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FACTORS AFFECTING THE SETTLEMENT OF BPJS AGAINST THE APPROVAL VERIFIERS BPJS AT CITAMA HOSPITAL

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ABSTRAK

The hospital claim process starts with completing the document file as a condition for submitting a claim by the hospital coding officer. A verifier verifies the claim file at the BPJS Center. Verification is researching and checking the claim's Completeness, validity, and feasibility. After verification, the claim file is sent to the Branch Office / District / City Operational Office of BPJS Kesehatan. The Completeness of the document file is an important part of the claim process. If the Hospital can meet the Completeness of the documents, it is likely that the faster the process of reimbursement of the cost of health services that have been provided. The method used in this study is the mixed method. The mixed method is a research method that combines quantitative methods with qualitative methods to be used together in a research activity so that more comprehensive, valid, reliable, and objective data are obtained. Hypothesis Results from First Hypothesis 1) Hypothesis Zero (Ho) There is no relationship between the Completeness of the inpatient medical records of the surgical care unit with the approval of the BPJS claim at Citama Hospital 2) Alternative Hypothesis (Ha) There is a relationship between the Completeness of the inpatient medical records of the inpatient care unit with the approval of the BPJS claim at Citama Hospital Based on the results of the Simple Regression in the previous section, it can be concluded that Ho was rejected, Ha received. The Completeness of the inpatient medical records of the inpatient care unit significantly affects the approval of BPJS claims at Citama Hospital.

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INTRODUCTION

Health services in Indonesia cannot be separated from government programs, namely national health insurance (JKN) and national health insurance (JKN). The implementation of JKN in hospitals uses an insurance payment system. The payment method used in the national health insurance program (JKN) at this time with a prospective payment method is a method that refers to Casemix (Case by payment) or using the Case Base Group (INA-CBGs) system. The INA-CBGs payment system uses claims that will later receive reimbursement from BPJS for services provided to BPJS participants (Mininjaya, 2012).

Submitting a certificate from the Hospital to BPJS Kesehatan has several stages, including verification, Completion of the administrative claim file for service administration participation, and verification of health services. Suppose an incomplete claim file is found in the verification process (NURKONITA, 2014). In that case, it will cause delays in submitting a claim or even returning the file to the claim for delay in submitting a claim, and this unclaimed file can cause material losses to the Hospital.

The hospital claim process starts with completing the document file as a condition for submitting a claim by the hospital coding officer (Prapancha, n.d.). A verifier verifies the claim file at the BPJS Center. Verification is researching and checking the claim's Completeness, validity, and feasibility. After verification, the claim file is sent to the BPJS Kesehatan Branch Office/Regency/City Operational Office. The claim file that arrives at the BPJS Kesehatan Branch Office is approved by the Head of the Referral Health Service Management Unit (MPKR) to be submitted to the finance unit (Sembiring et al., 2019).

The Completeness of the document file is an important part of the claim process. If the Hospital can fulfill the Completeness of the documents, the reimbursement process for health services provided will likely be faster. Several conditions must be completed in the claim process, namely as follows: a claim submission form, softcopy of the application output, original stamped receipt, proof of service that the participant or family member has signed, and other Completeness required by each claim bill. And the Completeness of DPJP in writing its Completeness in the medical record (Cheah, 2000).

Problems commonly found in the implementation of claim procedures are claim file problems, the number of follow-up claims, inconsistency in the rates submitted by hospitals with INA CBGs rates or paid by BPJS Kesehatan, irregularities in coding disease diagnoses, and delays in payment of claims by BPJS Kesehatan. Therefore, good management is important for BPJS Kesehatan (Chew et al., 2007).

The claim procedure is a series of activities to research and prove that a transaction has occurred and make the appropriate payment at a predetermined time. The claim procedure is complex, from claims being accepted to claims being paid or rejected (Showalter, 2012).

Problem boundaries are used to avoid deviations and widening of the subject matter so that the research is more directed and focused and achieves the research objectives. Some of the limitations of the problem in this study are as follows: Factors

affecting the settlement of BPJS claims to the approval of claims by verifiers include: a) Incompleteness of the file provided, b) Wrong coding on Inacbgs application, c) Inappropriate coding rules d) Medical resim files that are more than 2x24 hours e) The processing time the file is compiled inputted until it is sent. Problem Formulation By cooperating with BPJS Kesehatan, the Hospital is obliged to provide services to BPJS Kesehatan participants. Then the Hospital has the right to submit a claim for payment to BPJS for the service (Hussien et al., 2019).

METHODS

Conceptual Description Concept of Claim i. Definition of Claim A claim is a bill for health care costs for health insurance participants submitted individually or collectively by a Health Service Provider (PPK). A claim is a request of one of the two parties to the bond for its rights given to BPJS participants. However, in the implementation, sometimes the payment of BPJS claims to hospitals is in arrears, amounting to above 10% of the total claims. This has an impact on hospital operations.

Research Objectives 1) General Purpose Get an overview of the factors that affect the settlement of BPJS claims at Citama Hospital in 2022 2) Special Purpose a. Get an overview of the flow of the claim process at cinema hospital. b. Get an overview and analyze input factors (Man: Coder, Verifier, DPJP), Material (medical record file, adm file, receivables file), Method (Standard Operating Procedure), Machine (SIM RS). c. Get an overview, analyze the process factors of completing the claim file, and verify the file before being billed to BPJS. d. Get an overview and analyze the output factors of the results of submitting a claim, whether it is feasible, delayed payment (revision/confirmation), or not worth paying.

Scope of Research

This research was carried out at Citama Hospital Jl. Pabuaran no 52, Bogor Regency, from July to August 2022. General Provisions for Claims at BPJS (Kesehatan 1) Health facilities file a monthly claim regularly by the 10th of the following month. 2) BPJS Kesehatan must pay health facilities for services provided to participants no later than 15 (fifteen) working days after the claim documents are received in full at BPJS Kesehatan Branch Offices/Regency/City Operational Offices 3) The Hospital and BPJS Kesehatan keep all claims collection and fund liability documents. They can be audited at any time by the authorities. 4) Expired claims six months.

Based on the Ministry of Health No. 4718 of 2021, it is stated that claim verification is carried out by looking at three elements, namely the Completeness of participation administration, patient service administration, and individual patient reports by BPJS verifiers. Based on the 2014 BPJS Claim Verification Technical guidelines, BPJS verifier officers will verify by matching the suitability of the submitted claim file with predetermined requirements. If there is a discrepancy, the verifier will return the claim file to the Hospital for repairs. The claim request file corrected by the Hospital can be re-submitted to be billed according to the predetermined flow. This claim submission

file is very important for the claim submission process because it is proof of patient services carried out by the Hospital.

Concerning technical guidelines for claims administration and verification of the National Health Insurance program for the community, the Completeness of the documents for filing claims is a letter of reference, examination, diagnostic support services, and medical actions authorized by the doctor in charge. Based on the Minister of Health of the Republic of Indonesia Number 903/Menkes/Per/2011 concerning Guidelines for Implementing the National Public Health Insurance Program. If one of the requirements needs to be included or the items need to be filled in completely, it will result in the success of the claim process.

The Completeness of a medical resume can be influenced by several factors, namely knowledge, attitudes, and behavior. The impact that occurs if the medical resume is not complete, namely the obstruction of the administration process, where the medical record documents that should have been in the storage room but are still returned to the doctor in charge to be completed, The obstruction of the insurance claim process by a third party, namely BPJS due to the deposition of the principal diagnosis or accompanied by a secondary/additional diagnosis will greatly affect the amount of insurance claims submitted Completeness of medical resume can be Concept: Looking for factors that affect the settlement of BPJS Kesehatan claims at Citama Hospital.

Research Design

The method used in this study is mixed methods. Mixed methods combine quantitative and qualitative methods to be used in research to obtain more comprehensive, valid, reliable, and objective data.

In this study, quantitative data played a role in obtaining measurable data that was descriptive, comparative, and associative. Qualitative data plays a role in proving, deepening, expanding, weakening, and aborting quantitative data obtained.

The type of research used in this study is observational analytics with a cross-sectional design. This study simultaneously compares independent variables with dependent variables, aiming to determine the relationship between independent variables (Completeness of medical records and conformity of diagnosis codes with ICD 10) with dependent variables (approval of BPJS claims).

Based on the concept of variable thinking stated above, the variable mindset studied is compiled as follows: Location and Time of Research This research was carried out in the Medical Record Management section of Citama Hospital. The implementation time of this study is July 2022 – August 2022. C. Population and Research Samples The population in this study is the entire inpatient medical record file of the BPJS patient inpatient care unit in January 2022-May 2022 at Citama Hospital, which the BPJS verifier returned. The population in this study is the entire inpatient medical record file of the BPJS patient inpatient care unit, which was returned by the BPJS verifier from January to May 2022 at Citama Hospital. Data Collection of data taken both qualitative data and quantitative data will support each other. In this study, data collection was used several

ways, namely: a) Questionnaire, which is data collection using questions asked to respondents. The questionnaire was inspired by the research of Shirin and Hanzaee (2011). Scale using the Likert scale. b) Interview is a meeting of two people to exchange information and ideas through question and answer to construct meaning in a particular topic. c) Documentation, a method of collecting data obtained by viewing or analyzing documents created by the subject himself or others on the subject. In this study, a quantitative approach was used. Research with a quantitative approach emphasizes its analysis of numerical data (numbers) processed with statistical methods. A quantitative approach is carried out on inferential research (to test the hypothesis) and leans the conclusions of the results on a probability of error in rejecting the hypothesis nil. We will obtain the results of the significance of group differences or relationships between the variables studied with quantitative methods. In general, quantitative research is large sample research.

The population is the entire subject of study or object under study. The population in this study was all specialist doctors at Citama Hospital. The criteria for inclusion and exclusion of the samples taken are: 1. Inclusion criteria are general characteristics of research subjects of an affordable target population and will be studied (Nursalam, 2017). The inclusion criteria in this study are a. Willing to be a respondent b. The doctor who fills out the inpatient medical resume c. The doctor was present at the time of giving the questionnaire. 2. Exclusion criteria The exclusion criterion is to eliminate or exclude subjects who do not meet the inclusion criteria due to various causes (Nursalam, 2017).

Research Instruments This study's instrument or data collection tool is a guideline observation checklist sheet. The observation checklist is used to determine the Completeness of the medical information on the medical resume. This observation checklist contains 1). The existence of medical record completeness items: a) DRM No. b) Patient Identity c) Service Date (exit date and entry date) d) Primary Diagnosis e) Secondary Diagnosis and Action f) Clear Name and Signature of DPJP Doctor. 2). Primary Diagnosis 3). Diagnosis Code 4). Conformity of Diagnosis Code 5). BPJS Claim Approval.

Data Collection Techniques: 1). Primary Data The primary data in this study is inpatient medical record data at Citama Hospital for January 2022-May 2022, which was obtained by direct observation and checking the Completeness of the file on the claim returned by the BPJS verifier 2). Secondary Data The secondary data in this study are data on the Completeness and timeliness of inpatient RM deposits based on patient care rooms in January 2022- May 2022 and data on the Completeness and timeliness of inpatient BRM deposits based on patient payment methods until July 2022. Researchers use the data as preliminary data on initial observations.

Data Presentation

The data from this study are presented as graphs, frequency distribution tables, cross-tabulation tables, and narratives to discuss the research results. Research Variables and Operational Definition of Variables Free Variables Free variables are variables

because they affect or are independent variables or variables that are influenced. The free variable in research is the doctor's knowledge and attitude about medical records. Bound Variables A bound variable is dependent, consequential, affected, or dependent. They are called hanging or dependent variables because free variables or independent variables influence these variables. The bound variable in this research is the doctor's actions in filling out a medical resume.

RESULTS AND CONCLUSIONS

From the results of observational research and interviews conducted by the author, it is known that the implementation of BPJS claims at Citama Hospital is carried out by the case mix section where this section is in charge of managing files and submitting BPJS claims from coding doctors' diagnoses/actions, verifying claim requirements, making txt files to sending claim files to BPJS Bogor regency (Iman & Wahyuni, 2022).

The BPJS claim flow is preceded by the coded RM file a filing is made by attaching the terms of the claim, at the end of each month before being sent to BPJS will be attached a txt file and a cover letter from the Hospital then will only be sent to the cibinong branch of the BPJS office (KHORIDA, 2019). There is a delay in submitting a claim, including 1). Completeness of medical resume up to medical records over 2x24 hours 2). Time-consuming file scanning process 3). Maintenance of the innings application for 21 days throughout Indonesia 4). Lack of appropriate personnel competence in coding.

The Simple Regression Method was used in this study to test whether there was an effect of Medical Record Completeness and ICD Code 10 with BPJS Claim Approval (Sabarguna & Wahyudi, 2020). From the results above, it can be seen that the Completeness of medical records significantly affects BPJS Claim Approval because the value of Sig. in the Coefficients table (0.000) is less than Alpha 5% (0.05) (Abdullah, 2019). Based on the Anova test, the Completeness of Medical Records simultaneously has a significant effect on BPJS Claim Approval because the value of Sig. in the Anova table (0.000) is smaller than Alpha 5% (0.05). Based on the Coefficient of Determination, the Completeness of Medical Records explains BPJS Claim Approval by 6% (0.060). The rest are explained variables outside this study. From the above results, it can be seen that ICD Code 10 is insignificant to BPJS Claim Approval because the value of Sig. in the Coefficients table (0.908) is greater than Alpha 5% (0.05). Based on the Anova test, ICD Code 10 is simultaneously insignificant against BPJS Claim Approval because the value of Sig. in the Anova table (0.908) is greater than Alpha 5% (0.05). Based on the Coefficient of Determination, ICD Code 10 describes BPJS Claim Approval by 0% (0.000). The rest is explained variables outside this study.

The Independent T-test method was used in this study because the research data is categorical. After all, it consists of codes based on the Completeness of medical records and information on file errors and code errors in the BPJS claim approval data (EP, 2018). However, the results of the normality and homogeneity test are violated. In that case, the Mann-Whitney test is used in subsequent hypothesis testing because the Mann-Whitney

Test is a non-parametric test that does not require a normality test or homogeneity test. First Hypothesis: Null Hypothesis (Ho), There is no relationship between the Completeness of inpatient medical records and the approval of BPJS claims at Citama Hospital. Alternative Hypothesis (Ha), there is a relationship between the Completeness of the inpatient medical record of the inpatient care unit with the approval of BPJS claims at Citama Hospital (Bambona et al., 2022).

Based on the results of the Simple Regression in the previous section, it can be concluded that Ho was rejected, and Ha was accepted (EP, 2018). The Completeness of the inpatient medical record of the inpatient care unit significantly affects the approval of BPJS claims at Citama Hospital because the Sig value of the Coefficients table is significant. Second Hypothesis 1) Null Hypothesis (Ho) There is no relationship between writing a diagnosis code that complies with ICD 10 on the inpatient medical record of the inpatient care unit with the approval of BPJS claims at Citama Hospital 2) Alternative Hypothesis (Ha) There is a relationship between writing a diagnosis code that complies with ICD 10 on the inpatient medical record of the inpatient care unit with the approval of BPJS claims at Citama Hospital Based on the results of Mann-Whitney in the previous section, it can be concluded that Ho was accepted, Ha was rejected, The writing of a diagnosis code corresponding to ICD 10 on the inpatient medical record of the inpatient care unit had no significant effect on the approval of BPJS claims at Citama Hospital, the Sig value of the Coefficients table was not significant.

CONCLUSION

Conclusion After researching "Factors Affecting the Settlement of BPJS Claims against the Approval of BPJS Claims by BPJS Verifiers at Citama Hospital, Bogor Regency, it can be concluded as follows: 1). The flow of bpjs claim implementation. The flow of bpjs claim implementation at Citama Hospital has been implemented like the rules made by BPJS, and so far, there have been no significant problems. 2). Knowing the requirements for BPJS claims The requirements for submitting BPJS claims, both outpatient and inpatient at Citama Hospital, have been running according to the requirements set by BPJS 3). Knowing the factors causing pending claims based on 5 M: a). Reviewed from the man factor (human), in terms of the quantity or adequacy of human resources, bpjs claims lack human resources. It has been met regarding the quality or qualifications of staff in the case mix section. The length of time for completing a medical resume is made by DPJP b). Money factor In terms of finances in the BPJS claim process, Citama Hospital is very supportive, such as the procurement of infrastructure and finances training held by BPJS. c). Machine Factor In terms of engines, RS Citama has met the needs of the machine. In this case, it is a computer (CPU), although there are still those that do not meet the specifications. d). Method Factor (Methode) In terms of methods, in this case, the rules or SOPs for the implementation of the BPJS claim process, at Citama Hospital there is no SOP for implementing BPJS claims. 4). Most doctors have sufficient knowledge of medical records. 5). Many doctors have a positive attitude toward medical records. 6). The doctor's actions in filling out the Completeness of the medical resume

most doctors fill in the recording component completely and a small percentage of doctors fill out important reports completely. 7). There is a relationship between the Completeness of the inpatient medical record of the inpatient care unit with the approval of BPJS claims at Citama Hospital. 8). There is a relationship between writing a diagnosis code that complies with ICD 10 on the inpatient medical record of the inpatient care unit with the approval of BPJS claims at Citama Hospital.

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