

Conference Paper

Overview of the National Health Insurance Claims Process in Private Hospital X in Jakarta

Supriadi

Department of Hospital Administration, Vocational Education Program, Universitas Indonesia, Kota Depok, Jawa Barat 16424, Indonesia

Abstract

The National Health Insurance (JKN) is a health maintenance program that ensures that the people of Indonesia are organized by an agency called Social Security Agency (BPJS Health) in terms of health care facilities from the level of the hospital on the program followed by all government and private health facilities. The payment scheme requires hospitals to provide the service first and then make a claim to BPJS on the service by using the tariff package called INA CBGs. There have been few complaints in the media on the process of health care claims submitted to BPJS. This study aims to find out the process of filing a claim to BPJS at a private education hospital in Jakarta. This study was done through qualitative in-depth interviews of several informants associated with the process of filing a claim to BPJS. The researcher also checked the documents' claims. The results of this study found that the amount of staff coding was inadequate compared to the number of patient visits. BPJS had so many Medical Records files accumulating. In addition, there are many who do not complete the claim file, especially the results of laboratory examinations. This delays the file for Billing Section, as a result of which BPJS has been charged on the late claims. It is recommended that the amount of coding and file verification officers be increased so that the billing could be done on time.

Keywords: JKN, BPJS, claim

Corresponding Author:
Supriadi
supriadi.vokasi@gmail.com

Received: 8 June 2018
Accepted: 17 July 2018
Published: 8 August 2018

Publishing services provided by
Knowledge E

© Supriadi. This article is distributed under the terms of the [Creative Commons Attribution License](#), which permits unrestricted use and redistribution provided that the original author and source are credited.

Selection and Peer-review under the responsibility of the 2nd ICVHE Conference Committee.

1. Introduction

The National Health Insurance (JKN) is a government program to guarantee health care of its citizens began to be implemented on January 1, 2014. The program was organized by the Social Security Agency (BPJS) Health. In this JKN program, BPJS Health partnered with health care facilities ranging from health facilities of First Instance (FKTP), that is, clinics and health centers and health facilities Advanced Reference (FKRTL), that is, hospitals both public and private [1].

 OPEN ACCESS

Model payment for health services performed by the clinic or health center via capitation, that is, payment in advance per member with a certain value multiplied by the number of registered members in the clinic or health center. The model of payment for health services performed by hospitals by using the INA CBGs. INA CBGs is a tariff package with a payment system based on diagnosis. In the payment system using INA CBGs, both the hospital and the BPJS no longer specify the charges based on the details of the services provided, but only by passing out the patient's diagnosis and DRG code (Disease Related Group). The amount of reimbursement for the diagnosis has been agreed between BPJS the hospital. Estimated time of treatment duration (length of stay) to be undertaken by the patient also been expected adjusted to the type of diagnosis and disease cases [2].

To obtain payment of BPJS health services that have been performed by the hospital, the hospital make a claim for these services comes with a complete document to BPJS later than the 10th of the following month. After verification by BPJS Health, the payment of such claims will be paid by the parties BPJS [1].

Private hospital X is a type B hospital in Jakarta belong to an educational foundation that has served the social security program for a long time, ranging from Social Security, JAMKESMAS, Gakin and currently JKN. The process of claim bills for services given to BPJS always late. Delay bill could claim 1 to 2 months ahead.

This study aims to determine the causes of delays in the submission of claims for health care services that have been performed by the hospital x to BPJS.

2. Literature Review

The claim is a request of one of the two parties that have ties so that their rights are met. One of the parties conducting the bonding will submit a claim to the other party in conformity with the treaty or policy provisions agreed upon by both parties. The success of his claim and claim payments are very influential and determining the cash flows hospitals [3].

The payment mechanism to FKRTL by BPJS using a system of tariff packages CBG's. Tarif INA INA-CBGs a package rate that includes all components of hospital resources are used in the service of both medical and non-medical [1].

Applications INA-CBGs one patient data entry devices that are used to perform grouping rates based on data derived from medical resume. INA-CBGs applications already installed in the hospital that serves participants JKN. To use the application INA-CBGs, hospitals already have to have a hospital registration code issued by the

Directorate General of Health Services, will be conducted activation software INA-CBGs each hospital according to the hospital and regionalization classes [4].

Patient data entry process into the application of INA-CBGs performed after the patient has completed receive care at the hospital (after the patient's discharge from the hospital). INA-entry process CBGs 4.0 application made by the officer or officers coder claims administration in hospitals using data from medical resumes, it should be noted about the completeness of administrative data for purposes of validity of the claim [4].

Claims submitted collectively by the health facility to the maximum date BPJS next 10 months using the INA CBGs application Ministry of Health regulations. The claims are the administrative requirements of the public and other equipment as follows: (1) Summary of services, (2) File support each patient, comprising: (a) Letter of Eligibility Participants (SEP), (b) Resume medical/status report patient/caption diagnosis from the treating doctor when needed and (c) evidence of other services, for example, treatment protocols and regimens (schedules of drug administration) special drug administration, details of hospital bill (manual or automatic billing), other supporting files needed [5].

Health BPJS obliged to pay health facilities for services provided to participants no later than fifteen (15) working days since received complete claim documents at the branch/office operational service districts/cities BPJS [1].

3. Method

This study is a qualitative research. The primary data obtained by conducting interviews with medical record officer who served as an operator of coding, billing clerk and the clerk BPJS verification. Secondary data were obtained from the document claims bill compared to SOP force, nor with the existing provisions in the rules or instructions implementing INA CBGs payment claims.

4. Results

The number of outpatient visits and the number of participants JKN inpatient hospital x's in 2015 are as follows:

Total outpatient hospital JKN x 2015 reached 52 225 patients with an average of as many as 4,352 patients per month. While the number of hospitalization as much as 4,595 patients with an average of 383 patients per month.

TABLE 1: Number of patients in Hospital X JKN 2015.

No.	Σ Outpatients	Σ Inpatients
1	3,294	359
2	2,897	302
3	3,998	413
4	4,258	372
5	4,027	350
6	4,498	379
7	4,183	354
8	4,766	399
9	5,064	418
10	5,323	453
11	5,307	402
12	4,610	394
Sum	52,225	4,595
Average	4,352	383

Entry of data from files outpatient and inpatient patient JKN to the INA CBGs carried out by a unit of coding in the Medical Record. The number of officers for outpatient coding by 2 people and the hospitalization of as much as 1 person. According to interviews with officials outpatient coding data entry that any delay causes a high number of patient visits each month when compared to the number of outpatient coding clerk that exist today. Delays can be up to one month, as an example of the service in June 2016 will be completed in the entry at the end of August 2016. In addition to the high number of outpatient visits, sometimes based on incomplete medical file such medical resume making the entry process to be hampered. For data entry process inpatients to the INA CBGs also always late. The main cause of delay is the incompleteness of the file among others resume physicians, laboratory test results, prescriptions and referrals from FKTP file. The long delay on average nearly one month.

JKN patient files that have been in your entry by officers of coding, then sent to the billing section for invoiced or claimed to BPJS. In this section all the files checked back in its completeness and then attached with the print-out of data CBGs code that entry by the officer coding. This process is also quite time consuming, thereby increasing the length of time for submission of claims to BPJS. So that the claim is always the 10th

of the following month, and even do some special stage for claims due to incomplete files. Letter claims along with the completed send it to BPJS officer who was in hospital x's. Payment by BPJS to the hospital did 15 days after the file is received by BPJS.

5. Discussion

The number of visits is high at an average of 4,352 outpatients and the number of coding which is disproportionate to the number of visits caused the late submission of claims to BPJS. The speed and accuracy in filing a claim is highly dependent on several things, namely, human resources are insufficient and have the ability and skills. Facilities and equipment such as computers that support the data processing speed and final policies and procedures for each stage of the process before and after the claims in the Post. (Malonda et al.) the research found that the number of coding that is less, causing delays in the submission of claims BPJS.

Incomplete file claims to be one of the obstacles in the claims process to BPJS. Files are most often incomplete is a medical resume. Also, results of investigations are files that are always less [7, 8, 10]. Incomplete files can be caused by ignorance of good nursing care workers, and other health workers will SOP JKN patient care [7, 9]. Socialization of the SOP needs to be done so that all personnel associated with patient care JKN determine which files should be prepared for the benefit claims to BPJS.

Delay claims that health care has been given to the patient JKN, will be able to result in reduced working capital hospital and will affect the current asset ratio [6]. If a claim can be filed as a rule BPJS, that is, every 10th of the following month [5], then the cash flow will always be maintained, in because BPJS Health will always pay claims submitted no later than 15 days after the file is received by a team of verifiers BPJS [5].

6. Conclusion

The process of filing a claim JKN patients still often late between 1–2 months, this is due to lack of coding assigned to the file mengentri CBGs INA application. Besides frequent incompleteness JKN patients claim file that caused delays in the claims process in which medical resume is most often file incomplete. Extra power SOP coding and dissemination of all personnel associated with patient care JKN can accelerate the process of filing a claim to BPJS.

References

- [1] Republik Indonesia. Peraturan Menteri Kesehatan no 28 tahun 2014 tentang *Pedoman Pelaksanaan Program Jaminan Kesehatan Nasional*. Jakarta. 2014.
- [2] BPJS. *fee-for-service-vs-ina-cbgs-mana-yang-lebih-menguntungkan*.
<http://bpjs-kesehatan.go.id/berita-183-fee-for-service-vs-ina-cbgs-mana-yang-lebih-menguntungkan.html>. di akses 22 Agustus 2014.
- [3] Ilyas Y. *Mengenal Asuransi Kesehatan, Review Utilisasi Manajemen Klaim dan Fraud*. FKMUI. Depok. 2006.
- [4] Republik Indonesia. Peraturan Menteri Kesehatan no 27 tahun 2014 tentang *Petunjuk Teknis Sistem Indonesian Case Base Groups (INA -CBGs)*. Jakarta. 2014.
- [5] BPJS Kesehatan. *Panduan Praktis Administrasi Klaim Fasilitas Kesehatan BPJS Kesehatan*. Jakarta. 2014.
- [6] Rose, Peter S. *Financial Institution: Understanding and Managing Financial Services*. Texas: Business Publications. 1988.
- [7] Raymanel, F. *Analisis Manajemen Piutang Pasien Rawat Inap Jaminan Asuransi di Rumah Sakit XYZ Tahun 2012*. Skripsi. FKMUI. Depok. 2012.
- [8] Wilda, Yuliza T. *Analisis Pelaksanaan Prosedur Klaim Rumah Sakit di Wilayah Kerja BPJS Kesehatan Cabang Solok tahun 2015*. Thesis. Unand. Padang. 2015.
- [9] Malonda. T.D., et al. *Analisis Pengajuan Klaim Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan di RSUD Dr. Sam Ratulangi Tondano*. JIKMU. Vol 5 no 2B. Manado. 2015.
- [10] Primasari, K. L. *Analisis Sistem Rujukan Jaminan Kesehatan Nasional RSUD. Dr. Adjidarmo Kabupaten Lebak*. Jurnal ARSI vol:1 no:2 FKMUI. Depok. 2015.