



Analysis of the Causes of Disputes in Medical Record Files for Inpatient BPJS Patients at the Imelda General Hospital for Indonesian Workers in 2022

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Abstract. Coded clinical data is needed to retrieve information for the benefit of patient care, research, improving service performance, planning and resource management, and to obtain appropriate reimbursement for health services provided. The purpose of this research is to find out the causes of Dispute in Medical Record Files of BPJS Patients Hospitalization at RSU Imelda Pekerja Indonesia 2022. This type of research is qualitative with a case study approach. The method used is observation and direct interviews to the field. The subjects used in this study were the Medical Record Files of BPJS Inpatient Patients who were in dispute in October - December 2022 as many as 58 claim files. The informants used in this study were 6 BPJS Kesehatan claimants. Based on the results of the study, the causes of dispute claims on hospitalization files that were resubmitted after experiencing pending, were caused by: Administrative Disputes: Incomplete supporting requirements for submitting RITL service claims, such as action reports, procedures or operation reports, as well as supporting examinations of 2 files (4 %) from October-December 2022. Dispute Coding includes, discrepancies in the main diagnostic codes and secondary diagnoses and discrepancies in the main diagnoses and secondary diagnoses with supporting examinations on medical resumes in 28 files (48%) from October-December 2022. Medical Disputes include, medical indications are not attached (initial admission), scan results of supporting examinations are unclear and illegible, scan results of action/surgery reports are unclear and unreadable in the operation/action reports, no schedule for administration of as many drugs is attached, and discrepancies in actions or administration of drugs of the patient's main diagnoses of 28 files (48%) from October to December 2022.

1. INTRODUCTION

According to Minister of Health Regulation Number 24 of 2022 concerning Medical Records, Medical Records are documents that contain patient identity data, examinations, treatment, procedures and other services that have been provided to patients. Coded clinical data is needed to retrieve information for the purposes of patient care, research, improving service performance, resource planning and management, as well as to obtain appropriate reimbursement (payment) for the health services provided (Kresnowati, 2017). According to Presidential Regulation of the Republic of Indonesia Number 82 of 2018, health insurance is a guarantee in the form of health protection so that participants obtain the benefits of health care and protection in meeting basic health needs provided to every person who has paid health insurance contributions or whose health insurance contributions are paid by the central government or local government.

The Social Security Administering Body, abbreviated as BPJS (Law No. 24 of 2011) is a legal entity formed by the Indonesian government. In this Law, the House of Representatives of the Republic of Indonesia and the President of the Republic of Indonesia have decided and established the Law on Social Security Organizers. BPJS consists of BPJS Health and BPJS Employment. Health insurance is provided by BPJS Health, which began operating on January 1 2014.

Claim administration is a claim file which includes a Participant Eligibility Letter (SEP), proof of service, with membership data required as a requirement in the BPJS claim process which must be completed to be submitted to BPJS Health which must previously go through a verification stage by the BPJS verifier. Administration of submitting claims for payment of benefits at Health Facilities in



collaboration with BPJS Health includes claims for payment of health service benefits at FKTP and FKRTL (BPJS Health Regulation No. 7 of 2018).

Coding is the activity of providing primary diagnosis codes and secondary diagnoses according to ICD 10 and providing procedure codes according to ICD9-CM. Coding is very important in the prospective financing system which will determine the amount of costs paid to the hospital. Coding in INA-CBGs uses ICD-10 2008 to code primary and secondary diagnoses and uses ICD9-CM to code actions/procedures. The data source for coding comes from medical records, namely diagnosis and action/procedure data contained in the patient's medical resume (PMK No. 27 of 2014). The main diagnostic criteria according to the WHO Morbidity Reference Group is the final diagnosis chosen by the doctor on the last day of treatment with the criteria using the most resources or the longest day of treatment. Secondary Diagnosis is a diagnosis that accompanies the primary diagnosis at the time of patient admission or that occurs during an episode of care. Secondary diagnoses are comorbidities or complications. Comorbidities are diseases that accompany the main diagnosis or condition of the patient at admission and require special services/care after admission and during treatment (Minister of Health Regulation No. 27 of 2014).

In implementing the National Health Insurance program, BPJS Health invites the cooperation of several hospitals, both private hospitals and government hospitals. BPJS Health provides health services to health insurance participants using a prospective payment system. In Indonesia, the prospective payment method is known as the casemix system and was implemented as a payment method in the Public Health Insurance (Jamkesmas) program in 2008 (Suhartoyo, 2018). Hospitals will submit claims for health service costs to BPJS using the Indonesia Case Base Group (INA-CBGs) casemix system. BPJS claims are applications for treatment costs received by BPJS participating patients by the hospital and billed every month to BPJS Health. The claim process is carried out using the INA-CBGs application manually (Triatmaja, Ariqurna Bayu, 2022). When submitting a claim from a hospital to BPJS Health there are several stages of participation administration, health service verification, service administration, and verification of the completeness of the claim file (Mustika et al, 2020).

In Indonesia, many hospitals still experience problems in the BPJS claim verification process, one of which is the rejection of files by the verifier. This rejection occurred due to inappropriate coding, lack of medical supporting examinations, incomplete resumes which resulted in rejection which led to delays in the BPJS claim process (Alfiansyah et al., 2019). Due to the rejection and return of the claim file, the claim file experienced pending claims and claim disputes. In the journal (Alfiansyah et al., 2019), the return of claim files is likely to occur if it is found that the claim requirements file is incomplete, thereby slowing down the claim payment process.

There are several requirements that must be completed in the claims process, namely as follows: recapitulation of services and patient support files consisting of participant eligibility letter (SEP), medical resume/patient status report/diagnostic statement from the treating doctor, proof of other services, for example; therapy protocol and regimen (drug administration schedule), details of hospital bills (manual or automatic billing) and other necessary supporting files (BPJS, 2014).

Based on the results of Icha Bernitasari Amir's research (2020) regarding the identification of the causes of returning BPJS inpatient claim files at the Bahteramas regional general hospital, Southeast Sulawesi province, namely the causes of returning BPJS claim files based on administrative disputes due to misuse of cards, inappropriate methods for returning patients, no there is supporting evidence and therapy, and there are errors in demographic data. Second, the reason the BPJS claim file was returned based on coding disputes was due to the coding not being in accordance with the diagnosis, the lack of clarity in the doctor's writing which made the proposed diagnosis incorrect, and the final diagnosis not being filled in on the medical resume. Mustika Kurniawati's research (2020) on factors influencing the return of BPJS health claim administration in terms of the completeness requirements for claim administration, found that of the 882 BPJS claim administration files submitted, 31 (3.15%) of the files were returned and the majority came from the unit. inpatient care, namely 26 (2.92%), while from outpatient units only one fifth (1/5) of the total BPJS patient files claimed were returned. The cause is a lack of understanding by health workers in inpatient and

outpatient settings in filling out patient medical resumes and the absence of procedures that regulate the flow and requirements for completeness of claims administration files.

Based on the initial survey conducted at the Imelda Workers Indonesia Hospital in Medan in 2022, it was found that in the implementation of claims for BPJS Health inpatients, problems were found such as inconsistencies in diagnostic codes, incomplete files such as supporting examinations not being attached and incomplete administrative files. Claim data at the Imelda Indonesian Workers Hospital in Medan shows that when making claims in March-May 2022, it was discovered that there were cases of claims being rejected and returned, which led to pending claims and claim disputes. In March, 94 (22%) of the 420 submitted claim files were rejected, in April 2022, 100 (21%) of the 472 submitted claim files were rejected, and in May there were 84 (18) rejected claim files. % files from 464 files submitted.

Based on the data and survey results above, it is important to complete the membership administration files, service administration files, and suitability of diagnosis, so the author is interested in conducting research with the title "Analysis of the Causes of Disputed Medical Record Files for Inpatient BPJS Patients at the Imelda General Hospital for Indonesian Workers in 2022 " to find out what is the cause of the dispute over the medical record files of BPJS patients hospitalized at the Indonesian Imelda Workers General Hospital.

2. METHOD

The type of research used in this research is qualitative research with a case study approach which aims to describe pending and dispute events in the BPJS Health claim process for inpatients at RSU Imelda Workers Indonesia. This research method uses direct observation and interviews in the field. This research was conducted at the Indonesian Workers' Imelda RSU with the following considerations:

- a. There has been no research on the same topic at this research location.
- b. The Indonesian Workers' Imelda General Hospital is one of the health service facilities that accepts BPJS Health patients.
- c. There are frequent disputes over BPJS claims regarding the medical record files of BPJS patients hospitalized at the Imelda Workers Indonesia general hospital.

The subjects that will be studied are the Medical Record Files of Inpatient BPJS Patients which were disputed in October - December 2022, totaling 58 claim files. To find out the cause of the dispute at RSU Imelda for Indonesian Workers, namely the Medical Record Files of Inpatient BPJS Patients. The informants for this research were 6 medical records officers from the BPJS coding/claims section. The implementation and procedures for coding and claims were carried out by medical records officers to gather information through interviews regarding the analysis of the causes of medical record file disputes for inpatient BPJS patients at the Indonesian Workers' Imelda General Hospital. .

Direct primary data collection will be collected using the triangulation method. Observations were carried out to observe the resources of RSU Imelda Indonesian Workers which could be seen physically and medical record files using a check list sheet. Interviews will be conducted in depth using an interview guide that has been prepared by the researcher. Interviews will be conducted with informants. Documentation is a data collection method aimed at obtaining recordings that strengthen information. Documentation includes documents and recordings of conversations between researchers and informants. Secondary data collection will be carried out at RSU Imelda Workers Indonesia Medan by searching medical record documents for inpatient BPJS patients.

Table 1. Concept Definition

Aspect	Information
Administrative Dispute	Claim dispute is a disagreement between BPJS Health and health facilities regarding service claims in the administrative (payment) process aspect.
Dispute Coding	Claim dispute is a disagreement between BPJS Health and health facilities regarding service claims in the aspect of assigning diagnosis

Dispute Coding and action codes.
 Claim dispute is a disagreement between BPJS Health and health facilities regarding service claims in the aspect of establishing diagnosis and action.

The data analysis used in this research is qualitative descriptive analysis, by describing the data that has been collected as it is. Qualitative research is research that is used to investigate, discover, describe and explain the qualities or features of social influence that cannot be explained, measured and described using a quantitative approach (Sugiyono, 2018). The analysis used in this research is qualitative, to look at the causes of disputes over the medical record files of BPJS patients hospitalized at the Imelda Workers Indonesian General Hospital in 2022.

3. RESULTS AND DISCUSSION

The informants who provided information to the researchers during the interview were the claims officers who made claims for BPJS Health for inpatient care at the Imelda Workers' Indonesian RSU as many as 6 officers with a D-III RMIK background, as shown in table 2.

Table 2. Characteristics of Informants

Claims Officer	J. Gender	Age	Education	Position
Informant 1	Woman	29 years	D-III RMIK	Chief Coder
Informant 2	Woman	22 years	D-III RMIK	BPJS Coder
Informant 3	Woman	23 years	D-III RMIK	BPJS Coder
Informant 4	Woman	26 years	D-III RMIK	BPJS Coder
Informant 5	Woman	23 years	D-III RMIK	BPJS Coder
Informant 6	Woman	23 years	D-III RMIK	BPJS Coder

According to Table 2, the informants consisted of six women aged between 22 and 29 years and had a D-III degree in Medical Records and Health Information (RMIK).

Inpatient BPJS Health Claim Process at Imelda Indonesian Workers RSU Medan

The results of the interviews were obtained from 6 informants, namely BPJS Health claims officers who were hospitalized at the Imelda Workers Indonesia Hospital in Medan. The following are excerpts from interviews conducted by researchers with the informants, namely:

Claiming SOP

SOP for BPJS Health Inpatient claims at Imelda Indonesian Workers RSU Medan as per the results of the following interview:

"There is no SOP for claims, but the management procedures are there, such as preparing files, the SOP for BPJS claims is not made because BPJS has already regulated the claim procedures" (Informant 1)

"There are SOPs for coding, but there are none for the BPJS claim process" (Informant 5)

"There is no SOP for BPJS Health claims, but the terms and conditions of the claim process have been regulated by BPJS" (Informant 2.4)

"There is no SOP for claims, the reason there is no SOP for BPJS claims is because BPJS has already regulated the claim procedures" (Informant 3.6)

Based on the results of the interview above, it can be concluded that there is no SOP for BPJS claims for inpatients at the Imelda Indonesian Workers' Hospital so far, because the terms and conditions of the claim process have been regulated by BPJS. However, for the overall coding management process at the Imelda Indonesian Workers' Hospital there is an SOP.

Claim Terms

Requirements for claiming BPJS Health Inpatient at Imelda Indonesian Workers RSU Medan as per the results of the following interview:

"The files that must be complete are the SEP file, emergency room assessment, hospitalization order, death certificate, medication administration schedule (JPO), action results, radiology results, billing." (Informant 1.4)



"SEP, emergency room assessment, resume, SPO, death certificate (if any), referral letter (if any), drug administration schedule, anesthesia report, surgical report, diagnostic/laboratory report, hospital billing." (Informant 2)

"SEP sheet, assessment, medical resume, introductory inpatient report from the ER/police, chronology of events for accident patients (if necessary), anesthesia report, operation/action/procedure report, lab/diagnostic/X-ray results and other supporting diagnoses, report on use of medical equipment (if used), hospital billing." (Informant 3.5)

"Letter of application, scan results of patient files." (Informant 6)

Based on the results of the interview above, it can be concluded that the conditions that must be met when claiming BPJS health for inpatients at RSUD Imelda Workers Indonesia are completeness of files such as SEP sheets, chronology of events for accident patients (if necessary), emergency room resume, referral letter (if any), emergency room assessment, hospitalization order, diagnosis support, death certificate, medication schedule (JPO), anesthesia report, surgical report, diagnostic/laboratory/X-ray report, action results, radiology results, medical equipment usage report (if used), hospital billing.

PrBPJS Inpatient Claim Process

The BPJS Health Inpatient claim process at the RSUD Imelda Indonesian Workers' Hospital in Medan is as follows from the results of the following interview:

"First you have to enter into the INA-CBGs application, then enter the hospital fee, doctor's name, admission date and discharge date, the patient's way of returning home, and diagnosis code, then click send on the e-claim application. Then all the files are in one bundle and then the files are scanned and dated according to the date of return. "After the files are complete, a submission letter, an absolute letter and a fraud letter must be made to state that the files are suitable to be submitted to BPJS, then we scan the letter we submitted and then enter it into the Viis application." (Informant 1.3.)

"For file delivery by the 10th, after the 10th there is an agreement. The process is first the files from the Republic of Indonesia, we bundle them in, then we verify them, then enter them, after they have been entered they are arranged on the 1st, the 2nd, until the 30th. After that, log in to INA-CBGs to enter hospital bills, DPJP, admission and discharge dates, how the patient went home, and diagnosis code, then click send on INA-CBGs. File verification is carried out, namely checking the completeness of the bundle to be scanned, if it is complete then it is scanned. "After it is complete, the next step is to make an application letter, an absolute letter and a fraud letter to state that the file is complete and submitted to BPJS." (Informants 2,5,6)

"In the entry in the INA-CBGs application, enter the hospital billing, doctor's name, date of admission, date of discharge, treatment class, method for the patient to go home, then disease coding according to the diagnosis in the resume. Then click save, click grouper, click final, and send online. Verification of completeness of status is carried out. If it is complete it will be scanned. The file is scanned and entered into the file according to the return date. Once complete, the next step is to create an application letter, absolute letter and fraud letter to state that the files are complete to be submitted to BPJS. "The application letter is uploaded in the Viis application and the scan is inserted into the hard disk for delivery to the BPJS office." (Informant 4)

Based on the results of the interview above, it can be concluded that the process for BPJS Health claims for inpatients at RSUD Imelda Workers Indonesia is to enter files into the INA-CBGs application, enter hospital fees, doctor's name, date of admission and date of discharge, method for the patient to return home, and diagnosis code, then click send on the e-claim application. Once all the files are in one bundle, the files are scanned and dated according to the return date. "After the files are complete, a submission letter, an absolute letter and a fraud letter must be made to state that the files are suitable to be submitted to BPJS, then we scan the letter we submitted and then enter it into the Viis application."

What to do if the requirements required at the time of claim are not complete

What to do if the requirements required when claiming BPJS Inpatient Health are incomplete at RSU Imelda Kerja Indonesia Medan as per the results of the following interview:

"If it is incomplete, we usually send the status back to the room so that the incomplete files are completed." (Informant 2.5)

"If there are incomplete files, the room status will be completed again." (Informant 1.3)

"If there are incomplete files/status, we will complete the status back to the room to complete it again." (Informant 4.6)

Based on the results of the interview above, it can be concluded that if the requirements required for an inpatient BPJS Health claim at RSU Imelda Workers Indonesia are incomplete, then the files will be sent back to the inpatient room where the patient is being treated so that the files/status can be completed by the nurse or the doctor concerned.

Lama Time Given to Complete the Claim Requirements

The length of time given to complete the requirements for claiming BPJS health for inpatient care at RSU Imelda Indonesian Workers Medan is as per the results of the following interview

"A maximum of 2 x 24 hours. Files should be down 2 x 24 hours, but what happens is sometimes more than the specified time." (Informants 1,2,3,4,5,6)

Based on the results of the interview above, it can be concluded that at the Imelda Indonesian Workers' Hospital, the time given to complete the BPJS Health claim requirements from the inpatient unit is a maximum of 2x24 hours.

Kendwhat happens when executing a claim

Obstacles that occurred during the process of implementing the BPJS health claim for inpatient care at RSU Imelda Indonesian Workers Medan are as follows from the results of the following interview:

"What often happens is that there is a lack of facilities and the network often has problems." (Informants 1,4,5,6)

"Network, facilities such as printers, and human resources." (Informant 2)

"The network and facilities often have problems, and the process of completing the files is quite long" (Informant 3)

Based on the results of the interview above, it can be concluded that the obstacles that occur when implementing BPJS inpatient health claims at the Imelda Workers' Hospital of Indonesia are the network which often has problems, the facilities are still inadequate, and the process of completing the files is still quite long. The implementation of BPJS Health claims does not yet have an SOP at the Imelda Indonesian Workers Hospital in Medan, but is in accordance with the procedures for the claim process and requirements regulated by BPJS. The medical record patient claim file is entered into the INA-CBGs application and the medical record file will be scanned and entered into the hard disk, after which it is delivered to BPJS Health.

If an inpatient's medical record file is incomplete, it will be returned to the inpatient room to be completed with the medical record file which will be claimed within the given time of 2 x 24 hours. Obstacles often experienced by claim officers when making claims are the lack of required facilities (e.g. printers), network problems which often have problems when making claims for inpatient patient files, as well as the length of time for inpatient officers (doctors, nurses) to complete medical record files. inpatients. After the claims officer makes a claim to the INA-CBGs application, the claims officer makes a submission to BPJS Health. The claims officer makes the submission by providing the requirements to BPJS Health.

Claim Dispute

The results of the interviews were obtained from 6 informants, namely BPJS Health Coding and Claims Officers for inpatient care at the Imelda Workers Indonesia Hospital, Medan. Based on the results of the interview, it can be concluded that when submitting a claim at RSU Imelda for Indonesian Workers, claim disputes often occur and what causes claim disputes is the discrepancy in the diagnosis code and medical indications of the patient at the time of initial admission, the

discrepancy in supporting examinations, as well as the files/administration of the files submitted. is still incomplete and will be re-verified and revised in accordance with BPJS policies and regulations.

From the results of the interview above, it can be concluded that disputes over BPJS claims still often occur due to discrepancies in primary diagnosis codes and secondary diagnoses and initial patient admission indications, as well as incomplete files or administration files which must be fulfilled as a condition for BPJS claims. The time given by BPJS to verify dispute data until it is successfully claimed is 6 months according to the Regulation of the Social Security Administering Body Number 7 of 2018 concerning Administrative Management of Health Facility Claims in the Implementation of Health Insurance.

Administrative Dispute

Based on the results of the interview, it can be concluded that at the Imelda Workers Indonesian Hospital, what officers do if the claim file requirements are incomplete is to identify any data that is incomplete, then re-confirm with the doctor and nurse where the patient is hospitalized, then re-scan, then combine them, then sent back to the BPJS verifier and incomplete supporting requirements for submitting RITL service claims, such as action reports, procedures or operation reports, as well as supporting examinations, as well as a medical resume that includes the main diagnosis and secondary diagnoses (if any) and procedures that are not appropriate.

Through the results of interviews conducted by researchers, there is still an administrative dispute where the files requested by the BPJS verifier are incomplete, or do not meet the requirements, so the files are returned to the hospital, to be completed again, in accordance with BPJS Health regulation no. 7 of 2018.

Dispute Coding

Based on the results of the interview above, it can be concluded that the obstacles experienced by officers at the Indonesian Workers' Imelda RSU in inputting coding are network problems, choosing the right code according to the casemix, where if there are 2/3 diseases, just 1 code according to the one in INA-CBGs and during the financing process, where if a code error occurs it will affect the patient's rates on the INA-CBGs application.

From the results of interviews conducted by researchers, there is still a coding dispute where there is a discrepancy in the codes for the main diagnosis and secondary diagnosis and a discrepancy between the main diagnosis and secondary diagnosis with supporting examinations in the medical resume, so the file is returned to the hospital, to be completed again, in accordance with BPJS Health regulations. No. 7 of 2018.

Medical Dispute

Based on the results of the interview, it can be concluded that at the Indonesian Workers' Imelda General Hospital where medical disputes are the case, it is to determine the main diagnosis of patients who have many disease diagnoses, so they have to determine which one gets more treatment or medication and medical disputes still occur where indications are not attached. medical (initial admission), the scan results of supporting examinations are unclear and unreadable, the scan results of the action/operation report are unclear and cannot be read in the operation/action report as much as possible, as many drug administration schedules are not attached, and the action or drug administration is inconsistent with the main diagnosis patient, so that the file is returned to the hospital, to be completed again, in accordance with BPJS Health regulation no. 7 of 2018.

Number of Disputed Claim Files

In October 2022, the number of inpatient claim files submitted again was 84 files, of which 67 inpatient claim files were accepted (80%) and 17 claim files were rejected (disputed claims) (20%). In November 2022, the number of inpatient claim files that were resubmitted was 71 files, of which 51 inpatient claim files were accepted (72%) and 20 claim files were rejected (disputed claims) (28%). In October 2022, the number of inpatient claim files that were resubmitted was 84 files, of which 63 inpatient claim files were accepted (75%) and 21 files of rejected claims (disputed claims) were 21 files (25%).



Claim Files Rejected (Disputed) Monthly

In October 2022, the number of disputed inpatient claim files was 17 files, including 10 coding dispute files (59%), and 7 medical dispute files (41%). In November 2022, the number of disputed inpatient claim files was 20 files, including 2 administrative disputes (10%), 9 coding disputes (45%), and 9 medical disputes (45%). In December 2022, the number of disputed inpatient claim files was 21 files, including 9 coding disputes (43%), and 12 medical disputes (57%).

Discussion

Inpatient BPJS Health Claim Process at Imelda RSUMedan Indonesian Workers

Claiming SOP

Based on the results of the interview above, it can be concluded that there is no SOP for BPJS claims for inpatients at the Indonesian Workers' RSU Imelda itself so far, because the terms of the claim process and conditions have been regulated by BPJS in the 2014 BPJS Health claims administration guidebook. However, this is not the case. The existence of this SOP regarding BPJS claims makes it difficult for officers to process and procedure BPJS claims, considering that the number of patients visiting is 70% -85% per year. This data shows that the number of BPJS patients is greater, so claims handling must also be given more attention and improvement, one of which is by creating an SOP for BPJS claims for inpatients, so that the process and management of claims runs according to applicable procedures. There are no SOPs,

Claim Terms

Based on the results of interviews conducted by researchers with informants, it can be concluded that the conditions that must be met when claiming BPJS health for inpatients at RSU Imelda Workers Indonesia are completeness of files such as SEP sheets, chronology of events for accident patients (if necessary), emergency room resume, referral letter (if any), emergency room assessment, hospitalization order, diagnosis support, death certificate, drug schedule (JPO), anesthesia report, surgical report, diagnostic/laboratory/X-ray report, action results, radiology results, report on use of medical equipment (if used), hospital billing. This is in accordance with the provisions set by BPJS Health in the 2014 BPJS Health claims administration guidebook.

BPJS Inpatient Claim Process

Based on the results of interviews conducted by researchers with informants, it can be concluded that the process of BPJS Health claims for inpatients at RSU Imelda Workers Indonesia is to enter files into the INA-CBGs application, enter hospital fees, doctor's name, date of admission and date of discharge, how the patient goes home, and the diagnosis code, then click send on the e-claim application. Claims for inpatients at RSU Imelda for Indonesian Workers are submitted at the beginning of every month, maximum on the 10th of each month. Once all the files are in one bundle, the files are scanned and dated according to the return date. Once the files are complete, an application letter, an absolute letter and a fraud letter must be made to state that the files are suitable to be submitted to BPJS. then we scan the letter we submitted and then enter it into the Viis application. This is in accordance with the provisions set by BPJS Health in the 2014 BPJS Health claims administration guidebook.

What to do if the conditions are required at the timeIncomplete Claim

Based on the results of interviews conducted by researchers with informants, it can be concluded that if the conditions required when claiming BPJS Health for inpatient care at RSU Imelda Workers Indonesia are incomplete, then the files will be sent back to the inpatient room where the patient is being treated so that the files/status can be completed by the nurse or doctor concerned. The process of returning files to the inpatient room should take 2 x 24 hours (Permenkes 24, 2022). However, in its implementation, it was still found that files were being returned more than 2x24 hours from the inpatient room. This causes the claims process to take longer, besides that the coder's burden increases due to the accumulation of BPJS claim files.

Length of Time Given to Complete the Claim Requirements

Based on the results of the interview above, it can be concluded that at the Imelda Indonesian Workers' Hospital, the time given to complete the BPJS Health claim requirements from the inpatient unit is a maximum of 2x24 hours. The process of returning files to the inpatient room should take 2 x



24 hours (Permenkes 24, 2022). However, in its implementation, it was still found that files were being returned more than 2x24 hours from the inpatient room. The reason for returning files in more than 2x24 hours is because of the length of time it takes for inpatient staff (doctors, nurses) to complete inpatient medical record files. This causes the claims process to take longer, besides that the coder's burden increases due to the accumulation of BPJS claim files.

Obstacles that Occur During Claim Implementation

Based on the results of interviews obtained by researchers, it can be concluded that the obstacles that occur when implementing inpatient BPJS health claims at RSU Imelda Workers Indonesia are the network which often has problems when making claims for inpatient patient files, inadequate facilities such as printers, and processes. Complete the documents which are still quite old. This results in a buildup of files that must be claimed. The process of procuring facilities and network maintenance must be improved by the hospital, to support the inpatient BPJS Health claim process.

Claim Dispute

The results of interviews obtained from 6 informants, namely BPJS Health Coding and Claims officers for inpatient care at the Imelda Workers' Indonesian RSU, Medan, can be concluded that when submitting claims at the Imelda Workers' Indonesian RSU, claim disputes still often occur. Things that cause claim disputes are discrepancies in the patient's diagnosis code and medical indications at the time of initial admission, discrepancies in supporting examinations, as well as files/administration of files that are still incomplete, and if there is a claim dispute at the Indonesian Workers' Imelda RSU then re-verification will be carried out, and repairs are carried out in accordance with BPJS policies and regulations.

Disputes in BPJS claims still occur frequently, this is caused by discrepancies in the main diagnosis codes and secondary diagnoses and the initial patient admission indications, as well as incomplete files or administration files which must be fulfilled as a condition for BPJS claims. The time given by BPJS to verify dispute data until it is successfully claimed is 6 months according to the Regulation of the Social Security Administering Body Number 7 of 2018 concerning Administrative Management of Health Facility Claims in the Implementation of Health Insurance.

The results of the research showed that the number of inpatient claim files that were rejected by BPJS Health (Dispute) in October 2022, the number of inpatient claim files that were disputed, was 17 files, including 10 coding dispute files (59%), and 7 medical dispute files (41%). In November 2022, the number of disputed inpatient claim files was 20 files, including 2 administrative disputes (10%), 9 coding disputes (45%), and 9 medical disputes (45%). In December 2022, the number of disputed inpatient claim files was 21 files, including 9 coding disputes (43%), and 12 medical disputes (57%).

Three aspects that influence disputes are: administrative disputes, coding disputes, and medical disputes, where these three aspects are interconnected and influence the process of disputes. For example, if the file requirements are incomplete, such as supporting examinations, this will not only affect administrative disputes, but also coding and medical disputes, the reason is that establishing the main diagnosis and secondary diagnosis will be difficult, because there are no supporting examination attachments in the medical record file, If the main diagnosis is wrong, then coding enforcement will also affect the tariff (reimbursement) that will be billed to BPJS.

Administrative Dispute

The results of interviews obtained from 6 informants, namely BPJS Health Coding and Claims officers inpatients at the Imelda Workers Indonesia RSU Medan, can be concluded that at the Imelda Workers Indonesia RSU what the officers do if the claim file requirements are incomplete is to identify what data is required. incomplete, then re-confirm with the doctor and nurse where the patient is hospitalized, then re-scan, then combine, then send back to the BPJS verifier. Problems found in administrative dispute cases, apart from incomplete files, are incomplete supporting requirements for submitting RITL service claims, such as action reports, procedures or operational reports, as well as supporting examinations. The results of this research have several similarities with the research of Icha, et al (2020) regarding the identification of the causes of returning inpatient BPJS claim files at the Bahteramas regional general hospital, Southeast Sulawesi province, where the cause of returning

BPJS claim files based on Administrative Dispute is due to card misuse, how to go home inappropriate patients, lack of supporting evidence and therapy, and errors in demographic data.

Based on the results of interviews conducted by researchers, there is still an administrative dispute where the files requested by the BPJS verifier are not complete. or does not meet the requirements, so the file is returned to the Hospital, to be completed again, in accordance with BPJS Health regulation no. 7 of 2018.

Dispute Coding

The results of interviews obtained from 6 informants, namely coding officers and BPJS Health claims for inpatients at the Imelda Workers Indonesia RSU, Medan, were that the obstacles experienced by officers at the Imelda Workers Indonesia RSU in inputting coding were network problems, incorrect code selection. according to casemix, where if there are 2/3 diseases, just 1 code according to INA-CBG's. The impact that occurs if there is an error in the coding process is during the financing process, where if a code error occurs it will affect patient rates on the INA-CBGs application.

Based on the results of interviews conducted by researchers, there is still a coding dispute where there is a discrepancy in the codes for the main diagnosis and secondary diagnosis and a discrepancy between the main diagnosis and secondary diagnosis with supporting examinations in the medical resume, so the file is returned to the hospital, to be completed again, in accordance with BPJS Health regulations. No. 7 of 2018. The results of this study have several similarities with the research of Icha, et al (2020) regarding identification of the causes of returning BPJS claim files for inpatient treatment at the Bahteramas regional general hospital, Southeast Sulawesi province, where the cause of returning BPJS claim files based on Dispute Coding was due to coding that did not match the diagnosis. , lack of clarity in the doctor's writing which makes the proposed diagnosis incorrect, as well as the final diagnosis not being filled in on the medical resume.

Medical Dispute

The results of interviews obtained from 6 informants, namely BPJS Health Coding and Claims officers inpatients at the Imelda Workers Indonesia RSU Medan, can be concluded that at the Imelda Workers Indonesia RSU the case of medical disputes is to determine the main diagnosis of patients who have many disease diagnoses. , so you have to determine which one gets more treatment or medication.

Based on the results of interviews conducted by researchers, there are still medical disputes where medical indications (initial admission) are not attached, scan results of supporting examinations are unclear and unreadable, scan results of action/operation reports are unclear and cannot be read in the operation/action report, are not attached. medication administration schedule, and incompatibility of actions or medication administration with the patient's main diagnosis, so that the file is returned to the Hospital, to be completed again, in accordance with BPJS Health regulation no. 7 of 2018. The results of this study have several similarities with the research of Icha, et al (2020) regarding the identification of the causes of returning inpatient BPJS claim files at the Bahteramas regional general hospital, Southeast Sulawesi province, where the cause of returning BPJS claim files based on Medical Dispute was due to a disagreement between the verifier and the officer. claims at the hospital regarding the diagnosis submitted, many surgical cases experienced problems because they were not accompanied by supporting evidence. The causes of claim disputes in inpatient files that are submitted again after being pending are due to:

- a. Administrative Dispute: Incompleteness of supporting requirements for submitting claims for RITL services, such as action reports, procedures or operation reports, as well as supporting examinations of 2 files (4%) from October-December 2022
- b. Dispute Coding includes, discrepancies in the main diagnosis codes and secondary diagnoses and discrepancies in the main diagnoses and secondary diagnoses with supporting examinations in medical resumes in 28 files (48%) from October-December 2022.
- c. Medical Disputes include, medical indications not attached (initial admission), scan results of supporting examinations unclear and unreadable, scan results of action/operation reports unclear and unreadable in operation/action reports as much as possible, not attached as many

drug administration schedules, and discrepancies 28 patients (48%) received procedures or medication for the patient's main diagnosis from October-December 2022.

The largest percentage of claims disputes at RSUD Imelda Medan are due to discrepancies in primary and secondary diagnosis codes and incompatibility with supporting examinations. The results of this research are in accordance with research by Supriadi and Rosania (2019) regarding "Review of Pending Claim Files for JKN Patients at Hermina Ciputat Hospital" explaining that there were 68 files pending because they did not pass Health service verification. This is mostly because the diagnosis codes do not match, there are 2 diagnosis codes combined into 1, there is no diagnosis code, and the diagnosis code is deleted. The research results also showed that the number of inpatient claim files that were rejected again by BPJS Health (dispute claims) after the pending claim files were resubmitted in October-December 2022, namely 58 claim files submitted by the Imelda Indonesian Workers RSUD Medan. There are dispute claims in inpatient files which are claimed to be caused by disagreements on the main and secondary diagnosis codes in INA-CBGs between hospitals and BPJS verifiers in 28 files (48%), inconsistencies in actions or administration of medication with the patient's main diagnosis in 28 files (48%) , and incomplete supporting requirements for submitting RITL service claims as many as 2 files (4%).

The results of research by Jasmen Manurung, et al (2018) show that the factors that cause claim disputes in the BPJS claim process are the discrepancy between hospital diagnosis codes and those determined by BPJS Health due to lack of coordination between DPJP and coding officers and the research results of Yatmi Wahyuni and Suharyo, (2019) The factors that cause claim disputes in the BPJS claim process are differences in the perception of diagnosis and determination of ICD 10 and ICD 9 CM codes between the doctor in charge of the service and the coder.

4. CONCLUSION

Administrative Dispute: Incompleteness of supporting requirements for submitting claims for RITL services, such as action reports, procedures or operation reports, as well as supporting examinations of 2 files (4%) from October-December 2022. Dispute Coding includes, non-conformity of main diagnosis codes and secondary diagnoses and discrepancies primary diagnoses and secondary diagnoses with supporting examinations in medical resumes totaling 28 files (48%) from October-December 2022. Medical Dispute includes, medical indications not attached (initial admission), scan results of supporting examinations unclear and illegible, scan results the action/operation report is not clear and cannot be read in the operation/action report, the drug administration schedule is not attached as much as, and there were 28 cases (48%) of the patient's main diagnosis (48%) from October-December 2022.

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