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Causes of Dispute for COVID-19 Outpatient and Inpatient Claims at the Muhammadiyah University General Hospital of Malang

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Abstract.
Muhammadiyah University General Hospital of Malang is a COVID-19 referral hospital for Malang. Between April 2020 and June 2021, the hospital submitted 62 outpatient and 1364 inpatient cases for COVID-19 claims to the Ministry of Health of the Republic of Indonesia. The percentage of outpatient dispute claims was 25% and of inpatient dispute claims was 39%. These disputed claims disturbed the cash flow of the health facilities. The aim of our study was to describe the causes of outpatient and inpatient COVID-19 dispute claims. Our methodology was descriptive, and the secondary data were taken from claim submission documents. There were ten criteria that caused dispute claims based on KMK Number HK. 01.07/MENKES/4718/2021. This was related to administrative and medical issues. The most common cause of inpatient dispute claims (35%) was that the criteria for discharge from the hospital were not in accordance with the guarantee limit. Additionally, the most common cause of outpatient dispute claims (60%) was the management of isolation that was not related to the guidelines for management and prevention of COVID-19.

Keywords: claim dispute criteria, hospital, COVID-19

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1. Introduction

Cases of Coronavirus Disease 2019 (COVID-19) show a very rapid increase and spread throughout the world, including Indonesia. On June 28, 2021, the total number of confirmed cases of COVID-19 in the world is 180,867,689 cases with 3,924,264 death. Data in Indonesia up to date 28 June 2021, there are 2,135,998 confirmed COVID-19 people,57,561 deaths and 1,859,961 patients recovered. The treatment is borne by the government in accordance with (KMK) Number HK.01.07/Menkes/4718/2021. BPJS data as of January 28, 2021 shows a total of 433,077 claims submitted by hospitals, from the verification results there were 266,737 cases that matched (61.59%), 165,189 disputed (38.14%) and 1,151 did not match (0,27%). The Ministry of Health provides payments for

COVID-19 claims to hospitals in 2021 amount to Rp23.94 trillion. The Indonesian Private Hospital Association (ARSSI) noted that 40 to 60 percent of total claims for health services for COVID-19 patients at private health facilities had not been paid because the ministry's budget had not been disbursed. This causes disruption to the cash flow of private hospitals[1].

The claim verification process has referred to Law no. 24 of 2011 concerning BPJS, that BPJS Health has the authority to carry out the claim verification process from Advanced Level Referral Health Facilities (FKRTL) or hospitals as regulated in Presidential Regulation 82 of 2018 concerning Health Insurance[2]. So on this basis the government through the minister with letter number S.22/MENKO/PMK/III/2020 regarding a special assignment to BPJS Kesehatan to verify COVID-19 claims. The Ministry of Health has prepared a comprehensive policy in the mechanism for financing claims that is implemented in all hospitals providing services. However, there is a challenge to equalize understanding in a short time. It has been proven that since the claim policy based on technical instructions for claiming reimbursement for COVID-19 health care costs, organizing hospitals has undergone 7 changes to regulatory changes, starting with KMK No. 238 of 2020 dated April 6, 2020, then issued SE No. 295 of 2020 dated 24 April 2020, then KMK No. 413/2020 dated 13 July 2020, then KMK 446/2020 dated 22 July 2020, then KMK No 4344/2021 dated April 5, 2021, then KMK 4641/2021 dated May 11, 2021, and the last amendment was dated May 21, 2021 KMK No. HK 01.07/MENKES/4718/2021 concerning Technical Instructions for Claims for Reimbursement for COVID-19 Patient Service Fees for COVID-19 Service Provider Hospitals[3].

Muhammadiyah University General Hospital of Malang as a COVID-19 referral hospital since April 9, 2020. This is based on Governor's Decree Number 188/157/KPTS/013/2020. The hospital has treated 1364 inpatient cases and 247 outpatient COVID-19 cases. While providing services there are problems in health financing. Differences in understanding in the implementation of KMK 4718 regardingTechnical Instructions for Claims for Reimbursement for COVID-19 Patient Service Fees for Hospitals resulting in claim disputes for hospitals.The verified Covid claims are for the period April 2020 to June 2021.

Based on (KMK) Number HK.01.07/Menkes/4718/2021The cause of the claim dispute is the discrepancy in the administration sheet, comorbid diagnosis, patient identity, criteria for hospitalization for COVID-19 insurance participants, PCR swab supporting examination, laboratory, radiology, isolation management and KRS criteria not in accordance with the guarantee limits. These criteria are taken according to the verification results. The causes of dispute claims from health facilities are different and there are

no definite criteria. This is because the understanding of the verifier in each region is different. This dispute causes the hospital burden to increase because the payment of COVID-19 claims is not optimal. The purpose of this study was to determine the cause of the outpatient and inpatient COVID-19 dispute claims at the Muhammadiyah University General Hospital of Malang.

2. Materials and Methods

This study is a descriptive observational research, with secondary data. Secondary data was taken fromthe claim submission documents inpatients and outpatients at the Muhammadiyah University General Hospital of Malang between April 2019 to June 2020.Data were analyzed descriptively by displaying tables to provide information about the data held.This research was conducted at the Muhammadiyah University General Hospital of Malang in August 2021. This study did not use a population and research sample. It was carried out by comparing the causes of dispute COVID-19 Outpatient and Inpatient Claims with the literature. The analysis carried out is about 10 criteria, namely1) Incomplete/inappropriate administration sheet; 2) Diagnosis of comorbid/accompaniment is not in accordance with the provisions; 3) Co-incident/complication diagnosis is part of the main diagnosis (signs and symptoms); 4) Identity does not comply with the provisions; 5) The criteria for hospitalization of Covid-19 patients are not in accordance with the provisions (mild cases/reactive rapid tests and coinsiden without symptoms of covid-19); 6) PCR examination does not comply with the provisions; 7) Laboratory supporting examination is not in accordance with the provisions; 8) Radiological supporting examination is not in accordance with the provisions; 9) The isolation procedure is not in accordance with the provisions of the Guidelines for the Prevention and Control of COVID-19; 10) The criteria for leaving the hospital are not in accordance with the guarantee limit.

3. Results

The Covid-19 claim submission process uses files in accordance with KMK 4718, namely: Statement of Absolute Responsibility with stamp duty, application file for hospital management claims, Work Order, treatment room certificate.

3.1. The claim submission process is as follows:

1. Addressed to the Director of Referral Health Services with a copy of BPJS Health and the district or city health office.
2. *Upload* file in the form of a scanned document through the E-CLAIM application.
3. For field hospitals, they submit claims through the Pengampu Hospital.
4. Submission of claims in the same month can only be done at most only 2 times with a distance of 14 calendar days from filing claims between the first and second claims.
5. No later than 14 working days after receiving the claim by BPJS Kesehatan, a Minutes of Verification Results must be issued.
6. Hospital leadership must sign the BAHV.
7. The BAHV is issued to the Ministry of Health.
8. The contents of the BAHV include: non-conforming claims, dispute, pending and appropriate.
9. If from the results of verification by BPJS Health there are incomplete documents or claim files, the claim is declared pending.
10. Within 14 working days after the hospital receives the pending claim information from BPJS Kesehatan, it must immediately correct and complete the documents.
11. Hospitals must follow the mechanism and timing of claim verification for COVID-19 patient services in pending settlement.
12. BPJS Kesehatan can declare a claim that is not appropriate if the hospital does not complete the required documents.
13. Claims related to the service of COVID-19 patients cannot be resubmitted by the hospital if the claim is declared inappropriate.
14. In BAHV, for BPJS Health verification claims, the Ministry of Health will make payments in the form of appropriate claims[3].

3.2. Dispute Claim

Occurs when there is disagreement between the hospital and BPJS Health regarding the service of COVID-19 patients. The stages for submitting a dispute claim are as follows:

1. Dispute claims are resolved in accordance with BAHV BPJS Health.
2. In the dispute resolution process, the provincial TPKD or the central TPKD verify.
3. If clarification is needed, the hospital management must meet supporting data.
4. After receiving the report on the dispute claim, the provincial TPKD must resolve it within 14 working days.
5. The decision of the provincial TPKD to provide service guarantees to COVID-19 patients in the form of claims worth paying for.
6. If the decision made by the provincial TPKD in the form of a COVID-19 patient service guarantee claim is not appropriate, the hospital can file an objection to the central TPKD and request a dispute settlement claim.
7. The central TPKD performs procedures for resolving disputes and claims with instructions from the Director General of Health Services.
8. Within 14 working days after receipt of dispute.
9. The decision of the TPKD Central Management is final. The results of the TPKD center's decision became the basis for the Ministry of Health to make claims and payments.
10. The results of claims dispute decisions that are worth paying for can be downloaded via the application as a verification report[3].

3.3. Procedure for Verification of Claims for COVID-19 patient service fees.

1. Administration Verification

a. The verification team conducts administrative checks on the completeness of the claim file in accordance with the dispute criteria set by the Ministry of Health. The 10 criteria for the Covid-19 guarantee dispute are:

b. Match the invoice with the supporting evidence attached.

c. If BIf the file is incomplete, then the hospital completes the deficiency.

2. Patient Service Verification

1. The verifier ensures the completeness of the claim file.
2. The verifier calculates the cost and length of service.
3. The results of the verification by BPJS Health in the form of a Verification Result Report (BAHV) are submitted to the Director General of Health Services with a copy to the Inspectorate General of the Ministry of Health for functional supervision of the claim file. Verification can be done at the hospital making the claim[3].

Total claims for inpatient COVID-19 inpatient disputes from April 2020 to June 2021 were 537 (35%) out of 1364 and Outpatient COVID-19 was 62 (25%) out of 247.The highest disputed claims in May 2021 were 90 inpatient claims (56%) and 3 outpatient claims (33%).

The results of research conducted at RSU UMM on data taken from April 2020 to June 2021, showed that the most common cause of outpatient dispute claims was the payment criteria for COVID-19 patient services that were not in accordance with BPJS Kesehatan. Where the data obtained from UMM RSU, criteria related to isolation management that are not in accordance with the guidelines for the prevention and prevention of COVID-19 disease are the highest cause of outpatient dispute claim data at UMM RSU with a percentage of 60%. The second largest number of causes of outpatient dispute claims at UMM RSU was radiological supporting examinations that were not in accordance with the provisions with a percentage of 35%. And the third highest number of causes of outpatient dispute claims at UMM RSU is the criteria for laboratory supporting examinations that are not in accordance with the provisions where the percentage is 34%. Meanwhile, the lowest criteria that caused the COVID-19 outpatient dispute claim at UMM RSU with a percentage of 5% was the identity of the patient who did not comply with the provisions[4].

The three highest criteria for the cause of the claim *dispute*Outpatient treatment at UMM General Hospital has differences with data from BPJS Health in November and December in the Ambarwati journal. Where in Ambarwati's journal it was explained that the most disputed criteria were COVID-19 insurance participants who did not comply with the provisions, incomplete claim files and comorbid diagnoses became the most disputed criteria[1].

The following is the percentage of the causes of COVID-19 outpatient dispute claims at UMM Hospital for the period April 2020 to June 2021.

Table 1: Overview of Dispute Criteria for Outpatient Covid-19 Claims April 2020 – June 2021 at UMM RSU.

Criteria code	Dispute criteria	Percentage
1	Administration sheet is complete / inappropriate (introduction letter for hospitals, certificate letter for treatment room, confirmation letter for complete financing replacement)	10%
2	Comorbid diagnosis not according to the provisions (writing the diagnosis not according to the treatment provided)	0%
3	Co-incidental diagnosis / complications are part of the main diagnosis (sign and symptom)	0%
4	Identity doesn't fit the provisions	5%
5	Criteria for inspiring participants with covid-19 insurance is not according to the provisions (mild case / reactive rapid + co-incidental without covid-19 symptoms)	0%
6	Pcr supporting examination is not according to the provisions	11%
7	Supporting laboratory inspection is not according to the provisions	34%
8	Radiological supporting examination is not according to the provisions	35%
9	Management of isolation is not according to guidelines for management and prevention of covid-19 disease	60%
10	KRS criteria does not compatible with the limitation of guarantee	0%

As for the description of each criterion for the cause of the claim *dispute* Outpatient treatment at RSU UMM refers to the criteria code above based on the description regarding the reasons for the dispute claim from **BPJS Health as follows:**

Table 2

CRITERIA CODE	DESCRIPTION
1	The patient care room is not attached. The writing on the medical record looks like it has been edited, there are many scribbles with the impression of replacing without initials. no guarantee letter form (form 4)
2	The writing of the NIK does not match the attached ID card (Identity is not valid) The patient's identity has not been attached (only in the form of NIK data)
3	
4	No follow-up swab done There are differences in the results of swab I and II: Swab 2 is negative but still being treated in the isolation room confirm swab taking discrepancy between swab results and patient discharge swab collection distance is too far
5	No lab results attached discrepancy in attaching lab results gap between lab not done or not uploaded
6	Not attaching patient ro results no ro thorak d rs, only from referring rs. but billed ro thorak. Thorax DBN results, there is no picture of infiltrates
7	The patient does not meet the criteria for suspect The patient does not meet the criteria for suspect according to attachment 1 kmk 446 There are no symptoms of ARI, there is no examination for the patient, there are supporting examinations belonging to the Lab/Rapid mother so that they do not meet the criteria for a suspect.

Table 3: Overview of Dispute Criteria for Claims for Covid-19 Hospitalization April 2020 – June 2021 at UMM RSU.

Criteria code	Dispute criteria	Percentage
1	Administration sheet is complete / inappropriate (introduction letter for hospitals, certificate letter for treatment room, confirmation letter for complete financing replacement)	34%
2	Comorbid diagnosis not according to the provisions (writing the diagnosis not according to the treatment provided)	3%
3	Co-incidental diagnosis / complications are part of the main diagnosis (sign and symptom)	2%
4	Identity doesn't fit the provisions	5%
5	Criteria for inspiring participants with covid-19 insurance is not according to the provisions (mild case / reactive rapid + co-incidental without covid-19 symptoms)	18%
6	Pcr supporting examination is not according to the provisions	19%
7	Supporting laboratory inspection is not according to the provisions	5%
8	Radiological supporting examination is not according to the provisions	7%
9	Management of isolation is not according to guidelines for management and prevention of covid-19 disease	34%
10	Krs criteria does not compatible with the limitation of guarantee	35%

Table 4

CRITERIA CODE	DESCRIPTION
1	No date of isolation room mrs on resume; The date of entering the isolation room does not match the CPPT; Positive Patient Swab Results should not enter the diagnosis B34.2 so that the patient's status is confirmed without comorbidities; Cppt, igd assessment, transfer form between rooms, RIC room billing, intra-hospital transfer sheet, ICU monitoring sheet, certificate of treatment room signed by hospital leadership, Letter of Approval/Confirmation of Payment for COVID-19 Guarantee Payment, proof of convalescent plasma therapy not yet attached; The identity attached does not comply with the KMK provisions; The writing on the medical record looks like it has been edited, many scribbles with the impression of replacing without initials; the patient's status does not match the results of the attached swab; convalent top up is not yet available; date of patient on invasive ventilator intubation ett is not appropriate; there are differences in the writing of symptoms on the ER assessment sheet, ER triage, and CPPT; mortuary care rates have not been entered; the entry treatment room does not match the treatment room listed on the treatment room certificate; double claim RI and RJ
2	confirmation of whether pleural effusion is a comorbid/complication of COVID19; correction of whether angina pectoris meets the criteria for comorbidities/complications according to KMK 4718; Is STEMI a comorbid and not a coincident?
3	a history of appendectomy surgery with complaints of fever and no symptoms/signs of respiratory disease such as cough/shortness/sore throat/runny nose, does not meet the criteria for suspect accompanied by co-incidence; double lumen installation and HD is done, is it a co-incident?; complaints of hematuria and treatment carried out together with a urology specialist is it a co-incidence?
4	The writing of NIK does not match the attached KTP (Identity is not valid); The patient's identity has not been attached (only in the form of NIK data)
5	radiological results of the patient did not show any pneumonia which indicated that the patient had mild symptoms and could self-isolate at home; In the anamnesis the patient did not show any symptoms of ARI; Patients only have close contact with confirmed COVID-19 patients (ODP) so they only need to be billed to outpatients; On ED observation, the patient did not meet the criteria for hospitalization; Suspect without comorbid age less than 60 years is not included in the criteria for hospitalization; The patient has not had a PCR swab done but has been discharged, so it is hoped that there will be confirmation of the patient's discharge based on what?; There are differences in the results of swab I and II: possible false negative or false positive and no comparison test;
6	The results of the diagnostic swab and follow-up swab results are not attached; The results of the second follow-up swab are not attached; The results of the third and fourth follow-up swabs are not attached; Swabs with positive results came out the day before the patient was admitted to the hospital where the swab was not carried out again while the patient was hospitalized; The distance between the first swab and the second swab is too far, more than 2 weeks;
7	Patient lab results are not attached; The results of the d-dimer (laboratory results) are only the attached information, there is no nominal result of the d-dimer; The results of blood gas are only the attached information, there is no information regarding the nominal results of blood gases; Not attached lab results during the treatment period; The deducting factor does not match the attached lab; Teprocalcitonin lab results are missing / not attached

Table 4

8	The results of radiological examination did not support the comorbid diagnosis, namely pneumonia J18.9; The results of radiological readings have not been attached to support the results of pneumonia in patients; The results of the radiological examination are not attached; The RO thorax is not attached which shows the development of the thorax in the patient during hospitalization; No RO inspection is performed during the treatment period; RO is only done at the Referring Hospital, but is billed at the Thorax RO; The RO examination at the referring hospital was not evaluated; The patient has not been tested for RO but has been discharged, so it is hoped that there will be confirmation of the patient's discharge based on what?
9	discrepancy in the diagnosis of PDP with comorbid so that it is changed to PDP without comorbid; non-compliance with hospitalization criteria and age <60 years without comorbidities are not included in the Covid-19 outbreak cost guarantee; Criteria for probable cases of suspected severe ARI/ARDS/died with a convincing clinical picture of COVID-19 there is no RT-PCR laboratory test result and based on the assessment there is no picture of Severe ARI/ARDS; unsupported suspect criteria; positive swab result but charged by suspect; The results of the clinical assessment as outlined in the medical resume, including radiological images showing improvement and/or blood examination showing improvement, carried out by DPJP; non-conformance of the indication of the isolation concurrent room; cppt maintenance date mismatch, isolation room transfer sheet and inpatient service billing; the patient was billed for confirmation but at KRS there were no swab results. should have been billed probable; the distance between the results of swab 1 and 2 is too far; the result of the swab is negative but treatment is still being carried out; conformity with co-incidence criteria; The criteria for the Covid Assurance Participant do not comply with the provisions; LOS mismatch between patient status and system input; discrepancy of care with the completeness of the patient's file as evidence the patient was given care during the episode of hospitalization LOS mismatch between patient status and system input; discrepancy of care with the completeness of the patient's file as evidence the patient was given care during the episode of hospitalization LOS mismatch between patient status and system input; discrepancy of care with the completeness of the patient's file as evidence the patient was given care during the episode of hospitalization
10	if the results of the PCR swab are negative twice, it will be declared KRS on that date; On the CPPT it is written that the clinical condition (symptoms of shortness of breath) is improving, so it is declared KRS on that date; on the written CPPT clinically improved but not accompanied by the results of follow-up investigations, it is declared KRS on that date. On the medical resume no clinical criteria are written, follow-up investigations are improving as the basis for discharge criteria; patients with severe symptoms were not subjected to PCR swab follow-up on day 7; The medical resume does not include the category of symptoms experienced by the patient; On the CPPT it is written that the physical examination (RR and Spo2) is normal then it is declared KRS on that date; on the CPPT it says "tomorrow KRS plan"; ICU discharge criteria

3.4. Percentage of Causes of Dispute Inpatient Claims

Based on research with data collection at UMM RSU from April 2020 to June 2021, it was found that the highest criteria for inpatient dispute claims were KRS criteria (Out of Hospital) which did not comply with the guarantee limit and had a percentage of 35%. The second most common cause of dispute claims is the isolation management that is not in accordance with the guidelines for the prevention and control of COVID-19 with a percentage of 34%. These criteria have the same percentage as the criteria for inpatient dispute claims, which are related to incomplete administrative sheets by 34%. In line with BPJS Info 2020 that on November 14, 2020, one of the most disputed criteria is the incomplete claim file[5].

Based on the results of the highest number of causes of claims *dispute*, the criteria for the cause of outpatient and inpatient dispute claims have differences. Where the highest data that causes COVID-19 outpatient disputes is isolation management that is not in accordance with COVID-19 prevention and control guidelines. Meanwhile, the data that causes the highest inpatient dispute criteria is the KRS (Out of Hospital) criteria which are not in accordance with the guarantee limit. This difference cannot be compared, because there are several different criteria between outpatient and inpatient. Where outpatient has a shorter examination time, namely on the day the patient checks for the first time at the hospital. So that the outpatient visit does not use the KRS criteria. These criteria are only found on inpatient visits[6].

Cause of claim *dispute* The second highest number of hospitalizations is isolation management that is not in accordance with COVID-19 prevention and control guidelines. Where the second highest criteria is the cause of inpatient dispute claims is also one of the highest causes of outpatient dispute claims. Where from the criteria data for the cause of outpatient dispute claims, it was obtained that laboratory supporting examinations that were not in accordance with the provisions were the second highest cause of dispute claims. Meanwhile, the other highest cause of dispute claims for inpatient care, namely incomplete administration sheets, also differs from the criteria for the third highest cause of outpatient dispute claims in outpatient care. Where the cause of the most outpatient dispute claims is laboratory supporting examinations that are not in accordance with the provisions[7].

The description of each criterion causing the claim for inpatient dispute at UMM RSU refers to the criteria code above based on the description regarding the reasons for the dispute claim from BPJS Health as follows:

4. Conclusion

The results of research conducted at Muhammadiyah University General Hospital of Malang on data taken from April 2020 to June 2021, showed that criteria related to isolation management that are not in accordance with the guidelines for the prevention and prevention of COVID-19 disease are the highest cause of outpatient dispute claim data at the hospital in 60%. The most common cause of inpatient dispute claims was that the criteria for discharge from the hospital were not in accordance with the guarantee limit of 35%. It is hoped that the next researcher will come up with a solution regarding the disputed claim.

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