



# Analysis Of Inpatient Patient Claims Pending To Support The X Hospital's Bpjs Health Claims' Effectiveness

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**Abstract :** A pending claim is something that occurs when insufficient or inaccurate data is submitted, making it more difficult for hospitals to file claims to BPJS. Discovering the reasons behind pending inpatient claims is the focus of this research. This study used a qualitative, descriptive methodology with a sample of 1000 files obtained using the Slovin method and a pending file population of 8,931 files from January to March of 2024. According to the study's findings, coding errors accounted for 73% of pending files, incomplete supporting materials for 23% of files, and administrative completeness for 4% of files. The partial completion of the file that needs to be submitted to BPJS, disagreements between the hospital and BPJS over the validity of the diagnosis, and the lack of supporting documentation are the reasons why the claim is still pending. The author recommends that relevant parties and units enhance the completeness and correctness of patient file completion to ensure smooth operation of the claim process. Additionally, frequent meetings and assessments should be held each month to reduce the number of unresolved claims.

**IndexTerms – Health Claim, BPJS, Efectivity, Inpatient, Analisis Pending Claim.**

## I. INTRODUCTION

In order to give the community access to high-quality healthcare services, hospitals are essential. as [1] emphasizes. Hospitals are healthcare facilities tasked with giving patients the best possible care. These services are intended to satisfy the requirements of the general population in addition to being professionally delivered by physicians, nurses, and other medical professionals. provide medical services that are specialized, secondary, subspecialty, or tertiary, as indicated by [2], represents the hospital's primary duty. In light of this, hospitals have an additional duty to provide more sophisticated and specialized services in accordance with patient needs, in addition to providing medical care.

All Indonesian citizens are obliged by the National Health Insurance to register with the Health Social Security Administration Agency (BPJS). Following payment of dues or through the payment of contributions covered by the government, the goal of BPJS is to guarantee that everyone has sufficient access to the medical care they require. [3] Therefore, meeting fundamental public health needs and facilitating patient access to hospitals constitute the primary objectives.

The procedure by which hospitals submit to BPJS Kesehatan the treatment costs for BPJS patients is known as a BPJS claim. [4] Hospitals require supporting documentation for this process, which is often conducted on a monthly basis. Examples of these documents include a proof of inpatient care form, a medical résumé, supporting examination findings, a Participant Eligibility Letter (SEP), and payment receipts. To ensure that the hospital will be reimbursed for the patient's treatment costs in line with the Case Base Groups Indonesia (INA-CBG) rate during the patient's treatment, these documents must be completed when the hospital wishes to file a BPJS Kesehatan claim. handled. [5]

A comprehensive document is necessary throughout the claims process, as indicated by [6]. Hospitals with a higher probability of expediting the procedure of patient health expense reimbursement are those that fulfill all paperwork criteria. Many documentation, including the SEP (Participant Eligibility Letter), test results, invoices, medical resumes, and patient diagnoses, must be filled during the claim submission procedure. The claim for the payment of monies to BPJS participants will be submitted for verification by BPJS if all documents are completed and meet the necessary standards.

The BPJS claim file will be marked as "pending" if it does not adhere to the requirements outlined in the BPJS provisions. This may result in a number of issues at the hospital, like the fact that hospitals suffered financial losses as a result of BPJS Kesehatan claim payments being made later than expected. Furthermore, delayed payments may lead to late payments from physicians and other healthcare providers, thereby interfering with the efficient operation of hospital services and funding.

According to the Minutes of Collective Agreement (BA) No. 1693 of 2019, BPJS and the Hospital will utilize the outcomes of the agreement to settle the situation that gave rise to the claim and to verify the information provided by INA-CBG.

Because processing pending claims necessitates investigation, identification, and improvement in order for BPJS to complete them, it is crucial for hospitals to handle them carefully. Because of how crucial this is, researchers wish to study "Analysis Of Pending Patient Claims To Bolster The Effectiveness Of BPJS Kesehatan Claims At RS X"

## II. RESEARCH METHODOLOGY

According to (Sugiyono, 2018), the sampling technique using probability sampling by determining the sample of each member of the population has the same chance to be used as a sample. [16] Observation, interviews, and literature reviews utilizing research tools from pending BPJS claim files, stationery, and interview protocols are the methods utilized in this study to collect data. This study employed a descriptive qualitative research methodology.

## III. RESULTS AND DISCUSSION

The following findings are the outcome of the author's fieldwork practice in Hospital X's Casemix Unit on the Analysis of Pending Inpatient Claims to support the efficacy of BPJS health claims at Hospital X:

### A. Data Recapitulation of Hospital X's January–March 2024 Inpatient Claim Verification Status Outcomes

Table 1. Number of claim files submitted and number of pending claim files for inpatients at Hospital X January-March 2024

No.	Month	Number of files submitted	Number of pending files		Number of files successfully claimed	
			N	%	N	%
1.	January	3007	337	3,2	2670	29
2.	February	3015	396	4,4	2619	29
3.	March	2909	267	2,9	2642	29
<b>Amount</b>		<b>8.931</b>	<b>1.000</b>	<b>10,5%</b>	<b>7931</b>	<b>87%</b>

.Based on table 3.1, in January-March 2024, the number of claim files submitted in January was 3007 files with 337 pending files, in February as many as 3015 files with 396 pending files, and in March 2909 with 267 pending files Therefore, there are a total of 8,931 outstanding files out of 1,000 inpatient submissions that were made to Hospital X between January and March of 2024.

### B. Examination of Hospitals' Pending Inpatient Claims x

The number of samples to be taken using the basic random sampling technique using the formula, also known as the Slovin formula, is determined by recapitulating the status of BPJS Claim Verification at Hospital X from January to March of 2024.

$$n = \frac{N}{1 + N(e)^2}$$

Information:

n : Number of Samples

N : Total Population

e : Sampling Error Tolerance (10%)

$$n = \frac{1000}{1 + 1000(0,1)^2}$$

$$n = \frac{1000}{1 + 1000 \times 0,01}$$

$$n = \frac{1000}{1 + 10}$$

$$n = \frac{1000}{11}$$

$$n = 90,9$$

**n = 91 (Rounding)**

The 91 filings that caused pending from January to March yielded the following outcomes.

Table 3.2 Causes of Delay in Outpatient Claims at Hospital X

No	Penyebab Pending Klaim	Berkas Pending Bulan Januari-Maret 2024	
		N	%
1.	Koding	66	73
2.	Berkas Penunjang	21	23
3.	Administrasi	4	4
<b>TOTAL</b>		<b>91</b>	<b>100%</b>

Table 3.2 shows that 73% of the cause of waiting claim files, or coding, accounted for the highest percentage of pending claim data from January to March. Administrative completeness, at 4%, had the lowest percentage. We can deduce that the relationship among the administrative file completeness, supporting file completeness, and coding accuracy influences the occurrence of determining when to claim BPJS inpatient at Hospital X.

**The following describes the timeliness of BPJS claims to back up the efficacy of claims at RS X:**

The fifth of every month is the deadline for hospitals to submit their claims to BPJS, according to data gathered from casemix employees. When a file is pending, BPJS allows a maximum of three months for the hospital to fix it. The hospital is then required to return the updated file to BPJS within the next three months.

**C. Claim Process to Enhance Hospital X Claims Effectiveness**

The process of filing inpatient health BPJS claims at Hospital X follows the current standard operating procedures (SOP) in light of the findings of the research that was conducted.

1. In order to verify the diagnosis, the room attendant enters the information from the medical record into the casemix unit along with the doctor's actions and supporting results on the medical resume sheet.
2. The filing officer verifies the completeness of the file; if the patient's BPJS card, reference letter, ID card, family card, medical resume content, and signature are present in the SEP, the file is considered complete.
3. Additionally, the file is sent to the Verifier section, where it will be reexamined to determine whether or not it is appropriate to be sent to the Coding section. Complete and workable files, such as LIP, billing, SEP, medical resume, supporting results, and therapy, are submitted to this section.
4. The hospitalization file is in the sickness code according to ICD 10 and the action code according to ICD 9, and it is in the grouper to be delivered through the E-claim application if it is complete and complies with the requirements.
5. The final phase involves the internal verifier sending TXT to the V-claim application to submit a claim if the medical resume has been formalized.

**D. Issues that arise with hospital x inpatients' pending claims**

According to the findings of the study and an interview with the head of the Casemix department, the following factors contributed to the delay in the BPJS health claim file at Hospital X:

1. Administrative incompleteness, including different medical resumes, SEP, LIP, and DPJP doctors; no steps are recorded to impede the claim process
2. Recurrent disagreements about how to enforce the diagnostic code between the hospital and BPJS, which results in unresolved inpatient and outpatient claims
3. The lack of supporting documents, such as CT scan and RO results, leads in pending claims.

**E. Efforts made by casemix unit officers in overcoming the problem of pending claims of inpatients at Hospital X**

The following are the actions taken by Hospital X's casemix unit officer to resolve outstanding inpatient claims:

1. Conducting socialization to the administration, DPJP doctors, and related units so as to prevent pending claims.
2. Assessing staff performance and casemix unit employees' correctness on a monthly basis.

**IV. Conclusion**

The following conclusions can be drawn by the author based on the findings of the study on Pending Inpatient Claims to support the efficacy of BPJS Kesehatan claims at Hospital X:

1. The quantity of claim files from January to March 2024
2. which ranged from 8,931 files that were submitted to 1,000 files that were pending. Of the 3015 files that were filed and 396 files that were pending, February had the highest number of outstanding claims.
3. A total of thirty files were sampled in January, thirty files in February, and up to thirty-one files in March. The sampling technique utilized was simple random sampling.
4. The high percentage of pending claims at RS X from January to March was caused by three factors: administrative completeness (4% of 4 files), supporting files (23% of 21 files), and coding accuracy (73% of 66 files).
5. The Hospital's prompt submission of claims to BPJS on the fifth of each month; BPJS will allow a maximum of three months for the follow-up or pending file. In order for any files that have been fixed and are still pending from January to March of 2024 to be returned to BPJS on the 15th of the following three months.
6. standard operating procedures (SOP) have been followed throughout the BPJS claim procedure at Hospital X.
7. Hospital X, in particular the casemix unit, makes a consistent effort to avoid pending claims by conducting assessments and regular meetings each month to reduce the likelihood of pending and ensure that claims to BPJS are processed efficiently.

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