Clinical Coding and Auditing Governance Structure and Framework

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Summary

Case mix and patient classification systems are important building blocks for contemporary health systems and crucial transparency enablers. One of the most important tools, and what is known as one of the most successful health care financing systems, Diagnosis Related Groups (DRGs), have been present in Saudi Arabia since 2009. However, the most considerable progress in their implementation has been achieved in the past five years because of Vision 2030 transformation efforts. Being part of Vision 2030, the health insurance sector in Saudi Arabia is spearheading the implementation of new and innovative ways toward more transparency in healthcare financing and provision such as the National Platform for Health Information Exchange Services (NPHIES), Saudi Billing System (SBS), and Minimum Data Set (MDS). The implementation of Australia Refined Diagnosis Related Groups (AR-DRG) is one of the most important projects as part of the Council of Health Insurance (CHI) 2020-2024 strategy and through the CHI white paper demonstrates the concepts of case mix, patient classification, and plans for AR-DRG implementation in the Saudi health insurance market.

Objectives

The Council of Health Insurance (CHI) Coding Audit Framework is to develop a standardized framework, methodology and guidelines for clinical coding audits to ensure accuracy, consistency, and compliance in the coding process, to assure data quality for providers participating in submitting their data to NPHIES and, correspondingly, to provide recommendations for improvement of quality and processes.

The primary focus of CHI will be on improving the quality of healthcare data by:

- assessing the accuracy of clinical codes assigned to diagnoses, procedures, and services.
- providing healthcare providers with recommendations on areas of improvement in the quality of coding.
- verifying that the coding practices are following the Saudi Coding Standards.
- establishing trust between insurance companies and providers by ensuring that the claims submitted are appropriate, complete, and compliant with current regulations.

Achieving high quality coded data would further strengthen the payer and provider relationship. This approach assists the providers to avoid Fraud, Waste and Abuse (FWA); especially in minimizing coding errors, which in turn would lead to less frequent payer audits and reduce audit recovery amounts.

In accordance with CHI's strategy to implement AR-DRG and Value-Based Health Care following Saudi Vision 2030, this document explains how a coding audit should be planned and performed in healthcare entities regulated by CHI.

The audit will apply to all health records and claims generated from inpatient, outpatient, day-care, and emergency room departments. Health records belonging to Home Health Care (HHC), Primary Health Care (PHC), and Long-Term Care (LTC) are not within this document's scope but will be included in the near future.

CHI's implementation framework has a comprehensive approach to introducing AR-DRG by addressing all areas deemed as prerequisites for AR-DRG implementation (clinical coding, clinical documentation, episode grouping, technology, and financial impact). This will require significant communication efforts and a change of management in the market. The successful planning and implementation of AR-DRG in the private healthcare sector by CHI will enable seamless utilization of this system via NPHIES and pave the way to more transparency and value-based health care in the market.

In the following sections, we will describe the main points of Auditing Governance and Structure as well as the suggested processes thereof and not limited to country specific examples.

Governance

Aligning with the objectives to improve services to the beneficiaries, enable sustainability, and increase transparency in care delivery, the Council of Health Insurance has introduced regulations and standards around medical coding and auditing. A medical coding and auditing governance framework is comprised of key stakeholders that are identified throughout the process. Stakeholder advice and consultation is regularly solicited to evaluate whether auditing policies and processes meet key stakeholders' needs and regulatory expectations. Governance is defined as a formed committee of stakeholders that take on primary and secondary roles that conduct governance reviews of internal and external audits. During our review we have considered the coding and auditing governance frameworks in the following countries: United Arab Emirates Abu Dhabi, Australia, Germany, and the United States. These countries have been selected as they have well-established coding and auditing governance frameworks. Given the complexity of each of the countries' approach to medical coding and auditing frameworks we are

describing the rules and regulations for each framework with the governance alignment of the U.A.E. Once stakeholders have been defined the following considerations should be incorporated.

Components

- Structure, process, and outcome improvements across the health sector.
- Improve quality of medical coding and clinical documentation.
- Focus on the delivery of quality healthcare.
- Rules and regulations to collaborate with stakeholders and apply fair processes.
- Disseminate information and knowledge to improve care.

Clinical Coding Process Review

During the clinical coding process review, major non-conformities identified for any of the below will impact review scores as an underlying cause affecting the documentation. Coding processes will be audited at the facility to assess the establishment of policies based on standard and regulatory requirements of CHI and adherence thereto.

- The clinical coding process review is valid for all healthcare organizations licensed by CHI submitting coded claims to the NPHIES portal.

Aspects of Clinical Coding Process Review:

- Authorized and updated Clinical Coding policy that addresses the coding practices followed in the organization including Coding ethics, Physician query process, List of approved references coders utilize and their accessibility, Internal quality control activities, etc.
- Coding process Flow Chart which reflects the flow of activities involved in coding and claim submission.
- Adherence to the ethical coding practices of HIMAA.
- Coding practice workflow and adherence to the coding practice policies.
- Evidence of continuous training of clinical coding staff.
- Adherence to the documented physician query process.
- Implementation of the internal coding audit process.
- Coder's awareness of the entire revenue cycle processes.

Frequency of the Audit Process

All healthcare providers are mandated to participate in an initial audit before December 2025.

The frequency of the consecutive audits depends on the score of the previous audit result.

In case of failure, re-audit must be completed within three months (90 days).

Suggested Governance Framework

Internal and External Audit

The governance committee is a formed board of stakeholders who take on primary and secondary roles and that conduct governance reviews of internal and external audits. The function of a formed governance committee is to assess the methodologies used to complete the audits. Policy and regulatory efforts can be formed because of such committees. An organization will need to define the cadence of audits, general governance rules, and establishing responsibility, confidentiality, data governance, timelines, and mandates. Under the auspice of forming a governance committee the suggestion to create an audit committee that is comprised of stakeholders to ensure conflict management, compliance, or arbitration policies are created.

- **External:** Audits that are performed by external entity. External audits evaluate risks objectively and produce recommendations for coding practices, compliance, education and awareness. If external audits are delegated to vendors these firms should specialize in providing audits, education, and consultation.

- **Internal:** Internal coding audits are usually performed to evaluate current coding practices, compliance, and assist with indication of problematic areas requiring additional review and education.

The following attributes are essential to the formation of an internal and external auditing framework.

- Audit planning
- Accreditation
- Appeals
- Arbitration
- Coding accuracy
- Compliance
- Communication
- Selection criteria
- Documentation review

Audit Planning

Applicable to external audits, the audit work plan is influenced by the budgetary restrictions and imposed upon by the findings from the review process. The review process should be monitored for auditing and compliance changes and auditing results carefully documented. Prior planning, open communication, and clarifying expectations of all parties' results in a smoother and more efficient audit process. The planning process should enable the reviewer to resolve a significant number of audit issues related to documentation and medical coding. It will also directly impact the appeals process by providing better provider understanding of the issues and requirements.

- The mandate of CHI accreditation will recommend that the providers will undergo an external audit periodically. (Based upon the certification validity) refer to scoring methodology.

- Define coding audit methodology, clinical service line selection, scoring and the development of performance and performance indicators for quality reporting.

- Providers cannot decline an external audit and a randomized audits without the written consent of CHI.
- Only CHI Audit Committee Team or CHI endorsed Audit Vendors with an approval from CHI can perform audits without prior notification to providers.

Accreditation

Accreditation is intended to assist practices in developing an accreditation/compliance program that promotes adherence to statutes and regulations applicable to health care programs. The goal of voluntary compliance programs is to provide a tool to strengthen the efforts of health care providers to prevent and reduce improper conduct. Accreditations serve to benefit practices by helping to streamline business operations.

When forming an accredited audit committee the following points should be considered:

- Certification of medical coding staff
- Certification of medical auditing staff
- Experienced vendors with ability to work in the country
- Data privacy certification
- ISO 27001 certification
- Clinical medical board
- Background checks are required (due diligence)
- After formation of committee, ensure the following steps should be maintained by the board committee.
- The scrutiny of data integrity practices.
- Complete implementation of security improvements for computer systems, including implementation of unique user identity and password controls.

Appeals

The appeals process will ensure that coding audit reviews accurately reflected the health service policy intent and service provision. During the appeals process, streamlining of coding processes will improve compliance, medical necessity, and will serve to identify areas of risk. The appeal process allows for a feedback mechanism to provide continuous and open feedback between the providers and CHI. CHI can further identify areas of risk towards specific providers or specific audit vendors based upon the number of appeals received and resolutions. Program should ensure accurate reflection of health service policy intent identified under coding and staff educational deficiencies.

The program should establish regular cadence of committee review of regulatory activity including medical coding changes and clinical advancement of medicine. The cadence should be annually.

Standardized appeals process by written review and rebuttal within 30 days. The governance committee will review all appeals. Second level coding audit appeals processes must include clinical medical review before arbitration.

Arbitration

In case of any inconsistencies or ambiguities between these guidelines, and any legislation, regulations, and contractual obligations with the Kingdom, acting through the Ministry of Health, the legislative,

regulatory and contractual obligations take precedence. The creation of an arbitration policy assists compliance and is an effort to engage the private health care community in preventing the submission of erroneous claims and in combating fraudulent conduct.

The audit committee then conducts preliminary review to ensure eligibility, informs petitioner of decision to proceed, and coordinates with an independent review panel made up of two independent members, ensuring that they have the appropriate skills and credentials to perform the review. Each organization should refer to the relevant statute (where applicable), regulation or contract to ascertain all details of its legal obligations. If any organization has specific queries regarding its legal obligations, it should seek independent legal advice. The committee should make every reasonable effort to achieve resolution of said arbitration within 30 calendar days of receipt and notify all involved parties in writing within 15 calendar days of a decision rendered by the audit committee.

Coding Audit process

The audit can be conducted either on-site or remotely according to the technical maturity of the HCP. The HCP should provide all the required access to the auditor during a remote audit.

The audit will be conducted in two domains:

- Clinical coding accuracy
- Review of clinical coding policies and processes

Clinical coding accuracy

The coding accuracy audit scoring is comprised of the following:

- Accuracy score
- Completeness score

Accuracy score: The accuracy score will be determined by reviewing coded data to assess the correctness of diagnosis and procedure code assignments. This evaluation will involve a comparison with both the relevant Australian Coding standards and CHI coding standards.

Completeness score: The completeness score reflects the diagnosis and procedures missed by the coder, which could have provided more information on the patient's status. It will be used to identify education opportunities, gaps in the coding process, and deficiencies in physician documentation.

The coding errors are classified as accuracy and completeness errors. Based on their weightage they are further categorized as minor, major & moderate. The full list of errors is provided in Appendix B.

- During review, each record will start with 100 points and the identification of errors will lead to the subtraction of a specified number of points, as indicated in the error tables. Refer to Appendix B.
- There can be no more than one error scored per code or one error per error category in one claim.
- In the accuracy and completeness scoring process, each code within a claim can have only one error assigned. Even if a code could potentially fit into multiple error categories, it will be assigned to the error with the highest score. Any additional errors applicable to the code will be noted in the audit report.
- Similarly, each claim can only be assigned one error per error category. Even if there are multiple errors of the same error category within a claim, it will only be counted once during scoring. Points will be deducted only once for the same error repeated in an encounter.

Clinical Coders Threshold

Each coder will be assessed and, based on their training and/or experience level, will be assigned an accepted accuracy threshold. A plan should be put in place to help clinical coders gradually reach the desired accuracy threshold.

The healthcare provider should aim to maintain an accuracy threshold of 95% as per CHI accreditation standard HI.4 (CHI Provider's Accreditation and Classification program).

Compliance

Compliance within the governance framework is essential to the monitoring of ethical reporting of healthcare services. When compliance issues are identified, the governance program must be notified, and a formal investigation will be completed. Investigation of compliance cases should not be communicated directly with the provider until a formal investigation has been completed.

- Audit findings should be written documentation and should align with applicable laws and regulations and include the following:

- Report on the coding audit should contain a statement of positive assurance on those items which were audited for compliance and provide assurance on those items not tested.

- It should include all material instances of noncompliance, and all instances or indications of illegal acts which could result in criminal activity or prosecution.

- Penalties can be financial in nature as well as losing licensure to practice.

- Adding the following definitions is essential to creating a well-established coding compliance work plan:

- Fraud is the intentional obtainment of something of value through unlawful and willful misrepresentation. It allows for theft, embezzlement, false statements, illegal commissions, kickbacks, conspiracies, obtaining contracts through collusive arrangements and similar devices.

- Waste is defined as the thoughtless or careless expenditure, mismanagement, or abuse of resources to the detriment (or potential detriment) of the government or institutional policy. Waste also includes incurring unnecessary costs resulting from inefficient or ineffective practices, systems, or controls.

- Abuse is a violation of agency regulations that impair the effective and efficient execution of the auditing; such violations result in the denial, reduction, and loss of authorized benefits to participants.

Communication

Governance should include expressed communication requirements for all individuals conducting, planning, reviewing, and reporting code audits. Communication of audit findings will result in the continued development of quality measures and refine auditing programs applicable to both internal and external coding audits. The preparation of a comprehensive report summarizing findings, recommendations, and corrective actions and feedback should be completed at the end of each audit. The formation of a solid communication plan that includes communicating audit results to coding staff, stakeholders, compliance officers, and management teams.

- Preparation of a comprehensive report, summarizing audit findings, recommendations, any corrective actions taken and feedback.

- Communication processes should be rewritten and distributed to all stakeholders and to the market in a timely manner. The governance committee will review all incoming communication requests or constraints.

- The Arbitration committee will be notified of escalation; arbitration is to be held only after internal appeals processes have been exhausted.

- Communication of any results or findings must be held on a regular basis and received in writing.

Selection Criteria

Define the selection criteria for the internal and external selection of records. The sample size will be selected from 12 months of claims of the defined audit period. The sample size will be provided by CHI based upon the volume of claims submitted or discharges of each hospital for each encounter type.

CHI can provide a predetermined standardized sample size based on provider categorization and average or range of claims or volume per year using any preferred calculation methodology with capping. The table can be adjusted annually based on audit sampling and results.

Facilities that fail to obtain the accuracy score will undertake a re-audit within three months from the date of issuance of the final report. The major non-conformities with respect to the error categories will be reviewed during the re-audit. The re-audit will be performed on all encounter types irrespective of their individual scores. The HCP should apply for the re-audit within the mentioned timeline. The application should clearly include the corrective actions taken based on the audit, and the HCP's readiness for a re-audit. Evidence of coder and physician training, revision of coding process, improvement of internal audit process etc., if recommended by the auditor, should be appended with the application.

The sample selected for the re-audit will be selected from the period after the issuance of the final report. A failed audit will result in a re-audit.

Scoring and Certification

At the end of the audit, the HCPs who pass the audit will be awarded with the CHI coding audit certificate. The final audit score will be graded according to the tables below. The validity of the CHI coding audit certificate will be dependent on the grade to which the HCP belongs. The certificate is subject to renewal based on its validity.

Table 1: Year 1 - Audit Scores

Tier	Final Audit score	Validity of the audit certificate
• 1	• 70-100	• 12 months
• Failed	• Below 70	• Re-Audit

Table 2: Year 2 - Audit Scores

Tier	Final Audit score	Validity of the audit certificate
• 1	• 80-100	• 12 months
• Failed	• Below 80	• Re-Audit

Table 3: Year 3 onwards - Audit Scores

Tier	Final Audit score	Validity of the audit certificate
• 1	• 96-100	• 18 months
• 2	• 90-95	• 12 months
• 3	• 86-89	• 9 months
• Failed	• Below 86	• Re-audit

Documentation Review

Applicable to both internal and external audits is documenting the evidence obtained, procedures applied, and tests performed to provide sufficient competent evidence to support the auditor's opinions, judgments, conclusions, or recommendations. After obtaining and testing the various types of evidence considered necessary in the circumstances, the committee shall retain such evidence and its relationship to the basis for the opinions, judgments, conclusions, or examinations. Where materiality is a factor, it shall define "materiality" within the scope and objective of the review.

- Examine the medical record associated with the selected cases.
- Ensure that the documentation of the medical record reflects the severity of illness, intensity of services provided and supports the assigned codes.
- Evaluate the completeness and accuracy of the medical documentation.
- Establish criteria for documentation review program.

Coding Assignment

Correct assignment of medical codes is directly related to the applicable use of ICD-10-AM and Saudi Billing System it is the process by which abstracting medical diagnostic conditions using strict coding guidelines. These guidelines provide official conventions and instructions for use based upon the classification and take precedence over any other guidelines. These guidelines are based upon a sequential set of instructions located in the ICD-10-AM manual. An alphabetic index and tabular listing are also included for ease of use to achieve complete and accurate documentation and code assignment. Without proper use and training of this manual proper coding is not achieved.

The Saudi Billing System

The Saudi Billing System codes and standards (SBS) are based on the Australian Consortium for Classification Development of Australian Coding Standards (ACS) for the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) and Australian Classification of Health Interventions (ACHI), both 10th Edition. As mentioned above, SBS is made up of ICD-10-AM, SBS procedure codes, ACS and SBSCS. A classification of diseases can be defined as a system of categories to which morbid entities are assigned according to established criteria. The purpose of the SBS is to standardize data for claims, and for morbidity analysis and mandated reporting. The SBS enables the translation of diagnoses and procedures and other health problems from words into an alphanumeric/numeric code, which permits easy storage, retrieval and analysis and use of the data.

The evaluation of accuracy in principal and secondary code assignment is an essential component of compliance along with verifying the specificity in code selection to capture the complexity of all audit types. The verification of assigned codes should align with the clinical documentation and medical services rendered. Compliance with medical coding guidelines should be adhered to mitigate and reduce risk with the medical record and coding pathways.

Clinical Coding Auditor Competence

1. An Advanced, intermediate or CCC certificate from HIMAA, or other local entities such as SHC or SCFHCS with at least 3 years of experience, or equivalent.

*AHIMA/AAPC Certified Clinical Coder with 5 years of experience, with evidence of formal ICD-10-AM training program.

2. Have expertise and advanced knowledge in the application of the rules and conventions of ICD-10 -AM, SBS, ACHI, AR-DRG and a thorough understanding of Australian Coding Standards (ACS) and SBS coding standards (SBSCS).

3. Coding experience across major specialties including medicine, surgery, trauma and orthopedics, cardiology, and obstetrics is required.

4. Demonstrate evidence of continuous professional development.

Conclusion

In conclusion, the formation of a healthcare auditing governance committee is a critical step in enhancing financial oversight, risk management, and overall organizational performance for hospitals and healthcare systems. By establishing an independent audit committee composed of qualified members, healthcare organizations can improve their financial reporting processes, strengthen internal controls, and ensure compliance with regulatory requirements. The audit committee serves as a vital link between the board, management, and external auditors, fostering transparency and accountability in financial matters.

Furthermore, the adoption of best practices, such as those outlined in the "Council of Health Insurance, Coding Audit Methodology Framework" will significantly bolster the effectiveness of healthcare governance. Regular meetings, clear responsibilities, and ongoing education for stakeholders and committee members is essential for maintaining a high-functioning audit committee. As healthcare organizations face increasing pressure for better performance and accountability, the formation of a robust auditing governance committee is not just advisable but necessary for ensuring long-term financial health and maintaining public trust.

International Benchmarking

United States of America

The United States Office of Inspector General sets forth guiding principles in the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse within the provision and delivery of all health and human services in the nation. These services are rolled out in a systematic framework that addresses every state, private, or publicly held administered health or human services program. Variations of audits are conducted such as Health Information Technology, Provider/Facility, Payer, and Contractual Healthcare Services. Strict enforcement is through the United States Office of Inspector General and Department of Justice. (DOJ, 2024)

The creation of an executive steering committee that includes representatives from regional, public, and private stakeholders that will provide oversight of rules, regulations, and shared decision making. The Office of Inspector General is the leading practice for internal/external audit assists with the coded data, quality of documentation, reviews of data operations and quality assurance.

The standards and review procedures that ensure information disseminated to the public are reviewed for objectivity and integrity.

- initiate investigation

- initiate an audit or inspection; or

- refer the allegation to management or another agency

Health Information Technology serves to assist with assessing compliance with technology requirements and effectiveness including application controls for systems that support the department of Health and Human Services. Includes payer technology requirements, electronic medical records, claims scrubbers, and intermediaries.

- The following principal points are the basis for an auditing work plan created in the United States. (OIG, 2024)

- Use standardized testing procedures that ensure integrity and completeness.

- Test actual transactions and compliance outcomes.

- Evaluate timeliness processing conditions.

- Align the duration of review periods.

- Target samples related to the original root cause(s) of noncompliance.

- Request impact analyses for noncompliance found in sampled cases.

- Include a summary of any work previously performed for the sponsoring organization by the independent auditing firm.

- Identify a minimum of two auditors per program area, including their credentials.

- Provide a copy of the proposed validation audit report template.

The Office of Inspector General has created a primary statistical tool for the auditing of services including claims. The name of the tool is RAT-STATS, and the software assists the user in selecting random samples and estimating improper payments. Although OIG does not require the use of RAT-STATS, many providers download the software as part of their efforts to fulfill the claims review requirements for corporate integrity agreements or provider self-disclosure protocol. (RAT-STATS OIG, 2024)

Germany

The German MDK "Medizinscher Dienst der Krankenkassen" (*Medical Service of the Health Insurance Companies*), at the request of the health care insurance company, is responsible for inpatient medical audits. The health insurance fund must meet hospital-specific quotas for the allocation of audits to the MDK. The binding rules for coding hospital cases are the German coding guidelines, including the German coding guidelines for psychiatry/psychosomatics. In addition to hospital doctors, the experts from the medical service are the users most affected and are therefore confronted with ambiguities and room for interpretation when coding. (Hohe Zufriedenheit mit dem Pflegeservice Bayern, 2024)

Comparing Germany to other countries we consider that within German healthcare social security follows the principle of subsidiarity. This means that the legislature has set up a framework e.g., Sozialgesetzbuch SGB Chapter V for healthcare. Within this framework different parties' public corporations or bodies represent physicians, health insurance, and hospitals are responsible for the content design (DRGs, fees for outpatients, coding guidelines etc.). MDK belongs to those governing bodies but does not belong directly to the Ministry of Health in Germany. Only in the event of a dysfunctional process or an unresolvable conflict is the ministry of health allowed to intervene.

Currently there are 15 medical service lines checked to assess the quality of outpatient and inpatient care facilities. The objective is to determine the care and make recommendations on questions from the insurance companies relating to the medical and nursing care of their insured persons. Compliance is viewed as the ongoing development and implementation of programs that include policies and procedures that are designed to help healthcare organizations comply with all applicable laws and regulations. (Hohe Zufriedenheit mit dem Pflegeservice Bayern, 2024)

Validated claims data is then analyzed for irregularities using various machine learning approaches such as: deep neural networks, vector technology, gradient boosting, and regression. Health insurance companies are also known to utilize AI to optimize detection. Then the health insurance mandates the MDK for an audit of this case and the hospital must render all relevant documents to the MDK. Only the MDK and their staffed physicians are allowed to conduct audits, not the health insurance. The definition of quality is defined in Social Code Book, Volume V (SGB V); which provides standards in compliance reporting and quality, including safety, clinical governance, quality, and prevention. SGB V is the fundamental law which rules the documentation for quality purposes. Besides the coding audit, the MDK is assigned to check the structural requirements of a hospital. (Hohe Zufriedenheit mit dem Pflegeservice Bayern, 2024)

The renumeration process in Germany is the process by which experiences of the medical staff are documented and medical services are continuously incorporated into a cross-border database with coding recommendations. The database maintenance is entrusted to the Social Medical Group (SEG4) and the recommendations of coding require ongoing coordination and discussion with the medical community. These recommendations are consistent and continuously updated across the country of Germany. Communication promotes transparency in medical service assessments and creates procedural security for all providers of healthcare. The German Society for Medical Controlling is also applying binding coding rules exclusively for the individual case constellations, but they do not represent general regulations. The Federal Arbitration Committee plays an inherent part of the German coding guidelines, which are directly applicable as coding rules, and the reformulation of the mandate from the senior doctors of the medical services. (Hohe Zufriedenheit mit dem Pflegeservice Bayern, 2024)

Australia

Within the Australian State of Victoria, the data quality principles underpin Department of Health data collection processes. These principles are based on the dimensions of quality from the Australian Bureau of Statistics Data Quality Framework. They consist of institutional environment, relevance, timeliness, accuracy, coherence, interpretability, and accessibility. Data quality is the combination of input editing and

output editing to maintain a high level of data quality measured against the dimensions of relevance, accuracy, coherence, interoperability, and accessibility. The State of Victoria operates healthcare audits by an assigned health data integrity unit. The editing and activities of this department experience annualized updates where the department undertakes recommendations and changes to the process of health data. The use of quality indicators provides statewide benchmarking and reporting, and it measures data accuracy against defined clinical indicators. The quality indicators also assist with problematic areas of specific clinical service lines and records that require correction.

The Independent Health and Aged Care Pricing Authority (IHACPA) has established the Australian Classification Exchange (ACE) which is an online portal that allows registered users to make public submissions regarding the following:

- International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)
- Australian Classification of Health Interventions (ACHI)
- Australian Coding Standards (ACS)
- Australian Refined Diagnosis Related Groups (AR-DRGs)

United Arab Emirates - Abu Dhabi

The DOH is the regulatory body of the healthcare sector in the Emirate of Abu Dhabi. Its primary objective is to ensure excellence in healthcare for the community by monitoring the status of the population. The audit provides clarifications on specific aspects of the auditing cycle and methodology as they have broken down the methodology into working parts beginning in 2019, 2020, and 2021. The summarization provides insight on the successful implementation thereof.

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 use all applicable DoH-approved code sets related to clinical documentation and Coding for Data reporting requirements.

The data certification process for Abu Dhabi coding audits is known as JAWDA Data Certification Process.

Key aspects of this process:

1. Purpose: JDC aims to ensure high-quality clinical data documentation, collection, coding, and submission by healthcare providers in Abu Dhabi.

2. Scope: The certification includes four main domains:

   o Claims review

   o Clinical coding process review

   o KPI data validation (for hospitals, home health care centers, and long-term care centers)

   o KPI process review (for hospitals, home health care centers, and long-term care centers)

3. Certification body: TASNEEF-RINA Business Assurance (TRBA) is the authorized external certifying body to conduct JDC compliance audits and issue certificates.

4. Applicability: JDC is mandatory for all healthcare providers in Abu Dhabi, including dental and self-pay facilities, with some exceptions like pharmacies, laboratories, school clinics, and optical services.

5. Audit process:

   ○ Facilities must apply for certification at least two months prior to their scheduled audit date.

   ○ The audit duration depends on the facility's tier system and sample size.

   ○ Auditors review claims, coding processes, policies, coder credentials, and conformity with standards.

6. Scoring and certification:

   ○ A total score of 86% is required to meet the passing criteria.

   ○ Grades are assigned based on overall scoring, which determines the validity of the certification.

   ○ Follow-up audits may be conducted to verify that major non-conformities have been addressed.

7. Frequency: Certification must be renewed prior to the expiry date listed on the current certification.

8. Leadership involvement: Facility top management must demonstrate commitment to complying with JDC methodology and Department of Health (DoH) regulations.

9. KPI process review: This aspect aims to improve the validity of KPI data collection, validation, and submission processes, focusing on patient safety, clinical effectiveness, and patient experience.

The JDC process replaced the previous Clinical Coding Certification and now includes audits on JAWDA Quality KPIs in addition to claims review and clinical coding process review. This comprehensive approach aims to enhance the quality of healthcare data and achieve the vision of delivering high-quality services in the healthcare sector of Abu Dhabi.

Medical coding audits enhance patient safety by ensuring that patient records are correctly documented and assist with care coordination and communication with providers. When a facility undergoes continuous audits facilities/providers can enhance coding practices, education of coding guidelines, and implement corrective measures. Medical coding audits proactively approach quality improvement and contribute to better patient care.

Patient safety is 'the discipline in the health care sector that applies safety science methods toward the goal of achieving a trustworthy system of health care delivery.' Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events. Clinical effectiveness is "the application of the best knowledge, derived from research, clinical experience, and patient references to achieve optimum processes and outcomes of care for patients.

The process involves a framework of informing, changing and monitoring practice." Clinical effectiveness is about doing the right thing at the right time for the right patient and is concerned with demonstrating improvements in quality and performance that can be summarized by:

1. The right thing (evidence-based practice requires that decisions about health care are based on the best available, current, valid, and reliable evidence.)

2. In the right way (developing a workforce that is skilled and competent to deliver the care required).

3. At the right time (accessible services providing treatment when the patient needs them).

4. In the right place (location of treatment/services).

5. With the right outcome (clinical effectiveness/maximizing health gain).

Accessibility is "ensuring that the population of Abu Dhabi has access to quality medical services that will lead to achieving desired outcomes and enhancing patient experience." This is measured through a set of waiting time indicators within the quality framework to guide healthcare future strategies and improvements. The Health System of the Emirate of Abu Dhabi is comprehensive, encompassing the full spectrum of health services and it is accessible to all residents of Abu Dhabi. The system is driven towards excellence through a continuous outcome 'improvement' culture and monitoring achievement of specified indicators. Providers of health services are independent, predominately private and follow the highest international quality standards. The system is financed through mandatory health insurance.

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