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BPJS PENDING CLAIM MANAGEMENT MODEL FOR INPATIENT CARE AT KENDARI CITY HOSPITAL

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Abstract

This study discusses the BPJS healt delayed claim management model for inpatient care at Kendari City Hospital. This study aims to analyze the facilities, infrastructure, and human resources that support the BPJS healt claim submission process. This research will be conducted at RSUD Kota Kendari, Kendari City Regional General Hospital located at Jl. Brigjend Z.A Sugianto Number 39, Kambu Village, Kambu District, Kendari City. The researcher used a purposive sampling technique, namely selecting informants based on criteria made in accordance with the objectives of the study or selected intentionally or appointed directly to people who are considered to know the most about what is expected. It was found that existing facilities, including computers, servers, and claim applications, were in good condition but often experienced obstacles such as unstable internet connections. In addition, there were challenges in collecting medical resumes and supporting documents that caused delays in claim submission. By involving experienced workers, this study recommends increasing network capacity and adding resources to speed up the claim submission process. The results of this study are expected to contribute to more efficient and effective BPJS Kesehatan claim management in hospitals.

Keywords: BPJS Health, Claim Submission Process, Inpatient Care and Kendari City Hospitals.

1. INTRODUCTION

Management is a series of activities to introduce, plan, organize, lead, coordinate, control, estimate and plan considering the future and prepare activity plans in the organization. Organizing means developing the structure, materials and people of an organization. Leading means binding, uniting and aligning all forms of activity and effort. Controlling means paying attention that everything that happens is in accordance with established regulations and existing demands. Management is the achievement of organizational goals effectively and efficiently through planning, management, leadership and control of organizational resources (Richard L Daft, 2020).

In carrying out the administrative process, hospitals have the meaning of a series of activities consisting of planning, organizing, coordinating and evaluating, so that demands and needs related to services can be met through the provision and implementation of various health efforts aimed at individuals, groups or the community (Kartikasari, 2019). The goal of health development is to guarantee the rights of every citizen to realize a good, healthy and prosperous life physically and mentally. Public health development requires health efforts, health resources and health management to improve the highest level of public health based on the principles of welfare, equity, non-discrimination, participation and sustainability in the context of developing quality and productive human resources, reducing disparities, strengthening health services, ensuring a healthy life, and advancing welfare for all citizens (Health Law, 2023).

Efforts made to improve health services in Indonesia include the government establishing a Social Security Administering Body which is tasked with administering National Health Insurance for all Indonesian citizens. Based on data obtained from health insurance BPJS, it is known that in 2021 it was 86.07% or 235.719 million people, in 2022 it was recorded at 248,077,000 people and 90.70% of the total population of Indonesia of 270,020,000 people. Southeast Sulawesi reached 1,466,999 people or 86.94% of the total population of 1,687,466 people (health insurance BPJS, 2022).

This phenomenon of delaying payment of inpatient claims certainly causes problems for health services at Kendari Regional Hospital, if not resolved it will become a conflict that can lead to a health service dispute between the hospital and BPJS Health. According to Subekti (2005), default is when the debtor does not do what he promised, then he is said to be in default, negligent or negligent or broken a promise or also he violates the agreement, if he does or does something that he should not do. Mentioning that the implementation of obligations that are not on time or are not carried out properly can be said to be a default. Even in the realm of civil law, default is a form of malpractice (Turingsih, 2012) so that in the implementation of the agreement between BPJS Kesehatan and Health Facilities, it must be carried out with the principle of caution.

In previous research conducted by (Honcy Ernesta Nomeni & Rina Waty Sirait, 2020) Soe Regional General Hospital, the implementation of BPJS file claim submission for inpatient care in terms of input, process, and output was considered still not good, because the claim submission flow that starts from the patient returning home after receiving inpatient services, then the file enters the claim file processing room in this case the assembling section is still lacking, the file is checked for completeness but is still incomplete after being analyzed, then this will affect the data process that will be coded and entry into the INA CBG's system so that it can result in delays in submitting claims to BPJS according to the date and month agreed by the hospital with BPJS health. This study attempts to observe the management process in assessing the quality of BPJS health claims management including input, process and output. Claim management is certainly influenced by several factors, namely factors that inhibit the submission of inpatient BPJS Health claims, factors that support the submission of inpatient BPJS Health claims, and the development of a BPJS Health inpatient claim management model at Kendari City Hospital.

2. LITERATUR REVIEW

National Health Insurance

National Health Insurance is part of the National Social Security System as a social health insurance. National Health Insurance is a mandatory national social health insurance based on Law Number 40 of 2004 concerning National Social Security System, Law Number 36 of 2009 concerning Health and Law Number 24 of 2011 concerning BPJS. This program aims to meet the basic health needs of the community, both for those who have paid contributions independently or paid by the government. National Health Insurance provides health services to the community through two health facilities, namely Primary Health Facilities and Advanced Referral Health Facilities. Capitation Rate is the amount of per capita payment per month paid in advance by BPJS Kesehatan to Primary Health Facilities based on the number of

registered participants without taking into account the type and amount of health services provided. Non-Capitation Rate is the amount of claim payment by BPJS Kesehatan to Primary Health Facilities based on the type and amount of health services provided. Indonesian-Case Based Groups Tariff, hereinafter referred to as INA-CBG Tariff, is the amount of claim payment by BPJS Kesehatan to Advanced Referral Health Facilities for service packages based on disease diagnosis and procedure groupings, covering all hospital resources used in both medical and non-medical services. Non INA-CBG Tariff is a tariff outside the INA-CBG package tariff for certain types of services with the claim submission process carried out separately from the INA-CBG tariff.

Evaluation

According to Stufflebeam, et al (1971) defines evaluation as "The process of delineating, obtaining, and providing useful information for judging decision alternatives". This means that evaluation is the process of describing, obtaining, and presenting useful information to formulate a decision alternative. Evaluation according to Kumano (2001) is an assessment of data collected through assessment activities. Meanwhile, according to Calongesi (1995) evaluation is a decision about value based on measurement results. Zainul and Nasution (2001) stated that evaluation can be stated as a decision-making process using information obtained through measuring learning outcomes, either using test or non-test instruments. Evaluation is a tool or procedure used to find out and measure something in an atmosphere with predetermined methods and rules.Meanwhile, according to Brinkerhoff in Sawitri (2007:13), evaluation is a systematic investigation (information gathering process) of various aspects of professional program development and training to evaluate its usefulness and benefits. In the study of evaluation, many models of evaluation are found with different formats or systematics, although in some models there are also the same. Meanwhile, according to Brinkerhoff in Sawitri (2007:13), evaluation is a systematic investigation (information gathering process) of various aspects of professional program development and training to evaluate its usefulness and benefits. In the study of evaluation, many models of evaluation are found with different formats or systematics, although in some models there are also the same.

3. RESEARCH CONCEPTUAL FRAMEWORK

This study discusses the conceptual framework as a paradigm of thinking about the concept of managing BPJS health claims, which underlies theoretical and empirical thinking in this study. The flow of thought of this research study is built based on phenomena, gaps, objectives and theoretical and empirical studies as a basis for conducting research. The approach used is through in-depth interviews with informants who are respondents in this study.

This research begins with reviewing theories relevant to the delay of BPJS health claims. The theoretical study guides the researcher's thought process in compiling this dissertation in addition to being based on the results of studies sourced from theory, also from empirical studies sourced from previous studies relevant to this research. The concept is an abstraction of a theory that explains the relationship between variables (variables that will be studied and those that are not studied). The conceptual framework as a basis for researchers in connecting the findings with theory (Nursalam, 2003). The model framework regarding the management of inpatient BPJS health

claims at Kendari City Hospital. The model framework is the basis for conducting research in an effort to answer the problem of BPJS health claims.

Structure (input) is all resources related to the management of BPJS health claims including administrative completeness, claim files, supporting infrastructure in claim management. Process is a system of activities carried out professionally by medical recorders, starting from administrative services, coding, recapitulation and entry of INA-CBG E-Claims. Outcome is an output that can be used as an approach to assess better claim management.

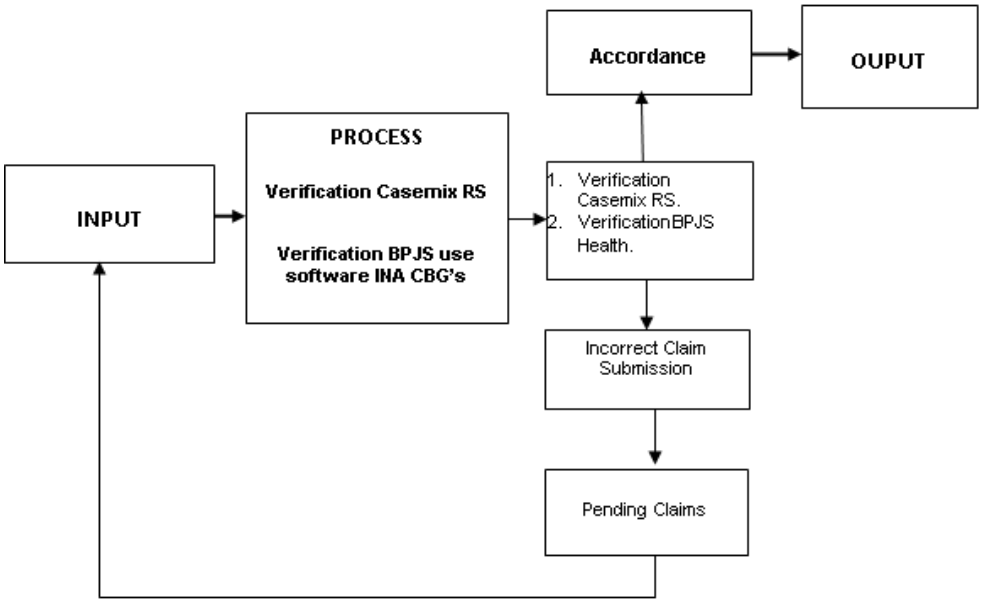

Figure 1: Research Conceptual Framework

4. RESEARCH METHODS

The research approach used in this study is a qualitative approach. This research will be conducted at Kendari City Hospital, Kendari City Regional General Hospital located at Jl. Brigjend Z.A Sugianto Number 39, Kambu Village, Kambu District, Kendari City. Researchers use purposive sampling techniques, namely selecting informants based on criteria created in accordance with research objectives or selected intentionally or appointed directly to people who are considered to know the most about what is expected (Sugiyono, 2014). Data analysis techniques used in qualitative research include interview transcripts, data reduction, analysis, data interpretation and triangulation. Data analysis in this qualitative research is part of a process that is inseparable from data collection techniques either through interviews, observations of theoretical studies or documentation in the form of notes, recordings, photos and videos.

5. RESULTS AND DISCUSSION

Inhibiting and Supporting Factors in Submitting BPJS Health Claims for Inpatient Care at Kendari City Hospital

Several problems that caused the delay in payment of BPJS health claims at the Kendari City Hospital were incomplete administration, the Patient's Responsible Doctor (DPJP) in writing medical resumes, medical recorders and coding processes,

internal verifiers, and infrastructure. Based on data from the last 3 years, pending claim cases in 2022 amounted to 1,160 cases with a total cost of 5,550,818,900, - (Five billion five hundred fifty million eight hundred eighteen thousand nine hundred rupiah) have not been paid because they are not in accordance with the applicable rules and regulations. In 2023, there were 565 cases with a total cost of 3,120,686,400, - (Three billion one hundred twenty million six hundred eighty six thousand four hundred rupiah) in 2023, the Kendari City Hospital had 547 cases or an amount of Rp. 2,481,655,959, -. This pending case was caused by incomplete claim submission files.

Administration

Based on the results of observations and interviews conducted with informants at the inpatient registration location, it is in accordance with the inpatient service flow. Informants said that registration is quite easy, just show your ID card, referral letter or inpatient introduction, besides that the registration system already uses the online SIMRS application, here is an excerpt from the interview with the informant:

"For the current document requirements, BPJS is made easy by simply showing the original or photocopy of the ID card and being served immediately. In addition, if the patient is from the Emergency Room, they must show a referral letter from the hospital, if from outpatients, they must show a referral letter from the Health Center".

Several factors that become obstacles in the registration section regarding the process and completeness of inpatient document requirements, several problems related to administration were found, namely the patient's BPJS Kesehatan was inactive due to arrears in contributions for independent BPJS participants and the patient's name in the application did not match the patient's ID card name, the following is an excerpt from the interview results:

"Sometimes many patients' BPJS cards are not yet active because they are in arrears on premiums for independent BPJS participants. If BPJS is covered by the government, there are mostly data updates from BPJS, for example, if a family member has died but has not been reported, there are also patients who are considered capable, usually BPJS is deactivated ".

Responsible Doctor for Patient

The Responsible Doctor for the Patient is a doctor who is responsible for providing services to patients until the patient is allowed to go home, in addition, the Responsible Doctor for the Patient is also responsible for completing the writing of complete, clear and specific medical resume documents based on the results of diagnostic studies and supporting examinations, so that the main diagnosis and secondary diagnosis can be determined and the procedure and treatment are in accordance with the medical diagnosis. In submitting a claim for financing to BPJS Kesehatan, the Responsible Doctor for the Patient is responsible for filling out the patient's medical resume documents. Incomplete filling of the medical resume, not being signed by the Responsible Doctor for the Patient, unclear writing of the diagnosis so that the coder has difficulty reading the writing are some of the causes of claim returns so that claim payments are postponed. This is in accordance with the results of an interview with one of the informants, the interview excerpt is as follows:

"Personal constraints alone, time issues such as the number of patients so that work piles up resulting in delays in filling out the medical resume when the patient goes home".

Sometimes we DPJP find out for ourselves which coding is appropriate to cover the actions and materials that have been used, I don't know how much the LBP and Tension Headhdace claims are, so we don't immediately fill out the resume, we have to consult again with the casemix section.

Medical Recorder/ Coder

The coder is a medical records officer who is responsible for coding diagnoses and procedures written by the Responsible Physician for Patient on the medical resume in accordance with applicable coding rules. The results of the diagnosis coding will be entered into the e-claim application system according to the Indonesian Case Based Groups (INA-CBGs) standards. If in coding the diagnosis or action/procedure the coder finds difficulties or inconsistencies with the general coding rules, the coder must clarify with the doctor.

The following are the results of an interview with an informant who served as a coder:

"Most of them have been equipped with supporting data, but some are incomplete, we usually ask for the completeness, usually they forget to include it'

"The problem was that in the third month, the doctor usually gave the code, but the meeting results agreed that whatever it was, it was still from the casemix who coded and verified the code"

"There are three of us coders, I am also the inpatient coder so I don't have time to verify the files first"

Room In Charge

The obstacles found in the process of submitting claims for BPJS Kesehatan inpatients stage one are delays in collecting medical resumes and supporting files. This is due to waiting for the DPJP visit schedule, in addition to the limited number of computers and inpatient room administration officers, only one person in each room, not comparable to the number of inpatients which is quite large. The results of interviews with informants are as follows:

"The first delay was in filling out the resume by the Responsible Physician for Patient because every time a patient returned home, there were still some doctors who did not immediately fill out the resume of the patient who had gone home, usually it took two or three days to fill out the medical resume".

"Another obstacle is that the facilities in the room are only one computer unit, and that is also shared with nurses in inputting actions or writing implementations... so we wait for their free time before we also go in to complete the medical record documents to be collected for casemix".

Internal Verifier

The internal medical verifier plays a role in carrying out the verification process on the suitability of services, actions, completeness of medical resumes, supporting documents and analyzing the codes given to each medical resume before the claim is sent to BPJS Kesehatan. The role of the internal verifier is responsible for ensuring the completeness of the medical record documents, including medical resume documents and supporting documents before the claim submission is sent to BPJS Kesehatan. The following is an excerpt from an interview with an informant:

"In casemixkan there is an internal verification team, sir, so the internal verification function before submitting a claim, in the minutes there is also a statement letter that one of the statements is that the claim submitted by the hospital is complete".

BPJS Health Verifier

The duties and responsibilities of the BPJS Kesehatan verifier are to verify with the verification application the completeness of the submitted claim files and the conformity of the diagnosis and actions written by the doctor in the medical resume with the ICD-10 version of 2010 and ICD-9-CM version of 2010. Conduct verification in accordance with the INA-CBGs coding rules and the provisions that have been set (implementation guidelines, technical instructions, circulars, etc.).

"The problem is usually a disagreement between the verifier and the casemix team, usually the pending problem is the same thing, for example, coding problems, completeness of files, so usually they change officers, new officers again, I have also communicated to casemix my suggestion is if there is a claim that is returned as feedback, make a summary of small notes on the wall when there is a new officer or you forget, you can see the notes that are the completeness of the documents".

Supporting Facilities and Infrastructure

The facilities and infrastructure that support the activities of submitting claims for inpatient BPJS Kesehatan patients at the Kendari City Hospital are adequate and in good condition and well maintained. Usually there are obstacles caused by disrupted internet networks or slow loading. The proposed plan is to increase network strength again from 5 MBPs to 10 MBPs. This is certainly one of the inhibiting factors for submitting inpatient BPJS Kesehatan claims, the following is an excerpt from the results of interviews with informants:

"The completeness of the files must be printed while there is only one computer in the room, we have to wait for the others to finish inputting the actions and then take turns to finish"

"The network is half dead, it often loads when we want to input the old medical records in E-claims, here the main thing is that the network must be fast"

BPJS Health Inpatient Claim Management Model at Kendari City Hospital

Kendari city regional general hospital is a partner of BPJS Kesehatan Kendari branch in terms of cooperation in organizing health insurance programs and managing social security funds for the benefit of participants. In managing BPJS Kesehatan claims, this cannot be separated from the management process so that if the management function can be functioned properly, of course claim management can be managed properly so that there are no more claim delays by BPJS Kesehatan.

Claim File Recapitulation and Data Entry

BPJS Kesehatan claim file recapitulation is the process of collecting important documents for submitting claims, including SEP sheets, JKN verification forms, and complete resumes. The recapitulation officer checks the completeness of the files using a checklist and records them in the deposit book. If there are incomplete files, the officer will return them to the treatment room to be completed. Complete files are then submitted to the coder for coding. Recording of medical records must be done within 1x24 hours according to regulations, so it is important for officers to follow good

documentation procedures. However, problems often occur such as incomplete signatures and delays in collecting medical records. Inputting financing claim data is also carried out based on the diagnosis and actions listed in the medical records for the service fee billing process.

Encoding

Coding is a crucial step in submitting BPJS Kesehatan claim files, where the coder arranges the files by date and separates outpatient claims from inpatient claims. Before coding, the officer checks the completeness of the files; if there are any missing files, the files are returned to be completed. Kendari City Regional General Hospital has implemented electronic medical records, but the electronic signature on the medical resume form is not yet fully functional, so the filling process must be done manually. The problem that often arises is incomplete files, which can slow down the claims process and cause a backlog of files that must be returned to be completed. The completeness of medical records greatly affects the accuracy of coding diseases and actions, making coders very important in providing codes for approval of inpatient BPJS Kesehatan claims.

Internal verifier

The results of the study indicate that Kendari City Hospital does not yet have internal medical verifiers specifically tasked with verifying the suitability of services, completeness of medical resumes, and supporting documents before claims are sent to BPJS Health. The role of internal verifiers who should ensure the completeness of documents and the suitability of diagnoses with ICD 10 and ICD 9 CM codes is currently taken over by the person in charge of casemix, who also functions as an inpatient coder. This causes the verification task to not run optimally. The completeness of documents that need to be verified includes patient identity, diagnosis, summary of examination results, and other administrative documents. Verifiers are expected to have basic medical knowledge to ensure appropriate health services for National Health Insurance participants. However, the lack of medical understanding among internal verifiers, who often come from medical records personnel, causes difficulties in clarifying the necessary data. Verifiers are responsible for checking the suitability of claims with INA-CBGs rates and communicating disputed claims to hospital management and the relevant team from BPJS Health.

Submission of BPJS Health claims

Submission of claims for inpatients of BPJS Kesehatan at Kendari City Hospital is done collectively at the beginning of each month, with a submission deadline of the 10th. Disbursement of funds can be done 15 days after the Minutes of Completeness of Files are issued by BPJS Kesehatan. The process begins after the patient is declared discharged, where the family completes the administration and the officer scans the claim files which are then uploaded to the system. The inpatient coder codes the diagnosis and actions according to the ICD-10 and ICD-9 rules, after which the claim files are checked by the claim officer and entered into the INA-CBGs E-Claim Application. Although there should be internal verification, the absence of a verification officer causes the claim documents not to be verified. After the documents are sent to BPJS Kesehatan, calculations are carried out to ensure the completeness of the files, although there is still the potential for Data Not Matching. Incomplete claims are required to be completed before the second stage submission. The results of observations show that although claim files are often incomplete, submissions are still

made so as not to experience delays in payment, although sometimes submissions exceed the agreed deadline.

Facilities, Infrastructure and Human Resources

Facilities and Infrastructure Facilities and infrastructure that support the activities of submitting claims for inpatients of BPJS Kesehatan at the Kendari City Hospital consist of 10 computers, 1 server, 9 printers, 7 scanners, 5 MBPs astinet network, INA-CGGs E-Claim application, V-claim application, 10 work desks, 1 central AC unit and a room area of 7.20 M x 9.60 M (69 M2).

Facilities and infrastructure that support the activities of submitting claims for inpatients of BPJS Kesehatan at the Kendari City Hospital are adequate and in good condition and well maintained. Usually there are obstacles caused by disrupted internet networks or slow loading. The proposed plan is to increase network strength again from 5 MBPs to 10 MBPs. Observation results and personnel data, Human Resources (HR) implementing the submission of BPJS Kesehatan inpatient claims at Kendari City Hospital amount to 10 officers, 4 medical record graduates, 3 public health graduates, 2 midwifery diplomas, 1 biology graduate, with an average work period of more than 5 years. In general, the claim management officers have assigned tasks, namely 3 officers as coders, 2 outpatient coders and 1 inpatient coder. 7 administrative and data entry officers, 5 outpatient data entry officers and 2 inpatient data entry officers.

6. CONCLUSION

Inhibiting factors in claims management are interrelated with each other, therefore effective and efficient management is needed to minimize delays in inpatient claim payments by BPJS Kesehatan. Inhibiting and supporting factors are administration, DPJP, medical recorders/coders, inpatient room personnel, internal verifiers, BPJS Kesehatan verifiers, facilities and infrastructure and human resources.

The management of Kendari City Hospital needs to develop an effective inpatient BPJS Kesehatan claims management model by adding internal medical verification officers as good communication negotiators between the hospital's internal verifiers and BPJS Kesehatan in order to find solutions that can be accepted by Kendari City Hospital as a service provider and BPJS Kesehatan as a guarantor of patient services. Internal medical verifiers are responsible for ensuring the completeness of documents, verifying the suitability of services, completeness of medical resume documents, supporting examinations and the completeness of other administrative documents before claims are sent to BPJS Kesehatan. Internal medical verifiers have the advantage of being able to facilitate two-way communication between DPJP and coders regarding diagnostic coding and between casemix as the claim manager for Kendari City Hospital and the BPJS Kesehatan verifier.

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