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BPJS Patient Billing Claims: Study On Hospital Polyclinic Services As Outpatient Revenue

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ABSTRACT

Several issues have been raised regarding the uneven payment of bills related to BPJS health insurance. The purpose of this study is to contribute to the accountability of BPJS patient billing claims for outpatient services at the Hospital as outpatient income. The flow of BPJS special patient services from reception to settlement of claims is the focus for identifying pending services. Design/Methodology/Approach: this qualitative research uses in-depth interviews with relevant informants. Interviews were conducted with the head manager of the KMKB, the head of the BPJS officer's office and two outpatient coder staff. We also conducted a triangulation test to test the validity of the data. The data from the interviews were then analyzed to explain the findings. Findings: several technical findings are the cause of claims for bad claims, including claims of outpatients and inpatients on the same day and date, incomplete medical resumes filled out by the doctor in charge of the patient, patients who are referred back but the time period has expired, network problems when accessing INA CBG's, and delays in settlement of claims so that the BPJS claim period expires. Originality/Values: This research offers unique insight into health services related to BPJS patient claims services by explaining how to understand them and anticipate pending claims or claims that cannot be disbursed through the results of qualitative research using an in-depth interview approach.

Keywords: Casemix, BPJS health insurance, INA CBG's, Outpatient Income

1. Introduction

Indonesia started implementing the National Health System (JKN) in 2014, based on the United Nations Working Conditions Agreement for Children's rights. The JKN system was developed by the Social Welfare Agency (BPJS). Hospitals that have coordinated with BPJS Health can submit claims to always be paid by BPJS Health if the claim is declared feasible (Kusumawati & Pujiyanto, 2018). Hospitals are health institutions that provide inpatient, outpatient and emergency services easily. Hospitals can be built by mayors, districts, or foreign countries. hospitals established by the central government and regional governments as referred to in the current system are in the form of technical implementation units from agencies in charge of health, or certain agencies with public service delivery agencies or regional public service agencies in accordance with statutory provisions (Saputri, et. al 2022). *Permenkes* No. 71 of 2013 concerning Health Services at the National Health Insurance states that health insurance is a guarantee in the form of health protection, so that participants receive health care benefits and protection in meeting basic health needs provided to everyone who has paid contributions whose contributions are paid by the government. Everyone who already has a BPJS card and pays their dues, the cost of their basic health needs will be suspended by BPJS through the claim process submitted by the hospital to BPJS. In *Permenkes* No. 51 of 2018 concerning Imposition of Fees and Differences in Costs in the Health Insurance Program, to improve the quality and sustainability of the health insurance program, it is necessary to provide a reference for charging fees and cost differences as part of efforts to control quality and cost control and prevent abuse of services in Health facility (Santiasih, 2021).

The Social Security Administrative Body (BPJS) is a legal entity formed to administer social security programs, with the aim of providing guarantees of certainty and social welfare to the people. The purpose of the establishment of the BPJS is to realize the provision of guarantees for meeting the basic needs of a decent life for participants and/or their family members. The basic needs of life in question are the essential needs of every person

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in order to be able to live properly for the realization of social welfare for all people. BPJS was created to reduce participants' feelings of worry about the risk of loss caused by their illness so that the assets owned by participants can be used for other things that are more productive (Mardiyoko et al., 2020). BPJS claims are the treatment of BPJS Health participant patients by hospitals to BPJS Health which is carried out collectively and billed to BPJS Health every month. This health financing is one of the interests of JKN which is held in hospitals to BPJS through filing claims. To get this benefit, hospitals are required to submit proof documents as a condition for claims (Maulida & Djunawan, 2022). BPJS claims are submissions for the cost of treating BPJS participant patients by the Hospital and billed to BPJS Health every month. Claims are made manually using the INA-CBG's software. Claims submitted by health facilities are first verified by the BPJS Health verifier whose purpose is to test the correctness and completeness of administration of accountability for services that have been provided to patients (Ministry of Health, 2016).

Pending BPJS claim files can cause late payment of claims from BPJS to the hospital and harm the hospital's finances and result in delays in payment of medical services for doctors and other health worker services (Triatmaja). facilities that cooperate with BPJS Health must complete Claim Settlement within 10 months by following procedures according to the BPJS Health verification process (Mardiyoko et al., 2020). The file verification process has two steps, claim file and claim administration. So, if there is a jam in the claim file it will have an impact on the hospital's cash funds, and result in disruption to problems in paying the claim.

Outpatient service is a functional unit in a hospital that accepts patients for outpatient treatment and patients to be treated. Outpatient services are also the patient's first access to the hospital, an indicator of medical record services. The health financing system in Indonesia currently in effect is the National Health Insurance (JKN) which began in 2014 which is gradually moving towards Universal Health Coverage. The goal of JKN in general is to make it easier for people to access health services and get quality health services. In the implementation of JKN, the payment pattern for advanced level health facilities has been regulated by INA-CBG's in accordance with Presidential Regulation Number 82 of 2018 (Saputri, 2022).

Administration of JKN claims is carried out using the INA-CBGs (Indonesian Case Based Groups) system. Where claim payments are made based on the severity of the condition. BPJS Kesehatan Accredited The INA-CBGs payment process must be completed in its entirety. Claims submitted by health facilities will be verified by BPJS verifiers who will look for ways to improve the quality of life and efficiency of health facilities (Santiasih et al., 2021; Azmi, 2018). Claims submitted are inseparable from what is called coding. Coding is an activity of medical records and processing to provide codes with letters and numbers and combinations of letters and numbers that represent data components. Diagnosing the current disease classification using ICD-10 to code disease, and ICOPIM and ICD-9 CM to code action, with the computer (online) to code disease and action (Pratama et al., 2023). Claim files that are pending in writing the diagnosis code and action code are incomplete medical record files and inaccuracies in writing the diagnostic code and action code. The inaccuracy of writing diagnostic and action codes is a perception between the house coders.

2. Methods

This study was designed using descriptive qualitative methods with interpretive phenomenological analysis. This interpretative phenomenological analysis focuses on understanding the essence of a particular phenomenon, so that it will focus on exploring, explaining, translating, understanding the situation felt by participants from their experiences in the field. To do this, we conducted semi-structured interviews to gather information. In addition, we also collected secondary data in the form of BPJS patient transaction documents prepared by hospital staff and documents resulting from BPJS responses with their analysis and direct observations made to see the flow of the cycle process. bills to BPJS in several cases.

This research was conducted at Hospital in Pekanbaru. Researchers made direct observations in May-July 2023 in the Casemix room and the main object was outpatient care. The informants in this study were a head of the KMKB manager, a head of the BPJS officer's office and two outpatient coder staff (Azmi et al., 2018). We collected related documents as a basis for explaining the information we extracted from informants. Data was collected through in-depth interview techniques with informants.

The interview results were written down and recorded by the researcher to ensure that nothing was missed from the interview results. Information obtained from interviews is then recapitulated, classified to facilitate analysis. We first transcribed all the results obtained from the interviews, then carried out a sorting process so that we reduced some irrelevant data, then we developed coding and categorization to facilitate the interpretation process. We guarantee the level of trust in both the data collection process and data analysis. To maintain credibility, a data triangulation test was carried out to convince researchers whether the data is valid and can be used. Finally, we organize our findings by describing the situation and analyzing the findings.

3. Results and Discussion

The results found that there were cases of outpatient BPJS bad claims in January and February. BPJS claims are submissions for medical expenses for BPJS participant patients by the Hospital and are billed to BPJS Health

every month. Furthermore, BPJS Health will process claims and pay claims that are appropriate in accordance with the claim requirements, but for files that are not eligible for claims or are stuck, they will be returned to the hospital for re-examination. Hospital x still has BPJS bad claims. This BPJS default claim occurs due to differences in perceptions between the hospital and the BPJS verifier. In January received 94 cases of defaulted claims and 45 cases of February defaulted claims from a total submission of 139 outpatient claims for BPJS patients.

Table 1. Results of cases of outpatient traffic jam claims at Hospital x in 2023

No	Month	Amount of Cases	Total
1.	January	94	139
2.	February	45	

Source: Data Processed 2023

Based on table 1 above in outpatient cases at Hospital x filed 139 bad claims in January and February. From the problems that occurred at Hospital x concluded that the cause of the problem was in accordance with an interview I had with one of the casemix coder officers, who was still experiencing a stalled claim in submitting claims to BPJS. These claims often occur due to several factors, including:

3.1 Identification of Unsuitable January and February FPKs

Claims processing is prioritized to provide timely and accurate results. Implementation of claims that are not thorough in settlement of claims causes BPJS Kesehatan to return claim files. Based on the outpatient coder informants I interviewed, the following results:

Coder casemix says 1:

"The processing of stalled claims or what is commonly called revisions or not appropriate, can occur because of 1 episode with hospitalization, for example a patient is treated with outpatient care on the same date and treated as inpatient at the same time, this is one of the causes of bpjs claims submitted every month and returned again by the BPJS. "

Coder casemix says 2:

"Outpatient claims for outpatient coder staff are working on revisions to bad claims, for example the number of revised cases in January totaled 94 cases, so there were 2 people working on the settlement of bad claims to speed up processing of claims, outpatient bpjs bad claims, causes of bad claims this could be a revision from an incomplete medical resume or it could be from an error in inputting the DPJP at the INA-CBGs."

Kanit casemix says:

"The cause of outpatient claims can be congested, usually the patient seeks treatment in 1 episode on the same day the patient seeks outpatient treatment and enters the hospital in the evening again, and also PRB patients or patients who refer back, the referral period has expired from every 3 months of treatment to Dr. internal medicine, but the patient still wants to go to the lungs, for example like the disease has nothing to do with going to the internal medicine polyclinic and is not consulted but sent home to the patient to the health facility."

The KMKB Manager said:

"Outpatient non-performing claims greatly affect hospital costs in terms of management, so every month it is monitored in the execution of outpatient revisions of bad claims to what extent because revisions of bad claims are expired for 3 months, so if the submission to BPJS is more than 3 months, then BPJS outpatient claims will not be paid again."

Based on the results of interviews that I observed with pending FPKs in January and February 2023, there must be completeness from patients to come for outpatient treatment at Hospital x because if the outpatient file is incomplete, the BPJS will return the file back to the hospital, then it will be called a default claim which will be valid for 3 months from the submission of the file, after 3 months of filing the regular FPK file. But if the claim is jammed If it is not submitted back to BPJS, the default claim will expire.

3.2 Constraints on the Use of Software from the INA-CBGs Application

Claim JKN BPJS Kesehatan at the hospital using the INACBG application. The "INA-CBGs" (Indonesian - Case Based Groups) tariff is the payment of claims made by BPJS Health to Health Facilities. Advanced Level to a package of services targeted to a diagnostic grouping of diseases and procedures. Based on the outpatient coder informants I interviewed, the following results:

Coder casemix says 1:

"The problem with the INA-CBGs application is usually the network of fellow applications in all hospitals in Pekanbaru because they both use the same application."

Coder casemix says 2:

"The processing of outpatient traffic jam claims from a software perspective can also affect it because it happened when finalizing a BPJS jammed claim, but suddenly the network has problems from the BPJS."

Kanit casemix says:

"For the network itself, we usually have a separate network that is not netted by any unit because every month the hospital will make an application, so the network belonging to Hospital x is not connected to the casemix network. So, if there is a problem maybe it's the network from BPJS itself. "

The KMKB Manager said:

"The software network for casemix is specifically separate, there should be no connection because if someone uses it, for example from another unit there will be problems in submitting outpatient revision claims. To avoid delays in claims sent to BPJS, the hospital creates a software network for casemix separately."

Based on the results of interviews that I observed, the effect of bad claims on Hospital's finances. Hospital x is large, so you have to pay attention to every date because you have to be on the spot if we are slow in working on the BPJS default claim, at the beginning of the month casemix will be overwhelmed to catch up with the target of the bad claim.

There is a claim for Hospital X every month, but it is possible if it has been filled in completely, whether it is an outpatient medical resume or other support, even though there is an error in giving the diagnosis code, this default claim does not only occur at Hospital X, but also in all hospitals with payments based on regular FPK. If these factors cause outpatient BPJS bad claims, a series of outpatient procedures can only be carried out 1 (one) time for each episode. BPJS claim verifiers will identify cases of bad claims for a maximum of 3 days, while regular claim cases will identify them for 14 days. This health facility will only aim to test the correctness of the health services provided by the hospital to BPJS Health patients in order to maintain service quality and cost efficiency of health services for BPJS Health participants. If an improper claim is found, the BPJS will not pay for the claim. Hospital health facilities are required to complete BPJS claim documents before submitting them to BPJS Health to get reimbursement for treatment costs according to the Indonesian Case Base Groups (INA-CBG's) rates.

If there are always bad claims, it will have a major influence on the inclusion of funds for the hospital and can affect the quality indicators of the hospital's health insurance team and can affect the quality indicators of the health insurance team. This outpatient service is a functional unit in a hospital that accepts patients for outpatient treatment and patients who will be treated. Outpatient services are also the first access of patients at the hospital, one of the indicators of medical record services at the hospital.

Based on observations, BPJS claims were recorded 94 cases in January and 45 cases in February, FPK On outpatient BPJS outpatient claims the FPK itself has outpatient jammed claims which are directly worked on outpatient casemix coders the cause of bad bill claims, including claims outpatients and inpatients on the same day and date, incomplete medical resumes filled out by the doctor in charge of the patient, patients who are referred back but the time period has expired, there are network problems when accessing INA CBG's, and delays in claim settlement so that the bpjs claim period expires . so that there is no expiration of the expired outpatient jammed claim itself which must be done by the casemix coder within 1 month or no later than 2 months, so that no expired jammed claims occur, because if it is expired the BPJS is not responsible for paying to the hospital.

4. Conclusion

4.1 Conclusion

Based on the results, the factors causing bad claims for outpatient BPJS patients in January and February at Hospital x were caused by 95 cases of bad BPJS claims in January and 45 cases in February with bad claims for outpatient BPJS patients. there are claims for bad bills, including claims for outpatients and inpatients on the same day and date, incomplete medical resumes filled out by the doctor in charge of the patient, patients who are referred back but the time period has expired, network problems when accessing INA CBG's, and delays in settlement of claims so that the BPJS claim period expires, the party from BPJS is not responsible for paying the hospital, so this greatly affects the hospital's finances.

4.2 Suggestion

After conducting interviews regarding the January and February 2023 default claims at Hospital x, there are several suggestions: First, It is best to double check the outpatient claim files, both from medical resumes, supporting results, such as laboratory documents and supporting documents such as radiology, must be complete so that outpatient claims are not jammed. Second, We recommend that the application at INA CBGs in hospital x software should use an application that is bridging or directly connected to BPJS such as ERM, to minimize errors in filling out medical resumes, as well as to make it easier to send bad claims to BPJS. Third, In order to achieve the target for claims at the beginning of the month, it can be submitted as well as possible, casemix staff can input them on the spot so that there is no accumulation of claims at the end of the month.

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