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Original Research

The Completeness of Filling Out Medical Record Documents and the Accuracy of Codes at Reksodiwiryo Hospital

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Abstract

A hospital is an institution whose primary function is to provide health services to the community. One of the government's efforts to provide health services to the community is implementing the National Health Insurance Program (JKN), which the Social Security Program Organizing Agency organizes in the health sector. This research analyzed the factors associated with delays in BPJS claims at Dr. Hospital. Reksodiwiryo Padang. This research was a descriptive quantitative study with a cross-sectional study design. The research showed that six medical record files (6.5%) had inaccurate codes, while 86 (93.5%) used the correct ones. In addition, 91 files (98.9%) of inpatient medical records needed to be completed, and only one file (1.1%) was completed. Inaccuracy in diagnostic coding affects delays in submitting claims at Dr. Hospital. Reksodiwiryo Padang. It is hoped that officers can understand the coding rules based on ICD-10 for diagnoses and ICD-9 CM for actions or procedures to guarantee the quality of service at the hospital.

Keywords: Compliance, Code, Claim, BPJS, Hospital

INTRODUCTION

Based on the Presidential Regulation of the Republic of Indonesia Number 12 of 2013 concerning Health Insurance, it is stated that Health Insurance is a guarantee in the form of protection so that participants receive the benefits of health protection to fulfill basic health needs provided to all people who pay contributions or the contributions have been paid by the government. To implement a health insurance program, the government should implement a legal entity, usually called a social security administration body. According to Republic of Indonesia Law No. 40 of 2004 concerning the National Social Security System (2004), the Social Security Administration Agency (BPJS) is established to administer social security programs in Indonesia. BPJS was formed into 2, namely BPJS health and BPJS employment. BPJS Health is an insurance company we previously knew as a Limited Liability Company (PT) Health Insurance (ASKES). BPJS employment is a transformation of Employment Social Security (Jamsostek). BPJS employment provides programs such as work accident insurance, old age insurance, pensioner insurance, and death insurance (The Republic of Indonesia Act Law No. 24, 2011).

Hospitals, as facilities providing advanced health services, aim to provide health services that are both promotive, preventive, curative, and rehabilitative. One form of a government effort to provide health services to the community is by implementing the National Health Insurance (JKN) program using a prospective payment system based on

medical or non-medical service diagnosis units, namely the Indonesia Case Group (INA-CBG's). BPJS claims are submissions for treatment costs for patients participating in BPJS by the hospital to the Health Social Security Administering Agency (BPJS), which is carried out collectively and billed to BPJS every month (Perdana et al., 2022).

BPJS verifiers verify claim files before health facilities submit them to test the correctness and completeness of the administrative responsibility for patient services. Incomplete medical record files and incorrect writing of diagnosis and action codes cause claim files to be pending. The inaccurate writing of the code was due to differences in perception between the coders from the hospital and the BPJS verifier officers. This can affect the determination of the claim rate, resulting in inaccurate financing of INA-CBG rates (Muluk et al., 2023). Based on research results (Maimun, 2020), Factors for delays in the BPJS claim service process for the outpatient section at the Annisa Pekanbaru Maternity Hospital in 2019, namely the health insurance claim service process (BPJS) at the Annisa Pekanbaru Maternity Hospital, there are still obstacles or delays seen from the lack of Human resources specifically for coding, facilities are lacking and there is no SOP for insurance claim service procedures (BPJS). It is recommended that hospitals create SOP policies so that work is addressed. It is necessary to increase human resources so that coding work is done on time; insurance claims printer facilities must be added to make insurance claim work efficient (Maimun, 2020).

Based on research results (Tambunan, 2022), the factors that cause BPJS Health patients' claims for inpatient treatment to be delayed at Tarakan District Hospital are the discrepancy between hospital diagnoses and BPJS Health due to differences in perception between DPJP doctors who write diagnoses and BPJS Health, incompleteness and file errors. When filling out the administration, the hospitalization order should require reasons for medical indications and a cover letter from a specialist doctor to the patient containing the diagnosis and treatment plan provided to BPJS as tangible evidence of the patient's hospitalization and errors, other deficiencies in confirmation of medical support due to the form Medical support is not attached to the BPJS assessment application requirements for inpatient claims. In the case of a diagnosis of an action or procedure that requires additional medical support (Tambunan, 2022). Based on an initial survey at TK Hospital. III Dr. Reksodiwiryo Padang that there was indeed a delay in inpatient BPJS claims in the January – March 2022 period, amounting to 30 pending claim file documents. This research aims to analyze the factors associated with delays in BPJS claims at Dr. Hospital. Reksodiwiryo Padang.

METHODS

The type of research used was a descriptive method with a quantitative approach, which explains a study to determine the factors related to late bpjs claims in the inpatient department at dr. hospital. reksodiwiryo padang during 2022-2023. quantitative research introduces a theory, explanation, and desired relationships, describes the theory to be used, and explains why the theory is important to study. at the end of the research, the researcher reviewed the existing literature and compared the research results with findings in the literature. The population of this study was medical record documents; the research sample was 94 medical record files. the variables in this research include the independent or independent variable, namely the completeness of filling in medical record documents, while the dependent variable was the accuracy of the diagnosis code. data analysis used univariate analysis.

RESULTS

The data was collected in the medical records installation room at Tk.III Dr. Hospital, Reksodiwiryo Padang, using a sample of 94 medical record files. This study was conducted by observational methods utilizing a checklist table.

Table 1. Distribution of Code Inaccuracy Rates and Inpatient File Completeness Rates

Variables	f	%
Inaccuracy Code		
Not accurate	6	6.5
Appropriate	86	93.5
Completeness		
Not Complete	91	98.9
Complete	1	1.1
Total	92	100.0

Data source: Secondary data

Based on Table 1, it shows the distribution of code inaccuracy numbers. There were 6 (6.5%) incorrect codes and 86 (93.5%) correct codes. The table above shows the distribution of completeness numbers for inpatient patient file stays. File patient takecare stays incomplete at 91 (98.9%), and file complete inpatient treatment was only 1 (1.1%).

Table 2 presents a cross-tabulation that indicates the relationship between code inconsistencies and the completeness of documents, as well as their impact on claim delays. Particularly with relation to unfinished documents, there was a propensity for late claims to arise. The research findings on code accuracy in relation to claim submission delays revealed that out of the six papers examined, all of them had accurate code writing and no pending claims were submitted with erroneous code writing. In addition, there were now 23 code writings that have not yet been completed accurately, whereas 63 code writings have been completed accurately and are not pending claims. In regards to the correlation between incomplete document completion and accuracy in claim submission, a total of 29 documents were found to be incomplete, resulting in delayed claim submissions. Despite the timely submission of claims, there remains a backlog of 62 papers yet to be finalized. This is a crucial aspect of the discovery process, indicating that the claim submission is still done despite the deficient medical record document.

Table 2. Crosstabulation Between Code Inaccuracy and Delay in Claims at Tk.III Hospital Dr. Reksodiwiryo Padang

	Late Claims		Total
	Late	**On-time**	
Inaccuracy Code			
Not accurate	6	0	6
	100.0%	0.0%	100 %
Appropriate	23	63	86
	26.7%	73.3 %	100 %
Completeness			
Not Complete	29	62	91
	31.9%	68.1 %	100 %
Complete	0	1	1
	0.0%	100.0 %	100 %

Data source: Secondary data

DISCUSSIONS

The finding of this research was code accuracy regarding delays in submitting claims. This problem was due to the officers' need for more accuracy in providing coding. The results of research conducted by (Oktamianiza, 2022) in Inpatient Patients at RSI Siti Rahmah Padan said that of 100 medical records, 76 (76.0%) were correct, and 24 (24.0%) had an incorrect primary diagnosis. The inaccuracy of this code shows a higher number than the research conducted, namely 28 (28.0%). This is caused by the doctor's lack of concern in writing down the correct primary diagnosis and the doctor's inconsistency in determining the main diagnosis (seen from the RM 1 sheet with the RM 2 sheet and the RM 3c sheet, which have different patient diagnoses), due to the doctor's limited time, many patients, A lot of workload (required to work quickly but still adding other work), takes a lot of time.

According to (Oktamianiza, 2022), an incomplete and unclear diagnosis in the patient's medical record will affect the accuracy of a code. If the coding of a disease diagnosis is miswritten and incomplete or even not written (there are gaps), then it can cause difficulties in the following process; namely, the indexing process will reflect deficiencies, and the resulting data will be inaccurate in statistical presentation and reporting.

According to (Nurmalasari & Afrizal, 2023), the coding quality element is consistent when coded by different officers; the code remains the same (reliability), and the code is appropriate according to the diagnosis and action (validity). Includes all diagnoses and actions in the medical record (completeness). Based on the researchers' analysis of the causes that influence code inaccuracy, the clarity and completeness of the diagnosis written in the file must be clear and according to the rules. So that medical records officers can determine the correct code for the diagnosis. It is best if the officer has difficulty distinguishing the code for the diagnosis to clarify it first with the coder in charge.

The research results showed that from 92 inpatient files, 91 (98.9%) inpatient files were incomplete, while 1 (1.1%) inpatient file was complete. According to the book Practical Administration of BPJS Health Facilities, complete information (medical record files) is crucial for verifying claims. Claim verification is specially prepared to become a reference for claim verifiers at BPJS. Complete medical records also maintain health facilities for service quality and cost efficiency of health services (Nilasari et al., 2023).

According to the results of research conducted at Koja Regional Hospital entitled "Factors Causing Pending Claims for Hospitalization at Koja Regional Hospital," it was found that the number of pending claims was due to incomplete medical resumes, and 2,026 files were requested to be completed or 37.4% of the total pending claims. This is because the Doctor in Charge of the Service (DPJP) has not been able to complete a comprehensive medical resume, analysis, and therapy (Tri Utami et al., 2022). Based on the results of research conducted by (Rahmatiqa et al., 2020) regarding "Completeness of Medical Record Files and BPJS Claims at M. Medical data shows the completeness and accuracy of the data submitted by the hospital regarding the information files required by BPJS (Christy et al., 2023).

Service Recapitulation: All data must be written in full to speed up the claims process and as an archival document at the hospital. Incompleteness and delays in filling in medical record status directly impact proposing and submitting claims for health facilities to BPJS Health (Putrianda et al., 2022). Based on the analysis conducted by (Maha Wirajaya & Made Umi Kartika Dewi, 2020), there is a significant relationship between the completeness of documents and medical records regarding the approval of Jamkesmas claims with the INA CBGs system. Medical personnel responsible for completing each inpatient file should prevent claims and maintain the quality of medical records (Siahaan, 2023).

CONCLUSIONS

The findings from the research highlight significant issues regarding the accuracy and completeness of medical record coding and documentation, particularly in inpatient settings. The study revealed a concerning rate of incorrect coding, attributed to the need for more precision among medical officers responsible for coding, which consequently impacts claim processing efficiency. Moreover, the research underscores the prevalence of incomplete medical records, indicating potential challenges in claim verification and service quality maintenance. While complete information is crucial for claim verification and service quality, the study found no direct relationship between file completeness and claim delays. Nevertheless, the presence of incomplete records greatly contributes to the number of outstanding claims, highlighting the importance of comprehensive documentation in order to speed up the claims process. In summary, the research highlights the significance of precise and comprehensive medical record documentation in order to facilitate prompt claim processing and uphold the quality of healthcare services. It advocates for enhanced coding practices and documentation standards to minimize delays and preserve the reliability of medical records. This remark serves as a reminder to conduct additional study in order to investigate the factors using qualitative methods.

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