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Review Of The Causes Of Inpatient Dispute Claim At RSUD Prof. Dr. Margono Soekarjo Purwokerto

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Abstract

Dispute claims are caused by 3 things, namely administration, coding, and medical. At RSUD Prof. Dr. Margono Soekarjo Purwokerto in 2020 there were inpatient claim dispute files of 3.6% and in 2021 there were inpatient claim dispute files of 7.4%. The purpose of this study was to identify the causes of inpatient claim dispute at RSUD Prof. Dr. Margono Soekarjo Purwokerto. This type of research is quantitative with a cross-sectional approach. The research sample was 50 inpatient claim dispute files for the period January-July 2022. Data processing techniques using collecting, editing, entry, cleaning, tabulating, presenting data. The results showed that the percentage of coding disputes related to the suitability of diagnosis and procedure codes using ICD 10 and ICD 9 CM was 52%, related to diagnoses or procedures that should be coded in combination, but coded separately by 18%, related to diagnoses or procedures that should not be entered by 18%, and related to the determination of the main diagnosis by 14%. Medical disputes related to the appropriateness of medical actions amounted to 32%, related to the appropriateness of medical treatment with diagnosis codes amounted to 2%, and related to the appropriateness of supporting examination results with diagnosis codes amounted to 2%. Administrative disputes related to the appropriateness of the results of supporting examinations / actions amounted to 4%, related to the SEP was 2% inappropriate, and 2% there was no SEP KLL.

Keywords : Claims, dispute, BPJS Health

INTRODUCTION

The national social security system as described in Law No. 40/2004 has the aim of making the community obtain protection and guarantees to meet basic health-related needs. The national health insurance program officially began operating to meet the health needs of the community on January 1, 2014. This program is intended for people who have paid health insurance contributions or whose contributions have been paid by the central government or local government. Health services in the JKN program held in hospitals are carried out with the INA-CBGs payment system where payments are paid based on a codification system of diagnoses and actions grouped by severity. (Supriadi, Rosania, 2019).

The hospital financing system uses INA-CBGs claims that will get reimbursement of claim costs from BPJS Kesehatan. The process of submitting hospital claims to BPJS Health has verification stages, namely file completeness, membership administration, service administration and health services which have the aim of maintaining service quality and cost efficiency of health services for BPJS Health. (Irmawati, Marsum, Monalisa, 2019).

Presidential Regulation of the Republic of Indonesia Number 82 of 2018 concerning Health Insurance The submission of claims by health facilities to BPJS is given no later than 6 months after the health service is completed. If the claim exceeds this time, the claim cannot be

resubmitted. The verification process of the completeness of the submitted claim file is the task of the BPJS Health verifier. If there are discrepancies in the claim file in the verification process, the claim file will be returned by BPJS Kesehatan. The *output of* the BPJS Health verification results consists of 3 types, namely appropriate claims, inappropriate claims, and dispute claims. (Eliyah, Ratriana, 2022)

According to Permenkes RI Number 26 of 2021 concerning Guidelines for *Indonesian Case Base Groups* (INA-CBG) in the Implementation of Health Insurance, there are many problems in the field between BPJS Kesehatan and FKRTL, especially regarding coding. There are many problems in the field between BPJS Kesehatan and FKRTL, especially regarding coding. This results in *dispute* and pending claims so that payment of claims from BPJS Kesehatan to health facilities is delayed. *Dispute* claims, namely the non-approval of payment of health service claims by the BPJS Health due to a disagreement between the BPJS Health and the health service facility. The existence of a claim *dispute has a* huge impact on the performance of officers because the workload on submitting claims has increased. The existence of *dispute* claims has a big role in hospital income. Most *dispute* claims are caused by 3 things, namely administration, coding, medical. The accuracy of coding diagnoses and actions for submission of claims greatly affects the eligibility of the claims submitted. (Yastori, 2022).

The results of research by Irmawati, Marsum, Monalisa (2019), show that the cause of *dispute* mostly occurs because the hospital diagnosis code in the main diagnosis code or secondary diagnosis code is not equipped with supporting examination data which has a percentage of 79.10% or 53 cases. Most of the first group conditions occurred in the case of the *case-mix main groups* classification group code A in code A01.0 and in the *case-mix main groups* classification group code J in code J18.0. Based on this data, it can be concluded that coding mismatches have an impact on hospital income, namely on the amount of INACBGs rates that will be paid by BPJS to hospitals.

Regional General RSUD Prof. Dr. Margono Soekarjo Purwokerto is a class B Education Hospital owned by the Central Java Provincial Government. The number of human resources in the medical records section of RSUD Prof. Dr. Margono Soekarjo Purwokerto is 50 people, with a division of 9 people in the EDP (*Entry Data Processing*) section, 2 people in the TPPRI section, 8 people in the archive section, 8 people in the TPPGD section, 5 people in the TPPRJ section, 18 people in the coder section and 2 medical record officers have received *casemix* training.

Based on the results of a preliminary study conducted by the author in December 2022 at RSUD Prof. Dr. Margono Soekarjo Purwokerto by conducting observations and interviews with internal verifiers of medical records, it was found that in 2020 the return of claim files was 3,728 with 135 *dispute* files or 3.6%. Meanwhile, in 2021, the return of claim files was 2,225 with the number of *dispute* files increasing from 2020, namely 166 or 7.4%. Based on this description, the authors are interested in conducting research with the title "Review of the Causes of Inpatient Claim *Dispute* at RSUD Prof. Dr. Margono Soekarjo purwokerto"

METHODS

This study uses a type of quantitative research with a *cross-sectional* approach. In using this *crosssectional* approach, researchers will identify four variables, namely administration, coding, medical and *dispute*. The sample of this study used total sampling, namely all inpatient claim *dispute* files at RSUD Prof. Dr. Margono Soekarjo Purwokerto in the January-July period

as many as 50 documents. Data analysis in this study was carried out descriptively on the results of the completeness *checklist* sheet and the suitability of inpatient claim *dispute* files at RSUD Prof. Dr. Margono Soekarjo Purwokerto so as to get the results of the description of the causes of inpatient claim *dispute* at RSUD Prof. Dr. Margono Soekarjo Purwokerto from administrative, coding, and medical aspects.

RESULTS AND DISCUSSION

Inpatient Claim *Dispute* File at RSUD Prof. Dr. Margono Soekarjo Purwokerto

Research on BPJS Health claim files at the RSUD Prof. Dr. Margono Soekarjo Purwokerto for inpatients for the period January-July 2022 consisted of 50 files declared dispute by the BPJS Health with the number of dispute from each month, namely in January as many as 5 files (2.3%), February as many as 8 files (5.1%), March as many as 11 files (6.3%), April as many as 10 files (2.6%), May as many as 5 files (2.6%), June as many as 9 files (5.6%), July as many as 2 files (1.5%).

Causes of Inpatient Claim *Dispute* at RSUD Prof. Dr. Margono Soekarjo Purwokerto Based on Administrative Aspects

Dispute claims based on administrative aspects are disagreements between BPJS Kesehatan and health facilities over incomplete claim submission files. The results of research on inpatient claim dispute files in terms of administrative aspects, which consist of inpatient online SEP, online referral letter or original control letter, drug card, and photocopy of supporting examination results / actions. The results are as follows:

Table 1 *Frequency Distribution of Inpatient Claim Dispute Based on Administrative Aspects at RSUD Prof. Dr. Margono Soekarjo*

No	Administrative Verification Aspects	Claim Dispute File						Total	
		There is				None			
		Suitable		Not suitable					
		F	%	F	%	F	%	F	%
1	SEP	48	96	1	2	1	2	50	100
2	Referral Letter/Control Letter	50	100	0	0	0	0	50	100
3	Medicine Card	50	100	0	0	0	0	50	100
4	Result of supporting examination/treatment	48	96	2	4	0	0	50	100

Source : Primary Data

Based on table 4.2, it can be seen that the completeness and suitability of referral letters / control letters and drug cards from the January-July 2022 claim dispute files are 100% complete and appropriate, while there are 1 file (2%) that is not suitable, 1 file (2%) does not have SEP KLL, and for the results of supporting examinations / actions there are 2 files (4%) that are not suitable. In the period January-July 2022 there were 4 files that were declared administrative dispute.

In the SEP category, there were 2 cases with details of the minutes from BPJS Health, 1 case due to the absence of SEP KLL and 1 case because the Jasa Raharja ceiling was not optimal.

In the case of incomplete SEP KLL, the hospital has not received a police report related to the patient's accident so that the officer has not been able to add a police report number to make SEP KLL. From this case, if there is no SEP KLL, it will affect the claim submitted to BPJS Health. In accordance with Indonesian Presidential Regulation Number 82 of 2018 concerning Health Insurance, it states that BPJS Health coordinates with PT Jasa Raharja (Persero) for the traffic accident insurance program so that police reports will be an absolute requirement for single accident or multiple accident guarantees. Meanwhile, in the case of a less than maximum Jasa Raharja ceiling, it is because the patient still has a remaining balance of Jasa Raharja but the patient is treated at another health facility as well but does not report the remaining balance of Jasa Raharja so the hospital does not know the patient's remaining Jasa Raharja. This causes the amount of the Raharja Services claim to not be determined and adjusted to the amount of the BPJS Health claim so that the officer cannot maximally make the Raharja Services guarantee.

In the category of incomplete results of supporting examinations / actions, there were 2 cases with details of the minutes from BPJS Health, namely 1 case due to incomplete evidence of procedure 36.07 (Insertion of drug-eluting coronary artery stent(s)) and 1 case due to incomplete supporting data for code I49.3 (Ventricular premature depolarization). In the case of inappropriate supporting data for code I49.3 (Ventricular premature depolarization), the hospital considers the supporting data for the code to already exist with the ECG results reading VPD / VES. The results of supporting examinations and actions are authentic evidence that is used as supporting data in submitting BPJS Health claims, if there is no supporting examination data, according to the provisions of the technical instructions for verification of claims in 2014 which explain that at the claim verification stage there needs to be supporting evidence in the form of supporting examination results or actions, then claims cannot be paid until all requirements are met. In the absence of supporting examination results / actions, it cannot be the supporting data for ICD 10 and ICD 9 CM codes submitted to BPJS Health.

Causes of Inpatient Claim Dispute at RSUD Prof. Dr. Margono Soekarjo Purwokerto Based on Coding Aspect

Dispute claims based on coding aspects are disagreements between BPJS Health and health facilities related to INA CBGs coding rules according to applicable regulations. The results of research on inpatient claim dispute files in terms of coding aspects are carried out by looking at the suitability and accuracy of coding diagnoses and actions based on ICD 10 and ICD 9 CM. The results are as follows:

Table 2 *Frequency Distribution of Inpatient Claim Dispute Based on Coding Aspect at RSUD Prof. Dr. Margono Soekarjo*

No	Coding Aspect	Claim Dispute File				Total	
		Suitable		Not suitable			
		F	%	F	%	F	%
1	Appropriateness of diagnosis and procedure codes using ICD 10 and ICD 9 CM	24	48	26	52	50	100

2	Appropriateness of diagnosis and procedure codes using ICD 10 and ICD 9 CM	41	82	9	18	50	100
3	Diagnoses or procedures that should not have been entered	41	82	9	18	50	100
4	Determination of the main diagnosis	43	86	7	14	50	100

Source: Primary Data

Based on table 4.3, it can be seen that in the category of suitability of diagnosis and procedure codes using ICD 10 and ICD 9 CM as many as 26 files (52%) are not appropriate, the category of diagnoses or procedures that should be coded in combination, but coded separately as many as 9 files (18%) are not appropriate, the category of diagnoses or procedures that should not be entered as many as 9 files (18%) are not appropriate, and the category of determining the main diagnosis as many as 7 files (14%) are not appropriate. In the period January-July 2022 there were 49 files that were declared coding dispute.

One case related to the suitability of diagnosis and procedure codes using ICD 10 and ICD 9 CM based on BPJS Health minutes is code 54.0 (Incision of abdominal wall) should be coded 54.91 (Percutaneous abdominal drainage). Based on the operation report, the drainage incision on the abdominal skin does not open the abdominal wall. Patients with hepatic abscess infiltration of the abdominal wall performed abscess potential to cause cardiac arrest and is managed in accordance with cardiac arrest management.

One case related to the determination of the main diagnosis based on the BPJS Health minutes, namely I21.4 (Acute subendocardial myocardial infarction) is used as the main diagnosis because it is an acute phase but the hospital makes the code a secondary diagnosis code while the main code is I25.1 (Atherosclerotic Heart Disease). The hospital still maintains code I25.1 (Atherosclerotic Heart Disease) as the main diagnosis because the patient entered with IHD (Ischemic Heart Disease) and a history of NSTEMI (Non-ST-segment Elevation Myocardial Infarction) code I21.4 then performed CAG (coronary angiography) with the results of I25.1 (Atherosclerotic Heart Disease). Hospitals use the main diagnosis I25.1 (Atherosclerotic Heart Disease) because there are the most resources for code I25.1 (Atherosclerotic Heart Disease). This is related to the use of morbidity coding rule MB1 which explains that minor conditions are recorded as the main diagnosis, while more significant conditions are recorded as secondary diagnoses. When minor or long-standing conditions or incidental problems are recorded as the primary diagnosis, conditions that are more significant, relevant to the treatment and/or procedures provided and/or specialty of care are recorded as secondary diagnoses.

Causes of Inpatient Claim Dispute at RDUD Prof. Dr. Margono Soekarjo Purwokerto Based on Medical Aspects

Dispute claims based on medical aspects are disagreements between BPJS Kesehatan and health facilities regarding medical management/services that are not in accordance with applicable regulations (Syafitri, Novita, 2021). The results of research on inpatient claim dispute files in terms of medical aspects are carried out by looking at the suitability of medical management with diagnoses and the suitability of the results of supporting examinations and actions. The results are as follows:

Table 3 *Frequency Distribution of Inpatient Claim Dispute Based on Medical Aspects at RSUD Prof. Dr. Margono Soekarjo*

No	Medical Aspects	**Claim** Dispute **File**				**Total**	
		Suitable		**Not Suitable**			
		F	**%**	**F**	**%**	**F**	**%**
1	Appropriateness of Medical Treatment with Diagnosis Code	49	98	1	2	50	100
2	Conformity of Supporting Examination Results with Diagnosis Codes	49	98	1	2	50	100
3	Appropriateness of Medical Actions	34	68	16	32	50	100

Source: Primary Data

Based on table 4.4, it can be seen that in the category of suitability of medical management with the diagnosis code, 1 file (2%) is not suitable, the category of suitability of supporting examination results with the diagnosis code is 1 file (2%) is not suitable, and the category of suitability of medical action is 16 files (32%) not suitable. In the period January-July 2022 there were 18 files declared medical dispute.

In the case of discrepancies in medical management with the diagnosis code, namely BPJS Health requested code T23.3 (Burn of third degree of wrist and hand) to L92.9 (Granulomatous disorder of skin and subcutaneous tissue, unspecified) because the current treatment of vulnus granulosum is not a burn but the hospital still persists with the burn code because burn treatment is carried out graft and debridement. When viewed from the patient's medical record, the case is a control patient post debridement of subacute phase burns manus dextra-sinistra with amputation. In the results of the operation report, the diagnosis given by the doctor is vulnus granulosum 3rd degree burns (T23.9) with debridement (86.22) and skin graft reconstruction (86.6). In this case there was a disagreement with the use of the ICD 10 code due to differences in perceptions between BPJS health and hospitals from the results of medical management and patient surgery reports.

In the case of a mismatch between the results of the supporting examination and the diagnosis code, namely BPJS Health requests the main diagnosis code to use Z51.1 (Chemotherapy session for neoplasm) because the hb lab results are 6.5 but not transfused directly and scheduled for hospitalization for chemotherapy. Meanwhile, the hospital gave the main diagnosis to the patient C26.9 (Malignant neoplasm of ill-defined sites within the digestive system) and secondary diagnosis D63.0 (Anemia in neoplastic disease) because the patient entered with hb <8 (improvement of KU) for anemia first instead of entering with a chemotherapy program. When viewed from the initial assessment, the patient came from the oncology surgery clinic with anemia and on day 5 of treatment chemotherapy was carried out. Based on Permenkes Number 26 of 2021, it explains related to chemotherapy coding which states that patients who come to outpatient or inpatient care and get chemotherapy injection, then use code Z51.1 (Chemotherapy session for neoplasm) as the main diagnosis and neoplasmas code as a secondary diagnosis.

One of the cases related to the suitability of medical actions is the disagreement of the ORIF (Open
Reduction Internal Fixation) facial bone procedure (code 76.76) which is billed with reconstruction of facial bones (code 76.43). In this case there is a difference in perception between the hospital and the BPJS Health. The hospital coded the procedure with the reconstruction action code on the facial bone because in the operation report the action performed was mandibular

reconstruction. But the BPJS Health does not agree with the code and considers the code that should be used is ORIF (Open Reduction Internal Fixation) of facial bones (code 76.76). The BPJS thinks that facial reconstruction must have bone cutting and graft installation, but according to the hospital in the PPK (Clinical Practice Guidelines) oral surgery facial bone reconstruction does not have to be done.

In the case of dispute claims 2022, no cases have been resolved. Claim dispute cases at RSUD Prof. Dr. Margono Soekarjo Purwokerto will be resolved with the BPJS by triangulating data through Focus Group Discusion (FGD) to find solutions to existing perceptual differences and the BPJS Health can pay claims to hospitals based on the conclusion of the claim dispute settlement. Claim disputes have a long settlement process that has an impact on hospital opinions being delayed and even hospital revenues can decrease if the conclusion of the claim dispute resolution does not match the claim submitted by the hospital.

CONCLUSIONS

Based on the results and discussion of the research "Review of the Causes of Inpatient Claim Dispute at RSUD Prof. Dr. Margono Soekarjo Purwokerto", the following conclusions can be drawn:

a. The causes of inpatient claim dispute at RSUD Prof. Dr. Margono Soekarjo Purwokerto based on administrative aspects, namely there are 2 files (4%) related to the completeness and suitability of supporting examination results / actions, 1 file (2%) that does not have SEP KLL and 1 file (2%) SEP KLL is not appropriate.
b. The causes of inpatient claim dispute at RSUD Prof. Dr. Margono Soekarjo Purwokerto Hospital based on the coding aspect were mostly related to the suitability of diagnosis and procedure codes using ICD 10 and ICD 9 CM as many as 26 files (52%) were not appropriate, then for the category of diagnoses or procedures that should be coded in combination, but coded separately and the category of diagnoses or procedures that should not be entered had the same percentage of 9 files (18%) were not appropriate, while the category of determining the main diagnosis was 7 files (14%). Dispute based on coding was the biggest cause in the January-July period of 2022.
c. The cause of the dispute over inpatient claims at RSUD Prof. Dr. Margono Soekarjo Purwokerto, based on the most medical aspects, is related to the category of suitability of medical treatment, 16 files (32%) are not suitable, while the category of suitability of medical management with the diagnosis code and the category of suitability of supporting examination results with the diagnosis code have the same percentage, namely 1 file (2%) is not appropriate. In the cause of the dispute based on this medical aspect, there are differences in perceptions from the hospital and BPJS Health regarding the medical management of patients regarding the diagnosis given to the patient, supporting examinations, and also related to medical procedures.

SUGGESTION

Here are some suggestions for further research:

1. Conduct qualitative research to understand the perspectives and experiences of various parties involved in the health insurance claims process, including the Regional Hospital,

BPJS Health, and patients. This can help identify subjective factors that may influence claims disputes.

2. Compare inpatient claims management practices in Indonesia with other countries that have similar health insurance systems. This can provide insight into best practices that can be adopted or adapted in the Indonesian context.

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