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DEPARTMENT OF HEALTH

JAWDA DATA CERTIFICATION (JDC) FOR HEALTHCARE PROVIDERS

Part-4 (2021)

Technical Clarifications to Methodology 2019 & 2020

December 01

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Technical Clarifications to Part-1 *of* JDC Methodology

1 INTRODUCTION

The purpose of this document is to provide clarifications on specific aspects of Part-1, Part-2 and Part-3 of JDC methodology 2019 & 2020.

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 2020 remains the same however, as new KPI profiles are published by DoH, such KPIs will be under the audit scope and accordingly KPI Domain may be applicable also to centers.

8. Documentation Requirements and Implementation

8.2 Claims Review Records Implementation requirements

(Performance and Operational Controls of Processes Execution)

8.2.2 Claims Review Aspects (All other points mentioned in 2019 remain valid)

- When assigning an Evaluation and Management Level of Service for a patient encounter, significant factors to consider are the Nature of the Presenting Problem (NOPP) in addition to **management options** contributing to the complexity of Medical Decision Making (MDM) as it explains the medical necessity.
- Any issues in claims resulting from errors in claims submission will be marked as billing error in addition to all other applicable errors as per applicable guidelines and documentations.
- A claim received in the audit sample will be evaluated based on the Claim date and documentation available. All the codes that do not have supporting documentation specific to the claim date will be considered as coded without documentation in addition to billing error.

8.3.2 Clinical Coding Process Review Aspects

- During the clinical coding process review, Major non-conformities identified for any of the below will impact claims review scores as an underlying cause affecting the claims documentations:
    a. Access to medical records after closure/ locking time
    b. Date and time of computer is editable
    c. Audit log is not available for the claim requested
    d. Any modifications or updates are Not reflected on audit log status

8.4 JAWDA KPI Process Review Implementation Requirements

KPI audit is conducted by random indicators selection and the audit process will flow according to the selected indicators, therefore, cannot be associated with previous audit in terms of findings, scoring etc.

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Technical Clarifications to Part-2

JDC Methodology

2 APPLICATION AND PLANNING FOR CERTIFICATION

2.1 Contract formation

- Facility shall be in the scope of audit until the license is showing active on DoH website, till the day of the audit. Similarly, if a specialty or setting is cancelled by the time of audit, audit will still be conducted on the submitted claims. This can be excluded only if there are not enough claims to be audited.

2.2 Audit Planning

- Facilities maintaining both electronic and paper medical records should present the full documentation to the auditor at the start of the audit and is facility's responsibility to ensure a mechanism in place to indicate the presence of any additional paper medical documentations. Extracting additional pieces of paper documentations during the audit cannot be accepted for evaluation.

3 PERFORMANCE OF AUDITS

3.3 Audit Evidence Collection - Confidentiality

1. TASNEEF-RINA Business Assurance management is responsible for all information obtained or created during the performance of certification activities at all levels of our structure, including committees and external bodies or individuals acting on our behalf. Information about the client shall be treated as confidential, consistent with the certification body's policy.
2. All the acts (documents, letters, communications, etc.) relating to the system/Process assertion certification activities shall be regarded as confidential.
3. Access to and consultation of documents relating to the certificate/statement are reserved to the purposes involved in the certification process and to the organization in question.

4. CERTIFICATION REQUIREMENTS AND GUIDELINES FOR CRITERIA

4.2 Claims Review

4.2.3 Claims Review Audit Verification Points and Scoring Criteria:

- During the clinical coding process review, if Major non-conformities are identified for any of the below, it will result in deduction of five-point (5.00) score from over all claims review score:
    a. Access to medical records after closure/ locking time
    b. Date and time of computer is editable
    c. Audit log is not available for the claim requested
    d. Any modifications or updates are Not reflected on audit log status

4.5 KPI Validation for Collection and Submission of Jawda Quality Indicators

4.5.1 Audit Verification Points and Scoring Criteria: For KPI Data validation scoring, Validation is inclusive of numerator and denominator validations.

Every conformity will be assigned with full points, non-conformity with no scoring points and a partial conformity with partial score.

6 AUDITS ON SELF-PAY SERVICES/PROFORMA SERVICES

6.1 Audit Verification Points: Claims review

Self-pay submission if not consistent for 6-8 months at least, shall reduce the overall self-pay claims review score by 5 points

11 RE-AUDITS

- 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 3-6 months). If facility will pass in re-audit, then facility listing will be calculated from the provided conditional listing period till the period of applicable grade. If failed in re-audit, back dated de-listing will be done.

20 NEW FACILITY LISTING AND EXTENSION OF LISTING

Extension of New Facility listing: Facility can apply for extension, if they cannot go for renewal audit due to not enough claims (temporary closure).

21 Complaints Management

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.
4. If facility is requesting for further analysis on JDC evaluations and committee decision even after final report results and response, an appeal request can be sent to DoH at **ba.jdcsupport@tasneef.ae and/or jawda@doh.gov.ae**
5. 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.
    a. Appeals should be received with all details of disagreements and supporting documentations, reference guidelines within 10 calendar days of receipt from the final report date. (new evidences that are not with TRBA possession cannot be accepted)
    b. Any disagreements or concerns not raised during the formal report stage cannot be accepted for review during the appeal stage.
    c. An opinion or personnel interpretation or internal practice of an entity that is not supported by any standards (DoH standards take priority) cannot be the basis to consider for arbitration and the request cannot be processed further and no additional appeals can be made or forwarded to DoH.

d. Appeals cannot be made on grey scenarios as certification body will have the credibility to form final conclusions. Any such grey aspects will be forwarded to DoH for appropriate measures and accordingly can be incorporated to guidelines and or methodology of next release.
e. Concerns or aspects pending DoH decision will follow the evaluation and conclusion of TRBA till the matter is addressed and decided.
f. No appeals can be raised, over-riding the methodology criteria and rules.
g. To ensure the efficiency of appeal process and maintaining the position of certification body, every appeal request will be evaluated to verify the eligibility criteria to accept or deny the appeal request. If not meeting the criteria, appeal will not be processed.

Appendix-II:

Facilities that are in scope of KPI but without KPI submissions (temporarily) will be applicable for score weights as

- Claims Review 90%
- Process Review 10%

APPENDIX-II

Scoring Weights & Examples

Table 3- Summary of scoring weights – Applicable KPI Facilities without KPI submissions

Applicable KPI Facilities without KPI submissions	
Scope	**Weight**
Claims Review Score	90
Clinical Coding Process Review Score	10

Example1: Details of scoring for the facilities without KPI will be as shown in the below table as an example:

Table

HOSPITALS/CENTERS-DETAILED SCORING WEIGHT								
Facility Type	Domain	Domain details	Claim Count (60+20+18)	Claim distribution ratio	Score-Each Setting	Weight as per claim ratio	Domain weights	Final Score
HOSPITALS/CENTERS-	Claims Review Each Setting 100	OUTPATIENT (100)	33	34%	96.22	32.40		
		INPATIENT (100)	9	9%	94.33	8.66		
		DAY CASE (100)	9	9%	95.66	8.79		
		HOME CARE (100)	0	0%	0.00	0.00		
		EMERGENCY (100)	9	9%	88.66	8.14		
		DENTAL-OP (!00)	20	20%	91.50	18.67		
		DENTAL-DC (100)	0	0%	0.00	0.00		
		SELF-PAY (100)	12	12%	94.00	11.51		
		MEDICAL TOURISM (100)	6	6%	93.00	5.69		
	Claims Review Score - 100					93.87	90%	84.48
	Clinical Coding Process Review	Process flow Map / effectiveness - 15				13.00		
		Clinical Coding/Documentation Polices & Practices - 40				38.00		
		Coder Credentials - 05				5.00		
		Orientation/Training - 10				8.00		
		Policies Adherence - 30				28.00		
	Clinical Coding Process Review Score - 100					92.00	10%	9.20
	FINAL JAWDA DATA CERTIFICATION SCORE							93.68

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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
E&M AND PROCEDURE ACCURACY ERROR – CODING RELATED			
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, anesthesia etc., are coded without documentation / Coded wrong CPT.
DIAGNOSIS ACCURACY ERROR – CODING RELATED			
7. Major Diagnosis Error-20			
Major	20	Diagnosis coded without documentation or coding sign & symptom INSTEAD of the diagnosis. OR Coded Final Impression or diagnosis has no supporting visit notes justification as per DoH JDC Methodology 4.2.1(iv)	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.

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
2. Moderate Per-Diem code error-5 (Billing Related Error)			
Moderate	5	Missing / Incorrect Per-Diem or Service Code/coded without documentation;	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, service codes; 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;
DIAGNOSIS ACCURACY ERROR – CODING RELATED			
6. Major Diagnosis Error-15			
Major	15	Diagnosis coded without documentation or coding signs & symptoms INSTEAD of the diagnosis. OR Coded Final Impression or diagnosis has no supporting visit notes justification as per DoH JDC Methodology 4.2.1(iv)	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.

Table 5 Error Scoring: Home Health Care – Accuracy

SCORING TABLE FOR HOME CARE – ACCURACY ERRORS			
Category-Score		Accuracy Error	Example and Explanation
DIAGNOSIS ACCURACY ERRORS			
6. Major Diagnosis Error - 15			
Major	15	Diagnosis coded without documentation. OR Coded Final Impression or diagnosis has no supporting visit notes justification as per DoH JDC Methodology 4.2.1(iv)	Coded diagnosis is not per the documentation.

Table 7: Error Scoring: Dental Setting – Accuracy

SCORING TABLE FOR DENTAL CARE – ACCURACY ERRORS			
Category- Score		Accuracy	Example and/ or Explanation
PROCEDURES ACCURACY ERRORS			
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 / Tooth Canals	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 / Tooth Canals;
Moderate	10	An additional procedure/Minor procedure code which is inclusive in the Examination code or major procedure;	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; OR Coded Final Impression or diagnosis has no supporting visit notes justification as per DoH JDC Methodology 4.2.1(iv)	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