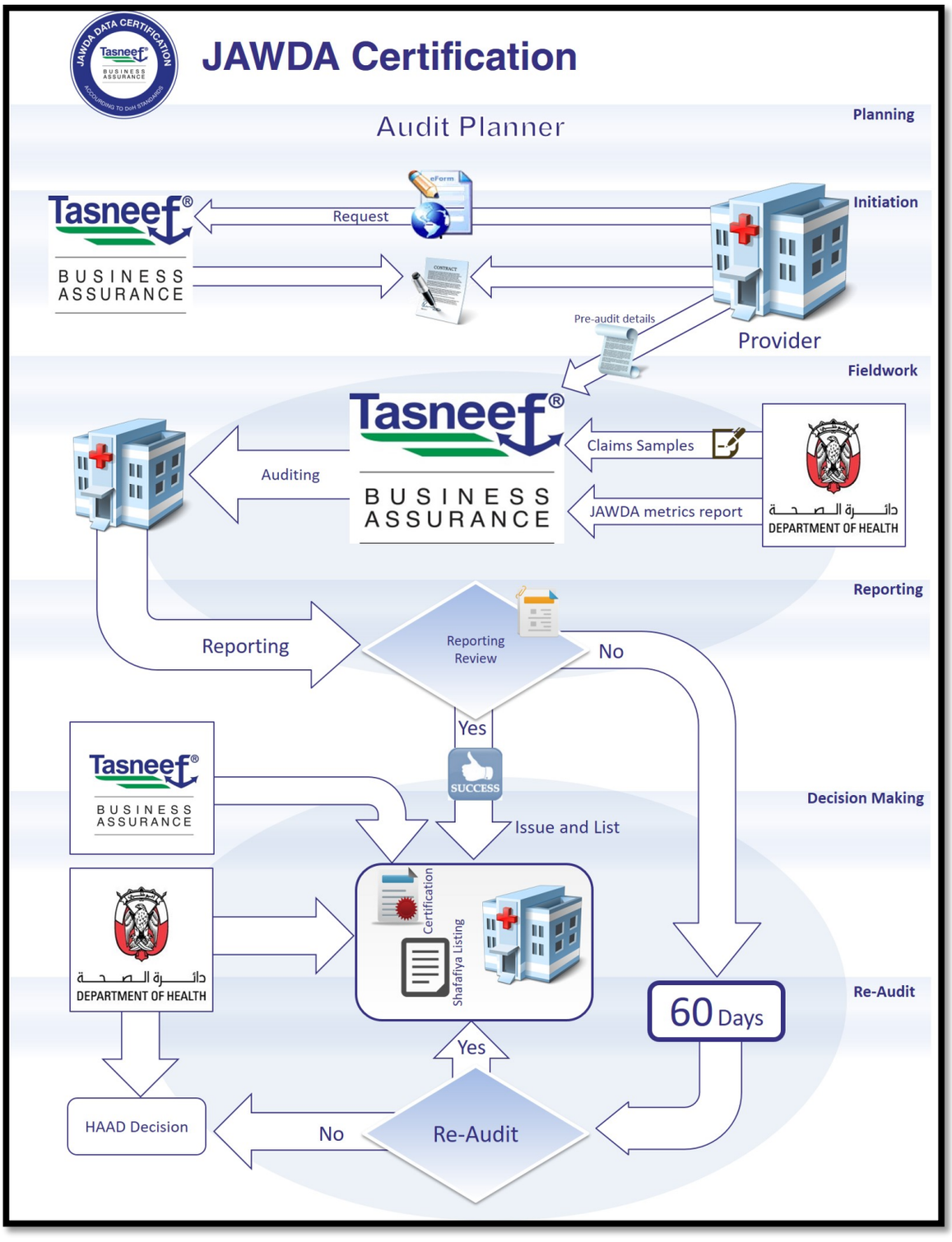
WHO - World Health Organization

4 CERTIFICATION BODY

Aiming at continuous improvement of quality care, patient safety and data quality in the Emirate of Abu Dhabi, the Department of Health (Health Authority Abu Dhabi) has signed a service level agreement with TASNEEF through its subsidiary TASNEEF-RINA Business Assurance (TRBA).TASNEEF is the only external certifying body to conduct JAWDA Data Certification compliance audits, and to issue certificates, to healthcare providers as described in this methodology, however DoH reserve the right to conduct its own assessment and auditing using internal resources if needed

Per the Notice as of 25th August, 2016, which is published on DoH website, “TASNEEF-RINA Business Assurance (TRBA) is authorized to issue “Clinical Coding Certifications” (CCC) defined in “HAAD Periodical No. 45 – Health Insurance HAAD Circular-45” as of 11 July 2011 which is now known as JAWDA Data Certification (JDC) as per the reference of circular DG-02-2018.” Any new circular or notice from DoH having any influence or impact or relation to JDC is applicable to this methodology.

JAWDA Data Certification-Audit Process



5 GENERAL REQUIREMENTS

1. The facility shall establish a documented JDC management system addressing all the mentioned requirements.
2. The Facility shall determine the processes that are necessary for coding, claiming, quality governance, and key performance indicators mandated by Department of Health - Abu Dhabi
3. Determine the interaction and sequences of the processes
4. Determine criteria and methods needed to ensure that both the operation and control of these processes are effective
5. Ensure the availability of resources and information necessary to support the operation and monitoring of these processes
6. Monitor, measure where applicable, and analyses these processes
7. Implement actions necessary to achieve planned results and continual improvement of these processes

For outsourced coding & claims process it is the facility's responsibility to identify the relevant controls which assure the compliance of performance of submitted claims by the outsourced entity.

5.1 Facility Authorized Compliance Representative

Each Facility is required to have a designated Point of Contact regarding:

- Coding Updates
- JDC Certification related activities
- Ensure adherence to HAAD Code of Ethics as mentioned in HAAD coding Manual. Please refer to Normative references
- In-house compliance monitoring, Documentation, Coding training workshops etc.,
- Discuss with CEO/Top Management to keep informed about the compliance status and concerns
- Initiate or take actions with the approval of CEO/Top Management when internal compliance has been threatened.
- All activities related to Quality & Monitoring to be routed through the CEO.
- DoH JAWDA Quality Performance KPI Profile (if applicable)
- Audit Evidences collection
- Audit coordination
- Leadership, Delegate or Representative to attend opening and closing meeting to ensure commitment of required corrective actions.

6 LEADERSHIP

Facility Top Management shall demonstrate relevant commitment to comply with the requirements of the JDC methodology and DoH regulations by the following:

a) Promoting the culture of quality, patient safety and proper performance of clinical coding & claims and JAWDA key performance indicators in compliance with regulations and requirements regardless of any other implications

b) Encouraging staff to participate in quality programs and fostering no blame and just culture to empower staff to report on errors.
c) Ensuring the necessary control measures in the implementation based on the risk assessment of the interactions between different functions' interests.
d) Ensuring the availability of resources for the implementation of requirements of JDC as well as any other DoH regulations.
e) Defining and approve clearly the roles & responsibilities, authorities, scope of work and objectives of the involved personnel individually or collectively in regard of quality aspects, medical records, data governance and risk management.
f) Commitment for the corrective actions required coming from the non-conformities raised by Third Party audits and or external parties and or regulatory bodies.
g) Ensuring policies for the internal communications to the relevant personnel to promote effective communication, such as easy reporting, safely communication without blaming, concerns, escalation, resolving conflicts, feedback and lesson learnt for Quality and patient safety concerns
h) Appointment of Leads required for the implementation, coordination, monitoring and reporting to top management about the facility performance of JDC. The responsibilities of Nominated leads should include but not limited to the following:
    - Coding Updates
    - Coding Certification related activities
    - Ensure adherence to HAAD Code of Ethics as mentioned in HAAD coding Manual. Please refer to Normative references
    - In-house coding monitoring, Documentation, Coding training workshops
    - Discuss with top management to keep informed about the compliance status and concerns
    - Initiate or take corrective actions with the approval of top management when internal compliance has been threatened.
    - All activities related to quality & monitoring to be routed through the top management

7 PLANNING

The Facility shall plan to develop, implement, maintain, and continually improve the clinical coding& claims and JAWDA KPI processes for all the applicable considering the following:

a) The facility shall establish, develop, document, implement, and regularly review and update Risk management
b) Program policy determining the criteria required to assess different kind of risks which may include but not limited to operational, clinical, financial, safety, Environment Risks with its relevant control measures
c) Assessment of clinical coding & claims and KPI process, the current practice putting in consideration the Facility internal and external issues, and regulatory requirements.
d) Identify the Gaps between current practice and requirements
e) Identifying the relevant control measures to reduce the identified gaps level to the most accepted tolerable level, and regularly review its suitability

f) Plan for control measures required for monitoring and measurements of different processes performance
g) The facility shall develop a documented quality program that includes but not limited to the DoH requirements, Facility vision, mission, values, quality model, quality and patient safety framework, responsibilities and accountabilities structure.
h) The Facility shall develop KPI profile defining different aspects like definitions, calculations, inclusion criteria, exclusion criteria, data source, way of collection, involved staff roles & responsibilities, validation roles & Responsibilities and the champion for the performance necessary actions within the different functions
i) Plan targeted objectives for all relevant functions and individual level for coding & claims process to improve the performance of the current practice.
j) Plan Targeted objectives for all functions and individual level for JAWDA KPI process to achieve targeted DoH value as well as to improve the current practice performance.
k) Plan to provide, and maintain required competencies consistent with identified roles, responsibilities and regulatory requirements.
l) Ensuring the proper interaction implementation between different functions in the processes interaction design that leads to the fulfillment of the planned arrangements.
m) The facility shall establish, develop, document, and implement Emergency preparedness policy that determining required resources, roles& responsibilities, competencies for different scenarios of potential IT system downtime. the planned arrangements shall be reviewed on planned interval to assess readiness' suitability to different identified scenarios recording the strength and weakness of the implemented drills and address the required corrective actions

8 Documentation Requirements and Implementation

(Performance and Operational Controls of Processes Execution)

DoH defines two key elements to quality in healthcare – Reliability and Excellence.

Reliability:

- The systematic reduction in errors or untoward events defined in DoH Standards
- Monitoring through self-checking or audits and inspections by DoH or by bodies on its behalf.

Excellence:

- The continuous improvement, beyond minimum Standards, of clinical care delivery, customer satisfaction and cost-effectiveness.
- Underpinned by the routine collection, analysis and use of health data for routine clinical audit by Providers (and Departments) and Professionals.
- Driven towards continuous improvement through a clear "pay for quality" incentive system with intention of improving clinical data quality thereby improving quality of patient care.

To obtain JAWDA Data Certification, the facility must:

- Have established a Management System and keep it active in total conformity with the requirements of the DoH JDC Methodology 2019.
- The management system is considered as being fully operative when processes, verification points and documented information are established.

8.1 General

All the documentations as seen necessary per the regulatory requirements References, Regulations and developed policies that are seen by the Facility are necessary for the planning and implementation of the JDC scope or facility requirements.

8.1.1 General Documents and Records controls

A documented procedure shall be established to define the controls needed

a) to approve documents for adequacy prior to issue,
b) to review and update as necessary and re-approve documents,
c) to ensure that changes and the current revision status of documents are identified,
d) to ensure that relevant versions of applicable documents are available at points of use,
e) to ensure that documents remain legible and readily identifiable,
f) to ensure that documents of external origin determined by the Facility to be necessary for the planning and operation of the JDC are identified and their distribution controlled
g) to prevent the unintended use of obsolete documents, and to apply suitable identification to them if they are retained for any purpose.

Records established to provide evidence of conformity to requirements and of the effective operation of the JDC shall be controlled.

The Facility shall establish a documented procedure to define the controls needed for the identification, storage, protection, retrieval, retention and disposition of records.

Records shall remain legible, readily identifiable and retrievable.

The Facility shall plan and carry out service provision under controlled conditions putting in consideration the output of the planning stage and the records coming from the implementation of Process documents.

Controlled conditions shall include, as applicable,

a) the availability of information that describes the implementation requirements that might include and not limited to (Policies, checklists, instructions, References, Regulations, Guidelines)
b) the availability of developed treatment protocols, as necessary,
c) the use of suitable resources
d) the availability and use of monitoring and measuring tools,
e) the implementation of monitoring, measurement and validation of data
f) the availability of adequate and maintained equipment or applications ensuring the proper implementation of the process

g) Accessibility of updated information or processes required for effective implementation of process

JAWDA Data Certification documentation and records requirements for the below domains of certification are to be considered:

- Claims Review (Applicable for all licensed healthcare facilities)
- Clinical Coding Process Review (Applicable for all licensed healthcare facilities)
- "KPI" Process Review (Applicable for all facilities relevant to Quality Indicators Data Submission)
- "KPI" Data Validation (Applicable for all facilities relevant to Quality Indicators Data Submission)

8.2 Claims Review Records Implementation requirements:

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 a confidence that the submitted codes on claims that also forms 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 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

Claims Review is one of the domains of the JAWDA Data Certification. Claims review is a validation process to review physician documentation against the submission of reported clinical coded data by all healthcare providers. Below mentioned is the reference to clauses from HAAD Policy Manuals.

With Reference to HAAD Provider Policy Manual Chapter V. General Duties, Governance, and Change of Control, PART A, 45 Claims, Each Healthcare Provider must ensure that any claim (HAAD Healthcare Insurers Policy Manual and specified requirements thereof), (HAAD Standard Provider Contract), (HAAD Coding Manual), for payment which is submitted by it to a Health Insurer in respect of treatment provided at a Facility which it operates

- 45.1.1 relates only to treatment actually provided
- 45.1.2 is accurate in all other respects.
- 45.2 Each Healthcare Provider must ensure that it complies at all times with all DoH regulatory requirements relating to insurance fraud, abuse, misuse and mistakes and errors (Chapter VI: HAAD Healthcare Insurers Policy Manual).

With reference to Data Reporting requirements as stated in Healthcare Regulatory Policy Manual Chapter-6 Data Management, all Healthcare Providers and Healthcare Payers must submit healthcare data to HAAD, as specified in the HAAD Data Standards and Procedures, within the following three broad sources and reporting systems mentioned as below from Data Standards published by HAAD

- 67.1.1 routine transactions
- 67.1.2 public health notifications regarding
    a) vital statistics
    b) notifiable diseases
    c) injury and poison surveillance, and
    d) others for which HAAD may provide custom online interfaces.
- 67.1.3 additional healthcare data which may be requested by HAAD in accordance with its mandate as Abu Dhabi Health Regulator.
- 67.4 Healthcare Providers and Healthcare Payers must submit to HAAD healthcare data that are accurate, complete, in the format, by the means, and within the timeframe specified by HAAD.

All the facilities providing healthcare services to patients without claiming for insurances, either as paid by patient out of pocket or other.

8.2.1 Applicability

Claims Review will be applicable for all the claims generated from medical, surgical, home health care, Long term care, Rehabilitation, Telemedicine, Dental and Self-Pay services specific to ICD-10 CM diagnosis and CPT 4th Edition procedure codes, E/M codes for all applicable visits, All applicable Service codes, DRG when applicable, USC&LS Codes for Dental, as well as HAAD Telemedicine Service Codes.

- Drug Codes provided for prescriptions will not be considered in scope. (i.e. Green Rain).
- In addition, codes for supplies, and other ancillary services (Laboratory and Pathology) will not be part of the audit however, the diagnosis codes supporting the ancillary services will be checked for supporting documentation of medical necessity. Physicians should clearly document the intention and justification for lab order or prescriptions.
- CPT codes or any codes billed with zero charges are still considered as part of the audit, will be verified for the relevant documentation
- Technical errors or malfunctions and typographical errors resulting in incorrect claim submissions or submissions with mismatched documentation details will still be part of audit and verified as per the standard criteria.

NOTE 1: All the diagnosis codes provided to support the prescriptions, diagnostic investigations should be identified in documentation as “Working Diagnosis” or “Rule out Diagnosis” or “Provisional Diagnosis” and should be reflected in schema of submission.

8.2.2 Claims Review Aspects

Same criteria of documentation and claims are applicable for Self-Pay. However, the billing or adjudication rules for Self-Pay services may not be completely applicable.

Aspects specific to claims review are mentioned as below:

a) The audit focus is on clinician documentation and accurate application of codes assignment on the claims irrespective of billed charges.
b) In all Established E/M visits, the mandatory key component should include Medical Decision Making.
c) Considering the regional variation for prescription drugs and OTC, Prescription drug management alone cannot be considered as moderate severity of Risk in E/M table. Nature of presenting problem that support the medical necessity shall also be taken into consideration in such scenarios.
d) All Clinical judgements should have corresponding medical necessity documentation in the medical record to conclude on such diagnosis.
e) In addition to coding incorrect level of E/M or incorrect category of E/M compared to documentation, the other possible E & M errors also include the following:
    - No E&M code assigned in Outpatient, Day Case/Emergency, where relevant.
    - No E&M code assigned in Inpatient, when documented
f) DoH recommends the 1995 Guidelines for Evaluation and Management codes be utilized. However, if a facility has used the 1997 E&M Guidelines, this must be stated at the onset of the audit. The auditor will then audit using the appropriate guidelines and state the specified guidelines.
g) The facility must state one guideline or another, as the use of a combination of these two guidelines is not acceptable.
h) If a facility has shifted from use of one guideline to another, it should be stated at the time of application for audit providing a declaration letter.
i) When assigning an Evaluation and Management Level of Service for a patient encounter, significant factors to consider are the Nature of the Presenting Problem (NOPP) and the complexity of Medical Decision Making (MDM) as it explains the medical necessity.
j) As per the ICD guidelines, Symptoms that are routinely or usually associated with the condition are considered as integral to the disease or condition. This cannot be an exception unless physician clearly documents that the symptom is not considered as integral to such condition and provide the reason for further investigations and differential conditions suspecting to be the cause for such symptom (excluding from current condition). The references for symptoms can be Merck's Manual, Dorland's Dictionary listed as references in coding manual. Additionally, coders can refer to Medlineplus.gov from National Library of Medicine and or Mayo clinic.
k) Any specific details of coding where there is no one specific guideline, facility can choose to adopt any of the standard best practices guidelines however, shall be documented clearly in the clinical coding policies of the facility regarding the adopted guideline and its implementation shall be clearly stated. Missing details of the specific guideline, applicability and implementation shall be considered as no policy.
l) All grey areas in coding which are not addressed in coding manual or adjudication rules or DoH standards or coding guidelines, should be mentioned in internal coding practice policy and procedures of that facility. A specific aspect in coding is considered as grey area only when the regulator and certification body have agreed it as such.
m) Any special circumstances specific to a facility can be notified with sufficient documentation and evidences to forward the request to concerned authority for a decision. The exceptional circumstance should be considered as an exception by the concerned regulatory authority and shall not be a decision by the facility.
n) As part evaluation of the Clinical Coding and Data Process, facility should be able provide with complete access to required data and documentation as per contract with TASNEEF. Facility shall provide auditors with access to all the requested information regarding the claims and process, not limited to any single visit or document. If required, auditors can review the documentations of previous visits to form thorough conclusions required for complete evaluations. Evaluation is not restricted to provided sample claims information only.

o) Occasionally, all healthcare providers shall agree to provide with all the requested claims information, though previously audited by TRBA, considering as an ad-hoc audit. This may involve same sample or different sample or a mix of claims or any other verification as requested by regulatory authority.

8.2.3 Verification Points

The facility shall always make available the medical records required for claims review. All the documents or reports generated from each visit should be compiled and are integral part of patient's medical record. All such information should be linked to patient file or medical record and should be readily available. The required documents are listed as applicable below but not limited to:

- Patient Visit information forms / Visit note
- Physician Assessment or evaluation or consultation records
- Consultation evaluation Records
- Nursing assessment Nursing Documentation Records
- Procedures Notes records/operative notes records
- Physician Assessments prior to admission
- Medication administration records
- Referral summary notes/records
- Laboratories and radiology orders and results records
- Insurance approval/Pre-authorization documents
- Medical Reports
- Pathology notes
- Patient Consent forms and records
- Therapy assessments and notes
- Counselling and education notes
- BMI assessment forms
- Specialty specific procedure forms
- Anesthesia records
- Physician Progress notes
- Discharge summary
- Face to Face forms
- Medication/ Prescription order forms
- Infusion/Hydration/Nebulization forms
- Input / Output monitoring forms
- Vital signs monitoring forms
- NICU/PICU Report
- Obstetrics/Delivery Report
- ER Consultation or ER physician assessment sheet
- Initial assessment with History and Physical examination
- Subsequent Assessment forms and or progress notes
- Discharge Summary of Referring Physician (Home Care/LTC)
- Referral Notes/face to face form from the treating Physician (Home Care/LTC)
- In house Physician evaluation form (Home Care/LTC)
- Daily Activity forms (Home Care/LTC)
- Nursing care plan (Home Care)

- Insurance approval documentation records
- Therapy assessments and notes records
- Counselling and education Records
- Nursing assessment records
- Progress notes records by nursing
- Any reports from EKG, Doppler or any other medical evaluation reports

8.3 Clinical Coding Process Review Implementation requirements

With reference to HAAD Professional Policy Manual, Chapter 45.2, Each Healthcare Professional must communicate fully with all Patients and keep them informed about the nature and purpose of all tests and treatment and communicate promptly and fully all results and the clinical implications of such results.

With Reference to HAAD Provider Policy Manual Chapter V. General Duties, Governance, and Change of Control, PART B, 48 Policies -

- 48.4 The policies and procedures must be revised by the Provider to ensure that they remain accurate and up to date at all times.
- 48.5 A copy of the policies and procedures must be available to and readily accessible by all staff at each Facility to which they relate.
- 48.6 Each Provider must ensure that its policies and procedures are complied with.

With reference to HAAD Provider Policy Manual Chapter VII Standards of Care, Patient Assessment and Records, Each Healthcare Provider must maintain a record for each of its Patients (a Patient Record).

- 96.2 A Patient Record shall document
- 96.2.1- the health history of the Patient
- 96.2.2- the patient consent to the health intervention, services to be provided and likely access to the Record for the purposes of health insurance coverage
- 96.2.3 - the date, any referrals and the findings of each assessment or physical examination of him which is carried out at any of the Provider's Facilities
- 96.2.4 - the treatment provided to him at any of those Facilities, and
- 96.2.5 - where the Patient is treated at an Inpatient Facility
- 96.2.5.1 - a clinical summary of his condition and plan of care at the time of his discharge from the Facility, and
- 96.2.5.2-Adverse incidents affecting the patient in the course of treatment at the inpatient Facility.
- 96.3 - A Patient Record must be written in the English language.
- 96.4 - The Provider must ensure that each Patient Record is readily available to all those of its staff who are responsible for the treatment of the Patient.

Coding processes will be audited at the facility to assess the establishment of policies based on standard and regulatory requirements of HAAD Coding manual, Criteria and normative references mentioned in this document, and adherence to it.

It is imperative that properly trained hospital staff are involved at the appropriate phases to ensure accuracy of information reported on each claim.

8.3.1 Applicability

Clinical Coding Process Review will be applicable for all the departments involved in the claim and coding cycle starting from registration to completion of claim cycle.

8.3.2 Clinical Coding Process Review Aspects

Successful processes should be understood and followed by all involved. The facility will be rated on the facility's understanding and adherence to their process. The process of adherence check is to understand the deficiencies in the Management System.

The facility shall document the coding processes in suitable form relevant to the complexity of the process and size of facility ensuring the following:

A. **Organizational Claims and Coding Process Flow chart:** Reflecting the process flow of activities involved in the Claim process of the subject facility addressing the following:
    a. Completeness of documentation by querying physician
    b. Accuracy of the coding determining the controls
    c. Interaction of coder with other functions of claims cycle

B. **Clinical Coding Practice policies(s):** The updated and authorized coding policy addressing the practices of clinical coding at the facility. The policy should be able to state all the guidance and standard coding and claiming references to be reviewed and followed for effective and accurate coding process. The specific scenarios where there is no clear stated guideline available from authentic sources or regulatory, facility can adopt to include a suitable and international best practice in the policy to be put into practice. The policy(s) should be able to address the below mentioned but not limited to:
    a. Accessibility of updated Coding references
    b. List of Standard Coding References
    c. Ethical coding Assignment
    d. Effective Coder-Physician query process
    e. Coding for Pre-Authorization and Resubmissions
    f. Dental Coding, claiming, Pre-authorizations
    g. Self-Pay specific coding and Claim process

C. Health Care Medical Record Documentation policies:

A patient's health record plays five unique roles: (1) It represents that patient's health history (2) It provides a method for clinical communication and care planning (3) It serves as the legal document describing the healthcare services provided. (4) It is a source of data for clinical, health services, and outcomes research. (5) It serves as a major resource for healthcare practitioner education. The facility shall put in place the policies and processes of medical records documentation ensuring the following and shall be able to present the relevant records for review as necessary for JDC process:

i. **Timeliness:** Time lines of documentation completion and encouraged to enter all details at the time of rendering service. Completion of addendums within timelines.

ii. **Completeness and relevancy:** Maintaining the medical records and for ensuring that they are completely and accurately documented, readily accessible, and systematically organized. State the system of E/M guidelines to use and the template of documentation reflects the stated guidelines format. Completeness of medical record which shall expand to include the all generated records from

different functions, documentation establishing medical necessity of the performed services, describe the basis and assumptions upon which the medical decision is taken by addressing the clinical significance of abnormal test results, the description shall be written in narrative manner instead of mere code selection. In all Established E/M visits, the mandatory key component should include Medical Decision Making. Established patient visit documentation has equal requirements as of new patient. Distinguish clearly the differential diagnostic conditions from Final or confirmed diagnosis. Extent of Documentation Examples not limited to: (No. of views of X-ray, ultrasound techniques, detailed report of findings and conclusion, contrast documentation, physician authentication of orders, physician confirmation of ancillary report results, start and stop times, documentations of technique, site, type of anesthesia, course of procedure, observations if any, complications or risks if any, closure technique, hemostasis status and patient instructions, details of counseling and education along with the specific times, Chief complaint, applicable histories, Review of systems, relevant Physical examination, orders with justifications, obtained or reviewed results or records, treatment, management plan, education if required, referral if required, and so on further as required per the best practices of international documentation and medical standards.

iii. **Medical Necessity documentation:** Medical necessity is defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. Medical necessity is best supported in MDM documentation. Address the clinical significance of abnormal test results
    1. Support the intensity of patient evaluation and treatment
    2. describe the thought processes and complexity of medical decision making;
    3. include all diagnostic and therapeutic procedures, treatments, and tests ordered and performed, in addition to the results.

iv. **Quality of Documentation:** Processes to establish the integrity of documentation by creating controls to avoid cloning, copy/paste, template documentations practices, documenting related and relevant information to the current visit reason, and all the information that is affecting care plan and management of patient health.

v. **Confidentiality of Patient Health Information** (Paper and Electronic medical records)

D. **Medical Records Keeping Policy:** The facility shall put in place the policies and processes of record keeping principles and controls for both electronic and paper generated records ensuring the following:
Facility shall state in the policy regarding the type of medical records as paper, electronic or hybrid.
    a. Paper Medical Records (PMR)
        i. Clearly and permanently identify any amendment, correction or delayed entry as such(PMR)
        ii. Clearly indicate the date and author of any amendment, correction or delayed entry, and(PMR)
        iii. Not delete but instead clearly identify all original content (PMR)
        iv. Protect the integrity of documentation
    b. Electronic Health records (EHR):
        i. Distinctly identify any amendment, correction or delayed entry (EHR)
        ii. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record. (EHR)
        iii. Security: As per the Data Standards Fourth revision 14 April 2014 according to Data Standards Panel decision 265, published by HAAD and per other applicable regulatory standards

1.1 to protect electronic health information created, maintained, and exchanged encryption and decryption of electronic health information

2.1 Controls determined related to modifications authority, deleting, approval authority, and audit log for record history

The scope of verification is limited to data creation, generation, implementation, reporting, security, accessibility, availability, readiness of information, audit trail system, access controls, back up and data retention, and Data integrity.

There is no published UAE official guidance regarding records management. In the absence of any official specific technical guidance, as a minimum, entities need to implement systems and processes that meet currently recognized industry best practices for electronic information record keeping.

E. Training Policies:

a. Training policies for new hire orientation on the regulatory (DoH) policies and standards, Coding and documentation requirements, training manuals and or SOP's for orientation of Internal applications involved in the activities of handling and generating health data. Documents or forms or plans for supporting the continuous education of involved personnel, as and when required.

b. Competencies Maintenance: Continuous education and competencies maintenance documents for involved personnel in the coding & claims process shall be evident not limiting to nominees of process interview

NOTE 1: one of the required competency in coding & claims process is mandatory Certified Coder with active status of AAPC or AHIMA or:

Evidence of contracted outsourcing for coding services

Action plan to train and certify a coder within the facility in a specific time (maximum 1 year)

NOTE 2: Certified coder is not a requirement for facilities with exclusive dental services, however, a training on coding guidelines for reporting ICD should be evident.

8.3.3 Verification Points

JDC methodology documentation requirements for Clinical Coding Process review includes developing, implementing and updating of processes, policies relevant to clinical coding, claim process and data submission but not limited to the following:

a) Organizational flow chart reflecting the claims and coding process being followed in the facility
b) Policies review - such as Coding Practice Policies
c) Healthcare Medical Record Documentation policies
d) Medical records keeping policy
e) Training and orientation policy
f) Record of Coder certification validation based on submitted proofs (Coder Credentials and Continuous education validation)

g) Adherence and Implementation of policies through respective departments
h) Verify the effective implementation of quality control process
i) Verify the effectiveness of query process and timely response
j) Verify the effectiveness of coding certified personnel interaction or involvement for pre-authorizations and resubmission process
k) Verify the understanding and adherence of healthcare documentation and medical records policies, and requirements as per the applicable criteria
l) Understanding and adherence of coding standards and coding practice policies
m) Verify the accessibility and demonstrated awareness of coding references.
n) Accuracy of the coding determining the controls for the availability of relevant Documentation, and updated references and regulations at the point of use
o) Verify the adherence of training policy and processes
p) Review understanding of ethical practices for coding
q) Gaps or deficiencies in the data creation, transformation, generation, submission and resubmission process
r) Review of control and modification of documents
s) Verify the awareness of claim cycle process and coding requirement by each function or department involved

8.4 JAWDA KPI Process Review Implementation Requirements

The aim of this quality measure is to improve the validity of KPI data collection, validation, and submission processes. This will add an extra layer of prioritization for the quality at the healthcare providers' level. Patient safety, clinical effectiveness and patient experience are recognized as the main pillars of quality in healthcare. Healthcare providers will be evaluated on processes in planning for data collection, validation and submission.

The process approach is the most relevant aspect of any quality system. The Abu Dhabi Health Authority orients its methodology to it for better control of any healthcare outcome.

A process is a set of activities that are interrelated or that interact with one another.
Processes use resources to transform inputs into outputs.

Processes are interconnected because the output from one process often becomes the input for another process.

Organizational processes should be planned and carried out under controlled conditions. An effective process is one that realizes planned activities and achieves planned results.

The objective is to ensure the fundamental requirements are in place by ensuring that the measures necessary for assuring quality and patient safety are in place with regards to structure, process and outcome. This is coupled with the processes and policies needed to achieve a continuous improvement in our healthcare.

8.4.1 Applicability

- JAWDA Program for Quality Indicators and metrics as applicable.
- DoH quality KPI; waiting time as applicable.
- Applicable to Hospitals, Home Health Care, Long term Care/ Rehabilitation providers, Centers/Clinics and please add the note just below the point:

Note: KPI Domains are Applicable to all healthcare providers who are submitting Jawda KPIs to DOH.

8.4.2 KPI Aspects

The facility shall establish, implement, maintain and continually improve a documented policy for Jawda key performance indicators, data collection, calculation, validation, and submission management system, including the processes needed and their interactions, for each applicable KPI ensuring the following in accordance with the requirements of this Standard.

Healthcare providers shall implement the data collection and submission under controlled conditions. Controlled conditions shall include:

- Nominate responsible data collection and quality leads(s).
- Ensure data quality leads are adequately skilled and resourced.
- Involved staff Roles and responsibilities
- Involved staff competencies and qualification
- Understand and identify what data is required, how it will be collected (sources) and when it will be collected.
- Create a data collection and validation plan.
- Identification of Data source and Involved functions
- Ensure adequate data collection systems and tools are in place.
- Maintain accurate and reliable data collection methodology.
- Data collection, cleansing and analysis for reliability and accuracy.
- Back up and protect data integrity.
- Verification and validation controls
- Have in place a data checklist before submission.
- Submit data on time and ensure validity.
- Review and feedback data findings to the respective teams in order to promote performance improvement.

Failing to submit valid data will be in breach of the licensing condition and could result in fines being applied, penalties associated with performance or revoke of license.

When needed, documentation and tracks will be provided instantly to DOH, or their representative (TRBA), to assure DOH that all dues processes are being followed in collecting, analyzing, validating and submitting your performance

8.4.3 Verification Points

Healthcare Provider must consider the following requirements to ensure the Robustness & Quality Governance points in consideration:

KPI Process for Planning, Support and Operations:

Planning to establish a process which can effectively perform while its variables or assumptions are altered, so that it can operate without failure under a variety of conditions. In general, the process established should be able to handle variability and yet remain effective;

* The Quality department can determine the resources selected for the roles of data collectors/validators/ KPI owners based on established criteria that ensures the accuracy of the data; and to determine the accountability for entire process as process owner.

The following shall be considered to ensure the robustness of KPI Data Process and submission to DoH, but not limited to.

i. Applicability of KPIs:
    a) List of all applicable KPI and its profiles approved by the top management with each KPI profile addressing- KPI title, Description, Rationale, Target, Calculation, KPI Owner, Data Sources, Data Collection and validation methodology, Data collection frequency, Inclusion/Exclusion Criteria, KPI Reporting Frequency etc., (4 points).
ii. Data Quality leads(s):
    a) Documented appointment or assignment letter from top management
    b) Job description with Clear roles & Responsibilities relating to Jawda KPIs and healthcare quality
    c) Training records on healthcare quality
iii. Data collectors/Validators:
    a) Documented Appointment or assignment or nomination letter from KPI owner or Quality Lead
    b) Competency determined for personnel involved (To demonstrate the relevant criteria established while nominating/assigning a role).
    c) Training records (ex. on data collection and/or validation methods)
    d) Performance evaluation at frequent intervals (at least annually and with every new assignment) to ensure the collectors/validators performance.
iv. Data Collection and Validation process:
    a) Approved Data collection and validation plan with defined components of data sources, frequency, measuring tools, responsibility
    b) Well-designed structure for data collection and validation
    c) Validation of collected data and Data can be traced to the source
    d) Completed data collection forms are signed off by the frontline KPI Owners prior to submission to Quality Department.
v. Corrective / Preventive action:
    a) Approved Corrective / Preventive action policy
    b) Associated forms
    c) Corrective / Preventive action (Ex: Patient complaint, …)
vi. Adverse and sentinel events:
    a) Approved Adverse and sentinel events Policy
    b) Associated forms
vii. Incident Reporting:
    a) Approved Incident reporting policy
    b) Associated forms
viii. KPI Report:
    a) Statistics report generated from the health information system are 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 prior to submission to DoH
ix. Data Submission:

a) Filled data checklist signed/approved
b) Signed Log of submission
c) Date of submission

x. Data Integrity and Backup plan:
a) Data privacy & confidentiality statement policy
b) Approved Backup plan in place

KPI Process for Quality Governance and Improvement:

Quality Governance provides a framework for organizations and individuals to ensure the delivery of safe, effective and high-quality healthcare. Its purpose is to help organizations, like hospitals, and their staff, monitor and improve standards of care. The healthcare facility should have in place established ongoing processes that are in alignment with the JDC certification needs. This chapter and domain should be considered in co-ordination and alignment with Chapter 10 of this document. The following can be considered to implement a framework of governance but not limited to:

i. Management review:
a) Management Review Policy and report (Management Review in alignment with clause 10.3)
b) Annual meeting plan and Meeting agenda (Quality topics such as KPIs progress, Trend analysis, Complaints management process, patient satisfaction, Facility performance on JDC management system etc. …)
c) Approved minutes of meeting
d) Corrective / Preventive action

ii. Quality Committee / Medical records Committee / Any Relevant Committee:
a) Committee Policy
b) Terms of reference include Purpose, Objective, Membership, Declaration of Conflict of Interest, Duties and Responsibilities, Authority, Distribution of minutes.
c) Annual meeting plan
d) Meeting Agenda
e) Approved minutes of meeting (signed by members and chairman)
- The last two minutes of meeting with clear reference to actions and defined responsibility
- The minutes to include the review of relevant topics from the last minutes of meeting.
- The minutes of meeting for the Quality Committee and Medical Records Committee are available, latest one being no less than 90 days from day of inspection

iii. Staff Awareness (Data collection Plan, Trend analysis, Progress, Calculation, Lesson learnt, Improvement):
a) Approved policy
b) Annual regular Internal communication plan
c) Minutes of Staffs meeting

iv. Quality monitoring:
a) Approved Quality policy
b) Quality program includes the organization mission, vision, values, quality model, quality and patient safety framework, responsibility/ accountability structure, etc.
c) Quality monitoring records / report and Quality Improvement process – actions /records (consider also criteria from 10.4 and 10.5)

d) Corrective / Preventive action

v. Internal Audits:
   a) Approved Internal Audit Policy
   b) Jawda KPI policies and performance audit (Planning, Checklist, Finding, Report, consider also criteria from 10.2)
   c) Corrective / Preventive action

vi. Jawda KPI Risk management: Documented risk assessment
   a) Approved risk Assessment Policy
   b) Approved Mitigation Plan for all identified risk
   c) Also refer to chapter 6 and 10.4

8.5 KPI Data Validation Implementation Requirements

The vision of DoH 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.

KPI validation is to ensure that KPI's definitions are followed as stated in DoH guidelines.

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.

The healthcare provider shall establish, implement, maintain and continually improve a Data Verification and Validation management system, including the processes needed and their interactions, in accordance with the requirements of this Standard.

Data verification is a way of making sure the user does not make a mistake when inputting data (An example of this includes double entry of data such as when creating a password or email to prevent incorrect data input).

Data validation is about checking the input data to ensure it conforms to the data requirements of the system to avoid data errors (Example: *Data range check / inclusion / exclusion*).

8.5.1 Applicability

vii. JAWDA Program for Quality Indicators and Metrics as applicable.
viii. DoH quality KPI; waiting time as applicable.

8.5.2 Verification Points

The different verification point, as applicable, are but not limited to the calculation of the following variables:

- Numerator
- Inclusions Numerator
- Exclusions Numerator
- Denominator

- Inclusions Denominator
- Exclusions Denominator
- Calculation
- Traceable data elements and Regeneration of report

The KPI values included in the management approved KPI Report shall be identical to the values uploaded on DoH JAWDA system.

9 AD-HOC KPI AUDITS

Ad-Hoc KPI audits shall be conducted on all the hospitals under the scope of Jawda KPI, except Rehabilitation hospitals.

Every facility in the scope of KPI data submission will undergo an ad-hoc KPI audit at least once in a year and it would be the responsibility of the facility to demonstrate their compliance status and to co-operate for the audit process as soon as the auditor arrives.

This audit doesn't belong or substitute to JAWDA Data Certification (JDC) planned audits.

The score generated from this audit is not related to JDC.

Ad-hoc audits are unannounced audits and facilities will not be given any prior information on the schedule. Refusal of this audit shall inevitably result as negative outcome of the verification to the facility, as per DoH.

10 MONITORING, MEASUREMENT & CONTINUAL IMPROVEMENT

The organization shall evaluate the performance of the JDC management system and its effectiveness. The organization shall retain appropriate documented information as evidence of the evaluations.

10.1 Patient and customer satisfaction

The facility shall monitor customers and patients' perceptions of the degree to which their needs and expectations have been fulfilled. The facility shall determine the methods for obtaining, monitoring and reviewing this information.

10.2 Internal Audit Program

At planned intervals, the facility shall conduct internal audits at least annually to evaluate if the JDC management system is implemented, maintained and is effective.

The organization shall:

a) implement an internal audit program including the frequency, responsibilities, JDC criteria, and reporting and retaining evidences and documented information of the audit results and follow up
b) conduct audits by impartial auditors
c) appropriate reporting to the relevant management

d) follow up on correction and corrective actions

10.3 Review of the Performance

10.3.1 General

Top management shall review the facility's management system, to ensure its alignment with the JDC requirements. The facility shall retain documented information as evidence of the results of management reviews. The overall review should be performed and documented annually.

10.3.2 Review Agenda

The management shall review the performance of facility's JDC system taking into consideration:

a. Follow up from previous review and any JDC audit aspect related
b. changes in the organization or from external aspects that may affect for the JDC system
c. information on:
    1)feedback from relevant interested parties such as DoH
    2)the extent to which objectives of JDC have been met
    3)status of nonconformities and corrective actions
    4)audit results from internal and external parties such as the certification body
    5)any other verification points as per 10.3.5
d. risks affecting JDC requirements, trends in quality indicators

10.3.3 Outputs of the review

The outputs shall include action plans related to:

a) improvements
b) verification and evaluation of system quality verification points in JDC Processes
c) assignment of responsibilities.

10.3.4 Periodical Management reviews

Regular reviews should be reported, documented and retained quarterly on the facility performance of JDC processes by pre - defined agenda, attendants list, how to whom, follows up from previous meetings, actions plan with clear responsibilities and timeframe.

Regular reviews could be partial management review meetings or other top management meetings with fixed agenda inputs and outputs on planned intervals.

At least one review has to be performed after JDC audits, and any changes to JDC methodology and/or DoH policies related to scope of JDC.

10.3.5 Verification Points

Verification points could be internal review and validation of data before pre-authorization and submission, regular verification of completeness of medical records, completeness of documentation, checklists, and different kinds of registers

NOTE. Audits could be Internal Audits, Peer evaluation, and retrospective/prospective Audits, second and third-party audits. Competencies and independency are important to be considered.

Resulted implementation Records to be maintained like but not limited to the following:

- Different committees signed and approved minutes of meetings
- Management review signed and approved minutes of meetings
- Audit records
- Corrective actions record
- Analysis studies records
- Incident investigations records

10.4 Improvement

10.4.1 General

The facility shall implement any necessary actions to meet JDC requirements and continuously improve the related system.

10.4.2 Nonconformity and corrective action as opportunity of Improvement

Nonconformities are also opportunities of improvement. The facility shall reply to a non-conformity from internal or external parties such as the certification body, by:

1) corrective actions
2) analyzing the nonconformity and determining the causes
3) Update risk registers if necessary

The facility shall document and retain information on:

a) analysis of the non-conformities
b) corrective actions

10.5 The Improvement Cycle

The facility shall verify the results of any audits internal or external, any customer or patient feedback and any study or trend made available from any parties including the review of the performance from the management, to determine the opportunity to improve the JDC system.