هيئة الصحة
HEALTH AUTHORITY

JAWDA Data Certification (JDC) for Healthcare Providers

Methodology 2017

1. Content

2. Introduction & Background:

The Health Authority-Abu Dhabi (HAAD) ensures excellence in Healthcare for the community by monitoring the health status of the population.

JAWDA Data Certification is a process to build trust between all key stakeholders.
This involves the comparison of actual reporting of data and coding practices against agreed, documented, referenced data, documentation and coding standards with the standard and regulatory requirements with an intention of improving clinical data quality thereby improving quality of patient care.

3. Normative References

The following table summarizes the references as web links in this document.

Reference Document	Web Link
Coding Manual, Health Authority Abu Dhabi V12;	HAAD Coding Manual
AHIMA-Recertification; AAPC CEU Information	AHIMA ; AAPC
Coding Manual, Health Authority Abu Dhabi V12; Page 6,7	HAAD Code of Ethics
HAAD JAWDA Quality Performance KPI Indicators	HAAD - Circular CEO 38/ 12
CPT 4th Edition procedure	AMA
ICD-9-CM Official Guidelines for Coding and Reporting	HAAD Coding Manual
ICD-10-CM Official Guidelines for Coding and Reporting	CMS

American Medical Association (AMA)	AMA
American Hospital Association (AHA) Coding Clinics	AHA-Central Office
HAAD JAWDA - Quality Metrics	HAAD-JAWDA

4. Terms and Definitions

Adjudication – Claims judgement process for settlement

Ancillary Services – Laboratory, Pathology services

Claim(s) - All Outpatient, Day case, Home care and Emergency Department claims with Evaluation and Management codes and all Inpatient claims.

Coding Experience - Coding for an acute care facility inpatient, and may also have experience in coding for outpatient, using ICD 9 CM, ICD 10 CM and CPT.

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

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

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

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

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

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

Delisting - Removal of certification status due to expiry

Denial – Claim rejected for payment

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

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

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

Facility - Each individually licensed provider

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

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

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

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

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

Principal Diagnosis - Inpatients:

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

Principal Diagnosis - Outpatients:

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

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

Re-audit – Audit conducted after a failure in Initial audit. It is conducted in 2 phases.

Recertification - Renewal of Certification within 30 days of expiry of Certification.

Resubmission – Claim resubmitted to insurance for reimbursement

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

Secondary Diagnosis - Inpatients: All conditions that co-exist at the time of admission, including chronic conditions, or develop subsequently, which affect the treatment received and/or the length of stay -

that affect patient care in terms of requiring: Clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and/or monitoring; excluding diagnoses that refer to an earlier episode that have no bearing on the current hospital stay.

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

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

5. Abbreviations

AAPC	-	American Academy of Professional Coders
AHIMA	-	American Health Information Management Association
CEU	–	Continuing Education Unit
CPT	–	Current Procedural Terminology
DRG	–	Diagnosis Related Groups
E/M (E & M)	–	Evaluation and Management
EMR	–	Electronic Medical record
ER	-	Emergency Room / Emergency Department
HAAD	–	Health Authority Abu Dhabi
HIPAA	-	Health Information Portability and Accountability Act, 1996
HIS	–	Health information System
IP	-	Inpatient
J**DC**	-	JAWDA Data Certification
KEH	-	Knowledge Engine for Health

KPI	-	Key Performance Indicators
NOPP	-	Nature of Presenting Problem
MDM	–	Medical Decision Making
OP	-	Outpatient
SPC	–	Standard Provider Contract

6. Objectives

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

In addition, JAWDA Data Certification will strengthen the trust between payers and providers by: • Enhancing the quality of health data

- Enhancing coding quality standards in the Emirate of Abu Dhabi
- Ensure data processing and governance is effective and resulting in valid data
- Creating a shared understanding of the facility's coding quality
- Giving the payers confidence that a facility is coding and submitting accurately to HAAD and other entities
- Providing healthcare providers with recommendations on the areas of improvement of quality of coding and collection and submission of clinical data.

7. Scope of JAWDA Data Certification

This Certification is a mandatory requirement for all health care facilities for all contracted with health insurance companies for providing healthcare services, including the lowest Evaluation and Management level of service.
The certification includes four domains for audit:

- Claims
- Clinical Coding Process
- KPIs Data Submission *(Applicable only for Hospitals)*
- KPI's Process and Governance *(Applicable only for Hospitals)*

8. Certification Body

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

Per the Notice as of 25th August, 2016, which is published on HAAD website, "TASNEEF-RINA Business Assurance (TRBA) is authorized to issue "Clinical Coding Certifications" (CCC) now known as JAWDA Data Certification (JDC) defined in "HAAD Periodical No. 45 – Health Insurance HAAD Circular-45" as of 11 July 2011." (New Circular to be issued from HAAD to mandate audits including for low level E/M codes)

9. Facility Authorized Compliance Representative

Each Facility is required to have a designated Point of Contact regarding: i.Coding Updates

ii. Coding Certification related activities

iii. Ensure adherence to HAAD Code of Ethics as mentioned in HAAD coding Manual. *Please refer to Normative references* iv.In-house coding monitoring, Documentation, Coding training workshops

v. Discuss with CEO to keep informed about the compliance status and concerns

vi. Initiate or take disciplinary actions with the approval of CEO when internal compliance has been threatened.

vii. All activities related to Quality & Monitoring to be routed through the CEO.

viii. HAAD JAWDA Quality Performance KPI Profile (if applicable)

ix. Audit Evidences collection

x. Audit coordination

10. Audit Scope

Audit scope for JAWDA Data Certification constitutes of

- Claims review*
- Clinical Coding Process Review
- KPI Data validation. *(Applicable only for hospitals)*
- KPI Process Review *(Applicable only for Hospitals)*

*For Claims Review the Newly listed facilities that do not have minimum 200 claims for audit - Please refer to New facilities section.

The results of the JAWDA Data Certification audit provide the facility management with an overall understanding on the quality of their Clinical data documentation, collection, Coding and submission by identifying gaps. The standard guidance and references for the Clinical Coding Process Review are available as Certification Rules.

The audit report will identify:

- A Comprehensive JAWDA Data Certification Score along with individual Claims Review, Process review and, additional score for Hospitals as KPI Process, and KPI Data Validation.
- Recommendation for the Areas of improvement based on deficiencies identified during audit.

- For serious observations (minor and major) a mandatory action plan should be sent by the facility to TASNEEF, for the identified non-conformities or deficiencies
- This should be endorsed by the CEO or CFO of the facility.

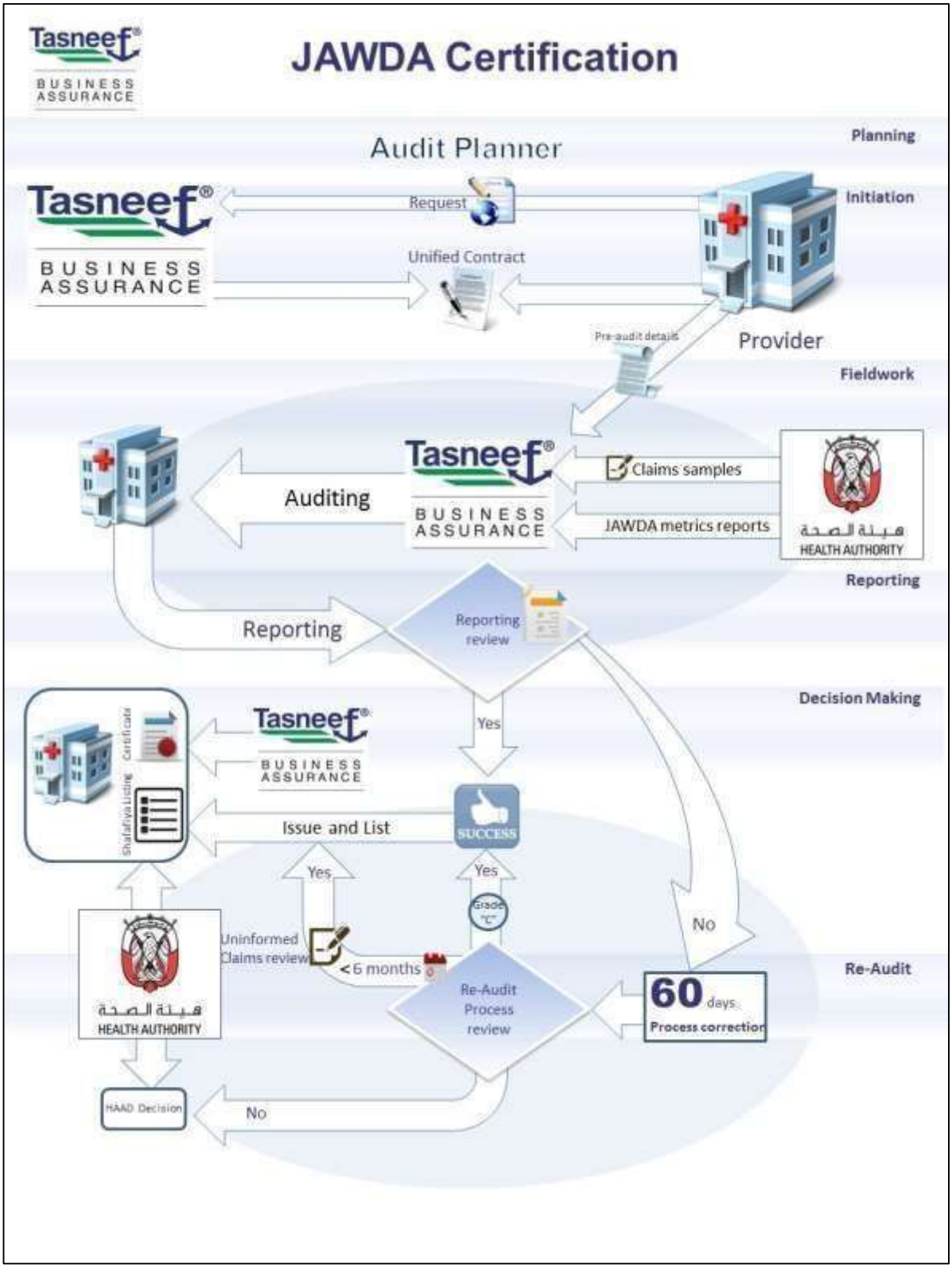


Figure1: JAWDA Data Certification-Audit Plan

11. Audit Initiation

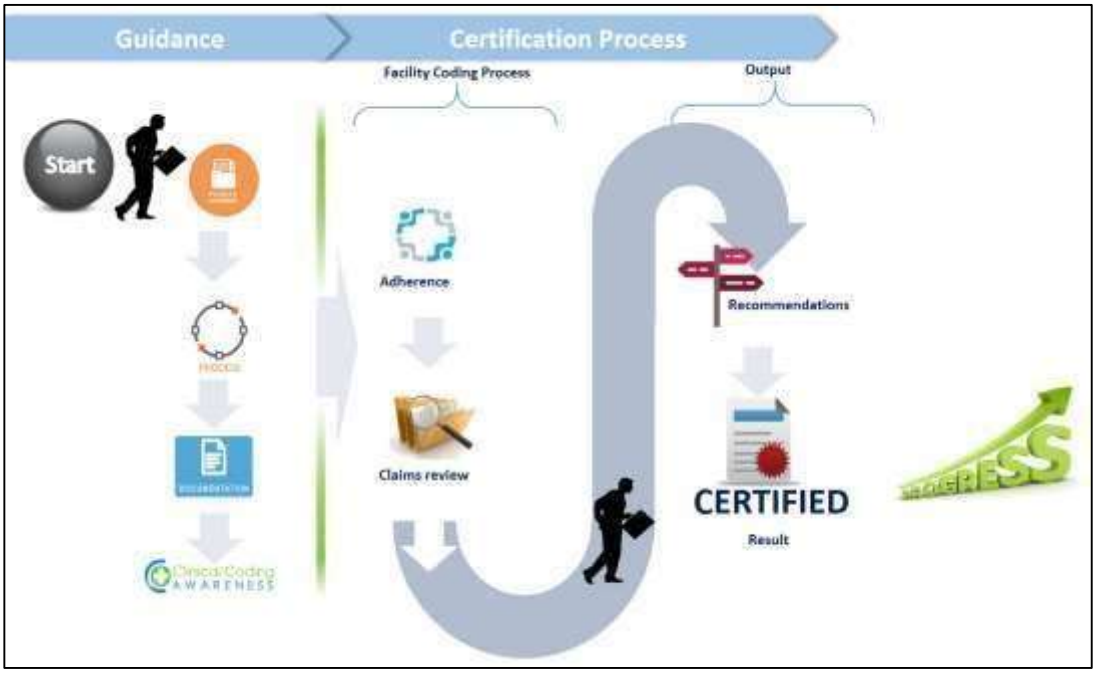
- The “Apply for certification” request with required information must be submitted to TASNEEFRINA Business Assurance (TRBA) on the webpage; to initiate the Certification process
- The application for certification should be initiated by the facility at least two months prior to the schedule of audit published in the Audit Calendar and audit plan will be communicated to the facility at least 3 weeks prior to the actual schedule.
- Contract with fixed prices approved by HAAD will be sent to the provider per the type of facility and tier system based on volume of claims submission. The Pricing Tariff list will be published
- After confirmation of audit schedule, facility must share the facility location and contact details along with location map and landmark
- 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

12. Audit of Claims and Clinical Coding Processes

Clinical Coding is the process of translating the written or electronic medical documentation of a patient's diagnosis and services performed for an episode of care into a meaningful representation of numeric or alpha numeric codes. To record this information, healthcare providers, like hospitals and clinics in Abu Dhabi assign codes using the International Classification of Diseases systems (ICD-09CM or ICD-10CM from 1st Jan, 2017) for diagnosis and, CPT4 codes for services.

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

Audit on Claims and Clinical Coding Processes will follow the concepts and steps as following:



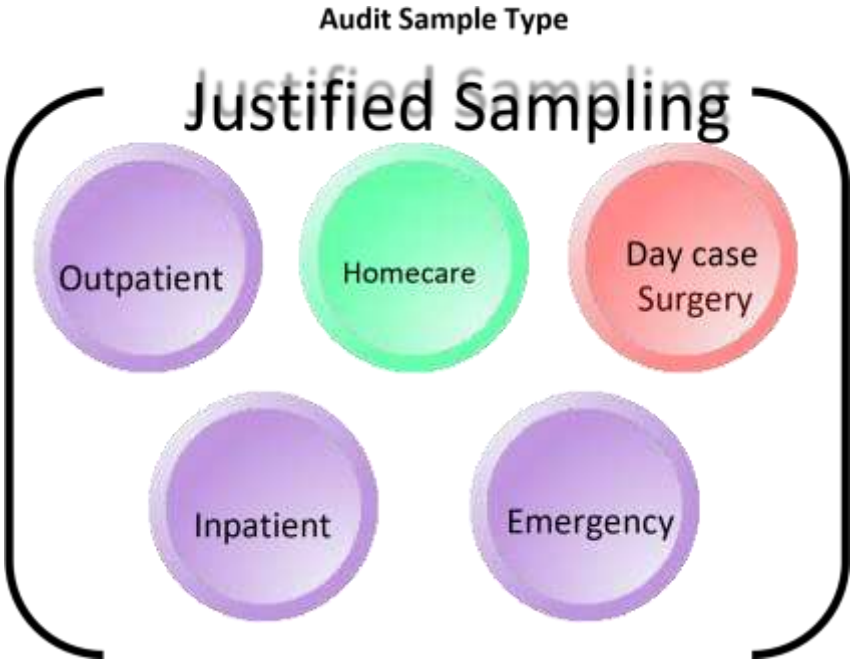
i. Figure 2: **Audit of Claims and Coding Processes**

12.1 Audit Sample Type

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.



12.2 Sampling method

- The audit sample will include claims from past 12 months from the audit process initiated audit.
  - Random sample size is as per the Tier system mentioned below. Each facility Tier information is provided by HAAD based on volume of claims submitted to KEH during the past 12 months.
- Sampling is done using a scientific formula based on international best practices of accreditation.
  - The sample count indicated below represents the sum of sample from all encounter types.
- In case of insufficient number of claims in one specific setting, the difference of claim sample count will be selected from another setting with high volume of claims.

The tier system

A. Medical Centers:

Table 8.2.A

Tier	Billing Volume/Year	Claim Sample
Tier 6-M	150,001 to >=250,000	125
Tier 5-M	100,001 to 150,000	100
Tier 4-M	50,001 to 100,000	80
Tier 3-M	25,001 to 50,000	55

Tier 2-M	10,001 to 25,000	40
Tier 1-M	<=10,000	30

B. Home care:

Table 8.2.B

Tier	Billing Volume/Year	Claim Sample
Tier 2-HC	15,001 >= 26,000	55
Tier 1-HC	<15,000	40

C. Hospitals:

Table 8.2.C

Tier	Billing Volume/Year	Claim Sample
Tier 6-H	700,001 to 1,000,000	350
Tier 5-H	400,001 to 700,000	290
Tier 4-H	200,001 to 400,000	220
Tier 3-H	100,001 to 200,000	160
Tier 2-H	50,001 to 100,000	110
Tier 1-H	<50,000	80

12.3 Sample Sharing Time

• For facilities with physical filing of Medical records, audit samples will be shared 1 working day or 24 hours prior to audit visit. Holidays and weekends are excluded. • Facilities should map the claim ID to a medical record and should be kept ready for the auditors.

12.4 Clinical Coding Process Review

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

The Clinical Coding Process review will assess on the below mentioned:

** Please refer to Standard References Clinical Coding Process Review at:*

http://www.tasneefba.ae/jdc-methodology

- Coding Process Flow chart/policy reflecting the coding process followed in the facility

- Policies relevant to Clinical Coding:
  - Coding Practice policies ○ Healthcare Documentation policies
  - New Employee Orientation and/or Training policy

- Coder Credentials and CEU validation
  - Validation of Coder current certification and/or experience
  - Current continual education (CEU's)

- Evaluate compliance of concerned personnel to the required standards and policies by conducting interviews

- **Check on Coding Process adherence by relevant staff**
  Successful processes should be understood and followed by all involved. The Auditor will rate the facility's understanding and adherence to their processes by interviewing nominated members of staff from the various departments that are involved and relevant to the coding process.
  The process of adherence check is to understand the compliance levels and to identify the deficiencies in the implementation of processes, but not to evaluate any personnel.

- **Coder Observation** (Duration: 15 minutes)
  - The Auditor will observe a coder performing the coding role to verify and gain a thorough understanding of whether the observed coding processes are as per the required standards and guidelines.
- **Physician Interview** (Count- 2; Duration: 30 minutes)

- The Auditor will interview nominated physicians at each facility who contribute to the coding process by means of clinical documentation and or direct coding in EMR or claims forms.
- The Auditor may additionally choose from a list of physicians based on the documentation findings during claims review.
- Evaluate the understanding of coder physician interaction importance in regards to ambiguous or non-specific clinical documentation done by physicians.

Medical Records Department Interview (Duration: 10 minutes) The Auditor will interview at least one member of the Medical records department at the facility to understand the process of filing an additional documentation and availability of medical records for editing.

Insurance Department Interview (Duration: 10 minutes) The Auditor will interview at least one member from insurance department to understand how a pre-authorization process is followed and if there is any interaction with the coders in the processes of pre-authorization, billing, claim submission and re-submission.

Finance or Billing Department Interview (Duration: 10 minutes)

- The Auditor will interview at least one member of the Finance Department at the facility to trace any influences of revenue impact on the claims after being determined by the Coders.

- 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, HAAD will be notified for further action. Impact rating of non-conformities will affect certification.
- Clinical Coding Process Review nonconformities or deficiencies will have impact rating as Major, Moderate, Minor which will affect certification.

12.5 Scoring of Clinical Coding Process Review (Impact based)

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.

i. Major ii.

Moderate iii.

Minor

a. *Coding Policies Review*
b. *Compliance Interviews*
c. *Process flow Map*
d. *Coder Credentials*
e. *Orientation and or training*

12.6 Claims Review Process

- TASNEEF will download an audit sample as per the applicable Tier system through HAAD portal for each type of setting identified within the facility scope.
- TASNEEF will then complete the audit in accordance with this methodology, and collect audit evidence.
- Copies of audit Evidence will be retained.
- The scoring against each criterion will be applied as per this Methodology and the inclusive Error Scoring Tables.
- Claims review will be done applying the audit concepts and claims scoring criteria of this methodology.

12.7 Claims review criteria

- The codes to be audited are strictly the ICD-9 CM and/or ICD-10 CM diagnosis and CPT 4th Edition procedure codes and E/M codes for all applicable visits as well as HAAD Telemedicine Service Codes. Codes provided for prescriptions will not be considered part of the audit. In addition, codes for drugs, supplies, and other ancillary services will not be part of the audit however the diagnosis codes supporting the ancillary services will be checked for supporting documentation of medical necessity.

- All Outpatient, Day case, Homecare and Emergency records must have CPT codes or HAAD Telemedicine Service Codes as listed in the most current version of the Claims and Adjudication Manual. The audit focus is on clinician documentation related to assigned codes and/or code levels that were used on the claims for reimbursement.

- In all Established E/M visits, the mandatory key component should include Medical Decision Making.

12.8 Claims Audit references

The Auditor will use relevant coding and process resources to review coding and ascertain the coders' compliance to these standards, to document and collect findings:

- American Hospital Association's Coding Clinic
- ICD-9-CM/ICD-10-CM Official Guidelines for Coding and Reporting
- CPT Assistant
- The version of HAAD Coding Manual applicable to the audited period (Please Refer Normative references)
- Recommended standards for Coding Processes Review
- HAAD Adjudication rules
- 3M or Encoder-Pro
- Marshfield Clinic Tool or Trailblazer tool for E/M
- Internal Audit Tool

12.9 Evaluation and Management Scoring:

The Auditor will audit and score the E&M code(s) in the Accuracy Score. These will be scored as an error if the code level is higher than what is appropriate as documented or in the wrong category. The possible E & M errors also include the following:

- No E&M code assigned in Outpatient, Day Case/Emergency, where relevant.
- No E&M code assigned in Inpatient, when documented
- Incorrect E&M category
- Incorrect E&M Level when the documentation is not sufficient to support level coded.
- HAAD recommends the 1995 Guidelines for Evaluation and Management codes be utilized. However, if a facility has used the 1997 E&M Guidelines, this must be stated at the onset of the audit. The auditor will then audit using the appropriate guidelines and state the specified guidelines in his report as well as showing this in the record of the audit.
- The facility must state one guideline or another, as the use of a combination of these two guidelines is not acceptable.
- When assigning an Evaluation and Management Level of Service for a patient encounter, significant factors to consider are the Nature of the Presenting Problem (NOPP) and the complexity of Medical Decision Making (MDM) as it explains the medical necessity.

12.10 Claims Scoring Criteria

- The Accuracy and Completeness will be scored against the set of criteria, as supplied by Error Scoring Tables of this methodology.
- The error scoring tables for outpatient will be applicable to Day case and Home care

- These scored errors have been rated by Diagnosis and by Procedures as Major, Moderate or Minor.
  - The full list of possible errors and their rating is included in Error Table 1 to 4 as follows:

1. Each record will start with 100 points and the presence of any errors will result in the deduction of the set number of points
2. There can be no more than one error scored per code or one error per error-category in one claim.
3. The Medical Record Manager/Coding Supervisor/Coding Lead will be given an opportunity to discuss the individual errors before the Audit is final, in case there is a difference of opinion where there is a possibility of different coding outcomes. In these cases, the audited facility will be given the benefit of the correct score.
4. The difference of opinions in coding audit findings should be documented with coding references.
5. The justification with references to be provided and documented in the report for assigning the benefit to either party.
6. In case of no clear references available to both parties on the grey areas of coding concepts, the topic can be sent for arbitration, while the benefit can be given to the facility.
7. A coding completeness score for the facility will be utilized and recorded as a tool to track education requirements or coding process recommendations for future follow-up reviews.
8. The Passing grade system is as mentioned in the chapter 14 of this Methodology.

The scoring and on each claim, is as per the error categories mentioned in detail as per the below tables of Error Scoring Table 1 to Table 4:

Table 1 Error Scoring: Coding Error List Inpatient – Accuracy

CODING ERRORS FOR INPATIENT – ACCURACY			
ENCOUNTER TYPE ERROR			
1. Major Encounter Type - 10			
	Major 1	Claim uploaded to wrong Encounter Type	Claimed codes are uploaded to incorrect encounter type
PROCEDURES ACCURACY ERRORS			

Accuracy Errors			Example and Explanation
2. Major Procedure Error - 25			
	Major 1	Procedure coded without documentation	"31623 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings" is coded when there is not the documentation to substantiate brushing. Also coding an add-on code without a relevant primary procedure code.
3. Moderate Procedure Error - 15			
	Moderate 1	E & M code missing, high or in the wrong category	• 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.
4. Minor Procedure Error - 10			
	Minor 1	Principal Procedures do not have corresponding principal diagnosis code	Principal diagnosis – J45.909 Unspecified Asthma Principal procedure - 36660 Catheterization, umbilical artery, newborn, for diagnosis/therapy
DIAGNOSIS ACCURACY ERRORS ICD -9 CM/ ICD-10 CM			
5. Major Diagnosis Error - 25			
	Major 1	Diagnosis coded without documentation	A diagnostic code, including all codes, is assigned when the documentation does not support this code, including Chapter 20 and Chapter 21 Codes

	Major 2	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. If another code (incorrect) is listed, then it would be a Major Error of "Diagnosis coded without documentation".
6. Moderate Diagnosis Error - 10			
	Moderate 1	Missing relevant secondary diagnosis specific to this encounter	Missing required and/or pertinent secondary diagnosis which is relevant to this encounter, including Chapter 20 and 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 Fracture occurred due to a motor vehicle accident and the relevant Chapter 21 codes are not assigned.
	Moderate 2	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/Subcategory or is coded to specificity not in the documentation, then it would be a Major Error "Diagnosis coded without documentation". Example: assigning a code for the wrong stage of Chronic Kidney Disease would be coding without documentation, but coding to unspecified stage and documentation shows the specified stage, would be an error in specificity.
7. Minor Diagnosis Error - 5			
	Minor 1	Coding Signs & Symptoms integral to Diagnosis additionally	Coding additionally Signs & Symptoms that are associated routinely with a disease process, unless otherwise instructed by the classification

Table 2 Error Scoring: Coding Error List Inpatient – Completeness

CODING ERRORS FOR INPATIENT – COMPLETENESS			
PROCEDURES COMPLETENESS ERRORS			
Completeness Errors			**Example and Explanation**
1. Major – Procedure Error - 30			
	Major 1	Missing procedure code	Documentation shows a procedure is performed which is not coded.
2.Moderate – Evaluation & Management Error - 20			
	Moderate	1 Low E & M Inpatient	E & M are mandatory to be coded on every claim. If the E & M is lower than what is shown in the documentation, a moderate error will be scored.
DIAGNOSIS COMPLETENESS ERRORS ICD-9 CM / ICD-10 CM			
3. Major Diagnosis Error - 30			
	Major 1	Missing additional diagnoses	Not assigning, as per documentation, all Complication and Co morbidities (CC) or Major Complication and Co morbidities (MCC).
4. Moderate Diagnosis Error – 20			
	Moderate 1	Does not code "Possible, Probable etc."	Coding Guidelines specify that in an Inpatient setting, the documentation of "possible'', ''probable'', "?" etc. are to be coded.

Table 3 Error Scoring: Coding Error List Outpatient, Day case, Homecare & ED – Accuracy

CODING ERRORS FOR OUTPATIENT AND EMERGENCY (DEPARTMENTS) – ACCURACY			
ENCOUNTER TYPE ERROR			
1. Major Encounter Type -10			
	Major 1	Claim uploaded to wrong Encounter Type	Claimed codes are uploaded to incorrect encounter type

PROCEDURES ACCURACY ERRORS			
	Accuracy Errors		**Example and Explanation**
2. Major Procedure Error - 20			
	Major 1	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.
3. Major Evaluation & Management Error - 25			
	Major 1	E&M level high and/or in wrong category	E & M code does not meet the documentation criteria.
4. Moderate Procedure Error - 10			
	Moderate 1	Incorrect procedure code	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.
	Moderate 2	A minor procedure code which is inclusive in the E & M code	Follow coding guidelines for "distinct &/or separate service. Example: A cast application is coded in addition to the E & M

DIAGNOSIS ACCURACY ERRORS ICD 10 CM	
Accuracy Errors	**Example and Explanation**
5. Major Diagnosis Error - 20	

	Major 1	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- R30.0 Dysuria coded when documentation shows a PDx- N39.0: Urinary tract infection NOS
	Major 2	Claimed code does not match documentation	The code which is on the Claim does not match what is documented and/or coded.
	Major 3	Coding Possible, Probable or questionable diagnosis (see Coding Guidelines)	Coding Guidelines specify that in an Outpatient setting, the documentation of "possible'', ''probable'', "?" etc. are not to be coded.
6. Moderate Diagnosis Error-10			
	Moderate 1	Procedures or Prescription orders do not have corresponding diagnosis code	Principal diagnosis – J45.909 Unspecified Asthma Principal procedure - 36660 Catheterization, umbilical artery, newborn, for diagnosis/therapy. Or Prescription order documented for Erythromycin but no sign/symptom or condition is coded to support the medical necessity of the order.
	Moderate 2	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
	Moderate 3	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 4	Missing relevant diagnosis specific to this encounter	Missing required and/or pertinent secondary diagnosis which is relevant to this encounter, including Chapter 20 and 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 Fracture occurred due to a motor vehicle accident and the relevant Chapter 21 codes are not assigned.
7. Minor Diagnosis Error - 5			
	Minor 1	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 4 Error Scoring: Coding Error List Outpatient & ED – Completeness

CODING ERRORS FOR OUTPATIENT AND EMERGENCY (DEPARTMENTS) – COMPLETENESS	
PROCEDURES COMPLETENESS ERRORS	
Completeness Errors	**Example and Explanation**
1. Major Procedure Error - 30	

	Major	Missing Procedure Codes	Documentation shows a procedure is performed, which are significantly and separate from E & M code and the code are not assigned.
2 Major E & M Error - 30			
	Major	Low E & M	shown in the documentation, a major error will be scored.
DIAGNOSIS COMPLETENESS ERRORS			
3. Major Diagnosis Error - 40			
	Major	Missing additional diagnoses code(s)	There is not complete and full code assignment(s), according to coding rules and guidelines and available documentation

12.10.1 Accuracy Score:

- Inpatient – Errors include incorrect diagnosis and procedure code assignments, incorrect documentation used in selecting these codes and incorrect selection of principal diagnosis and principal procedure. Inpatient E&M codes are mandatory in all records. Any claims with encounter start date from 1st January 2014 onwards must have the Inpatient E&M codes assigned. (Scores range from 0-100, where 100 is best).
- All audits as of 1st January 2016 will have all Inpatient E&M codes scored as per the Inpatient E & M errors on the Accuracy Score.
- Outpatient, Day Case, Homecare, Telemedicine and Emergency - Errors include incorrect diagnosis and procedure code(s) or Telemedicine Service code(s) assignments, including E & M codes, incorrect documentation used in selecting these codes and incorrect selection of principal diagnosis and principal procedure(s) or Telemedicine Service code (scores range from 0-100, where 100 is best).

12.10.2 Completeness Score:

- Errors include missing diagnoses and procedures, (scores range from 0-100, where 100 is best)

12.10.3 Total Accuracy Score for Claims Review:

Once each record has been scored, a mean score will be calculated for each department (Inpatients-DRG, Day-case, Outpatient clinics, Emergency and Home Care). These scores will then be combined to give a combined accuracy score and a combined completeness score for the facility.

- The accuracy scores for each setting will be combined into the Total Score in accordance with the weights:

  ○ Inpatients (DRG) – 20% ○

  Day case- 20% ○ Outpatient

  Clinics – 20% ○ Emergency

  – 20% ○ Home care-20%

If a facility does not offer one of these services, the above weights will be altered to reflect this. Facilities with only one setting will have 100% weight to it.

Facilities with two settings will have 50% equal weights for each setting.

In facilities with multiple settings, the weights will be distributed equally across all available settings.

12.10.4 Examples of Scoring Calculation weights

Calculate Average Accuracy Score Example 1:

Encounter type	Score	Weight	Points
Outpatients	*87.4*	*100%*	*87.4*
Accuracy Score		***87.4***	

Calculate Average Accuracy Score Example 2:

Encounter type	Score	Weight	Points
Inpatients	*87*	*50%*	*43.5*
Outpatients	*90*	*50%*	*45.0*

Accuracy Score	***88.5***

Calculate Average Accuracy Score Example 3:

Encounter type	Score	Weight	Points
Outpatients	*87*	*25%*	*21.75*
Emergency	*88*	*25%*	*22.0*
Day case	*88*	*25%*	*22.0*
Inpatient	*90*	*25%*	*22.5*
Accuracy Score	***88.25***		

13 KPI Quality Performance Indicators - KPI Process Review and Data Validation

The Health Authority-Abu Dhabi (HAAD) ensures excellence in Healthcare for the community by monitoring the health status of the population.

HAAD has mandated:

- To achieve the highest standards in health curative, preventative and medical services and health insurance in the Emirate.

- To lay down the strategies, policies and plans, including future projects and extensions for the health sector in the Emirate and to follow-up their implementation.

- To apply the laws, rules, regulations and policies which are issued as they are related to its purposes and responsibilities, in addition to what is issued by the respective international and regional organizations in line with the development of the health sector.

13.1 Guidance

As per Circular CEO 38/ 12 issued this guidance applies to all HAAD Licensed Hospital Healthcare Facilities in the Emirate of Abu Dhabi.
The guidance sets out the definitions, parameters and frequency by which KPI Quality indicators will be measured and submitted to HAAD and will ensure Healthcare Providers provide safe, effective and high quality services in the Emirate of Abu Dhabi.

The aim of this quality measure is to improve the validity of submission of the KPIs data. This will add an extra layer of validation for the quality at the healthcare providers' level. Patient safety, clinical effectiveness, timeliness of care and patient experience are recognized as the main pillars of quality in healthcare.

In alignment with the focus of Healthcare Strategy department, HAAD is working towards establishing a robust competence framework of healthcare system to ensure high quality and safety of healthcare services offered to patients in the Emirate of Abu Dhabi.

The already existing, and whatever other measures added later, JAWDA program will be included in the JAWDA Data Certification and will be applicable only to hospitals already in the JAWDA program.

The KPI Quality Performance Indicators will check the three main dimensions as mentioned below:

- Robustness and validity of collection process
- Strength of the quality governance in place
- Validity and matching of submitted reports

The three dimensions are strengthened by conducting:

- KPI Process Review ○ Data Collection ○ Data process governance ○ Data submission KPI Data Validation.

The audit will undertake the validation of reports submitted to HAAD and process review for the internal data validation and governance.

13.2 KPI's Process Review

In planning for data collection and submission, Healthcare Facilities must adhere to reporting, definition and calculation requirements as set out in the KPI Profile. The following must also be considered:

- Nominate responsible data collection and quality lead(s)
- Ensure data collection lead(s) are adequately skilled and resourced.
- Understand and identify what data is required, how it will be collected (sources) and when it will be collected

- Create a data collection plan
- Ensure adequate data collection systems and tools are in place
- Maintain accurate and reliable data collection methodology
- Data collection, cleansing and analysis for reliability and accuracy
- Back up and protect data integrity
- Have in place a data checklist before submission
- Submit data on time and ensure validity
- Review and feedback data findings to the respective teams to promote performance improvement

KPI Quality Indicators Scoring will be as per the scoring tables published in Chapter 13 of this Methodology and in certification rules.

13.3 KPIs Validation

The certification body will validate the reports submitted to HAAD, by an audit on internal reports available to verify the consistency of what reported.

The Certification Body could perform Mystery Shopping Audits to validate the reports.

14. Reporting

All the audit activities (Reviews, Validations and Process Reviews, for Claims and KPIs) will be performed in the same schedule for each facility.
Upon the completion of the audit of the Facility, the Lead Auditor of TASNEEF will submit the Final Audit Report to the facility Manager, or Compliance Representative or other responsible parties at the facility for understanding and acknowledgement of the report and required action plans.

The final report with acknowledgement should be endorsed by the CEO or CFO or COO of the facility and should be submitted to TASNEEF for final decision.
The Final endorsed report will be for the review of Certification Controller and for final decision from TASNEEF in collaboration with HAAD.

14.1 Audit Report Format

The report includes:

1. Over all report summary as PDF or Word with JAWDA Data Certification - Final Score, Claims review score, Process review score and KPI Process Score, KPI data validation score, Grade achieved by Facility and ratio of error classification for coding and documentation.
2. The Process review work book to include:

a. Claims Review

b. Process flow map: Shared by the facility – Word or Excel

c. Gaps or deficiencies in the process flow identified by the Lead Auditor

d. Coding Policies review check list

e. Coder certification validation check list

f. Claims Process Review result

g. KPI Validation result

h. KPI Process Review result

i. Identified non-conformities of compliance to policies and process flow by relevant personnel- To be documented by Auditor/Lead Auditor

j. Process Recommendations: based on process, policies and compliance check

k. Partial Scores and Total Scores

3. Claims review report must include:

A. A Summary sheet with general details of the Audit, inclusive of the following: i.

the date of the audit

ii. the facility's name and license number as listed on the HAAD license, (This information must also be on *all* communications referencing the certification process, e.g. letters, emails etc.,)

iii. the E&M Guidelines: The Summary Sheet must state whether the Provider is following the 1995 or 1997 E & M Guidelines and which of the two guidelines was used by the Auditing Company. The use of both guidelines is not allowed.

iv. Name of the Auditor and Lead Auditor

v. The Final Accuracy Score

vi. the individual (Inpatient, Day case, Outpatient, Emergency and Home Care) Departments encounter totals with calculations to establish record numbers to be audited

vii. All extenuating circumstances that have been verified and validated by TASNEEF viii. Completeness score contributing to recommendations on specific coding concepts and recommended training areas

B. Each additional Data sheet(s) for each department divided by sections, Inpatient, Outpatient, Emergency, Day-case/ Homecare or Telemedicine with:

i. The full list of all claims/encounters

audited ii. Claim Id iii. Date of encounter

iv. All CPT codes and descriptors, including E&M codes if applicable, except ancillary services (i.e., Laboratory and Pathology).

v. All ICD-9CM/ICD-10 CM codes and descriptors indicating the principal and secondary codes clearly

vi. Details of error, corrections, with codes, descriptor, Auditor Comments, error categories and scores on each claim reviewed

vii. Scores following the specified scoring methods and points with totals for each department

Note: 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.

14.2 Audit Evidence

Evidence of documentation, and identified deviations will be collected, as agreed in Provider - TASNEEF contract. The evidence will be retained for a duration of maximum 2 years in accordance with certification rules as annex of this methodology.
Protected health information of patient will be handled as per the HIPAA standards of privacy and security.

14.3 Decision Making

TASNEEF reviews the submitted Final Audit Report referring to the collected evidences and endorses the Audit score with recommendations and requested action plan, where applicable.
The facilities will be graded based on the scores achieved and the certification validity is as per the grades obtained.

15. Scoring

The Final JAWDA Data Certification Score will be a comprehensive score obtained as per the assigned scoring weights for each domain - Claims Review Score, Process Review Score -Clinical coding and, additional score for Hospitals as KPI Process Review Score and, KPI Data Validation score.

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

Table 15.1- Summary of scoring weights

Hospitals	
Scope	**Weight**
Claims Review Score	60
Clinical Coding Process Review Score	20
KPI Process Review Score	15
KPI Data Validation Score	5

Centers/Clinics	
Scope	**Weight**
Claims Review Score	80
Clinical Coding Process Review Score	20

Table 15.2 Details of Scoring weights - Hospitals

HOSPITALS -DETAILED SCORING						
Facility Type	Domain	Domain details	Weights	Score	Points	Over all weights
Hospitals	Claims Review	Outpatient - 100	20%	90	18.00	
		Emergency - 100	20%	88	17.60	
		Inpatient - 100	20%	88	17.60	
		Day case - 100	20%	88	17.60	
		Home Health care- 100	20%	88	17.60	
	Claims review Score - 100				**88.40**	**60.00**

Clinical Coding Process Review	Process flow Map - 20		15	15.00	
	Clinical Coding Policies Review - 30		20	20.00	
	Coder Credentials - 10		5	5.00	
	Orientation/Training - 20		15	15.00	
	Compliance-4 departments - 20		15	15.00	
Clinical Coding Process Review Score - 100				70.00	**20.00**
KPI Process review	**Robustness**	50%	40	40.00	
	Quality Governance	50%	30	30.00	
KPI Process review Score - 100				70.00	**15.00**
KPI Data Validation Score - 100	**Data Validation (9-Indicators-WT)**	100%	88	88.00	**5.00**
FINAL JAWDA DATA CERTIFICATION SCORE					

Table 15.3 Details of Scoring weights - Medical Centers /Clinics /Home Care Centers

CENTERS / CLINICS -DETAILED SCORING WEIGHTS					
Facility Type	Domain	Domain Details	Weights	Final weights	Over all weights
Medical	Claims Review	Outpatient (100)	50%		
Centers /Clinics /Home care centers		Day case* (100)	50%		
	Claims review Score for 100			80%	80%
	Clinical Coding	Process flow map (15)	15%		

	Process Review	Coding Policies (5+35)	40%		
		Coder Credentials (20)	20%		
		Orientation/Training (5)	5%		
		Compliance-4 departments (20)	20%		
	Clinical Coding Process Review Score for 100			20%	20%
	FINAL JAWDA DATA CERTIFICATION SCORE				

*** In case of facilities with only one setting, the Claims Review weights will be 100% for the available setting.**

15.4 Passing Grade system for JAWDA Data Certification

- The passing grade for all facilities is based on the Final score which includes as a comprehensive score of individual Claims Review, Process review and, additional score for Hospitals as KPI Process, 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 13.1, 13.2, and Table 13.3
  - 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.

Table 14.4: Grades and validity assigned 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

16. 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 in 2 phases.

- Phase I - process review for major non-conformities
- Phase II - Uninformed audit visit for claims review (within 6 months from the date of Phase-1)

- Facility should respond to TASNEEF through e-mail with a definitive action plan to resolve the identified deviations of process, within 7 working days.
- Facility should ensure the relevant personnel were trained on the recommended areas of improvement.
- Revised policies and processes per the standard requirements of clinical coding to proceed for a reaudit.
- Facility can apply for re-audit after 60 days by submitting the proof of corrective actions.
- The Re-audit will be on the Facility Clinical Coding Process Review only. There will not be any claims review. Facility will be given a score of 86% if the process review shows correction of major deviations or non-conformities.
- After a re-audit, the facility score will be graded "C" with internal flagging and the facility will be in the scope of uninformed audit to ensure the continuous progress.
- An uninformed audit will be done for Claims review within 6 months of phase-1 of reaudit.
- If the facility scores B or A in the uninformed audit, validity will be as per the achieved grade.
- If the facility fails again in the un-informed audit, the certification will be revoked.

17. 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 HAAD to be published in the listing as they see fit.
- 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 publication of Certification, as applicable, will be within 30 days of receipt of the completed audit by TASNEEF, as applicable per the general terms and conditions of annexure for this methodology.
- It is the responsibility of the Providers and Payers to review the published list to ascertain pertinent information on scores and/or coding certification validity.

- If the Audit fails to meet the scoring criteria, after being reviewed by TASNEEF the re-audit criteria is as per Chapter-14 of this methodology.
- The list of certified facilities will consist of three parts:
    - Active certifications
    - New facilities listing (see section 19 below)
    - Archive of expired certifications
- 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

18. New Facilities Listing

18.1 Criteria and Process

a. Any new facility 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 (www.haad.ae/shafafiya/standards) 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 200 claims. 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, 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 HAAD and TASNEEF, and a final decision of listing under exemption will be given.

18.2 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 200 claims to proceed for certification, an extension request should be sent to ba.jdc@tasneef.ae
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 HAAD that there are not enough submitted claims, the extension will be issued in the list of Certified – New Facilities list.
d. The maximum duration of the extension period is 6 months.

19. Initial Phase of Methodology: Quarter 1, January 2017

Taking into consideration, that the facilities would need reasonable time to understand and adopt the methodology, and to prepare accordingly for the scheduled audits communicated as per the audit planner, the audits conducted during the First quarter of 2017 will be as per the new methodology 2017, partially, as listed below.

20. Annexures

1. Guidelines For Criteria And Certification Rules