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Research

BPJS Verification Pending Claim Case Accuracy Diagnostic Codes Inpatients

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A B S T R A K

Background: The process of submitting claims for BPJS (Badan Penyelenggara Jaminan Sosial) under the INA-CBGs (Indonesian Case-Based Groups) program is contingent upon the utilization of the ICD-10 (International Classification of Diseases, Tenth Revision) code. The delay in BPJS claims can be attributed to problems in the ICD-10 coding process conducted by the Casemix coding team.
Objective: The objective of this research is to assess the precision of coding pending claims.
Methodology: The chosen research methodology is descriptive in nature, employing a quantitative approach. The research employed the Simple Random Sampling approach for the purpose of sampling. The gathering of research data was conducted through the method of direct observation of pending claim documents. The study was carried out in the Casemix Unit of RSU Aisyiyah Padang. The study encompasses the entirety of claim files from January to June 2022, constituting the research population. A sample size of 94 papers has been selected for analysis. The process of data analysis encompassed descriptive, graphical, and inferential methods in order to present a comprehensive understanding of coding errors.
Result: The findings indicate that a total of 29 documents, accounting for about 30.85% of the total, had delays throughout the period of January to June 2022 as a result of inaccuracies related to ICD-10 diagnostic codes. The number of pending inpatient claims reached its peak in January, with a total of 25 cases, of which 11 were attributed to code problems. The majority of the current claim cases are concentrated in Block E, which pertains to coding for endocrine, nutritional, and metabolic illnesses.
Conclusion: In conclusion, the suspension of BPJS claims at RSU is influenced by the accuracy of diagnostic coding that is based on ICD-10.

INTRODUCTION

The act of asserting one's entitlement to health insurance coverage The Social Security Administration, often known as BPJS, is a government-operated health insurance program. In the context of treatment cost reimbursement, it is incumbent upon each healthcare provider to fulfill the necessary BPJS claim requirements during the application procedure. The objective of this initiative is to streamline the procedure for reimbursing maintenance expenses by utilizing the rates established by the Indonesia Case Base Groups (INA-CBG's) (Susan, 2016). In order to initiate the claim procedure, the healthcare institution is required to compile a set of documents, which encompass a service recapitulation, diagnosis records from the DPJP physician, a Participant

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Eligibility Letter (SEP), a medical résumé, and any further supporting evidence. The process of making payments through INA-CBGs, which are managed by BPJS at healthcare institutions, necessitates the completion of a document verification phase. This step is crucial as it allows BPJS Health verifiers to assess the proper administration of services and verify the appropriateness of diagnoses and procedures listed on bills in accordance with the coding systems ICD-10 and ICD-9. BPJS Health is responsible for approving and processing claims for eligible papers, while documents that do not meet the criteria for a claim or are pending must be returned to the health facility for further verification. The utilization of a payment method of this nature will have a significant impact on the financial viability of BPJS health claims, as it heavily relies on the precision of coding.

According to a research study conducted by Santiasih (2021) at RSUD Dr. RM Djoelham Binjai in March 2020, with a subsequent review in February 2021, several issues were identified in relation to pending BPJS Health claims. These issues included incomplete requirements or medical resumes, coding errors, and discrepancies between the coding and the medical resume. Consequently, the verifier officer at the hospital had to return the claim requirements files to the BPJS verifier in order to ensure the completeness of the necessary documents (Santiasih, 2021). Based on the findings of Tambunan et al. (2022), a research study examining the causes of delayed inpatient BPJS health claims at Tarakan District Hospital, it was determined that the primary factor contributing to delays in the processing of inpatient BPJS health claims is coding. Specifically, 49 files (53%) exhibited discrepancies between hospital diagnoses and BPJS records. The secondary factor responsible for claim delays is other medical support, with 33 files (35%) showing errors and deficiencies in the confirmation of medical support. Lastly, a lesser number of delayed claim factor files were attributed to administration, specifically incomplete files at the time of processing. The Tarakan Regional Hospital had delays in processing the administration of 11 out of the total inpatient BPJS health claim files, which accounts for 12% of the total.

According to a preliminary investigation carried out at RSU Aisyiyah Padang in 2022, a total of 94 case papers were identified as outstanding. This research holds significance in the context of mitigating the occurrence of delayed claims. The objective of this study is to assess the precision of coding procedures for pending BPJS confirmation claims pertaining to inpatient cases at RSU Aisyiyah Padang.

METHOD

The research methodology employed in this study is descriptive in nature, utilizing a quantitative approach. The study was carried out within the casemix unit of RSU Aisyiyah, Padang, over the period of September to November 2022. The study sample consisted of all BPJS claim records from January to June 2022. The research sample consisted of pending documents for BPJS claims throughout the period of January to August 2022, for a total of 94 documents. The employed sample approach was simple random sampling. The process of data collection involved a thorough examination of pending claim paperwork. A descriptive data analysis was conducted. The objective of this study is to provide the data in a graphical format and derive conclusions from it, in order to acquire a comprehensive understanding of coding inaccuracies that contribute to the accumulation of pending claims.

RESULT DAN DISCUSSION

The findings of a study conducted at RSU Aisyiyah Padang pertaining to accuracy are presented based on an analysis of BPJS pending claim documents from January to June 2022. Out of a total of 94 documents examined, the results (Table 1 and Figure 1) indicate that 29 documents (30.85%) were associated with pending claims resulting from inaccurate ICD diagnosis codes.

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Table 1. Total Pending Claim Cases Based on ICD-10 Diagnosis Inaccuracy

No	Month	Number of pending claims	Number of Cases diagnosis code
1	January	25	11
2	February	12	4
3	March	13	3
4	April	19	1
5	May	10	3
6	June	15	7
Total		94	29

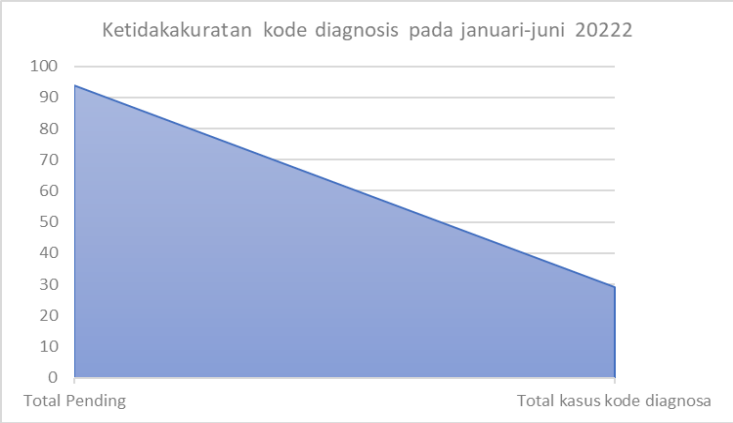

Figure 1. Total Pending Claim Cases Based on Inaccurate ICD-10 Diagnosis January-June 2022

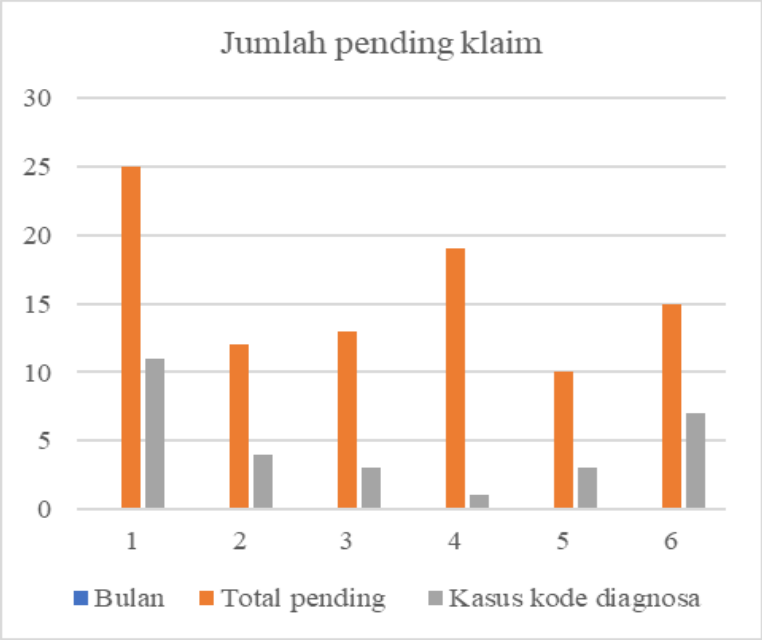

Figure 2. Graph of the number of pending claim cases based on inaccurate diagnosis codes January-June 2022

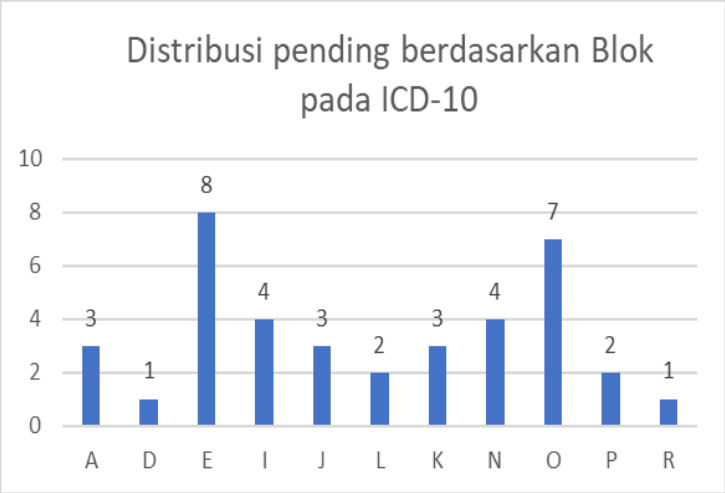

Figure 3. Graph of distribution of diagnostic inaccuracies based on Blocks in ICD-10 January-June 2022

Figure 3 displays the monthly statistics about the quantity of pending claims resulting from inaccuracies in diagnostic coding. In January, the highest number of pending claims for inpatients was seen, totaling 25, of which 11 were attributed to pending coding inaccuracies. In the month of May, the number of outstanding cases reached its lowest point, with a total of 10 cases waiting. Among these instances, up to 3 were found to have erroneous diagnosis codes. In January, there was a notable increase in the number of cases resulting from improper coding of diagnoses, as depicted in Figure 2, with a total of 11 instances. Conversely, the month of April exhibited the lowest number of pending cases, specifically one pending case. Figure 3 displays the graphical representation of the distribution of erroneous diagnoses attributed to Blocks in the International Classification of Diseases, Tenth Revision (ICD-10) during the period spanning from January to June of the year 2022. The location with the highest number of unresolved cases in Block E pertains to the coding of endocrine, nutritional, and metabolic illnesses. The present study aims to evaluate the diagnostic accuracy of disease coding in Block E for type 2 diabetes (E11.-), thyroid gland disorders (E00-E07), imbalance of food intake elements (E63.1), hypokalemia (E87.6), and malnutrition (E40-E46). Coding mistakes were observed in the BPJS verification results, which can be attributed to the implementation of coding practices for diabetes in accordance with the ICD-10 regulations. The coding for E87.6 is currently pending as the primary diagnosis is hypokalemia, rendering it unnecessary to provide a code for this condition. The Block O currently has the second highest number of pending claims cases pertaining to pregnancy, labor, and the postpartum period, with a total of seven ongoing cases. The act of delivering a baby through an elective caesarian section, as classified under the International Classification of Diseases (ICD-10) code O82.0. Cephalopelvic Disproportion, often known as a narrow pelvis (O33.9), is not included in the medical curriculum vitae. Confirmation of therapy linked to endocrine, nutritional, and metabolic illnesses that complicate pregnancy (O99.2) is necessary in order to establish a diagnosis code. Hyperemesis gravidarum, also known as extreme nausea and vomiting during pregnancy (O21.0), Pyrexia (O86.4), and false contractions of pregnancy occurring before 37 weeks (O47.0).

The research findings indicate that coding inaccuracy is a contributing factor to the occurrence of pending claims. According to Ulfa et al. (2017), their study examined the accuracy of disease diagnostic codes across hospitals and the BPJS using the ICD-10 coding system. The researchers emphasized the significance of certain factors in coding, particularly highlighting that the quality of the coder directly influences the quality of coding. The quality features of disease coding encompass the coder's reliability in accurately assigning diagnoses and the imperative to possess a comprehensive understanding of the rules governing the application of ICD-10, in order to mitigate discrepancies in code assignment. The degree of correctness and comprehensiveness in coding will be contingent upon the filing of the claim. The adaptation of coding policies and procedures, together with the adherence to relevant rules pertaining to coding, is necessary in the context of ICD-10, hospital, and BPJS legislation.

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Various factors might influence the process of coding, such as the proper diagnosis made by the physician, which may be misinterpreted by the coder leading to incorrect coding and subsequently inaccurate coding outcomes (Budi, 2011). The text pertains to the Regulation of the Minister of Health of the Republic of Indonesia No. 512/Menkes/PER/IV/2007, which specifically addresses the licensing and implementation of health services. In Chapter I, specifically Article 1, Paragraph 10, the following information is presented. Standard procedures refer to a collection of standardized instructions or steps that are utilized to execute routine work processes. Meanwhile, Standard Operating Procedures (SOPs) offer the most suitable and optimal steps, determined through consensus, for performing various functions and service-related tasks in accordance with the professional standards upheld by healthcare institutions. Effective planning has the potential to mitigate the occurrence of uncollected BPJS files resulting from administrative and medical factors.

It is recommended that hospitals use a postponed review process in order to mitigate the occurrence of future pending claims. Evaluation is a quantitative assessment that compares the degree of achievement with predetermined objectives. According to Syafrudin (2009), the primary objective of assessment in management is to assess the effectiveness of implemented initiatives. Periodic evaluations are necessary and should not be limited to instances where issues arise with the application. Furthermore, it is imperative to include the BPJS conformance certificate in the assessment process in order to minimize the occurrence of uncollected BPJS files resulting from coding errors.

The findings of the study revealed that the highest number of unresolved instances of erroneous diagnosis coding were observed in Block E, which pertains to endocrine, nutritional, and metabolic illnesses in the ICD-10 classification system, with a total of 8 cases. Additionally, Block O, which encompasses pregnancy, childbirth, and the postpartum period, exhibited 7 occurrences of wrong coding. The identification of the diabetes code in the International Classification of Diseases, Tenth Revision (ICD-10) should be conducted in adherence to the relevant regulations governing the use of ICD-10. The research findings indicate that there is an issue with the pending claim code E11, which is used for Non-insulin-dependent diabetic mellitus or type 2 diabetes mellitus. This issue arises due to a discrepancy between the code determination and the 4th character in the ICD-10 coding system. The code E11 should be associated with the fourth character within the ICD-10 volume 2 range of E10-E14, as specified in the table. Coders must ensure that, during the process of identifying the fourth subcharacter, they verify if type 2 diabetes exhibits problems in certain regions. In the event that the aforementioned condition is present, the programmer will select the fourth character that aligns with complications as a unified code regulation inside ICD-10 volume 2. In the absence of a specific code, the programmer may opt to utilize code E11.9 to represent type 2 diabetes in the absence of complications. According to Kasim and Erkadius (2014), it is imperative to commence the coding process with a comprehensive examination of the patient's medical data.

CONCLUSION

The study's findings indicate that the precision of diagnostic coding, which is based on the International Classification of Diseases, Tenth Revision (ICD-10), has a significant impact on the processing of pending BPJS claims at RSU. The subject of discussion is Aisyiyah Padang.

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