

## **Factors Causing Delayed Claims At The Hospital In Collaboration With Health Social Security Agency Branch Office Of Tasikmalaya**

**Irwanto Ali Udin**

Universitas Jenderal Soedirman, irwantofk04usk@gmail.com, Indonesia

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### **ABSTRACT**

**Background:** The Government's efforts to reduce the cost of health services and improve the health of the Indonesian people have been carried out by the National Health Insurance Program by the Health Social Security Agency (BPJS), Health Social Security Agency is the Health Social Security Administering Body which is a legal entity formed to administer the health insurance program. social services that work closely with health facilities to help Indonesian people to obtain basic health services. The hospital is an advanced level health facility that serves National Health Insurance participants on condition that they have collaborated with Health Social Security Agency to be able to organize the National Health Insurance program. Based on previous studies, there are still pending claims in various hospitals throughout Indonesia, thus disrupting hospital cashflow. **Research Objectives:** To find out the factors causing pending claims for BPJS health in hospitals in collaboration with Health Social Security Agency (BPJS) branch office of Tasikmalaya. **Research Methods:** The type of research used is descriptive with a qualitative approach **Research Results:** from the results of the study it is known that the contributing factors include billing and payment of chronic drug claims, claims that are not in accordance with the provisions of the treatment episode, billing claims with diagnostic codes and procedures that not in accordance with the 2010 ICD-10 and ICD-9 CM coding rules, other coding rules and guidelines for the management of claims problem solutions, traffic accident claims that are not in accordance with the provisions and are billed in a fragmented manner. **Conclusion:** Currently, in general, BPJS claims at advanced health facilities in collaboration with Health Social Security Agency (BPJS) branch office of Tasikmalaya are going well, there are still several causes of pending claims that can be improved, suggestions need to be done. Analysis of the level of knowledge of HR in the Hospital Casemix section, there is a need for an application to assist in the settlement of claims in terms of warnings or blocking of regulatory rules as well as evaluating the utilization review of each hospital on the services provided.

**Keywords:** Health insurance administration body, Pending, Claim

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### **1. Introduction**

The National Health Insurance Program (JKN) has been officially established by the Indonesian government since January 1, 2014. The JKN program is managed by the Social Security Administration Agency (BPJS) which is regulated in Law No. 24 of 2011. Hospitals that have collaborated with BPJS Kesehatan can submit a claim to be subsequently paid by Health Social

Security Agency (BPJS) if it has been declared eligible for a claim (Kusumawati & Pujiyanto, 2020).

Health Social Security Agency (BPJS), which is a legal entity established to administer the social security program. The Social Security System is a state program that aims to provide certainty of protection to ensure that all people can meet their basic needs for a decent life (Undang-undang No. 24 of 2011 concerning the Social Security Organizing Agency). The Health Social Security Agency (BPJS) financing system uses tariffs based on Indonesian-Case Base Groups (INA CBGs). The classification of tariffs on INA CBGs is based on the provision of a diagnosis code ICD-10 and an action code on ICD-9 CM. Implementing the Health Social Security Program applies to health service facilities such as clinics, health centers, hospitals, and so on

The Casemix INA-CBGs (Indonesian Case Base Groups) payment method is a grouping of diagnoses and procedures that refer to clinical characteristics and the use of similar or similar resources, the grouping is done using the Eclaim grouper software (Kemenkes RI, 2021).

The payment system with INA-CBGs in hospitals must go through the file verification stage, before a claim is submitted to BPJS Health, verification is carried out first by the hospital's internal verifier to test the correctness of the administration of service accountability that has been carried out by health facilities in order to maintain service quality and efficiency. the cost of health services for BPJS Health participants. The verification flow begins with the health facility preparing a claim file, then the BPJS Health verifier verifies membership administration, verification of service administration, verification of health services and verification using the INA-CBG software. After that, BPJS Kesehatan will approve claims and make payments for files that are considered feasible, but files that are considered unfit must be returned to the hospital to be repaired through the confirmation stage whether the file can be claimed or not (Kemenkes RI, 2014).

Therefore, to understand the health system clearly and completely, it is necessary to understand the health financing subsystem well. However, in reality it is still poorly understood where there are problems detected between health services received by submitting claims that are not in accordance with hospital procedures and rates. This then causes problems that occur in one of the General Hospitals

## **2. Literature Review**

According to the Minister of Health Regulation Number 28 of 2014, the completeness of files for inpatients includes the completeness of medical record information that must be completed and signed by the doctor in charge. Inappropriate health services are often caused by discrepancies between claim sheets and medical resumes such as diagnosis and treatment codes that are not in accordance with ICD-10 and ICD 9 CM.

Based on a preliminary study conducted at RSUD DR. RM Djoelham Binjai in March 2020 and a review was carried out in February 2021, researchers found problems in the BPJS administration regarding the submission of BPJS Health insurance claim files. This is due to incomplete requirements or incomplete medical resumes, coding errors or coding that does not match the medical resume,

Then based on a study at RSUD dr. Abdoer Rahem Situbondo 2021, the factors causing pending claims for BPJS Hospitalization are related to the behavior of officers in submitting BPJS claims (Miliana, 2021).

Meanwhile, based on the research, it shows the return of claim files for BPJS Health inpatients at Dr. Hospital. R.M. Djoelham Binjai occurred due to discrepancies or incomplete filling of items in filling out medical records, errors by officers in the input process, in addition to differences in understanding regarding the completeness of the claim file between the hospital's internal verifier and the BPJS Kesehatan verifier (Wayan, et al, 2021).

The causes of pending inpatient claims in research at Kojas Hospital in 2018 that entered the JKN and Service Development unit were divided into four, namely errors in the coding process, errors in the input process, incorrect placement of diagnoses, and incomplete medical resumes. This is partly due to human error by hospital staff. Therefore, a good verification system prior to submission to BPJS Health is needed as a filter to avoid pending claims. (Kusumawati, 2018)

One of the most common causes is the absence of the signature of the doctor in charge of the patient on the medical resume, even though legally the signature of the medical resume is one of the legitimacies of the medical resume (Permenkes no. 269/MENKES/PER/III/2008 article (4) paragraph 2). The absence of a medical resume signature makes BPJS Health claims unable to be grouped by the guaranteed unit so that Health Social Security Agency (BPJS) claims are pending.

### **3. Research Methodology**

This research was conducted with a qualitative research method which aims to describe the meaning of the subject's experience in the phenomenon under study, in order to dig deeper into the causes of the pending claim files for hospitals in collaboration with Health Social Security Agency (BPJS) branch office of Tasikmalaya. The time of this research was carried out in September 2022. The informants in this study were 7 verifiers of Health Social Security Agency (BPJS) branch office of Tasikmalaya

### **4. Results**

The results of in-depth interviews found that the most common causes of pending claims are:

- Incomplete claim file,  
Inappropriate or incomplete filling of the patient's medical record, such as a discrepancy between the diagnosis and the medical resume, then the therapy given is not in accordance with the existing diagnosis that has been made by the doctor in charge of the patient (DPJP).
- There is an error in billing chronic drug claims  
There is an error in the amount of drug claim payment with details of chronic PRB drug billing, especially insulin with an indication of an unreasonable amount of medicine
- Submission of claims that are not in accordance with the provisions of the treatment episode  
Based on data processing for advanced level outpatient services (RJTL) and advanced level inpatient services (RITL) FKRTL in the Tasikmalaya KC working area for the period June 2020 to May 2021, it was found that there were claims for RJTL services that continued to

RITL at the hospital. At Tasikmalaya sub-district there are 8 hospitals with a total of 56 cases, there are RITL – RITL Slice Claims equal to 3 hospitals with a total of 4 cases, Payment of RITL claims with a tendency for repeated admissions/readmissions found 5 indications of claim billing readmission on 10 samples of SEP. The recapitulation of the condition of repeated admissions is 2 hospitals with a total of 5 cases. claims for services less than 6 hours later referred to which should have been paid as claims for RJTL instead of RITL in 8 cases.

- There are claims with diagnostic codes and procedures that are not in accordance with the 2010 ICD-10 and ICD-9 CM coding rules, other coding rules and guidelines for managing claims problem solutions. Recapitulation of health facilities for all regrouping of non-conforming conditions 341 diagnoses and 123 procedures
- Payment of traffic accident claims that do not comply with the provisions and are billed in a fragmented manner based on the processing of RITL service claim data with repeated cases, it is known that there are claims of participants who experience multiple fractures due to traffic accidents for 3 times billing at one of the hospitals in Garut.
- Claims outside the validity period of SIP/substitute doctor's assignment

## **5. Discussion**

- The claim file is incomplete, due to an understanding of the applicable rules and the absence of checking before submitting a claim
- There is an error in billing chronic drug claims. Should comply with: a. Minister of Health Regulation Number 71 of 2013 concerning Health Services in JKN Article 23
- Submission of claims that are not in accordance with the provisions of the treatment episode
- There are claims with diagnostic codes and procedures that are not in accordance with the 2010 ICD-10 and ICD-9 CM coding rules, other coding rules and guidelines for managing claims problem solutions. Should match:
  - Minister of Health Regulation Number 76 of 2016 concerning Guidelines for Indonesian Case Base Groups (INA-CBGs),
  - Minutes of Minutes Number JP.02.03/3/1906/2017 and Number 780/BA/1217,
  - Minutes of Minutes Number JP.02.03/3/2411/2018 and Number 620/BA/1118,
- Minutes Number JP.02.03/3/1693/2018 and Number 411/BA/0720,
- Claims outside the validity period of SIP/substitute doctor's assignment letter
- This is due to:
  - The hospital does not submit SIP data updates for practicing medical personnel and no longer practicing in a timely manner
  - Indications of doctor's practice in hospitals that do not have legal aspects according to applicable regulations (SIP)

- Monitoring of the incompleteness of the administration of health facilities that have not been optimal
  - This condition results in:
  - Billing and payment of claims for doctors' practices at FKRTL that have not been paid<sup>6</sup>.

## **6. Conclusion**

BPJS Health claims pending due to incomplete claims files, errors in billing chronic drug claims, claims with diagnosis codes and procedures that do not comply with the 2010 ICD-10 and ICD-9 CM coding rules, other coding rules and guidelines for managing claims problem solutions, Payment of traffic accident claims that do not comply with the provisions and are billed in a fragmented manner and claim claims outside the validity period of the SIP / replacement doctor's assignment letter

Hospitals must immediately evaluate to reduce the return of pending claim files, by reading the regulations and always communicating about all existing problems and discussing from each related section and improving the performance of each section, following the regulations correctly.

Health Social Security Agency (BPJS) related to the problem of Pending claims, conducting utilization reviews for claims that have been paid and socialization of applicable regulations related to BPJS Health regulations

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