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Causes and Solutions for Pending Cases of Outpatient Claims at RS X Bukittinggi

Yastori[1]*

[1]*Apikes Iris, Padang, West Sumatera*

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CORRESPONDING AUTHOR

Name: Yastori

Email: yastori2810@apikesiri.ac.id

ABSTRACT

Pending claims have an impact on the delay in payment of medical services which has an impact on the performance of hospital employees, thus affecting the quality of hospital services. The purpose of this study was to determine the causes and solutions to cases of delayed outpatient claims. The research design used was qualitative descriptive research in the form of a review of delayed outpatient claim documents and in-depth interviews. The study was conducted in February-September 2023. The population of this study was cases of delayed claims in 2023 totaling 2,627 cases. The sample in the study used the Slovin formula, obtaining a sample of 91 delayed outpatient claim documents. The sampling technique was Total Sampling. The causes of late inpatient claims are errors in the completeness of claim submission documents, errors in determining primary and secondary diagnoses, errors in diagnosis codes and medical actions, unclear writing on the CPPT, incomplete medical resumes, confirmation of supporting evidence in determining primary and secondary diagnoses, confirmation of diagnosis determination for extraordinary cases that occur due to indications determined by the doctor after the results of further examinations, provisions in determining the category of care class, compliance with related provisions. Problems from the BPJS Verifier side, there are complete claim submission documents, but they are stated as incomplete, many cases are categorized as pending, many pending in the form of confirmations and questions. The solution for BPJS is to implement regulations by inviting all parties including doctor registration, coders, doctors and other users and to socialize new regulations to all stakeholders and users. Determination of the pending category is based on cases that have been analyzed, because if pending appears due to cases with a large number, there is no error in submitting claims. The solution for medical records officers and coders to understand BPJS claim regulations, submit complete claim documents, pay attention to clinical codification rules in code enforcement. Communicate effectively with health workers involved.

INTRODUCTION

The Indonesian government implemented the National Health Insurance (JKN) program in early 2014 which refers to the Regulation of the Minister of Health (PMK) No. 28 of 2014 concerning the guidelines for implementing JKN. The obstacles in the billing process by the hospital to BPJS Kesehatan are mostly because the claim files are declared ineligible by BPJS Kesehatan according to the claim submission flow in the Practical Guide to BPJS Kesehatan Health Facility Claim Administration [1]. The prospective method explains that the financing method is based on how much health services are known before the service is provided. The upcoming financing method in Indonesia is known as case-based group or casemix and has been introduced with the JKN program financing method. This financing method requires hospitals

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to apply for payment for services provided to patients [2]. Several studies have examined the factors causing claims delays, but these issues are not yet known because each hospital has different problems.

Based on research shows that pending BPJS Health claims cause claim payments to decrease so that the hospital's cash flow is disrupted because almost 90% of hospital patients are BPJS Health patients. This is in line with the conditions experienced by Sijunjung Regional Hospital, due to the late submission of BPJS claims so that the income of Sijunjung Regional Hospital decreased which resulted in Sijunjung Regional Hospital experiencing a deficit. As a result of this deficit, many drugs are out of stock, operational activities in the hospital are not running smoothly, payment of service fees to employees is late and this will have an impact on the quality of service at Sijunjung Regional Hospital. The first factor related to the delay in submitting BPJS claims is the knowledge of the officers. Delays in submitting claims by officers can hamper hospital operational activities such as the availability of drugs, procurement of medical equipment and payment of employee incentives which will then have an impact on the quality of service provided by the hospital to patients. The implementation of JKN claim submission is determined by the knowledge of medical record officers, especially coding officers who play a role in determining the diagnosis and action codes so that they ultimately determine the cost of services. This shows that the factor causing pending JKN inpatient claims is related to the knowledge of officers in submitting JKN claims [3].

According to [4], it explains that Pending claims have an impact on the delay in payment of medical services which has an impact on the performance of hospital employees, thus affecting the quality of hospital services. Then, the hospital's cash flow is also disrupted because the payments that should have been claimed are not as they should be. In submitting claim files, if incomplete requirement files are found, there is a high possibility that the claim files will be returned, which can be detrimental to the hospital because it slows down the claim payment process. According to [5], hospital cash flow is disrupted due to problems in claim payments and problems with the claim process can also affect hospital operational activities as a result of insufficient data being required.

The speed or slowness of the disbursement of claims submitted by the hospital will be influenced by several factors, one of which is the completeness of the patient's documentation during treatment. There are several factors that cause claims submitted by the hospital to be returned, such as coding, completeness of files so that it is difficult to verify by BPJS, causing the submitted claim to be delayed [6].

Submission of claims to BPJS Kesehatan must use a medical resume with a diagnosis referring to ICD-10 or ICD-9-CM. Because the Submission Process in the implementation of BPJS Kesehatan claims is a claim administration process carried out using INA-CBG's, where claim payments are made based on the group of diseases suffered [7]. INA CBG's can be done if coding has been carried out. According to the Minister of Health Regulation Number 27 of 2014, INA CBG's coding is an activity of providing primary diagnosis codes and secondary diagnoses according to ICD-10 and providing procedure codes according to ICD-9-CM [8]. Coding greatly determines the amount of costs paid to the hospital. After coding using INA CBG's coding, the BPJS claim process is carried out. The claim process is carried out to ensure that the Health Insurance program costs are used appropriately, so it is necessary to verify the claim.

Based on a survey at Hospital X Bukittinggi, the number of pending outpatient claim data was 2,627 pending claim cases with an average of 218 medical record files each month and information was obtained from interviews with claim officers that the causes of pending claims at Hospital X Bukittinggi include incomplete data entry in the Integrated Patient Progress Notes (CPPT) which is documentation of the development of the patient's condition carried out by health service experts and has been integrated. In addition, the unclear writing of doctors on medical documents, the unavailability of medical resumes, incomplete claim submission documents, errors in enforcing diagnosis codes and medical actions, errors in adjusting claims with applicable regulations. In relation to this, the researcher is interested in knowing more

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deeply what factors cause pending BPJS claims at X Bukittinggi Hospital. The purpose of this study is to determine what factors cause pending outpatient claims at X Bukittinggi Hospital.

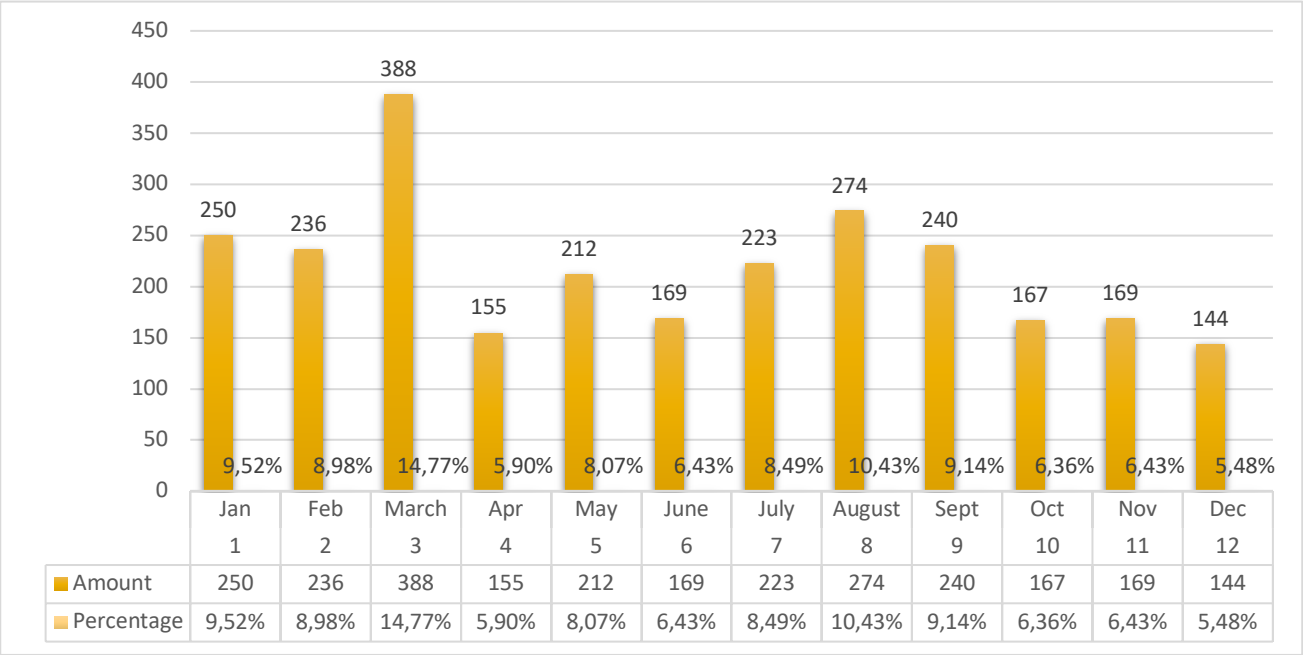
METHODS

The research design is a descriptive qualitative study of outpatient pending claim document review and in-depth interviews. The review of pending claim documents was carried out on all pending claim files returned by BPJS Kesehatan to Hospital X Bukittinggi during 2023. The results of the document review process will be grouped based on the cause of the return and analyzed.

The study was conducted at the Casemix Unit of Hospital X Bukittinggi in February - September 2024, data came from the JKN and Service Development Unit in the form of medical resumes, coding results, and details of hospital costs. The data taken were outpatient pending claim data related to medical problems and resumes; and clinical codification problems. The number of files from January to December 2023 that were reviewed was 2,627 files. The sampling technique used in this study was Simple Random Sampling. The sample of this study was 91 files. The study conducted a document analysis of the pending claim documents sent from BPJS to the hospital Verifier. Then an analysis was carried out based on the claim documents, Patient medical record documents, claim submission documents and examination of claim submissions on the claim application in the form of V-Claim. The results of the analysis were filled in on the observation sheet and analysis sheet. Each file will be detailed with the problems that must be confirmed and then grouped according to type. In-depth interviews were conducted with coders in the Casemix unit who made cost claims. Interviews were conducted to find out the cause of the claim problem that required confirmation in order to find a solution to prevent recurrence and confirmation regarding the claim problem between the hospital and BPJS

RESULT AND DISCUSSION

Frequency Distribution of Pending Outpatient Claim Cases in 2023



	Jan	Feb	March	Apr	May	June	July	August	Sept	Oct	Nov	Dec
	1	2	3	4	5	6	7	8	9	10	11	12
Amount	250	236	388	155	212	169	223	274	240	167	169	144
Percentage	9,52%	8,98%	14,77%	5,90%	8,07%	6,43%	8,49%	10,43%	9,14%	6,36%	6,43%	5,48%

Figure 1. Pending claim cases January – December 2023

In the picture above, it is known that pending claim cases occur every month at X Bukittinggi Hospital. The highest number of pending claim cases was in March, amounting to 388 cases. The number of cases is fluctuating, where there is an increase and decrease in the number that is not stable every month. From

January-December, pending claim cases did not decrease. The number of pending claims cases in Indonesia shows variation throughout the year. In 2023, there were around 2,038 pending claim files out of a total of 15,202 files submitted. An increase in pending cases was also recorded, with an increase of 5.9% from August to September.

Grouping of Factors Causing Pending Claims for Outpatients at Hospital X Bukittinggi in 2023

Based on the analysis conducted on 91 pending outpatient claim documents, the factors causing pending claims can be grouped, as can be seen in the image below:

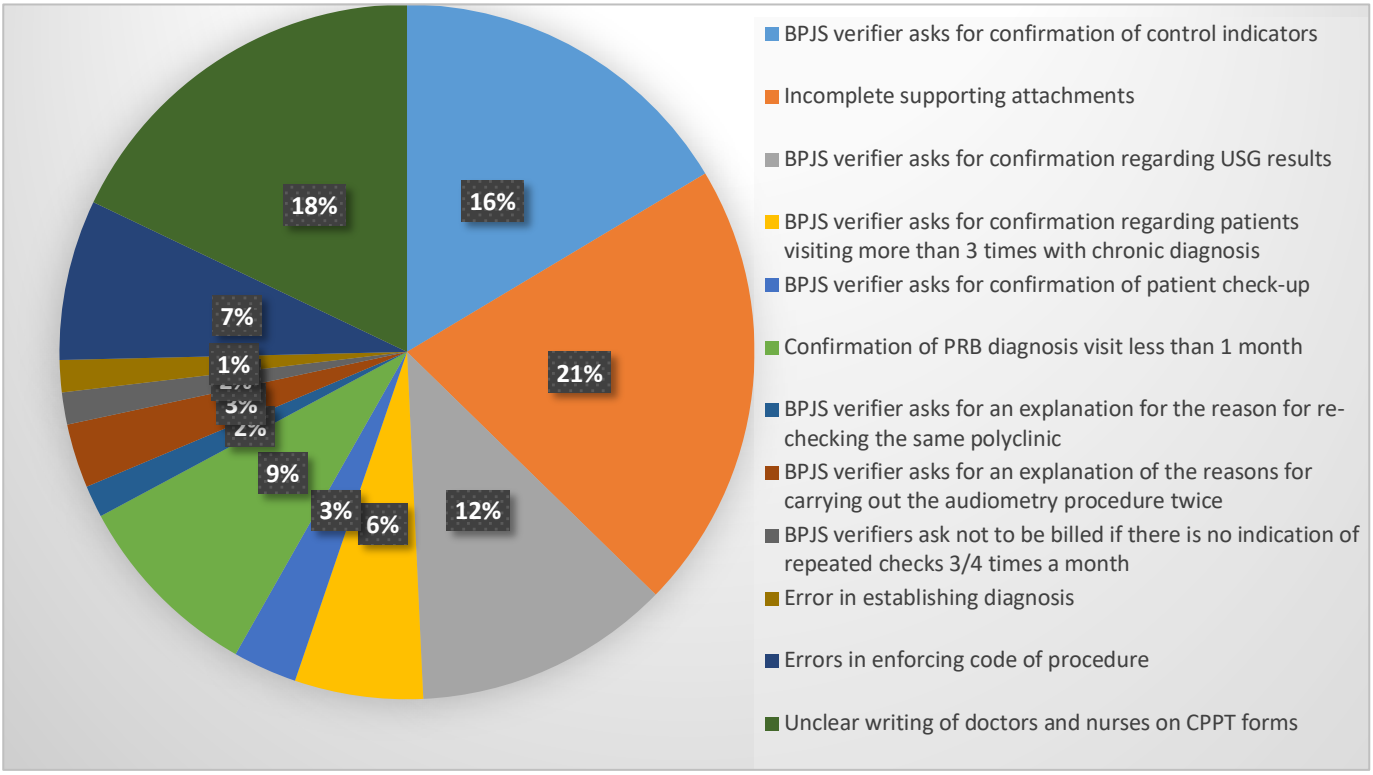


Figure 2. Grouping of Factors Causing Pending Claims for Outpatients Pending claim cases January – December 2023

Grouping of Factors Causing Pending Claims for Outpatients at Hospital X Bukittinggi in 2023

Incomplete documents in digital claim submission

The solution for this case is that the coder must review the patient's status and claim submission documents to see if all procedure reports have been attached, if not, the coder must attach the procedure report. The need for knowledge of coders, internal hospital verification officers related to regulations governing the completeness of documents in submitting claims at the hospital. In the regulations set by BPJS, it has been clearly regulated what documents must be attached.

Regulation of the Social Security Administering Agency (BPJS) Health No. 7 of 2018 concerning the management of health facility claim administration in the implementation of health insurance includes general administration of submission, membership administration and service administration. Then the claim file will be verified by the Social Security Administering Agency (BPJS) Health, if the claim verification results are not in accordance and require confirmation, then the claim file is returned to the original hospital to get confirmation [9]. Then an analysis was carried out based on the claim documents,

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Patient medical record documents, claim submission documents and examination of claim submissions on the claim application in the form of V-Claim.

The BPJS verifier asks for confirmation regarding the diagnosis
The solution for this case is that the coder must provide an explanation regarding the patient's diagnosis, where the coder must check the patient's status.

The BPJS verifier asks for confirmation regarding the diagnosis and the absence of supporting examination results.
The solution for this case is that the coder must provide an explanation regarding the patient's diagnosis, where the coder must check the patient's status. And check whether the patient has undergone supporting examinations on the patient's status, and re-check whether it has been attached to the digital claim submission.

BPJS verifier Confirms regarding the enforcement of the diagnosis and treatment facilities.
The solution for this case is that the coder must re-check the submitted diagnosis code and re-check whether the patient is under control. If under control, it can be coded Z.

The BPJS verifier asks for confirmation of the results of the procedure report and the lack of secondary diagnosis codes.
The solution for this case is that the coder must provide an explanation regarding the results of the patient's supporting examination, the coder must check the patient's status.

The BPJS verifier asks for confirmation regarding the indication for a re-control
The solution for this case is that the coder must provide an explanation regarding the patient's diagnosis, where the coder must check the patient's status

The verifier asks for confirmation regarding PRB <1 Month
The solution for this case is that the coder must provide an explanation regarding the patient's diagnosis, where the coder must check the patient's status.

The BPJS verifier asks for confirmation regarding the diagnosis and the absence of supporting examination results.
The solution for this case is that the coder must provide an explanation regarding the patient's diagnosis, where the coder must re-check the patient's status, and check the supporting examinations in the status and re-check whether they have been attached to the digital claim submission.

The BPJS verifier asks for confirmation that the patient has had more than 1 check-up
The solution for this case is that the coder must explain why the patient had more than 1 check-up.

The BPJS verifier asks for confirmation of the results of the procedure report and the lack of secondary diagnosis codes.
The solution for this case is that the coder must provide an explanation regarding the patient's supporting results, the coder must check the patient's status.

The verifier asks for confirmation of the indication that the procedure is performed twice a month and an error in code enforcement

The solution for this case is that the coder must re-check the submitted procedure code.

According to research [10] with the title of the research "Analysis of Factors Causing Pending Inpatient Claims Due to Medical Record Coding at the Dr. Soedirman Kebumen Regional General Hospital (RSUD)" said the factors that influence the Difference in understanding between the hospital and the verifier regarding the coding of diseases or actions. Differences in concepts or perceptions of the diagnosis and its coding between the treating doctor at the hospital and the BPJS coder and verifier. And what is still an obstacle for coding officers is the incomplete filling of supporting data such as physical examinations and supporting examination results in medical records, as well as the inconsistency of the diagnosis with ICD-10 so that the coding that has been made is questioned again because the diagnosis has not been accompanied by supporting data.

Completeness of outpatient e-claim file filling can affect the process of submitting claims to BPJS. In terms of HR (Human Resources), factors that cause incomplete e-claim files can be seen in terms of discipline, workload and communication. The causes of incomplete e-claim files are the indiscipline of doctors and the lack of responsibility of officers in filling out the files. Because doctors are too busy and have limited time due to the high workload of doctors, the time used to fill out e-claim files is very limited. Another factor is the lack of awareness of doctors about the importance of the completeness of these files [11].

The results of this study were found in line with research [12] found that incomplete forms were the cause of the return of claim files. Officers who have better knowledge of BPJS claim procedures tend to experience lower claim delays. Education also plays an important role in BPJS claim delays. Officers with higher levels of education tend to experience lower claim delays. Training also has a positive and significant relationship with BPJS claim delays. Officers who receive training on BPJS claim management have lower claim delays. Officers' work experience also has a positive and significant effect on BPJS claim delays. Longer work experience provides officers with expertise and efficiency in managing BPJS claims [13].

According to [4] explained that Pending claims have an impact on late payment of medical services which have an impact on the performance of hospital employees, thus affecting the quality of hospital services. Then the hospital cash flow is also disrupted because the payments that should have been claimed are not appropriate. According to [5] stated that hospital cash flow is disrupted due to problems in claim payments and problems with the claim process can also affect hospital operational activities as a result of insufficient data being needed.

The results of the study showed that the factors causing pending BPJS claims were inappropriate coding between hospital staff and BPJS verifiers [14]. Pending BPJS claims are coding factors and incomplete medical records [15]. Payment delays due to pending claims by BPJS Kesehatan affect the smoothness of the hospital's cash flow because new payments will be made by BPJS Kesehatan after the confirmation process is complete [16].

There was 65.9% complete medical record information, 87.6% correct primary diagnosis, and 85.7% of BPJS Health claims were approved [17]. The BPJS claim implementation process at Panti Nugroho Hospital has been smooth but there are still claim files that are submitted late. The factors causing late claims come from human factors, namely initial completeness verification officers, doctors, and coding officers [18]. The results of the study stated that the cause of pending claims from claim submission files was due to four factors: incomplete files, inaccurate coding, lack of supporting examinations, and lack of

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understanding of the minutes of agreement related to coding [19]. The results of the study [20] stated that pending claims were caused by the absence of a written SOP regarding the implementation of claims in hospitals and incomplete claim requirements. Factors causing pending claims include human factors related to inaccuracy of officers causing inaccurate coding, errors in inputting claim data, incomplete supporting information for diagnosis and actions on medical resumes. Machine factors come from disruptions to the Jasa Raharja application system, and method factors due to differences in perceptions of coders and BPJS Kesehatan verifiers regarding coding rules and claim regulations [21]. Incomplete medical resume 41.8% (38 files), inaccurate coding 48.4% (44 files that do not match), incomplete claim files 29.7% (27 files that are incomplete), regulations for managing BPJS inpatient care at RSAB Harapan Kita are incomplete 61.5% (8 respondents), knowledge of implementing officers 53.8% (7 respondents), [22]. The Hospital found that there were still pending BPJS claims due to differences in perception between the hospital and the BPJS verifier [23].

Conclusion

The factors causing pending claims for inpatient care at Hospital X Bukittinggi in 20023 consisted of errors in the coding process by the coder and the coding input process by the grouper, errors in placing primary and secondary diagnoses on the medical resume, unclear writing on the CPPT, incomplete medical resume, confirmation of supporting evidence in establishing the primary and secondary diagnoses, evidence of supporting examinations, confirmation of diagnosis establishment for exceptional cases that occur because there are indications determined by the doctor after the results of further examinations, regulations in determining the category of treatment class, compliance with related regulations.

Future suggestions for a common perception between BPJS verifiers and hospital verifiers regarding applicable regulations. The need for clear operational standards related to claim submission and the implementation and settlement of pending claims that are known to all related parties. It is necessary to conduct socialization if there is a new regulation or revision to all related parties. The need for monitoring and evaluation by the hospital management, especially in the field of claim submission and settlement of pending claims

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