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Claim Analysis of Cost Reimbursement COVID-19 Patient Service to Badan Penyelenggara Jaminan Sosial (BPJS) in health by Hospital

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The BPJS COVID-19 fee claim is the government's support in accelerating the handling of COVID-19 in Indonesia. BPJS Health data from January to October 2021, the submission of claims for COVID-19 reached 1,345,970 cases with a cost value of 72.3 trillion IDR. Of the claims submitted by the hospital, only 79.07% were following BPJS claim verification or equivalent to 64.1 trillion IDR. There are still 21% of COVID-19 cost claims that require clarification on dispute resolution. Therefore, it is necessary to study the COVID-19 cost claim according to the provisions and find out the obstacles that occur in submitting BPJS claims by hospitals. The method used is descriptive-analytic by using literature searches, reading materials, and scientific journals. The results obtained are that the claim for COVID-19 costs uses the provisions of the tariff per day/cost per day which is regulated in the technical instructions for claiming reimbursement of costs for COVID-19 patient services number HK.01.07/MENKES/5673/2021. The conclusion obtained is that there are still problems with COVID-19 cost claims in the administrative aspect, the limitations of the verifier team, and the integration of the claim submission system.

Kata kunci:

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Klaim Pembiayaan COVID-19
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A B S T R A K

Klaim biaya BPJS COVID-19 merupakan dukungan pemerintah dalam percepatan penanganan COVID-19 di Indonesia. Data BPJS Kesehatan Januari-Oktober 2021, pengajuan klaim COVID-19 mencapai 1.34.970 kasus dengan nilai biaya mencapai Rp. 72,3 triliun. Dari pengajuan klaim yang diajukan rumah sakit hanya 79.07% yang sesuai verifikasi klaim BPJS atau setara dengan Rp. 64,1 triliun. Masih ada 21% klaim biaya COVID-19 yang membutuhkan klarifikasi penyelesaian dispute. Oleh karena itu perlu pengkajian mengenai klaim biaya COVID-19 sesuai ketentuan dan mengetahui hambatan yang terjadi dalam pengajuan klaim BPJS oleh rumah sakit. Metode yang digunakan adalah deskriptif analitik dengan menggunakan penelusuran literatur, bahan bacaan dan jurnal ilmiah. Hasil yang diperoleh bahwa klaim biaya COVID-19 menggunakan ketentuan tarif per hari/cost per day yang diatur dalam petunjuk teknis klaim penggantian biaya pelayanan pasien COVID-19 nomor HK.01.07/MENKES/5673/2021. Kesimpulan yang didapat adalah masih ditemukan masalah klaim biaya COVID-19 dalam aspek administrasi, keterbatasan tim verifikator dan integrasi sistem pengajuan klaim.

INTRODUCTION

Coronavirus Disease 2019 (COVID-19) was initially known to have occurred in December 2019, marked by a case of pneumonia that occurred in Wuhan, Hubei Province, China. This disease spreads very quickly to various places. Coronavirus 2019 is caused by the Severe Acute Respiratory Syndrome Coronavirus 2 (SAR-CoV 2) (World Health Organization, 2020). From December 30, 2019, to January 20, 2020, this case infected 1,985 people in China (WHO dashboard). The World Health Organization (WHO) announced on March 12, 2021, the COVID-19 disease is a pandemic outbreak (WHO). As of November 23, 2021, COVID-19 has spread to 226 countries, 256,966,237 people have been confirmed with a Case Fatality Rate (CFR) / 2% death rate, while in Indonesia 4,253,992 people have been confirmed with a 3.5% mortality rate (World Health Organization, 2021).

COVID-19 is a big challenge in the health sector in handling it because there is no definitive treatment yet (Sekretariat Negara RI, 2020). The Ministry of Health is mandated to handle COVID-19 through quality health facilities. It is necessary to accelerate the handling of COVID-19 in the form of providing health services to COVID-19 patients in hospitals. So hospitals need to increase the capacity of clinical services and prepare facilities according to standards and require sufficient logistics for operations (Satuan Tugas Penanganan COVID-19, n.d.). The operation of COVID-19 services requires costs as a continuity of the supply chain in hospitals. The Ministry of Health continuously issues Minister of Health Regulation No. 59 of 2016 concerning the exemption of fees for certain emerging infectious disease patients to support supply chain operations. It was recorded in the 2020 State Budget report that the health allocation increased to 13% of the APBN or the equivalent of 132.2 Trillion (Kementerian Kesehatan RI, 2021b).

Financing for certain emerging infectious diseases in this case COVID-19 is borne by the government and claimed to the Ministry of Health through the Directorate General of Health Services (Kementerian Kesehatan RI, 2021a). This financing claim applies to patients being treated at hospitals that provide COVID-19 services (Kemenkeu, 2021). BPJS Health data from January to October 2021, the submission of COVID-19 claims submitted by hospitals was 1,345,970 cases with a total cost of Rp. 72.3 trillion. There are 1,180,858 confirmed cases of COVID-19 with a total cost of Rp. 64.1 trillion (Kementerian Kesehatan RI, 2021c). From the submission of verified COVID-19 claims, there were 933,708 appropriate cases or 79.07% cases with a cost of Rp. 50.5 trillion (Direktorat Penyusunan Anggaran APBN, 2020). Dispute claims were 170,335 cases or 14.42% of cases for Rp. 9.9 trillion. And as many as 4,567 cases or 6.12% of cases have expired or are not following the provisions with a cost value of Rp. 193 billion (BPJS) (BPJS Kesehatan, 2014). The number of dispute cases that occurred disrupted the hospital's cash flow. The high burden of hospital operating costs but not being paid has resulted in the hospital's losses getting heavier in the continuity of COVID-19 health services (BPJS Kesehatan, 2021).

Based on the background described above, there is a need for an assessment of COVID-19 service claims to be able to apply claims for reimbursement of costs of COVID-19 patient services to BPJS according to the provisions and find out the obstacles that occur in submitting BPJS claims by hospitals

METHOD

This study is analytical descriptive using secondary data based on literature searches, reading materials, and scientific journals. The descriptive approach is used to find out and understand a process and the facts of the phenomenon that occurs from an overall perspective. The inclusion variables in this study are the mechanism for submitting claims for COVID-19 treatment and obstacles in the claim process for reimbursement of costs for services for COVID-19 patients.

RESULTS AND DISCUSSION

Claims for reimbursement of costs for COVID-19 patient services have been determined by the government and are changing to improve benefits and convenience. The current regulation is based on the Decree of the Minister of Health Number HK.01.07/MENKES/5673/2021 concerning Technical Instructions for Claims for Reimbursement for the Cost of Services for Coronavirus Disease 2019 (COVID-19) Patients. These technical instructions are a reference for hospitals that provide COVID-19 services at hospitals owned by the central government, provincial governments, and local/district/city governments for the mechanism for reimbursement of COVID-19 services. The submission of claims for COVID-19 services is given to reimburse the costs of COVID-19 services and cases of follow-up events after COVID-19 vaccination. Before providing COVID-19 services, hospitals must obtain prior approval from the Director-General of Health Services (Qiu et al., 2021).

The amount of the tariff for health services used follows the provisions of the tariff per day/cost per day for inpatient care and uses the INA-CBG rate for outpatient class A regional 1(Miller et al., 2022). The financing components that can be claimed include administration, hospital accommodation, doctor services, medical treatment, use of ventilators, diagnostic examinations, consumable medical materials, drugs, personal protective equipment, referral ambulances, relocation of corpses, and other health services according to the medical needs of COVID-19 patients. The cost of personal protective equipment and medicines is not included in the claim if the hospital receives a grant from the central government (Wahezi et al., 2021).

Payment of claims is carried out starting from the time the hospital submits a claim for reimbursement for COVID-19 services (Waitzberg et al., 2021). Payments for COVID-19 patient guarantees that are complete administratively will be given an advance of up to 50% of each claim submitted by the hospital. As for the down payment given which is greater than the result of BPJS Health verification, the difference in overpayment becomes a deduction factor for the next claim payment. If the hospital does not file a claim for COVID-19 patient services, the difference in overpayment must be returned to the Ministry of Health through the COVID-19 claim payment account or the state treasury. The calculation of the insurance rate for COVID-19 patients in inpatient care is the INA CBG rate plus the total Length of Stay (LOS) of the patient multiplied by the cost per day minus the PPE component and medicine grants/donations/government assistance (Iorio et al., 2022).

Claim Mechanism

The mechanism for submitting claims for reimbursement for COVID-19 patient services is carried out by hospitals

collectively addressed to the Director-General of Health Services CQ. Director of Referral Health Services and copied to the district/city Health Office and BPJS Health for case verification via email and the E-claim and V-claim application. The e-claim application is connected to the BPJS Health v-claim application and the dispute application of the Directorate General of Health Services. File submission is done by uploading/uploading documents/claim files in the form of scanning results/photos. Documents/files consisting of patient identity, medical resume, treatment information, laboratory results, radiology results, other supporting results, prescription drugs/medical devices, hospital bills, death certificate if the patient dies, and approval letter for reimbursement of COVID-19 insurance payments. Meanwhile, physical/hardcopy documents are kept by each hospital (Borno et al., 2021).

Submission of claims with the E-Claim application will be connected to the server of the Ministry of Health. From submitting a claim to the E-Claim, an encrypted text file will come out which will be uploaded to the BPJS Health V-Claim. Submission of claims is carried out by the hospital at most 2 (two) times in the same month with a distance of 14 calendar days from the previous submission. The submission of claims for field hospitals/emergency services for COVID-19 is carried out by a supporting hospital that has been determined by the central government/local government and paid to the account of the supporting hospital that has collaborated between the nursing hospital and the COVID-19 field/emergency hospital (Diel & Nienhaus, 2022).

BPJS Health shall verify the file no later than 14 (fourteen) working days from receipt by BPJS Health and issue the final verification result in the form of a Verification Result Report (VRR) for payment of claims for services for COVID-19 patients. VRR claims for COVID-19 patient services must be signed by the hospital leadership and BPJS Health and the file signature can be replaced with an electronic signature. Then VRR claims for COVID-19 patient services are submitted by BPJS Health to the Ministry of Health for payment of claims with in 7 (seven) days.

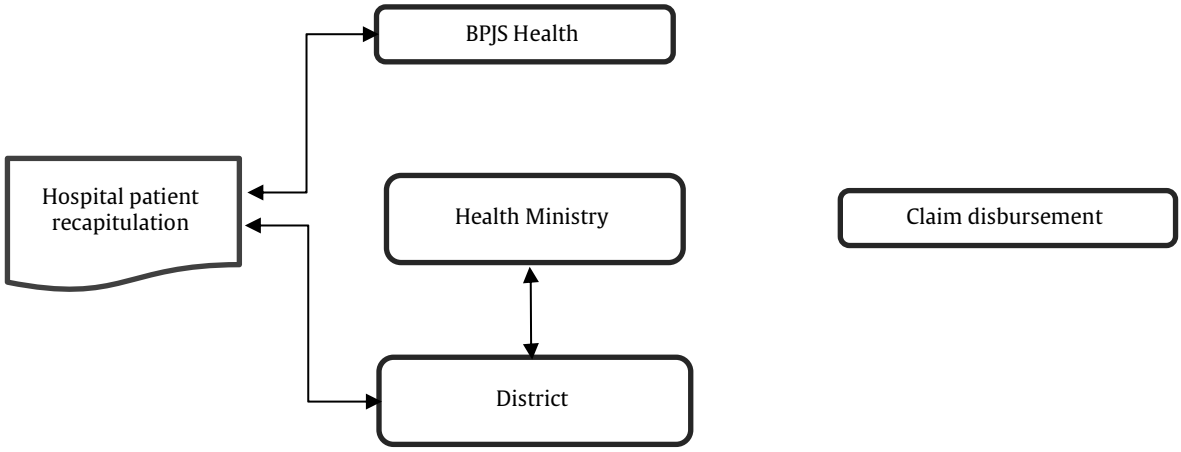

Figure 1. Flow of claim submission

BPJS Kesehatan will declare a pending/pending claim if the results of file verification contain incomplete documents/files. The hospital must make quick repairs to complete the required claim documents/files based on the results of the initial BPJS Health verification through the E-Claim application. The submission for repair of pending claims is made at most 2 (two) times with a maximum period of 14 (fourteen) working days since the hospital receives information on pending/pending claims from BPJS Health (Smith et al., 2022). Mechanisms and settlement times for pending claims that have been completed and resubmitted by the hospital are like the initial mechanism again. If the hospital has completed repairs of the claim document/file 2 (two) times, then BPJS Kesehatan declares the claim submitted by the hospital as an inappropriate claim and cannot be resubmitted by the hospital as a COVID-19 patient service claim. Claims that do not match will be resolved by a claim dispute mechanism. Hospitals that have been paid in full for each claim submission are required to update the COVID-19 report in the hospital information system online within a period of 2 (two) months after the health service is completed (Arikusnadi et al., 2020).

Claim Dispute

The dispute claim was declared based on VRR by BPJS Health from the submission of a claim for reimbursement of costs for services for COVID-19 patients submitted by the hospital. Dispute claim settlement is carried out by the provincial health office through the Provincial Dispute Claims Settlement Team (DCST) and the Ministry of Health through the Central Dispute Claims Settlement Team (DCST) in stages (Setyawan, 2015). The dispute claim settlement process is carried out by the Provincial DCST or the Central DCST for verification, data validation, and/or cross checks to hospitals, and in coordination with the local BPJS Health. The Provincial or Central DCST will notify the lack of claims for reimbursement of COVID-19 patient service fees within 14 (fourteen) working days to the hospital (BPJS Kesehatan, 2019). Hospital clarification must fulfill data/documents no later than 10 (ten) working days after receiving notification of lack of fulfillment of requirements from the Provincial DCST or Central DCST. The fulfillment of the required supporting data is submitted online through the E-Claim application(Spence et al., 2022).

Appropriate claims will be paid by the Ministry of Health with a copy to BPJS Health and non-conforming claims will be followed up by the Central DCST. The Central DCST resolves dispute claims within 14 (fourteen) working days from receipt of dispute claims through the COVID-19 dispute application of the Directorate General of Health Services(EP, 2018). The result of the decision of the Central DCST is the final decision in the settlement of dispute claims.

DISCUSSION

In general, the implementation of claims for reimbursement of services for COVID-19 patients is carried out based on the Decree of the Minister of Health Number HK.01.07/MENKES/5673/2021 concerning Technical Instructions for Claims for Reimbursement of Costs for Patient Services for Coronavirus Disease 2019 (COVID-19). In the process of submitting a claim, it is carried out by the hospital through BPJS Health, the Ministry of Health, and the Regional / Regency / City Health Office (Ettinger et al., 2022). Hospitals that can apply have special requirements to be able to cooperate in financing health services. Hospitals that collaborate with BPJS Health are required to have national and international accreditation certificates.

The financing of COVID-19 services is carried out using a prospective method, meaning that the payment method is based on services that have been provided to patients with the amount of the fee already known before health services are provided. This payment method uses case-mix or case-based payment in grouping the types of diagnoses and procedures regarding similar/same clinical characteristics using the software grouper. WHO issued COVID-19 coding instructions on March 25, 2020, with the code U.07.1 which is virus identified and U.07.2 for viruses not identified such as clinically-epidemiologically diagnosed COVID-19, probable, and suspected (WHO). In the Decree of the Minister of Health Number HK.01.07/MENKES/5673/2021, coding for COVID-19 with treatment time from January 28, 2020, to September 30, 2021, the main diagnosis of suspected/probable COVID-19 patients using coding Z03.8, namely observation for other suspected disease. Meanwhile, for patients with a confirmed diagnosis of COVID-19 using coding B34.2, namely coronavirus infection, unspecified. Up to code U.07. 1 is not used and is equivalent to B.34.2. Patients since October 1, 2021 have used the coding of patients with suspected COVID-19 and confirmed COVID-19 with coding issued by WHO. The coding of actions/procedures given to patients is following the 2010 adjusted ICD 9 CM. Research conducted by Ni Wayan et al (2020) The cause of returning BPJS claim files in determining a diagnosis of 90.6% is due to coding difficulties and there are differences in perception between hospital verifiers and BPJS Health.

Files for filing claims are done collectively and can be submitted a maximum of 2 (two) times in the same month as submission. Files are submitted by completing the documents for each activity and the requirements for establishing a diagnosis. The patient's condition was carried out according to the patient's symptom category, namely mild and moderate/severe symptoms. The condition of the patient's symptoms is adjusted to the care the patient needs in treatment, so all forms of examination and action must be written and proven in the BPJS health claim submission file. The most important thing in submitting a patient financing claim is the patient's medical resume record which must comply with the coding provisions, diagnosis enforcement, actions/procedures, and approval signed by the Patient's Responsible Doctor (An et al., 2022).

Verification is carried out administratively to test the truth, validation, and accuracy of claims submitted by health facilities. This administration should not be an obstacle in providing health services during this pandemic. Priority in the resilience of national health insurance in addition to finance is a quality problem, which can reduce mortality. However, administratively the claim verification system still has problems in the process of disbursing claims for reimbursement for COVID-19 services at this time (Treitler et al., 2022).

The administrative process due to incomplete and incompatible files in filling out documents in the application resulted in a dispute claim. Criteria for dispute claims include: identity does not match the provisions, criteria for COVID-19 insurance participants do not comply with regulations, PCR swab laboratory supporting examinations, no routine blood tests and no X-ray results, isolation management is not following COVID-19 prevention and control guidelines (Hare et al., 2020). , incomplete files, coding the main diagnosis wrong with comorbid diagnoses, comorbid diagnoses not following the provisions, hospitalization being carried out outside the isolation room, and the use of the E-claim application (Wong et al., 2022). The verifier's ability to use applications and coding is very limited. The competence of hospital verifiers, the ministry of health, and the province which is still inadequate to comply with the technical instructions for cost claims is an essential problem that must be corrected (Choi et al., 2021).

The provision of claim applications used is very diverse. There are at least 3 (three) applications used, namely E-Claim, V-Claim, and dispute application. This causes a double claim made by the hospital due to incorrect input in the application. The use of the device resulted in the verifier team needing to re-socialize the application users. Errors in using the application lead to incorrectly addressed and irreplaceable claims (van Kessel et al., 2022). To minimize the occurrence of errors in the use of applications is to use a data center that is managed in big data. In the new normal era, hospitals need to rearrange health services to transform to digital. Digital transformation is needed to support seamless health services (Hsu, 2022).

CONCLUSIONS AND SUGGESTIONS

Reflected in the flow described in the regulations, the results of the verification must be returned to the hospital for agreement. The relationship between the mechanism for submitting claims for reimbursement for COVID-19 services is very complicated. And this is what causes a claim dispute and the possibility of passing the allotted time. This is what causes the BPJS file to be unclaimed. The use of claims applications that are not in one platform, namely between E-claims, V-claims, disputes, and the health information system in hospitals causes hospital staff to do the same thing but on a different application. The incompleteness of documents that do not match is an obstacle to claiming BPJS fees by hospitals to identify coding, and guarantee criteria according to the needs determined by BPJS Health.

The use of one application that is integrated and complementary. The roles of Civil administration, BPJS Health, Ministry of Health and Hospital Information Systems are united on the same platform. Applications that cover nationally must be supported by adequate servers and databases / support and have secure security. Improving the ability/competence of the ministry of health verifier team, hospital verifier, BPJS verifier and regional verifier. And there is socialization or technical guidance (what and how) regarding claims regulations, procedures and mechanisms for submitting claims.

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