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Juridical analysis of excessive diagnostic code writing (upcoding) reviewed from the regulation of the minister of health number 16 of 2019

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Abstract

The Indonesian government created a system in an effort to achieve health insurance for all Indonesian people, namely the National Social Security System (SJSN). The National Health Insurance Program (JKN) is a manifestation of the implementation of Law Number 36 of 2009 concerning Health. The Social Security Administering Body (BPJS) for Health as the manager of the JKN program is regulated in Law Number 24 of 2011 concerning the Social Security Administering Body. The Social Security Administering Body (BPJS) for Health uses the latest version of INA-CBG's (Indonesia Case Based Groups) rates, namely version 4.0, in the National Health Insurance (JKN) payment pattern. The INACBG rate really depends on the diagnosis made during the patient's treatment at the health service facility. In practice, doctors will establish primary and secondary diagnoses, as well as actions and examinations carried out on patients, which will then be given a diagnosis code by the medical record coder. Writing diagnosis codes is an important part of the process of managing health information in hospitals or other health service facilities. Diagnosis codes are used to record and classify patient diagnoses, making it easier to manage patient data, provide medical care, research, and also insurance claims. Inaccuracy of diagnosis codes will have an impact on health service costs. Related to this, if the coder is not precise and accurate in codifying the disease, it will have an impact on the quality of claim payments. Upcoding is changing a diagnosis and/or procedure code to a code that has a higher rate than it should. There are several factors that cause upcoding to occur. It is important for Follow-up Referral Health Facilities (FKRTL) to take preventive measures to prevent Upcoding from occurring through the efforts mentioned in PMK No. 16 of 2019. If Upcoding or other types of circumstances (Fraud) occur, the authorized agency can impose administrative sanctions starting from verbal warning up to the revocation of the operational permit from the FKRTL.

Keywords: Writing excessive diagnosis codes; Upcoding; Fraud; Prevent; Referral Health Facilities (FKRTL); PMK number 16 of 2019

1 Introduction

The Government of Indonesia created a system in an effort to achieve health insurance for all Indonesia people, namely the National Social Security System (SJSN). The JKN program is a manifestation of the implementation of Law Number 36 of 2009 concerning Health. The Social Security Administration Agency (BPJS) Kesehatan as the manager of the JKN program has been regulated in Law Number 24 of 2011 concerning the Social Security Administration Agency. In the Law, BPJS Kesehatan No.5 tahun 2020 it is explained that JKN strives for all people to have the same right to access safe, quality, and affordable health services in all health services.

The Health Social Security Administration Agency (BPJS) uses the latest version of the INA-CBG's *(Indonesia Case Based Groups)* rate, namely version 4.0 on the National Health Insurance (JKN) payment pattern. This version came into effect in 2014. This provision is in accordance with Presidential Regulation No. 111 of 2013 as a revision of Presidential Regulation No. 12 of 2013 concerning Health Insurance [1].

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INA CBGs (Indonesia Case Base Groups) is a case-based disease classification system used by the Health Social Security Administration Agency (BPJS) in Indonesia. This system aims to regulate the financing and provision of health services based on groups of diseases or similar cases. In INA CBGs, each diagnosis or case of disease is categorized into a group referred to as a "casemix group" based on primary diagnosis, medical procedure, age, gender, and several other factors [2]. So INACBG's rates are highly dependent on the enforcement of the diagnosis during the patient's treatment period at the health care facility. In practice, the doctor will enforce the primary and secondary diagnosis, as well as the actions and supports that are carried out on the patient, which will then be given a diagnosis code by the medical record coder officer.

In the [3] concerning Guidelines for Indonesia Case Base Groups (INA-CBG) in the Implementation of Health Insurance, it is stated that the duties and responsibilities of a coder are to codify diagnoses and actions/procedures written by doctors who treat patients in accordance with ICD-10 (International Statistical Classification of Diseases and Related Health Problems 10th Revision) Version 2010 for diagnosis and ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) 2010 version for actions/procedures sourced from the patient's medical records. If in encoding the diagnosis or action/procedure the coder finds difficulties or inconsistencies with the general rules of coding, the coder must clarify with the doctor [3].

Writing diagnostic codes is an important part of the process of managing health information in hospitals or other health care facilities. Diagnostic codes are used to record and classify patient diagnoses, making it easier to manage patient data, provide medical care, research, and also make insurance claims [4].

The inaccuracy of the diagnosis code will affect the cost of health services. Related to this, if the coder is not precise and accurate in codifying diseases, it will have an impact on the quality of claim payments. Low health service rates will certainly disrupt the cash flow of the Hospital, on the contrary, high hospital rates will seem to benefit the Hospital, so that it can harm BPJS or patients. It is also possible that there will be an Over Payment or Under Payment where BPJS may make an overpayment or underpayment to the Hospital due to the inaccuracy of the diagnostic code carried out by a coder. The discrepancy of the diagnosis code is influenced by the inaccuracy of diagnosis writing, the workload of the coder, and the knowledge of medical record officers about medical terminology [5].

According to [6] concerning the Prevention of FRAUD in the Health Insurance Program, it is stated that a Health Insurance Claim or referred to as a Claim is a request for payment of health service fees by health facilities to the Health Social Security Administration Agency [6]. In article 5 of [7], it is stated that one of the things that can have the potential for fraud in the JKN program is excessive diagnostic code writing (Upcoding). Over-writing of diagnosis (Upcoding) is the change of diagnosis codes and/or procedures into codes that have a higher rate than they should be [3].

The accuracy of clinical coding data is crucial. The amount of claims paid and approved depends on the accuracy of the clinical coding produced. It is important to conduct an analysis of the accuracy of filling in the diagnosis code on medical record documents to prevent a decline in the quality of service in hospitals and can affect the data, report information, and accuracy of INA-CBGs rates. So that these inaccuracies can cause higher rates (*upcoding*) or lower rates (*down coding*). For example, in the enforcement of pneumonia diagnosis. Coders may select this diagnostic code if the criteria for enforcing the diagnosis of pneumonia are met. If the coder chooses the pneumonia code without meeting the criteria in question, it will cause a high INA CBGs rate, which will cause fraud upcoding.

Upcoding rates cause a tendency to *fraud* because they have to be paid higher than they should, on the other hand, rates due to *downcoding* cause losses to hospitals because they are paid below what they should be.

The high *level of fraud upcoding* in the health insurance system that is not resolved can have an impact, which can cause financial losses to the state and disrupt BPJS Kesehatan finances because the funds paid to provide benefits to participants are very large. If this continues to happen, the finances of the health social security fund will be disrupted and even the sustainability of the JKN program will be threatened.

To prevent *fraud upcoding* in the health insurance system, communication and cooperation between doctors, coders and internal verifier teams are needed in the process of verifying claim data. One of them is the role *of coders* in providing diagnostic codes, requiring precision and knowledge of applicable coding rules and rules. Classification and codification of diseases, problems related to health and medical procedures are one of the competencies that must be possessed by medical recorders [4].

If the patient's diagnosis code is not coded accurately, the information generated will have a low validation rate. This will result in inaccurate reports, namely inpatient morbidity reports, top ten disease reports and JAMKESMAS claims [8].

Based on the description above, the formulation of the problem in this study is how to write excessive diagnosis codes reviewed from [6].

2 Material and methods

This study uses a normative juridical approach, which is a legal research method that involves a literature review by examining secondary data. The normative juridical research method uses an approach by studying legislation, theories and conceptual concepts related to the problem to be studied.

This research is a qualitative research that is descriptive, namely by describing how the writing of excessive diagnostic coding (upcoding) is reviewed from what has been mentioned in the [3] concerning the Prevention and Handling of Fraud and the Imposition of Administrative Sanctions Against Fraud in the Implementation of the Health Insurance Program.

3 Results and discussion

3.1 Legal basis for writing excessive diagnostic code (Upcoding)

Upcoding is the conversion of diagnosis and/or procedure codes into codes that have a higher rate than they should. This is regulated in [6] concerning the Prevention and Handling of Fraud and the Imposition of Administrative Sanctions Against Fraud in the Implementation of the Health Insurance Program, replacing [7] concerning the Prevention of Fraud in the Implementation of the Health Insurance Program in the National Social Security System.

One type of fraud that can be committed at the Advanced Referral Health Facility, hereinafter referred to as FKRTL is to manipulate diagnoses and/or actions to increase the amount of claims by falsifying diagnoses and/or medical actions, such as [9]:

- The patient should have been diagnosed *with acute appendicitis*, after surgery without complications but in the resume/medical record written *acute appendicitis* with perforation; and
- Patients with *grade I pterigium* but in the resume/medical record are written squaomous cell ca conjuntiva and an excision biopsy is performed without evidence of anatomical pathology examination.

3.2 Types of Fraud Upcoding

- Coding claims are not in accordance with the rules in multiple conditions or coding errors in multiple conditions, this usually only occurs in inpatient treatment because if it occurs in outpatient there is no difference in rates, for example kidney failure disease in patients with hypertensive kidney in cases like this, the coding should not be claimed separately, namely hypertension (I10) and kidney failure (N00) should be coded for hypertensive kidney disease accompanied by kidney failure (I12.0). It is even expanded again to codes N00 – N07, N18, N-19, N26.
- Coding a diagnosis that is not accompanied by supporting examinations. An example is blood tests in anemia patients (other than bleeding) but there is no lab evidence in the supporting beams.
- Procedure coding errors due to choosing the ICD-9-CM code are not what they should be, for example, the use of an incubator for less than 96 hours (96.71) but the use of an incubator for 96 hours or more (96.72) is coded, in outpatient cases of pregnancy ultrasound (88.78) is coded abdominal ultrasound (88.76) or other ultrasound (unspecified) (88.79).
- Swapping the primary diagnosis for a secondary diagnosis or vice versa (coding needs to be selected). For example, the main condition is written as cataract and the secondary condition is hypertension, but the patient is treated for hypertension, so a reselection is carried out.
- Diagnostic coding errors are choosing codes that are not in accordance with the conditions that should be, for example, patients come to visit for re-control (z-code) but are coded like the first visit [10].

3.3 Causes of Upcoding

- Fraud Upcoding in health care facilities occurs because:
- Low-paid medical personnel
- There is an imbalance between the healthcare system and the healthcare burden
- Service providers do not provide adequate incentives Shortage of medical equipment supply
- Inefficiencies in the system
- Lack of transparency in healthcare facilities
- Cultural factors

According to [11], the *fraud triangle* consists of 3 conditions that are generally present when *fraud* occurs, namely:

- Pressure to commit fraud (pressure)
- Pressure can be divided into:
- Financial problems
- Involved in criminal acts or not in accordance with norms
- Work-related stress
- Opportunity or opportunity to commit *fraud* (opportunity)
- Weak internal control system
- Poor organizational governance

A pretext to justify action (*rarionalization*). *Rationalization* occurs because someone seeks justification for their activities that contain *fraud*. Fraudsters believe or feel that their actions are not fraud but something that is indeed their right, there are even perpetrators who feel that they have contributed because they have done a lot for the organization.

3.4 Solutions to Prevent Upcoding

- Improvement of coder capabilities;
- Identify important factors i.e. coding accuracy
- Fraud knowledge
- Correct coding training
- Adjustment of coder workloads with their number of personnel and competencies
- Interaction with clinical staff in confirming primary and secondary diagnosis
- Understanding and use of coding systems
- Understanding Steps Prevention and sanctions for fraud Compliance with SOPs
- Write and give a medical resume in a clear, complete and timely manner
- Awareness Building
    - Awareness building is the key to preventing the occurrence or spread of *health service fraud* . Building awareness about the potential *for fraud* and its dangers in hospitals is one of the efforts to prevent the occurrence or development of *fraud*.

- Reporting

    - Parties who know of fraud incidents should be able to make a report. Reporting of suspected fraud at least includes the identity of the complainant, the name and address of the agency suspected of committing JKN fraud, as well as the reason for reporting.

- Detection

    - Potential *fraud* detection can be done by analyzing claim data which is carried out with an approach to finding data anomalies, *predictive modeling*, and case discovery. Claim data analysis can be done manually and utilize clinical verification applications that are integrated with the INA-CBGs application. In analyzing claim data, the JKN fraud prevention team can coordinate with BPJS Kesehatan verifiers or other parties as needed.

- Investigation

- Corruption in health services in the JKN era investigation i is carried out by an investigation team appointed by the JKN fraud prevention team by involving expert elements, hospital associations/health facility associations, and professional organizations. An investigation was carried out to confirm the alleged JKN fraud, an explanation of the incident, and the background/reason.

- Sanctions/Enforcement

    - The sanction is carried out to crack down on fraudsters. Based on the Minister of Health Regulation 36 of 2015 concerning JKN fraudulent acts, the parties entitled to sanction are the Minister, the Head of the Provincial Health Office, and the Head of the Regency/City Health Office. The sanctions recommended in the Permenkes are administrative sanctions in the form of verbal reprimands, written reprimands, and orders for the return of losses due to JKN fraud to the aggrieved parties.

3.5 Administrative Sanctions in the event of Fraud Upcoding

In the event that Health Facilities commit fraud in the implementation of the Health Insurance program, officials of authorized agencies can provide administrative sanctions in the form of [12]:

- verbal reprimands;
- written reprimand;
- order for the return of losses due to fraud
- to the aggrieved party;
- additional administrative fines; and/or
- revocation of permits.

The categories of fraud and administrative sanctions are as follows:

In the event of fraud committed;

- Causing losses of less than Rp50,000,000 (fifty million rupiah) for each type of fraud, is categorized as a minor violation.
- Causing losses between Rp50,000,000 (fifty million rupiah) to Rp500,000,000,- (five hundred million rupiah) for each type of fraud or having been sanctioned for minor violations, is categorized as a moderate violation.
- Causing losses of more than Rp500,000,000 (five hundred million rupiah) for each type of fraud or having been sanctioned for moderate violations, is categorized as a serious violation.

4 Conclusion

Upcoding is one of the frauds that can occur in FKRL by manipulating diagnoses and/or actions to increase the amount of claims by falsifying diagnoses and/or medical procedures. It is important for FKRTL to take preventive measures so that upcoding does not occur through the efforts mentioned in PMK No. 16 of 2019. If there is an Upcoding or type of fraud (Fraud), the authorized agency can provide administrative sanctions ranging from a verbal reprimand to the revocation of the operational permit from the FKRTL.

It is recommended to all coders in charge of providing diagnostic codes and actions to always improve their abilities and knowledge in the field of coding. The diagnostic code and the actions given should be re-checked before submitting a claim to the BPJS team, so that upcoding does not occur.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

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