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Relationship between the Accuracy of Diagnosis and Action Codes with Pending BPJS Claims for Inpatients at Idaman Banjarbaru Hospital

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ABSTRACT

Background: Hospital claims are bills in the form of fees for services that have been provided to insurance participant patients, in this case BPJS Health. If the file verification process is not correct in its coding, it results in pending BPJS claims to health facilities. The purpose of this study was to determine the relationship between the accuracy of diagnosis and action codes with pending claims for inpatients at Idaman Banjarbaru Hospital.

Method: The research design used quantitative research methods with a cross-sectional approach using a checklist sheet instrument. The population amounted to 3,964 inpatient claim submission files from January to March 2024. The sample of this study amounted to 363 files with random sampling technique. Data analysis used univariate and bivariate analysis.

Results: The results of this study found that 69 (19%) claim files were pending and 294 (81%) were not pending, while the diagnosis and action codes were correct 344 (94%) and inappropriate 19 (8.3%). The Chi Square test analysis value with a p-value of 0.001 < α 0.05 means that there is a relationship between the accuracy of diagnosis and action codes with pending BPJS claims for inpatients at Idaman Banjarbaru Hospital.

Conclusion: Idaman General Hospital needs to hold socialization, evaluation meetings, training and making written SOPs with coding officers with doctors and BPJS verifiers so that there is no pending claim payment process by the JKN team.

Keywords*: Pending BPJS claim files; Inpatient; Hospital*

Introduction

According to Presidential Regulation No. 82 of 2018, it is explained that the Health Social Security Organizing Body, hereinafter referred to as BPJS Kesehatan, is a legal entity established to implement the Health Insurance program. Health Insurance is a guarantee in the form of health protection so that participants can obtain health maintenance benefits and protection in meeting basic health needs, provided to every individual who has paid the Health Insurance Contribution or whose Health Insurance Contribution is paid by the Central Government or Local Government. BPJS Kesehatan can develop a health service system. The provisions for health insurance financing are carried out based on Indonesian Case Base Groups (INA-CBGs), which serve as guidelines for claim submissions (Oktamianiza et al., 2019).

Hospital claims are bills that consist of costs for services provided to patients who are participants in insurance, in this case, BPJS Kesehatan (Artanto, 2016). In the claims process, a disease code is required to be inputted in order to determine the amount of costs that BPJS must pay to the healthcare facility. Hospitals are one of the healthcare facilities that must pay close attention to the accuracy of disease code assignment to support the JKN financing process, ensuring that the payments made correspond to the costs of the services and/or actions that have been provided. (Amanda & Sonia, 2023). The purpose of verifying this claim is to test the accuracy of the administrative accountability of the services provided by healthcare facilities and to ensure that they are utilized in the right amount, at the right time, and for the right target. In terms of claim verification, there are several possibilities, including claim returns (pending) and disputes regarding JKN claims (Wandra, 2023). Pending claims result in the amount paid by BPJS being smaller than the initial claim submission. This impacts the hospital's cash flow and creates issues with employee payroll, payment for specialist medical services, availability of medications, and maintenance of hospital facilities and medical equipment (Oktamianiza et al., 2019).

The causes of claim delays include issues related to the determination of the primary diagnosis and the completeness of the diagnosis writing, which in turn affects the accurate assignment of diagnosis codes (Oktamianiza et al., 2019). Diagnosis is the identification of a disease suffered by a patient or a condition that causes an individual to seek medical care. The coding stage of diagnosis in medical records must be carried out meticulously,

completely, and accurately (Reza, 2022 in Hapsari et al., 2024). This is because the accuracy of diagnosis coding significantly affects the amount of claims submitted by hospitals to BPJS Kesehatan (Ministry of Health, 2021 in (Hapsari et al., 2024). In the claims submission process, the rejection of documents by the verifier, which leads to pending claims, is one of the common obstacles that often occurs. The factors causing this are incorrect or insufficient coding, the absence of supporting medical examinations, and incomplete resumes (Hapsari et al., 2024).

The diagnosis code serves as the basis for determining BPJS claim rates, so the diagnosis code must be established accurately. Inaccurate diagnosis coding can lead to incorrect BPJS claim results, resulting in losses for both hospitals and BPJS. To ensure the accuracy of diagnosis codes, the coding process is carried out by professionals. In this case, the medical record keeper is responsible for coding diagnoses using ICD-10 (Maryati et al., 2023). Based on previous research conducted by Siswati and Pratami, it was mentioned that there are still many inaccuracies in diagnosis codes and procedures, amounting to 45.3%. As a result, claims rejected by BPJS reached 59.3%. The analysis results prove that the accuracy of diagnosis codes and procedures is related to claim approval. (Maryati et al., 2023). Based on the results of a preliminary study conducted through observation and interviews with one of the medical staff handling patient BPJS Health claim files at REGIONAL HOSPITAL Idaman Banjarbaru, it was found that in the implementation of JKN at REGIONAL HOSPITAL Idaman Banjarbaru, there were delays in the confirmation of JKN patient claims by the verifier. The delay in the BPJS inpatient claim files from September to November 2023 reached 7.71%, with 83 out of 3,226 submitted inpatient files being pending and returned by the BPJS verifier for corrections.

The pending claim is a suspension of payment, which means a delay in the payment of debts that are already due to prevent bankruptcy (Puspaningsih, 2022). The issue of pending claims will disrupt the hospital's cash flow because the payment process can only be carried out by BPJS Kesehatan. Pending claims must be resubmitted within a maximum period of 6 (six) months after the healthcare service has been provided. If there is no resubmission by the specified deadline, the pending claim cannot be submitted again and will be forfeited. This issue will also indirectly affect patient services related to the availability of medication and other operational costs of the hospital (Wandra, 2023).

Based on the background that has been presented, the researcher is interested in exploring further the "Relationship between the Accuracy of Diagnosis Codes and Actions with the Pending Claims of BPJS Inpatients at REGIONAL HOSPITAL Idaman Banjarbaru."

Method

This research design uses a quantitative approach with a cross-sectional method. The research population consists of 3,964 inpatient claim submission files from January to March 2024, with a random sampling technique applied to 363 claim files from BPJS Kesehatan inpatient patients submitted by REGIONAL HOSPITAL Idaman Banjarbaru during the same period. The data analysis used in this study is univariate analysis and bivariate analysis using a checklist research instrument.

Results

Table 1. Distribution of Frequency based on Pending Claims Inpatients of Idaman Banjarbaru Hospital January-March 2024

Pending claim	**F**	**Percentage (%)**
Pending	69	19
Not pending	294	81
Total	**363**	**100**

Source: Primary Data, 2024

Based on Table 1 frequency distribution based on Pending Inpatient Claims of Idaman Banjarbaru Regional Hospital January-March 2024, it can be seen that the claim files of inpatients who experience pending claims at the Banjarbaru Idaman Regional Hospital are 19%. While the claim files of inpatients who did not experience pending claims were 81%.

Table 2. Frequency Distribution based on Accuracy of Diagnosis and Action Codes of Hospitalized Patients of Idaman Banjarbaru Hospital January-March 2024

Accuracy of Diagnosis and Action Codes	**F**	**Percentage (%)**
Correct	344	94,8
Inappropriate	19	5,2
Total	**363**	**100**

Source: Primary Data, 2024

Based on Table 2, the frequency distribution based on the accuracy of diagnosis and action codes for inpatients at the Banjarbaru Idaman Regional Hospital January-March 2024, it can be seen that there are fewer inappropriate claims, namely 19 claim files (5.2%) than correct claim files on BPJS Health claim files at the Banjarbaru Idaman Regional Hospital, which amounted to 344 claim files (94.8%).

Table 3. Relationship between the Accuracy of Diagnosis and Action Codes with Pending BPJS Health Claims for Inpatients of Idaman Banjarbaru Hospital January-March 2024

Accuracy of Diagnosis and Action Codes	Pending Claim						P
	Pending		Not Pending		Total		
	n	%	n	%	n	%	
Correct	57	16,6	287	83,4	344	100	<0,001**
Not correct	12	63,2	7	36,8	19	100	

Source: Primary Data, 2024

Table 3 shows 69 (19%) pending claims where the accuracy of diagnosis and action codes that are inappropriate is 12 (63.2%) and appropriate is 57 (16.6%). Claims that did not experience pending were 294 (81%), of which 7 (36.8%) were inappropriate with the accuracy of diagnosis and action codes being correct as many as 287 (83.4%). The results of the Statistical Test can be seen, the significance value is <0.001 <α0.05 where the value of Ho is rejected Ha is accepted, which means that there is a relationship between the accuracy of diagnosis and action codes with pending BPJS Health claims for inpatients at Idaman Banjarbaru Regional Hospital.

Discussion

It can be seen that the factors that affect the pending BPJS Health claims for inpatients at regional hospital Idaman Banjarbaru are caused by the incorrect accuracy of diagnosis and action codes so that confirmation is needed again by BPJS health for the accuracy of the code. In its implementation, coding officers need to continuously update their knowledge and skills in coding in accordance with the latest developments in the classification of diseases and medical actions. Evaluation of coding performance is very important to maintain the quality and accuracy of coding in hospitals.

According to Permenkes No. 27 of 2014, INA CBGs coding is the activity of providing main diagnosis and secondary diagnosis codes in accordance with ICD-10 and

providing procedure codes in accordance with ICD-9 CM. Medical personnel as coders are responsible for the accuracy of the code (Hendra et al., 2021). Coding as referred to in paragraph (1) letter a of the Regulation of the Minister of Health of the Republic of Indonesia Number 24 of 2022 concerning Medical Records, coding is an activity of providing clinical classification codes in accordance with the latest international classification of diseases and medical actions / International Statistical Classification of Disease and Related Health Problems, in accordance with statutory provisions. Coding must be done carefully and accurately so that payments using INA CBGs can be carried out appropriately, because the accuracy of the code determines the amount of fees paid to the hospital in the BPJS Health claim submission file for inpatients at regional hospital Idaman Banjarbaru. Accuracy and precision in the coding of medical diagnoses and procedures is very important because proper coding ensures that diagnoses and medical procedures performed are properly documented, which supports transparency in medical reporting and accountability of health services. Accurate codes determine the amount of fees that will be paid by BPJS Kesehatan to the hospital. Incorrect codes can result in claims being rejected, pending or payments that are not in accordance with the services provided.

The accuracy of diagnosis and action codes greatly affects the pending BPJS Health claims. This research is in line with research conducted by Sitorus et al (2023) at the Sultan Sulaiman Hospital in Serdang Bedagai that there is a relationship between the inaccuracy of diagnosis codes and pending claims caused by omit code mismatches, namely in claim files with a diagnosis of Pulmonary TB + COPD, the officer diagnoses the diagnosis code one by one (separately), namely A16.2 + J44.9. Meanwhile, based on the results of the analysis conducted by the claims officer, it turns out that it is not in accordance with the coding rules in ICD-10. The correct diagnosis code for the case is J44.0. This caused the inaccuracy of the diagnosis and action codes and eventually the claim was pending (Sitorus et al., 2023).

According to research by Ariqpurna Bayu Triatmaja et al (2022) coder officers at Haji Surabaya General Hospital had difficulty in coding patient diagnoses and actions. This is because the doctor's writing is difficult to read, and there are several abbreviations of medical terms that officers do not know. In improving the accuracy of diagnosis and action

codes, it is necessary to socialize so that doctors write the main diagnosis clearly, specifically and consistently and coder personnel are expected to be more careful in determining codes so as to produce quality coding and the need for clear and detailed SPOs on the coding process with ICD-10 and ICD-9 and the process of implementing BPJS claims (Triatmaja and Wijayanti, 2022).

The results of research also conducted by Kusumawati (2020) showed that the coding errors were due to the coder's lack of knowledge about the latest BPJS Health circular rules and rushed processing of claim files. In addition, coders are also not fully familiar with the merge code, which is a coding rule that must be used if the coder finds two certain diagnoses suffered by a patient but by rule must be one integrated code (Kusumawati, 2020). This merge code is still often coded by coders into two separate codes, resulting in errors that cause pending claims. This coding process error is related to the merge code because the coder only reads ICD 10 volume 3.6 while the explanation of this merge code is contained in ICD 10 volume 1.7. This is in line with Salma Firyal Nabila's research (2020) that regulations related to coding in BPJS often change, this requires a coder officer to always keep up with existing changes. However, the distribution of information is not evenly obtained by coders so that the knowledge of coding officers is uneven, which is due to the absence of special meetings to discuss the latest information updates attended by all coding officers at Dr. Cipto Mangunkusumo Hospital because time has been consumed to complete their respective work, even though this knowledge is closely related to the common perception shared by all coder officers in coding a disease or action (Nabila, 2020). Idaman Banjarbaru regioal hospital has been very good in the process of submitting claims, but it needs to continue to optimize services so that inpatient claim files no longer experience pending claims on BPJS Health payments. Therefore, it is necessary to hold regular meetings as a performance evaluation between the hospital and the BPJS Health in coding issues, because the common perception between coders can determine the smoothness of goals in dealing with pending claims problems. The more effective the communication, the more effective the work produced.

Conclusion

Based on the statistical test, the p value is 0.001 < α 0.05, it can be seen that H0 is rejected and Ha is accepted, which means that there is a relationship between the accuracy of diagnosis and action codes with pending BPJS claims for inpatients at Idaman Banjarbaru Hospital. Idaman Banjarbaru regional hospital needs to hold an association meeting at least once a month between coding officers with doctors and BPJS verifiers in order to equalize opinions related to diagnosis and action codes as well as training related to ICD 10 and ICD-CM 9 guidelines as a determinant of diagnosis codes related to diseases claimed by BPJS. This needs to be done so that there is no more inaccuracy of diagnosis and action codes on BPJS claims so that no more inpatient claim files will be pending.

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