Cases of Dispute and Pending Claims in Hospitals in the Era of National Health Insurance

Yastori, S.Si, M.Si
Department of Medical Record and Health Information Management
Apikes Iris, West Sumatera, Indonesia
yastori10@gmail.com

ABSTRACT

Background: Indonesia began to implement a National Health Insurance System based on the National Social Security System in 2014 with the support of government regulations which states that Indonesia requires every citizen to have access to comprehensive and quality health services so that can continue their life through the National Health Insurance. Pending and dispute claims are problems that often occur in the era of national health insurance that can affect hospital budget allocation and planning policies, increasing the high cost burden for hospitals which will affect the quality of health services provided. The purpose of this study was to determine pending cases and dispute claims in hospitals in the Era of National Health Insurance.

Methods: The study used a descriptive method with a qualitative approach. The data collection technique used is the observation method, namely directly to the e-claim file at several hospitals. 15 e-claim files taken in total from April - July 2021.

Results: Obtained 13 cases of pending claims and 2 cases of dispute claims. Cases pending claims are caused by not complying with the code with evidence or resources, not in accordance with medical clinical practice guidelines and the rules of the health insurance provider.

Conclusions: In coding, it is necessary to match the theory on the ICD-10, update the ICD-10. It is necessary to understand the rules and provisions made by the insurer and the related guidelines and rules. Please be aware of every latest code update.

Keywords: Dispute, Pending Claim, ICD-10.

INTRODUCTION

The National Health Insurance System (JKN) established by the Health Social Security Administering Agency (BPJS) in 2014 is an advanced health insurance program for the government in the previous year. In the Minister of Health Regulation No. 69 of 2013 Regarding the tariff for health services for the JKN program, the tariff for Indonesian case based groups, hereinafter referred to as INA CBG's tariff, is payment using INA CBG's, both hospitals and the paying party no longer detail the bill based on the details of the services provided, but only by submitting the patient's diagnosis and actions from the hospital. INA CBG's code (Permenkes, 2013).

There are several studies on the problem of implementation by the health provider. Based on Putra's research, it shows that in the implementation of the national health insurance, various obstacles were found, one of which was related to financing, such as delays in disbursing claims due to pending in the claim filing process and the difference in the value of service rates for the INA-CBGs service package (Putra, WM. 2014) Tettey's research
et al., found that the rejected claims caused the payment of health facilities to be not in accordance with the proposed costs. As a result of the rejected claim, the health facility in Kassena Nankana lost 10.65% of the claim fee filed and the health facility in Builsa district lost 14.48% of the claim filed (Tettey, SS, et al. 2012). This shows that the occurrence of rejected claims can cause losses for hospitals, especially government-owned hospitals that accept many health insurance patients so that they experience losses due to the incompatibility of service financing with the amount of claims paid (Ernawati, D dan Kresnowati L. 2013).

Since the launch of the BPJS Health program by the government, it has had a major impact on the Health Information Medical Record (PMIK) profession. The accuracy of Ina-Cbg's coding and grouper for submitting claims based on the disease code and procedures code, greatly affects the eligibility of claims to be submitted based on Minister of Health Regulation No. 76 of 2016 concerning Ina-Cbg's Guidelines in the Implementation of JKN. This claim process is very important for hospitals as a reimbursement for insurance patients who have been treated. Facilities that cooperate with BPJS Health must be able to submit claims every month on a regular basis no later than the 10th of the following month, along with the required documents that must be completed according to the BPJS health verification procedure.

Research on pending claims by BPJS Health has been widely studied. The results of the research by Irmawati, Marsum, Monalisa, Poltekkes Kemenkes Semarang entitled "Analysis of Dispute Diagnostic Codes for Hospitals with the Health Social Security Administering Body (BPJS)", showed that most of the claim files returned were cases classified as Case-Mix Main Groups (CMG) code A (Infectious and parasitic diseases Groups) as much as 35.82%. The description of the disputed diagnosis code by BPJS and the hospital occurs when the code is not specific, the DU code (Primary Diagnosis) or DS code (Secondary Diagnosis) is not supported by supporting examination data, the DS code is part or a continuation of the code, the code is in the suspect diagnosis condition. Completion of return claim files due to code dispute with MB2 rule code reselection as much as 59.70%. Determination of the code should always be read back and follow the rules. Medical personnel need to understand that completeness and consistency in filling out medical records are needed to produce an accurate code (G. Alfiansyah, N. Nuraini, R. A. Wijayanti, F. Putri, A. Deharja, and M. W. Santi, 2019).

Another research by Ayu Nadya Kusumawati, Pujiyanto Postgraduate Program in Hospital Administration Studies, Department of Health Administration and Policy, Faculty of Public Health, University of Indonesia, Jakarta, Indonesia, on "Factors - Factors Causing Pending Claims for Hospitalization at Koja Hospital in 2018", indicating that file returns with the reason of revision of diagnosis placement amounted to 1,190 files or 21.9% of all pending claim files. This happens because the coder only does the coding according to the diagnosis written on the medical resume. Coders are not allowed to change the primary and secondary diagnoses in the medical resume. After further investigation, this error stems from the lack of understanding of the Patient Responsible Doctor (DPJP) regarding the placement of primary and secondary diagnoses. Settlement of pending claims related to this is done by contacting the DPJP and inquiring about the diagnosis that uses the greatest resources or the cause of the patient being treated. This problem can be prevented by re-socializing to the DPJP regarding the rules for writing diagnoses and the rules for completing medical resumes so that there are no more pending claims due to the discontinuity between diagnosis and history taking, physical examination, action, and therapy (Kusumawati, A.N. 2021).

Based on the above, it can be seen several things that cause the emergence of pending and dispute claims. PMIK plays an important role in the smooth process of filing until the payment of BPJS claims, the disagreement between BPJS and the hospital is one of the factors for the occurrence of pending or returning claims, where this term is usually called dispute claims. Based on the description and problems above, the author wants to describe cases of dispute and pending claims at the hospital
METHODS

The study used a descriptive method with a qualitative approach. The data collection technique used is the observation method, namely directly to the e-claim file at several hospitals. 15 e-claim files taken in total from April - July 2021.

RESULTS

Based on the results of direct observation of the e-claim file, the following results were obtained:

Table 1: Pending Cases and Dispute Claims at the hospital

| No | Diagnosis | Procedure | Result |
|----|-----------|-----------|--------|
| 1  | Main Diagnosis: E11.9 Non-insulin-dependent diabetes mellitus without complications  
Secondary Diagnosis: K30 Dyspepsia  
D69 Thrombocytopenia, unspecified | - | Pending Claim  
D69.6 There is no specific resource Supportive examination / treatment does not meet the standard |
| 2  | Main Diagnosis: K30 Dyspepsia  
Secondary Diagnosis: R04.0 Epistaxis | - | Pending Claim  
R04.0 Not coded, no specific resource Supportive examination / treatment does not meet the standard  
Kode K30 now on the latest version of ICD-10 R10.1 |
| 3  | Main Diagnosis: O42.9 Premature Rupture of membranes, unspecified  
Diagnosa Sekunder: O80.9 Single spontaneous delivery, unspecified  
Z37.0 Single live birth | 73.59 Other manually assisted delivery | Pending Claim  
Q24.9 not coded, there is no special procedures such as surgery and others  
KPD with normal delivery, PROM cannot be an indication because it is considered normal for the case for patients who are about to give birth |
| 4  | Diagnosa Utama: P22.0 Respiratorydistress syndrome of newborn  
Secondary Diagnosis: Q24.9 Congenital malformation of heart, unspecified  
P39.4 Neonatal skin infection  
Q89.7 Multiple congenital | 96.01 Insertion of nasopharyngeal airway | Pending Claim  
Q24.9 not coded, there is no special procedures such as surgery and others |
| Main Diagnosis | Secondary Diagnosis |
|----------------|---------------------|
| P22.1 Transient tachypnea of newborn | P39.4 not coded, no specific resource for dermatitis |
| P22.0 Respiratory distress syndrome of newborn | P36.9 not coded, not suitable for infant sepsis PNPK Not in accordance with medical clinical practice guidelines |
| P36.9 Bacterial sepsis of newborn, unspecified | 89.67 Monitoring of cardiac output by oxygen consumption technique |
| 93.96 Other oxygen enrichment | Pending Claim |
| 96.1 Insertion of nasopharyngeal airway | G04.9 There are no CT scan, EEG or other results |
| K74.6 Other unspecified cirrhosis of liver | Pending Claim |
| I22.9 Subsequent myocardial infarction of unspecified site | R18 Uncoded, part of K74.6 |
| R18 Ascites | 99.03 Other transfusion of whole blood |
| 99.60 Cardiopulmonary resuscitation, not otherwise specified | Pending Claim |
| 99.03 Other transfusion of whole blood | Diagnosa utama : D649 |
| 99.60 Cardiopulmonary resuscitation, not otherwise specified | N93.8 no specific procedures |
| I50.0 Congestive heart failure | Pending Claim |
| I49.3 Ventricular premature depolarization | I49.3 tidak ada tatalaksana spesifik |
| K30 Dyspepsia | 99.03 Other transfusion of whole blood |
| 99.60 Cardiopulmonary resuscitation, not otherwise specified | Pending Claim |
| 99.03 Other transfusion of whole blood | DU D649 |
| 99.60 Cardiopulmonary resuscitation, not otherwise specified | N93.8 no specific procedures |
| P28.5 Respiratory failure of newborn | Pending Claim |
| P39.4 not coded, no specific resource for dermatitis | P39.4 not coded, no specific resource |
DISCUSSION

Since the enactment of the National Social Security System (SJSN) with the issuance of Regulation number 40 2004, there was a paradigm shift from cost-based or out-pocket services to managed care based on prospective payments based on the existence of the Social Security Administration Agency (G. Alfiansyah, N. Nuraini, R. A. Wijayanti, F. Putri, A. Deharja, and M. W. Santi, 2019).

From the research results obtained 15 cases for pending and dispute claims. The results obtained that there are pending and disputed on the diagnosis and medical action. For pending cases, there are pending or disputes due to the absence of supporting resources or supporting evidence. In addition, there is also a code discrepancy based on the code update on ICD-10. BPJS financing cause pending claims. The complete BPJS health claim requirements are said to be complete if there are requirements as follows: Reference letter, SEP, maintenance/ administration fee (receipt), sheet and drug use action, supporting examination, grouper INACBG. Called incomplete if one of the BPJS health claims

| Case | Main Diagnosis | Secondary Diagnosis | Code | Description | Pending Claim | Dispute Claim |
|------|----------------|---------------------|------|-------------|---------------|---------------|
| 12   | A09.0 Other and unspecified gastroenteritis and colitis of infectious origin | E87.1 Hypo osmolality and hyponatraemia | P39.8 Other specified infections specific to the perinatal period | E87.1 is not coded, part of GE | | |
| 13   | K30 Dyspepsia | J06.9 Acute upper respiratory infection, unspecified | B37.0 Candidal stomatitis | | | |
| 14   | M24.50 Contracture of joint | 86.64 Relaxation of scar or web contracture of skin | | | | |
| 15   | K35.3 Acute appendicitis with localized peritonitis | 47.19 Other incidental appendicitis | | | |
requirements is not met (G. Alfiansyah, N. Nuraini, R. A. Wijayanti, F. Putri, A. Deharja, and M. W. Santi, 2019).

There are still some problems in coordination and teamwork, as well as delays in submission and incomplete documents and the absence of a billing system, which causes delays in the payment of BPJS health claims. (BPJS, 2014)

The incomplete requirements cause BPJS Health claims cannot be grouped by the guarantee unit, resulting in a pending claim for BPJS Health. This delay caused payment of claims to decrease and hospital cash flow also decreased because almost 90% of hospital patients were BPJS Health patients. (Manaida dkk, 2016)

Another cause of the BPJS Pending claim for outpatients is the claim administration requirements and conditions that are always changing, so that many claim files are returned by verifiers. If the claim file submission is late, then the claim file will be pending the surrender and will be included in the next month’s claim process (T. D. Malonda, A. J. M. Rattu, and T. Soleman, 2015).

The occurrence of pending claims has a major influence on the inclusion of funds for hospitals and can affect the quality indicators of the health insurance team. Besides that, the pending claim is not in accordance with the expected target, the director of the Nur Hidayah Hospital provides a zero pending target for submitting claims every month. At Nur Hidayah Hospital, claims that have pending claims become a serious problem because the average patient who is hospitalized at Nur Hidayah Hospital uses BPJS insurance. The cause of pending claims on the Vedika system is caused by several influencing factors, such as human factors, method factors and material factors. Judging from the human factor or labor, which is caused by a lack of human resources that can affect the workload of officers, the occurrence of double jobs, while the hospital only has 3 officers. In these circumstances, the coding officer performs multiple tasks, from claim administration to file preparation, and performs coding which can affect the workload of the officer, so that the claims submitted do not match the BPJS criteria. With so many claims that are not matched by sufficient human resources, it can cause officers to be tired and become less focused in carrying out their duties. (A. A. Ep, 2018).

ACKNOWLEDGEMENTS

We would like to thank the hospital for agreeing and allowing this research to be carried out.

DECLARATIONS

Funding: No Funding
Conflict of interest: -

REFERENCES

1. Peraturan Menteri kesehatan Republik Indonesia Nomor 69 tahun 2013 tentang Standar Tarif Pelayanan Kesehatan Pada Fasilitas Kesehatan Tingkat Pertama Dan Fasilitas Kesehatan Tingkat Lanjutan Dalam Penyelenggaraan Program Jaminan Kesehatan
2. Putra, WM. 2014. Analisis Implementasi Kebijakan Jamina Kesehatan Nasional di Rumah Sakit Umum Kota Tangerang Selatan Tahun 2014. Skripsi Universitas Islam Negeri Syarif Hidayatullah. Jakarta.
3. Tettey, SS, et al. 2012. Challenges In Provider Payment Under The Ghana National Health Insurance Scheme: A Case Study Of Claims Management In Two Districts. Ghana Medical Journal, Volume 46.
4. Ernawati, D dan Kresnowati L. 2013. Reimbursement Berbasis System Casemix di Beberapa Rumah Sakit yang Melayani Jamkesmas di Kota Semarang. Indonesia Health
5. G. Alfiansyah, N. Nuraini, R. A. Wijayanti, F. Putri, A. Deharja, and M. W. Santi, “Optimalisasi Manajemen Penanganan Klaim Pending Pasien BPJS Rawat Inap di Rumah Sakit Citra Husada Jember Tahun 2018,” Kesmas Indones., vol. 11, no. 1, pp. 24-35, 2019, doi: 10.20884/1. ki.2019.11.1.1314.

6. Kusumawati, A.N. 2021. Faktor-Faktor Penyebab Pending Klaim Rawat Inap di RSUD Koja tahun 2021.

7. G. Alfiansyah, N. Nuraini, R. A. Wijayanti, F. Putri, A. Deharja, and M. W. Santi, “Optimalisasi Manajemen Penanganan Klaim Pending Pasien BPJS Rawat Inap di Rumah Sakit Citra Husada Jember Tahun 2018,” Kesmas Indones., vol. 11, no. 1, pp. 24-35, 2019, doi: 10.20884/1. ki.2019.11.1.1314.

8. BPJS Kesehatan, Panduan Praktis Tentang Kepesertaan Dan Pelayanan Kesehatan Yang Diselenggarakan Oleh Bpjs Kesehatan Berdasarkan Regulasi Yang Sudah Terbit, 1st ed. Jakarta: BPJS, 2014

9. Manaida dkk, “Analisis Prosedur Pengajuan Klaim Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan di Rawat Inap Rumah Sakit Umum Pancaran Kasih GMIM . Manado,” E-Journal Heal., pp. 1-11, 2016, doi: 10.14257/ijsia.2016.10.1.30.

10. T. D. Malonda, A. J. M. Rattu, and T. Soleman, “Analisis Pengajuan Klaim Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan di RSUD Dr . Sam Ratulangi Tondano,” Jikmu, vol. 5, no. 5, pp. 436-447, 2015.

11. A. A. Ep, “Faktor-Faktor Penyebab Klaim Tertunda BPJS Kesehatan RSUD Dr . Kanujoso Djatiwibowo, Periode Januari - Maret 2016,” ARSI, vol. 4, no. 2, pp. 122-134, 2018.

12. Hendra Rohman. 2021. Analysis Pending Claim Payments The Indonesian National Health Insurance System In Vedika System Nur Hidayah Hospital Yogyakarta. Jurnal Wiyata. Vol. 8 No. 1 Tahun 2021.