# ANALYSIS OF PENDING CLAIMS DUE TO INCOMPATIBILITY OF DIAGNOSTIC AND ACTION CODES IN INPATIENTS IN HOSPITALS

**Puguh Ika Listyorini[1], Nadia Arifah Ramadhan[2]**
Faculty of Health Sciences, Duta Bangsa University [1,2]
Email: puguh_ika@udb.ac.id[1], rifahnadia28@gmail.com[2]

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**ABSTRACT**

*This research was conducted at UNS Sukoharjo Hospital. Based on the preliminary study, it was found that 19.5% of the claims filed were pending in inpatient claims and 31% were due to coding cases. This study was conducted to determine pending claims due to coding discrepancies in hospitalized National Health Insurance patients.*

*This is a case study research type with a qualitative research design. Data were taken by observation and interviews with the head of the medical record installation room, coding officer, head of the guarantee installation room, and the verifier of the Health Insurance Administration. The data collected, presented descriptively, and analyzed using content analysis techniques.*

*The results showed that the coding of claim files had been carried out according to hospital standards. Submission of the claim file is carried out after verification by the internal verifier. The pending claim occurs due to a mismatch in coding caused by the need for a join code, an error in determining the main diagnosis, the need for confirmation of the action code, and the need for confirmation of supporting reports. Other influencing factors are support from colleagues, technology support, limited knowledge, and lack of staff training, as well as system changes and problematic servers both from hospitals and from Health Insurance Providers.*

*The conclusion is that there are still pending claims caused by coding cases, so it is better for officers to take coding training*

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| | *and perform server maintenance..* |
| KEYWORDS | National Health Insurance, pending claims, coding discrepancies |
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## INTRODUCTION

The government strives for a quality health service program by enacting Law No. 40 of 2004 concerning the National Social Security System. One of the social security programs is the Health Insurance Program.

Through Law Number 24 of 2011 concerning Health Insurance Providers, the government stipulates that the Health Insurance Provider is an agency that has the task of administering the National Health Insurance program. Hospitals as Advanced Referral Health Facilities will receive payments from patients participating in the National Health Insurance based on INA-CBGs rates paid through HIP. In inputting data both diagnosis and procedure into the INA-CBGs system, accuracy in coding is an important factor.

It is known through previous research (Sari: 2020), the majority of hospitals (approximately 65%) in Indonesia have not provided coding or lack the accuracy of a precise, clear, and complete diagnosis code based on the ICD. This is influenced by many factors, some of which are according to the literature, namely the lack of clarity in the notes provided by doctors, clarity and completeness of medical record documents, and length of work/experience/education/training of a coder.

The level of accuracy of the code is also very influential on the smooth process of filing a claim for reimbursement of health services costs to the Health Insurance Provider. In practice, many HIP claims are returned or pending status by HIP due to the lack of complete information and inaccurate coding.

Based on preliminary observations made by the author at the Sebelas Maret University Hospital, Sukoharjo, the average data obtained from outpatient Health Insurance Providers per month is 6870 patients and National Health Insurance patients are inpatient per month 363 patients with the calculation of pending claims for HIP verification for outpatients of 5.7% and hospitalization by 19.5%. With pending claims for care that occurs in the coding aspect, it reaches 31%. Therefore, it is necessary to conduct an analysis to find out what affects pending claims due to coding discrepancies. The results of the analysis can be used in policy making to deal with pending claims mainly due to coding discrepancies

## RESEARCH METHOD

his type of research is classified as case study research. Case study research is an activity that seeks to explore a problem with detailed boundaries, in-depth data collection techniques, and includes various sources of information (Saryono and Anggraeni, 2013). The research method used is qualitative.

The subjects in this study were the head of the medical record room, the coding officer, and the verifier. The head of the guarantee installation room is a resource for

triangulation. As for the object of research, namely the file for filing claims, minutes of verification of the results of the Health Insurance Administration, and standard operating procedures for hospitals.

The method used in this research data collection, namely by observation and interviews. Then, for data processing carried out, namely collecting, editing, and presenting data by conducting content analysis

## RESULT AND DISCUSSION

**Encoding of Inpatient National Health Insurance Patient Claim Files**

Sebelas Maret University Hospital Sukoharjo in carrying out the coding for filing claims for patients with National Health Insurance is done electronically with the application owned by the hospital, namely "PILAR". In coding, there are files that need to be checked, namely: patient's medical resume, supporting examination report, treatment/therapy, and Minutes of Agreement with Advanced Referral Health Facilities issued by the Health Insurance Provider.

The coder officer at the medical record installation coded the diagnosis on the patient's medical resume and on the "PILAR" application. The coding takes into account the results of the diagnosis written by the doctor, the supporting examinations the patient undergoes, and the operation report (if undergoing surgery)/Integrated Patient Progress Record.

The following is the coding activity carried out by the coder at the medical record installation which is inputted directly into "PILAR":

1. Prepare a complete medical record document.
2. Open “PILLAR”.
3. Go to "Menu" then "Registration, Billing and Billing, Service & Patient Billing" select "Inpatient Room" for inpatient and select "Registration" for outpatient.
4. Enter the patient's medical record number.
5. Right-click on the mouse, then select the “Patient Diagnosis” item.
6. Enter the diagnosis code according to the diagnosis in the patient's medical record document.
7. Enter the action code according to the action recorded in the patient's medical record document.
8. Select the “Save” menu

Sebelas Maret University Hospital, Sukoharjo, in coding for the submission of patient claims for the National Health Insurance has been done electronically. This is supported by the PILAR application system which has been integrated with the E-Claim application.

At the guarantee installation, the coding for claim submission is done completely electronically. In accordance with the procedures established by the Director of the hospital. The following are the coding activities as well as data entry in the INA-CBGs/E-Claim application:

1. Request a medical record document that has been completely filled in and has been coded by the coder from the medical record installation.
2. Perform data entry on the application, by filling in the data including:
   a. Fill in the Patient Eligibility Letter number.
   b. Check the date of initial examination of the patient until the patient goes home.
   c. Enter the name of the Doctor in Charge of the Patient who treats the patient during treatment.
   d. In the method of discharge column, select the method of discharge based on the patient's condition.
   e. Enter the cost rate in the hospital rate column based on billing.
   f. Entering the diagnosis and action based on the medical resume written by the Doctor in Charge of the Patient. In addition, in the diagnosis code, it is necessary to check special notes both on the ICD and the Minutes of Agreement with Advanced Referral Health Facilities.
   g. Click save, do grouper then click final.
   h. Print the patient's individual output.

According to Santoso (2014: 24), Standard Operating Procedures are a collection of writings according to specific specific steps, which explain every detail of activities to complete tasks in accordance with company regulations, health, education, aviation, industry, military, or others. even running a small business. This is supported more specifically by Naga (2012) who describes a sequence of actions from analyzing medical record documents to coding.

The implementation of the coding procedure both at the medical record installation and at the guarantee installation at the Sebelas Maret University Hospital Sukoharjo is in accordance with the theory presented. The implementation of the coding procedure has been stated in the Standard Operating Procedure and the officer has carried it out by referring to the Standard Operating Procedure.

**Ubmission of Inpatient Patient Claims by the Hospital**
**Internal Verification**

Verification activities at the Sebelas Maret University Hospital Sukoharjo were carried out by officers in the guarantee room. There are 3 (three) people who are responsible for claims of inpatient National Health Insurance patients, namely 1 (one) person with a bachelor's background in Nursing and 2 (two) people with a doctor background. The implementation of submitting claims for National Health Insurance patients begins with a request for files needed at the medical record installation until the submission of files to the Health Insurance Provider, the collection of which is in the form of softfiles and hardfiles. The following is the flow regarding the verification of file claims for the National Health Insurance patient claim:

1. Verify the completeness of the medical resume and its supporting examination data.
2. Verify the suitability of the diagnostic and treatment coding.
3. Verifying the suitability of the billing data with the disease and the actions taken on the patient.
4. Scan the files related to the submission.

5. Make adjustments or corrections to claims that are not in accordance with the services obtained by patients with evidence of services submitted to the Health Insurance Provider.

According to the results of research by Lewiani, et al (2017:1-16) verification of claim files is part of administrative verification, which includes Participant Eligibility Letters and proof of service that includes diagnoses and procedures as well as the signature of the doctor in charge. This is directly proportional to Indawati, et al (2018), which stated several things in conducting verification, including the claim file to be verified and the claim administration verification stage. Verified claim files for inpatient claim submission, namely hospitalization warrant, Participant Eligibility Letter, and medical resume. For the verification stage, namely verification of claims administration, verification of service administration and verification of services.

The implementation of the verification of the claim file for the National Health Insurance patient at the Sebelas Maret University Hospital is in accordance with the theory presented. The suitability is in the form of verification of both the completeness of the files and the suitability of the diagnostic and action codes.

**Submission of Inpatient Patient Claims**

Sebelas Maret University Hospital Sukoharjo in activities for filing claims for National Health Insurance patients is carried out by the hospital with the patient's consent. Sending files is done online and offline. So that the files submitted are also in the form of softfiles and hardfiles. Online submissions are verified using the V-claim application. As for offline submissions, it is done by sending a hard file to the Health Insurance Provider's office.

In Iskandar's research (2016: 8) states that in filing a claim online using the Vclaim application is an application that is used to make Patient Eligibility Letters, send txt data files to external verifiers, and make referral Patient Eligibility Letters. In line with this statement, Indawati et al (2018) it is written that the sending of data and claim files is in txt form.

In the activity of filing claims for inpatient National Health Insurance patients at Sebelas Maret University Hospital, Sukoharjo, it is in accordance with the statement above. Where to send files online in txt file format and sent via the Vclaim application.

**Causes of Return of Claim Files from Health Insurance Provider Verification Results**

After verification by the hospital (internal verification) the file is submitted to the Health Insurance Provider for further processing and claiming. After being received by the Health Insurance Provider, the file submitted by the hospital is verified by the Health Insurance Provider (external verification). It turned out that after external verification, there were files that were considered incomplete, so the files were returned to the hospital. This returned file is called a pending claim.

Based on the results of observations, the causes of pending claims caused by the coding case are:

1. Diagnostics that should receive a join code.
2. Too many diagnostic codes so that there are errors in determining the main diagnosis.

3. Action code requested for confirmation.
4. Supporting reports that are requested to be confirmed because they affect the code of action.

Indawati (2019: 105-119) in her research mentions the causes of returning inpatient claims related to coding accuracy, namely the lack of supporting examinations to support the diagnosis of inaccuracy in coding, and incompatibility with rules and consensus. The results of Indawati's research strengthen Bowman's theory (1992, in Bustomi: 2017), which states about the factors that cause coding errors, namely: (1) failure to review all records; (2) incorrect selection of the primary diagnosis; (3) wrong code selection; (4) coding the wrong diagnosis or procedure due to the contents of the record; and (5) an error in entering the code into the database or on the invoice.

The results of the author's research regarding the causes of returning inpatient claim files as a result of the verification of the Health Insurance Provider for coding cases are in accordance with several factors presented in theory. From the results of Indawati's research, the inaccuracies in determining the code and supporting examinations are not appropriate. Meanwhile, Bowman's theory (1992, in Bustomi: 2017) is in full accordance with the results of the author's research.

**Supporting and Inhibiting Factors of Verification Implementation**

Based on the results of interviews that the author conducted with the inpatient verifier and the head of the guarantee installation room at the Sebelas Maret University Hospital, Sukoharjo, there were several factors supporting officers in conducting verification as follows:

1. There is the use of technology in the form of the internet to support filling out E-Claims and sending online submission files as well as hospital management information system which is integrated with E-Claims.
2. There is cooperation from roommates, where they provide information and share their knowledge about coding, especially if there are pending claims caused by coding.

According to Rohman & Hariyono (in Budiarti & Iskandar, 2021) stated that training and work motivation are problems that can cause problems with incomplete codes in hospitals which reflect how hospitals manage patient data appropriately, quickly, and accurately. The results of Indawati's research (2016) describe more broadly the supporting factors of the coder in coding, namely: (1) support from the head of the medical record; (2) support from hospital management for training opportunities; (3) information technology in the form of the internet. Meanwhile, the inhibiting factors are: (1) limited knowledge of disease science, terminology, and pharmacology; (2) there are differences in the concept of determining the diagnosis between doctors and verifiers of Health Insurance Providers; (3) Number of cases to be coded

Based on the theory of Rohman & Hariyono (in Budiarti & Iskandar, 2021) and the theory of Indawati (2016) in their research, the supporting and inhibiting factors of the verifier at the Sebelas Maret University Hospital are appropriate. Conformity with the theory lies in training factors that affect performance, support from management/coworkers, support in the form of access to technology in the form of the internet

## CONCLUSION

Sebelas Maret University Hospital Sukoharjo in carrying out the coding has been in accordance with the established Standard Operating Procedures. In addition, the coding performed by the medical record installation takes into account medical records and doctor's actions, as well as supporting reports and operating reports (if any). This is the same as coding at the guarantee installation which is carried out for input at INA-BGs, but the officers also pay attention to the Minutes of Agreement with Advanced Referral Health Facilities that have been issued by the Health Insurance Provider and the applicable law.

Implementation of verification of claim submission files at Sebelas Maret University Hospital Sukoharjo, namely: (1) verifying data; (2) verify the diagnosis and treatment coding; (3) verifying the billing data with the disease and the actions performed on the patient; (4) scan the files related to the submission; (5) make adjustments or corrections to claims that are not in accordance with the service.

The implementation of the submission of the claim file for the National Health Insurance patient which was carried out at the Sebelas Maret University Hospital, Sukoharjo, was carried out online and offline. submit claims online using the E-claim application and submit claims offline, namely by sending the hardfile file directly.

The reason for the return of the claim file is due to the coding of the verification results of the Health Insurance Provider, namely: the existence of arrangements regarding the joining code, requests for confirmation of the action code, and requests for confirmation of supporting reports that affect the action code.

In carrying out their duties, verification officers are influenced by supporting and inhibiting factors. Supporting factors in carrying out their duties, namely the cooperation of colleagues and support from the hospital in the form of technology and the existence of standard operating procedures. As for the inhibiting factors, namely the lack of knowledge and training activities that have not been supported, as well as system changes and problematic servers both from the hospital and from the Health Insurance Provider.

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