

Workshop of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9cm) at RMC Pakandangan Clinic

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Abstract

Completeness of BPJS claim documents at the hospital includes service recapitulation and patient support files consisting of a Participant Eligibility Letter (SEP), medical resume, diagnostic statement from the treating doctor, and other proof of service. The BPJS claim process already uses the INA-CBGs program. Payment patterns with INA-CBGs organized by BPJS in hospitals must go through the file verification stage so that BPJS Health verifiers verify service Administration and ensure the suitability of diagnoses and procedures on bills with ICD-10 and ICD-9 codes. In coding patient medical actions/procedures, coders use ICD-9 CM rules to assign medical action codes to the patient's resume sheet. Coding of medical procedures is carried out to provide classification and specific information regarding medical actions grouped based on ICD-9 CM. Based on these problems, the author is interested in holding ICD-9 CM coding training at the RMC Pakandangan Clinic. This community service is important because it will reduce pending claims from PBJs. Objective: This community service aims to provide training related to ICD-9 CM coding and increase knowledge of medical recorders. This community service method is carried out using 3 stages, namely preparation, implementation, and evaluation. This workshop is to provide material regarding the use of ICD-9 CM and provide direct practice in coding ICD-9 CM based on applicable regulations. Results: This Community Service Activity (PKM) was carried out on April 8 2023 at the RMC Pakandangan Clinic, Padang Pariaman. The Community Service activity was attended by 10 participants. From the results of the pre-test and post-test in the ICD-9 CM coding training, there was an increase in understanding of ICD-9CM coding. Conclusion: This Community Service has a positive impact on the understanding of ICD-9 CM coding training participants.

Keywords: BPJS, ICD-9 CM, pending claims, coding

INTRODUCTION

Law No. 40 of 2004 states that Indonesia requires every resident to have access to comprehensive and quality health services to survive through the National Health Insurance (JKN) administered by the Social Security Administering Body (BPJS). The implementation of the BPJS program has a payment method. The payment method used in this program is prospective, namely case-mix (case-based payment). BPJS claims are submissions for

treatment costs for patients participating in BPJS by the hospital to BPJS Health, carried out collectively and billed to BPJS Health every month. Hospital health facilities are obliged to complete BPJS claim documents before submitting them to BPJS Health to receive reimbursement for treatment costs by the Indonesia Case Base Groups (INA-CBG's) rates (Susan, 2016).

Completeness of BPJS claim documents at the hospital includes service recapitulation and patient support files consisting of a Participant Eligibility Letter (SEP), medical resume, diagnostic statement from the treating doctor, and other proof of service. The BPJS claim process already uses the INA-CBGs program. Payment patterns with INA-CBGs organized by BPJS in hospitals must go through the file verification stage so that BPJS Health verifiers verify service administration and ensure the suitability of diagnoses and procedures on bills with ICD-10 and ICD-9 codes. After that, BPJS Health will approve the claim and make payment for files that are worthy of being claimed, but files that are not worthy of being claimed/pending must be returned to the hospital to go through the confirmation stage. With this payment method, the accuracy of the action code greatly determines the financing of health services.

In coding patient medical actions/procedures, coders use ICD-9 CM rules to assign medical action codes to the patient's resume sheet. Coding of medical actions is carried out to provide classification and specific information regarding medical actions which are grouped based on ICD-9 CM (Rahayu et al., 2022). Accuracy in coding a disease and action is very important. Many factors influence the accuracy of clinical data coding. In several studies regarding the factors causing the accuracy of clinical data coding in several literature, some of them explain the lack of clarity in the notes made by doctors, clarity & completeness of medical record documentation, use of synonyms and abbreviations, experience, length of work and education of coders, differences between the use of electronic medical records and manual, quality assurance program, indexing errors, coder quality where coders lack attention to ICD principles and key aspects of the coding process, coders only use the diagnosis code tabulation list guide which is often used as a reference in coding instead of the ICD-10 book and/ or ICPC. Coders still often do not use the ICD-10 book in assigning diagnosis codes but only use the smart book or search directly in the INA-CBGs program which is used for the grouping process. Although ICD-10 includes a large number of codes, it does not mean coders have to memorize every applicable ICD-10 code. Coders must use reference books and coding manuals to find new codes (Bowman & Abdelhak, 2001; Eramo, 2012; Ernawati, 2013; Hasan; Ifalahma, 2013; Nuryati, 2015; O'Malley et al., 2005; Quan; Silfen; Surján; van Walraven & Demers, 2001).

The results of research by Gugun Priyadi & Cahyani Dwi Lestari (2017) at Sumber Waras Hospital. The results of research conducted with a sample of 94 surgical case medical records found that 43.6% of the action codes were accurate and 56.4% of the codes were inaccurate (Tarjana, 2021). The results of research by Gugun Priyadi & Fasya Rizka Fauziyyah (2021) conducted at the Majalengka Regional General Hospital with a sample of 100 surgical case medical records found that 30% of the action codes were accurate and 70% of the codes were inaccurate. Based on research by Agustin Tri Wahyuni (2022) at Dr. Reksodiwiryono Padang, the results of the study showed that doctors' handwriting was not as clear (31.0%), the completeness of diagnostic procedures was incomplete (50.7%), and the accuracy of surgical codes (53.5%) was incorrect (Tahun et al., 2022).

Based on the results of initial observations of inpatient BPJS files at the RMC Main Clinic (Ringan-Ringan Medical Center) Pakandangan. pending claims are caused by inaccuracies in

coding. To improve the quality of PMIK and avoid losses in insurance financing claims, the service will carry out Community Service (PKM) activities. Implementing PKM is a mandatory activity for lecturers in implementing one of the three principles of higher education. This activity is a form of Apikes Iris' dedication to the benefit of the medical records field, especially in health service facilities. The PKM activity is a development program where the service team carries out outreach regarding the Action Coding Regulations in ICD-9 CM. Then the team will carry out follow-up activities in the form of ICD-9 coding practices in cases of pending claims to partners. The partner in this community service activity is the RMC Main Clinic (Ringan-Lingan Medical Center) Pakandangan. The big topic of this PKM is ICD-9 CM coding training in cases of pending BPJS claims that occurred at the RMC Main Clinic (Lingan-Lingan Medical Center) Pakandangan. From the topics that have been raised, several activities will be carried out in the form of:

- Socialization of regulations for the use of ICD-9 CM
- Action coding training in pending BPJS claim cases

This service aims to provide socialization regarding appropriate action coding regulations based on ICD-9 CM. Another aim is to provide training or practice coding ICD-9 CM in cases of pending BPJS claims. The expected benefit is that the medical recorder and case-mix team understand the appropriate action coding regulations so that the hospital avoids coding errors which will result in pending claims at the hospital.

METHOD

This community service has three stages: preparation, implementation, and evaluation (Mekar Ismayani et al., 2020). Details of the stages of community service activities are as follows:

- Preparation, includes activities by carrying out coordination activities related to the analysis of the problems that partners are facing. Next, discuss the needs and solutions offered to partners. After mutually agreeing on the problem to be solved and the solution technique, namely workshop of International Classification of diseases, ninth revision, clinical modification (ICD-9 CM). After that, coordinate with the supervisors to determine the location of activities, time of implementation, permits for medical record and case-mix team who will take part, resource persons and a rundown of events to be carried out.
- Implementation, the implementation will be carried out on 08 April 2023 which is located at RMC Pakandangan Clinic, Padang Pariaman. This activity is presented with the first material, namely the introduction of the regulation ICD-9 CM, and workshop procedure case used ICD-9 CM.
- Evaluation, the activities carried out in the evaluation are to reflect on the activities that have been carried out. The PMIK answered question about procedure coding base on ICD-9 CM.

RESULTS

This Community Service Activities (PKM) were carried out at the RMC Main Clinic (Lingan-Lingan Medical Center) Pakandangan on April 8, 2023 (Figure 1). The activities were carried out

by providing socialization regarding the ICD-9 CM action coding regulations and continued with action case coding training. This activity was attended by 10 participants from the medical records and casemix teams.

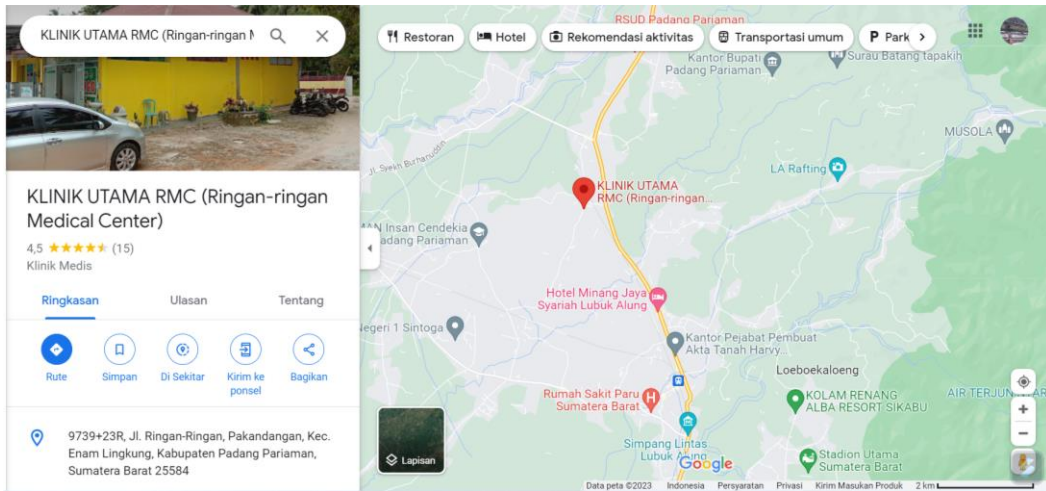


Figure 1. Location of activity

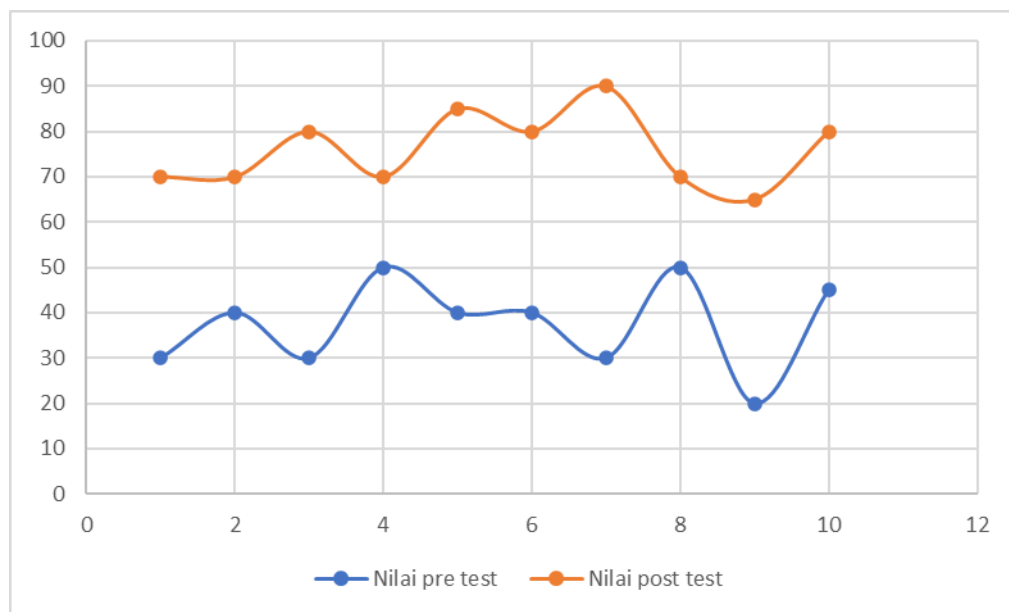


Figure 2. Result of Pre-test and post -Test workshop ICD-9 CM

Community Service (PKM) is carried out using two methods, namely socialization by conveying coding regulations based on ICD-9. In the explanation of the material, it was also conveyed regarding the urgency of coding accuracy in appropriate coding based on ICD-9. The next activity is practice coding pending claims cases that occur at the RMC Main Clinic. The resource person discussed 10 cases of coding pending claims along with how to code them according to ICD-9 coding regulations and regulations set by BPJS. This PKM activity has had a positive impact on medical recorders and coder teams, this can be seen from the increased knowledge and understanding of coders and case-mix teams based on the pre-test and post-test results of 10 PKM participants. The participants' pre-test results in Figure 2 are in the value

interval of 20-50 points. Meanwhile, the participants' post-test results were in the interval of 65-95 points. Figure 3-4 shows the conditions of PKM activities in socializing the ICD-9CM coding regulations and the practice of coding cases-pending claims.



Figure 3. Workshop of activity



Figure 4. Photo with PMIK



Figure 5. Workshop of coding ICD-9 CM

Factors that influence coding errors are based on research results from the Institute of Medicine (Bowman and Abdelhak, 2001) as follows:

- Mistake in reading the diagnosis in the medical record file.
- Mistakes in determining the main diagnosis made by the doctor and coder team.
- Inaccuracies in determining diagnosis and procedure codes.
- Diagnosis and procedure codes are not the same as filling out the medical record document form.
- Errors in rewriting or entering code into the system.

Submitting a good claim can use controlling (supervision) organization (Organization), actuating (Implementation), and planning (Planning), and through the use of human resources and other resources. Apart from that, non-existent SOPs also have an impact on communication. Having SOPs can help leaders provide instructions to officers so that the final results of officers' work are by the process of completing the requirements for submitting BPJS Health claims (Nuraini, 2019). Most of the obstacles or personal problems faced by Koder are related to incomplete or non-existent medical resumes. New vocabulary that is not well known by medical record officers also hinders the claim pending process. The medical records officer must confirm with the DPJP doctor to equalize perceptions. The coordination process with the doctor responsible for the patient causes the claim document to be rejected. This problem is a personal problem for medical records officers (Cut Juli Muroli, 2019).

Other factors that cause delays, usually referred to as human resource factors in submitting BPJS claims, are found in case-mix staff with non-medical record educational backgrounds and a shortage of coding staff. Efforts are made by officers to overcome the causes of delays due to HR factors by providing information to patients so that in the future the patient will bring complete requirements. The coding officer communicates with the doctor so that the doctor immediately completes the patient's resume. Medical records officers also make efforts to recruit medical records personnel (Faik Ahgiwayunto, 2019).

CONCLUSIONS AND RECOMMENDATIONS

The conclusions related to community service activities that have been carried out are: Results of the pre-test and post-test, there was an increase in understanding regarding ICD-9 CM coding regulations and solving pending claim cases. In this case, the Community Service also conveyed suggestions that several things need to be done by the clinic, such as providing training for medical record officers, ensuring that the human resources who work have the qualifications, facilities, and infrastructure, especially in the coding section, are appropriate and can support the coder's work, as well as the need for analysis. quality management at the Pakandangan Clinic. Good practices need to be applied in BPJS claim using ICD-9 CM regulation.

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AUTHORS' NOTE

The authors declare that there is no conflict of interest regarding the publication of this article. Authors confirmed that the paper was free of plagiarism.

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