

EVALUATION OF PENDING CLAIMS BAKTI TIMAH KARIMUN HOSPITAL IN ASSESSING THE EFFECTIVENESS OF THE V-CLAIM APPLICATION

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ABSTRACT

The presence of the VClaim application as a form of innovation in industry-based health services 4.0 seeks to create efficiency in submitting claims by the Hospital. However, in its implementation, especially at the Bakti Timah Karimun Hospital, *Pending claims still occur* which can disrupt the operation of the Hospital. Based on data obtained by researchers, in January-September 2022 there were *pending claims* with a total INACBGS of IDR 1,537,233,700, - with 1,353 total cases consisting of 7% inpatient care and 3% outpatient care. This study was conducted to assess the effectiveness of the VClaim application in capturing claims that still require confirmation back to the hospital. In addition to improving claim management as well as being used as material for evaluating V Claim applications in submitting claims for JKN participant patients. This research is a non-experimental observational study with qualitative data collection at the Bakti Timah Karimun Hospital. This research uses document review. The occurrence of *Pending Claims* at RSBT is caused by certain factors both inpatient and outpatient requiring specific improved data to make it easier for verifiers to verify Hospital claims. The VClaim application algorithm in verifying hospital claims against JKN patients is considered effective in measuring the feasibility of claims submitted by FKRTL or hospitals.

Keywords: *Claims, Pending Claims, JKN*

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INTRODUCTION

Indonesian citizens have the right to health, access health services and to obtain quality and affordable health services (*Law of the Republic of Indonesia Number 36 of 2009 Concerning Health*, n.d.). Indonesian citizens are also obliged to participate in the National Health Insurance Program (JKN) as stipulated in the Law of the Republic of Indonesia Number 36 of 2009 concerning Health (*West Java DJKN Regional Office*, 2004). In 2011 a special administering body for health social security was formed, namely the Health Social Security Administering Body (BPJS) which was mandated to manage the national health insurance program as well as develop a health insurance system with quality control and cost control, and develop efficient and effective health service payments so that the JKN program can be sustainable (Health BPJS, 2014). JKN services include services at first-level health facilities (FKTP) and advanced referral health facilities (FKRTL) (Handayani et al., 2018).

The JKN payment model is different, that is, for Hospitals or FKRTL, *prospective payments* are made using Indonesia Case Based Groups (INA-CBGs) as stipulated in Law Number 40 of 2004 concerning the National Social Security System (SJSN) (Law Number 40 of 2004 Concerning the National Social Security System, n.d.). Hospitals after providing services to JKN patients have the right to request payment of claims to BPJS Kesehatan. Claims are bills or rewards for services that have been provided, in exchange for the services of doctors, nurses, pharmacists, supports, and so on (Health BPJS, 2014a). In filing claims, BPJS verifies claims submitted by the Hospital (Nuraini et al., 2021). Therefore, the Hospital needs to pay

attention to and complete the claims that will be verified in advance to avoid filing claims that are returned or what are called pending claims. The more pending claims, of course, affect the hospital's operations due to disrupted cash flow.

The Vclaim application is a *website-based online application* developed by BPJS for submitting claims by hospitals that work together in administering the National Health Insurance (JKN) (BPJS Kesehatan, 2018). This application has been used since 2018 to facilitate the claim process to make it faster and more accurate.

The facilities are available in the Vclaim application which can be accessed *online* in an effort to develop industry-based health services 4.0 are expected to make it easier for health facilities to submit claims against JKN patients. In terms of access, Vclaim is far more efficient because it is done *online* using the internet network and the files needed for submitting claims can be uploaded in the form of *soft files*, while claims made manually are done face to face and the required files are collected in *hardcopy* or *photocopy form* (BPJS Kesehatan, 2018).

Bakti Timah Hospital (RSBT) Karimun is a private hospital in Karimun Regency, Riau Archipelago Province. RSBT Karimun has been working with BPJS Kesehatan since November 2014. In organizing JKN health services, until January – August 2022 RSBT accumulated claim submissions with a total INACBGS of IDR 19,542,658,400, - with 36,564 total cases, where income from JKN is income the highest in RSBT Karimun that is equal to 64%. There are also *pending* claims with a total INACBGS of IDR 1,537,233,700, - with 1,353 total cases or the equivalent of 34% of monthly operating costs (RSBT Karimun, 2022). This needs special attention from the hospital management because there are pending claims that are high enough to disrupt the operation of the hospital.

Because researchers want to assess the effectiveness of the Vclaim application in capturing claims that still require confirmation back to the hospital, in addition to improving claim management RSBT Karimun can also serve as material for evaluating Vclaim applications in submitting claims for JKN participant patients (Fama & French, 2004).

METHOD

The research method used is observational and non-experimental with qualitative data collection (Mays & Pope, 1995). Data collection was obtained through document review using document review guidelines (Xiao & Watson, 2019). The stages of data analysis consist of data collection, data reduction, data presentation, and drawing conclusions.

RESULTS AND DISCUSSION

Review documents using financial reports and minutes of returns on claim files from BPJS Kesehatan in January - September 2022. pending claims with a total INACBGS of IDR 1,537,233,700, - with 1,353 total cases consisting of 7% inpatient care and 3% outpatient care with a value of 1.2 billion (10% of the total INACBGS claims submitted) and 322 million (5% of the total INACBGS claim filing).

The time for submitting pending claims for RSBT Karimun is attached in the table below:

Table 1 Claim Submission Time

BULAN PELAYANAN	BULAN PENGARAHAN KLAIM	PENGALIHAN REGULER			PENGALIHAN REVISI		
		TGL. PENYERAHAN KLAIM	TGL. BAST	TGL. BASTV	TGL. PENYERAHAN KLAIM	TGL. BAST	TGL. BASTV
Desember 2021	Februari 2022	19 Februari 2022	16 Februari 2022	15 Februari 2022	2 Juni 2022	9 Juni 2022	9 Juni 2022
Februari 2022	Maret 2022	19 Maret 2022	16 Maret 2022	15 Maret 2022	1 Juli 2022	16 Juli 2022	15 Juli 2022
Maret 2022	April 2022	19 April 2022	16 April 2022	15 April 2022	11 Juli 2022	14 Juli 2022	14 Juli 2022
April 2022	Mai 2022	19 Mei 2022	16 Mei 2022	15 Mei 2022	14 Agustus 2022	21 Agustus 2022	1 September 2022
Mai 2022	Juni 2022	19 Juni 2022	16 Juni 2022	15 Juni 2022	11 September 2022	22 September 2022	27 September 2022
Juni 2022	Juli 2022	19 Juli 2022	16 Juli 2022	15 Juli 2022	9 Oktober 2022	9 Oktober 2022	9 Oktober 2022
Juli 2022	Agustus 2022	19 Agustus 2022	16 Agustus 2022	15 Agustus 2022	2 November 2022	9 November 2022	18 November 2022
Agustus 2022	September 2022	19 September 2022	16 September 2022	15 September 2022			
September 2022	Oktober 2022	19 Oktober 2022					

Submission of claims every month 1x regular, 1x revision and for disputes carried out according to the agreement with the verifier, usually 1 billing a year.

Submission of revision claims is scheduled by the verifier.

There is a time gap between returning regular claim files to RS for revisions and resubmitting, it should be N+2, on average N+4, and there is a difference of 2 months.

The reasons for the pending claim are as follows:

Table 2 Classification of Causes of Pending Claims

No Cause	Service Month 2022					
	Total	Outpatient	%	Hospitalization	%	
1 Fragmentation Potential	824	824	67%	0	0,00%	
2 Confirm coding and Diagnosis	523	344	28,10%	165	45,08%	
3 Ultrasound confirmation	20	20	1,63%	0	0,00%	
4 Level 3 protocols and Product Batch	23	14	1,14%	9	2,46%	
5 Supporting Examination Results	9	9	0,74%	0	0,00%	
6 IGD same day	13	13	1,06%	0	0,00%	
7 Potential Readmisi	100	0	0,00%	100	27,32%	
8 Rawat Indications	78	0	0,00%	92	25,14%	
TOTAL	1590	1224	100%	366	100%	

Outpatient pending claims until September 2022 amount to 3% of the total submitted □72% have been submitted with a composition of 68% feasible, 3.8% not feasible, and 0.2% dispute. There is a significant difference between the revised bill and the phase 2 claim, which is Rp. 186,868,400 due to coding changes. There are 2 months of services that have not been submitted for revisions waiting for a schedule of 28% of pending claims.

From the results of the flagging fragmentation study, it was found that in patients with >2x visits, 97% of chronic diseases (DM, Hypertension) passed pending verification, 3% were not eligible (physiotherapy cases >3x a week, visits on different days to see the results of supporting examinations), inter-policy consultants.

The results of the review of claims which stated that confirmation was needed and outpatient diagnosis obtained confirmation of the coding regarding the ultrasound code for post-sc control patients or spontaneous parturition to be removed, the procedure code did not match the change in the diagnosis code without medication/therapy/referred asked to be changed.

The results of the claim review stated that an ultrasound examination was needed, namely, an ultrasound examination was carried out on patients with diagnoses that were not in line with it and was not performed by a radiologist.

The results of the review of claims that cause other pending claims are level 3 protocols and product batches in the case of hemophilia patients who receive restriction drugs tk.3 at Fornas, as well as claims that do not include product batches. Weaknesses in the results of supporting examinations, namely the results of the CT scan are not attached, and the results of laboratory tests are not attached. This happened because of an external examination of the hospital. In addition, there were also flagged patients who came to the emergency room twice on the same day, namely patients with a diagnosis of asthma and observation of fever.

Claims pending hospitalization until September 2022 amounting to 8% of the total submitted □61% have been submitted with a composition of 51% feasible, 8.6% inappropriate, and 1.4% dispute. There is a significant difference between the revised bill and the phase 2 claim, which is Rp. 807,917,800, - due to coding changes. There are 2 months of services that have not been submitted for revisions waiting for a schedule of 39% of pending claims.

The results of the review of claims stated that confirmation was needed and the diagnosis of inpatients obtained requests for patient confirmation, especially severity levels 2 and 3, requests for confirmation for combination diagnostic codes, requests for procedure code changes, and requests for changes in diagnostic coding.

From the results of a review of potential readmissions, it was found that patients who were admitted to inpatient care >2x in 1 month, with an interval of less than 1 week □, 100% passed the second verification, as well as patients who were admitted to inpatient care, for outpatient care they were still billed so that readmissions were flagged.

From the results of a review of the causes of pending claims for outpatient indications, namely hospitalized patients <3 days, patients with soft tissue tumor surgery, abscesses, debridement, mild-moderate asphyxia, and cases of Obgyn Bartholin.

DISCUSSION

V claim application

The Vclaim application is a new breakthrough owned by the government in Indonesia as an effort to develop industry-based health services 4.0 online. V claim is made in the form of an internet-based application that can connect nationally with features that have the function of making Participant Eligibility Letters (SEP) as well as a National Health Insurance claims collection platform that can only be made by hospitals to BPJS Kesehatan.

The presence of the Vclaim application in health services for users of the National Health Insurance makes it easier for hospitals to provide health services, especially when patients need emergency medical treatment.

Evaluation of Pending Claims at Bakti Timah Karimun Hospital in Assessing the Effectiveness of the Vclaim Application

From the results of the document review, it was found that there were 8 causes of pending claims at RSBT Karimun.

Causes of hospitalization pending claims consisted of coding and diagnosis confirmations (45.08%), potential readmissions (27.32%), indications for hospitalization (25.14%), level 3 protocols, and product batches.

The causes of outpatient pending claims consisted of confirmation of potential fragmentation (67%), confirmation of coding and diagnosis (28.10%), confirmation of USG (1.63%), protocol level 3 and product batch (1.14%), emergency room day and the results of supporting examinations are lacking.

The results of this study are in line with previous research by Kusumawati AN (2018), which showed that there were 2199 or 40.6% pending claims from the entire claim file caused by coding errors that previously required coding confirmation as well as a diagnosis. 8 This can also affect changes in the number of claims when filing a claim for the second time. According to Agiwahyunto F (2021), things like this can also happen due to a lack of understanding of coders and the existence of information and BPJS circulars that are not conveyed evenly to all hospital coders so that coders still have the possibility of coding that is not according to the rules.

Another thing that affects the incidence of pending claims is the process of fragmentation including repeated patient visits for chronic diseases, readmissions, and the process of administering chronic drugs that are not in accordance with BPJS rules. This is in accordance with previous research by Oktamianiza (2021), which showed that the administrative suitability of medical services, in this case, the conformity of BPJS regulations regarding the number of visits and the determination of episodes of treatment for the diagnosis of the disease with the claims submitted by the hospital.

Outpatient pending claims until September 2022 are 3% of the total submitted, 72% have been submitted with a suitable composition of 68%, 3.8% are not feasible, and 0.2% dispute while Claims pending hospitalization until September 2022 are 8% of the total submitted, 61% have been submitted with a proper composition of 51%, 8.6% not feasible and 1.4% dispute.

This shows that Vclaim is able to make it easier for verifiers to verify incoming claims from RS or FKRTL by flagging incoming claims with certain criteria.

The document review results show that it is necessary to further develop the algorithm for flagging it and establish periodic monitoring and evaluation by involving relevant stakeholders such as collegiums. This is because from the data obtained, the results of filing revisions that had previously been flagged passed 68% - 100% and were finally eligible to pay.

Of course, it will greatly impact cash flow and hospital operations if the claim passes immediately in the first stage of submission, especially RSBT Karimun, considering that the revision submission is made N+4 and the submission time is determined by the verifier.

CONCLUSION

Based on the results of the study of RSBT Karimun documents, it can be concluded that Vclaim is very effective in being used by verifiers to verify its algorithm. There are inappropriate claims below 10% which pass the supervision of the hospital or FKRTL.

Furthermore, BPJS Health as the owner of the Vclaim application should continue to monitor evaluations of its use and update the algorithm if discrepancies are found or add new algorithms.

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