The influence of outpatients medical information completeness in the emergency departments and policlinics on returning BPJS health claim status

Pengaruh kelengkapan informasi medis pasien rawat jalan di instalasi gawat darurat dan poliklinik terhadap pengembalian status klaim BPJS kesehatan

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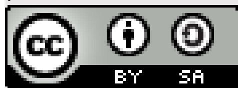

ABSTRACT

Background: In order to comprehend the medical data required for BPJS Health claims, this study was done. BPJS Health claim status returns require some outpatient data.
Objective: Some outpatient data are needed for BPJS Health claim status returns.
Methods: Analyses in retrospect that take a quantitative approach. Case groups in the form of confirmation from BPJS Kesehatan regarding the review of outstanding claim files, which were differentiated by case type, served as the study variables. In terms of observations, 396 samples of pending claim files were taken and divided into 8 confirmation groups.
Results: 16.9% of confirmations related to Z codes as diagnoses, 11.1 percent of confirmations related to secondary codes, 17.2% of confirmations related to outpatient and inpatient potential, 7.6% of confirmations related to systems, 11.6 percent of confirmations related to medical support, 11.1 percent of confirmations related to number of visits, 5.3 percent of confirmations related to medical actions, and 19.2% of confirmations containing authenticated data were other confirmations.
Conclusion: Confirmation related to Z code as a diagnosis, confirmation of secondary codes, and confirmation of outpatient and inpatient status indicate the completeness of medical information.
Keywords: BPJS health patients, completeness, emergency departments and polyclinic, medical information, review

ABSTRAK

Latar Belakang: Untuk memahami data medis yang diperlukan untuk klaim BPJS Kesehatan, penelitian ini dilakukan. Pengembalian status klaim BPJS Kesehatan memerlukan beberapa data rawat jalan.
Tujuan: Beberapa data rawat jalan diperlukan untuk pengembalian status klaim BPJS Kesehatan.
Metode: Analisis dalam retrospeksi yang mengambil pendekatan kuantitatif. Kelompok kasus berupa konfirmasi dari BPJS Kesehatan terkait review berkas klaim outstanding yang dibedakan berdasarkan jenis kasus, menjadi variabel kajian. Dalam hal pengamatan, diambil 396 sampel berkas klaim tertunda dan dibagi menjadi 8 kelompok konfirmasi.
Hasil: 16,9% konfirmasi terkait kode Z sebagai diagnosis, 11,1% konfirmasi terkait kode sekunder, 17,2% konfirmasi terkait potensi rawat jalan dan rawat inap, 7,6% konfirmasi terkait sistem, 11,6 persen konfirmasi terkait penunjang medis, 11,1 persen konfirmasi terkait jumlah kunjungan, 5,3 persen konfirmasi terkait tindakan medis, dan 19,2% konfirmasi yang berisi data terautentikasi adalah konfirmasi lainnya.
Simpulan: Konfirmasi terkait kode Z sebagai diagnosis, konfirmasi kode sekunder, dan konfirmasi status rawat jalan dan rawat inap menunjukkan kelengkapan informasi medis.
Kata Kunci: BPJS kesehatan pasien, kelengkapan, informasi medis, review unit gawat darurat dan poliklinik

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INTRODUCTION

The health equity and population health is among main target of World Health Organization.[1,2,3] Universal Health Coverage (UHC) aims to ensure the availability of health services for everyone.[2] Indonesia an upper middle-income country has grown committed to achieving UHC through the enforcement of Law no. 40/2004 on the Sistem Jaminan Sosial Nasional (SJSN) (National Social Security System) and Law no. 24/2011 on the Badan Penyelenggaran Jaminan Sosial (BPJS) Health or the Social Security Agency for Health (SSAH) in January 2014.[5,6] One of the government's efforts in realizing the highest health degree and health development goals towards healthy Indonesia then the government sets National Health Insurance (JKN). Since January 1, 2014, the Ministry of Health Republic of Indonesia has launched BPJS Health whose participants started from Askes participants, Jamkesmas, Jamsostek, and member health insurance on TNI/POLRI. The government targets in 2019 is Universal Coverage that membership of the Health Care Guarantee which means that all residents in Indonesia by 2019 must have health insurance. Badan Penyelenggaran Jaminan Sosial (BPJS) Health or Social Security Agency of Health is an Indonesian institution of social security so that the existence of social security, financial risk faced by person whether it is because the productive age, get sick have an accident and even death will be taken over by the agency that organizes social security. This legislation will provide an opportunity for health centers, family doctor, clinic or hospital to provide health services to people who are funded by the government and employees. This act also provided an opportunity for healthcare institutions to improve services. This has the effect of changing the payment of BPJS Health claims, which are paid using the Indonesian Case-Based Groups (INA-CBGs) package system and outside the INA-CBGs package. With this system, hospitals are required to provide optimal health services to patients and their families.[4]

Efforts to improve the quality of life and optimal health services for the community, the government and the private sector provide institutions for health services called hospitals. The hospital's role is to provide individual health services in complete manner and to provide emergency, outpatient, and inpatient services. PT. BPJS Health (Persero) is State Owned Enterprise (SOE) are specifically assigned by the government to hold health insurance for civil servants, civil servants Pension Recipients, and other business entities. The health insurance got from PT. BPJS Health (Persero). The participants must submit some documents as requirements. Broadly speaking, the process to get bail on health insurance is government health agency referral and information filing patient medical records from health centers and hospitals that have cooperated with PT. BPJS Health (Persero).[5]

Medical records are files containing notes and documents about patient identity, examination, treatment, actions, and other services that have been given to patients. Also

explained are the requirements for quality medical records related to the completeness of medical record entries, accuracy, accuracy of medical record records, timeliness and fulfillment of legal requirements.[6] Remarks and notes about the patient should be complete including medical resume sheets and all the information that describes the patient. The medical record is also used as the next patient reference, especially when the patient returns post-hospital/control treatment, the patient's medical record should be ready when the patient returns.[7]

Completeness of medical record file is one of the requirements in filling claim, in addition to the medical record file must be filled with complete also must be timely for the claiming process went smoothly. If the completeness of the medical records file is incomplete, it may result in rejection by the BPJS Health verifier so that the claim file must be returned to the Hospital for immediate completion. Thus the process of filing claim to BPJS Health becomes too late and the claim process does not go smoothly. This will also affect the delay in disbursement of funds from BPJS Health. The determination of the tariff to be issued can be seen from the completeness of the medical record file, because it contains various information about the patient who get service in the hospital. Hospitals that apply INA-CBGs become very important in making complete and clear diagnosis based on ICD-10 and the accuracy of their diagnostic code.[8]

In filing BPJS Health claim, an important factor is the role of doctors in completing medical resumes and enforcing diagnoses, information technology, SOP which is guideline in the process of filing claims, rewards / compensation and supervision by superiors. The administrative process of BPJS Health claims relates to the completeness of claim documents in the form of filling out diagnoses and actions given by the doctor in charge.[9] The hospital itself needs to improve the competence of coders and doctor discipline in documenting service procedures into medical resumes and the completeness of supporting files as part of claim collection documents and elucidation and communication to doctor related to the understanding of service regulations. To obtain payment of BPJS Health services that have been performed by the hospital, the hospital make claim for these services comes with complete document to BPJS Health 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 Health.[10]

The completeness of the patient's medical information really determines the smoothness of the claim, therefore, the completeness of the medical information must be sought, so that the claim process is smooth. At the XXX Hospital Semarang Central Java Indonesia, to be found several cases that caused delayed claims, based on revision of claims, both outpatient and inpatient. According to outpatient claims data for December 2019, the hospital submitted 16,920 outpatient cases from the emergency department and specialist polyclinics. Pending claims were 396 cases, 2.3% of pending claims arose due to clarification from BPJS Health regarding files that were declared incomplete with medical

information. Of course, if cashed out, the 2.3% figure in one month means lot to type C hospital income.

RESEARCH MATERIALS AND METHODS

Study Design

Retrospective analysis with quantitative approach.

Data Collection

The population was based on the number of pending claim files from all outpatient services, both services at Emergency Departments and specialist Polyclinics, which were recorded from January to December 2019, were 246,505 outpatient claim files, 238,322 files were approved to be paid immediately, while 8,182 files were pending claims. Total population were 8,182 cases. The study was conducted every month by means of simple random sampling on the claim files of outpatient BPJS Health patients monthly. Sample were 396 cases. This study used secondary data in the form of medical record documents, which were seen by informants.

Variables

a. Complete Identity and administrative requirements
b. Complete authentication
c. Completeness of supporting/medical action reports
d. Complete medical diagnosis and treatment
e. Complete registration of going home/ leaving the hospital
f. Integration of identity data and membership validity
g. Integration of diagnostics and services
h. Other confirmations

Data Analysis

Data analysis is way of analyzing research data, namely based on claim review report from BPJS Health as feedback on submitting claims, this monthly data shows/states that there is incomplete medical information in outpatient claim files throughout 2019. After "fixing" the claim files, the data will be grouped based on the elements that determine the incompleteness of the medical information, so that the number of figures for each element is obtained.

RESULTS AND DISCUSSION

Data retrieval

Starting with data collection in the accounts receivable section/unit submitted to the casemix section for review by the internal verifier (the informant team of the research), by viewing the file (PDF) Minutes of Claim Returns from January to December 2019, as well as data pending claim in excel format. Data pending at the XXX Hospital in the form of confirmation of administration and services from an external verifier (BPJS Health)

Data grouping

The sample is 396 cases, then the cases will be sorted every month according to the confirmation. Cases that are considered similar will be grouped into one case theme. Classification of cases based on themes, in which the researcher groups into 8 case confirmation groups.

Table 1. Results of the observations based on the 2019 complete case groups

No	Cases	Months												Total	%
		1	2	3	4	5	6	7	8	9	10	11	12		
1	Confirmation related to Z code as diagnosis	13	8	1	0	11	3	7	11	1	2	4	6	67	24.7
2	Confirmation of secondary codes	0	0	0	0	0	0	0	0	0	2	0	5	7	2.6
3	Confirmation of potential outpatient and inpatient care	14	17	7	2	2	5	5	5	1	1	4	5	68	25.1
4	System confirmation	0	7	9	3	2	1	1	3	2	1	1	0	30	11.1
5	Confirmation related to medical support	1	3	0	0	5	1	1	6	1	1	1	0	20	7.4
6	Confirmation regarding number of visits	0	0	10	4	4	6	9	3	2	3	1	2	44	16.2
7	Confirmation related to medical actions	0	0	0	4	5	1	2	0	1	1	1	2	17	6.3
8	Other confirmations	1	0	0	1	0	5	1	0	0	0	0	10	18	6.6
	Total	29	35	27	14	29	22	26	28	8	11	12	30	271	100.0

Table 2. Results of the observations based on the 2019 incomplete case groups

No	Cases	Months												Total	%
		1	2	3	4	5	6	7	8	9	10	11	12		
1	Confirmation related to Z code as diagnosis	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0
2	Confirmation of secondary codes	1	0	0	11	6	6	4	1	4	1	3	0	37	29.6
3	Confirmation of potential outpatient and inpatient care	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0
4	System confirmation	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0
5	Confirmation related to medical support	0	2	2	5	0	2	1	3	6	1	1	3	26	20.8
6	Confirmation regarding number of visits	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0
7	Confirmation related to medical actions	0	0	1	0	0	0	0	0	1	1	1	0	4	3.2
8	Other confirmations	0	0	0	2	0	2	1	0	16	20	17	0	58	46.4
	Total	1	2	3	18	6	10	6	4	27	23	22	3	125	100.0

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1. **Results of the observations based on the 2019 complete case groups**

Table 1 show results of the observations based on the 2019 complete case groups that confirmation related to Z code as diagnosis were 67 cases (24.7%), confirmation of secondary codes were 7 cases (2.6%), confirmation of potential outpatient and inpatient care were 68 cases (25.1%), system confirmation were 30 cases (11.1%), confirmation related to medical support were 20 cases (7.4%), confirmation regarding number of visits were 44 cases (16.2%), confirmation related to medical actions were 17 cases (6.3%), and other confirmations were 18 cases (6.6%).

2. **Results of the observations based on the 2019 incomplete case groups**

Table 2 show results of the observations based on the 2019 incomplete case groups that confirmation of secondary codes were 37 cases (29.6%), confirmation related to medical support were 26 cases (20.8%), confirmation related to medical actions were 4 cases (3.2%), other confirmations were 58 cases (46.46%). There was no cases about confirmation related to Z code as diagnosis, confirmation of potential outpatient and inpatient, system confirmation, and confirmation regarding number of visits.

Improving socialization of regulations and consequences of late payments of BPJS Health increasing participants' awareness of the importance have healthcare insurance continuously and give priority to the basic health needs at the household expenses are efforts that could be done to reduce the number of late payments in the premium payments of BPJS Health to the participants of PBPU.[11] Hospital already has referral operational service standard. This operational service standard is intended as reference in referring patients to the hospital. In this operational service standard, two work procedures have been arranged, namely, if the patient is referred vertically and if the patient requests referral himself. Operational service standards at hospital are incomplete because there are no operational service standards for emergency patients.[12] In general, hospitals could be prone to fraud if fraud prevention system does not exist.

Guidelines medical record service in Indonesia states that medical records are complete is document medical records completed by physicians within ≤ 24 hours after completion of service or as inpatients decided to return include the identity of the patient, anamnesis, care plans, implementation of care, follow-up and resume. Complete medical records, providing information that can be used for various purposes. Such necessities are as evidence in lawsuit, research and education materials and can be used as tool for analysis and evaluation on the quality of services provided by the hospital. Hospitals in case of incomplete documentation of information, it is possible that the diagnosis codes are also inaccurate and affect the cost of health services. The inaccuracies of the diagnostic codes and the

completeness of the medical record will affect data and report information that ultimately affects the patient. The current accuracy of INA-CBGs tariffs is currently used as method of payment for patient services organized by BPJS Health. If the coding officer incorrectly assigns diagnosis code, then the claim payment amount will also be different.

Challenges of claim management processing involve computer using skill, low quantity, and integrity of human resource, unclear responsibility as management claim team, doctor compliance in clinical pathway, completeness of medical resume, and inaccuracy of coding.(13) The process of paying health care claims according to INA- CBGs by the Social Security Organizing Agency (BPJS) Health to hospitals is strongly influenced by the completeness of medical record documents. Complete Medical Record Documents such as completeness of the investigations used by doctors to support doctor's diagnosis are very important for the coder in determining the diagnosis code in accordance with ICD-10 and for actions/procedures with ICD-9 CM. The accuracy of diagnosis is very important also in the field of clinical data management, cost collection, along with other matters relating to care and health services. Incomplete medical record documents can reduce claims costs indirectly. If there is medical record document that is incomplete when verified, the verifier will look for the truth of the service provided in accordance with the claim sheet submitted. This will slow down the claim process because the Social Security Organizing Agency (BPJS) will return the file for revision so that it can be paid.(14)

CONCLUSION

Completeness of medical information on outpatients from emergency departments and polyclinic of BPJS Health patients were confirmation related to Z code as diagnosis, confirmation of secondary codes, confirmation of potential outpatient and inpatient care, system confirmation, confirmation related to medical support, confirmation regarding number of visits, confirmation related to medical actions, and other confirmations.

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