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Review of BPJS Claim Requirements for Service Efficiency in RS X

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Abstract

The purpose of this study is to analyze the information system as one of the factors supporting the health services provided. Provide computerized services that are used to collect patient information in medical records for making treatment decisions for patients. The research method with a quantitative approach, in the form of informant interviews, surveys and literature study. The research time was from January - March 2020. The completeness of the medical record files was 66.4% and 33.6% incomplete, while the BPJS claim approval was 60.8% and 39.2%.2% were not approved. The conclusion is that there is a relationship between the completeness of medical records and the approval of BPJS claims. It is highly recommended that there is a high awareness for medical record officers, nurses, and doctors to complete medical record files properly, assisted by computerized records that are easy to understand and operate.

Contents

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1 Introduction

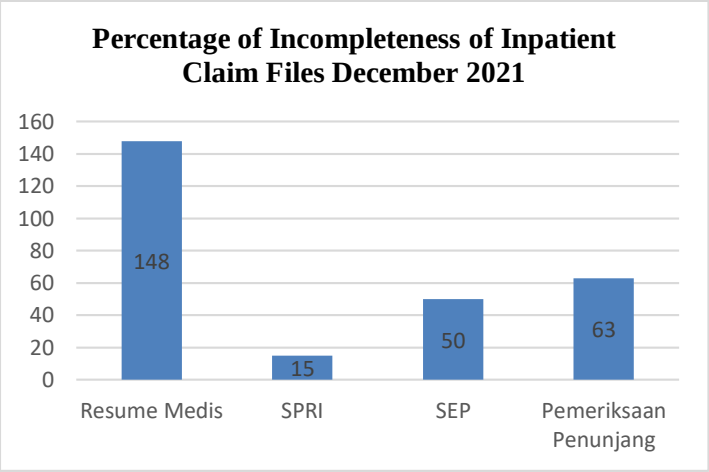
The 58th World Health Assembly (WHA) in 2005 in Geneva encouraged every country to develop Universal Health Coverage (UHC) or universal health coverage for its entire population. According to BPJS Health, (2018). Social health insurance is a health care funding mechanism that is increasingly used around the world because the reliability of this system guarantees the health needs of the people of a country. So based on law number 40 of 2004 every resident of Indonesia must have social security, one of which is BPJS. The social security organizing agency or BPJS is a guaranteed service in the form of health protection, related participants obtain health maintenance benefits and protection in meeting the basic health needs provided to each person, either in the form of individual dues or dues paid by the government (Hariyanti et al., 2020; Rolindrawan, 2015; Sufriyana et al., 2020). As for the types of procedures carried out in the BPJS guarantee process, one of them is the claiming process which is the final process of the guarantee framework (Osaro & Charles, 2014; Araichi et al., 2016).

The claymation process itself refers to an application, called a case-based group (INA CBG) in presidential regulation no. 12 of 2013 on health insurance, (Wijaya, 2018). Which states the provision of payment to an advanced referral health facility, in order in an application called case-based groups (INA CBGs). In the claim verification process, there are several conditions attached, including:

1) Inpatient warrant
2) Participant eligibility letter (SEP)
3) The medical resume lists diagnoses and procedures and is signed by the Doctor in Charge of Patients (DPJP).
4) In certain cases, if there is a payment of claims outside the CBG INA, additional supporting evidence is needed. (a). Therapeutic protocols and regimens (scheduled administration) of drugs specific to Oncology, (b). Prescription medical aids (motion aids, collar neck, corset, etc. (c). Medical aid receipt.

Based on the preliminary study at RS X. Researchers found a problem, in the enforcement section of BPJS claims related to the BPJS insurance claim submission file, bpjs returned the claim submitted. (Rahayuningrum et al., 2016). This is due to the incomplete distribution of medical resume items, which are not filled out and not attached. So bpjs must return the claim requirements file to the officer who is in the hospital. Of course, the above will trigger the emergence of failed claims caused by incomplete requirements of the claim. Based on Permenkes RI Number 903/Menkes/Per/2011 concerning guidelines for the implementation of the community's national health insurance program. If one of the requirements does not exist or the item is not filled in will result in the success of the claim process (Liu, 2016; Lee et al., 2008).

The results of the interview conducted by the author with the inpatient case-mix officer mentioned the cause of the return of the claim, namely the incompleteness of the claim requirements proposed (Trisnantoro et al., 2018). The files submitted in December 2021 contained 965 files in the process of submitting inpatient claims, the files returned as many as 295 files (30.5%), which were dominated by the incompleteness was on the medical resume items as many as 148 files (53%) the cause of the medical resume items was incomplete due to the lack of orderly doctors in filling out diagnoses and the number of hospitalization files that had not been done the previous day, causing a buildup of files that affected time of analysis on the inpatient file, on sep items eligibility letter as many as 50 files (16%), SPRI items (inpatient warrants) as many as 15 (0.05%), supporting examination items as many as 63 files (21%).



Graph 1. Incompleteness of Hospitalization Claims File December 2021

This will certainly hinder the claiming process both those that have been submitted or that have not been submitted it is seen from the graph that filling a medical resume by 55% requires accuracy and speed in filling a medical resume to be able to increase claims. Therefore, researchers are interested in researching the "Review of BPJS Inpatient Claimability Requirements for Service Efficiency at RS X"

2 Materials and Methods

The type of research used is quantitative analysis with a descriptive approach, namely the results of research that are then processed and analyzed for conclusions, meaning that the research conducted is a study that emphasizes its analysis of numeric data (numbers), (Sugiyono, 2019). Using this research method will be known a significant relationship between the variables studied, to produce conclusions that will clarify the picture of the object being studied. With observation and interview data collection techniques, the object of the study is the BPJS claim file in December 2021, based on the Slovin Formula:

$$n = \frac{N}{N \,.\, d^2 + 1}$$

Information:

n = Number of Samples

N = Population Amount

d^2 = Absolute Accuracy Level (0.1)

Then it is set:

$$n = \frac{965}{965 \times (0{,}1)^2 + 1}$$

$$n = \frac{965}{965 \times o{,}o1 + 1}$$

$$n = \frac{965}{10.65}$$

n = **91** BPJS Hospitalization claim files

From the results of the population above it was concluded that with a population of 965 files of hospitalization claims, (Retnaningsih, 2018). it can be concluded from the calculation of the sample formula above used is as many as 91 files of hospitalization claims.

3 Results and Discussions

Claiming procedure

RS X already has standard operating procedures related to bpjs claims of hospitalization, but it is not explained specifically, (Mundiharno, 2018). The claiming activities are carried out by case-mix officers. The inpatient medical record document is submitted to the medical record unit or coder officer 2x24 hours after the patient goes home along with the patient's complete medical record. Items that must be fully contained include:

1) Sep verify results (Participant eligibility letter) Hospitalization
2) SPRI verifies results (Inpatient's letter)
3) Medical Resume
4) Supporting checks

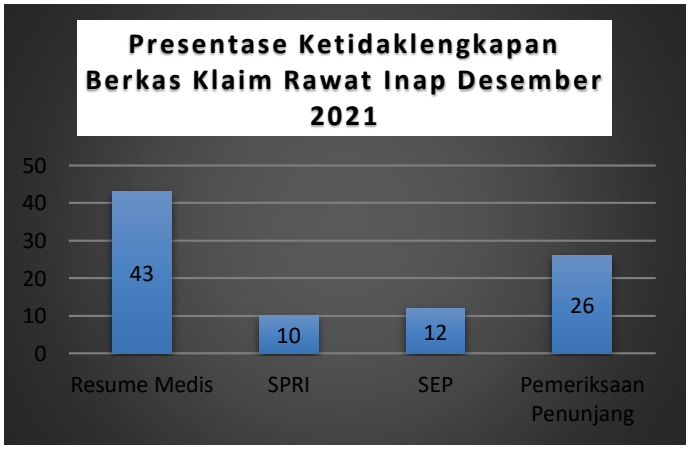
Completely composed verify files and files are given to the coding officer to be given the ICD X and ICD IX diagnosis codes (EP, 2018). After that, it is input into the INA CBGs application and then the grouping results are uploaded and then scanned lip (individual sheet of the patient). Then the e-claim validation stage corresponds to the SEP order. Then separate the hardcopy file that will be sent to BPJS (SEP and medical certificate or medical resume) and which will be archived for 6 months (claim expired period) (Husariev et al., 2021).

Factors Cause Inhibition of BPJS claims

Based on the results of the researcher's interview with case-mix officers, it can be known that the inhibition of BPJS hospitalization claims is caused by several factors including:

Completeness of the claiming process file

It can be known that in the files submitted in the claim application process in December there are 965 files, and the returned files are 295 files (30.5%) (Kurniawati et al., 2017). The sample that the researchers took was 91 files.



Graph 2. Percentage of Incompleteness of Hospitalization Files December 2021

1) Medical resume Based on the results of the interview, the incompleteness of the dossier that dominates is the medical resume of 43 files (47%), this is due to the doctor's inaccuracy in filling out the medical resume by not completing the signature (for doctors who visite) and doctors who have not added

additional diagnoses submitted. This makes case-mix officers collect claim files sober, due to the deadline that has been set by BPJS.

2) Inpatient warrant (SPRI). In SPRI items, there are 10 (11%) files incomplete, this is because there is no signature item that should be filled in by DPJP, this could be due to human error.
3) SEP (Participant eligibility letter) (Muchtar, 2019). On sep items, the incompleteness of 12 files (13%), is because the officer did not review the SEP number to be submitted so it could cause a cancellation of the submission.
4) Supporting Examination. In this item incompleteness as many as 26 files (28%), this often occurs in ob-gyn cases that are not supported by ultrasound examination, it occurs because the patient forgets to attach an ultrasound.

File stacking

Based on the results of research and interviews, claiming activities were carried out by case-mix officers. (Pardede, 2018). The inpatient medical record document is submitted to the medical record unit or coder officer 2x24 hours after the patient goes home along with the patient's complete medical record. But sometimes the officer is concerned even though he already knows the SPO about the claiming process, there are still often delays in the handover process (Haineset al., 2006; McMullan, 2006; Wang & Luo, 2005).

Table 1
Return of Medical Records Files

Items	Number of Files	Timely files	%	File not on time	%
Medical resume	43	13	30%	30	68%
SEP	12	9	75%	3	25%
SPRI	10	7	7%	3	3%
Supporting checks	26	5	19%	21	80%
Sum	91	34	37%	57	58,2%

This proves that the late submission of medical records files from relevant officers has not been efficient because it takes a long time to return them (Rany, 2017). This has an impact on the inhibition of claims and data processing that will be implemented.

Facilities and infrastructure

Based on the results of research and interviews, Bawasannya Sarana and prasaran become an important part of the efficiency of the claimant process, but the scanning machine is limited, being one of the factors hampering the claimant process.

Claiming procedure

Based on the standard of operational procedures on inpatient BPJS calibration, it can be known that the officer receives a file of inpatient medical records from each treatment room, and the file is submitted to the case-mix installation 2x24 hours after the patient is declared home, with SEP verification, SPRI, (Imelda et al., 2019). Medical resume and supporting examination in the contents completely. But in the implementation of the procedure, the claiming file is still often found files that have not been filled with glue which means that the standard of the operational procedure has not been implemented properly.

Factors causing inhibition of claims

Based on the results of research and (Atipah, 2016). Interviews can be known if the delay in the claiming process is caused by several factors:

Completeness of claims

1) The medical resume is a conclusion of the course of the disease of one of the patients who was discharged by DPJP (Doctor in charge), Based on the results of the research percentage of the incompleteness of filling the medical resume, namely 43 (47%) files, or the highest of several other items. This is due to the disorderly doctor filling out diagnoses and signatures (for doctors who do visit). Of course, this will hinder efficiency in claiming according to KEPMENKES 2008 No. 129 on hospital minimum service standards mentioning that, filling out the medical resume must be complete and filled within 1x24 hours after the patient is declared home. However, in its implementation, there are still doctors who are not filling out their resumes.
2) Inpatient warrant (SPRI). The form issued as support that the patient is required to undergo hospitalization by the IGD guard doctor who checks, on the SPRI item incompleteness as much as 10 (11%) files, this is due to the absence of signature items that should be filled out by the doctor in charge of DPJP patients.
3) Participant eligibility letter (SEP). The participant's eligibility letter is a document stating that the patient is treated at bpjs fees. In sep items incompleteness of as many as 12 (12%) files, this is because the officer did not review the SEP number to be submitted so it could cause the submission to be canceled.
4) Supporting examinations are part of a medical examination performed by a doctor to diagnose certain diseases. In the items supporting incompleteness as many as 26 (28%) files, it is assumed that the patient forgot to attach the results of supporting examinations such as ultrasound for ob-gyn patients.

File stacking

Based on the results of research and interviews, bawasannya claims activities were carried out by case-mix officers. (EP, 2018). The inpatient medical record document is submitted to the medical record unit or coder officer 2x24 hours after the patient goes home along with the patient's complete medical record. But sometimes the officer is concerned even though he already knows the SPO about the claiming process, there are still often delays in the handover process. This proves that the late submission of medical records files from relevant officers has not been efficient because it takes a long time to return them. This has an impact on the inhibition of claims and data processing that will be implemented.

Facilities and infrastructure

Based on the results of research and interviews, (Putro et al., 2017). To become an important part of the efficiency of the claimant process, but the scanning machine is limited, being one of the factors hampering the claimant process.

Efforts Made

Standard Operating Procedures are already running however, have not been implemented properly. It takes a lot of discipline to bring order to the aspects related to the claimant process, besides that the case-mix installation can socialize continuously with the relevant officers, as well as reward officers who obey and punish the violating officers.

4 Conclusion

Based on the findings analyzed in the discussion above, several conclusions can be drawn as follows:

1) Completeness of Claims. BPJS inpatient claymation procedures already exist but are not specifically explained, but there is still incompleteness of both the contents and its enforcement.

2) File Stacking. The officer already knew about the procedure for submitting the inpatient medical record file to the case-mix officer, but there was still a discrepancy between the medical record installation officer and the case-mix installation officer, which means that it has not been carried out properly.
3) Facilities and Infrastructure. A suggestion and infrastructure become important for the efficiency of the claimant process, but in its implementation, there are still limitations in meeting the needs of facilities and infrastructure that result in hampering the claymation process.
4) Efforts that can be carried out to minimize the inhibition of the claiming process are, by socializing continuously about the importance of completeness of BPJS claim files. This can change the habits of relevant officers who have not been orderly in the filling process, and also coordinate continuously between related parties so that there are no errors in coordination. The next effort is rewarding the officer who obeys and punishing the violating officer.
5) As for improving the efficiency of the claimant process, the effort that can be done is to complete the hospitalization claim file and fill in documents in an orderly manner so that the inpatient BPJS claiming process is carried out appropriately and quickly.

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