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Evaluation of the Role of Internal Verification Doctors in Reducing Pending Claims at Murni Teguh Medan Hospital in 2022

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Abstract: In the claim verification process, errors are still encountered which cause the claim to be pending. The problem of pending claims that occurs causes many losses for the Hospital. Therefore, an internal verifier is needed to supervise claim verification so that problems with pending claims can be minimized. Internal verification doctors have an important task in reducing the number of pending claims, especially to control the suitability of coding with diagnoses on medical resumes. The aim of this research is to analyze and describe the contribution of internal verifier doctors in reducing pending claims as well as the factors that cause pending claims and claims coding errors. The type of research used in this research is qualitative research. The research design used in this research is a descriptive research design. This research has sources as key informants, namely 4 internal verification doctors. This research also has sources as supporting informants, namely coder representatives. The conclusions of this research are: (1). Factors causing pending claims at RSU Murni Teguh Medan include: (a). Administrative factors, (b). Coding factors, (c). Medical factors. (2). The factors that cause errors in coding claims at RSU Murni Teguh Medan include: (a). HR Factors (Natural Resources) and; (b). Disagreement factor. The role of the internal verifier doctor in reducing pending claims includes: (a). Medical Document Examination; (b). In-Depth Clinical Verification; (c). Collaboration with the Filing Team; (d). Communication with BPJS.

Keywords: Hospital; Pending claim; Verifying doctor

Introduction

A hospital is a health service institution that provides complete individual health services by providing inpatient, outpatient and emergency services. The health services provided must be optimal because health is not only a citizen's right, but also determines the welfare of society and is an investment that determines a country's economic growth.Every citizen has the right to have access to quality and necessary promotive, preventive, curative and rehabilitative health services at affordable costs.

The National Health Insurance Program (JKN) has been organized by the Health Social Security Administering Agency (BPJS Health) in order to reduce the cost of health services and improve the level of public health, as an effort to provide health protection to participants to obtain health care benefits and protection in meeting basic needs health. BPJS is the Social Security Administering Agency which is a legal entity formed to administer social security programs. The Social Security System is a state program that aims to provide guaranteed protection to ensure that all people can fulfill their basic needs for a decent life (Pratama et al., 2023).

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Health financing is an important part of the implementation of National Health Insurance (JKN). There are two hospital payment methods used, namely the retrospective payment method and the prospective payment method. Indonesia uses a prospective payment system for payment methods for health services at Advanced Referral Health Facilities (FKRTL). The prospective payment method is known as case based payment (casemix). The casemix system is a grouping of diagnoses and procedures based on similar/same clinical characteristics and similar/same use of resources/treatment costs (Sander et al., 2022).

In providing optimal health services, the hospital collaborates with the National Health Insurance (JKN) program. The health insurance in question is a guarantee in the form of health protection so that participants receive maintenance and protection benefits in meeting basic health needs which are provided to everyone who has paid contributions or whose contributions are paid by the government. All Indonesian residents are required to be participants in insurance managed by the Social Security Administering Body (BPJS), including foreigners who have worked in Indonesia for at least 6 months and of course have paid contributions, which using the Indonesia Case Base Group system is usually shortened to INA-CBGs.

In the claim submission process, Indonesia applies a prospective payment method (Prospective Payment System) based on INA CBGs. With this payment method, the accuracy of clinical data coding will greatly determine the financing of health services. The accuracy of clinical data codes greatly determines the smoothness of the process of submitting claims for reimbursement of health service costs to BPJS. In its implementation, many claims were returned by BPJS due to lack of complete information and inaccurate coding. Completeness of claims and correctness of data are the main prerequisites for verification (Sander et al., 2022).

Coding is an activity of processing medical record data to provide codes with letters or numbers or a combination of letters and numbers that represent data components. Determining codes for applicable disease classification diagnoses using the International Statistical Classification of Diseases and Related Health Problems (ICD-10) to code diseases, while the International Classification of Procedures in Medicine (ICOPIM) and the International Classification of Disease and Revision Clinical Modification (ICD- 9-CM) is used when coding actions, as well as a computer (online) to code diseases and actions (Pratama et al., 2023). Determination of diagnosis codes and medical procedures is carried out by a coder, in this case the coder comes from the medical records profession.

In the Republic of Indonesia Minister of Health Decree No.377/Menkes/III/2007 concerning Professional Standards for Medical Recorders and Health Information, it is stated that one of the competencies of a medical recorder is knowing the classification and codes of diseases, problems related to health and medical procedures. A medical record is a file that contains notes and documents including the patient's identity, examination results, treatment that has been given and other actions and services that have been provided to the patient (Widyaningrum et al., 2021).

Medical records are a collection of files or impressions of something said or written about a patient's condition from time to time. It is confidential in nature, the information contained therein can only be provided or released in accordance with confidentiality laws and regulations applicable in the medical profession or based on state regulations. In managing medical records there are many things that must be considered because in filling, changing, storing and destroying, each of these activities only certain people or professions can do it (Widjaja, 2015).

A medical record is a file that contains notes and documents including the patient's identity, examination results, treatment that has been given, as well as other actions and services that have been provided to the patient. Medical records must be made in writing, complete and clear. One of the ways in which quality medical records can be seen is the completeness of the contents of the medical record. This completeness is added with authentication of medical records such as the name of the treating doctor, signature and date of creation. A complete medical record is a medical record that has been filled in by a doctor within ≤ 24 hours after the decision to go home for outpatient or inpatient services, which includes the patient's identity, anamnesis, care plan, implementation of care, and resume. After every patient is provided with services in the form of treatment, a medical resume must be made (Nugroho P et al., 2022).

In its administration, medical records have the function of processing patient data, one of which is the function of coding or codifying diagnoses of diseases or actions. says diagnostic coding is assigning codes using letters or numbers that represent data components. In coding a diagnosis, there are several things that need to be considered, including the correctness, accuracy and completeness of the patient's diagnosis code (Syafitri, 2021).

A medical record in a hospital is a document owned by the patient and is very confidential, because medical record data contains information about the course of the disease and the patient's treatment at the hospital. Managing medical records in hospitals so that

confidentiality can be maintained is regulated in the regulations of the Republic of Indonesia Minister of Health No. 269 of 2008 concerning medical records. Medical record documents in health service institutions are managed by medical recording personnel and are regulated in Minister of Health Regulation No. 55 of 2012 concerning the administration of medical recorders. Medical record providers are said to be competent if they have taken a minimum DIII medical records and health information study program, passed the medical records competency exam and are sworn in by PORMIKI and the Health Service (Agiwahyuanto et al., 2021).

The function of medical records based on the Republic of Indonesia Minister of Health Regulation Number 269/Menkes/Per/III/2008 states that they are a form of patient health care and treatment, evidence in the law enforcement process, medical and dental disciplines, educational and research needs, the basis for payment of health service costs, as well as health statistical data (Oktamianiza et al., 2022). The process of medical record activities starting from patient registration to processing medical records in the form of reports is an inseparable unit and is carried out in an orderly manner, resulting in accurate and accountable information. Complete, accurate and accountable medical records are an effective basis for reducing the risk of errors, this is because medical records are a source of information for patients, because medical records can show whether the services provided are in accordance with health services (Widyaningrum et al., 2021).

Based on the background and problem phenomena that have been described, this research aims to analyze the role of internal verification doctors in reducing pending claims. So this research will be carried out with the title "Evaluation of the Role of Internal Verifier Doctors in Reducing Pending Claims"

Method

The type of research used in this research is qualitative research. Qualitative research is a type of research that explores and understands the meaning in a number of individuals or groups of people that originate from social problems. Qualitative research can generally be used for research on people's lives, history, behavior, concepts or phenomena, social problems, and so on. One of the reasons for using a qualitative approach is the researcher's experience where this method can discover and understand what is hidden behind phenomena which are sometimes difficult to understand (Creswell, 2014).

Qualitative research is a type of research that explores and understands the meaning in a number of individuals or groups of people that originate from social problems. Qualitative research can generally be used for research on people's lives, history, behavior, concepts or phenomena, social problems, etc. (Sugiyono, 2019). There are characteristics in qualitative research, namely as follows (Suharsimi, 2010): a) Carried out in natural conditions, directly to the data source and the researcher is the key instrument. b) Qualitative research is more descriptive. The data collected is in the form of words or images, so there is no emphasis on numbers. c) Qualitative research emphasizes the process rather than the product or outcome. d) Qualitative research carries out inductive data analysis. e) Qualitative research emphasizes meaning.

Result and Discussion

Factors That Cause Pending Claims

To minimize errors in administration, it is necessary to verify the administration process in accordance with procedures. Submission of patient claims has been carried out according to the procedures applicable to RSU Murni Teguh, and the patient does have indications for hospitalization. The claim has gone through the appropriate stages, including printing the inpatient SEP and completing the files. The role of the verifier is very important in checking the completeness of the file before the claim can be processed further.

The verifier is responsible for checking the submitted files, ensuring that all required documents and information are complete. They check whether all supporting documents, such as medical resumes, examination results, anatomical pathology (PA) reports, and other documents are present and in accordance with the claim requirements. If there is a lack of completeness or inappropriate information, the verifier can request additional documents or clarification from the hospital before continuing the claim process.

Apart from that, problems with the IT system can also affect the submission of claims. Technical problems or IT system failures can hinder or slow down the claims process. Therefore, it is important for hospitals and BPJS to continue to monitor and update their IT systems, and make necessary improvements so that claims can be processed smoothly.

Overall, to ensure that the submission of patient claims goes well, it is important to follow established procedures and ensure completeness of files and appropriate indications for hospitalization. Verifiers play an important role in checking the completeness of files, while maintaining a good IT system is also needed to avoid technical problems that can affect the claims process. Thus, overcoming administrative factors that cause claims to be pending, it is important for hospitals and BPJS to improve the management and monitoring of

claims administration. Training of administrative staff, improvement of filing procedures and file processing, as well as effective communication between hospitals and BPJS can help reduce administrative factors that cause claims to be delayed.

To address coding factors that cause pending claims, it is important for RS and BPJS to ensure there is a clear and consistent understanding of the applicable coding rules and guidelines. Training and knowledge updates for internal coders and verifiers are also required. Careful inspection of the completeness of administrative files by the verifier can be maximized. Apart from that, effective communication, such as coordination with room doctors and DPJP or communication between the hospital and BPJS as well as increased coordination in terms of coding can help reduce coding factors that cause claims to be delayed.

To overcome medical factors that cause pending claims, it is important for hospitals and BPJS to ensure that medical documentation is complete, accurate and in accordance with requirements. Good coordination between hospitals and BPJS in terms of interpreting medical examination results is also needed. In addition, training and knowledge updates for internal coders and verifiers regarding correct medical coding and applicable medical requirements are also important.

The results of this study are in line with research Simbolon et al. (2023) which shows the results of the factors that cause pending BPJS claims in inpatients are inappropriate coding, completeness of files, and differences of opinion in establishing diagnoses between DPJP and BPJS verifiers.

As for the results of other research by Kurnia et al. (2022), the factors causing pending claims for inpatients at Charitas Hospital Kenten Palembang are due to incomplete filling in of the claim file by the Doctor in Charge of the Patient, lack of human resources and the educational level of the coder is not yet optimal, mismatch in diagnosis and therapy is caused by the same perception between the Doctor in Charge Patients, Hospital Coders and BPJS Verifiers, due to lack of socialization of new knowledge.

Factors That Cause Claim Coding Errors

The results of the research show that the factors causing errors in coding claims at RSU Murni Teguh Medan include human resource (HR) factors and disagreement factors. HR factors can be the cause of coding claim errors due to lack of training and knowledge regarding applicable coding rules and guidelines, lack of experience in coding claims, lack of medical understanding, and lack of good communication and coordination between HR. Another factor, namely disagreement, is also the cause of coding claim errors. Several things that cause disagreements to cause errors in pending claims include disagreements in coding between RS and BPJS, lack of understanding of coding by HR, lack of clarification and coordination between RS and BPJS in terms of coding,

The results of this study support the statement Kurnia et al. (2022) Based on his research, the results showed that the factors causing inpatient claims to be pending were due to incomplete filling in of the claim file by the doctor in charge of the patient, lack of human resources and the coder's education level was not optimal, mismatch in diagnosis and therapy was caused by similarities in perception between the doctor in charge of the patient and the house coder. sick and BPJS verifiers, due to lack of socialization of new knowledge.

To overcome HR factors that cause coding claim errors, it is important for hospitals and BPJS to provide adequate training to human resources, such as coders and verifiers, regarding applicable coding rules and guidelines. Increasing medical knowledge and understanding also needs to be considered. Good communication and coordination between all related parties, including BPJS, can help in avoiding coding claim errors. In addition, forming a team consisting of various backgrounds, such as medical personnel and coding personnel, can help in better collaboration and validation in the coding claims process.

This research also shows results that are in line with research Prima et al. (2021) which shows the results that there is a need to improve the quality of human resources, especially coding officers, by holding training and outreach regarding policy updates related to claims. Optimizing activities by creating SPOs related to claims in order to minimize incidents of pending claims. The hospital always carries out evaluations to reduce the incidence of returning claim files, starting from always communicating existing problems and coordinating each related section and improving the performance of each section, following regulations well and also reminding each other.

To overcome the factors of disagreement that cause coding claim errors, it is important for RS and BPJS to improve communication and coordination between related parties. Clear clarification regarding coding requirements and claim criteria needs to be considered. Training and updating knowledge for human resources, such as coders and verifiers, regarding applicable coding rules and guidelines is also important. Increasing understanding between RS and BPJS regarding coding and relevant claim requirements can help in avoiding coding claim errors caused by disagreements.

This research supports Wardana et al. (2020) statement that errors in the coding process by coders and the coding input process by groupers, errors in placing primary and secondary diagnoses on medical resumes, and incompleteness of medical resumes are the factors

that cause the most pending claims. Study Heltiani et al. (2023) with the finding that the coding officer found it difficult to read the DPJP's writing in the form of unclear writing of the diagnosis being made, clarification had to be carried out, however, clarifying often took quite a long time because the DPJP was not always at the hospital, so the coder would contact if the DPJP had a schedule at home Sick. In order for clarification to be achieved, to carry out coding, the coder must look at the history of treatment, medication, symptoms on the anamnesis sheet and physical examination. Inaccuracy in coding obstetric diagnoses is caused by, among other things, writing diagnoses that are unclear and less specific, doctors' writing is difficult to read and uses non-standard abbreviations, making it difficult for coders to assign codes.

The Role of Internal Verifier Doctors in Reducing Pending Claims

The research results show that the role of internal verifier doctors is important in reducing pending claims at RSU Murni Teguh Medan. Several things explain the important role of internal verifier doctors in reducing pending claims, namely in terms of examining medical documents, in-depth clinical verification, collaboration with the filing team, communication with BPJS.

With the role of internal verifier doctors which includes in-depth clinical verification, examination of medical documents, collaboration with the filing team, and communication with BPJS, they contribute significantly to reducing pending claims. The presence of a verifying doctor helps ensure the accuracy, completeness and compliance of claims with applicable medical and administrative requirements, thereby minimizing the possibility of claims being delayed and speeding up the claims process at hospitals and BPJS.

This is in line with previous research by Kusumawati (2019) which states thatInternal verifier doctors have been proven to be able to reduce the number of pending inpatient claims due to coding errors and it was found that the causes of coding errors were incomplete medical resumes, lack of accuracy of coders, lack of knowledge of coders, lack of uniformity of information related to coding and overload of claim files which were not accompanied by appropriate number of coders. This can be minimized by using electronic medical records, training coders, team building and adding coders. This is because the internal verifier doctor has an important task in reducing the number of pending claims, especially to control the suitability of the coding with the diagnosis on the medical resume.

From the results of the interviews, it was also found that the role of technology in facilitating and assisting hospitals in the process of submitting patient claims so that pending claims do not occur should continue to be developed. The latest technology cuts queues at hospitals, but also makes it easier to pay claims. Because the system is directly integrated into BPJS Health, the administrative requirements for BPJS Health participants can be processed more quickly by the hospital and participants can obtain health services more quickly. With capable technology, it has various advantages and benefits, including speeding up the patient registration process, speeding up the claims process and functioning as an early prevention of re-admission of inpatients.

The role of technology allows hospitals to collect, store and manage patient data efficiently. With an integrated data management system, medical information, treatment history and other documents can be easily accessed and collected electronically. This minimizes the risk of data loss or errors that can cause claims to be delayed. technology allows hospitals to connect directly to the BPJS system.

With integration between the hospital system and the BPJS system, claims can be submitted electronically and data can be automatically sent to BPJS. This speeds up the claim submission process and reduces the risk of errors in data transfer. Technology enables automation of the patient claims process, including filling, processing and sending claims electronically. By adopting a claims automation system, hospitals can reduce dependence on manual processes that are prone to errors and take longer. Automation speeds up and simplifies the claims process, reducing the risk of claims becoming pending.

By utilizing the right technology, hospitals can optimize the process of submitting patient claims and prevent claims from becoming pending. Implementation of an efficient data management system, real-time validation, integration with the BPJS system, real-time claims monitoring, and automation of the claims process can speed up and simplify the claim submission process. This reduces the risk of errors, increases efficiency, and avoids claims becoming pending.

The results of this research are in line with the research of Pujihastuti et al. (2021) which states that from the economic aspect the Hospital Information System (SIMRS) produces data output that can be used by the SISRUTE, INA-CBGs systems by exporting data and from the security aspect of system control by operators equipped with servers. SIMRS, the BPJS INA-CBGs server with data backup and unlimited bandwidth overcomes system disruptions and failed processes for sending claim data to the BPJS server.

This research also shows results that are in line with research by Yulianti et al. (2022) which states that the role of technology in the claims process, namely the INA-CBG's E-Claim application makes the process of

submitting claims to the head office easier, so that the time for submitting claims is always on time. However, this application also has a weakness, namely that there are still errors in the application caused by the maintenance process from the head office.

Conclusion

Based on the results of the research and discussion, the author can conclude: a) the factors that cause pending claims at the claim verification stage at RSU Murni Teguh Medan are administrative factors, coding factors and medical factors. b) The factors that cause errors in coding claims at RSU Murni Teguh Medan are the Human Resources factor and the factor of disagreement. c) Internal Verifier Doctors play an important role in reducing pending claims.

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