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Overview of the Causes of BPJS Health Pending Claims Due to Inaccuracy of Diagnosis Codes in Sebelas Maret University (UNS) Hospital

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Abstract. In submitting a BPJS Health claim, not all submitted documents can be claimed. Claim status is declared ineligible or pending. A pending claim occurs if the claim file submitted by the hospital is incomplete or does not comply with the requirements set by BPJS Health. Delayed claims can disrupt hospital cash flow and cause losses for the hospital and BPJS Health participants. This research aims to describe the causes of pending claims at UNS Hospital. This research is a quantitative descriptive study with a population of 182 inpatients pending claim documents at UNS Hospital for the period August-October 2023. The sample for this research is 78 pending claim documents based on diagnosis code verification. The sampling technique is total sampling. Based on the data obtained, the number of documents with coding confirmation is 78 pending claim documents s or 11.3% of the total pending claims in the period August – October 2023. This data shows that the majority of pending claim documents are due to inaccurate diagnosis. The factor causing pending claims from BPJS Health inpatients at UNS Hospital occurs due to differences in perception between hospital staff and BPJS Health and is not purely due to coder error, but due to a lack of supporting data as a diagnosis enforcer which affects the accuracy of the code.
Keywords :Pending Claim, BPJS Health, Diagnosis Code

I. BACKGROUND

The National Social Security System (SJSN) is the framework for the implementation of social security programs by the Social Security Administration Agency (BPJS) for Health and Employment. The National Health Insurance Program (JKN) is a part of the SJSN, managed by BPJS Health through a mandatory health insurance mechanism [1].The JKN program was implemented in Indonesia in early 2014, referring to the Regulation of the Minister of Health (PMK) No. 28 of 2014.The implementation of the JKN program in hospitals restricts healthcare services to patients who require specialist or subspecialist care [2]. Therefore, specialized management within hospitals for the implementation of the JKN program is essential [3]. Hospitals are one of the healthcare facilities that serve as providers in the JKN program [4]. Hospitals that participate as providers in the JKN program collaborate with BPJS Health, allowing them to submit claims that are later reimbursed by BPJS Health [5]. BPJS Health claims are the collective process of submitting treatment costs for BPJS Health participants by hospitals to BPJS Health monthly. These claims are a crucial part of the JKN program's implementation [6].

In the process of submitting BPJS Health claims, not all submitted documents are approved. The final outcome of a claim submission is either a 'claim approved' status or a 'claim denied' status. A claim is deemed denied (pending claim) if the submitted documents are incomplete or do not meet the requirements set by BPJS Health (Practical Guide for BPJS Health Facility Claim Administration). Pending claims can disrupt the hospital's cash flow and result in losses for both the hospital and BPJS Health participants [7].Sebelas Maret University Hospital (UNS) is a Technical Implementation Unit of Sebelas Maret University (UNS) that supports the Rector's duties in healthcare services. UNS Hospital serves as an integrated center for education, research, and healthcare services in the fields of medical education, dentistry, continuing education, and other health education in a multiprofessional context. UNS Hospital is classified as a Type C hospital based on the Decree of the Head of the Sukoharjo District Health Office No. 445/8426/VI/2016 dated June 28, 2016.Based on a preliminary study conducted at UNS Hospital, it was found that there were 183 pending claims out of a total of 2,297 inpatient claim submissions for the JKN program from August to October 2023. Pending claims can be attributed to several factors, including administrative, medical, and coding issues [8]. Coding problems are still found in patient document where the assignment of diagnosis or procedure codes is incorrect, which is one of the causes of pending claims. Previous research on the causes of pending claims in Sebelas Maret University Hospital (UNS) has not been conducted, which prompted the researcher to undertake further study with the title 'Overview of the Causes of BPJS Health Pending Claims Due to Inaccurate Diagnosis Codes in Sebelas Maret University (UNS) Hospital.

II. METHOD

This research design is a quantitative descriptive study with an observational approach. The population in this study consists of pending inpatient claim documents for the JKN Program in UNS Hospital from August to October 2023, totaling 182 pending claim documents. The sample focuses on all pending claim documents due to errors in diagnosis coding, which amounts to 78 pending claim documents. The sampling technique used is total sampling.

III. RESULTS AND DISCUSSION

UNS Hospital collaborates with five insurance companies, including the Social Security Administration Body (BPJS), BPJS Employment, Taspen, Jasa Raharja, Mandiri In Health, as well as accepting general payment methods. The registration staff at UNS Hospital processes patient registrations through the hospital's Hospital Information System (SIMRS), specifically using the PILAR Registration module.The management of clinical data in the process of cost reimbursement and claim management, particularly with insurance companies such as BPJS Health, currently uses a prospective payment method, specifically the Casemix or Indonesian Case Base Groups (INA-CBGs) system. Prospective payment is a method where the payment amount for healthcare services is determined in advance before the services are provided.

In UNS Hospital, the claims submission process is handled by the Assurance Unit. This unit has distinct duties and authority from the Medical Records Unit, as all insurance claim management is the responsibility of the Assurance Unit. Under the prospective payment system using Casemix for claims submission, payments made by JKN follow the payment packages according to the Indonesian Case Base Groups (INA-CBGs). Additionally, the use of Casemix can serve as a reference for hospitals in evaluating the various services provided to patients.

Flow of Inpatient BPJS Health Claim Submission in UNS Hospital

Based on the findings, the flow of inpatient BPJS Health claims in UNS Hospital is as follows:You can then proceed to outline the specific steps or stages involved in the claim submission process. If you have detailed steps or a flowchart, you can list or describe them here.

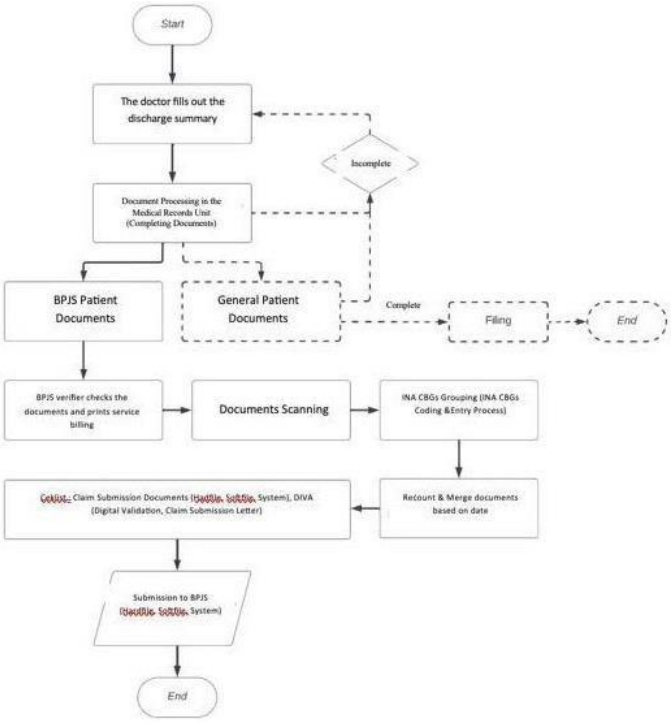

Figure 1. Flow of Inpatient Claim Submission in Sebelas Maret University Hospital

1. After the treatment is completed and the patient is discharged with the doctor's approval, the doctor fills out the diagnosis and procedures on the Discharge Summary form.
2. The documents are sent from the clinic to the Medical Records Unit for assembling.
3. Once the documents are assembled, they are sent to the Assurance Unit for the document scanning process.
4. The Assurance Unit staff then perform Coding & Grouping for INA-CBGs in the UNS Hospital Information System (SIMRS), specifically using the PILAR Assembling module, which is bridged with the E-Claim system.
5. Finally, the admin conducts a final check and tally of the claim submission documents, ensuring that the number of hard copy documents, soft copy documents, and the data submitted in the system are accurate and match.
6. Before sending, the Assurance Unit staff performs Digital Validation (DIVA) and prepares the Claim Submission Letter.
7. Once the documents are complete and compliant, and the DIVA status is null, the hard copy and soft copy of the claim submission are sent to the BPJS Health office in Surakarta.

Quarterly Data of BPJS Health Claim Submissions in UNS Hospital

Following the research, data on BPJS claims in UNS Hospital for the period of August to October was obtained. During the reporting period, the hospital submitted BPJS Health claims as follows: August: 12,788 claims, September: 12,435 claims, October: 13,057 claims The following is the data on BPJS claim submissions in UNS Hospital for the period of August to October:

Table 1. Quarterly Data of BPJS Health Claim Submission in UNS Hospital

Month	Claim Submission		Quantity
	Outpatient	Inpatient	
August	12.048	740	12.788
September	11.658	777	12.435
October	12.277	780	13.057
Total	**35.983**	**2.297**	**38.280**

Based on Table 1. Quarterly Data of BPJS Health Claim Submissions in UNS Hospital, the data shows a 5% increase in the number of submissions in October compared to September. This increase may reflect several factors, such as a rise in the number of patients using BPJS, an improvement in the quality of hospital services, or increased public awareness of the importance of health insurance.

Table 2. Quarterly Data of BPJS Health Pending Claims UNS Hospital

Month	*Pending Claim*		Quantity
	Outpatient	Inpatient	
August	628	64	692
September	884	68	952
October	785	50	835
Total	**2.297**	**182**	**2.479**

Based on Table 2, from the number of claims submitted during the period from August to October, the data shows pending claims as follows: 692 pending claims in August, 952 in September, and 835 in October. There was a 12% decrease in the number of pending claims in October compared to September during the August-October period.

Discussion

Sebelas Maret University Hospital uses a prospective payment system. This system involves claims that will receive reimbursement from the patient's insurance [9]. According to Minister of Health Regulation (PMK) No. 3 of 2023 on Health Service Tariff Standards in the Administration of the Health Insurance Program, a claim is a request for compensation for services provided, with an amount agreed upon in the contract. The contract refers to the agreement made by the parties involved in the cooperation contract established from the beginning [10]. Several factors affect claim document returns, one of which is related to the management of clinical data obtained from diagnoses and procedures [11].Coding links clinical diagnoses and procedures with the grouper codes in the INA-CBGs application. Based on these codes, the claim amount is determined. The medical information in the medical summary assists coders in accurately coding diagnoses according to ICD-10, in accordance with Minister of Health Regulation No. 26 of 2021 on Guidelines for Indonesian Case Base Groups (INA-CBG) in the Implementation of National Health Insurance [12].

The accuracy of diagnosis codes significantly affects the quality of health cost payments under the case-mix system (PMK 26 of 2021). Catharina's (2020) study indicates that the determination of codes greatly impacts the grouper results in the INA-CBG application, which in turn affects the claim amount the hospital will receive. Therefore, the coding of diagnoses and procedures must comply with BPJS Health regulations [13].Diagnosis and procedure factors in payment or claim procedures greatly influence the quality of health cost payments under the case-mix system. Coding of diagnoses and procedures is crucial as it determines tariffs based on ICD-10 guidelines for diagnosis [11]. This is in line with BPJS Health's guidelines, which state that verifiers must ensure the diagnosis on the invoice matches the ICD-10 and ICD-9 codes. The documentation must be complete and specific, supported by evidence proving the patient has the diagnosis. Errors in diagnosis coding can affect the claim tariff submitted by the hospital to the insurance company. According to field practice information, there are additional items outside the INA-CBGs health service package (LUPIS) that hospitals can claim from BPJS Health, including blood bags, medical equipment (such as respiratory aids, walking aids, arm slings, neck collars), referral ambulances, and medication for chronic diseases claimed through the online pharmacist system.

A decrease in the number of pending claims can indicate several factors, including:

1. Improved Claim Processing Efficiency: If the claim process becomes more efficient, such as through better data quality or enhanced verifier performance, the number of pending claims may decrease [5].
2. Enhanced Quality of Claim Documents: Complete and accurate claim documents can reduce the number of pending claims. An improvement in the quality of claim documents could result in a decrease in pending claims [5].

However, it is important to remember that a decrease in pending claims may not always indicate improvement. For example, if the decrease is due to a reduction in the number of claims submitted, it might reflect other issues, such as decreased utilization of health services. Therefore, it is crucial to conduct a thorough analysis to understand the underlying causes of changes in the number of pending claims [5].

Issues

Based on observations of pending BPJS Health claims for inpatient services from August to October 2023 in UNS Hospital, there are four types of claim statuses resulting from document verification:

1. Eligible Claim
   This means the claim has been received and processed by the claims system and meets the requirements set by BPJS Health.
2. Ineligible Claim
   This means the claim has been verified but does not meet the applicable administrative/service requirements and therefore cannot be paid.
3. Pending
   This indicates that the claim payment is delayed because the documents submitted by the hospital are incomplete or do not meet the requirements.

4. Dispute

   This means the claim cannot be approved yet due to disagreements or differences in views or assessments between the hospital and BPJS Health regarding the services or clinical actions provided. This type of claim must be resolved by the relevant parties, including provincial or regional authorities, professional organizations, and the Claims Dispute Resolution Team in their respective areas.

Based on the research conducted in UNS Hospital, there is an issue related to the submission of BPJS Health insurance claim documents, showing a 26.5% decrease in the number of documents returned with a pending status from the previous month. This indicates an improvement or increase in the quality of the submitted claim documents.

Table 3. Data of Inpatient Pending Claims for August-October 2023 in UNS Hospital

Month	Number of Submission	Claim Return Satus		
		Eligible	Pending	Dispute
August	740	676	64	0
September	777	709	68	0
October	780	730	50	0
Total	**2.297**	**2115**	**182**	**0**

As shown in Table 3, in August, out of 740 claims submitted, 64 claims experienced pending status. In September, out of 777 claims submitted, 68 claims were pending. This indicates a 5.9% increase in pending claims in September compared to August. In October, 50 out of 780 claims experienced pending status, reflecting a 26.5% decrease in pending claims from September. This suggests an improvement in the quality of the submitted claim documents.This study was conducted in the Claim Assurance Unit of UNS Hospital for approximately one month, observing and analyzing pending claims based on their causes. The aspects causing pending claims can be related to (1) Administration, (2) Diagnosis Codes (Coding), and (3) Supporting Medical Documentation. The results of the study can be seen in Table 4 below:

Table 4. Number of Inpatient Pending Claims Based on Verification Aspects

Verification Aspects	Month			Quantity	%
	August	September	October		
Administration	23	17	22	62	9
Diagnosis Code (Coding)	**27**	**31**	**20**	**78**	**11.3**
Medical Support	14	20	8	42	6.1
Total	**64**	**68**	**50**	**182**	**26.4**

According to Table 4, the causes of pending claims returned to the Claim Assurance Unit in UNS Hospital are categorized into three groups: administration, incorrect diagnosis codes, and incomplete medical resumes or other supporting documentation. These issues are attributed to differences in perception between hospital staff and BPJS Health. Therefore, a thorough verification system before submission to BPJS Health is crucial to prevent pending claims.Out of all the pending claim documents, the data were categorized based on the cause of the pending status, as noted in the return verification column. After sorting 182 pending claim documents by their causes, it was found that 62 were due to administrative issues, 78 due to incorrect diagnosis code confirmation, and 42 due to supporting documentation. The data shows that 78 claims, or 11.3% of the total pending claims from August to October 2023, were pending due to coding issues. This indicates that the most common reason for pending claims is inaccuracies in diagnosis codes. Therefore, this study focuses on the issue of pending claims resulting from incorrect diagnosis codes.

Causes of the Problem

Regarding the implementation of the JKN policy at UNS Hospital Surakarta, issues persist, particularly with pending claims due to errors in patient diagnosis coding. These errors can occur for several reasons that affect Medical Recorders in determining the correct diagnosis codes. In line with the research by Pratama et al. (2023), the factors leading to pending claims are not solely due to coder errors but also due to insufficient supporting data for diagnosis validation, which affects the accuracy of the codes [14].One of the competencies of Medical Recorders and Health Information Specialists (PMIK) is to perform coding or codification of diagnoses and procedures written by the attending physician. Medical Recorders use ICD-10 for diagnosis and ICD-9-CM for procedures. This task is crucial, especially in the context of JKN and the INA-CBG's System, where the accuracy of diagnosis and procedure coding significantly impacts the grouper results in the INA-CBG's application. Another factor contributing to the return of documents to the hospital for confirmation is the precision of the coder and grouper in the coding process and data entry into the INA-CBG's system. From the analysis, the accuracy of diagnosis codes from the returned inpatient claims data is detailed in the following table:

Table 5. Inpatient *Pending Claim* Based on Diagnosis Code Aspects

No.	Result	Quantity	%
1	Accurate	52	67
2	**Inaccurate**	**26**	**33**
	Total	**78**	**100**

Based on Table 5, the analysis of returned BPJS inpatient claims in UNS Hospital shows that out of 78 returned documents, 67% were correctly coded by the coder, while 33% were inaccurately coded. From this data, several factors influencing the inaccuracies in coding can be identified. The factors affecting the accuracy of coding include:

1. Lack of Supporting Data for Diagnosis

   One factor hindering the BPJS claim verification process in UNS Hospital is the incomplete medical record data needed by coders. Missing data includes physical examination results and supporting test results relevant to the diagnosis. This results in questioning the already determined diagnosis code because the diagnosis is not supported by valid data. Consequently, coders may inaccurately determine the appropriate diagnosis code according to ICD-10. Claims with incomplete supporting examination data or missing examination data will be delayed and returned to the hospital for clarification. BPJS Kesehatan also has the right to request confirmation of the diagnosis if there is anything inconsistent with the applicable regulations. For instance, in the cases found in the study, there were returns due to the confirmation of Gastritis diagnosis following endoscopy examination. The lack of information required by coders for diagnosis validation led to less specificity in diagnosis determination. This is in line with the Joint Agreement on INA-CBG Claim Management Guidelines of 2019.

   Another example found in pending claim data involves inaccurate coding by coders due to non-specific diagnosis written by doctors on the medical summary sheet. For example, chronic kidney disease (CKD) should be coded specifically from CKD Stage I to V based on the Glomerular Filtration Rate (GFR) from urea creatinine test results. According to Permenkes No. 24 of 2022 on medical records, data in medical records must be created by the doctor or other health professionals providing direct patient care, as doctors have the obligation, rights, and responsibilities to determine the diagnosis and services provided, and thus, should not be altered by others [15]. The quality of codes produced by coders is largely determined by the basic data written and determined by the responsible medical personnel [6].Research by Hartantri and Suryani (2024) indicates that one obstacle leading to inaccuracies in diagnosis coding is largely due to incomplete physical examination and supporting test results in the medical summary [16]. Similarly, Zalukhu et al. (2024) found that factors causing pending claims in RSUD Kembangan included insufficient supporting medical documents, which involved clarification related to inpatient diagnosis from radiology doctors [17].

2. Coder Accuracy in Assigning Diagnosis Codes

Another reason for returning documents to the hospital for confirmation is the accuracy of coders in the coding process. According to research by Kusumawati & Pujiyanto in 2020, coding errors occur due to a lack of coder knowledge about the recenct regulations in the Joint Agreement on INA-CBG Claim Management Guidelines Edition 2 of 2023. For instance, the diagnosis code for renal hypertension with renal failure should be a combination of I12 or I13. Upon analysis of the medical records, it was found that the diagnosis written in the medical summary was Acute Kidney Injury (AKI), for which the code was already correct. According to ICD-10 coding rules, there is no combined code for I10 with N17.9. Therefore, the code assigned by the coder was accurate. Based on the guidelines, diagnoses that can be combined with renal hypertension include Chronic Kidney Disease (CKD), according to ICD-10 rules which state that the includes clause for renal hypertension in ICD-10 codes can be combined with any condition in N18.-, N19.-, or N26.- with any condition in I10. However, AKI cannot be combined with renal hypertension because code N17.9 is not included in the ICD-10 includes clause. Research by Sulastri and Sugiarsi (2024) supports this, indicating that inaccuracies in diagnosis and procedure codes are caused by coders incorrectly assigning codes, lack of attention by coders when reviewing medical records, and the coder's insufficient diligence in assigning combined diagnosis codes [18].

Problem Resolution

Based on the issues described in the previous section, strategies are needed through the analysis of factors causing pending claims in the medical record unit as follows:

1. Enhance Cooperation and Communication Between Coders, Doctors, and BPJS Verifiers

Cooperation and communication between coders, doctors, and BPJS Health verifiers are crucial in the process of coding diagnoses and procedures using ICD-10 and ICD-9 CM classifications. Effective cooperation and communication can minimize coding errors, reduce pending claims, and improve healthcare service quality. According to the journal titled "The Impact of Coder Competence on Accuracy and Precision of Coding Using ICD-10 at Hospital 'X' Pekanbaru in 2016," cooperation and communication between coders, doctors, and BPJS verifiers can improve coding accuracy and quality, leading to INA-CBGs codes that accurately reflect the healthcare services provided [19]. Additionally, cooperation and communication can reduce the risk of pending claims or fraud due to incorrect or incomplete coding. Methods to enhance cooperation and communication include:

a. Conducting Regular Meetings or Discussions: To address coding and claims issues and collaboratively find solutions.
b. Creating Clear and Detailed SOPs: Regarding the coding and claims process and disseminating them to all relevant parties.
c. Implementing Routine and Objective Monitoring and Evaluation: Of coder, doctor, and BPJS verifier performance, with appropriate rewards or penalties.

2. Issuing Circulars or Official Memos

To address recurring issues related to the first factor, the casemix team from the Claim Assurance Unit proposes the creation of official memos or circulars. These documents are issued from the claims assurance unit through the Medical Records Installation, reviewed by the service department, and approved by the director before being provided to the authorized healthcare providers responsible for entering diagnoses into patient medical records. Recurring cases of pending claims, including supporting evidence for diagnoses like renal failure and creatinine tests, often require more specific coding such as N18.1-N18.5 based on Glomerular Filtration Rate (GFR) as listed in ICD-10. Coders will first cross-check supporting documents to ensure more specific diagnoses by the recenct regulations outlined in the Joint Agreement on INA-CBG Claim Management Guidelines of 2019 and the recenct Edition 2 of 2023.

3. Enhancing Staff Knowledge and Skills

Improving staff knowledge and skills is a crucial process in any organization or institution. This involves a series of training, seminars, and workshops designed to broaden staff understanding of their tasks and responsibilities. Enhanced knowledge can include a better understanding of updated procedures, new technologies, or current policies. Skill improvement may involve developing technical, management, or communication skills. The primary goal is to ensure that staff have all the tools and resources they need to perform their tasks effectively and efficiently. This also helps to increase productivity, improve service quality, and foster professional growth and development. Additionally, it contributes to job satisfaction and employee retention. Overall, enhancing staff knowledge and skills is a valuable investment that can yield

long-term benefits for both the organization and the individuals involved. According to Hapsari (2024), training is needed for coders on ICD-10 and ICD-9 standards and implementation as guidelines for diagnosis coding, as well as training on the recenct developments in diagnosis coding related to BPJS Health claims, which will improve coders' ability to accurately determine diagnosis codes [20]

IV. CONCLUSIONS AND SUGGESTIONS

Conclusion

Based on the research results and discussions conducted, it can be concluded that the administration of BPJS Health claims procedures for inpatient services in UNS Hospital is functioning effectively and by established procedures. This is evidenced by a 26.5% reduction in pending claims from August to October 2023. The causes of pending claims for BPJS Health inpatient services in UNS Hospital are due to differences in perception between hospital staff and BPJS Health, rather than purely coding errors. Instead, the issue arises from a lack of supporting data for diagnosis verification, which affects the accuracy of coding.

Suggestions

To address issues causing BPJS Health claims to be pending, the hospital can take several steps, including:

1. Ensure Completeness of Claim Documents: Verify that the submitted claims are complete and meet the requirements set by BPJS Health. Incomplete claim documents can lead to claim rejection or payment delays. Required documents include claim forms, medical summaries, supporting examination results, referral letters, medical certificates, statements, and others.
2. Conduct Regular Meetings: Hold periodic meetings or discussions to address coding and claims issues and to collaboratively find solutions for recurring pending claims.
3. Disseminate the Recenct Regulations: Communicate the recenct rules outlined in the Joint Agreement on the Management and Resolution of INA-CBG Claims Issues Edition 2 Year 2023, as well as circulars or official notes, to units involved in claim assurance, particularly for BPJS Health claims.

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