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Analysis of Factors Causing Delays in Submitting Inpatient Claims to BPJS Health Verifiers at Tanjungpura University Hospital

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ABSTRACT

Background: The National Social Security System is organized through a mandatory Social Health Insurance mechanism based on Law No. 40 of 2004 concerning the National Social Security System. The goal is to fulfill the basic needs of decent public health and the protection of the Indonesian people in the insurance system. However, the journey of the program with the most BPJS patients in the hospital is a problem, there are obstacles in the hospital regarding the submission of claims, the hospital bears the risk of costs if the claim submitted is delayed or the claim is not accepted. Objective: to determine the descriptive causes of the return of BPJS health claim files for inpatients in terms of claim submission requirements. Methods: Descriptive qualitative research using case studies where researchers explore a particular phenomenon (case) in a time and activity (program, event, process, institution or social group), collecting detailed and in-depth information using various data collection procedures during a certain period. Results: Some of the factors causing delays in claims are differences in coding perceptions by casmix officers, incorrect reading of diagnoses and medical records, less casemix officers as verifiers of internal claims in hospitals, regulations from health bpjs regarding disbursement of claims according to the MOU per month if it does not reach then the claim is postponed in the month of giving.

INTRODUCTION

The National Health Insurance (JKN) Program through BPJS Kesehatan aims to provide equitable access to healthcare services for all Indonesian citizens (Samodra & Wirantari, 2024). According to the 2013 Basic Health Research (Riskesdas), 50.5% of the Indonesian population did not yet have health insurance coverage. Coverage under ASKES/ASABRI accounted for approximately 6.0%, Jamsostek 4.4%, private health insurance and company-sponsored health benefits each accounted for 1.7% of the population. Health insurance ownership was predominantly under the Jamkesmas scheme (28.9%) and Jamkesda (9.6%). However, in its implementation, hospitals often encounter administrative challenges, particularly in the claim submission process. Delays in claim processing result in hospitals having to bear the financial burden independently, which adversely affects the financial stability of healthcare facilities (Yusriadi, 2019).

According to claim documents managed by BPJS Health claim officers, an average of 83 inpatient claim files can be processed in a single day. If any documentation is returned by BPJS due to ineligibility or failed claims, it becomes the hospital's financial responsibility (Nevy et al., 2019). This is consistent with the findings of Indrawati (2017), who noted several issues in the claims process, including incomplete documentation and discrepancies in claim payment determined by hospitals.

At Tanjungpura University Hospital, BPJS claim submissions are frequently returned or delayed due to incomplete documents, errors in medical record documentation, and a lack of qualified coders. These factors significantly hinder the smooth disbursement of BPJS claims. Furthermore, regulations outlined in the Memorandum of Understanding (MoU) between hospitals and BPJS also impact the claim process, such as the requirement that at least 75% of patients be active within a given month as a prerequisite for claim disbursement. Previous studies have indicated that internal management factors, mismatches in diagnosis, and limitations in information systems are dominant contributors to claim delays. The absence of specific Standard Operating Procedures (SOPs) and unclear workflow among teams further exacerbate administrative inefficiencies in claim processing.

Given this context, it is essential to systematically analyze the inhibiting factors. Hospital management must implement training programs for coding staff to enhance their competencies and regularly conduct socialization sessions for Responsible Physicians (DPJP) on proper and complete medical resume documentation. Irmawati (2018) also emphasized that service administration completeness and appropriateness indicate inconsistencies in diagnosis and responsible physicians. Additionally, the claim submission process lacks established SOPs. All these factors that hinder the submission of BPJS patient claims in hospitals warrant further investigation. Therefore, this study aims to analyze the factors contributing to the delay in inpatient claim submissions to BPJS Health verifiers at Tanjungpura University Hospital.

METHOD

This study employed a qualitative descriptive approach with a case study design**.** The case study explored the phenomenon of claim submission delays within a specific context and time frame by collecting in-depth information through multiple methods, including interviews, observations, and documentation. Informants were selected using the snowball sampling technique, in which an initially small group of sources is gradually

expanded until sufficient and relevant data are obtained. This sampling approach aimed to gather comprehensive insights on the analysis of the factors causing delays in inpatient claim submissions to BPJS Health verifiers at Universitas Tanjungpura Hospital.

The researcher selected key informants, including the head of the Integrated Administrative Services Unit, the head of the verification and accuracy sub-division, and inpatient claim officers. Additionally, four administrative staff responsible for BPJS patient admissions were included. These informants were chosen based on their knowledge and involvement in the hospital's administrative service system. Besides primary and regular informants, additional participants were selected, including family members of patients in the Emergency Unit and BPJS patients in the inpatient ward. The study was conducted at Universitas Tanjungpura Hospital in Pontianak.

The research took place from March to August 2023, encompassing the preparation phase, data collection, data processing and analysis, as well as the evaluation of research activities. The primary research instrument was the researcher, supported by supplementary tools such as notebooks, audio recorders, and documentation. The validity of the data was ensured through method and source triangulation. Data analysis included data reduction, where field data were summarized and focused on key aspects to identify themes and patterns, providing clarity and guiding subsequent data collection. Then, data display was carried out, presenting reduced data in the form of brief descriptions, tables, charts, flowcharts, or similar visualizations, thereby organizing data into structured relationship patterns for easier interpretation. Finally, conclusion drawing involved formulating initial conclusions from the displayed data, which were revised in light of any contradicting evidence until a credible conclusion was reached. Secondary data were obtained from relevant hospital documents and literature supporting the theoretical foundation of this study.

RESULTS AND DISCUSSION

The initial activity in the research process involved a site survey, starting with the introduction to the medical records room. This was carried out under the guidance of administrative staff at Universitas Tanjungpura Hospital (Figure 1).

Figure 1. Research Site Survey at Universitas Tanjungpura Hospital (RS UNTAN)

The site survey was welcomed by the administrative staff located on the second floor of the archive building. The purpose of this visit was to convey the researcher's objectives and intentions. The research permit process involved several stages, namely:

1. The initial stage required submitting a research implementation request accompanied by a letter of recommendation from the university.

2. The second stage involved a request from Universitas Tanjungpura Hospital (RS UNTAN) to include an ethics approval document.
3. In the third stage, after the ethics approval was submitted to RS UNTAN, the researcher was required to pay an administrative fee of IDR 150,000 for conducting fieldwork activities specifically at the hospital.

Figure 2. Preparation for Data Collection: Meeting and Souvenir Arrangement

The preparation activities for this research included:

1. A preparatory meeting was conducted to discuss field arrangements and the distribution of tasks among team members.
2. Souvenirs were prepared for the respondents who participated in the interviews.
3. The research activities were planned to take place over four visits, including permit processing, document observation, and a final farewell visit.
4. The room-to-room observation schedule had been confirmed with the management of Universitas Tanjungpura Hospital.

Figure 3. Field data collection and distribution of appreciation souvenirs.

Health insurance initially developed from the principle of mutual solidarity, often in the form of small community-based schemes such as health funds, sickness funds, and similar initiatives (Panjaitan, 2020). These small-scale efforts generally lacked the capacity to grow due to their voluntary nature and the inadequacy of calculated premiums or contributions. The failure of such small and localized insurance systems can be addressed through two main approaches: commercial management with a high level of professionalism, and social insurance management that is mandatory for all individuals within a defined group (Erniaty & Harun, 2020).

The insurance mechanism is a contractual relationship that governs the rights and obligations of both parties. Participants are obligated to pay premiums and are entitled to receive benefits or compensation, while insurers have the right to receive premium payments and are obliged to provide benefits (Syuhada & Mursyid, 2024). These benefits may be provided directly to participants in the form of cash or to third-party service providers such as healthcare facilities (Navisa & SH, 2022). Government-managed insurance, or insurance administered by a state-established body, operates based on legislation that serves as a substitute for a conventional insurance contract. Essentially, the legal provisions function as an insurance policy that defines the rights and obligations of each party (Intanida, 2023).

The key characteristics of insurance contracts are as follows:

1. Conditional – In an insurance contract, the insurer's obligation arises only when a specific condition is met (e.g., illness or loss of property).
2. Unilateral – While most contracts are bilateral, where both parties have enforceable obligations, in insurance contracts only the insurer can be held legally accountable. If the insured fails to fulfill their obligation (e.g.,

non-payment of premiums), their rights are automatically forfeited.
3. Aleatory – Unlike typical contracts that offer a balanced exchange of value, insurance contracts provide benefits that can significantly exceed the amount of premiums paid by the participant.
4. Adhesion – In standard contracts, both parties generally possess relatively equal access to information regarding the terms of exchange. In contrast, insurance contracts especially in individual insurance place policyholders at an informational disadvantage compared to the insurer.

Limitations

In addition to the various advantages that social insurance offers both at the micro and macro levels, it also has several limitations. These limitations include:

1. Limited or no choice of insurers
2. Management that tends to lack creativity or responsiveness
3. Negative perceptions from upper social classes
4. Rejection by certain healthcare facilities or professional medical providers

Payment Systems

The retrospective payment system is a model in which the amount and cost to be paid by the patient or a third-party payer (e.g., an insurance company or the patient's employer) are determined after the healthcare service has been provided (Syafrawati et al., 2023). The term retro implies that payment is set retrospectively, or after the service is rendered. This method aligns with the traditional or fee-for-service (FFS) model, where healthcare services are billed individually. In Indonesia, this model is often referred to as out-of-pocket payment, although this terminology is technically inaccurate. Fee-for-service payments involve charging for each specific medical service provided, such as physician visits, infusions, room charges, medications, laboratory tests, and other procedures (Maharani et al., 2024).

From a cost-control perspective, the fee-for-service model has several weaknesses (Calundu, 2018). It creates incentives for healthcare facilities and providers to increase the number of services delivered, as more services result in higher earnings. As a result, it is common for multiple specialists sometimes five or six per patient to conduct daily visits, each generating a separate charge. Similarly, diagnostic tests or procedures may be repeated unnecessarily (Sari, 2022). These repeated visits and procedures may not offer additional benefits to patients. For instance, conducting daily blood glucose checks when clinically unnecessary is a form of moral hazard or abuse in healthcare delivery. Consequently, the retrospective model carries a high risk of overutilization and increased healthcare costs (Nadjib & Setiawan, 2020).

Casemix Based Group (CBG) Payment System

The Casemix Based Group (CBG) payment system can be described as a diagnosis-based flat-rate payment model, where hospitals are paid a fixed amount per diagnosis rather than per individual service provided. Under this system, hospitals report a patient's final diagnosis using a Diagnosis Related Group (DRG) code at the time of discharge. The hospital's claim amount is pre-determined based on that diagnosis, as agreed upon by all hospitals within a region and the payer, typically a government-regulated insurance body.

The CBG payment system offers several advantages:

1. Encourages hospital teams to improve service quality and reduce the risk of medical errors.
2. Simplifies administrative processes for both hospitals and BPJS (Indonesia's national health insurance system).

3. Facilitates hospital revenue forecasting and financial planning.
4. Provides incentives for healthcare providers to use resources more efficiently.
5. Enhances patient understanding and acceptance, as BPJS patients are not required to pay during hospitalization.
6. Grants greater authority to hospital directors to manage workflows and distribute earnings more equitably.
7. Allows efficient hospitals to generate surpluses, while inefficient ones may incur losses, promoting performance accountability.

Despite these advantages, the CBG payment system also has notable limitations:

1. It requires a robust health information system, particularly for accurate and comprehensive medical record documentation.
2. It may restrict physicians from experimenting with new or expensive drugs and medical products offered by pharmaceutical or medical device companies.
3. In the early stages of implementation, it can create resistance among doctors who are accustomed to independently setting their service fees.

Other Payment Subsystems

Another commonly used payment model is the case rate system, which is often applied by hospitals for specific types of cases. This system is similar to the Diagnosis Related Group (DRG) model, in which various medical services are grouped into a single payment unit (Trisnantoro, 2021). In Indonesia, case-based payments are frequently applied in surgical procedures by categorizing them into types such as micro-surgery, minor surgery, moderate surgery, and major surgery, among others. The case rate payment method encourages more accurate diagnosis, more efficient use of resources, and more careful selection of laboratory tests and other supporting examinations (Banu, 2022).

In the context of BPJS Health implementation, claims are submitted after the patient has completed treatment. In practice, hospitals have a dedicated team responsible for handling claim processes, known as the casemix team. This team compiles data on patients each month, classifying them into categories and case counts to facilitate a more streamlined claims process, as illustrated in the table below:

Table 1. Outpatient Cases at Universitas Tanjungpura Hospital – February 2023

No.	Outpatient Category	Number of Cases
1	Hemodialysis	4,763
2	General (Regular)	4,687
3	Medical Rehabilitation	4,722

Table 2. Inpatient Cases at Universitas Tanjungpura Hospital – March 2023

No.	Inpatient Category	Number of Cases
1	Hemodialysis	4,743
2	General (Regular)	4,764
3	Medical Rehabilitation	4,752

In both tables, Universitas Tanjungpura Hospital (RS UNTAN) classifies patients into three categories: hemodialysis, general (regular), and medical rehabilitation. The purpose of this categorization is to facilitate the casemix

unit in organizing and preparing claim documents for submission to BPJS Health. Field findings revealed that verifiers frequently encountered incomplete medical records. As stated by a staff member in the casemix room, *"We often find incomplete medical records for BPJS patients, which has become a recurring obstacle in claim disbursement."*

The documents required for claims are often problematic, as explained by the head of the casemix unit: *"Some of the main issues we encounter are incomplete medical records by either general practitioners or specialists. The reasons given are usually forgetfulness or being too busy. However, we do impose sanctions on doctors who delay completing medical records to prevent prolonged submission times."*

From the patient's perspective, one interviewee shared: *"Alhamdulillah, I have been using BPJS for a long time and feel grateful because RS UNTAN made the process easy from registration to receiving care. I regularly visit the dental, eye, and internal medicine clinics, and everything has always gone smoothly."* In general, no significant administrative issues were reported by patients during their hospital visits.

The claim return process at RS UNTAN follows these steps: the patient is admitted to the hospital by presenting a BPJS card, a referral letter from the public health center (*puskesmas*), and administrative documents such as their National ID (KTP) and Family Card (KK). These documents are then brought to the BPJS branch office to obtain a SEP (Eligibility Letter)**.** After completing the forms, the patient is directed to the Emergency Unit (IGD) or inpatient services.

The verification of claim documents by BPJS involves an initial administrative review followed by a second-level verification to detect any errors or prevent duplicate claims. Payments are processed using the INA-CBGs method through a computerized application system, which facilitates both verification and payment procedures. The inpatient claim process begins with document review by the ward verifier to check for completeness. Once verified, the documents are forwarded to the BPJS claims verifier for cost calculation. After this, the case is reported to the casemix unit to input the diagnosis based on the patient's condition. Once reviewed and corrected by the medical records team, the documents are consolidated, and the hospital finance unit submits the complete claim package to the BPJS claims department. Based on field findings, the head of the casemix unit suggested: *"Ideally, RS UNTAN should have a dedicated casemix doctor to expedite claim verification processes, especially regarding diagnosis validation and coding, so that it aligns with the assessment of BPJS-appointed doctors."*

CONCLUSIONS AND RECOMMENDATIONS

At Universitas Tanjungpura Hospital (RS UNTAN), several challenges were identified in the BPJS claim process. These include claim delays by BPJS due to a clause in the Memorandum of Understanding (MoU) stating that if BPJS patient visits do not reach 75% in a given month, claim disbursement will be postponed to the following month. Additionally, there is negligence among doctors in completing medical summaries, often citing reasons such as being busy or forgetting. Although sanctions are in place for delays—such as withholding service fees—the issue persists. A shortage of casemix personnel, who are responsible for managing BPJS claim submissions, further contributes to delays in claim analysis and processing. Moreover, misunderstandings or inaccuracies in medical coding by hospital staff often occur due to limited understanding of the coding standards set by BPJS Health.

Suggestion

To improve the efficiency and quality of BPJS claim submissions at Universitas Tanjungpura Hospital, several strategic

steps are recommended. These include conducting regular training sessions for casemix personnel and increasing the number of qualified staff to accelerate the analysis and documentation process. Reorganizing patient medical records and claim documents should be prioritized to meet standardized formats, thus enabling the development of a structured and clear Standard Operating Procedure (SOP) for each staff member. It is also crucial to establish binding agreements with physicians to ensure timely completion of medical summaries, as delays in this area frequently hinder the claims process. The hospital is further encouraged to appoint at least one dedicated casemix doctor to oversee BPJS claim handling, thereby improving coordination between medical and administrative functions. Lastly, a revision of the MoU clause requiring a minimum of 75% active BPJS patients as a condition for claim disbursement is necessary. It is suggested that this threshold be reduced to 50% to prevent technical obstacles in the funding process and ensure the sustainability of healthcare services.

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