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IMPLEMENTATION MODEL OF TIMELINESS OF BPJS CLAIMS BASED ON PHENOMENOLOGY STUDY

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Kata Kunci:
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ABSTRAK

This study aimed to explore the factors of delay in BPJS claims for inpatients at the Yukum Medical Center Hospital. The type of research in this study using qualitative research using qualitative approach is expected to produce a basic model in providing the most appropriate recommendations in solving the problem of the timeliness of submitting BPJS claims at the Yukum Medical Center hospital. This subject is the accuracy of BPJS claims. The object of this research is the Yukum Medical Center case mix team. The analysis results conclude that the claim procedure already has an SPO/regulation regulating the procedure for submitting a BPJS claim but has yet to run according to the SPO/regulation. The delay in BPJS claims in 2021 is around 80%. Delays in BPJS claims due to the lack of quality of the case mix team's human resources and inaccurate and incomplete medical resumes. Factors causing delays in BPJS claims from aspects of Man, Method, Machine, Material, and Money. Expected recommendations so that recommendations/solutions are proposed again. The claim procedure is under the implementation flow, but the SPO/regulation needs to run better. BPJS RS claim. Yukum Medical Center, 80% of 2021 claims are late. Factors causing delays in BPJS claims there is no evaluation of the competency of the case mix team (man), late and incomplete medical resumes (material), lack of printers when there is an increase in the number of patients (machine), lack of budget for HR training (money). The BPJS claim recommendations at the Yukum Medical Center Hospital have been running, but the implementation results have yet to align with expectations, so recommendations are needed.

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INTRODUCTION

Due to changes in the current healthcare system and increasing health costs, hospital financing using health insurance is very relevant. In this health insurance, the case mix management system is one of the solutions to the problem. The case mix system is a healthcare financing system related to quality, equity and affordability, which are elements in paying healthcare costs for patients based on a case-based mix of main procedures. The government establishes a legal entity called the Health Social Security Administering Body to administer the health insurance program. The Health Social Security Administering Body aims to realize the provision of guarantees for the fulfilment of the basic needs of a decent life for each participant and their family members. The Health Social Security Administering Body membership is divided into participants who receive Contribution Assistance and non-participants of the Social Security Administering Body who receive Contribution Assistance (Law No. 24 of 2011 concerning BPJS).

Under the mandate of Law Number 40 of 2004 concerning the National Social Security System and Law Number 24 of 2011 concerning the Social Security Administering Body, the Health Social Security Administering Body as the Implementing Body is a public legal entity established to administer health insurance programs for all Indonesian people (Directorate of BPJS Services, 2014). The implementing Agency for Health Social Security is an institution that organizes health insurance programs by providing convenient, affordable health access for Indonesian citizens. The facilities provided by the Health Social Security Administration include the treatment process and relief in financing health facilities because premiums are more economical than other private insurance. The Health Social Security administering body administers the health insurance program. Where the hospital is one of the facilities that support health services is a hospital. The hospital is a health service agency that, in its implementation serves individuals in a plenary manner. Hospitals have various health services, including the availability of inpatient, outpatient and emergency services (Pujihastuti et al., 2014).

Health service facilities in collaboration with the Health Social Security administering Agency must agree to a Cooperation Agreement with the Health Social Security administering Agency and comply with the applicable laws and regulations. The Health Social Security administering agency will pay the first-level health facilities with Capitation. For Advanced Level Referral Health Facilities, BPJS Kesehatan pays with the Indonesia Case Based Groups package system. Indonesia Case Based Groups package tariff is a payment system based on a diagnosis. The amount of reimbursement for the diagnosis has been mutually agreed upon between the provider/insurance or determined by the previous government. Implementing the Indonesian Case Based Groups tariff system, the government is trying to change the tariff that previously used the fee-for-service system to become a prospective payment. Using the Indonesia Case Based Groups system ensures that patients get top service from the hospital without additional costs because patients no longer get other services other than according to their diagnosis, and patients may not incur any costs for the hospital. This makes the hospital must provide full service and obtain effective financing. Health services with good quality and affordable costs are the hope for the whole community. For this reason, hospitals that are the main health service providers are required to control costs and quality by providing services to patients per established clinical pathways.

The implementation of the National Health Insurance system in Indonesia is generally carried out in all types of hospitals, both government hospitals, private hospitals, and other types

of hospitals. Casemix is the basis for Indonesia Case Based Groups, a financing system for the 2014 National Health Insurance. Casemix is a grouping of disease diagnoses associated with treatment costs included in the group. Currently, the government makes payments for health services through the system. Meanwhile, Indonesia Case Based Groups is a payment system with a package system based on the patient's illness. Hospitals will receive payments based on the Indonesian Case Based Groups rate, the average cost spent by a group of diagnoses. Indonesia Case Based Groups tariff is the average cost for a group of diagnosis, Capitation to BPJS Health contributions paid to hospitals or health care facilities. In Indonesia, the prospective payment method is known as Casemix (case-based payment) and has been implemented since 2008 as a payment method for the Public Health Insurance program. The case mix system is currently widely used as the basis for health payment systems in developed countries and is being developed in developing countries.

The claim model used in implementing the Health Social Security Administering Body The case mix system was first developed in Indonesia in 2006 under the name Indonesia-Diagnosis Related Group. Implementation of payments with the Indonesia-Diagnosis Related Group began on September 1, 2008, at 15 vertical hospitals, and on January 1, 2009, was expanded to all hospitals collaborating for the Jamkesmas program. To use the Indonesia-Diagnosis-Related Group application, the hospital must have a hospital registration code issued by the Directorate General of Health Efforts and activate the Indonesia-Diagnosis-Related Group application according to the hospital class and regionalization. The Indonesia-Diagnosis Related Group application activation file can be downloaded on the website buk. Decks. Go.id (McClelland, 1965).

The Casemix system is a system that is offered to address the problem of effectiveness and efficiency of health services in general (generic term) from a system that refers to a mix of cases based on the level and type of patients served by hospitals or other health services. The case mix system provides a way to describe and compare hospitals and other health services, thereby assisting in the planning and managing of healthcare systems. Casemix classifies patients into specific clinical groups/groups that use similar healthcare resources. By doing this, clinical activity, quality, and cost efficiency of different hospitals can be compared.

State hospitals must implement a case-mix system and cooperate with the Social Security Administering Body. Private hospitals must also comply with the laws that are the umbrella for the regulations they make. Hospitals collaborating with the Social Security Administering Body have yet to implement the case-mix system effectively and efficiently. The human resources owned by the hospital have a very large role in the success of running an important program such as the case-mix system, which has been implemented in various countries, both developed and developing countries.

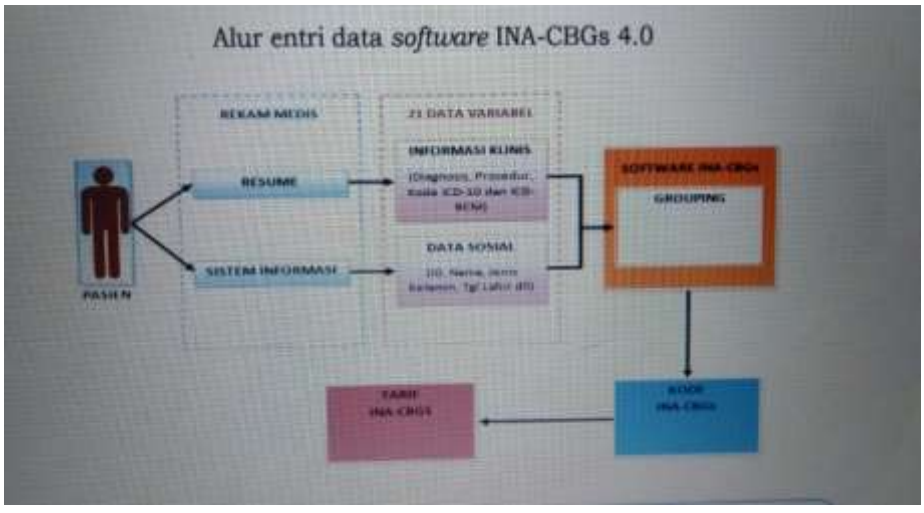
This Casemix system in Indonesia is called Indonesian Case Based Groups (INACBGs). Regulation of the Minister of Health of the Republic of Indonesia Number 59 of 2014 concerning Standard Tariffs for Health Services in the Implementation of the Health Insurance Program Article 1 Paragraph 3 stipulates "Indonesian - Case Based Groups Tariffs, starting now referred to as INA-CBG's Tariffs are the number of claim payments by BPJS Health to Health Facilities Referral Level The continuation of the service package based on the grouping of disease diagnoses and procedures. Furthermore, the grouping of disease diagnoses and procedures uses codes that have been used internationally, namely the International Classification of Diseases version 10 (ICD 10) and the International Classification of Diseases version 9 Clinical Modification (ICD 9 CM). Errors in coding diagnoses and procedures can result in huge losses

for the hospital when under-coded. Otherwise, if over-coded, the claim to BPJS will not be accepted, and there is a possibility that it is considered fraud.

Good cooperation between doctors and coders is needed to get the correct group results. The completeness of the medical record written by the Doctor will greatly assist the coder in providing the correct diagnosis code and action/procedure. The following are the duties and responsibilities of doctors and coders, and claim verifiers. The duties and responsibilities of doctors are to establish and write primary and secondary diagnoses under ICD10, write all actions/procedures according to ICD-9-CM that have been carried out and make a complete and clear medical resume of the patient while the patient is hospitalized. The duties and responsibilities of a coder are to codify diagnoses and actions/procedures written by doctors treating patients under ICD-10 for diagnosis and ICD-9-CM for actions/procedures sourced from the patient's medical record. If the coder finds difficulties coding a diagnosis or action/procedure or does not comply with the general coding rules, the coder must clarify with the Doctor.

The Indonesia-Diagnosis Related Group application is a patient data entry tool used to group rates based on data from medical resumes. The Indonesia-Diagnosis-Related Group application has been installed in hospitals that serve National Health Insurance participants, which is used for the National Health Insurance is Indonesia-Diagnosis Related Group 4.0. To use the Indonesia-Diagnosis Related Group application, hospitals must have a hospital registration code issued by the Directorate General of Health Efforts. Then the INA-CBGs software will be activated for each hospital according to the hospital class and regionalization. Hospitals who want to activate the Indonesia-Diagnosis Related Group application can download the hospital database according to hospital data on the website buk. Decks.go.id. The process of entering patient data into the Indonesia-Diagnosis Related Group application is carried out after the patient has finished receiving service at the hospital. The required data comes from a medical resume, according to the flow chart as follows:

Figure 1. INA-CBGs 4.0 software data entry flow



Health Facilities submit claims every month regularly no later than the 10th of the following month, except for Capitation. There is no need to submit claims by Health Facilities. The Health Social Security Administering Body is required to pay the Health Facilities for the

services provided to the participants no later than 15 (fifteen) working days from the time the claim documents are received in full at the Branch Offices/Regency/Municipal Operational Offices of the Health Social Security Administering Body. Based on a preliminary study conducted at the Yukum Medical Center hospital, the claim submission activity from the hospital to BPJS Kesehatan was delayed. In 2021, BPJS claim files should be submitted by the 5th of each month, but in the field where BPJS claims are submitted can only be submitted by the 5th of each month.

Table 1. Report on BPJS Claim Submission in 2021

Claim time	Bulan												
	an	eb	ar	p	ei	uni	uli	gt	ep	kt	ov	es	an
Claim date/month									4			6	0

Source: Finance Department of RS. Yukum Medical Center 2021

From the report data on the time of filing the claim above, based on a preliminary study of several factors that cause delays in claim time, among others, medical resumes that are not on time and not filled out completely, lack of case mix team human resources who have competence related to groping INACBG, lack of facilities in the form of computers and printers. as the main component of carrying out grouping activities into INACBG, as well as incomplete claims files consisting of supporting evidence of services which are often delayed by expertise by radiology specialists and incomplete Doctor's writing in medical resume sheets and operating reports. Currently, the steps taken to overcome delays in submitting claims are coordinating with the Patient's Responsible Doctor and reminding the Patient's Responsible Doctor regarding the completeness of writing a medical resume or operating report, coordinating with radiology specialists regarding delays in the results of supporting examination expertise and the case mix team. Help between one section and another if needed.

Digital verification of claims is a transition from the verification process previously done manually, which is now carried out with the help of the system. At the Yukum Medical Center hospital, Digital Verification of Claims has been carried out. With the Digital Verification of Claims, the hospital must routinely submit the claim submission file on the 10th of the following month. If the claim submission reaches 80% of the total claim submission, the system will be accepted, and BPJS cannot pay the cost of patient care to the hospital. Suppose Yukum Medical Center Hospital is still experiencing problems related to the late submission of claims and incomplete claim files. In that case, BPJS will only pay some of the patient care costs submitted. Therefore, it is necessary to analyze the claim submission process by the Yukum Medical Center

Hospital to the BPJS. And hospitals have obligations that must be fulfilled, one of which is the administration of medical records.

This study seeks to uncover the factors that cause delays in BPJS claims at the Yukum Medical Center Hospital. A study regarding delays in BPJS claims has been carried out, but they focus only on medical resumes, registration employees and sterilization room employees (Agustin et al., 2022). So to fill the gap from previous research, researchers will focus on finding out how the case mix team and the quality of medical resumes are related to the timeliness of BPJS claims by involving the case mix team as the object of research through qualitative methods. With the implementation of JKN/BPJS in 2014, it is hoped that Yukum Medical Center Hospital can contribute to health services as a referral hospital. So it is necessary to have a common perception among all implementers, to implement the things that must be done in the field in response to this JKN/BPJS program. In this regard, Yukum Medical Center Hospital must prepare itself with various breakthroughs for cost control and quality control of services related to the current INA CBG rates.

Through qualitative research, researchers hope to explore data and influencing factors related to the delay in BPJS claim time. In addition, through the results of this study, it is hoped that a researcher can obtain important information from respondents as basic data to develop a protocol or prevention model related to delays in BPJS claims in hospitals.

METHOD

In this study, the researcher used a retrospective cohort study design. A retrospective cohort is a type of research that examines backwards using secondary data with a phenomenology approach to explore the implementation of the timeliness of BPJS claims. In this study, the researcher used a retrospective cohort study design. A retrospective cohort is a type of research that examines backwards using secondary data with a phenomenology approach to explore the implementation of the timeliness of BPJS claims.

Informants in this study are key informants who can provide information related to the Casemix Team's HR Competence and the Quality of Medical Resume on Timeliness of BPJS Claims. The key informants in this study were 12 people consisting of the head of case mix (1 person), a user (3 people), a verifier (2 people), a medical resume quality department (1 person), a coder (2 people), case manager (1 person).), scan section (1 person), and claim section (1 person). The sampling technique in this research is using purposive sampling. Purposive sampling determines the sample according to the researcher's wants so that previously known population characteristics can represent the sample.

In this study, several instruments will be used, namely the interview guide (Interview Guideline) compiled by the researcher. The interview guide will go through an expert test to test the quality and suitability of the content of each question item. Before conducting interviews, each participant was explained the purpose of the study and asked

to sign an informed consent for recording during the in-depth interview. The interview lasted approximately 60 minutes.

The data in this study will be analyzed using thematic analysis techniques. The recorded data will be transcribed in text form. After that, the data in this study will be analyzed using thematic analysis techniques. The recorded data will be transcribed in text form. After that, the collected data is categorized and sorted. The sorting and categorization of the data aim to find key themes and sub-themes.

HASIL DAN PEMBAHASAN

A. The case mix team's HR competence affects the timeliness of BPJS claims.

Based on the qualitative results, this is supported by the competency of the case mix team's HR, which simultaneously affects the timeliness of submitting BPJS patient claims because the more competent the HR in the case mix team, the more precise the time of claiming BPJS patients will be. This is under the theory of Robbins (2013) that competence is an ability or capacity of a person to do various tasks in a job, where this ability is determined by two factors, namely intellectual ability and physical ability. Capability is one of the factors that shape HR performance. Human resources with high capabilities greatly support the achievement of the organization's vision and mission to advance and develop immediately. A person's capabilities will make the HR different from others if the HR has above-average abilities. Ability will show the capability of a relatively stable person to realize certain activities. In comparison, skills or skills can be improved over time through training and experience.

This study is also under previous research conducted (Noviatri & Sugeng, 2016) that the cause of the delay in submitting BPJS claims at the hospital. Panti Nugroho comes from the Man factor, the initial completeness verifier officer, DPJP and coding officer. The machine factor is because SIMRS has not been integrated with INCBGs. The method is because the implementation of the SPO has yet to be smooth. The material factor is because the requirements are not suitable. This study also follows previous research (Umboh et al., 2021), which showed that quality human resources affect organizational performance. This study is also per previous research conducted by (Umboh et al., 2021) that the factors related to the performance of medical record officers are competence and communication related to the performance of officers. This study is also under previous researchers conducted by Silvia Intan Wardani, Wahyu Teja Kusuma, and Nindynar Rikatsih (2020) that the influence of motivation, competence and work environment affects the performance of medical record employees at RSJ Dr Radjiman Lawang.

B. Effect of completeness of medical resume on the timeliness of BPJS claims

Based on the study's results, information related to knowledge was obtained. All informants understood the importance of a medical resume in the JKN era. The informants believe that a complete medical resume starting from the date of admission, date of discharge, history taking, physical examination, supporting

examination, primary diagnosis, and secondary diagnosis, along with therapy or treatment is given to patients is the basis for generating INACBGs rates which will be a source of income. Hospital, where the complete medical resume and timely filling of the medical resume will affect the timeliness of filing BPJS patient claims at the hospital (Harus & Sutriningsih, 2015). Completeness of medical records is the main requirement in filing a claim. The medical record must be filled in completely about the services and treatment provided to the patient. The incomplete filling of the medical record impacts the incomplete filling of the resume/summary when the patient has finished undergoing treatment and automatically impacts the claim submission process.

This is per the theory Huftman explained that the quality of a good medical record could also reflect the quality of health services provided. Quality medical records are needed to prepare medical evaluations and audits of medical services retrospectively to medical records. In Health Service Quality Management, quality is a total description of the nature of a product or service related to its ability to provide satisfaction needs. The quality of medical records plays a very important role in the quality of hospital medical services. The incompleteness of filling in medical records greatly affects the quality of medical records because the quality of medical records reflects whether or not the quality of service at the hospital is good (Rosariani & Safrianto, 2022).

In terms of verifying claim files, the number of medical verifiers is felt insufficient, considering the quality of medical resumes is still not optimal (Pongpirul, 2011). Likewise, there are only two internal verifier officers, which is not proportional to the number of inpatient claim files that must be verified daily. The workload of coders who are technically still doing other structural work, so they don't focus on coding only. The final coder is only 1 person who is in charge of matching the coding results with the medical resume, if a discrepancy is found, the final coder will make improvements.

In the funding aspect, the research results show that the case mix team, as the implementing unit for billing service claims to BPJS Kesehatan, does not hold a special allocation to support the completeness of filling out medical resumes. The Yukum Medical Center Hospital has not implemented a reward and punishment system related to the completeness of the contents of the medical resume. Applying a reward and punishment system is one way to maintain a commitment to the completeness of the contents of a medical resume (Christina & Bua, 2020). (Indrian & Qurochman, 2020) her research states that the compensation factor is the most dominant one related to the completeness of the medical resume. To motivate doctors, it is better if the completeness of filling out a medical resume can be included as a doctor's performance and counted as an incentive.

To support the completeness of filling out medical records and medical resumes, RS. Yukum Medical Center has implemented SOP. However, the implementation has not run optimally because the SPO has not been regularly disseminated to related units, especially inpatient units and DPJP (Bambona, 2022). Ideally, to better understand a job, periodic SOP socialization related to the job should be carried out. The availability of facilities and infrastructure, both medical resume forms, is sufficient. DPJP considers the medical resume form to represent the need for information regarding the patient's medical history. However,

to collect claims to BPJS Health. However, the coder assesses that the medical resume form is still incomplete. In comparison, Soong et al., in their research, stated that a quality medical resume has an important role in providing key information in services to patients (Badan Pusat Statistik, 2021).

Regarding the difficulty of the coder and verifier in reading the Doctor's writing, it would be better if the electronic resume was immediately realized. Reinke (2014) reports that implementing electronic medical resumes can improve the timeliness of completing medical resumes. (Cheristina & Bua, 2020) in his research also reported that the successful use of electronic medical resumes can improve the quality, timeliness and completeness of medical resumes. To support the smooth running of work, the availability of computers for coders and verifiers and the case mix team is still lacking, especially when the number of patients increases. The existence of SIMRS in the hospital. Yukum Medical Center still has not accommodated the need for data on supporting examinations such as radiology results. Still, it is quite good for laboratory results and hospital billing. Information technology in hospitals is useful for integrating all service information and hospital management (herlambang Bayu et al., 2021). SIMRS is currently necessary in hospitals to serve administrative and clinical functions that will directly improve services (Rois et al., 2020). Pongpirul, in his research, also states that using software and coders with sufficient quality and quantity plays an important role in the coding process (herlambang Bayu et al., 2021).

This study is also per previous research (Rakhmatullah, 2015) that found research results showing that the submission of JKN claims by the Bahtera Mas Prov Public Service Agency hospital, Southeast Sulawesi is often not timely. This is due to the condition of internal factors in incomplete filling. Medical resumes by officers and lack of supporting files for medical actions. This study is also per previous research conducted (Almirza & Supriyadi, 2016) that to reduce incomplete medical resumes, it is necessary to make more detailed procedures/SOPs related to filling out medical resumes and disseminate them to doctors and nursing units. This study also follows previous research conducted by (Gibson et al., 1996), that the factor that affects delayed claims is the incompleteness of the medical resume. This study is also following previous research conducted by (Rois et al., 2020); the results indicate that the factors that influence pending claims are the incomplete claim documents and the absence of a billing system at RSUD Dr Sam Ratulangi Tondano.

This study also matches previous research conducted by (Handoko, 2016) that RS. Nur Hidayah experiences pending claims every month. The contributing factors are inaccuracies in coding, incomplete files and diagnoses that do not match the criteria. This study is also under previous research conducted (Qodir et al., 2016) that the delay in the verification file was due to the slow filling of medical records by the DPJP.

CONCLUSION

In this study, it was found that to model the implementation of the timeliness of BPJS claims. Which said it was found that the incompleteness of the medical resume starting from the main diagnosis, examination results and medication when the patient will affect the amount of the claim value will be billed to the guarantor (reimbursement).

which states that information systems, changes in rules regarding billing and disease codification and the low level of knowledge and experience of human resources in the administration of claim submissions are some of the causes of claim rejection. In this study, the themes that most dominantly affect the implementation of the timeliness of BPJS claims are the influence of HR competence on the quality of case mix team work, obstacles in the delay in submitting BPJS claims, and causes of incomplete medical resumes.

The claim procedure is under the implementation flow, but the regulations have not gone well. BPJS RS claim. Yukum Medical Center, 80% of 2021 claims are late. Factors causing delays in BPJS claims there is no evaluation of the competency of the case-mix team (man), late and incomplete medical resumes (material), lack of printers when there is an increase in the number of patients (machine), lack of budget for HR training (money). The BPJS claim recommendations at the Yukum Medical Center Hospital have been running, but the implementation results have not aligned with expectations, so recommendations are needed.

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