THE QUALITY CONTROL OF INA-CBG'S CODING AS A CAUSE OF NEGATIVE CLAIM AT BAGAS WARAS KLATEN HOSPITAL

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Abstract

The pattern of payment that is applied by *Jaminan Kesehatan Nasional* (JKN) in advanced health facilities (hospitals) is a prospective payment pattern. Prospective Payment pattern known as casemix is a grouping diagnoses and procedures with reference to clinical characteristics which is similar and resource used or maintenance cost is similar. The grouping is done by software groupers. Bagas Waras hospital in making diagnosis grouping sometimes experiences the negative difference (loss) between the real cost of hospital fees in accordance with the Indonesia Case Based Group (INA CBGs) cost package approved by Badan Penyelenggara Jaminan Sosial (BPJS).This study is to determine the cause of the change file BPJS claims that the negative consequences of coding problems after quality control of INA-CBGs coding in Bagas Waras hospital Klaten. This study was a qualitative research design action (Action Research). This study used a model of action research (Action Research) of S Kemmis and R McTaggart which is designed through two cycles of the procedure: (1) planning , (2) action (3) observation, (4) reflection in each cycle. The research instrument used a questionnaire. Analysis of the data used qualitative analysis and quantitative analysis.The results showed that the frequency of claims BPJS start of the cycle I, II and III, there was a decreasing in the proportion of the, it is due to an error coding, Leght Of Stay (LOS) extends, the cost of medical action that is excessive, and Excess Cost investigations. In improving the ability of diagnosis coding, Bagas Waras hospital continuously strives to improve their ability to apply the Hospital Information System (SIRS). The cause of negative claim in a file BPJS after INA-CBGs control coding in Bagas Waras hospital is the employees do not understand the overall coding system, and do not run the monitoring and evaluation system of coding.

Keyword : Negative Claim of BPJS, Coding INA CBG's

INTRODUCTION

Current development demands to change the mindset of the nation around the world including Indonesia, from traditional mindset to the modern one in any sectors, including health sector. World Health Organization (WHO) has gathered several countries to reach Universal Health Coverage (UHC) in 2014. According to Law No. 40 year 2004 about *Sistem Jaminan Sosial Nasional* (SJSN) in Indonesia, everyone has accessibility to the comprehensive and good quality health services to ensure their lives. Payment method used by JKN (National Health Insurance) in the advanced health facility (hospital) is prospective payments method. Prospective payment method was well known as Casemix which is diagnosis and procedure grouping refers to the similar clinical features and use resource or similar nursing cost. This grouping has done by using software grouper. Now Casemix system is commonly used as the basic health payment system in several nations. In China, they have started using Casemix system since 2009. A research in Xianmen, China, has proved that Casemix system is more precise in estimating financial, so it helps the management to control the hospital's cost.[1] Sometimes, when grouping the diagnosis in RSUD Bagas Waras, they find

negative difference (loss) between the real hospital cost to the INA-CBGs package cost approved by BPJS. It is caused by several problems which lead to negative difference (loss). A best way to control coding quality is needed to do by RSUD Bagas Waras. By knowing the INA-CBGs coding quality control, it can decrease BPJS negative claims that made by coding problems. So, the researchers are interested to conduct a research about coding INA-CBGs quality control in Bagas Waras HospitalKlaten.

RESEARCH METHODS

This research used qualitative and quantitative research (mix method) with action research design (Action Reseach).[2] The research used Action Research model from S Kemmis and R McTaggart which was designed through two cycles with procedure: (1) planning, (2) action implementation, (3) observation, (4) reflection in each cycle. The four components could be described as follows[3] ; the main subjects of the study were the coding officers who numbered 4 (four) people. While the supporting subjects were Director, Chairman of Medical Committee, Head of Medical Record Installation, Chairman of Nursing Committee, internal verifier, and SIMRS management officer located in Bagas Waras HospitalKlaten District. The research object was the claims file BPJS in August 2016 until January 2017 which had the difference negative. The research respondents were Director, Medical Committee Chairman, Head of Medical Record Installation, coding officer, Internal Verifier, Head of Nursing Committee, and SIMRS management officer located in Bagas Waras HospitalKlaten District. No sampling was done because the entire population became the object of research. Inclusion Criteria: Medical Record of BPJS patients December 2015-January 2017, Exclusion Criteria: Damaged Medical Record. Based on the existing concept framework, the variables that studied were the Negative BPJS Claim File, Quality Control of INA-CBGs Coding, Standard Operating Procedure, and the Cause of BPJS Negative Claims. The data used qualitative analysis and quantitative analysis.

RESULTS

Prior to the intervention, the researchers had made observations on the negative difference of BPJS claims in August before applying the Standard Operating Procedure (SOP) in Medical Record Installation. The results showed that the frequency of BPJS claim before the intervention which the total was 370 claims, obtained the following results; valued equal to the real cost of the hospital amounted to 15 claims or 4.1%, which was positive amounted to 208 or 56.2%, while the negative value amounted to 147 or 39.7%. From the 147 claims, caused by mistakes in coding amounting to 70 claims or 48%, due to Length Of Stay (LOS) amounted to 32 or 22%, due to excessive medical treatment costs amounted to 25 or 17%, while those were due to Overage Investigation fees amounted to 20 or 14%.

In Cycle I, the researchers conducted intervention by applying Standard Operating Procedure (SOP) Coding of Disease and Action in Medical Record Installation. After the implementation of SOP Coding of Disease and Action in September, the researchers conducted observations to the coding officers regarding the application of SOP Coding of Disease and Action. In October, the researchers analyzed BPJS Claim of September 2016 approved by BPJS. From the observation result, it was found that the frequency of Claim BPJS after Intervention amounting to 419 claims, which was equal to the real cost of the hospital amounted to 15 claims or 3.6%, which was positive value of 217 or 51.8%, while the negative value amounted to 187 or 44.6%. 187 claims, caused by the problem of coding error amounted to 50 claims or 27%, caused by Long Of Stay (LOS) amounted to 82 or 44%, caused by excessive medical treatment costs amounted to 30 or 16%, moderate due to Excess Cost Investigations amounted to 25 or 13%. After Intervention with SOP implementation, it had increased the proportion of claims with negative difference from 39.7% to 44.6%, but the cause of negative claims difference from coding error decreased from 48% to 27%. To find out the cause of coding error on the negative difference claim, the researchers conducted interviews to all officers Coding of Disease and Action in

Medical Record Installation to determine the possibility of the proportion of the increase in negative claims increased. The researcher asked a question like how was the officer's knowledge about the importance of SOP, how was the officer's understanding of the SOP steps, and how did the compliance officer implement SOP. From the interview result, only 1 informant had understood the importance of SOP Coding of Disease and Action / Coding, while 3 other informants did not really comprehend the importance of SOP Coding of Disease and Action / Coding. Based on the results of subsequent interviews that there had been no agreement and standardization of SOP from management, so the researcher concluded that the unresolved factor of the management in standardizing a Standard Operational Procedure rules resulted in the implementation of SOP had not significantly affected the results. Then the researchers also asked about the understanding of SOP steps, it was known that all informants still did not understand and had not been able to explain the steps of SOP Coding of disease and action, although it had been socialized and given notes. The final question of the researcher was whether they had implemented the SOP for the disease and the action correctly. All informants did not always implement SOP of disease and action based on the steps in the SOP that had been made. Several informants mentioned that the officers were too busy with the number of work they must be done, therefore the situation made the officers had not implemented SOP. Workloads performed by officers were to carrying out disease and action coding and also performed other medical record work due to limited personnel in the installation of medical records. After the intervention with the preparation of SOP coding of disease and action, the obtained results were they still had low knowledge and compliance officers in implementing the SOP.

In the second cycle, the researchers conducted training on coding for coding officers at RSUD Bagas Waras. The training was conducted for 4 coding officers. Here were the interview results after the coding training; the training was conducted in October 2016. Then, after observation in November 2016, the researchers conducted an assessment of the proportion of BPJS claims in November that was the negative difference. The implementation of reflecting conducted in December 2016 showed the frequency of claims BPJS in cycle II total amounted to 379 claims, results of value equal to the real cost of the hospital amounted to 0 claims or 0%, which was positive value amounted to 176 or 46.44%, while the value Negative amounted to 203 or 53.56%.

After intervention with training, it increased the claims of negative difference, from 44.63% in September to 46.44% in November, but the cause of claims was not only from the problem of coding but also caused by some other things. It showed the frequency of claim BPJS negative difference in cycle II totaling 203 claims, caused by coding error problems amounted to 5 claims or 2.46%, caused by Length of Stay (LOS) amounted to 70 or 34.48%, caused by the cost of action medical amount of 88 or 43.34%, while due to excess of investigation cost amounted to 40 or 19,70%. From the data mentioned above, it could be seen that the cause of negative claims derived from the problem of coding error decreased from 27% in claims of September to 2.46% in November 2016 claims. To determine the cause of the coding error on claims negative difference, the researchers conducted interviews to all the coding officers at Medical Record Installation to find out the possibility of why the proportion of negative claims became even greater. From the results of interviews, most of the (3) informants basically knew clearly about the importance of SOP Coding of Disease and Action, while the other informant (1) did not yet fully understand about the importance of SOP. From the results of interviews, all informants said there was agreement and standardization of SOP but there was no supervision of the implementation. Therefore, the researchers concluded that the lack of monitoring the implementation of management enforcement implementation Standard Operational Procedures resulting in the implementation of the use of SOP had not impacted the real results. Then, the researchers also asked about the understanding of SOP steps. Based on the interviews, it was known that all informants had understood and able to

explain the steps of SOP Coding of disease and action. The final question of the researcher was whether they had performed the SOP for the disease and the actions correctly and could explain why. From the interview result, it showed that 2 informants had done SOP Coding of disease and action according to step in SOP which had been made, but 2 informants mentioned that the number of work that must be done by officers made them not yet implement the SOP.

In the third cycle, the researchers undertook the improvement or rearrangement of SOP for disease and action in December 2016 by adding one step that involved internal verifier and Quality Control Team and Cost Control Hospital which was formed in January 2017. After that, the researchers did observation of SOP coding which was new in January 2017. After the observation, the researchers conducted interviews with informants.

In addition, to conduct a new SOP interview, the researcher assessed the proportion of BPJS claims in January that the negative difference. The implementation of reflecting is on February 6, 2017 because the claim approved by BPJS was received by the hospital on February 3, 2017. The reflecting on the proportion of claim negative difference was as follows the frequency of Claim BPJS in Cycle III. Total claims of BPJS amounted to 372 claims, obtained results of value equal to the real cost of the hospital amounted to 8 claims or 2.15%, which had a positive value of 156 or 41.93%, while the negative value amounted to 208 or 55.91%. After the intervention by fixing the SOP was actually increased the proportion of claims that the negative difference, from 46.44% in November to 55.91% in January 2017, but the cause of claims was not only from the problem of coding but caused by some other things. BPJS claims that the negative difference in Cycle III totaled 208 claims, the results obtained due to problems of coding error amounted to 2 claims or 0.96%, caused by Length Of Stay (LOS) amounted to 56 or 26.92%, which was due to The cost of excessive medical treatment amounted to 90 or 43.26%, was due to excessive investigation fees amounted to 60 or 28.84%. From the above data, it could be

seen that the cause of the negative difference claims derived from coding error problems decreased from 2.46% in November claims to 0.96%% in Claim January 2017. To find out the cause of coding error in negative claims, the researchers conducted interviews to all officers coding of disease and action in Medical Record Installation to determine the possibility of why the proportion of negative claims even became larger. The questions asked by the researcher were how the officer's knowledge about the importance of SOP, how the officers' understandings of SOP steps were, and how did the officers implement SOP. From the results of the interviews, it showed that all informants who basically knew clearly about the importance of SOP Coding of Disease and Action / Coding.

From the interviews, all informants said that there were agreement and standardization of SOP and there was a supervision of the implementation. Therefore, the researchers concluded that the enforcement of the Standard Operational Procedure implementation rules had been done, although it had not significantly affected the result to decrease the number of negative difference claims but it had the real impact on the decrease of coding problem causing the claim Negative difference. Then, the researchers also asked about the understanding of SOP steps. From the results of the interview, it showed that all informants had understood and were able to explain the steps of SOP Coding of disease and action. The final question of the researchers was whether they had performed the SOP of the disease and action correctly, and they could explain why. From 3 informants had done SOP Coding of disease and action according to steps in SOP which had been made but still there was 1 informant mentioned the amount of works that must be executed made the officer did not yet implement SOP. The works that should be done by the officers, to carry out disease and action coding, also their duties to perform the other medical record work due to limited personnel in the installation of medical records.

DISCUSSION

Bagas Waras Hospitalwas a Regional Device Work Unit (SKPD) led by

the director as stated in Perda Klaten Regency No. 10 of 2014. One of the goals that was established by the Regional General Hospital of Bagas Waras Klaten Regency was to facilitate public access to get health services. Therefore, in giving the best service, Bagas Waras Hospitalprioritized the interests of the patients. In accordance with the purpose, vision and mission of the hospital, the director was required to further improve the performance of the hospital from the standpoint of HR management, clinical management. and financial management. One of the challenges to be faced by the director was how could the hospital face the era of JKN that had been set by the central government, in which all hospitals in Indonesia were obliged to serve and should not reject JKN patients unless in the full condition. BPJS for health (*Badan Pengelenggara Jaminan Sosial Kesehatan*) was a state-owned enterprise specially assigned by the government to provide health care insurance for all Indonesian people. BPJS for health with the BPJS for employment (formerly *Jamsostek*) was a government program in the National Health Insurance unity (JKN) which was inaugurated on December 31, 2013.

On the other hand, the change in the way of financing should be followed by the changes in the thinking and behavior of the clinicians, i.e. from the fee for service payment to the package payment (INA CBGs). In the beginning, the hospitals in Indonesia were generally established with social objectives without considering the economic aspect. At that time, most of the hospitals received subsidies from the government as well as from religious social mission bodies which both of them were from the country as well as assistance from abroad. The social function was meant that a hospital must serve the patient on the basis of the medical needs and not on the patient's ability to pay. The economic function was meant that hospitals should think about profits by implementing their management, including financial management and financing following economic rules taking into account realistic and rational costs. In the development of the hospital and to carry out social functions also performed economic functions at once. Thus to maintain hospital operations, the hospital must seek a balance between social function and economic function.

The quality of hospital services could be seen in terms of the following aspects: clinical aspects (doctor services, nurses and related medical technical), aspects of efficiency and effectiveness of service, patient safety, and patient satisfaction. There were some indicators to determine the quality of hospital efficiency included: bed utilization, utilization of energy, utilization of medical support, and finance. Self-utilization bed indicators that we could easily see and know were through the numbers of BOR / Bed Occupancy Rate, BTO / Bed Turn Over, ALOS / Average Length Of Stay, TOI / Turn Over Interval (Sabarguna, 2004). In the implementation of the hospital supported by human resources, both medical personnel such as doctors, nurses, radiologists, laboratories and non-medical personnel like administrative, financial, household, public and other personnel. In some countries in Europe, payments using the DRG system were already in place, it could increase transparency and efficiency for hospitals.[9]

The DRG-based payment system was adopted at the US Congress for Medicare patients in 1983, and it had been the primary means of hospital income in most industrialized countries. DRGs system was the most widely used patient classification system in European countries, but despite many similarities, the systems in each country were very unique. DRGs were also used for a variety of purposes that were grouped into three categories: (i) improving transparency, (ii) boosting efficiency and (iii) supporting hospitals in management. The DRG-based payment system was principally built on two elements: (i) defined the DRGs, i.e. assigned hospital services submitted to individual patients to rabble-group companies, and (ii) determined the weight or price for each group.[4]

Case Based Groups payment pattern was one of the prospective payment patterns to FKRTL in the form of grouping of diagnoses and procedures that had clinical features and the use of similar or similar resources. For tariffs that were applicable on January 1, 2014, adjustments had been made to the INA-CBGs *Jamkesmas* tariff and had been stipulated in the Minister of

Health Regulation (*PerMenkes*) Number 69 Year 2013 on the Health Service Tariff Standard on FKTP and FKRTL in the provision of health insurance. Tariffs of INA-CBGs in the National Health Insurance The INA-CBGs tariff used in the JKN program per January 1, 2014 was enacted under the Minister of Health Regulation with several principles, one of which was the tariffs grouped by type and class of hospital, which consisted of: hospital tariff Class A, class B hospital tariff, hospital grade B grade tariff, class C hospital tariff, class D hospital tariff, National referral hospital tariff, and National referral hospital rate. In some hospitals in New York, the coding system was well-watched, including how to make a secondary diagnosis. One indicator of success in diagnosing the diagnosis was that the resulting nominal value was lower than the hospital rate. In a study conducted at several hospitals in New York, it was stated that the accuracy of data that doctors write in medical records greatly affect the results of coding. In this study found that the number of negative claims BPJS patients had increased but not significant enough. This was caused by several factors that were coding error factor, Length of Stay (LOS) factor, excessive medical cost factor and excess cost factor of investigation. One of the most important purposes of coding diagnostics was to provide the data required by the payment / charging system of applied / applied costs. One of the basics in diagnosing diagnosis in a hospital was the completeness of the medical record, since the medical records were manuscripts or files containing records or documents about the patient's identity, examination, treatment, actions and other diseases to the patient on health care facilities. In addition, to be a legal evidence that could provide legal protection to health provider patients (doctors, nurses and other health workers), managers, and owners of health care facilities, medical records were also useful in financial matters, i.e. any services received by patients when recorded was complete would be able to be used to calculate the cost to be paid by the patient. Also, the type and amount of service activities recorded in the form could be used to predict the income and cost of health service facilities. According to MOH RI 2008, most of the

hospitals in Indonesia that implemented the casemix / INA-CBG's system had not been able to make a complete and clear diagnosis based on ICD-10 and not yet coding properly. If the information contained in the medical records document was incomplete, then the possible diagnostic codes were also inaccurate and had an impact on the cost of health services. The inaccuracies of the diagnostic codes would affect data and report information, the accuracy of INA-CBG's tariffs that were currently used as payment methods for *Jamkesmas*, *Jamkesda*, *Jampersal*, and civil servant healthcare services organized by BPJS in Indonesia. If the coder was wrong in determining the diagnosis code, then the amount of claim payment would also be different. Low rates of health services would certainly harm the hospitals, on the contrary the high tariff of health services impressed the hospital benefited from the difference in tariffs to the disadvantage of the organizers *Jamkesmas* and patients.[5]

According to research from Widayanti (2016), the degree of incompatibility of outpatient diagnostic codes on outpatient medical records and INA CBGs software reached 22%. So far, what had happened in the health financing of patients in health care facilities was with Fee-for-Service (FFS), that was, health service providers charged the patients for each type of service provided. Any checks and actions would be charged according to rates in the hospital. Fees were determined after the service was done. With the fee for service system, the possibility of moral hazard by the hospital was relatively bigger, because there was no agreement from the beginning between the hospital with the patient, about the standard cost and the standard length of stay. The INA-CBG's system, anticipating such things continued to happen, with INA-CBG's hospitals required to deliver standards of service, and most importantly not pursuing profits.[6]

The health care package that the patient received, referred to the Minister of Health regulation. It included the type of medication and treatment class if you had to undergo hospitalization. The system was so efficient that there were uniform standards of service quality for the needy. The concept of INA-CBG's was compiled by the Ministry

of Health, this payment system would be implemented throughout Indonesia. Unlike the previous health insurance programs, INA-CBG's could be controlled better. The most fundamental difference was the presence or absence of health care standards where ever and the claims filled by the hospital was not controlled. The model of the hospital's essential service package was as if there was no limit to the claims of patients to influence in the service of varied or uneven.

Payment by using coding Diagnosis INA-CBGs was a process of classifying data (diagnoses) and determination of code number / alphabet / or alphanumeric to represent it. The grouping basis in INA-CBGs used the codification system of the final diagnosis and the action / procedure being the output of service, with reference to ICD-10 for diagnosis and ICD-9-CM for action / procedure. Grouping using information technology system in the form of Application of INA-CBG so that resulted 1,077 group / case group consisting of 789 group of case of inpatient and 288 group of outpatient case. Each group was denoted by a combination code of alphabet and numeric.

In improving diagnosis of diagnostic capability, the sensible baggage hospitals continually strived to improve their ability to apply Hospital Information System (SIRS). SIRS was a communications information technology system that processed and integrated the entire process of hospital service in the form of network coordination, reporting and administrative procedures to obtain information accurately and it was a part of the Health Information System. One of the benefits of SIRS was having data communications capability (interoperability) with Indonesia Case Base Group's (INA CBG's). The INA-CBG's application provided import features. Import feature was used to input mass data from SIRS in the form of text file with certain structure. No matter how to use the software, for example by creating a text file to import data, the most important was the contents of the text file was eligible with a predetermined standard.[7]

The role of management was very important to the success of a business enterprise, today's growing management evolved into one science that was important and absolutely required by every company. The bigger the company, the greater the amount of labor required, the management role would increase as well. Management was only a tool to achieve the desired goals. Good management would facilitate the realization of corporate, employee and community goals. By having the good management, efficiency and effectiveness of the elements of management would be improved. The elements of management that consists of: man, money, method, machines, materials, and market.

In addition, Bagas Waras Hospital had not implemented management functions well. As for the management functions according to be applied in the field of human resources was Planning, Organizing, Motivating, Controlling, Evaluating as follows:

1.   In lowering the negative claims, all staff of RSUD Bagas Waras, especially doctors, must have sufficient knowledge about Casemix and INA-CBG's. They should also have sufficient expertise to properly implement the casemix system in the hospital. They must change their thinking from the cost of the usual service to the prospective financing where the payment for patient was given in the form of package. Continuous capitation formation in casemix must be implemented. There were four working groups within the hospital under the hospital's casemix control committee: clinical coding group, casemix financing group, IT casemix group, clinical path group.[8] In casemix preparation, all hospital employees, especially doctors, should have sufficient knowledge about casemix and INA CBG's. Continuous capacity building in casemix must be implemented, which of course involved consultants and training.[9]

2.   Ask for support from the management (Top Management)
The hospital that was really serious in recording with casemix adjustment standards, should establish a special casemix unit. This unit would involve into the human and financial needs to implement casemix in RSUD Bagas Waras. Casemix units should provide sustainable facilities and infrastructure.

3. Preparing the casemix control committee in the hospital

The casemix committee was responsible for involving all employees at Bagas Waras Hospital and gave high priority for training. This committee was responsible for training all employees including nurses, doctors, and medical records recording officers. The role of the control committee was included in determining the objectives of the implementation of the casemix system, to propose policies relating to the use of casemix, to purchase the casemix grouper program and to seek financial resources.

4. Using data collected on a regular basis to collect the relevant data only, so it did not increase the workload of doctors or nurses.

5. Using the IT system available in the hospital Bagas Waras Hospitalshould start by utilizing any existing IT system. The development could be done on an available system, if the system was inadequate for the implementation of the casemix system.[10]

CONCLUSION

The cause of BPJS claims file which was negative before the controlling of INA-CBGs coding in RSUD Bagas Waras. There was no Standard Operating Procedure (SPO) in conducting Coding of Disease and Action Claim BPJS.

The reason BPJS claim file negative after the controlling of INA-CBGs coding in Bagas Waras Hospitalwas that the employees had not understood the whole coding system well and not yet running the monitoring and evaluation system coding. BPJS claims file negative caused by coding problems before the control coding INA-CBGs in Bagas Waras Hospitalwas also due to the management that had not been fully involved in conducting diagnosis coding start from the input data, process, and output of diagnosis.

Based on the results of the research, the researcher gave suggestions: the management should be involved directly in implementing the National Health Insurance (JKN) specifically the implementation of the system of recording in Medical Record Units, conducting training for the recording of Medical Record personnel, then monitoring and evaluating the implementation of coding in Medical Record Unit.

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