# Abu Dhabi Clinical Coding Audit

# 1. Objective

This coding audit will endeavor to build trust between payers and providers by:

- Creating a shared understanding of the facility's coding quality.
- Giving the payers confidence that a facility is coding accurately.
- Giving the facility the right, if they possess current certification, to bill or to continue to bill on the appropriate level of the Evaluation and Management (E&M) code(s)
- Providing the facility with information to improve the quality of coding within their facility.

The coding audit will give:

- A coding accuracy score for the facility, which will range from 0-100.
- A coding completeness score for the facility, which will range from 0-100.

# 2. Who May Ask for an Audit?

Confirmed by Health Authority-Abu Dhabi that the following may request a Coding Audit:

- All licensed HAAD healthcare entities, Payers or Providers.
- A third party acting for said facility may request, upon the presentation to the TASNEEF-RINA Business Assurance (TRBA), a Power of Attorney from the facility specifying that this third party is acting on their behalf and in the facilities' full knowledge, for the purpose of this specific Audit.
- The Payers may perform focused coding audits as specified in Section 4 and/or call for a re-audit, as specified in Section 12.

# 3. Who May Conduct the Audits?

According to the Notice on Clinical Coding Audits as of 25th August, 2016,which is published on HAAD website, "TASNEEF-RINA Business Assurance (TRBA) is authorized to issue "Clinical Coding Certifications" (CCC) as defined in "HAAD Periodical No. 45 – Health Insurance" as of 11 July 2011."
TRBA can issue CCC, exemptions and/or extensions when sufficient claims are not present in KEH to enable auditing, if the following criteria is met:

- Proof of Coder current certification and/or experience (which includes proof of coding experience of a minimum of 2 years coding NOT billing, and also 2 years of continuing education )

- A Coding Process Flow Chart which show a correct coding process within the facility (the coding flow chart is a chart and/or text which describes the process by which coding is done in the facility.)
- Does not have the minimum required claims (200) which meet the audit criteria, in KEH to enable an audit.

Audit Process up to 31st December, 2016

- All audit requests must be channeled through TRBA. (Providers will contact TRBA directly).
- TRBA will either arrange for TRBA to conduct the audit or give the provider an approval stating that they are allowed to contact an audit company directly along with the list of approved audit companies with contact emails.
- The audit company may contract to do the audit (but only with an approval e-mail/letter, as mentioned above, from TRBA)
- After the 31st Dec, 2016, no audit company will be allowed to submit an audit.

The TRBA Clinical Coding Audits (**Compliance Audits)** will be the only overall coding audits performed for assessing coding compliance for the purpose accreditation.

# 4. Payers' Audits

Payers may perform Non-Coding Compliance Audits or Focused Coding Audits as per the terms of the Standard Provider Contract (SPC) (*Article 3.4: Medical Record Maintenance and Access)* & Provider manual *(Article: Audit Process).*

**Non Coding Compliance Audits:**

The statutory audits as per SPC article *3.4 Medical Record Maintenance and Access* and according to the audit guidelines agreed in the Provider Manual.

**Focused Coding Audits:**

These are coding audits by the payers on selected records according to the audit guidelines agreed in the Provider Manual. The focused audits can be for any of the below.

1. The focused coding audits may be of a specific code (including a specific E & M code or level), a specific diagnoses or specific service(s) or specific procedure(s)
2. The focused coding audits can also be on a specific physician(s) or allied healthcare and professional(s).

**Criteria of Coding Audits:**

- Prior to the focused coding audit, the payers are required to submit a notification of the focus of the audit as per the terms of SPC & Provider manual. Findings of the focused audit will not be limited to the focus of the audit. Any other findings in the claim other than the focus will follow SPC and Provider Manual rules.
- The coding auditor conducting the focused coding audit will have relevant coding certification of CCS, CCS-P, CPC, CPC-H or CCA.
- The lead coding auditor reviewing and reporting these focused coding audit report findings must hold a relevant coding certification of CCS, CCS-P, CPC, CPC-H or CCA with three years coding experience. (See Glossary).
- To qualify as a Payer Coding Auditor, the individual must pass the Coding Assessment Exam proctored by HAAD Relevant findings in the focused coding audits can be resolved by mutual agreement between provider and payer or reported to HAAD for consideration of cause for a re-audit.

# 5. Pre-audit Requirements

The following must be submitted to HAAD on the Clinical Coding Audit Process (CCAP) website; prior to the audit:

- Providers who wish to be coding audited will contact TASNEEF-RINA Business Assurance (TRBA) and apply on http://www.tasneefba.ae/ccc for a clinical coding audit
- TRBA will reply with permission to be audited by an approved audit company or TRBA will conduct the audit themselves.
- The audit company may then contract to do the audit (but only with an e-mail approval confirmation, as mentioned above, from TRBA)
- If a Provider is already contracted, prior to 25th October, 2016, with an Audit Company, the audit will proceed as previously conducted, without the requirement of approval from TRBA.
- After the 31st Dec, 2016, no audit company other than TRBA will be allowed to submit an audit.
- When contractual agreements are completed, signed letters of "Declaration of No Conflict" from both Facility and TASNEEF-Approved Auditing Company for each license number being audited must be submitted to CCAP prior to download of claims to be audited.

# 6. Audit Requirements of Medical Records and Claims

The audit of medical records and claims at each facility will determine the accuracy and completeness of coding carried out on a random selection of Inpatient, Outpatient, and Emergency (Departments) records. (This will be done individually by Inpatient, Outpatient and Emergency).

**1. Coding Resources**

The Auditor will use relevant coding resources; American Hospital Association's Coding Clinic, ICD-9-CM Official Guidelines for Coding and Reporting, CPT Assistant, and ICD-9-CM Coding Manual for Hospitals or if appropriate, American Hospital Association's Coding Clinic, ICD-10-CM Official Guidelines for Coding and Reporting, CPT Assistant, and ICD-10-CM Coding Manual for Hospitals , and Other Healthcare Institutions, published byHealth Authority- Abu Dhabi, to review coding and ascertain the coders' compliance to these standards.

**2. Medical Records to be Audited**

a) A minimum of 50 claims with relevant records within the past 12 months (discharges/encounters of submitted claims) will be audited. The 50 Claim ID numbers for each Inpatient, Outpatient and Emergency (Departments) will be randomly selected in the KEH from previously submitted claims.

b) The list of the selected 50 Claims ID numbers, with relevant codes, will be downloaded by the Audit Company to comply with the specified deadline. (See Section 9)

c) If the completed audit is uploaded after the prescribed timeframe (see Section 8), it will be considered a failed audit.

d) The codes to be audited are strictly the ICD 9 CM diagnosis, or if appropriate the ICD-10CM, and CPT 4th Edition procedure codes for outpatient clinic visits, inpatient visits, homecare and emergency rooms 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.

e) All Outpatient, Homecare and Emergency records must have CPT codes or Telemedicine HAAD Service Codes as listed in the most current version of the Claims and Adjudication Manual.

f) The audit focus is on clinician documentation related to assigned codes and/or code levels that were used on the claims for reimbursement.

# 7. Audit Report Format

The Final Audit Workbook is to be submitted, by the audit company, to HAAD upon the completion of the audit of the selected claims. It must include data sheets on all audited encounters, divided by sections, Inpatient, Outpatient, Emergency or Telemedicine.

1. The report will be submitted in an Excel Workbook format as per the Sample Audit Workbook 2014 pubished on www.haad.ae/datadictionary. This Excel Workbook will include the following:The Summary Sheet, which must have the audited Provider's HAAD license number and name (as specified on the HAAD License). This information must also be on *all* communications referencing the audit, e.g. letters, emails etc.

2. 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.
3. It must also list the total number of E & M errors for each department as per the Sample Audit Workbook 2014.
4. The Workbook must also include:

- The full list of all encounters audited
- Date of encounter
- All CPT codes and descriptors, including E&M codes if applicable, except ancillary services.
- All ICD-9-CM codes, or if appropriate the ICD-10-CM, and descriptors indicating the principal and secondary codes clearly
- Corrections and corrected codes, if applicable, stating any errors clearly.
- Scores folling the specified scoring methods and points with totals for each department's E & M errors.

# 8. Audit Timeline and Process

1. Upon upload of Declaration letters (See Sections 5 and 6), the Auditor will receive an email of notification that the Declaration letters have been received. The time limit (deadline) for the submission of the audit will begin when the Declaration letters are uploaded. The time limits (deadlines) are as follows:
    a) The deadline to submit the audit for all facilities (license numbers) with two (2) to three (3) departments is ten (10) working days from time of the upload of the Declaration Letters.
    b) The deadline to submit the audit for all facilities (license numbers) with one (1) department is six (6) working days from time of the upload of the Declaration Letters.
2. The failure to upload the completed audit within the specified time (deadline) will result in an automatic failure of the audit.
3. After the upload of the Declaration Letters, within the next 2 to 3 hours, HAAD, through the CCAP website will randomly select 50 claims ID, with the relevant codes, for each department to be audited. These will be randomly selected from all claims submitted through the HAAD Post Office by the stated license number over the last twelve (12) months. HAAD will send an email to the Auditor when the completed list is available for download.
4. The Audit Company will then complete the Audit and submit within the deadline as specified above.

**Table 1: Steps to be taken for the audit**

| Action | Responsible Party | Inpatients | Outpatient clinic | Emergency | Notes |
|---|---|---|---|---|---|
| **1. Confirm with TRBA the approval to audit** | Auditor/Facility | | | | Auditor and Facility must agree on date of the audit |
| **2. Upload Declaration Letters to Audit Process on CCAP** | Auditor | If applicable | If applicable | If applicable | • Declaration Letters of both Audit Company and Facility (See Sections 5 and 6).<br>• The deadline for the submission of the audit begins (See Section 9 ) |
| **3. 50 Claim ID numbers will be randomly selected over the past 12 months for each department** | CCAP | If applicable | If applicable | If applicable | • Within 2 to 3 hours, Claim ID numbers for files to be audited for Inpatient, Outpatient, Emergency, Telemedicine and Homecare (See Section 7.2.e) will be randomly selected from KEH along with all relevant ICD 9 CM and CPT codes on the claim<br>• HAAD will send the Auditor an email when the list is ready to be downloaded. |
| **4. Upon receipt of email notification, down load Claim ID numbers to be audited** | Auditor | If applicable | If applicable | If applicable | Auditing Company will download the 50 Claims List to be audited for Inpatient, Outpatient, Emergency Telemedicine and Homecare (See Section 7) |
| **5. Upload the completed audit to the CCAP prior to prescribed deadline** | Auditor/Facility | See Section 9 a. and b.) | See Section 9 a. and b.) | See Section 9 a. and b.) | It is the responsibility of both Auditor and Facility to ensure that the audit is submitted prior to the deadline. (See 9.) |

# 9. Scoring

The final accuracy score will be based on the following:

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 after start encounter date 1st January, 2014 must have the Inpatient E & M codes assigned.
    - All audits as of 1st January, 2016 will have all Inpatient E & M codes scored as per the Outpatient E & M errors on the Accuracy Score. (See Coding Error Tables 2 and 3)
2. **Completeness Score:**
    - Errors include missing diagnoses and procedures, missing E codes and V codes as well as Inpatient E & M codes until 1st January, 2016. (scores range from 0-100, where 100 is best)
3. **E & M Error Totals**
    - The total number of E & M errors within the audited 50 records. (See Section 11)
4. **Total Score:**
    - Once each record has been scored, a mean average score will be calculated for each departments (Inpatients, Outpatient clinics and Emergency). These scores will then be combined to give a combined accuracy score and a combined completeness score for the facility.
    - The weightings assigned to each department will be:
        - Outpatient Clinics – 40%
        - Inpatients – 40%
        - Emergency – 20%

      If a facility does not offer one of these services, the weightings will be altered to reflect this.

### 4. Example Coding Calculation

| *Calculate Average Accuracy scores for encounter type:* | Score | Weight | Points |
|---|---|---|---|
| *Inpatients* | *87.00* | *40%* | *34.80* |
| *Outpatients* | *87.00* | *40%* | *34.80* |
| *Emergency* | *88.00* | *20%* | *17.60* |
| ***Accuracy Score*** | | | ***87.20*** |

# 10. Audit Scoring and Re-certification:

### Passing Grade for Coding Audit

- The passing grade for all facilities for the Clinical Coding Audits will be an Accuracy Score of 86%.
- In addition to meeting the criteria for the Accuracy Score, the audit must meet the following E & M criteria.
    - E & M errors, within any department's fifty audited-files, must not exceed 18 errors. If there are 19 E & M errors or more the Audit will fail, regardless of the fact that the overall passing grade criteria of 86% has being met. This means that there must be a minimum of 32 correct E & M coded files.
- The Accuracy and Completeness will be scored against the set of criteria, as supplied by the Health Authority - Abu Dhabi as per the Clinical Coding Methodology, January 2016 and the inclusive Error Scoring Tables.
- These scored errors have been rated by Diagnosis and by Procedures according to Major Moderate or Minor. The full list of possible errors and their rating is included in Tables 2 through 5 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, as displayed in Tables 2 through 5
    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.

Table 2: Coding Error list Inpatient – Accuracy

| CODING ERRORS FOR INPATIENT – ACCURACY | | | |
|---|---|---|---|
| **PROCEDURES ACCURACY ERRORS** | | | |
| | | **Accuracy Errors** | **Example and Explanation** |
| **1. Major Procedure Error - 30** | | | |
| | 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 |
| **2. Moderate Procedure Error - 15** | | | |
| | Moderate | E & M code missing, high or in the wrong category | **In Patient E & M codes are mandatory on all records 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** |
| **3. Moderate Procedure Error - 15** | | | |
| | Moderate | OR Procedures do not have corresponding diagnosis code | Principal diagnosis - 493.90 Unspecified Asthma<br>Principal procedure - 36660 Catheterization, umbilical artery, newborn, for diagnosis/therapy |
| | | | |
| | Moderate | Missing E & M Code | **Assigning Inpatient E & M codes is mandatory as of 1st** |
| **DIAGNOSIS ACCURACY ERRORS ICD 9 CM** | | | |
| **3. Major Diagnosis Error - 25** | | | |
| | Major | Diagnosis coded without documentation | A diagnostic code, including "V" codes is assigned when the documentation does not support this code. |
| | Major | 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". This is also inclusive of "V" codes. |
| **4. Moderate Diagnosis Error - 15** | | | |
| | Moderate | Missing relevant secondary diagnosis specific to this encounter | Missing "V" code as secondary diagnosis (i.e., 'history of' codes) Also missing "V" and "E" codes which are relevant to this encounter – Examples are;<br>Patient has coronary artery disease and history of CABG not coded<br>Or<br>Patient morbidly obese and BMI is not coded. |
| | Moderate | 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 of "Diagnosis coded without documentation". |
| | Moderate | 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 |

| DIAGNOSIS ACCURACY ERRORS ICD 10 CM | | | |
|---|---|---|---|
| **3. Major Diagnosis Error - 25** | | | |
| | Major | Diagnosis coded without documentation | A diagnostic code, including all codes, is assigned when the documentation does not support this code. |
| | Major | 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". |
| **4. Moderate Diagnosis Error - 15** | | | |
| | Moderate | Missing relevant secondary diagnosis specific to this encounter | Missing required and/or pertinent secondary diagnosis which are relevant to this encounter (i.e., 'history of' codes, BMI, Smoking)– Examples are; Patient has coronary artery disease and history of CABG not coded Or Patient morbidly obese and BMI is not coded. |
| | Moderate | 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 of "Diagnosis coded without documentation". |
| | Moderate | 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 3: Coding Error list Inpatient – Completeness

**CODING ERRORS FOR INPATIENT – COMPLETENESS**

| | | |
|---|---|---|
| **PROCEDURES COMPLETENESS ERRORS** | | |
| | **Completeness Errors** | **Example and Explanation** |
| **1. Major – Procedure Error - 30** | | |
| Major | Missing OR procedure code | Documentation shows a procedure is performed which is not coded. |
| **2.Moderate – Evaluation & Management Error - 15** | | |
| Moderate | Low E & M | In patient E & Ms 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** | | |
| **3. Major Diagnosis Error - 30** | | |
| Major | 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 – 15** | | |
| Moderate | Does not code "Possible, Probable etc." | Coding Guidelines specify that in an Inpatient setting, the documentation of "possible'', ''probable'', "?" etc. are to be coded. |
| Moderate | Missing "V" code as secondary diagnosis (i.e., 'history of' codes) | |
| **5. Minor Diagnosis Error - 10** | | |
| Minor | Missing "E" code | |

| | | |
|---|---|---|
| **DIAGNOSIS COMPLETENESS ERRORS ICD 10 CM** | | |
| **3. Major Diagnosis Error - 30** | | |
| Major | 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 – 15** | | |
| Moderate | Does not code "Possible, Probable etc." | Coding Guidelines specify that in an Inpatient setting, the documentation of "possible'', ''probable'', "?" etc. are to be coded. |
| Moderate | Missing appropriate codes from Chapter 21 Factors influencing health status and contact with health services (Z00-Z99) as secondary diagnosis (i.e., 'history of' codes) | |
| **5. Minor Diagnosis Error - 10** | | |
| Minor | Missing appropriate codes from Chapter 20 External causes morbidity (V00-Y99 | |

Table 4: Coding Error list Outpatient & ED - Accuracy

## CODING ERRORS FOR OUTPATIENT AND EMERGENCY (DEPARTMENTS) – ACCURACY

| | | |
|---|---|---|
| **PROCEDURES ACCURACY ERRORS** | | |
| | **Accuracy Errors** | **Example and Explanation** |
| **1. Major Procedure Error - 25** | | |
| Major | 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 | Claimed code does not match what is documented | "10140 Incision and drainage of hematoma, seroma or fluid collection" is the correct assignation according to the documentation but "10160 Puncture aspiration of abscess, hematoma, bulla, or cyst" is on the Claim. |
| **2. Major Evaluation & Management Error - 25** | | |
| Major | E&M level high and/or in wrong category | E & M code does not meet the documentation criteria. |
| **3. Moderate Procedure Error - 15** | | |
| Moderate | Incorrect procedure code | "31622 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed" is on the record and documentation and 31623 is coded. This can be either first-listed or secondary. |
| Moderate | An additional procedure code which is inclusive in the E & M code (mainly ED) | A cast application is coded in addition to the E & M |
| Moderate | OR Procedures do not have corresponding diagnosis code | Principal diagnosis - 493.90 unspecified asthma<br>Principal procedure - 36660 Catheterization, umbilical artery, newborn, for diagnosis/therapy. |
| **DIAGNOSIS ACCURACY ERRORS ICD 9 CM** | | |
| | **Accuracy Errors** | **Example and Explanation** |
| **4. Major Diagnosis Error - 25** | | |
| Major- | Diagnosis coded without documentation or coding sign symptom INSTEAD of the diagnosis | Code is not according to the documentation, e.g. documentation does not support the code.<br>OR<br>Code is a documented sign or symptom and not the documented diagnosis such as a PDx- 788.1 : Dysuria coded when documentation shows a PDx- 599.0 : Urinary tract infection NOS |
| Major | Claimed code does not match documentation | The code which is on the Claim does not match what is documented and/or coded. |
| Major- | 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. |
| **5. Moderate Diagnosis Error-10** | | |
| Moderate | Incorrect sequencing of diagnosis | This is strictly a sequencing issue, not a documentation issue. Both/all codes must be present and correct assigned; however the wrong code is selected as principal diagnosis. The correct code must be listed. If another code (incorrect) |

| | | |
|---|---|---|
| | | is listed, then it would be a Major Error of "Diagnosis coded without documentation". This is also inclusive of "V" codes which should be first or second listed. |
| Moderate | 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: "533.71 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 "536.8 Dyspepsia and other specified disorders of function of stomach". |
| Moderate | 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 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 | Missing relevant secondary diagnosis specific to this encounter | Missing "V" code as secondary diagnosis (i.e., 'history of' codes).<br>Also missing "V" and "E" codes which are relevant to this encounter – Examples are;<br>Patient has coronary artery disease and history of CABG not coded<br>Or<br>Patient morbidly obese and BMI is not coded. |

| DIAGNOSIS ACCURACY ERRORS ICD 10 CM | | |
|---|---|---|
| | **Accuracy Errors** | **Example and Explanation** |
| **4. Major Diagnosis Error - 25** | | |
| Major- | Diagnosis coded without documentation or coding sign symptom INSTEAD of the diagnosis | Code is not according to the documentation, e.g. documentation does not support the code.<br>OR<br>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 | Claimed code does not match documentation | The code which is on the Claim does not match what is documented and/or coded. |
| Major- | 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. |
| **5. Moderate Diagnosis Error-10** | | |
| Moderate | Incorrect sequencing of diagnosis | This is strictly a sequencing issue, not a documentation issue. Both/all codes must be present and correct assigned; however the wrong code is selected as principal diagnosis. The correct code must be listed. If another code (incorrect) is listed, then it would be a Major Error of "Diagnosis coded without documentation". |

| | | | |
|---|---|---|---|
| | Moderate | 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 - Examplle: "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 | 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 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 | Missing relevant secondary diagnosis specific to this encounter | Missing required and/or pertinent secondary diagnosis which are relevant to this encounter (i.e., 'history of' codes, BMI, Smoking)– Examples are; Patient has coronary artery disease and history of CABG not coded Or<br>Patient morbidly obese and BMI is not coded. |

Table 5: Coding Error list Outpatient & ED - Completeness

| CODING ERRORS FOR OUTPATIENT AND EMERGENCY (DEPARTMENTS) – COMPLETENESS | | |
|---|---|---|
| | **Completeness Errors** | **Example and Explanation** |
| **PROCEDURES COMPLETENESS ERRORS** | | |
| **1. Major Procedure Error - 60** | | |
| Major | Missing Procedure Codes | Documentation shows a procedure is performed, which is significantly separate from E & M code and the code is not assigned. |
| **DIAGNOSIS COMPLETENESS ERRORS** | | |
| **3. Major Diagnosis Error - 40** | | |
| Major | Missing additional diagnoses code(s) | According to the available documentation, there is not complete and full code assignment(s), according to coding rules and guidelines. |

# 11. Evaluation & 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 and documented or in the wrong category. If there is a conflict of interpreting the coding rules and criteria, the audited facility will be given the benefit of the correct score. (See section 10.3) The possible E & M errors also include the following:
    1. No E & M code assigned in Outpatient/Emergency , where relevant.
    2. No E & M code assigned in Inpatient, when there are E & M code(s) assigned on some records and not on others, where appropriate. If no IP E & M codes are assigned on any of the facility's IP records, there will not be any deductions.
    3. Incorrect E & M category.
    4. 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

# 12. Final Report

The Auditor will e-mail the final audit report to the Manager of the Medical Records Department, or other responsible parties at the facility, at the conclusion of the coding audit. The facility is to review this final report prior to the Auditor submitting it to HAAD CCAP. Upon approval, the Auditing Company will upload the completed audit, in the required format and prior to the prescribed deadline (See 9 a., b. and c.), to the CCAP website to be reviewed by TASNEEF-TRBA

- The Final Report in Excel Workbook format will contain the following worksheets:
  1. The *Audit Workbook* must include:
     a. A Summary Sheet with all 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,
        iii. any and all extenuating circumstances that have been verified and validated by HAAD.
        iv. the E & M Guidelines used by the facility and by the auditing company.
        v. the final Accuracy and Completeness Scores,
        vi. the total number of E & M errors in each department
        vii. the individual (Inpatient, Outpatient and Emergency) Departments encounter totals with calculations to establish record numbers to be audited.
     b. Data sheet(s) for each department with codes, descriptor, scoring and errors for each file, with:
        i. file number,
        ii. encounter date, and if applicable the discharge date
        iii. principal and secondary diagnosis code(s) and descriptors.
        iv. CPT procedure code(s) listed on claim.
        v. there must be code details for each file audited, not just the files with errors.

# 13. Listing and De-listing

1. The issuing of certifications and recommendations to that affect will not be within the Auditor's realm of responsibility. They will provide the audit to TRBA, who will review and issue certifications as they see fit.
    - The Certification Effective Date is date of publication on the Coding Certified Facilities List on www.haad.ae/datadictionary.
    - The Certification Expiry Date is one (1) year from the Certification date and is not extendable.
    - This publication of Certification, as applicable, will be within 30 days of receipt of the completed audit by HAAD CCAP.
    - 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-TRBA or fails to meet the Upload Deadline, the facility will be required wait until there are 60 days of new encounters (from the date of the upload of the audit to CCAP) before being re-audited. This will enable new records and claims to be available for new random selection. When an audit is repeated after failure, the method is as per the initial audit.)
2. TASNEEF-TRBA retains the right to revoke certification of a facility on the basis of 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 conflict of interest e.g. Copy of contract or letter(s) or email(s).
    - Evidence of sample manipulation.
    - Evidence of bribery or collusion.
3. The Payer(s) may apply to TASNEEF-TRBA for an independent re-audit of a specific facility, paid for by the Payer(s), based on the evidence as specified below:
    - Evidence of fraud and abuse through a focused coding audit, see Section 4
    - Evidence with supporting documentation and data of frequent, consistent and inaccurate CPT & ICD9CM, or if valid ICD10CM coding, including unbundling and upcoding, *over a period of no less than 3 months.*
    - HAAD will notify Provider that a re-audit is to be reflected

4. The failure of an independent re-audit (utilizing the same methodology as the current audit) commissioned (paid) by the Payer, will be as follows:
   a) Audits following the 2016 Coding Audit Methodology will be scored as follows:
      - If the facility does not pass the re-audit or receives an accuracy score lower than 5% or more than the score of the original audit, their Coding Certification will be revoked and payers can apply the terms and conditions of SPC & Provider Manual.
      - The re-audit will be comprised of the original 50 audited claims (per each category) and an additional 50 randomly selected claims (per each category) within the same original audit time frame.
      - The Final Report will be as the original audit; however, the original 50 records will be listed on a separate tab from the additional 50 records.
      - The Final Score will be listed on the Summary Sheet as per the Re-audit Sample Excel sheet. The Final Score will be comprised of the
        - Average of the total score for all categories and all 100 files both original and additional claims
        - Average of the total score for all categories and all 100 files both original and additional claims having a weight value of 40% for the original claims and 60% for the new claims
   b) Audits following the 01/09/2016 Coding Audit Methodology will be scored as follows:
      - If the facility does not pass the re-audit or receives an accuracy score lower than 5% or more than the score of the original audit, their Coding Certification will be revoked and payers can apply the terms and conditions of SPC & Provider Manual.
      - The re-audit will be comprised of the original 50 audited claims (per each category).
      - The Final Report will be as the original audit report.
      - The Final Score will be listed on the Summary Sheet as per the original audit. The Final Score will be as per the original audit.

## 14. Confidentiality

The auditing company and all staff members and/or sub-contracted staff members will maintain as confidential all patient information, facility financial and/or employee information and all other private and sensitive facility information,

including but not limited to auditing scores and/or reports. These will only be disclosed to authorize individuals/organizations, at authorized times and in an authorized manner.

All facilities who wish to be Coding Certified and thus allow to bill with the relevant E & M code groups will inform the Audit Company to release their Audit Score Summary, pre-audit scores and all relevant documents to HAAD. HAAD will then certify that they have scored a passing mark and list their Accuracy Score which will be published as part of the list of certified facilities. All further information, &/or reports will be considered confidential and only released upon the permission of said facility.

## 15. Exceptions and Unusual Circumstances

If a facility does not/cannot meet certain stipulated requirements, the auditor must contact TRBA prior to conducting the audit to ascertain the specific requirements or special circumstances for the audit of this facility.

# Glossary

**CCAP website** - Clinical Coding Audit Process website, accessible only to authorised users: https://bpmweb.haad.ae/UserManagement/login.aspx

**Claim(s)** - All Outpatient 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, or if valid ICD 10 CM and CPT.

**Date of Audit** – Is the date the audit is confirmed as having been received through the CCAP website

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

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

**Delisting** - Removal of certification status due to expiry

**Facility** - Each individually licensed provider

**Involvement** - For the purposes of this document it is read to mean involvement in the coding for Submissions and/or Re-submission of Claims within the Revenue Cycle of said facility

**Renewal** - Certification renewal

**Recertification** - Renewal of Certification

**Reaudit** - Payer commissioned audit of the facility post-certification as per methodology of the audit which is in question.

**Revoking of Certification** - Removal of certification status due to an unfavorable outcome of re-audit.

**TRBA** - TASNEEF-RINA Business Assurance