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DEPARTMENT OF HEALTH

JAWDA DATA CERTIFICATION (JDC) FOR HEALTHCARE PROVIDERS

Part-3

Technical Clarifications to Methodology 2019

December 19

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DEPARTMENT OF HEALTH

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Technical Clarifications to

Part-1 of

JDC Methodology

1 INTRODUCTION

The purpose of this document is to provide clarifications on specific aspects of Part-1 and Part-2 of JDC methodology 2019.

A Half-yearly update can be made if further clarifications are seen necessary to be published based on the updates received from the regulatory authorities. Any such updates or clarifications that is impacting the course of actions from part-2 will be applicable effective from the date of such clarification received.

2 METHODOLOGY SCOPE

The scope of JDC Methodology 2019 remains the same with inclusion of medical tourism claims under Claims review domain.

3 NORMATIVE REFERENCES

Requirements stated in this clause of JDC methodology 2019 are considered as still valid and applicable except the update to the versions or revisions as made applicable by DoH with current versions.

- DoH reference Quality Performance KPI Profile – As per the latest applicable from DoH

3.1 Terms and definitions

Audit observations for KPI: Audit observations identify a lack or gap in the process/ output that cannot be referenced to JDC methodology or DoH Jawda KPI Profiles. No score deduction will be applied for findings remarked as Observations. Score deduction is applied in full for major non-conformity and partially for minor non-conformity.

Date of Expiry – The expiry date listed on the Certified Facility List on www.doh.gov.ae/shafafiya/dictionary

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

8 Documentation Requirements and Implementation

(Performance and Operational Controls of Processes Execution)

8 .3 Claims Review Records Implementation requirements:

The clauses with Reference to DoH Provider Policy Manual, DoH Professional Policy Manual, DoH regulators Policy Manual and DoH Insurers Policy Manual cited in JDC Methodology 2019 should be reviewed in reference to the updates clauses from the revised manuals published by DoH.

Chapter V. General Duties, Governance, and Change of Control, PART A, the reference clause is updated to 41 instead of 45.

With reference to Data Reporting requirements as stated in Healthcare Regulatory Policy Manual Chapter-6 Data Management, the reference clause is updated from 67 to 59.

8.2.1 Applicability

In addition to Part-1, 8.2.1 clause of JDC Methodology 2019, claims from Medical tourism are also part of claims review and error scoring tables applicable are as per the setting in which medical tourism services are rendered, example Outpatient, Inpatient etc.,

8.3 Clinical Coding Process Review Implementation requirements

Reference of HAAD Professional Policy Manual, Chapter 45.2 is updated to 42.2.

Reference of HAAD Provider Policy Manual Chapter V. General Duties, Governance, and Change of Control, PART B, 48 Policies is revised to Chapter 44.

8.4 JAWDA KPI Process Review Implementation Requirements

8.4.3 **Technical clarifications are provided for Verification Points of Jawda KPI Process Review Implementation requirements**

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

- Criteria should be established for each group of indicators/specific indicator (E.g. Readmission/Infection control)
- Competency determination criteria for data validator should be different from data collector considering the below factors:
    - Need for better understanding on all dimensions of collected Jawda KPI aspects, including objective. Also, crucial that Data Validator has a knowledge of baseline metrics. (For eg. Wait time must not exceed a certain duration)
    - Same person may be assigned as data validators for many indicators, hence should have capability to interlink the indicators requirements, compare and analyze.
    - Validation should be done with different data sources if possible or regeneration of data with same data source if no other sources are identified.
    - Provide guidance/clarification to data collectors in case of any doubts.

1. As data validation is sample based, selection of random sample is important to identify any possible deficiencies
2. Non-applicability of any specific Jawda KPI indicators shall be determined by facilities in their Facility KPI profiles with appropriate justifications
3. Data collectors/Validators should be read as “Data Collectors and Data Validators”
4. KPI Process for Quality Governance and Improvement: Point no. vi- Jawda KPI Risk management shall be reviewed only for processes of risk management and mitigation to Jawda related processes
5. Regeneration of complete quarter data is mandatory and system or manual logic applied for KPI data collection should be readily available

* Please refer to 2019 JDC Methodology Part-1, 8.4.3 for this statement.

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Technical Clarifications to

Part-2

JDC Methodology

2 APPLICATION AND PLANNING FOR CERTIFICATION

- Facilities whose schedules are not published in annual planner should contact TRBA immediately for a schedule request
- Change of facility management/ownership or location will not change the audit schedules or JDC requirements for the purpose of audit unless there is a change in license number.
- Home care facilities not doing claim submissions on daily basis does not require to wait for audit to meet minimum 120 claims, but six months claim submission that can meet minimum required sample count as per Tier system is enough to proceed for audit.

4.2.3 Claims Review Audit Verification Points and Scoring Criteria:

- Extent of documentation review is determined by auditors. Facility co-operation is obligatory
- Medical tourism claims sample will be included within the self-pay claims tier system
- Services rendered under a one DoH license, but Claim submitted under another DoH license will be considered as an error. Lack of Supporting documentation for the whole visit will be scored as “0”
- Any technical issues or errors or mistakes cannot be exempted from scoring zero
- Claims submitted to DoH for services rendered out of jurisdiction will be considered as an error and the whole claim will be scored as “0”.
- Documentation supporting the established final Diagnosis should be available in the medical record
- Terminology from claims review scoring tables - “No documentation to support” to be interpreted as “No or Insufficient documentation to code”
- Additional clarifications as minor revisions in the wordings of claims review scoring tables is updated in Appendix-III

4.3.1 Audit Verification Points and Scoring Criteria for Clinical Coding Process Review:

- Narrative Diagnosis should be physician’s final impression of patient’s diagnostic condition in his own narrative words instead ICD of code description
- Confirm if a coder representing the facility for JDC audit belongs to the contracted company or an in-house coder as stated by facility or if is someone presenting only for the day of the audit.

6 AUDIT ON SELF-PAY SERVICES/PROFORMA SERVICES/MEDICAL TOURSIM

- Audit on all Self-Pay services, Proforma services, Medical tourism claims is mandatory as applicable
- Claims review sample for Medical tourism will be selected from the over-all Self-Pay Tier system count.
- Score weight is assigned as per the claim distribution ratio
- Claims review scoring tables will be applied as of applicable setting such as inpatient or day case etc.,

Appendix-II:

- Score weights of KPI Process Review is changed from 25 to 10% and KPI data validation from 25 to 40%;
- Self-Pay Medical Tourism claims score contribution to overall JDC score is illustrated in example score tables

Appendix-III:

- Minor changes as clarifications in the wordings of claims review scoring tables is made to clarify some of the misinterpretations noticed during previous year.
- Insignificant revisions to dental score tables to cover aspects related to documentation of dental surfaces and dental examinations

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APPENDIX-II

Scoring Weights & Examples

Scoring Weights and Examples

The Summary of scoring weights for the facility type – Hospitals, Home Health Care/Long term Care/Rehabilitation Hospitals is revised 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	10
KPI Data Validation Score	40

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 (75+10)**	**Claim distribution ratio**	**Score-Each Setting**	**Weight as per claim ratio**	**Domain weights**	**Final Score**
Medical Centers /Clinics	Claims Review Each Setting 100	**Outpatient (100)**	45	52.94%	93.00	49.24		
		Day case (100)	30	35.29%	89.00	31.41		
		Self-Pay (Routine) (100)	6	7.06%	90.00	6.35		
		Self-Pay (Medical Tourism) (100)	4	4.71%	89.00	4.19		
	Claims review Score for 100					**91.19**	**80%**	**72.9505882**
	Clinical Coding Process Review (General+Self-Pay)	**Process flow Map / effectiveness - 15**				13.00		
		Clinical Coding/Documentation Polices & Practices - 40				38.00		
		Coder Credentials - 05				5.00		
		Orientation/Training - 10				10.00		
		Policies Adherence - 30				28.00		
	Clinical Coding Process Review Score for 100					**94.00**	**20%**	**18.80**
	FINAL JAWDA DATA CERTIFICATION SCORE							**91.75**

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 25+10)**	**Claim distribution ratio**	**Score-Each Setting**	**Weight as per claim ratio**	**Domain weights**	**Final Score**
Home Health Care/Long Term Care/Rehabilitation Center	Claims Review Each Setting 100	Home Health care - 100	17	49%	95	46.14		
		Out Patient - 100	8	23%	93	21.26		
		Self-Pay (Routine) 100	7	20%	95	19.00		
		Self-Pay (Medical Tourism) - 100	3	9%	93	7.97		
	Claims review Score - 100					**94.37**	**40%**	**37.7485714**
	Clinical Coding Process Review (General+Self-Pay)	Process flow Map / effectiveness - 15				15.00		
		Clinical Coding/Documentation Polices & Practices - 40				38.00		
		Coder Credentials (Awareness) - 05				5.00		
		Orientation/Training - 10				10.00		
		Policies Adherence - 30				25.00		
	Clinical Coding Process Review Score - 100					**93.00**	**10%**	**9.30**
	KPI Process review	Operations, Planning, Support - 50				48.00		
		Quality Governance & Improvement-50				45.00		
	KPI Process review Score - 100					**93.00**	**10%**	**9.30**
	KPI Data Validation Score - 100	Quality Indicators - 100		100%		**95.00**	**40%**	**38.00**
	FINAL JAWDA DATA CERTIFICATION SCORE							**94.35**

Example 3: Details of scoring for the Hospitals will be as shown in the below table: Table 5

HOSPITALS -DETAILED SCORING								
Facility Type	**Domain**	**Domain details**	**Claim Count (Total-140+20+20)**	**Claim distribution ratio**	**Score-Each Setting**	**Weight as per claim ratio**	**Domain weights**	**Final Score**
Hospitals	Claims Review Each Setting 100	Outpatient - 100	76	42.22%	91	38.42		
		Emergency - 100	22	12.22%	90	11.00		
		Inpatient - 100	21	11.67%	89	10.38		
		Day case - 100	21	11.67%	94	10.97		
		Home Health care- 100	0	0.00%		0.00		
		Dental (OP) - 100	16	8.89%	92	8.18		
		Dental (DC) - 100	4	2.22%	87	1.93		
		Self-Pay (Routine) 100	14	7.78%	88	6.84		
		Self-Pay (Medical Tourism) - 100	6	3.33%	89	2.97		
	Claims review Score - 100					**90.69**	**40.00**	**36.28**
	Clinical Coding Process Review (General+Dental+Self-Pay)	Process flow Map / effectiveness - 15				15.00		
		Clinical Coding/Documentation Polices & Practices - 40				40.00		
		Coder Credentials (Awareness) - 05				5.00		
		Orientation/Training - 10				10.00		
		Policies Adherence - 30				25.00		
	Clinical Coding Process Review Score - 100					**95.00**	**10.00**	**9.50**
	KPI Process review	Operations, Planning, Support - 50				48.00		
		Quality Governance & Improvement-50				46.00		
	KPI Process review Score - 100					**94.00**	**10.00**	**9.40**
	KPI Data Validation Score - 100	Quality Indicators + Waiting Time - 100		100%		**92.00**	**40.00**	**36.80**
	FINAL JAWDA DATA CERTIFICATION SCORE							**91.98**

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. 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;	• 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 given without any supporting 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.	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. 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)]
8. Moderate diagnosis error-10			
Moderate	10	Missing relevant secondary diagnosis specific to this encounter or specific to performed procedure.	Missing required and/or pertinent secondary diagnosis which is relevant to this encounter, including Chapter 21 codes. (e.g. ‘history of’ codes, BMI, Smoking, place of occurrence, activity, external cause 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. And, all Complication and Co morbidities (CC) or Major Complication and Co morbidities (MCC).
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);

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.
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	Physiotherapy- Details of modalities, site of application of modality, time start and end, authentication etc., Procedures: Aseptic precautions, Technique/approach of procedure, detailed procedure notes, closure technique, hemostasis, risks encountered if any, post procedural complications if any. Injection: Site, route, strength, dose, time, initials 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.
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;	Indication for X-ray: Cough Technique or approach: PA view No. of Views: Single Findings: Impression: Pneumonic consolidation

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. Ex: Missed to code dressing 51-02 when documented.
Moderate	5	Other miscellaneous billing errors.	Incorrect Date of service on the claim; Other miscellaneous billing errors like incorrect anesthesia units; CPT 36415 billed without performing within the facility; Or CPT 36415 Venipuncture is not eligible to report as per adjudication guidelines; or any other billing scenario error;

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; Local anesthesia is billed with general anesthesia/Conscious sedation code;
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; or Insufficient documentation to assign E/M code	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	Non-surgical procedure/service codes like IM, IV, NEB, vaccination, anesthesia codes etc., not coded when it is 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., Procedures: Aseptic precautions, Technique/approach of procedure, detailed procedure notes, closure technique, hemostasis, risks encountered if any, post procedural complications if any. Injection: Site, route, strength, dose, start/end times, initials 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.
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 and/or interpretation	Indication for X-ray: Cough Technique or approach: PA view No. of Views: Single 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; or coded without documentation	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 without sufficient supporting 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 Diagnosis Hemiplegia is integral to condition hemiplegia due to CVA. Diagnosis unspecific Hyperlipidemia is integral to mixed hyperlipidemia.
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. 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.

Moderate	10	Missing relevant diagnosis specific to this encounter	Missing required primary 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. 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).
8. Minor Diagnosis Error-5			
Minor	05	Acute conditions are not codable; Resolved and/or History conditions are not codable	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.
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".

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 services 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	Claimed codes are uploaded to incorrect encounter type
	10	Other miscellaneous billing errors; or incorrect or missing per-diem/service codes	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 or Procedure coded without time/duration	''21111 Restorations, Amalgam, Non-Bonded, Primary Teeth One surface is coded'' when there is no documentation to support any restoration; No or insufficient information of time documentation for each time-based procedure;
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; Missing documentation of accurate/involved tooth surfaces	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/bill/report the Tooth number; Missed to document the tooth surfaces;
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; or Coded condition is integral to another condition;	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	Missed to assign additional code 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;