Evaluation of claim submission and returning for BPJS inpatient services: a case study of hospital X in 2017

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Abstrak

Latar belakang: *Keterlambatan dan ketidaklengkapan pengajuan klaim menyebabkan keterlambatan pembayaran klaim yang akan berdampak pada arus kas rumah sakit (RS). Artikel ini bertujuan untuk menilai pengajuan dan pengembalian klaim pada pelayanan rawat inap pasien BPJS.*

Metode: *Penelitian potong lintang dengan desain studi kasus. Sumber data menggunakan data pengajuan dan pengembalian klaim rawat inap pasien BPJS periode Januari-Juni 2017. Data dianalisis secara deskriptif.*

Hasil: *frekuensi pengajuan klaim rawat inap terbanyak 17 kali dan terendah 13 kali dalam sebulan, yang berarti RS mengajukan klaim ke BPJS hampir setiap 2-3 hari sekali.Dari 11,945 berkas klaim, sebanyak 3,013 (25,2%) berkas klaim dikembalikan ke RS oleh BPJS. Nilai klaim yang diajukan untuk 11,945 berkas adalah Rp. 146,967,494,700, sedangkan nilai klaim dari berkas yang dikembalikan sebesar Rp. 45,150,888,100-. Alasan berkas dikembaliakn antara lain masalah administrasi, ketidaklengkapan resume medis, pemeriksaan penunjang, konfirmasi koding, tidak layak, pinjam status, dan TXT yang tidak terbaca. Penyebab paling banyak berkas dikembalikan adalah konfirmasi koding (42,4%) dan ketidaklengkapan resume medis (30,3%).*

Kesimpulan: *tampaknya RS tidak pernah mengalami keterlambatan dalam pengajuan klaim, namun berkas klaim yang dikembalikan BPJS masih banyak, yang utamanya disebabkan oleh permasalahan koding dan ketidaklengkapan resume medis.* ***(Health Science Journal of Indonesia 2019;10(1):27-31)***

Kata kunci: *Penilaian, klaim, pengajuan, pengembalian.*

Abstract

Background: incomplete and late claim submission may result in the delay of claim payment. The impact of late payment will certainly disrupt the cash flow of the hospital. This study aims to evaluate the claim submission and returning for BPJS inpatient services.

Methods: this was cross sectional study with a case study design approach. The source of data used was submission and returned claim data from hospital financing department during the period of January to June 2017. The data were analyzed descriptively.

Results: the highest frequency for inpatients claim submission was 17 times and the lowest was 13 times. The hospital submit the claim file almost every 2-3 days. Of the 11.945 inpatient claims, as many as 3.013 claim files were returned by BPJS. The total claim amounts of 11,945 files was Rp. 146.967.494.700,- and, the total amount of returned claim was Rp. 45.150.888.100,-. The reasons of claim returned including administrative completeness, incomplete summary discharge , confirmation of coding, inappropriate files, unreadable TXT in BPJS application and supporting examination. The most common causes of claim files returned was confirmation of coding (42.4%) and incompleteness of discharge summary (30.3%)

Conclusion: the hospital was never late in submitting claim documents but the claim returned by BPJS were still high. The most common causes of claim returned to the hospital was coding confirmation and incompleteness of discharge summary. ***(Health Science Journal of Indonesia 2019;10(1):27-31)***

Keywords: Evaluation, claim, submission, returning

In the Jaminan Kesehatan Nasional (JKN) era, most of the hospital patients (80-90%) are the JKN participants.[1,2] This has caused the health insurance claims become the main income for hospital in Indonesia.[3] Incomplete and late claim submission may result in the delay of claim payment by Badan Penyelenggaraan Jaminan Sosial (BPJS). Therefore the claim file submitted must be complete in accordance with the requirements determined by the BPJS.[4] Claim management is a process since the claim is accepted by BPJS until the claim is verified, recorded and paid. Badan Penyelenggaraan Jaminan Sosial must pay the hospital claim no later than 15 days after the claim is verified.[2] If the document is complete, the claim payment process will be faster.[4] Conversely, the incomplete document will extend the claim settlement process.[4]

Badan Penyelenggaraan Jaminan Sosial will returns the claim file to the hospital when the file is incomplete or need to be revised after the verification process has been finished.[5] Revising and returning claim documents to BPJS can take time up to six months.[6] BPJS will postpone the payment for returned claim until the hospital resubmitted the claims. The impact of late payment will certainly disrupt the cash flow of the hospital, especially if 90% of hospital patients are JKN participants.[1] The hospitals in collaboration with BPJS depend on the income from BPJS for operational funding.[6] There are several problems faced by hospitals as a result of late claim payments such as the disruption of drug availability or lack the stock of medicines and consumables, poor maintenance of medical equipments as well as decrease in doctor's performance because of the delay in salary and incentive payment.[2,7]

BPJS targets all claims to be paid within one month after the claim document is submitted. However, the target has only been met as much as 60%. There is a tendency to delay claim settlement since November 2017.[2] Timely and appropriate claim reimbursement are very important to ensure provider satisfaction, fiscal stability, and compliance with regulations.[8] According to USAID report, in 2015 a total of pending claims for type B hospitals in Indonesia there are around 589 million USD or Rp. 8 trillion (the rupiah exchange rate in 2015: Rp. 13,726, -). Several studies on the BPJS claims previously found that pending claims are caused by disagreement of coding diagnosis or medical procedure between hospital coder and BPJS. The diagnosis code used is sometimes not approved by BPJS. In addition to coding problems, pending claims are also caused by incomplete claim documents, incomplete medical resumes, surgery report, and supporting examination documents.[6,9,10] After 4 years the implementations of JKN, the hospital X still faces the problem of pending claim payments from BPJS due to returning of claim file for inpatient services. This study aims to evaluate the claim submission and returning for BPJS inpatient services.

METHODS

This was a cross sectional study with a case study design approach. It was carried out at one type A government hospital in Jakarta, from July to Desember 2017. The data was collected from hospital financing department. The source of the data in this study was obtained from all claim data of submission and returning for hospitalization of BPJS patients during the period of January to June 2017 (first semester).

Claim submission is regarded since the patients discharge from the hospital until the claim is accepted by BPJS. Based on the guidance of health care facilities claim administration from the BPJS, the health facilities must submit claims every month, no later than the 10th of the following month regularly. Claim will be returned if BPJS does not approve the claim file after verification process. The data collected were the frequency of claim submission (times in a month), the number of claim submission, total amount of claim submission, number of returned claim, total amount of returned claim, and the causes of returned claim.

The data were analyzed descriptively. Ethical approval was obtained from Ethics Committee, Faculty of Public Health, University of Indonesia with letter number: 564/UN2.F10/PPM.00.02/2017.

RESULTS

This study used the inpatient claim submission and returning data from January to Juni in 2017 which consisted of 11.945 individual claims.

This following pie chart illustrates that during January, hospital had submitted the claim for BPJS inpatients as many as 17 times, followed by 13 times in February, 15 times in March and so on. During the first semester, the highest frequency for claim submission was 17 times and the lowest was 13 times. The hospital delivered the file claims to BPJS almost every 2-3 days.

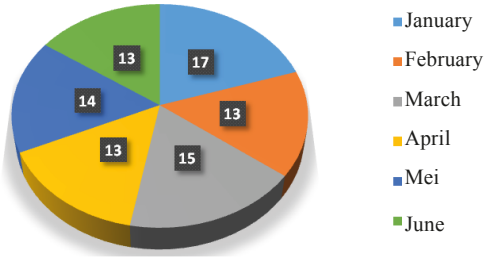

Figure 1. frequency of inpatient claim submission (times a month)

Tabel 1 shows that the average of BPJS inpatients is about 2000 patients per month. In term of claim submission during the first semester, there are 11,945 individual claims files submitted to BPJS which the total claim amounted to Rp. 146,967,494,700, -. Of the 11,945 filing claims, there are 3,013 file claims or as many as 25.2% were returned by BPJS. Meanwhile the total claim value of returned claims is Rp. 45,150,888,100 - for this period.

The pie chart on figure 2 demonstrates return of claim files from January to June 2017 by BPJS verifiers. There are several reasons including administrative revision, denied claims, incomplete discharge summary, confirmation of coding, borrowing documents in medical records by BPJS, unreadable TXT file and incomplete supporting examinations. The most common cause of claim files returned is confirmation of coding, which has 42.4%, following by incomplete discharge summary 30.3%, incomplete supporting examination 11.1% and administrative revision 9.8%.

Table 1. Condition of claim submission and returned for BPJS inpatient

Month	Submission (n)	Claim amount (IDR)	Returned		Claim amount (IDR)
			(n)	%	
January	2047	25,552,561,200	650	31.8	10,260,426,000
February	1839	22,883,642,800	584	31.8	8,985,010,200
March	2208	27,276,245,000	262	11.9	3,844,762,800
April	1924	23,434,893,500	454	23.6	6,305,600,000
May	2073	24,355,891,200	573	27.6	8,594,112,500
June	1854	23,464,261,000	490	26.4	7,160,976,600
Total	11945	146,967,494,700	3013	25.2	45,150,888,100

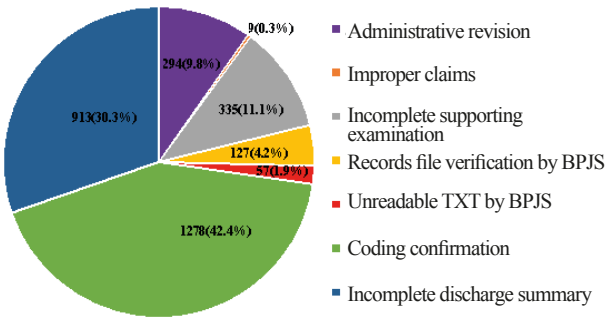

Figure 2. causes of returned claims for BPJS inpatients

DISCUSSION

This study has limitation. Among others, there was an absence of claim payment data and conformity of claim submission and claim payment by BPJS, interviews with financing department staff were not conducted to sharpen the result of the study.

This study found the frequency of claims submission to BPJS office around 13 to 17 times per month or in other word the claims was submitted more or less every 2-3 days per month. According to the practical guideline for BPJS administration claims, hospitals should submit claim documents that are complete no later than the 10th of the following month.[11] In this case, the hospital is quite good in submitting the claims because after the patients discharge from the hospital, the claim was submitted in the same month. Even for the patients discharge at the end of the month, the claim file can be delivered faster than the time set by the BPJS. In contrast, Sophia et al. found the claims in 2015 at the Mintoharjo public hospital were billed in 2016. Mintohardjo public hospital had not been able to carry out the claim submission according to the time set. Claims were carried out 2 to 3 times per month of service because of the problems in the hospital.[12]

Of the total claims submitted, there were 25.2% of claim documents returned by BPJS during the first semester of 2017. In other words, BPJS postponed the claim payments by 25.2% or worth Rp.45.150.888.100,- until the hospital revise the claim documents in accordance with BPJS

verification results and re-submitted these claims. Similiarly with this study, Park Y et al reported the claim returned to the providers was 25% and 24% for tertiary and general hospital respectively, where the claim returned was higher in inpatient groups in South Korea.[13] Compared to study done by Andi, the percentage of pending claims in this study was still higher, in Pontianak public hospital the pending claims was 6.98%.[14] Likewise, the study conducted by Ervita at the Muhammadiyah Malang General Hospital found that from the total inpatient claims submitted to BPJS, as many as 5.3% had been returned by BPJS.[9] The difference of the result may be due to the hospital X was a type A hospital which was set as a national referral hospital. Likely, the hospital treated the diseases or medical condition with severity level 3 which the diseases was more severe or complex.

The greatest percentage of claims returned by BPJS was coding confirmation, following by incompleteness of discharge summary and supporting examination. This issues will be coordinated by medical record department with the medical staff groups. Meanwhile the administrative revision, improper claims and unreadable TXT file will be handled by patient receivables management unit. The previous study done by Irmawati also reported similar causes for pending claims such as incomplete administration files, discharge summary, lack of supporting file and incompatibility of diagnosis made by physicians.[5] Other previous study done by Malonda et al found that many physicians did not write diagnosis and procedures code based on the ICD in the discharge summary.[15] Dhakal S revealed that coding errors in the discharge inpatients data as one of the major issues found in health information management department at Happy Valley Medical Center Hospital, Southern California.[16] However Cheng P suggested that accurate and complete clinical documentation is an important precondition for accurate clinical coding.[17]

In conclusion, the hospital was never late in submitting inpatients claim file but the returned claims by BPJS were still high. The most common causes of returned claims was coding confirmation and incompleteness of discharge summary.

The hospital management should coordinates with medical record department, medical staff groups and receivables management unit to address the issues.

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REFERENCES

1. Djatiwibowo K, Januari P, Ep AA. Faktor-faktor penyebab klaim tertunda BPJS Kesehatan RSUD Dr. J Adm Rumah Sakit. 2016;4:38–50. Indonesian.
2. Yuliyanti C, Thabrany H. Delayed claim payment and the treat to hospital cashflow under the national health insurance. Proc Int Conf Appl Sci Heal ICASH-A18. 2018;(3):122–8.
3. Ambarriani AS. Hospital financial performance in the Indonesian National Health Insurance era. Rev Integr Bus Econ Res. 2014;4(1):367–79.
4. Lewiani N, Kesehatan F, Universitas M, Oleo H. Proses pengelolaan klaim pasien BPJS unit rawat inap rumah sakit Dr. R. Ismoyo Kota Kendari tahun 2016. J Ilm Mhs Kesehat Masy. 2017;2(6):1–16. Indonesian.
5. Irmawati, Kritujanto A, Susanto E, Belia Y. Cause of fair reverse claims of social security institution (BPJS) patients representative required from terms of claims in RSUD R.A. Kartini Jepara. J Rekam Medis dan Inf Kesehat. 2017;1(1):45–51.
6. Broughton E, Achadi A, Latief K, Nandiaty F, Rianty T, Wahyuni S, et al. Hospital accreditation process impact evaluation. Final Report. Published by the USAID ASSIST Project. Chevy Chase, MD: University Research Co., LLC (URC).2018.
7. Amasha S. Causes and effects of delayed reimbursement to accredited health facilities by national health insurance fund in delivery of health services [Dissertation]. School of Public Administration and Management: Mzumbe University; 2015.
8. Frates, Janice, Ginty, Mary Jo, Baker L. Optimizing claims payment for successful risk management. Healthc Financ Manag. 2002 May: 56–60.
9. Ervita N, Suhartinah, Djoko Wahyudi EN. Evaluasi penyebab kegagalan klaim asuransi BPJS (Badan Penyelenggara Jaminan Sosial) kesehatan di Rumah Sakit. In: Prosiding Nasional SMIKNAS 2018 APIKES Citra Medika Surakarta. 2018. p. 55–62. Indonesian.
10. Guslianti W. Analisis kelengkapan resume medis dan ketepatan koding diagnosis terhadap potensi risiko klaim BPJS di Unit Rawat Inap RSUD Cempaka Putih tahun 2016. Depok: Univesitas Indonesia; 2016. Indonesian.
11. BPJS Kesehatan. Panduan praktis administrasi klaim fasilitas kesehatan BPJS Kesehatan. Jakarta: BPJS Kesehatan; 2014.
12. Sophia, Darmawan ES. Analisis keterlambatan pengajuan klaim kepada Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan pada Rumkital Dr. Mintohardjo, DKI Jakarta. 2017;101:83–8. Indonesian.

13. Park Y, Yoon J, Speedie SM, Yoon H, Lee J. Health insurance claim review using information technologies. 2012;18(3):215–24.
14. Sulaimana A. Pengembalian berkas klaim pasien peserta JKN di RSUD Sultan Syarif Mohamad Alkadire kota Pontianak [Tesis]. Yogyakarta: Universitas Gajah Mada; 2017. Indonesian.
15. Malonda TD, Soleman AJMRT. Analisis pengajuan klaim Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan di RSUD Dr. Sam Ratulangi Tondano. JIKMU. 2015;5(5):436–47. Indonesian.
16. Dhakal S. Coding errors, its impacts, and solution. The College of St. Scholastica Duluth, Minnesota; 2014.
17. Cheng P, Gilchrist A, Robinson KM, Paul L. The risk and consequences of clinical miscoding due to inadequate medical documentation: a case study of the impact on health services funding. Heal Inf Manag J. 2009;38(1):35–46.