



دائرة الصحة
DEPARTMENT OF HEALTH

**JAWDA DATA CERTIFICATION (JDC)
CERTIFICATION RULES
FOR HEALTHCARE PROVIDERS
Methodology 2019-Part II
(ANNEXURE & APPENDICES)**

December 18



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TABLE OF CONTENTS

1	GENERAL	6
2	APPLICATION AND PLANNING FOR CERTIFICATION	7
2.1	Contract formation	7
2.2	Audit Planning.....	8
2.3	Audit Sample Type for Claims Review	9
2.4	Sampling method For Claims Review	10
2.5	Sampling for KPI Process and Validation:	10
2.6	Random Sample Sharing for Claims Review:	10
3	PERFORMANCE OF AUDITS	11
3.1	General.....	11
3.2	Audit Process:	11
3.3	Audit Evidence Collection	12
4	CERTIFICATION REQUIREMENTS AND GUIDELINES FOR CRITERIA.....	12
4.1	JAWDA Data Certification	12
4.2	Claims Review	13
4.3	Clinical Coding Process Review	16
4.4	Process Review for: “KPI” Quality Indicators.....	18
4.5	KPI Validation for Collection and Submission of Jawda Quality Indicators	21
5	DENTAL SERVICES.....	22
5.1	Audit Verification Points:.....	22
6	AUDIT ON SELF-PAY SERVICES/PROFORMA SERVICES	23
6.1	Audit Verification Points:.....	23
7	REPORT.....	24
7.1	Audit Report Format.....	25
8	NON-CONFORMITIES AND CORRECTIVE ACTIONS	26
9	WEIGHTS AND SCORING	27
10	DECISION MAKING	27
10.1	Passing Grade system for JAWDA Data Certification.....	28
11	RE-AUDITS	28
12	LISTING AND DE-LISTING	29
12.1	Impact of De-listing (Gap in Listing).....	30
13	TRANSITION PHASE OF OLD TO NEW METHODOLOGY:.....	30
14	MAINTAINING VALIDITY OF THE CERTIFICATE	30

14.1	Management of Certificates	31
15	MODIFICATION OF CERTIFICATION AND COMMUNICATION OF CHANGES	31
16	CONDITIONS AT WHICH AUDIT PROCESS WILL STOP.....	31
17	CONDITIONS AT WHICH CERTIFICATION PROCESS MAY BE SUSPENDED	32
18	SUSPENSION, REINSTATEMENT AND WITHDRAWAL OF CERTIFICATION	32
19	RENUNCIATION OF CERTIFICATION	33
20	NEW FACILITY LISTING AND EXTENSION OF LISTING	33
21	COMPLAINTS MANAGEMENT	34
	APPENDIX.....	1
	APPENDIX-I	2
	APPENDIX-II	5
	APPENDIX-III	10

ANNEXURE

CERTIFICATION RULES

for

JAWDA Data Certification for Healthcare Providers -
Methodology 2019 Part -II

1 GENERAL

These rules constitute integrate the Contract between certification body (TASNEEF) and Healthcare Facilities. These Rules are an integral part of the Methodology to achieve the JAWDA Data Certification. In this perspective, the rules describe to identify criteria that Facilities can or must apply for the JAWDA Data Certification related to the DoH JDC Methodology 2019 and how facilities can apply for obtain, retain, renew and use this certification, as well as its possible suspension and revocation.

1.1. Certification is in accordance with DoH JDC Methodology (dated January 2019) to facilities where Management System must be recognised as conforming. The Criteria of the certification are represented from the Methodology and other requirements of the reference standards or guidelines described in this document.

1.2. Certification is open to all Healthcare facilities in Abu Dhabi belonging to the following categories and encounters:

- Hospitals
- Medical Centres, Clinics, Home care Centers, Telemedicine, Long Term Care Centers /Rehabilitation Centers facilities/Dental Centers and all facilities offering Self-Pay Services Excluding Pharmacies, Optical shops, School Clinics and exclusive diagnostic laboratories, Dental Laboratories, Orthotics and Prosthetics.

TASNEEF is entitled to refuse requests for certification by facilities whose activities have been subject to restriction, suspension or proscription by a public authority.

When TASNEEF declines an application, the reasons shall be communicated to DoH and the facility CFO/CEO/COO or delegated authority including the representative for audit.

1.3. This document provides also guideline to the Criteria applicable to the certification process because the JAWDA Data Certification is oriented to apply a complete third-party concept audit.

Quality means the ability to satisfy requirements of regulatory, moral, material, social and economic nature, translated into stated requirements.

The quality of the health service (intended as the ability to satisfy the associated needs) is the result of a:

- series of scientific, technical and technological, organizational, procedural, relational and communicational elements in which a determining role is carried on by the human variables (health operators and service customers – in this concept is patients) that strongly interact in the realization processes, even more than in other activities also essentially based on human relations, such as education

The elements to be considered in quality in health and associated achievement services are therefore numerous and complex for example through:

1.4. adequate organization of the structure and suitable management of the primary and supporting services, which are reflected, though not strictly, in the ISO 9000 and other international standards and accreditation systems;

- adequate definition of the "technical" content of the services provided (service specifications), which corresponds to a series of specialized standard references of which medical-scientific documentation and diagnostic-therapeutic protocols are particularly important;
- qualification of assigned personnel (basic training, applicative knowledge, human skills and ethics behavior), which is related to the mechanisms of recruitment, selection, training;
- medical-scientific reference documentation (Protocols, Procedures or Instructions, etc.) that are used to support the records.

1.5. The JAWDA Data Certificate issued pertains exclusively to a single healthcare facility identified by its HAAD (DoH) license number.

2 APPLICATION AND PLANNING FOR CERTIFICATION

Facilities wishing to obtain certification for their JAWDA must provide TASNEEF with their main facility data and site location by filling in all parts of the “APPLICATION FORM” on TASNEEF website at www.tasneefba.ae/jdc to initiate the Certification process

Facilities applying for the first time, apply for certification thru the [online application](#) and notifications are received in the ba.jdc@tasneef.ae e-mail.

- Name of the Facility
- DoH License No.
- Facility Settings
- Contact Details
- Other mandatory fields

This information should be provided by an authorized representative of the applicant organization and shall be the point of contact for the entire certification process.

- For the re-certification, apply thru downloading the [registration form](#) online and are sent the ba.jdc@tasneef.ae e-mail and /or to admins. Facility must confirm the schedule and share the facility location and contact details along with location map and landmark.
- All the requests should accompany with the copy of DoH license.
- All correspondence will be sent to the registered emails only, and changes must be notified to TRBA

2.1 Contract formation

- i. TASNEEF will open file with the provided information and a contract with fixed prices approved by DoH will be sent to the provider per the type of facility and applicable tier system based on volume of claims submission, which is provided by DoH, and then contract will be sent to the authorized representative for certification. The Pricing Tariff list is published on TRBA webpage.
- ii. Details of Tier information is as provided in Appendix-I Tables of Tier system
- iii. All the Licensed facilities with Facility type as Provision of Health Services, are applicable for contract category as (Tier HC) Home Healthcare. Facilities with license subtype as Medical Center but authorized as Homecare service provider additionally are also applicable for Tier HC contract.
- iv. All the facilities with Facility Type as Rehabilitation center are applicable for Contract Category-Medical Center (Tier-M) provided they do not have Home health and long-term care services.
- v. Facilities with License of facility subtype as Rehabilitation Hospital shall be applicable for contract as Tier-RH.
- vi. If a facility has a mix of settings, the facility will be considered with the contract of higher setting as per JDC tariff. Example, if a facility has settings as outpatient, and homecare, the contract shall be considered for homecare. If a facility has outpatient, day case and homecare, contract shall be of homecare.
- vii. If a facility has outpatient and inpatient claims, the contract shall be issued as a Center, however, there will be additional charges to cover the cost of additional man days required for the audit of Inpatient claims.
- viii. For Self-Pay, Tier system is applicable only if submission is done for a minimum of 6 months, otherwise contract with flat rate for Self-Pay will be applicable. This is to promote as an incentive for continuous submission compliance for Self-Pay activities.

- ix. The audit process for proforma payers (services which are not paid either by patient or insurance companies) is same as the self-pay audit process. Self-pay tier system and prices are applicable for Proforma services as well. For the purpose of this certification, Self-Pay and Proforma are considered to follow same audit process.
- x. In addition to Tier system, centers with applicability to KPI submissions will be charged additionally to cover the man days,
- xi. As per DoH, Ad-Hoc KPI is mandatory to be conducted at least once per year, hence a contract for ad-hoc KPI will be shared in addition to the contract of regular (annual) JDC audit, and the ad-hoc audit will be conducted at a later point of time.

Acceptance of the contract is made by sending TASNEEF the specific form signed and attached to the contract and any other document per which certification is requested.

On receipt of the signed contract for certification and the relative annexes as applicable and having ensured they are complete, TASNEEF will send the facility written acceptance of its application and will proceed to generate the invoice along with other additional steps for the audit process.

The agreement signed between TASNEEF and the facility includes:

- 1) Certification fee
- 2) Information on fee for Follow-up Audits if applicable to the facility as mentioned in the contract and as per the applicable General terms and Conditions
- 3) A single consolidated package price applicable as per the Tariff published on TRBA website. The tariff selection is done based on the Tier of General claims and applicability of dental and Self-pay services in scope.
- 4) Facilities which are exclusive dental centers without general medical services will follow the tier system of Dental and tariff accordingly.
- 5) Self-Pay tier system and Tariff are applicable to facilities only with exclusive self-pay services.
- 6) Facilities with only Dental and or Self Pay will be applicable for contracts related to specific services
- 7) After the satisfactory completion of the initial audit and after validation by TASNEEF, a Certificate of Conformity with the reference standard, if meets the criteria, will be issued.
- 8) Contract information for Re-audits as applicable per methodology

2.2 Audit Planning

- i. The application for certification should be initiated by the facility at least two months prior to the schedule of audit date of listing expiry published on Shafafiya.
- ii. The facility is required to share the list of Coders with their certification and other department personnel details in the scope of audit process and interviews at least 3 weeks prior to the audit schedule.
- iii. If facility management changes, but still bears the same DoH License Number, the facility will still proceed with the JDC audit with claim samples to be taken from the previous 12-13 months and not from the date of management change.
- iv. Any request for re-schedule should be sent at least 1-2 months before with documented reason for request. In the absence of relevant documentation supporting the reason, the schedule will not change, and the audit will proceed with actual schedule.
- v. Only one reschedule request can be accommodated for any emergency reasons with supporting documentation and the new schedule can be provided as per the availability of audit slot.
- vi. Schedules for KPI audit will be as per the claims schedule, however, if is delayed for specific reasons, will be communicated by TRBA with earliest possible schedule without causing any listing impacts due to delay.

- vii. Any request for re-schedule with-in one month from scheduled date will incur additional charges.
- viii. The assigned schedule may be canceled if application is not received in not less than 2 weeks prior to given schedule.
- ix. An audit plan will be communicated to the facility within a week before the audit schedule.
- x. In case of delay in application by facilities, the above timeline may be affected, and the audit plan shall be sent only after receiving the required information.
- xi. Facilities with electronic medical records should keep ready and send to TRBA, the process of mapping the Claim ID to the related medical records.
- xii. Facilities having electronic medical records, auditor should be given access to the visit information as required for the audit and need not print the copies for auditor evaluation.
- xiii. Facilities with paper medical records should arrange the total medical records related to provided claims for audit within first one hour of audit start.
- xiv. The auditing team may decide to perform any audit as on site or desktop/remote.

NOTE 1: Any delay in application resulting in missing the schedule will not be the responsibility of TRBA. Upon request, TRBA may arrange for another schedule depending on the availability however, will not guarantee the continuity of listing. The resulting gaps in listing will be the sole responsibility of the facilities.

NOTE 2: A maximum of 3 changes will be allowed for the nominees for interview and no changes shall be considered 1 week prior to the audit date. Any changes resulting due to emergency conditions shall be considered when provided with supporting evidences to file in our records for such emergency conditions.

NOTE 3: In case of absence of nominees for interview after confirmation of the schedule, shall be considered as zero for scoring, unless it is a documented emergency.

2.2.1 Special Requirements for Multi-Site Facilities

If a provider operates more than one facility, each facility must undergo the certification process individually. TRBA prefers to proceed with individual contracts to avoid major changes in the contract and Tier. However, if the facility still prefers for a group contract, it can be issued but the clause of change in tier system may change the price in contract. Nevertheless, audit activities will be performed for each facility anyway and the policies can be verified once unless there is any update;

Note: in case of centralized system, the auditor will verify if all facilities are following same methods and procedures and the awareness and adherence of centralized policies and processes is verified for each facility.

2.3 Audit Sample Type for Claims Review

Random sample will be spanning across each major encounter type as applicable to the provider's settings, to enable meaningful coverage of sample distribution for audit. The random sample does not contain any identifiable patient information.

Encounter Type	Setting
1	Outpatient
2	Emergency Room
3	Inpatient
5	Day case
12	Home care

Example: A hospital that provides care in Outpatient, Inpatient, Emergency room, Day case and Home care settings, five individual sets of claim samples will be audited.

2.4 Sampling method For Claims Review

A random sample of Dental and Self-Pay services will be audited if applicable.

- i. The audit sample will include claims available from past 12-13 months from the audit date for certification or re-certification
- ii. Random sample size is as per the Tier system mentioned as tables in Appendix-I
- iii. Each facility Tier information is provided by DoH based on volume of claims submitted to KEH during the past 12-13 months.
- iv. Sampling is done using a scientific formula based on international best practices of accreditation.
- v. The sample count indicated for each tier represents the sum of sample from all applicable encounter types/settings.
- vi. In case of insufficient number of claims in one specific setting, the difference of claim sample count will be selected from another setting.
- vii. Random sample contains a percentage of claims selected based on the specific quality criteria provided by DoH.
- viii. Random sample for Dental and self-pay services will be based on the specific applicable tiers.

2.5 Sampling for KPI Process and Validation:

For the KPI validation and process review, the audit will consider the typical third-party approach, that means sampling could occur however sampling will cover all the applicable KPIs. This shall also include but not limited to disease specific coding rules i.e. cancer, severity, cesarean, neonatal, complications etc., Sampling of KPIs for Data validation can be done considering the high-risk indicators however, KPI process covers the whole Jawda KPI system

2.6 Random Sample Sharing for Claims Review:

- Random sample shall be shared only on the day of audit (except for Inpatient and Homecare/Long Term Care).
- Healthcare providers shall keep ready the process of mapping the medical records to the claim IDs to avoid any delays in providing relevant medical records for audit.
- Claims directly accessible by claim ID in the health information systems without any need for mapping to medical records need not be shared to the facility. However, facility will receive the list of evaluated claims with the identified findings as an Annexure to formal report.
- The claims sample size for re-audits will be of Tier-1 of applicable setting.
- Claims samples from previous year after the issue of final report will be considered for re-certification.

- Claims samples from after the issue of final report of recent audit will be considered for re-audits.

NOTE 1: Upon request, for physical medical records of Day-case the sample may be shared in the morning before the audit team will arrive. Any delay impacting the audit schedule can result in incomplete audit and can impact the scoring and, TRBA cannot be held responsible for such impact if any. All the medical records relevant to the list of claims should be made available at the start of audit as 9:00 AM. Any unreasonable delays shall be impacting the score and any delays causing the auditors to extend the audit time (including evidence collection) may incur additional charges.

3 PERFORMANCE OF AUDITS

3.1 General

An “Audit Plan” is drawn up for each audit according which is sent to the customer facility in good time.

The audit has the following objectives:

- Determination of the conformity of the client’s management systems, or part of it, with audit criteria;
- Evaluation of the ability of the management system to ensure the client organization meets applicable and contractual requirements;
- As applicable, identification of areas for potential improvement of the management system.

The Audit Plan indicates the tasks assigned for audit. Specifically, for each facility covering the applicable domains:

- the structure, policy, processes, records and relative documents to the applicable Management system must be examined and checked;
- it must be established whether these satisfy the requirements applicable to the scope of certification;
- it must be established whether the processes and documented information are drawn up, implemented and kept efficient, to nurture trust in the Facility's management system;
- every inconsistency between the organization or facility’s policy, objectives, goals and the result obtained must be reported to the facility (authorized representative) to allow for appropriate action.
- Collecting audit evidences
- Communication with the Head of the facility/ Representative along with the nominees mentioned on the audit plan are seen to be required for opening and closing meetings to ensure a clear understanding of the audit objective, process, identified findings and required corrective actions.
- Presence of Top management for the closing meeting is important to show the commitment to continual quality improvement of organization and to understand the areas of improvement and actions.

3.2 Audit Process:

The audit process will be conducted as per the audit plan starting with opening meeting, simultaneous request for evidences and closing meeting.

3.3 Audit Evidence Collection

- i. Evidence of documentation, and identified deviations will be collected, as agreed in Provider Healthcare Facility - TASNEEF contract. The evidence will be retained for a duration of maximum 2 years in accordance with this
- ii. All the documents reviewed in electronic format will be directly collected as evidence by the auditors themselves. It shall be the responsibility of the facility to hand over all the other required documentation and requested evidences before the auditor leaves the facility on the scheduled day and time. Facility cannot extend the hours of auditor to collect the evidences.
- iii. Failure to provide the requested evidences within the time shall be considered as non-compliance with certification requirements and any documentations provided for any reason after the timeline cannot be accepted. Audit and or certification process for such facilities may be stopped, as the audit process will be useless and ineffective.
- iv. The Health Information Systems should have capability to electronic print/save the required visit documents as audit evidences. Not having the option or such feature to provide evidence shall be considered as no evidence provided and the auditor findings documented with specific reference remains valid.
- v. It is highly recommended to provide evidences in electronic format to save paper and time.
- vi. The evidences can be masked with confidential patient information retaining other required details of visit and other pertinent information.
- vii. It is the responsibility of the facilities to provide all the requested evidences of policies and claim related documentations requested during the audit. Required evidences if found absent during reporting phase, will be finalized based on the findings collected by auditors during the audit and cannot be negated by facilities.
- viii. Protected health information of patient will be handled as per the required standards of privacy and security.

NOTE 1: It shall be the responsibility of the facility to acquire all the required approvals prior to the audit day as per release of information to provide all the requested evidences on the day of audit with-out causing any hindrance to the audit process. Failure to provide evidences on the same day shall be considered as breach in compliance to the audit requirement and cannot be disputed.

NOTE 2: Any evidences missed from the list requested by the auditors will be a sole responsibility of the facility and shall be considered as no available documentation during our further reviews and providers cannot comment or disagree on the claims for which evidence is missing or not provided.

4 CERTIFICATION REQUIREMENTS AND GUIDELINES FOR CRITERIA

4.1 JAWDA Data Certification

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

To obtain JAWDA Data Certification the facility must:

- Have established a Management System and kept 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 for the required domains of certification as per below:
- Claims review (Applicable for all facilities including Dental and Self-Pay)
- Clinical Coding Process Review ((Applicable for all facilities including Dental and Self-Pay)

- “KPI” Process Review (relevant to Quality Indicators Data Submission)
- “KPI” Data Validation (relevant to Quality Indicators Data Submission)

4.2 Claims Review

Claims Review is one of the components of the JAWDA Data Certification. Claims review is a validation process to review clinical documentation against the submission of reported clinical coded data by all healthcare providers. Claims review does not exclude the activities billed with zero charges and cannot consider any exceptions for such reasons.

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

4.2.1 Claims Review

TASNEEF will receive an audit sample as per the applicable Tier system through DoH portal for each type of setting identified within the facility scope.

- As part evaluation of the Clinical Coding and Data Process, TASNEEF Auditors should be provided with complete access to data and documentation. 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.
- A claim not identified during the audit or identified as missing record after confirmation with the audit representative, will be considered as zero accuracy and completeness scores and should be documented. Any documents provided after audit day shall not be accepted as documentation for review.
- Missing chief complaint on the visit documentation will be considered as “0” score, as a claim is not billable without a chief complaint. However, a chief complaint can be considered if written in continuation as part of history of presenting illness.
- Diagnosis in the final impression shall be as a narrative description and should be supported by documentation details in the entire visit documentation (CC, HPI, PFSH, ROS, PE) to conclusion as diagnosis.
- TASNEEF will then complete the audit in accordance with this methodology and collect audit evidences.
- All healthcare providers shall agree to provide with all the requested claims information, though previously audited by TRBA, considering as an adhoc audit that can happen occasionally. This may involve same sample or different sample or a mix of claims or any other verification as seen required.

- vii. The scoring against each criterion will be applied as per this Methodology and the inclusive Error Scoring Tables in Appendix-III
- viii. Claims review will be done applying the audit concepts and claims scoring criteria of this methodology.
- ix. Errors related to deficient documentation of services, and procedures have specific categories in the error scoring tables. These are considered as completeness error. It may be considered as accuracy error for future.
- x. A claim can have both accuracy and completeness aspects applicable to same service or condition.
- xi. The E&M Guidelines: The provider must state the E/M guidelines being followed as 1995 or 1997. The use of both guidelines is not allowed. (The E/M documentation cannot be a mixed template of 1995 and 1997/ Cannot mix body areas and body systems)

4.2.2 Classification of errors for Claims Review:

Errors are classified as Coding related, Documentation related, and Billing related.

Coding related:

- Any errors related to general and chapter specific guidelines of diagnosis coding.
- Errors related to procedure guidelines in coding.
- Documentation is more specific to code for a higher specificity.
- Evaluation and management services either missing or coded in high or low level.
- Incorrect diagnosis or procedures coded to the available documentation.
- Missing relevant or secondary diagnosis, additional diagnosis.
- Coding signs and symptoms, incorrect sequencing of diagnosis.
- Missing additional procedure codes.
- Coding possible, probable or questionable diagnosis.
- Minor procedure included in E&M or E&M included in surgical procedure.
- Missing medical necessity for the procedures ordered.

Documentation related:

- Any diagnosis or procedures are documented insufficient.
- Incomplete report or missing report.
- Documentation of problem(s) pertinent physician examination as normal.
- Documentation of extensive physical examination than required as per the complaints.
- Copy and paste of the same documentation.
- Chief complaint(s) not related to the primary diagnosis.
- Lack of more specific documentation when required to specify
- Lack of mentioning relationships of conditions as cause and effect or late effect or complication or resolved or Due to.
- Any other abnormal clinical documentation.

Billing/Claiming related:

- Missing Per Diem codes
- Incorrect Per Diem or service codes.
- Missing no: of units of service codes.
- Missing anesthesia units.
- Claim submitted to incorrect setting as encounter type

- Follow up within seven days' period of the same complaint.

4.2.3 Claims Review Audit Verification Points and Scoring Criteria:

Claim level audit on random samples as per the guidelines mentioned in the methodology. The audit will focus on claiming aspects as Documentation, Coding, Billing and Submissions and shall provide with scoring as:

- Accuracy (ICD-10-CM, CPT 4th Edition for all services (including Radiology), USC&LS Codes, HAAD Service Codes, HAAD telemedicine codes)
- Completeness (ICD-10-CM, CPT 4th Edition for all services, USC&LS Codes, HAAD Service Codes, HAAD telemedicine codes)

Claims review will output an Accuracy Score by assignment and reporting of only the codes and data that are clearly and consistently supported by the health record documentation and in accordance with applicable code set and abstraction conventions, rules, and guidelines.

Accuracy

Claims reviews will also identify clinical coding submission or improper documentation practices intended to inappropriately increase reimbursement from payers or influence payer adjudication rules or deviating from the guidelines or not accurately reflecting the services provided.

Completeness analysis contributes to recommendations on claims coding practices and does not affect the passing criteria. It includes missing diagnoses and procedures that would have provided more detail on the condition or status of the patient but would not have an impact of unusual higher outcome of reimbursement from payer for the services provided.

The Completeness scoring will help determine and/or recommend improvements with regards to the reporting of clinical coding and/or deficiencies in physician documentation.

- The Accuracy and Completeness will be scored against the set of criteria, as supplied by Error Scoring Tables of this methodology in Appendix-III.
- Coding based on incomplete documentations resulting in errors are scored as accuracy.
- Incompleteness of documentation by itself will be considered as completeness errors for tracking and education.
- Completeness errors are limited to the details mentioned in the scoring tables.
- The error scoring tables for outpatient are also applicable to Day case and Emergency.
- These scored errors have been rated by Diagnosis and by Procedures as Major, Moderate or Minor.
- Each record will start with 100 points for accuracy and 100 points for Completeness and the presence of any errors will result in the deduction of the set number of points
- There can be no more than one error scored per code or one error per error-category in one claim for accuracy scoring.
- Score will be deducted only once for the same error repeated in Claims under same authorization of home health care.
- All Completeness errors will be scored per each error irrespective of error category unlike in Accuracy.

- xi. The facility will be given an opportunity to review the individual errors after sending the formal report and in case there is a difference of opinion in claims review where there is a possibility of different coding outcomes based on a standard guideline or reference, it can be brought to the notice of reviewer with a clear relevant standard reference. Only the comments with a justification referring to any circular from DoH(HAAD) or published guidelines or standard coding guidelines will be considered for review and response. It is to the sole discretion of the third- party audit body to decide based on the applicability to consider the provided references.
- xii. 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.
- xiii. In case of no clear references available to both parties on the grey areas of coding concepts, the facility should have a documented policy and a consistent implementation of such aspects in the facility to consider for the benefit assignment. Otherwise, the conclusions made by the audit team shall remain applicable and facility cannot be awarded with score benefit.
- xiv. Only coding accuracy score shall impact the passing criteria.
- xv. A coding completeness score for the facility does not have any impact for passing criteria and will be utilized and recorded as a tool to track education requirements or coding process gaps for corrective actions for future follow-up reviews.
- xvi. Complete absence of claims during audit shall be considered for scoring as zero.
- xvii. Report available only with diagnosis/prescriptions but without documentation of Chief Complaint/Review of Systems/Physical Examination is also considered score as zero.
- xviii. The scoring on each claim, is as per the error categories mentioned in detail as per the tables of Error Scoring Table 1 to Table 8: Appendix-III
- xix. Once each medical record has been scored, scoring weights equivalent to the ratio of claims distribution per each setting will be applied and an overall claims review score is generated. (E.g. Inpatients-DRG, Day-case, Outpatient clinics, Emergency and Home Care).
- xx. Claims from dental and self-pay will also generate the scoring weights per claims ratio to the total claims.

4.3 Clinical Coding Process Review

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.

Coding processes will be audited at the facility to assess the establishment of policies based on standard and regulatory requirements of HAAD Coding manual and normative references mentioned in this document, and adherence to it. The Clinical Coding Process review is an integrated process evaluation for General, Dental and Self-Pay services. However, all the applicable verification points will be evaluated for all applicable services.

Facility should be able to demonstrate the process being implemented for each service line (General, Dental, Self-Pay).

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

4.3.1 Audit Verification Points and Scoring Criteria:

- i. Process flow chart reflecting the entire claims cycle. It can be a single flow map or multiple to reflect different processes. However, there shall be at least one high level flow map reflecting all the functions and interactions, and the details can be verified in the respective function flow maps.
- ii. Updated and in-force policies as stated with reference to chapter 8 from Methodology standard
- iii. Evidences of physician coder query process reflecting the start, course and end points of the query process meeting the requirements of query as per HAAD code of ethics.
- iv. Documents meeting the requirements of active Certifications and continuous education
- v. In case of outsourced services, the outsourced party shall be responsible to submit all the required documents related to their scope of work relating to methodology requirements, however, the final responsibility lies with the facility
- vi. Evidences establishing internal quality control process that can be requested by auditor from any quarter of the year
- vii. Evidences of coder interaction with related departments when applicable (Pre-authorization, Resubmissions)
- viii. Interviews conducted to verify the adherence to policies and effectiveness of the process shall be documented however, the observations identified during the interview process is related to appreciative quality or perceptive quality and cannot be a matter of debate
- ix. Any additional evidence required to represent the compliance to requirements can be requested by auditors, hence evidences are not limited to documents as stated above
- x. Sample verification of coding and documentation practices mentioned as requirements in the methodology chapter 8. All the documents shall be legible and complete with facility name, date and required authentications
- xi. Any process being followed shall have documentations and lack of such evidences or records shall be considered as non-conformity and receives a score deduction
- xii. All the finalized nominees to be available as per the plan
- xiii. Each aspect of clinical coding process review will be verified as applicable and in relevancy with Dental and Self-Pay process.
- xiv. Facilities should submit to TASNEEF, an action plan for resolving any major deficiencies identified during the review. If requirements are not met by the next scheduled audit, DoH will be notified for further action. Impact rating of non-conformities will affect certification.

Scoring of Clinical Coding Process Review:

- Deficiencies identified during the reviews of coding processes, policies and non-conformity of adherence by relevant staff will be rated based on their impact, affecting the score.
- Observations made regarding the awareness of process and coding references cannot be contested as it is unbiased appreciable evaluation.
- Clinical Coding Process Review nonconformities or deficiencies will have impact rating as Major and Minor which will affect certification
- No separate score is generated for dental and self-pay Coding process review.
- Clinical Coding Process Review score is a consolidated score generated from comprehensive evaluation of applicable aspects for general, dental and self-pay services, as applicable to the scope of facility.
- Claims process flow and effectiveness: (15 points)
 - Coding Process Flow Chart/Map (5 points)
 - Comparison of Flow map to the implemented process (2 points)
 - Effectiveness of mentioned processes of functions (8 points)
- Training and orientation (10 points)

- Policies and Practices review (40 points)
 - Healthcare Documentation Policy and Practice review (16 points)
 - Medical Records Policy and Practice Review (Interview) (12 points)
 - Clinical coding Practices and Policy Review (12 points)
- Coder Credentials verification/Coding training (5 points)
- Process Compliance verification (30 points)
 - Coder Observation (4 points)
 - Physician Interviews (18 points)
 - Claims Process (Insurance – Pre-authorization, Billing, Submission, Denial management) function Interview (5 points)
 - Finance Department Interview (Claims related) (3 points)

Note: Certified Coder Requirement

One of the following criteria must be met for the JAWDA Data Certification audit:

- have a Certified Coder with active status of AAPC or AHIMA (or) evidence of contracted outsourcing for coding services, and the coder credentials of the coder representing facility for the scope of service from outsourced company

And/or

- Action plan and evidence of progress to train and certify a coder within the facility in a specific time (maximum 1 year)
- Certified coder is not a requirement for facilities with exclusive dental services, however, a training on coding guidelines for reporting ICD should be evident.

4.4 Process Review for: “KPI” Quality Indicators

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.

4.4.1 Audit Verification Points and Scoring Criteria:

The facility must make all necessary information available to TASNEEF for KPI planning for data collection and submission as required by DoH and as stated in the methodology.

KPI Process Review will generate scoring for the evaluation on KPI Process for Planning, Support and Operations and KPI Process for Quality Governance and Improvement as mentioned in the standard.

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

- i. Applicability of KPIs:
 - a. List of all applicable KPI approved by the top management with a profile for each KPI 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 lead(s):
 - a) Documented appointment or assignment letter from top management (2 points)
 - b) Job description with Clear roles & Responsibilities relating to Jawda KPI and healthcare quality (2 points)
 - c) Training records on healthcare quality (2 points)
- iii. Data collectors/validators:
 - a) Documented Appointment or assignment or nomination letter from KPI owner or Quality Lead (2 points)
 - b) Competency determined for personnel involved (To demonstrate the relevant criteria established while nominating/assigning a role (2 points)
 - c) Training records (on data collection and/or validation methods) (2 points)
 - d) Performance evaluation at frequent intervals (at least annually, and with every new assignment to ensure the collectors/validators performance) (2 points)
- iv. Data Collection and Validation:
 - a) Approved Data collection and validation plan with defined components of data sources, frequency, measuring tools, responsibility with well-designed structure for data collection (4 points)
 - b) Validation of collected data and Data can be traced to the source (2 points)
 - c) Completed data collection forms are signed off by the frontline KPI Owners prior to submission to Quality Department. (2 points)
- v. Corrective / Preventive action:
 - a) Approved Corrective / Preventive action policy (2 points)
 - b) Associated forms (1 points)
 - c) Corrective / Preventive action records (Ex: for Patient complaint etc., (2 points)
- vi. Adverse and sentinel events:
 - a) Approved Adverse and sentinel events Policy (2 points)
 - b) Associated forms (1 points)
- vii. Incident Reporting:
 - a) Approved Incident reporting policy (2 points)
 - b) Associated forms (1 points)
- viii. KPI Report:
 - a) Statistics report generated from the health information system are reliable (2 points)
 - b) Report prepared in an organized document (1 points)
 - c) Names of the approval panel, designations, date of signature, signatures (2 points)
 - d) Review and Approval of CEO or Head of Facility prior to submission to DoH (2 points)
- ix. Data Submission:
 - a) Filled data checklist and signed/approved (2 points)
 - b) Signed Log of submission with Date of submission (Non-Scoring)
- x. Data Integrity and Backup plan:
 - a) Data privacy & confidentiality statement policy (2 points)
 - b) Approved Backup plan in place (2 points)

The healthcare facility should have in place established ongoing processes that are in alignment with the JDC certification needs as per Chapter 10 of JDC Methodology part 1.

KPI Process for Quality Governance and Improvement (50 Points):

- i. Management review:
 - a) Management Review Policy and Report (Management Review in alignment with clause 10.3) (2 points)

- 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. ...) (2 points)
 - c) Approved minutes of meeting (2 points)
 - d) Corrective / Preventive action (2 points)
- ii. Quality Committee / Medical records Committee / Any Relevant Committee:
 - a) Committee Policy/Internal Memo (2 points)
 - b) Terms of reference include Purpose, Objective, Membership, Declaration of Conflict of Interest, Duties and Responsibilities, Authority, Distribution of minutes. (2 points)
 - c) Annual meeting plan (2 points)
 - d) Meeting Agenda with Approved minutes of meeting (signed by members and chairman) (2 points)
 - e) The minutes of meeting.
 - a. Minutes should be clear and includes the assigned person and action to be taken. (2 points)
 - b. The minutes should also include the review of the last minutes and items discussed should be relevant. (2 points)
 - c. The minutes of meeting for the Quality Committee and/or Medical Records Committee are available, latest one being no less than 90 days from day of inspection (2 points)
- iii. Staff Awareness/communication (Data collection and validation Process, Trend analysis, Progress, Calculation, Lessons learnt, Improvement etc.):
 - a) Approved policy/procedure (2 points)
 - b) Annual regular Internal communication plan (2 points)
 - c) Minutes of Staffs meeting (2 points)
- iv. Quality monitoring:
 - a) Approved Quality policy (2 points)
 - b) Quality program includes the organization mission, vision, values, quality model, quality and patient safety framework, responsibility/ accountability structure, etc. (2 points)
 - c) Quality monitoring records and Quality Improvement process – actions /records (consider also criteria from 10.4 and 10.5) (4 points)
 - d) Corrective / Preventive action (2 points)
- v. Internal Audits:
 - a) Approved Internal Audit Policy (2 points)
 - b) Jawda KPI policies and performance audit (Planning, Checklist, Findings, Report, consider also criteria from 10.2) (4 points)
 - c) Corrective / Preventive action (2 points)
- vi. Jawda KPI Risk management: Documented risk assessment (Also refer to Chapter 6 & 10.4)
 - a) Approved risk Assessment Policy (2 points)
 - b) Approved Mitigation Plan for all identified risk (2 points)

KPI Process Review for Home Health Care, Long Term Care, Rehabilitation Hospitals is same as the review process for General and Specialized Hospitals.

Each verification point under KPI Process for Planning, Support, Operations and KPI process for Quality Monitoring & improvement is assigned with distribution of given scores. Every conformity will be assigned with full points, non-conformity with no scoring points and a partial conformity with partial score.

KPI Process Review has a weightage of 25% for the overall Final Score.

4.5 KPI Validation for Collection and Submission of Jawda Quality Indicators

The vision 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.

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.

KPI validation is a method to verify if the information collected from the Hospitals for HAAD Quality Performance KPI Profile program has an objective evidence to confirm that the requirements which define the intended use have been met.

4.5.1 Audit Verification Points and Scoring Criteria:

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

- a) Count/Numerator
- b) Inclusions Numerator (when applicable)
- c) Exclusions Numerator (when applicable)
- d) Denominator
- e) Inclusions Denominator (when applicable)
- f) Exclusions Denominator (when applicable)
- g) Calculation
- h) Traceable data elements and Regeneration of report
- i) Timelines of Submission (Non scorable as the submission is according to the window period)

The facility should be able to re-generate the reports of KPI from a randomly selected duration as submitted to DoH.

- All relevant KPI indicators are validated for accuracy of the submitted data against the applicable KPI criteria and reliability of the submitted data.
- KPI Data Validation is categorized for scoring as Met/Partially Met/Not met resulting in score assignment.
- Depends on the variables (Count/Numerator.....) applicable as per definitions.
- Each indicator is considered with maximum 100 points which is equally distributed across all applicable verification points as mentioned in 4.5.1.
- Example 1:
QI001: Total score points assigned -100,
- Count/Numerator-25 points; Calculation criteria applied-25 points, Traceability-25 points; validation-25 points
- Example 2:
QI005: Total score points assigned -100
- Numerator: 16.67 points
- Numerator exclusion: 16.67 points
- Denominator: 16.67 points

- Denominator exclusion: 16.67 points
- Traceability: 16.67 points
- Validation: 16.67 points
- Every conformity will be assigned with full points, non-conformity with no scoring points and a partial conformity with partial score.
- Aggregate score of the evaluated KPI will generate score for a total of 100.
- KPI Data Validation has a weightage of 25% for the overall Final Score.
- The validation shall be done for all the applicable subdomains of indicators such as but not limited to, Adverse Events & Sentinel events, Patient Safety, Effectiveness, Effectiveness/Process, Emergency, Complication, Complication/Outcome, Readmission, Clinical Effectiveness, Prevention, Timeliness, Recovery and Disability, Admission, Recovery, Evidence Based Medicine, Healthcare associated Infection, Mortality, Safety/Environment and Timeliness as waiting time. (e.g. waiting time indicators, adverse incidents and outside critical care cardiac arrest, Worsening Pressure ulcers etc.,).

At least one Ad-Hoc KPI audit shall be performed on each facility (Hospitals) in a year which will follow the same methodology and Ad-Hoc audit specifications will be as per the agreement with DoH.

Ad-Hoc audits will be as un-announced visits and the facilities are requested to extend complete co-operation to the auditors without causing any delays.

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

All costs relative to ad-hoc KPI audits, as per the methodology and directions of DoH will be charged to the facility.

Additional Ad-Hoc audits could be performed by the certification body upon the request of DoH.

5 DENTAL SERVICES

Clinical Coding Process Review will be conducted for facilities with exclusive dental services and shall generate an individual score for 100.

For facilities with dental services as additional scope, clinical coding process review of dental will be conducted as an integrated process review.

5.1 Audit Verification Points:

A. Process review:

Includes verification of policies and processes for the below data points as documented in chapter 4.2 and 4.3, applicable as relevant:

- Medical records policies and adherence
- Documentation policies and adherence
- Coding and Claiming processes and practices including consents and pre-authorizations
- Universal Dental Charting
- Clinical Coding Process Review score is a comprehensive score from evaluation of process (general/dental/ Self-pay) as applicable.
- Clinical Coding Process Review for Dental is integrated with general services unless the facility is exclusively dental service provider.

B. Claims review:

- i. There are no minimum required claims count to conduct audit on dental claims for the first year or until further change.
- ii. A distinct random sample of dental claims shall be provided by DoH per tier system of medical centers if applicable.
- iii. To verify the documentations, consents and approvals for the submitted claims as per the Canadian classification system
- iv. Physician documentations are verified in detail to support the provided services and assigned codes shall be thoroughly reviewed.
- v. Claims review score is a weighted score proportionate to claims ratio
- vi. A score shall be generated based on identified error scoring criteria for claims and coding process.
- vii. The facilities with passing score will be listed on Shafafiya with the scores achieved.
- viii. Follow-up audits shall be conducted when a facility has achieved score greater than or equal to 86% but still have many major non-conformities to be rectified.
- ix. Re-audits shall be conducted for facilities where the score achieved is less than 86%.

6 AUDIT ON SELF-PAY SERVICES/PROFORMA SERVICES

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 DoH, as specified in the HAAD Data Standards and Procedures.

- All the healthcare facilities which are already in the scope of JDC audit with medical/surgical claims shall also be in the scope of audit.
- Audit for Self-Pay services or Proforma services is mandatory
- Facilities with exclusive self-pay/proforma services are applicable for self-pay specific tier system (Tier-SP) and listing on Shafafiya
- Clinical Coding Process Review and Claims review will be conducted as per the exclusive
- The audit process for proforma payers (services which are not paid either by patient or insurance companies) is same as the self-pay audit process and self-pay tier system and prices are applicable.
- Audit for Self-Pay services generates score which is inclusive of overall JDC score and shall be updated as listing on Shafafiya. Additionally, all the facilities scores shall be reported to DoH for their further actions and proceedings in case if any
- Follow-up audits shall be conducted when a facility has achieved score greater than or equal to 86% and still have many major non-conformities to be fixed.
- Re-audits shall be conducted for facilities where the score achieved is less than 86%

6.1 Audit Verification Points:

Claims review: All applicable guidelines of JDC criteria for claims review is applicable

Claims review:

- There are no minimum required claims count to conduct audit on self-pay claims for the first year or until further change.
- A distinct random sample of self-pay claims shall be provided by DoH per self-pay tier system.

- To verify the documentations, patient consents and bills of the rendered services to the submitted claims information.
- Physician documentations are verified in detail to support the provided services and, assigned codes shall be thoroughly reviewed as per applicable coding guidelines.
- A score shall be generated based on identified error scoring criteria for claims and coding process however, the facilities shall be recorded on Shafafiya certified facilities list with the scores achieved and results shall be notified to DoH for required actions or decisions.
- Facilities that have other general and or dental services in addition to self-pay, will generate an overall JDC score where the clinical coding process review score is a comprehensive score from evaluation of process (general, dental, Self-pay) as applicable and Claims review score is a weighted score proportionate to claims ratio.

All costs relative to audit on any Self-pay services will be charged to the facility

Process review: Clinical Coding Process Review for self-pay is integrated with general services unless the facility is exclusive provider of self-pay services. All applicable guidelines of JDC criteria for Clinical Coding Process review is applicable

Clinical Coding Process review shall be conducted on the Medical records, Data collection, recording, documentation, Coding and billing and Claim submission process as documented in chapter 4.2 and 4.3, applicable as relevant.

7 REPORT

All the audit activities (Reviews, Validations and Process Reviews, for Claims and KPIs) will be performed according to the plan with facilities as per the audit plan.

Upon the completion of the audit of the Facility, a copy of the written report will be delivered by Lead Auditor of TRBA to the authorized representative responsible for the facility, for understanding and acknowledgement of the report and required action plans with-in 2-3 weeks from the audit date

The formal report with acknowledgement should be endorsed by the CEO or CFO or COO delegated authority of the facility and should be submitted to TRBA for final decision.

The Formal endorsed report will be for the review of Certification Controller and for final decision from TRBA in collaboration with DoH.

The original audit report is owned by the certification body.

The facility may indicate any reservations or comments concerning the findings by the TRBA auditors in the relative space in the audit report. Only concerns with references to standard guidelines (Regional or International) from Claims review criteria-General/ Clinical Coding Process Review- Criteria or DoH (HAAD) circulars shall be reviewed and the conclusion shall be communicated in the final report. Comments with absence of such references does not be deemed to provide any response.

Considering the audit as Third-party concept, the comments from facility cannot be as a dispute or on- going discussion. TRBA reserves the right to make a decision after careful consideration of valid comments from healthcare facilities.

The final report will be issued prior to listing expiry, and facilities with late applications or delayed audit process will receive the final report within 30-40 working days from the date of the audit completion.

Any delay in reporting from TRBA from the specified timeline, TRBA shall inform the facility and assures that there will be no negative impacts on the listing resulting due to delays.

There cannot be any scope for reviews or revisions after the issue of final report.

The Final report will include:

- Scoring for claims review
- Scoring for Process Review – Clinical Coding
- Scoring for Process Review – KPI (applicable as per JAWDA program)
- Scoring for KPI data validation (applicable as per JAWDA program)
- Improvement areas

In the event of several major non-conformities, the certification process requires an extra visit for process review; this follow-up audit must be performed within two months to check the effectiveness of the proposed corrective actions;

All costs relative to any follow-up audit deriving from shortcomings in the Management System will be charged to the facility.

7.1 Audit Report Format

The Final report includes:

1. Over all report summary as PDF or Word with JAWDA Data Certification - Final Score and Grade, Annex-A with Facility Comments and Corrective Action Plan, Annex-B with Scoring Details of claims review score, Process review score and KPI Process Score, KPI data validation score.
2. The Process Review Details in the Final report includes:
 - a. Gaps or deficiencies identified in the process
 - b. Coding Policies review
 - c. Coder certification validation and observation
 - d. Summary of Claims Review findings
 - e. Identified non-conformities of compliance to policies and process flow by relevant personnel.
 - f. Improvement Areas: based on process, policies and compliance check
 - g. All extenuating circumstances if any, that have been verified and validated by TASNEEF
3. Claims review details of Formal Report must include:
 - a. A Cover page from DoH with Facility Name. license and Audit Type.
 - b. Each additional Data sheet(s) for each setting as Inpatient, Outpatient, Emergency, Day-case/ Homecare or Telemedicine /Dental/Self-Pay with:
 - i. The full list of all claims/encounters audited
 - ii. Claim Id

- iii. Date(s) of encounter
- iv. All CPT codes and descriptors, including E&M codes if applicable, except ancillary services (i.e., Laboratory and Pathology) and Green Rain Drug Codes.
- v. All ICD-10 CM codes and descriptors indicating the Diagnosis type as principal and secondary codes etc.
- vi. Details of error, corrections, with codes, descriptor, Auditor Comments, error categories and scores on each claim reviewed, Reference Criteria, Coding and/or Documentation error classification, Additional comments, if any
- vii. Scores following the specified scoring methods and points with totals for each department
- c. KPI Process Review findings- Applicable KPI findings on KPI process will be provided with the non-conformities as major or minor
- d. KPI Validation findings- Data validation for the verified KPIs will be reflected as scores

Facility should respond to TASNEEF through e-mail with a definitive action plan to resolve the identified non-conformities in process, within 5 calendar days after receiving the formal audit report. Any delay in sending the corrective action plan may delay the final audit report and result. Such delays resulting in any gap in listing or any other impacts shall not be the responsibility of TRBA.

Note 1: Additional Error Classification: To help overall reflection of concerned areas for improvement and to understand how each error is contributing to the score, identified coding errors will be additionally classified as Coding errors and/or Documentation based errors.

8 NON-CONFORMITIES AND CORRECTIVE ACTIONS

Each aspect of mentioned domains for audit shall be verified for conformance to the requirements of applicable standards.

Clinical Coding Process Review and KPI Process Review will be verified for conformance and the report shall clearly indicate the non-Conformities.

Claims Review will be verified for conformance to the relevant criteria and non-conformance is recorded with score deduction according to the scoring Tables published in the Appendix-III

KPI Data Validation shall be verified for the conformance of submitted data to the accuracy required as per the DoH KPI profile. Nonconformities for KPI Data Validation shall be recorded with score deduction.

Conformity: - Has an objective evidence of conformity to standard requirement Non-Conformance is categorized to Major and Minor.

Major Non-Conformity: A fundamental or important issue that requires an action as soon as possible without which a process may result in unproductive or ineffective outcome.

Minor Non-Conformity: An issue, resolution of which would improve overall effectiveness / efficiencies of the process.

All the Major Non-Conformities must be rectified with a corrective action plan.

Minor Non-conformities, can be verified for the root cause and to be rectified.

Corrective Action: Corrective actions are steps that are taken to eliminate the causes of existing nonconformities in order to prevent recurrence

Corrective Action Plan: A step-by-step plan of action and schedule for correcting a process or area of non-compliance. The corrective action should provide information as to What is the non-Conformance, identified Root cause, what is the corrective action, who is responsible for the corrective action, when is the corrective action targeted to be completed.

As per the International standards and best practices, a target date of corrective actions to be implemented is set to be within a maximum of 90 days.

The Leadership of the organization should understand, acknowledge and assume the responsibility to monitor the corrective actions and ensure the conformance.

After analyzing the reasons for any major or minor observations indicated in the above report, the Facility must, within the data indicated on the report, inform TASNEEF of its proposals for handling the observations, as well as the corrective action required, and the dates envisaged for its implementation.

Any disagreements documented in the corrective action plan are not considered as a corrective action, a proper corrective action is required to be submitted and thus not meeting the requirement of effective completion of audit process.

- A moderate non-conformity in the previous audit is identified as Major if the corrective action plan is not implemented. There is no moderate non-conformity in this version of methodology.
- The auditing team may decide to perform any audit as on site or desktop/remote.
- Facility can apply for re-audit after 60 days (from day of audit/result) by submitting the proof of corrective actions

9 WEIGHTS AND SCORING

- i. The final score will be weighted per the facility type, domains and services.
- ii. Examples of Domain weightages and Scoring Details can be seen in the tables in as shown in Appendix II. The passing scores for claims review, process review of clinical coding, process review for KPI and KPI data validation will be communicated annually from DoH.
- iii. The current passing score is 86% as an overall accuracy score.
- iv. Clinical Coding Process Review is a comprehensive process review covering general, dental and self-pay services that generates an integrated score out of 100.
- v. Claims review scores of General, Dental and Self-Pay are weighted scores per the claims ratio.

10 DECISION MAKING

TRBA reviews the submitted Formal Audit Report referring to the collected evidences and issues a final report with Final Audit Score details and acknowledging the corrective action plans. TRBA reserves the right to reject the corrective

action plans if supposed to be not meeting the requirements of corrective actions and any disagreements on auditor findings. Facility can request for more details to understand the non-conformity to provide the corrective action plan.

The facilities will be graded based on the scores achieved and the certification validity is as per the grades obtained.

10.1 Passing Grade system for JAWDA Data Certification

Grades and validity based on accuracy scores

Accuracy Score	Grade	Validity
96-100	"A"	18 months
90-95	"B"	12 months
86-89	"C"	9 months
<86	"D"-Failed	Re-Audit

- The passing grade for all facilities is based on the Final score which includes as a comprehensive score of individual Claims Review, Clinical Coding Process review and, additional score for Hospitals, Home Health Care, Long term Care, Rehabilitation facilities as KPI Process Review, and KPI Data Validation.
- The facility should score an overall Accuracy Score of minimum of 86% in total, as per the weights explained in Tables of Appendix-II.
- The validity of certification is based on the grades linked to the scoring achieved.
- There will be a bonus validity for high scores and reduced validity for lower passing scores.

11 RE-AUDITS

The facilities that could not meet the passing criteria will not be published on the Shafafiya Certified Facilities list.

- Re-audit will be done only for the problem area, where the score of individual domain is less than 86%.
- If a facility has scored less than 86% in process review and scored more than 86% in claims review and KPI, then re-audit shall be conducted only on Process review after 1 months from the date of audit result. The gap in listing will be approximately of a month.
- As the process review is comprehensive, all the major non-conformities will be reviewed during the re-audit irrespective of general/dental/self-pay.
- If score of Dental/Self-Pay/Proforma claims review is less than 86, re-audit will be conducted only on that service claims.
- If the facility has passed in process review and KPI but scored less than 86% in claims review, then the re-audit shall be conducted only on claims review "after 2 months" from the date of audit result. The gap in listing will be approximately for 2 months.
- If a facility has failed in both process and claims review and passed in KPI, re-audit shall be conducted on both the problem areas "after 2 months" from the audit result date. The gap in listing will be approximately for 2 months.
- The claims sample will be as per the least tier sample of applicable facility type
- Claims Sample is selected from the period after the issue of final report.

- ix. Prices for Re-audit are separate for Process review, claims review and KPI and are fixed per facility type.
- x. Facility should ensure the relevant personnel were trained on the recommended areas of improvement.
- xi. Revised policies and processes per the standard requirements of clinical coding to proceed for a re-audit.
- xii. Facility can apply for re-audit as per above mentioned timeline by submitting the proof of corrective actions or a letter of request stating readiness for re-audit (in case of re-audit only for claims review).
- xiii. Facility should respond to TASNEEF through e-mail with a definitive action plan to resolve the identified deviations in process, within 5 calendar days after receiving the formal audit report.
- xiv. If a facility has scored less than 86% in KPI process review and scored more than 86% in KPI data validation, coding process review and claims review, then re-audit shall be conducted only on KPI process review after 1 month from the date of audit result. Facility shall request for re-audit after implementation of corrective action plan. The gap in listing will be approximately for 1 month.
- xv. In case of facility failed only in KPI Data validation, as there will not be any KPI reports available for re-audit with-in 2 months, facility shall be listed under “Conditional listing”. Re-Audit will be done when a new submission of KPI data is available (approximately after 5-6 months). If failed in re-audit, back dated de-listing will be done.
- xvi. If a facility failed in both KPI process review and data validation, then re-audit shall be conducted on KPI process review after 2 months from the date of audit result and facility shall be listed under “Conditional listing” if the facility scores more than or equal to 86% in KPI process review. Re-Audit will be done when a new submission of KPI data is available (approximately after 5-6 months). If failed in re-audit, back dated de-listing will be done.
- xvii. Listing after passing in Re-Audit will be done after adding the scores of other passed domains and grade shall be assigned based on overall score.
- xviii. There will not be any temporary listing for re-audit other than “Conditional listing” for KPI data validation.

12 LISTING AND DE-LISTING

- The issuing of certifications and recommendations are the sole responsibility of TASNEEF based on facts. TASNEEF will provide the information to DoH to be published in the listing as they see fit.
- Facilities with The Certification Effective Date is date of publication on the Certified Facilities List on www.haad.ae/datadictionary
- The Certification Expiry Date is based on the grades obtained.
- This issue of Certification shall be forwarded to DoH, as applicable, and will be within 30-40 working days of receipt of the completed audit by TASNEEF, as applicable per the general terms and conditions of annexure for this methodology. The reflection of the results on the DoH website is subject to date of upload of updated listings by DoH.
- It is the responsibility of the healthcare facilities and Payers to review the published list to ascertain pertinent information on scores and/or coding certification validity.
- It is also the responsibility of healthcare facilities to apply for renewal certification 2 months prior to the certification listing expiry.
- If the Audit fails to meet the scoring criteria, after being reviewed by TASNEEF the re-audit criteria is as per Chapter 11 of this methodology.
- The list of certified facilities will consist of three parts:
 - New facilities listing (see TRBA website for New Facility listing guidance and process)
 - JAWDA Data Certified Facilities 2018
 - JAWDA Data Certified Facilities 2019

- TASNEEF retains the right to revoke certification of a facility based on substantive evidence that the audit of this facility was not representative of actual coding practice. There must be evidence of improper conduct which may include but is not limited to:
- Evidence of documentation manipulation
- Evidence of bribery or collusion

12.1 Impact of De-listing (Gap in Listing)

- Facilities shall understand that the gap in the listing resulted due to unsuccessful outcome of JDC audits might have an impact on the reimbursements from the payers or may have an impact on their participation to Health Insurance scheme, not mentioning the level of impact.
- Any gaps resulted in the listing of the facility due to late applications, missing audit schedules, or for any other delays or reasons caused by facility will not be the responsibility of TRBA.
- Delay in sending the corrective action plans resulting in gap of listing is the sole responsibility of the health care facility.
- Request for early schedules or schedules nearing to the existing expiry of listing may not be accomplished or provided due to unavailability of calendar schedules. Gaps resulting from such delays is a sole responsibility of the health care facility.
- Listing is provided from the date of audit to the new facilities who have no prior certification listing.
- New facilities proceeding for early audit schedules shall be listed as JDC certified from the date of audit, though they have a valid listing for another few months. Such listing of new facility shall be overlapped with the JDC certification listing.
- Facilities who have got certification previous year, but unable to proceed with certification due to less claims shall still proceed with certification to maintain continuity of listing provided they have a minimum sample of 30, putting into consideration that the facility may make up for more claims in the later part of the year and shall not incur gap in listing, unless the facility chooses to proceed with the listing gap, such action implies understanding of implications of liabilities resulting from claims process.

13 TRANSITION PHASE OF OLD TO NEW METHODOLOGY:

The New JDC Methodology of 2019 is applicable for the facilities for which the audit is conducted from January 1st, 2019.

14 MAINTAINING VALIDITY OF THE CERTIFICATE

The facility must ensure its System continues to comply with the Methodologies and other applicable reference standards or regulatory document. The facility must record any complaints / claims and the relative corrective action implemented and must make these records available together with the corrective action taken to address the identified deviations.

TASNEEF also reserves the right to perform additional audits based on the impact of identified deviations in the processes. Also, reserves the right to perform and charge Re-audits on failed facilities.

- May conduct a follow-up audit to confirm that the major deviations identified during the initial audit have been corrected by facility as per the action plan. Action plan should be sent by the facility to TASNEEF giving the details of action for corrections with-in a week after initial audit.
- TASNEEF shall conduct a Re-audit on failed facilities as required on Process or Claims review. Re- audit on Clinical Coding Process review is to verify the corrected Processes as per the action plan within two months' duration after audit.

If the facility refuses without a justified reason, TASNEEF may decide to suspend/withdraw certification.

14.1 Management of Certificates

1. The validity of the certificate is based on the scoring achieved by the facility
2. The validity of the certificate, could be subjected to the results of the subsequent audits.
3. The validity of the certificate may be suspended, withdrawn or relinquished

15 MODIFICATION OF CERTIFICATION AND COMMUNICATION OF CHANGES

1. The facility must promptly inform TASNEEF of any changes in factors that may affect the capacity of the Management System to continue to satisfy the requirements of JAWDA Data Certification.
2. These requirements concern, for example, modifications to the legal, commercial, facility or ownership status.
3. TASNEEF reserves the right to perform additional audits on the facility if the modifications communicated are considered particularly significant in regards maintaining the conformity of the Management System with the requirements of the reference standard and of these rules or to review the economic conditions for the possible modification of the contract.
4. TASNEEF promptly informs the facility whenever any changes in the methodology, reference standards or certification rules are published.

16 CONDITIONS AT WHICH AUDIT PROCESS WILL STOP

1. When required evidences are not provided on time (within the end of the audit time) as per the schedule for the audited function which leads to losing of audit time consequently audit process will be un-useful and ineffective
2. When the auditor faces difficulties to get and collect the relevant evidences at the time of audit (i.e. collection will be latter after the audit) which might lead to improper conclusion of audit findings
3. When the planned nominated personnel are not available and the one provided is not competent to provide the required evidences or to demonstrate responsible attitude, consequently audit process will be useless
4. Absence of authorized person from the top management who is authorized to facilitate the audit process with the competency and authorization levels that help him to understand, response, discuss, agree and sign the concluded findings during the whole audit process (i.e. from planning till audit report and certificates submission)
5. Any case that might be classified by the lead auditor to lose the professional objective of the audit process and provide unprofessional services like:
 - i. Unavailable agreed resources with the client like proper adequate and comfortable room space for the auditors, access to review the required medical records or documentation

- ii. Unavailability of required employees for the audit per the agreed plan communicated with the client, especially when no concern is received from the client side after plan communications
- iii. Any interaction from un-nominated auditee which will not pour in the sake of audit and may adversely effect on the auditor ability to conclude proper and professional conclusions.
6. If due to emergency situations TRBA auditors couldn't join the audit as per the planned arrangements client will be communicated to set another audit plan
7. Cases from 1 to 5- Client will be charged for compensated new planned time to complete the audit process
8. Case no. 6- TRBA will reschedule audit time compensation before certification expiry date.

17 CONDITIONS AT WHICH CERTIFICATION PROCESS MAY BE SUSPENDED

1. In cases when the audited facility cannot provide the evidences before the completion of the audit time.
2. In cases when TRBA will reject the facility proposed corrective actions not resulting in effective solution for identified non-conformities.
3. In case of not sending the corrective actions plan in the 5 Calendar days of sending the formal report.

18 SUSPENSION, REINSTATEMENT AND WITHDRAWAL OF CERTIFICATION

The validity of the certificate of conformity may be suspended as indicated in "GENERAL TERMS AND CONDITIONS" and in the following specific cases:

- if the Facility refuses to allow the scheduled audits to be performed at the required frequencies;
- if observations are found in the management system which have not been corrected within the time limits established by TASNEEF
- if the facility does not observe the deadlines established for the communication of corrective actions, following observations/observations indicated on the audit report;
- for evidence that the facility does not guarantee the respect of the laws and regulations applicable to the supplied services or activity
- if any justified and serious claims received by TASNEEF are confirmed.

The facility may also make a justified request to suspend certification, normally for not more than six months and in no case after the date of expiry of the certificate.

This suspension will be notified in writing, stating the conditions for re-instating certification and the date by which the new conditions are to be complied with.

Revocation of the certificate of conformity may be decided in the following specific cases:

- if the facility does not accept the economic conditions established by TASNEEF due to a modification in the contract tariff, approved with DoH
- for every other major reason, at TASNEEF 's discretion, such as the proven incapacity of the system to pursue its objectives of complying with legislative, contractual requirements.

Withdrawal of the Certificate of Conformity is notified in writing to the Facility and made public in DoH website

Any facility which, following revocation of its Certificate, wishes to be re-certified, must submit a new application and follow the entire procedure all over again.

19 RENUNCIATION OF CERTIFICATION

A certified facility may send formal communication of renunciation of certification to TASNEEF in case of business termination before the expiry of the certificate.

Upon receipt of this communication, TASNEEF starts the procedure for invalidating the Certificate. Within one month from the date of the communication, TASNEEF updates the validity status of the certificate.

20 NEW FACILITY LISTING AND EXTENSION OF LISTING

New Facilities Listing:

- a. Any new facility including Dental Centers and Self-Pay must apply for “New Facility Listing” within 6 months of obtaining their HAAD license.
- b. Facilities which have been operating over 6 months after obtaining HAAD license should present an explanation letter for the delay in request.
- c. Every request for New Facility Listing should be accompanied with the following documents:
 - i. A copy of the valid HAAD facility license
 - ii. The Facility’s CODING Process Flow Chart or policy
 - iii. A letter stating all the above as well as a summary description of the coding process flow in this facility
 - iv. Proof of Coder (internal or outsourced, as applicable) current certification and/or experience (proof that the certification is current and valid)
 - v. Proof of current Continuing Education of the coder vi. If applicable, a copy of the coding outsourcing service contract with companies.
- d. Once the documents are reviewed and if these meet the criteria as specified in this Methodology, the facility will be listed in Shafafiya with validity of 6 months.
- e. All Listed New Facilities should be able to proceed for JAWDA Data Certification process once the facility has submitted a minimum of 120 claims in total scope. For Hospitals, facility shall apply for an audit after submitting a minimum of 120 claims for each setting or completing six months of claim submission irrespective of claims count per settings, whichever is earlier. If by the date of expiry of initial listing the facility does not have sufficient number of claims, it can apply for extension as described below.
- f. If a facility is not new and submitted some claims previously or years ago, facility should provide a reason why the facility could not maintain the certification continuously or the reason for the gap years.
- g. The reason will be reviewed by DoH and/or TASNEEF, and a final decision of listing under exemption will be given.

Extension of New Facility listing

- a. After 6 months of new listing, if the facility is unable to start claiming process or could not meet the criteria of 120 claims for each facility setting to proceed for certification, an extension request should be sent to TRBA executives assigned to your facility.

- b. Facility should provide a justification letter for the request of extension in listing.
- c. The justification will be reviewed by TASNEEF and after confirmation from DOH that there are no enough submitted claims, the extension will be issued in the list of Certified – New Facilities list.
- d. The duration of the extension period may vary from 3- 6 months based on the submitted claims count. New facilities proceeding for early audit schedules shall be listed as JDC certified from the date of audit, regardless of the remaining months of the current listing. Such listing of new facility or extension of listing shall be overlapped with the JDC certification listing.
- e. Not more than 2 extensions of 6 months validity will be provided. Facility should be audited prior to the expiry of extension listing if the facility claims submission count meets the required sample and, need not necessarily meet 120 claims.
- f. Any case where the facility has not initiated any claims submission, should submit the supporting documentation as justification for the request of further extension as a special case.

21 COMPLAINTS MANAGEMENT

TRBA has always considered complaints and customer satisfaction as an incentive to improve the quality of the service provided. This chapter describes how third and interested parties can file a complaint with TRBA concerning its activities. All the complaints should be sent to email ba.jdcsupport@tasneef.ae Complaints routed through this email will be responded as per the complaints management procedure. The communication must include all the data enabling TRBA activity for which a complaint is being filed to be identified. The specific aspect of complaint for review will be identified, and a receipt notification will be sent to the facility within 5 working days describing the request management process.

Some of the critical comments are managed directly in the phase of the formal report as per the following points, however complaints, observations and request could include aspects of the certification process more in general.

As per reporting process:

1. All the audit findings are communicated to the facilities in the formal audit report and any concerns on the communicated findings can be flagged for additional review with appropriate justifications referring to specific guidelines and/or standards.
2. All the facility comments mentioning relevant references, guidelines and with appropriate justifications shall be reviewed to provide response in the final audit report.
3. All the evaluations shall be done as per the methodology criteria and normative references. In case of evaluations that are not justified in the final audit report, resulting in failure of audit results, facility can request for a meeting with TRBA to further understand the facility point of view.
4. If the meeting agenda is accepted, during the meeting, facility should be able to present the standard references to justify their comments. TRBA shall forward such scenarios for internal committee review and decision.
5. In case the facility is requesting for further analysis on JDC evaluations and committee decision, an appeal request can be sent to DoH at quality@haad.ae
6. The appeal request shall include the facility license, region, head of the facility details and the Audit representative details along with the details of audit concerns with supporting documents and references.
7. Additionally, as part of feedback process, a survey link is shared to the healthcare facilities to collect the feedback on the audit process.

8. Complaints/Feedback tab is available on the webpage of TRBA. Any concern or feedback can be shared by facilities using this option which shall automatically redirect the complaints to DoH and TRBA Higher management.

APPENDIX



Appendix-I – The Tier System

Appendix-II- Scoring Weights & Examples

Appendix-III- Scoring Tables

APPENDIX-I

The Tier System

The Tier System

The Tier system is classified based on the annual volume of claims submission. Tiers are classified by facility types as Tier H for Hospitals, Tier M for Centers/ Clinics, Tier D for exclusive Dental Centers (Services), Tier HC for Home Health Care Centers, Tier RH for Rehabilitation Hospitals (Long Term Care Centers) and Tier SP for exclusive Self-Pay services.

Table 1

	Tier	Billing Volume/Year	Claim Sample
Medical Centers	Tier 6-M	>=150,001	95
	Tier 5-M	100,001 to 150,000	75
	Tier 4-M	50,001 to 100,000	60
	Tier 3-M	25,001 to 50,000	41
	Tier 2-M	10,001 to 25,000	30
	Tier 1-M	<=10,000	24

Table 2

	Tier	Billing Volume/Year	Claim Sample
Home Health care	Tier 3-HC	>= 26,001	30
	Tier 2-HC	15,001 to 26,000	25
	Tier 1-HC	<=15,000	20

Table 3

	Tier	Billing Volume/Year	Claim Sample
Hospitals	Tier 6-H	>=700,001	221
	Tier 5-H	400,001 to 700,000	185
	Tier 4-H	200,001 to 400,000	140
	Tier 3-H	100,001 to 200,000	102
	Tier 2-H	50,001 to 100,000	70
	Tier 1-H	<=50,000	60

Table 4

	Tier	Billing Volume/Year	Claim Sample
Rehabilitation Hospitals	Tier 4-RH	>=50,001	35
	Tier 3-RH	25,001 to 50,000	30
	Tier 2-RH	10,001 to 25,000	25
	Tier 1-RH	<=10,000	20

Table 5

	Tier	Billing Volume/Year	Claim Sample
Dental	Tier 4-D	>=50,001	30
	Tier 3-D	30,001 to 50,000	26
	Tier 2-D	15,001 to 30,000	23
	Tier 1-D	<=15,000	20

Table 6

	Tier	Billing Volume/Year	Claim Sample
Self-Pay	Tier 4-SP	>=5,001	20
	Tier 3-SP	1,001 to 5,000	18
	Tier 2-SP	201 to 1,000	15
	Tier 1-SP	1 to 200	10
	Tier SP	No Submission- <1	10

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, KPI Process Review Score and, KPI Data Validation score for Hospitals, Home health Care, Long Term Care as applicable.

The Summary of scoring weights per the facility type is as shown below:

Table 1- Summary of scoring weights

Hospitals / Home Health Care/Long Term care /Rehabilitation Hospital	
Scope	Weight
Claims Review Score	40
Clinical Coding Process Review Score	10
KPI Process Review Score	25
KPI Data Validation Score	25

Table 2- Summary of scoring weights – Centers/Clinics

Centers/Clinics /Exclusive Dental/Exclusive Self-Pay	
Scope	Weight
Claims Review Score	80
Clinical Coding Process Review Score	20

Examples of Scoring per facility Type and settings as per applicable domain weights

Example1: Details of scoring for the medical centers and clinics will be as shown in the below table as an example: Table 3

CENTERS / CLINICS -DETAILED SCORING WEIGHTS									
Facility Type	Domain	Domain Details	Claim Count	Claim distribution ratio	Score-Each Setting	Weight as per claim ratio	Domain weights	Final Score	
			120						
Medical Centers /Clinics	Claims Review	Outpatient (100)	50	41.67%	90.00	37.50			
		Day case* (100)	30	25%	87.00	21.75			
		Dental (100)	25	20.83%	87.00	18.12			
		Self-Pay (100)	15	12.5%	89.00	11.12			
	Claims review Score for 100						88.49	80%	70.79
	Clinical Coding Process Review (General+Dental+Self-Pay)	Process flow Map / effectiveness - 15					13.00		
		Clinical Coding/Documentation Polices & Practices - 40					36.00		
		Coder Credentials - 05					5.00		
		Orientation/Training - 10					10.00		
		Compliance-4 departments - 30					26.00		
Clinical Coding Process Review Score for 100						90.00	20%	18.00	
FINAL JAWDA DATA CERTIFICATION SCORE								88.79	

Example2: Details of scoring for Home Health Care will be as shown in the below table as an example: Table 4

HOME HEALTH CARE - DETAILED SCORING									
Facility Type	Domain	Domain details	Claim Count (Total 35)	Claim distribution ratio	Score- Each Setting	Weight as per claim ratio	Domain weights	Final Score	
			25						
Home Health Care/Long Term Care/Rehabilitation Center	Claims Review Each Setting 100	Home Health care - 100	15	42.86%	86	36.86			
		Out Patient - 100	10	28.57%	92	26.28			
		Self-Pay - 100	10	28.57%	90	25.71			
	Claims Review Score - 100						88.85	40%	35.54
	Clinical Coding Process Review (General+Self-pay)	Process flow Map / effectiveness - 15					15.00		
		Clinical Coding/Documentation Polices & Practices - 40					35.00		
		Coder Credentials - 05					5.00		
		Orientation/Training - 10					10.00		
		Compliance-4 departments - 30					25.00		
	Clinical Coding Process Review Score - 100						90.00	10%	9
	KPI Process Review	Operations, Planning, Support - 50					45.00		
		Quality Governance & Improvement 50					38.00		
	KPI Process Review Score - 100						83.00	25%	20.75
KPI Data Validation Score - 100	Quality Indicators			100%		86.00	25%	21.50	
FINAL JAWDA DATA CERTIFICATION SCORE								86.79	

Example 3: Details of scoring for the Hospitals will include KPI Indicators validation along with Clinical Coding as shown in the below table: Table 5

HOSPITALS -DETAILED SCORING									
Facility Type	Domain	Domain details	Claim Count (Total-185+23+20)	Claim distribution ratio	Score- Each Setting	Weight as per claim ratio	Domain weights	Final Score	
Hospital Tier 5-H	Claims Review Each Setting 100	Outpatient -	100	97	42.54%	86	36.59		
		Emergency -	100	30	13.16%	86	11.32		
		Inpatient -	100	24	10.53%	86	9.05		
		Day case -	100	24	10.53%	86	9.05		
		Home Health care-	100	10	4.39%	86	3.77		
		Dental-	100	23	10.09%	88	8.88		
		Self-Pay-	100	20	8.77%	87	7.63		
	Claims Review Score - 100						86.29	40.00	34.51
	Clinical Coding Process Review (General+Dental+Self-Pay)	Process flow Map / effectiveness - 15					15.00		
		Clinical Coding/Documentation Polices & Practices - 40					35.00		
		Coder Credentials - 05					5.00		
		Orientation/Training - 10					10.00		
		Policies Adherence - 30					25.00		
	Clinical Coding Process Review Score - 100						90.00	10.00	9
	KPI Process review	Planning, Support & Operations 50					40.00		
Quality Governance & Improvement 50					45.00				
KPI Process Review Score - 100						85.00	25.00	21.25	
KPI Data Validation Score - 100	Quality Indicators + Waiting Time 100		100%			86.00	25.00	21.50	
FINAL JAWDA DATA CERTIFICATION SCORE								86.26	

APPENDIX-III

Scoring Tables

Tables of Error Scoring for Claims Review (Revised)

Table 1: Error Scoring: Inpatient /Long Term Care (LTC) – Accuracy

ERROR SCORING TABLE FOR INPATIENT / LTC - ACCURACY ERRORS			
Category-Score		Accuracy Error	Example and Explanation
1. Major Encounter type error-10 - BILLING RELATED			
Major	10	Claim uploaded to wrong Encounter Type.	Claimed codes are uploaded to incorrect encounter type.
2. Moderate Per-Diem code error- 05			
Moderate	5	Missing/ Incorrect - Per-Diem codes or service codes or Per-Diem codes or service codes added without documentation	Missed to bill appropriate Per-Diem codes/service codes OR Billed Per-Diem codes/service codes are incorrect for the service provided. Billed Per-Diem codes/service codes added without supportive documentation; (17-23 added without recovery room service)
Moderate	5	Other miscellaneous billing errors/ Incorrect units of billing with Zero charges	Other miscellaneous billing errors like incorrect anesthesia units, infusion or hydration units billed CPT 36415 billed without performing within the facility or CPT 36415 Venipuncture is not eligible to report as per guidelines
E&M AND PROCEDURE ACCURACY ERROR – CODING RELATED			
3. Major Procedure Error-20			



Major	20	Surgical procedure coded without documentation.	“31623 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings” is coded when there is no documentation to substantiate brushing. Also coding an add-on code without a relevant primary procedure code.
Major	20	Incorrect surgical procedure code.	Claimed code does not match what is documented “EGD diagnostic procedure done without specimen collection but coded EGD with biopsy”.
Major	20	Missed to code surgical procedure code.	Surgical (Minor or Major) Procedure not coded when it is performed.
4. Major Evaluation and Management Error-15			
Major	15	E & M code missing, high or in the wrong category; or coded without documentation or coded with insufficient documentation;	<ul style="list-style-type: none"> • Missed to code E&M code or E & M code does not meet the documentation criteria. • Inpatient E & M codes are mandatory on all records, assigned according to guidelines and rules, as of 1st January 2014. If they are missing, in the wrong category, or are higher than warranted by documentation, it shall be scored as an error (Please, see LTC below for clarity) • If LTC or a subtype must be claimed according the LTC Standard and use the applicable service codes. There is an error if an additional Inpatient E & M is assigned – (LTC and subtypes must be claimed through inpatient encounter type.) • If Rehab (or LTC) is claiming by DRG as Inpatient stay, then the scoring rules for Inpatient applies.
5. Moderate Procedure Error-10			

Moderate	10	Non-surgical procedure/medicine codes are coded without documentation / Incorrect CPT code.	Ex: Non-surgical procedure/services like radiology, immunization, injection, IV, respiratory services, ECG, etc., are coded without documentation / Coded wrong CPT.
6. Minor Procedure Error-5			
Minor	05	Procedures do not have corresponding diagnosis code documentation;	Turbinectomy Procedure performed but there is no corresponding documentation and diagnosis to support the procedure performed.
Minor	05	Unbundling of CPT codes.	Any CPT which is bundled into another procedure should not be billed together.
DIAGNOSIS ACCURACY ERROR – CODING RELATED			
7. Major Diagnosis Error-20			
Major	20	Diagnosis coded without documentation or coding sign & symptom INSTEAD of the diagnosis.	Code is not as per the documentation, OR Coded sign or symptom and not the documented diagnosis such as a PDx- R30.0 Dysuria coded when documentation shows a PDx- N39.0: Urinary tract infection NOS.
Major	20	Incorrect selection of principal diagnosis.	The “Incorrect selection of Principal Dx” - refers to a sequencing issue, not a documentation issue. Both codes must be present and the wrong one is selected as principal diagnosis, but the correct code must be listed.
Major	20	Missing relevant principal diagnosis.	Claim is not coded with principal diagnosis of the actual reason for patient admission.



Major	20	Claimed code does not match documentation / Incorrect diagnosis codes.	<p>Coded diagnosis is not accurate to the available documentation. Ex: Documented as GBS +ve and coded as O98.81X without current infection affecting the pregnancy.</p> <p>If the codes assigned are not within the correct Category, then it would be a Major Error of "Claimed code doesn't match/Incorrect diagnosis code". [Ex: Documented as Acute appendicitis (K35.80) but coded as Chronic appendicitis (K36)]</p>
8. Moderate diagnosis error-10			
Moderate	10	Missing relevant secondary diagnosis specific to this encounter or specific to performed procedure.	<p>Missing required and/or pertinent secondary diagnosis which is relevant to this encounter, including Chapter 21 codes. (i.e. 'history of' codes, BMI, Smoking, place of occurrence, activity etc.)– Examples; Patient has coronary artery disease and history of CABG not coded; Or Patient morbidly obese and BMI is not coded. If manifestation code is assigned without underlying condition or relevant Chapter 21 codes are not assigned.</p> <p>And, all Complication and Co morbidities (CC) or Major Complication and Co morbidities (MCC).</p>
Moderate	10	Error of specificity in diagnosis code.	<p>The "Error of specificity in diagnosis code" refers to coding within the correct Category or Subcategory but not coding to the specificity available in the documentation. (Ex: Acute Bronchitis due to RSV coded as Acute Bronchitis unspecified-J20.9 instead of J20.5);</p>



Moderate	10	Procedures orders do not have corresponding diagnosis code.	Order for ECG, however, there is no diagnosis documentation to justify the reason for order.
Moderate	10	Primary diagnosis doesn't have any relationship with the chief complaint.	Ex: Patient came with epigastric pain, but primary diagnosis coded as osteoarthritis knee.
9. Minor Diagnosis Error-5			
Minor	05	Coding Signs & Symptoms / condition is integral to Diagnosis additionally.	Coding additionally (not instead of) Signs & Symptoms that are associated routinely with a disease process, unless otherwise instructed by the classification - Ex: "K27.7 Chronic peptic ulcer of unspecified site without mention of hemorrhage or perforation, with obstruction" is the Principal diagnosis and a secondary symptom code is added "R10.13 Dyspepsia. OR Documented as osteoarthritis in knee and coded both ICD's M17.9 & M19.90. Against coding guidelines.

Table 2: Error Scoring: Inpatient – Completeness

SCORING TABLE FOR INPATIENT – COMPLETENESS ERROR			
Category-Score		Completeness Error	Example and Explanation
DIAGNOSIS AND PROCEDURE ERRORS			
1. Major Diagnosis Error-15			
Major	15	Does not code “Possible, Probable etc.”	Coding Guidelines specify that in an Inpatient setting, the documentation of “possible”, “probable”, “?” etc. are to be coded.
2. Moderate Diagnosis Error -10			
Moderate	10	Missing additional diagnosis.	Missed to assign additional code, according to coding rules and guidelines and available documentation.
3. Major Procedure Error-15			
Major	15	Missing non-surgical procedure codes	Non-surgical procedure/service codes like IM, IV, CTG, ECG, Anesthesia codes etc., not coded when it is documented.
4. Major E&M Error-20			
Major	20	Low E&M Inpatient;	E & M are mandatory to be coded on every claim. If the E & M is lower than the available documentation.
DOCUMENTATION ERRORS			
5. Major Documentation Error-20			



Major	20	Missing documentation or insufficient documentation to code Initial or subsequent day evaluation and Management	No or Insufficient documentation to code the lowest level E/M; example 99221
Major	20	Missing documentation details for Procedures/ Operative reports	<p>Physiotherapy- Details of modalities, site of application of modality, time start and end, authentication etc.,</p> <p>Procedures: Aseptic precautions, Technique/approach of procedure, detailed procedure notes, closure technique, hemostasis, risks encountered if any, post procedural complications if any.</p> <p>Injection: Site, route, strength, dose, time, initials</p> <p>Operative note: Date of procedure, Physicians, Type of Anesthesia, Pre-op and Post Op Diagnosis, Technique of procedure, detailed procedure note, closure technique, hemostasis, risks encountered if any, post procedural complications if any.</p>
6. Moderate Diagnosis Documentation Error-10			
Moderate	10	Missing Narrative Diagnoses	Missed to narrate the complete diagnoses in the clinical final impression by the treating physician;
6. Moderate Service Documentation Error-10			
Moderate	10	Radiology/Diagnostic reports have no documentation of indication for test, technique or approach of procedure/views of radiological examination;	<p>Indication for X-ray: Cough</p> <p>Technique or approach: PA view</p> <p>No. of Views: Single</p>

			Findings: Impression: Pneumonic consolidation
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Table 3: Error Scoring: Outpatient/ER/Day case – Accuracy

ERROR SCORING TABLE FOR OP, ER, DAY CASE – ACCURACY ERRORS			
Category - Score		Accuracy Error	Example and Explanation
1. Major Encounter type error-10 (Billing Related Error)			
Major	10	Claim uploaded to wrong Encounter Type.	Claimed codes are uploaded to incorrect encounter type.
2. Moderate Per-Diem code error-5 (Billing Related Error)			
Moderate	5	Missing / Incorrect Per-Diem or Service Code;	Missed to bill appropriate Per-Diem codes whenever applicable. OR Billed Per-Diem code is incorrect to the care provided (i.e., Medical or surgical) and hours of stay.
Moderate	5	Other miscellaneous billing errors.	Incorrect Date of service on the claim CPT 36415 billed without performing within the facility; Or CPT 36415 Venipuncture is not eligible to report as per adjudication guidelines
E&M / PROCEDURE ERROR - ACCURACY			
2. Major Evaluation and Management Error-20			



Major	20	E&M code missing, high and/or in wrong category; or coded without documentation or insufficient documentation;	Missed E&M code (Follow-up E&M) or E & M code does not meet the documentation criteria.
3. Major Procedure Error-20			
Major	20	Surgical/Diagnostic procedure coded without documentation.	“31623 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings” is coded when there is no documentation of to substantiate brushing.
Major	20	Incorrect surgical procedure code/Claimed code does not match what is documented	Claimed code does not match what is documented “31622 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed” is on the record and documentation and 31623 are coded. This can be either first-listed or secondary.
4. Moderate Procedure Error-10			
Moderate	10	Missed to code surgical procedure code.	Procedure not coded when it is performed. Documented as Simple Repair leg, but missed to code CPT 12001
Moderate	10	E&M code is inclusive in procedure code or procedure is inclusive in E&M.	Encounter only for injection, hence E&M should not be billed separately without physician intervention. Follow coding guidelines for “distinct &/or separate service. Example: A distinct E & M is coded in addition to initial cast application. Wound dressing inclusive of E/M
Moderate	10	Non-surgical procedure/medicine procedure coded without documentation / Coded with Incorrect CPT code.	Ex: Non-surgical procedure/services like radiology, immunization, injection, IV, respiratory services, ECG, etc., are coded without documentation / Coded wrong CPT.



5. Minor Procedure Error-5			
Minor	05	Unbundling of CPT codes. Minor procedure integral to other procedure.	Any CPT which is bundled into another procedure should not be billed together.
DIAGNOSIS ACCURACY ERROR – CODING RELATED			
6. Major Diagnosis Error-15			
Major	15	Diagnosis coded without documentation or coding signs & symptoms INSTEAD of the diagnosis.	Diagnosis coded without documentation in the claim OR documentation does not support the billed code. OR Code is a documented sign or symptom and not the documented diagnosis such as a PDX- R30.0 Dysuria coded when documentation shows a PDX- N39.0: Urinary tract infection NOS.
Major	15	Claimed code does not match documentation / Incorrect diagnosis codes.	The code which is on the Claim does not match what is documented and/or coded.
Major	15	Coding Possible, Probable, suggestive, likely or questionable diagnosis.	Coding Guidelines specify that in an Outpatient setting, the documentation of “possible”, “probable”, “?” etc. are not to be coded.
7. Moderate Diagnosis Error-10			
Moderate	10	Missing relevant primary or secondary diagnosis specific to this encounter.	Missing required and/or pertinent secondary diagnosis which is relevant to this encounter, including Chapter 21 codes. (i.e., ‘history of’ codes, BMI, Smoking, place of occurrence, activity etc.)– Examples are; Patient has coronary artery



			disease and history of CABG not coded, Or Patient morbidly obese and BMI are not coded. Also, if manifestation code is assigned without underlying condition. Or relevant Chapter 21 codes are not assigned.
Moderate	10	Coded condition is integral in another condition or Code (specific or non-specific or other)	Documented as osteoarthritis in knee and coded both ICD's M17.9 & M19.90. Against coding guidelines.
Moderate	10	Error of specificity in diagnosis code.	The "Error of specificity in diagnosis code" refers to coding within the correct Category or Subcategory but not coding to the specificity available in the documentation. (Ex: Acute Bronchitis due to RSV coded as Acute Bronchitis unspecified-J20.9 instead of J20.5); If the codes assigned are not within the correct Category, then it would be a Major Error of "Claimed code doesn't match/Incorrect diagnosis code". [Ex: Documented as Acute appendicitis (K35.80) but coded as Chronic appendicitis (K36)]
Moderate	10	Procedures or Prescription orders do not have corresponding diagnosis code/Diagnosis Documentation	Principal diagnosis – J45.909 Unspecified Asthma Principal procedure - 36660 Catheterization, umbilical artery, newborn, for diagnosis / therapy.
Moderate	10	Primary or Principal diagnosis coded is not relevant to the chief complaint or doesn't have any relationship with the chief complaint.	Ex: Patient came with epigastric pain, but primary diagnosis coded as osteoarthritis knee. This is not to be confused with sequencing error. In this case, there will not be any final diagnosis related to chief complaint in secondary or tertiary or other positions. Ex: Chief complaint: Cough, joint tenderness documented in PE, Final diagnosis is osteoarthritis



8. Minor Diagnosis Error-5			
Minor	05	Incorrect sequencing of diagnosis.	This is strictly a sequencing issue, not a documentation issue. Both/all codes are present; however, the wrong code is selected as principal diagnosis. If another code (incorrect) is listed, then it would be a Major Error of "Diagnosis coded without documentation".
Minor	05	Coding Signs & Symptoms to support for Prescriptions and labs or Coding Signs & Symptoms integral to Diagnosis additionally	Coding additionally (not instead of) Signs & Symptoms that are associated routinely with a disease process, unless otherwise instructed by the classification - Example: "K27.7 Chronic peptic ulcer of unspecified site without mention of hemorrhage or perforation, with obstruction" is the Principal diagnosis and a secondary symptom code is added "R10.13 Dyspepsia.

Table 4: Error Scoring: Coding Error List Outpatient/ER/Day Case – Completeness

SCORING TABLE FOR OP, ER, DAY CASE – COMPLETENESS ERRORS			
Category-Score		Completeness Error	Example and Explanation
DIAGNOSIS AND PROCEDURE ERRORS			
1. Major Diagnosis Error - 10			
Major	10	Missing additional diagnoses code(s);	Missed to assign additional code, according to coding rules and guidelines and available documentation.
2. Major Evaluation and Management Error-10			
Major	10	Coding Low E & M	E&M level coded low when the documentation is meeting to code higher level.
3. Major Procedure Error-10			
Major	10	Missing non-surgical procedure code or missing Service codes	Non-surgical procedure/service codes like IM, IV, NEB, vaccination, anesthesia codes etc., not coded when it is documented. Ex: Missed to code dressing 51-02 when documented.
CLINICAL DOCUMENTATION ERRORS			
4. Major Documentation Errors - 15			
Major	15	Missing documentation details for Procedures	Physiotherapy- Details of modalities, site of application of modality, time start and end, authentication etc.,



			<p>Procedures: Aseptic precautions, Technique/approach of procedure, detailed procedure notes, closure technique, hemostasis, risks encountered if any, post procedural complications if any.</p> <p>Injection: Site, route, strength, dose, start/end times, initials</p> <p>Operative note: Date of procedure, Physicians, Type of Anesthesia, Pre-op and Post Op Diagnosis, Technique of procedure, detailed procedure note, closure technique, hemostasis, risks encountered if any, post procedural complications if any.</p>
Major	15	Missing Narrative Diagnoses	Missed to narrate the complete diagnoses in the clinical final impression by the treating physician;
5. Moderate Documentation Errors - 10			
Moderate	10	Systems Review and Physical Examination is contrary to documented and coded conditions.	Diagnosed with Acute Tonsillitis, ENT examination shows normal;
Moderate	10	Relevant system examination is missing in the document.	Dermatitis as Final Diagnosis, examination of Skin/Integumentary system is Completely missing.
Moderate	10	Extensive template documentation of physical examination and review of systems. Not updated as per the relevancy to the visit conditions.	Documentation of 12 systems for dermatitis
Moderate	10	Radiology/Diagnostic reports have no documentation of indication for test, technique or approach of procedure/views of radiological examination	<p>Indication for X-ray: Cough</p> <p>Technique or approach: PA view</p> <p>No. of Views: Single</p>



Findings:

Impression: Pneumonic consolidation

Table 5 Error Scoring: Home Health Care – Accuracy

SCORING TABLE FOR HOME CARE – ACCURACY ERRORS			
Category-Score		Accuracy Error	Example and Explanation
1. Major Encounter Type -10			
Major	10	Claim uploaded to wrong Encounter Type	Claimed codes are uploaded to incorrect encounter type
Major	10	Other Billing Errors	Ex: Claim submitted with incorrect encounter date. Claim submitted with incorrect Quantity of each CPT & Service codes.
PROCEDURES ACCURACY ERRORS			
2. Major Procedure Error - 20			
Major	20	Procedure coded without documentation	“99507 Home visit for care and maintenance of catheter” is coded when there is no documentation to substantiate PEG tube care. “98960 Education & Training for Patient self-management” is coded when there is no documentation to substantiate timing.
3. Major Home Care Evaluation & Management Error - 15			
Major	15	E&M level high and/or in wrong category	E & M code does not meet the documentation criteria.
4. Moderate Procedure Error for Physiotherapy Evaluation-10			
Moderate	10	Physiotherapy evaluation / services coded without documentation	“97002 Physical therapy re-evaluation” is coded when there is no documentation to substantiate Physiotherapy assessment” “97110 coded without documentation”
5. Moderate Procedure Error -10			

Moderate	10	Incorrect procedure code	Claimed code does not match what is documented. “Documented as Sub cutaneous insulin injection but coded for IM injection 99506 procedure code” etc.,
6. Minor Procedure Error -05			
Minor	5	Unbundling of CPT codes.	Any CPT which is bundled into another procedure should not be billed together.
DIAGNOSIS ACCURACY ERRORS			
6. Major Diagnosis Error - 15			
Major	15	Diagnosis coded without documentation.	Coded diagnosis is not per the documentation.
Major	15	Claimed code does not match documentation.	The code which is on the Claim does not match what is documented and/or coded.
Major	15	Coding Possible, Probable or questionable diagnosis (see Coding Guidelines) Coding Possible, Probable or questionable diagnosis (see Coding Guidelines)	Coding Guidelines specify that outpatient setting, the documentation of “possible”, “probable”, “?” etc. are not to be coded.
7. Moderate Diagnosis Error-10			
Moderate	10	Coding Signs & Symptoms integral to Diagnosis additionally OR Coded condition is integral to another condition additionally	Coding additionally (not instead of) Signs & Symptoms that are associated routinely with a disease process, unless otherwise instructed by the classification - Example: “K27.7 Chronic peptic ulcer of unspecified site without mention of hemorrhage or perforation, with obstruction” is the Principal diagnosis and a secondary symptom code is added “R10.13 Dyspepsia

			<p>Diagnosis Hemiplegia is integral to condition hemiplegia due to CVA.</p> <p>Diagnosis unspecified Hyperlipidemia is integral to mixed hyperlipidemia.</p>
Moderate	10	Error of specificity in diagnosis code	<p>The “Error of specificity in diagnosis code” refers to coding within the correct Category or Subcategory but not coding to the specificity available in the documentation. If the codes assigned are not within the correct Category/Sub category, then it would be a Major Error of “Diagnosis coded without documentation”. The example would be the documentation showing the site as the toe and the code assigned is the foot when greater specificity is available.</p>
Moderate	10	Missing relevant diagnosis specific to this encounter	<p>Missing required and/or pertinent secondary diagnosis which is relevant to this encounter, including Chapter 21 codes. (i.e., ‘history of’ codes, BMI, Smoking, place of occurrence, activity etc.)– Examples are; Patient has coronary artery disease and history of CABG not coded, Or Patient morbidly obese and BMI are not coded. Also, if manifestation code is assigned without underlying condition. Or relevant Chapter 21 codes are not assigned.</p>
8. Minor Diagnosis Error-5			
Minor	05	Incorrect Selection of Primary Diagnosis	<p>Ensure that the diagnosis is the one most related to the patient’s current plan of care, is the chief reason home care is needed, and is the most acute condition requiring the most intensive skilled services (if more than one diagnosis is treated concurrently).</p>

Minor	05	<p>Acute conditions are not codable; Resolved and/or History conditions are not codable</p>	<p>Acute diagnosis currently not on medication cannot be coded in home care set up. Resolved diagnosis cannot be coded in home care set up. Ex-Cannot code history of CVA when patient is still having hemiplegia due to late effect of CVA. Documented as laryngeal carcinoma, status post laryngectomy, hence cannot code the diagnosis malignant neoplasm of larynx.</p>
Minor	05	<p>Incorrect sequencing of diagnosis</p>	<p>This is strictly a sequencing issue, not a documentation issue. Both/all codes are present; however, the wrong code is selected as principal diagnosis. If another code (incorrect) is listed, then it would be a Major Error of "Diagnosis coded without documentation".</p>

Table 6: Error Scoring: Home Health Care – Completeness

SCORING TABLE FOR HOME CARE – COMPLETENESS ERRORS			
Category-Score		Completeness Error	Example and Explanation
1. Major Procedure Error - 20			
Major	20	Missing Procedure Codes	Documentation shows a procedure is performed and the code is not assigned.
2. Major E&M Error - 10			
Major	10	Coding Low E & M / Missing E & M	Missed to code E&M when evaluation is performed
3. Moderate Procedure Home Physiotherapy - 10			
Moderate	10	Physiotherapy coded with insufficient documentation.	Insufficient documentation may be: Missing detail documentation of each Physiotherapy Modalities. Start time and/or end time of each Physiotherapy modalities is not documented
4. Moderate Procedure Home Nurse visits - 10			
Moderate	10	Nursing procedure coded from insufficient documentation.	Insufficient documentation found for the claim code may be: Missing detail documentation of each Home visit services. Missing detail documentation of pattern of care (Nursing duration, etc..)
5. Minor Physiotherapy Evaluation - 5			
Minor	5	Missing Physiotherapy Evaluation or re-evaluation code	Documentation shows physiotherapy assessment is performed but the code is not assigned.
DIAGNOSIS COMPLETENESS ERRORS			
6. Major Diagnosis Error - 10			

Major	10	Missing additional diagnoses code(s)	Missed to assign additional code, according to coding rules and guidelines and available documentation.
DOCUMENTATION COMPLETENESS ERRORS			
7. Major Documentation Error - 20			
Major	20	Missing Narrative diagnoses	Missed to narrate the complete diagnoses in the clinical final impression by the treating physician;
8. Moderate Documentation Error - 10			
Moderate	10	Systems Review and Physical Examination is contrary to documented and coded conditions.	Diagnosed with Pressure Ulcer, Integumentary examination shows normal;
9. Minor Documentation Error - 5			
Minor	5	Relevant system examination is missing in the document.	Dermatitis as Final Diagnosis, examination of Skin/Integumentary system is Completely missing.

Table 7: Error Scoring: Dental Setting – Accuracy

SCORING TABLE FOR DENTAL CARE – ACCURACY ERRORS		
Category - Score	Accuracy	Example and/ or Explanation
1. Major Encounter Type -10		
Major	10	Claim uploaded to wrong Encounter Type
	10	Other miscellaneous billing errors
		Claimed codes are uploaded to incorrect encounter type Incorrect Date of service on the claim Or Incorrect units of Additional or add-on non-surgical procedure codes

PROCEDURES ACCURACY ERRORS			
2. Major Procedure Error – 20			
Major	20	Procedure coded without documentation	"21111 Restorations, Amalgam, Non-Bonded, Primary Teeth One surface is coded" when there is no documentation to support any restoration.
3. Major Dental Care Examination Error - 25			
Major	25	Examination without documentation / Incorrect Examination Code	"01201 Examination and Diagnosis, Limited, Oral, New Patient" is coded" when there is no documentation to support any examination OR an Incorrect Dental Examination Code is coded to the available documentation.
4. Moderate Procedure Error -10			
Moderate	10	Incorrect procedure code / Claimed Procedure does not match what is documented / Incorrect tooth Number/Missing Tooth Number;	The Procedure code or tooth number for the procedure, which is on the Claim does not match what is documented and/or coded. Missed to document the Tooth number;
Moderate	10	An additional procedure/Minor procedure code which is inclusive in the Examination code;	A related minor procedure or examination is included in major procedure or examination performed on the same visit.
DIAGNOSIS ACCURACY ERRORS			
5. Major Diagnosis Error – 20			
Major	20	Diagnosis coded without documentation or coding sign symptom INSTEAD of the diagnosis;	Code is not per the documentation, e.g. documentation does not support the code. OR Code is a documented sign or symptom and not the documented diagnosis such as a PDx- K08.89: Tooth pain coded when documentation shows a PDx- K04.7: Dental Abscess

Major	20	Claimed code does not match documentation;	The code which is on the Claim does not match what is documented and/or coded.
Major	20	Coding Possible, rule out, Suspected, Probable or questionable diagnosis;	Coding Guidelines specify that in an Outpatient setting, the documentation of “possible”, “probable”, “?” etc. are not to be coded. Not Applicable in Inpatient setting.
6. Moderate Diagnosis Error-10			
Moderate	10	Dental Procedures do not have corresponding diagnosis code;	Any dental procedure code which is not supported by a related dental diagnosis.
Moderate	10	Missing relevant primary / secondary diagnosis specific to this encounter;	Missing required and/or pertinent secondary diagnosis which is relevant to this encounter. Examples are; Patient Encounter is for dental examination and cleaning with abnormal findings, abnormal findings were not coded. Also, if manifestation code is assigned without underlying condition.
Moderate	10	Coding Signs & Symptoms integral to Diagnosis additionally;	Coding additionally (not instead of) Signs & Symptoms that are associated routinely with a disease process, unless otherwise instructed by the classification. Example: “K04.7, Periapical abscess without sinus” is the Principal diagnosis and a secondary symptom code is added “K08.89 Toothache.
Moderate	10	Error of specificity in diagnosis code;	The “Error of specificity in diagnosis code” refers to coding within the correct Category or Subcategory but not coding to the specificity or Incorrect specificity as per the availability in the documentation. The example would be the documentation showing the dental caries into pulp and unspecified dental caries, when greater specificity is available.

7. Minor Diagnosis Error – 5			
Minor	05	Incorrect sequencing of diagnosis;	This is strictly a sequencing issue, not a documentation issue. Both/all codes are present; however, the wrong code is selected as principal diagnosis.

Table 8: Error Scoring: Dental Setting – Completeness

SCORING TABLE FOR DENTAL CARE – COMPLETENESS ERRORS			
Category-Score		Accuracy	Example and/or Explanation
PROCEDURE AND EXAMINATION ERROR			
1. Major Procedure Error - 20			
Major	20	Missing Dental Procedure Code;	Documentation shows a procedure is performed, which is significant and separate from other procedure codes and the code is not assigned.
2. Major Examination Error - 20			
Major	20	Missing Dental Examination;	Documentation shows a dental examination is performed, which is significant and separate, from other procedure codes and the code is not assigned.
DIAGNOSIS COMPLETENESS ERROR			
3. Major Diagnosis Error - 20			
Major	20	Missing Narrative Diagnoses;	Missed to narrate the complete diagnoses in the clinical final impression by the treating physician;
DOCUMENTATION COMPLETENESS ERROR			
4. Major Documentation Error - 10			
Major	10	Missing documentation details for Procedures;	Procedures: Aseptic precautions, Technique/approach of procedure, detailed procedure note, hemostasis, risks encountered if any, post procedural complications if any, Timing documentation for time-based codes

Major	10	Missing documentation details for Examinations; Or Relevant dental examination is missing, or documented examination is contradicting coded conditions	Examinations: Dental completeness of documentation like (Chief complaint, dental examination intra oral and or extra oral & its types (primary, mixed, permanent dentition not based on age criteria), charting, dental history, past medical history, allergy, pre-& post instructions, treatment plan, follow ups, prescription etc.) Follow-up visit – Chief complaint should correlate with the staged procedure/Reason for visit; (e.g. – RCT) Plaque & Gingivitis as Final Diagnosis, examination of Intraoral is Completely missing. Diagnosed with Periapical Abscess, Gingivitis. Dental Intraoral examination shows normal;
Moderate	10	Missing additional diagnoses	There is not complete and full code assignment(s), according to coding rules and guidelines and available documentation
Moderate	10	Radiology/Diagnostic reports have no documentation of indication for test, technique or approach of procedure/views of radiological examination & Interpretation of the X-ray;	Indication for X-ray: Caries/Pulpitis Technique or approach: Periapical view No. of Views: Single Findings: Impression: Dental caries penetrating the pulp Missed to document the interpretation in the Dental clinical visit; Histopathology/Test/Analysis documentation;