IMPLEMENTATION OF THE PENDING INPATIENT CLAIM PROCESS FOR BPJS KESEHATAN AT RSUD R.T. NOTOPURO SIDOARJO

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ABSTRAK

Sistem Jaminan Kesehatan Nasional Indonesia telah mengalami perkembangan yang signifikan sejak diberlakukannya Undang-Undang Nomor 44 Tahun 2009. Dalam konteks ini, rumah sakit dituntut untuk memberikan pelayanan kesehatan yang berkualitas, dengan klaim BPJS Kesehatan menjadi salah satu mekanisme klaim yang vital. Klaim rawat inap, sebagai layanan penting, memastikan pembiayaan perawatan pasien. Namun proses klaim tidak selalu berjalan lancar, apalagi dengan adanya klaim tertunda yang menghambat pelayanan dan keuangan rumah sakit. Penelitian ini bertujuan untuk memahami pelaksanaan proses klaim rawat inap BPJS Kesehatan dan penyebabnya, mulai dari aspek administrasi, pengkodean, dan klinis. Metode yang digunakan adalah deskriptif kuantitatif, dengan pengumpulan data pada bulan Januari sampai Maret 2024 dari Instalasi Asuransi RSUD R.T. Notopuro Sidoarjo. Hasil penelitian menunjukkan bahwa pengajuan klaim rawat inap dilakukan secara berkala setiap bulannya, dengan verifikasi oleh tim verifikator BPJS Kesehatan. Penyebab klaim tertunda berasal dari aspek administratif, pengkodean, dan klinis, dengan kriteria klinis yang paling sering terjadi. Pneumonia merupakan penyakit utama yang menyebabkan klaim tertunda. Inovasi dilakukan dengan mengembangkan aplikasi berbasis Excel 'Detektif Raja' untuk memverifikasi data klaim sebelum diajukan ke BPJS Kesehatan, dengan fokus pada diagnosis Pneumonia. Oleh karena itu, peningkatan komunikasi antara pembuat kode dan ahli paru diperlukan untuk memastikan kelengkapan data pendukung yang akurat. Kesimpulan penelitian ini menyoroti pentingnya kelengkapan dokumen klaim, peningkatan kompetensi coder, dan pengembangan aplikasi pendukung. Rekomendasi diberikan untuk meminimalkan jumlah klaim yang tertunda, termasuk pemeriksaan kelengkapan dokumen yang ketat, peningkatan kompetensi pembuat kode, dan pengembangan lebih lanjut aplikasi verifikasi.

Kata kunci **:** BPJS kesehatan, klaim rawat inap, klaim tertunda

ABSTRACT

The Indonesian National Health Insurance System has undergone significant development following the enactment of Law Number 44 of 2009. This study aims to understand the implementation of the BPJS Health inpatient claim process and its causes, from administrative, coding, and clinical aspects. A quantitative descriptive method was used, with data collected from January to March 2024 from the Insurance Installation of RSUD R.T. Notopuro Sidoarjo. The results showed that the submission of inpatient claims is carried out periodically every month, with verification by the BPJS Health verifier team. Causes of pending claims stem from administrative, coding, and clinical aspects, with clinical criteria being the most frequent. Pneumonia is the main disease causing pending claims. Innovations have been made by developing the 'Detektif King' Excel-based application to verify claim data before submission to BPJS Health, focusing on Pneumonia diagnoses. Therefore, improved communication between coders and pulmonologists is necessary to ensure accurate completion of supporting data. The conclusion of this study highlights the importance of complete claim documents, increased coder competence, and the development of supporting applications. Recommendations are provided to minimize the number of pending claims, including strict examination of document completeness, increased coder competence, and further development of verification applications.

Keywords ***:*** *pending claims, BPJS health, inpatient claims*

INTRODUCTION

The National Health Insurance System in Indonesia has undergone significant development with the enactment of Law Number 44 of 2009, which emphasizes the role of hospitals as healthcare facilities providing comprehensive, individual services, including inpatient, outpatient, and emergency care. All hospitals are obligated to provide safe, high-quality, non-discriminatory, and effective healthcare services that prioritize patient interests based on hospital service standards set by health regulations (Minister of Health Regulation Number 4, 2018). According to the Regulation of the Minister of Health of the Republic of Indonesia Number 24 of 2022, medical records are documents containing patient identity data, examinations, treatments, actions, and other services provided to patients (Minister of Health Regulation Number 24, 2022).

Based on the Law of the Republic of Indonesia Number 24 of 2011 concerning the Social Security Administration Agency (BPJS), a non-profit legal entity was established to ensure the fulfillment of basic decent living needs and has provided wider access to the public through the Social Security Program to obtain quality healthcare services (Law Number 24, 2011). Furthermore, the existence of the Health Social Security Administration Agency (BPJS) as an institution responsible for health social protection for all citizens introduces a claim mechanism that allows participants to obtain reimbursement for medical expenses in hospitals. A BPJS claim is a billing submission from the hospital to BPJS Kesehatan for the treatment of BPJS participant patients, processed collectively and billed to BPJS Kesehatan monthly. To receive reimbursement for medical expenses at INA-CBG rates, hospital healthcare facilities must complete and submit BPJS claim forms to BPJS Kesehatan (Valentina & Halawa, 2018). One of the most crucial services in this program is inpatient claims, ensuring participants receive coverage for hospital care costs.

The claim process includes several verification stages aimed at maintaining service quality. The verification process is carried out by BPJS verifiers. BPJS verifiers will monitor compliance with the claim provisions agreed upon between BPJS Kesehatan and the Hospital. If there is a discrepancy in the claim documents, the documents will undergo pending claims (Hidayat, 2023). If there are incomplete claim documents or inaccuracies in coding, BPJS Kesehatan will return the claim documents to the hospital (Lestari, 2023).

Complete data is essential in the claim submission process, including medical records, personal data, insurance cards, and others. Hence, a claim is considered incomplete or pending when the documents submitted by the hospital are not complete (Maulida & Djunawan, 2022). Pending claims mean that BPJS Kesehatan returns the claim documents submitted by the hospital due to incomplete or insufficient requirements (Sahir & Wijayanti, 2022). One of the main challenges faced is pending claims, where the claim documents submitted by the hospital are verified by BPJS but payment is delayed due to administrative, coding, or clinical incompleteness (Kurnia, E. K., 2022).

Pending claims not only impact the hospital's finances but also hinder timely healthcare services to BPJS Kesehatan participants. This study aims to understand the implementation of the BPJS Health inpatient claim process and its causes, from administrative, coding, and clinical aspects. A quantitative descriptive method was used, with data collected from January to March 2024 from the Insurance Installation of RSUD R.T. Notopuro Sidoarjo.

METHOD

Research Type

This study employs a descriptive quantitative research type, which involves describing, investigating, and explaining the studied subject as it is, and drawing conclusions from

observable phenomena using numerical data,the research was conducted from June 10 to June 28, 2024. The research location is at the Insurance Installation of RSUD R.T. Notopuro Sidoarjo, located at Jalan Mojopahit No.667, Sidowayah, Celep, Kec. Sidoarjo, Kab. Sidoarjo, East Java 61215.

Population and Sample

The population in this study consists of the total number of inpatient claim documents submitted to BPJS Kesehatan from January to March 2024. The population size is 846 claim documents. The sampling technique used in this study is total sampling, where all members of the population are taken as samples,the variables in this study are pending inpatient claims of BPJS Kesehatan, viewed from administrative, coding, and clinical aspects.

Data Collection

The data collection method used in this study is observation. In this study, observations were made on the pending claim documents returned by BPJS Kesehatan verifiers and needed to be revised by the hospital during the period of January to March 2024 by observing the criteria for pending claims based on administrative, coding, and clinical aspects.

Research Instruments

The instrument used in this study is a Checklist. In this study, an observation Checklist related to the criteria for pending claims covering administrative, coding, and clinical aspects in claim documents pending by BPJS Kesehatan verifiers was used.

Data Processing

Editing: Data processing is done by re-checking the checklist data sheets on administrative, coding, and clinical aspects, which are structured systematically. Data Entry: Re-entering observation data into the checklist and inputting it into a computer using Microsoft Excel. High accuracy is required in this data entry. Tabulating: Rearranging the obtained data based on the studied variables to facilitate data analysis, grouping all similar data, calculating percentages, and then writing them in table form to facilitate data analysis.

Data Analysis

This study uses univariate analysis (descriptive analysis). Descriptive analysis is performed on pending BPJS Kesehatan claim documents categorized according to administrative, coding, and clinical aspects. To facilitate analysis, the research data is presented in tabular form. The data analysis results are the percentage of pending claim documents based on administrative, coding, and clinical aspects.

RESULT AND DISCUSSION

Inpatient Claim Submission Flow at RSUD R.T. Notopuro Sidoarjo

The results of the research at the Insurance Installation of RSUD R.T. Notopuro Sidoarjo regarding the flow of inpatient claim submission to BPJS Kesehatan indicate that it involves several stages. The inpatient claim submission process is carried out by the Insurance Installation, which consists of 25 staff members and 1 head of installation.

The inpatient claim submission process begins with receiving the claim documents of medical records for patients discharged from inpatient care. The documents are then coded by the staff according to ICD 10 for disease diagnoses and ICD 9-CM for procedure codes. The staff enters the coded documents into the E-Claim INA-CBG's application, where grouping and costing are performed. After that, the staff verifies the data using an Excel application,

and if everything is in order, they extract the data in txt format and send it to BPJS Kesehatan.

According to the Regulation of the Health Social Security Administration Agency Number 3 of 2017 on the Management of Administrative Claims for Health Facilities in the Implementation of the National Health Insurance, it is stated that health facilities must submit collective and complete claims to BPJS Kesehatan no later than the 10th of the following month (BPJS Kesehatan Number 3, 2017). At RSUD R.T. Notopuro Sidoarjo, the claim submission process is carried out accordingly. Inpatient claim submissions are done monthly. The claim documents for one month that have been entered into the system are submitted collectively and billed to BPJS Kesehatan in one submission process, typically conducted on the 10th of the following month. BPJS Kesehatan will then perform verification, and within 14 days, the hospital receives feedback on the submitted claims. The feedback includes a report on claims that are approved for payment and those that are pending. If there are revisions or pending claims from BPJS Kesehatan, the hospital will revise and resubmit the claims in the following month.

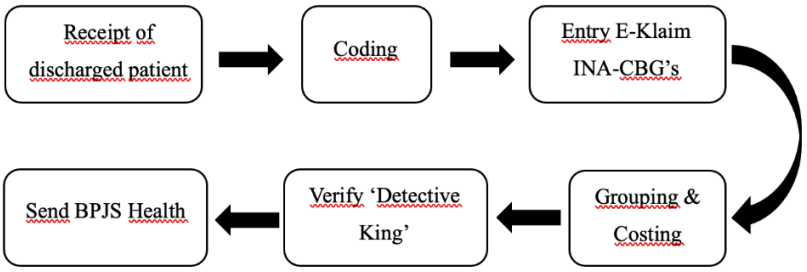

Figure 1. Inpatient Claim Submission Flow at RSUD R.T. Notopuro Sidoarjo (Source: Secondary Data from the Insurance Installation, 2024)

Criteria for Pending Claims

The research was conducted on hospital claim submissions from January to March 2024 for BPJS Kesehatan inpatient patients at RSUD R.T. Notopuro Sidoarjo.

Table 1. Data on the Status of Inpatient Claim Submissions to BPJS Kesehatan for the Period January – March 2024 at RSUD R.T. Notopuro Sidoarjo

Month	Total	frequency	Test Result			
			Worthy	frequency	Pending	frequency
Januari	3.912	100%	3.695	94%	217	6%
February	3.575	100%	3.314	93%	261	7%
March	3.938	100%	3.570	91%	368	9%

Based on table 1, it can be seen that the submission of inpatient claims to BPJS Kesehatan for the period of January – March 2024 still had documents pending or returned by BPJS Kesehatan verifiers each month during that period. Of the total documents submitted from January to March 2024, the highest number of pending claims was in March, with 9% or 368 documents. Below are the data on pending inpatient claims for the period of January – March 2024 at RSUD R.T. Notopuro Sidoarjo based on the criteria of administrative aspects, coding aspects, and clinical aspects.

Based on table 2, from all pending claim documents, the data was separated based on the criteria of the cause taken from the reason column. The causative factors are divided into 3 criteria: administrative aspects, coding aspects, and clinical aspects. From the filtering of a total of 846 pending claim documents from January to March 2024, it was found that 6% or 52 documents were due to administrative issues, 25% or 212 documents due to coding issues, and 69% or 582 documents due to clinical issues.

Table 2. Criteria for Pending Inpatient Claims to BPJS Kesehatan for the Period of January – March 2024 at RSUD R.T. Notopuro Sidoarjo

Departement	Month			Amount	%
	January	February	March		
Administration	12	18	22	52	6%
Coding	62	69	81	212	25%
Clinical	143	174	265	582	69%
Total	217	261	368	846	100%

Based on the criteria for pending inpatient claims obtained from the analysis of the data, the findings are:

Administrative Aspects

Absence of billing attached that matches the patient's service class. Absence of the JR guarantee amount. Absence of an operation report. Inpatient episode. Absence of patient chronology. Duplicate inpatient records.

The causes of pending claims in the administrative aspect are due to incomplete documents and failure to attach the necessary documents for BPJS Kesehatan claim submission requirements. The study found that the incomplete documents originated from inpatient medical records. The completeness of inpatient medical records is crucial in the claim submission process; therefore, it is important for staff to check and ensure that all required documents are complete to meet the claim requirements, ensuring accurate and appropriate funding for the specified types of care provided.

Coding Aspects

Inaccurate coding. Lack of supporting data for diagnosis. Differences in understanding between the hospital and BPJS Kesehatan verifiers regarding disease or procedure coding. The causes of pending claims in the coding aspect are due to discrepancies in the INA-CBG's coding with diagnoses using ICD 10 or ICD 9-CM. Inadequate supporting data and inconsistencies in diagnoses with ICD 10 result in coding that needs to be re-verified for diagnostic indications.

Clinical Aspects

Insufficient supporting examinations. Lack of therapy evidence. The causes of pending claims in the clinical aspect are the most frequent among the three criteria. Supporting examinations and therapy evidence are essential requirements in BPJS Kesehatan claim submissions. Reports of supporting examinations and therapy evidence must be attached to determine the additional costs that need to be billed to BPJS Kesehatan.

Factors Causing Pending Inpatient Claims

The study found that the most frequent criteria causing pending claims from January to March 2024 were in the clinical aspect, accounting for 69% or 582 pending claim documents, with Pneumonia being the most common diagnosis leading to pending claims.

Table 3. Examples of Factors Causing Pending Inpatient Claims in Clinical Aspects

Number of RM	Pending Causation Factors
1593xxx	Don't meet the criteria for dx pneumonia according to PNPK 2147 of 2023, culture examination?
2257xxx	Pneumonia Support
2258xxx	J18 Support
1320xxx	Does this qualify as a condition for pneumonia?
2237xxx	The resume doesn't show Pneumonia, just pleural effusion? pleural puncture?

Based on table 3, the examples of factors causing pending inpatient claims from a clinical perspective show that Pneumonia is the most common diagnosis leading to pending claims. This issue arises due to insufficient supporting examinations and management of the diagnosis, which do not meet the criteria for diagnosing Pneumonia according to (PNPK 2147, 2023) and are not in compliance with the requirements outlined in (BA Kesepakatan Bersama, 2018), as follows: Pneumonia can be diagnosed according to KMK RI No. HK 02.02/MENKES/514/2015 if a chest X-ray shows new or progressive infiltrates plus two or more of the following symptoms: a. Persistent cough b. Changes in sputum characteristics/purulent c. Body temperature >38°C (axilla) or history of fever d. Physical examination: signs of consolidation, bronchial breath sounds, and rales e. Leukocyte count >10,000 or <4,500

Innovation in Insurance Installation

Pending claims result in unpaid healthcare services by BPJS Kesehatan, leading to decreased hospital revenue and impacting operational activities at the hospital. Given these issues, there is a need for efforts/innovations to minimize the occurrence of pending claims.

Figure 2. 'Detektif King' Excel Application
(Source: Insurance Installation)

Based on figure 2, the Insurance Installation has developed an Excel-based application called 'Detektif King' used to verify claim data before it is sent to BPJS Kesehatan, thus reducing the risk of input errors or pending claims during the submission process. After coding and entering the claim documents into INA-CBG's, the Verification Team from the Insurance Installation will review the documents. If there are errors in the input process, incorrect coding, or missing supporting reports, the documents will be returned to the input staff for revision. If the claim documents are correct, a txt file will be extracted, and the claim documents will be sent to BPJS Kesehatan. For pending claims in the clinical aspect, the documents are returned to the responsible doctor for re-verification.

Based on the author's research on pending claims from January to March 2024, Pneumonia is identified as the most frequent disease causing pending claims in the clinical aspect. This issue arises from inadequate supporting examination reports and therapy evidence that have not been attached. Therefore, there is a need for efforts/innovations to

minimize pending claims by verifying the claims before sending them to BPJS Kesehatan, including the following: Currently, the Insurance Installation uses the 'Detektif King' Excel application to verify claim data before submission to BPJS Kesehatan. Adding specific filters for Pneumonia diagnoses to align with the latest BA Kesepakatan and PNPK Pneumonia guidelines to minimize Pneumonia-related pending claims. Conducting monitoring and evaluation of the use of the 'Detektif King' Excel application. Enhancing communication between coders and pulmonologists.

CONCLUSION

Based on the research titled "Implementation of the Pending Inpatient Claims Process for BPJS Kesehatan at RSUD R.T. Notopuro Sidoarjo," the inpatient claim submission process begins with the receipt of patient discharge documents, followed by coding, entry into E-Klaim INA-CBG's, grouping and costing, verification using 'Detektif King,' and finally sending the claims to BPJS Kesehatan. From the findings of pending claims during the period of January to March 2024, the following conclusions can be drawn: The criteria for pending claims in the administrative aspect account for 52 documents, or 6%, due to incomplete documentation in fulfilling BPJS Kesehatan claim submission requirements,the criteria for pending claims in the coding aspect account for 212 documents, or 25%, due to insufficient supporting data, resulting in the need for re-verification of diagnostic indications,and the most common criteria for pending claims from January to March 2024 are in the clinical aspect, with a total of 69% for 582 pending claim documents, and Pneumonia being the most frequent diagnosis.

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