

Overview of Claim Return for Outpatient JKN Hospital X in South Tangerang [†]

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Abstract: Hospital X in the South Tangerang serves BPJS outpatients, every month sending claims for outpatient services to BPJS Health, but not all submitted claims are processed by BPJS Health. There are a number of claims that are returned because they are not in accordance with the provisions for submitting claims. This study aims to overview the causes of claims returns and follow-up the returned claims of Hospital X. The method used in this study is a quantitative description where the documents studied are claim documents returned by BPJS Health to Hospital X in the period of September 2020 to August 2021. A total of 3795 claim documents were returned; there were 3194 claims returned due to repeated control indicated factors, while the rest were due to physiotherapy service indication factors more than 8 times per month, errors in determining the procedure code, incomplete supporting files and other reasons. After hospital X corrected the returned claims, there were 974 claims that could not be resubmitted, so these claims were considered as a cost to Hospital X. The cause of the claim not being resubmitted was because the patient eligibility letter was printed more than once. This article offers suggestions to minimize patient visits in the near future and to follow the latest policy developments from BPJS Health regarding outpatient claims.

Keywords: returned claim; outpatient; repeated control



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1. Introduction

The Indonesian government implemented the National Health Insurance (JKN) program which was managed by the Health Social Security Administration (BPJS) in early 2014, which refers to the Minister of Health Regulation (PMK) No. 28 of 2014 concerning guidelines for the implementation of JKN. The implementation of the JKN program in hospitals makes the hospital a specialist or sub-specialist health service institution for both outpatient and inpatient care [1].

In the implementation of the JKN program, the hospital will provide services to the patient, then the hospital will submit a claim related to the costs incurred for the patient's treatment. According to the Practical Guide to BPJS Health Facility Claims Administration, hospitals can submit claims on a regular basis no later than the 10th of the following month and BPJS Kesehatan is obliged to pay claims for services provided to hospitals no later than 15 working days from time the claim file is received at the BPJS Kesehatan Branch/Regency/City Operational Office [2].

The claim document submitted must meet the terms and conditions set by BPJS Health. The claim document received by BPJS Health will be checked by the verifier. After the file is verified by the verifier, the file will be divided into two possibilities. The first possibility is that the file passes verification, which means that the claim document submitted by the hospital will be paid by the government through BPJS Health, and the second possibility is the document does not pass the verification where the document will be returned by BPJS Health to the hospital for repairs and to complete deficiencies [2].

Hospital X South Tangerang is one of the hospitals that collaborates with BPJS Health. According to data from the casemix unit of the hospital, there are still many claim files that are returned to the hospital because they do not comply with the BPJS Health claim requirements. Therefore, the author wants to see an overview of the causes of the return of the claim document.

2. Material and Methods

This research is descriptive with a quantitative approach to determine the number of outpatient claim documents that are returned, the factors that cause these claims to be returned and the follow-up of the causes of returning these claim document.

The proportion of claim documents returned by BPJS Health is found by calculating the number of claim documents returned in the period September 2020 to August 2021, then divided by the total number of outpatient claim documents submitted in that period.

The factors causing the claim document to be returned are identified through the records provided by BPJS Health for each returned document and then grouped according to the same groups. After that, five groups with the most claims were taken. Explanation of the factors causing claim documents to be returned in the five most groups was discussed with the head of the casemix unit.

The follow-up of causes are grouped according to the same group and then separated into claim documents that can be resubmitted and claim files that are not eligible to be resubmitted to BPJS Health. An explanation of the follow-up was carried out by interviewing the head of the casemix unit.

3. Result and Discussion

3.1. Number of Claim Documents Returned

A claim is a bill or claim for a fee for the services provided. Hospital claims against BPJS Health are demands for compensation for services provided by hospitals through their workforce, both doctors, nurses, pharmacists and others or to BPJS Health participants who seek treatment or are hospitalized. All claim documents sent to BPJS Kesehatan are verified by the verifier. If a discrepancy is found between the claim documents submitted and the claim submission requirements, the claim will be returned by BPJS Health to the sending hospital to be completed with the documents and confirmed regarding the difference [3].

During the period from September 2020 to August 2021, Hospital X South Tangerang submitted outpatient claim documents to BPJS Health, but from a number of claim documents submitted there are claims that are returned to Hospital X Tangerang Selatan because they are considered not in accordance with the claim requirements from BPJS Health. Outpatient claims data submitted and returned are as follows in Table 1:

Table 1. Number of Claim Documents from September 2020 to August 2021.

No.	Claim	Number	Percentage
1	Claim Submitted	113,473	96.8%
2	Claim Returned	3795	3.2%
	TOTAL	117.268	100%

Source: Casemix Unit Hospital X South Tangerang.

The number of outpatient claim documents for RS X South Tangerang returned by BPJS Health in the table above is 3795 claim files or approximately 3.2% of the total claim documents submitted. Research at Singaparna Medika Citrautama Hospital in 2014 found 476 rejected files from 9815 outpatient claims submitted or approximately 4.8% [4], while in research at the Pulmonary Hospital, Dr. M. Goenawan Partowidigdo who sent as many as 6895 patient claim documents for outpatient services to BPJS Health in 2019, and there were 448 patient claim documents submitted by hospitals that were returned by BPJS Kesehatan [5].

The return of claim documents will cause delays in disbursing funds that should be received by the hospital, which has an impact on the hospital’s finances and also on the quality of service, and the level of satisfaction can decrease [6].

3.2. Factors Causing Claim Documents Returned

Of the submitted claim documents for outpatients at RS X South Tangerang in the period September 2020 to August 2021, there were 3795 claim documents that were returned because they did not comply with the requirements for submitting claims to BPJS. The reason for the return of the claim is due to several factors. Of these factors, they were then grouped into five groups of causal factors as follows:

3.2.1. Repeated Control Indication

Based on Table 2, the factors causing the return of outpatient claim documents from RS X South Tangerang to BPJS Health are repeated control indications. According to the Minister of Health Regulation No. 26 of 2021 concerning INACBG’s Guidelines, it states that repeated outpatient visits at the same advanced health facility in cases with the same diagnosis from the previous outpatient episode in less or equal to 7 days are considered as fragmentation. The data can be seen in Table 2 as follow;

Table 2. Factors Causing Claim Documents Returned.

No.	Factors	Number	Percentage
1	Repeated Control Indication	3194	84.1%
2	Indications for Physiotherapy >8 times	252	6.7%
3	Procedure Code Error Supporting	130	3.4%
4	Examination Document	115	3.0%
5	Others	104	2.8%
	TOTAL	3795	100%

Source: Casemix Unit Hospital X South Tangerang.

A total of 3194 claim documents submitted are indicated as fragmentation where it is suspected that the patient made repeated visits and violated the provisions of BPJS Health. According to the head of the casemix unit, the claim documents indicated as repeated control, for example, there was a patient who had to be checked after 3 days of taking the drug, where on day 3 the patient had to do a laboratory or x-ray examination, so a cover letter was given for the control. The control on day 3 was considered as fragmentation because the control measures were still in the same outpatient period. In addition, this indication of repeated control always occurs in patients who require in-depth examination, especially elderly patients.

This causative factor also occurs in filing claim documents at the Lung Hospital, Dr. Goenawan Partoidigdo, where the claim file was returned due to an error in entering hospital class rates, repeated control indications, and the absence of supporting examination reports [5].

3.2.2. Indications for Physiotherapy >8 Times

Regulation of the Director of Health Service Insurance, BPJS Health number 05 of 2018 concerning the Guarantee of Medical Rehabilitation Services. The regulation states that physiotherapy actions for BPJS Health participants will be limited to a maximum of two times a week. This means that the physiotherapy measures covered by BPJS Health are eight times. From the number of claims submitted, it was indicated that there were 252 claims containing physiotherapy >8 times, so the claim was returned to X Hospital South Tangerang. The maximum limit of 2 times a week or 8 times a month is closely related to BPJS Health’s finances as the guarantor of the health care costs of its participants.

3.2.3. Procedure Code Error

The Regulation of the Minister of Health of the Republic of Indonesia No. 76 of 2016 concerning the INACBG guidelines, states that the INACBG-based payment system where grouping in INACBG uses the codification of the final diagnosis and the action or procedure becomes the service output, requires reference to ICD-10 for diagnosis and ICD-9 for action or procedure.

In this case, every claim submitted should match the supporting documents with the procedure for action. A total of 130 claim documents submitted by RS X South Tangerang indicated an error in including the procedure code, so they were returned to RS X Tangerang Selatan for repair.

Several indicators that cause delays in BPJS Health claims at RSUD Dr. Kanujoso Djatiwibowo, due to a INA CBG difference of 4.8%. This is because the coding and diagnosis of the hospital is different from the coding of the BPJS health validator. Equalization of the diagnostic point of view between DPJP, hospital codes, and verifiers should be encouraged to further reduce coding differences [7].

The results of this study found 142 inpatient claim documents submitted and 82 outpatient claim documents returned. The reason for the returns is because of failure of the service management review and the healthcare review. The reason for not passing the verification was mainly due to the inaccuracy of the filing officer and the different points of view on the diagnostic code of Hermina Ciputat Hospital and BPJS Health [2].

There were 49 (53%) claim files that were rejected by BPJS Health due to coding at Tarakan Hospital, namely the occurrence of a mismatch between the hospital's diagnosis and BPJS Health. Medical record filling is done by the DPJP, but the claim is made by the general practitioner in charge in the casemix unit, and sometimes the perception of the diagnostic coding from the hospital to the BPJS Kesehatan is different. Thus, the possibility of this difference in perception raises a discrepancy between the hospital diagnosis and BPJS Health diagnosis coding [8].

3.2.4. Supporting Examination Document

According to the head of Casemix Hospital X South Tangerang, the factor that caused the return was an incomplete patient document. Patient documents include photocopies of ID cards, BPJS cards, SEP as well as medical supporting documents, such as results of laboratory examinations, supporting action expertise and medical resumes. There were 115 claim documents that were returned due to incomplete supporting files.

PKU Muhammadiyah Yogyakarta Hospital found that there were two highest factors that caused BPJS claims to be rejected, namely incomplete supporting reports and individual patient reports [9]. Meanwhile, at RSUP DR Soeradi Tirtonegoro Kalten, it was found that claim documents were rejected due to incomplete patient membership administration files and service administration and individual patient reports [10]. At Tarakan Hospital Jakarta, it was found that the factors that caused the delay of claims to BPJS Health included patient administration and other medical supports, as much as 44% [8].

3.2.5. Others

The lowest factor for the cause of the return of claim documents for South Tangerang Hospital X to BPJS Health amounted to only 105 claim files. According to the head of the casemix unit, this factor was mostly just a question to verify what polyclinic the patient visited. This was asked with the aim of ascertaining whether the treatment carried out is in accordance with the patient's illness. By knowing this, BPJS will estimate the amount of claims that can be disbursed and provide an opportunity for hospitals to make improvements to files that have deficiencies.

3.3. Follow Up

After knowing the reason for the returned claim documents by BPJS Health, the hospital needs to follow up on the documents. The hospital's follow-up aims to verify the

submitted claim documents. When making repairs, the hospital will re-check the returned claim documents. In addition, the hospital can also provide an explanation for claim documents that are considered ambiguous so that it can be considered whether the file is eligible to be claimed or not

In the process of repair, the hospital has time to submit the claim document back to BPJS Health no later than 6 months after the official report is published. If the application exceeds this limit, it will be considered forfeited and claims cannot be made [2].

From the results of follow-up and completion of claim files, the following results are obtained in Table 3:

Table 3. Follow-Up and Claim Returns.

No.	Claim	Number	Percentage
1	Eligible to Re-submit	2821	74%
2	Not Eligible to Re-submit	974	26%
TOTAL		3795	100%

Source: Casemix Unit Hospital X South Tangerang.

The follow-up action taken by Hospital X South Tangerang on the claim documents returned from BPJS Health was to correct the claim documents by paying attention to the notes provided for each claim document. Of all the claims documents returned by BPJS Health, as many as 2821 claim documents were submitted back to BPJS Health to be billed, however there were 974 claim files that were not eligible to be submitted back to BPJS Health because they could not fulfill the claim document requirements from BPJS Health and these claims were considered forfeited.

According to the head of the casemix unit, Hospital X South Tangerang, the most common cause was the SEP was printed twice. For example, a patient who initially received treatment through outpatient treatment but turned out to be hospitalized, causing the SEP to be reprinted. This causes the outpatient service to not be claimed because it is considered a period of hospitalization and is billed as an inpatient claim. Claim files that are not feasible and cannot be billed to BPJS Health are a cost burden for Hospital X South Tangerang.

According to Nurdiah’s 2016 research, there were 1956 inpatient documents claim at RSUD dr. Soekardjo Tasikmalaya that was unclaimed. The cause of these unclaimed files was due to a lack of knowledge and discipline from the coding officer, the number of printers was lacking, the coding officer’s workspace was narrow, the computer network was inadequate and the INA-CBGs application often had errors [11].

4. Conclusions

The number of claims for Hospital X South Tangerang returned by BPJS Health in the period September 2020 to August 2021 is quite large, namely 3795 claim documents.

The highest factor causing claims returned by BPJS Health is the indication of repeated control, which is 3194 or 84.1% of the total claims returned.

With regard to the follow-up of the returned claim documents, there are 974 claim documents or approximately 26% of claim documents that are not eligible to be billed again, and they become a cost burden for Hospital X South Tangerang.

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