IDENTIFICATION PENDING CLAIM OF HEALTHCARE AND SOCIAL SECURITY AGENCY INSURANCE AT NIRMALA SURI HOSPITAL

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ARTICLE INFO **ABSTRACT**

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A pending claim is a claim that is returned by the BPJS (Social Security Administering Agency) Health verifier to the hospital for revision which can later be resubmitted. This study aims to determine the causes of pending BPJS claims for inpatients at Nirmala Suri Sukoharjo Hospital in 2020.
This study is a descriptive study, with a retrospective approach. Samples of 685 claims are pending with the saturated sample technique. The research instrument was in the form of observation guidelines and interview guidelines. Data processing with classification, editing, and presentation of data in text form. Data processing with data analysis is done descriptively.
The implementation of BPJS patient claims at the Nirmala Suri Sukoharjo Hospital has been implemented and has implemented the existing SPO (Standard Operating Procedures). There are 14 classifications of pending BPJS claims for inpatients at Nirmala Suri Sukoharjo Hospital. The causes of pending BPJS claims for inpatients at the Nirmala Suri Sukoharjo Hospital in 2020 include: completeness of medical record documents, clarity of doctor's writing, and application system updates.
Coordinate with related units such as medical records and registration units, inpatient installations, emergency units, cashier units, and pharmacy installations regarding matters that affect pending claims so that they do not happen again. It is better if the coder requires updating the latest knowledge and rules related to coding rules or BPJS Health rules and it takes the accuracy of the coder and grouper in the coding and input process.

KEYWORDS	*Pending Claim, BPJS, coding*

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INTRODUCTION

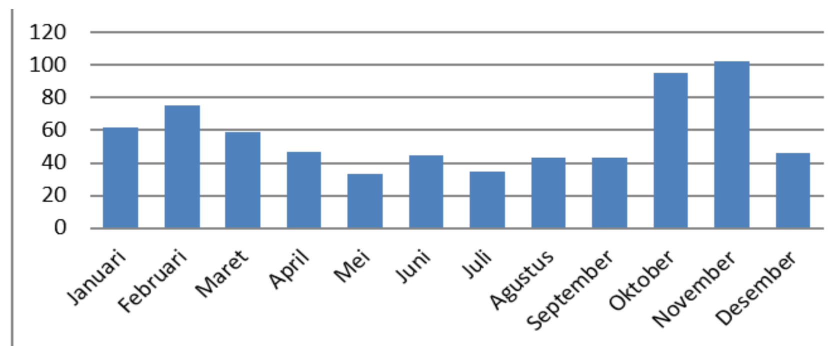
Health financing is an important part in the implementation of national health insurance. One of the health financing systems used in health care institutions is the prospective payment system, which is a method of payment made for health services whose amount is known before health services are provided. The prospective payment method in Indonesia is known as casemix (case base payment). The casemix system is a grouping of diagnoses and actions with reference to clinical characteristics that are similar or the same and the use of resources or treatment costs that are similar or the same, the grouping is done using the software grouper (PMK No. 27 of 2014).

BPJS Health claims are submissions for the treatment of BPJS participants by the hospital to BPJS Health, carried out collectively and billed to BPJS Health every month (Ardhitya, 2015). BPJS Kesehatan is a legal entity formed to organize a health insurance program, one of which is in charge of paying claims submitted by advanced level referral health facilities based on disease codes according to WHO ICD-10 and medical action codes according to ICD-9-CM according to INA- CBGs. The definition of INA-CBGs is a payment system with a package system, based on the patient's disease. The diagnostic codes and medical procedures are grouped using the INA-CBGs software by the medical record officer to determine the tariff. Based on the Decree of the Minister of Health of the Republic of Indonesia No. 55 of 2013 concerning the Implementation of Medical Recorder Jobs, that medical recorders have the authority to implement a clinical classification system and codification of diseases related to health and medical actions in accordance with medical terminology.

The results of research conducted by previous researchers regarding the Analysis of Claims Payment Delays in the Vedika System of the Health Social Security Administering Body at Nur Hidayah Hospital Yogyakarta with a total of 23 pending inpatient claims each month or 7% of all submitted files. The percentage of pending claims on the BPJS Health vedika system at Nur Hidayah Hospital reaches 7% of files returned. The causative factor is the percentage of inaccurate coding 43%, incomplete files 23% and the diagnosis does not match the criteria 34%. Efforts were made to provide coding training assignments, approach the DPJP and disseminate information to all sections directly involved in treating patients. This is caused by several factors including coder knowledge, completeness of medical supporting information, use of abbreviations and diagnostic legibility (Rohman, et al, 2017). Nirmala Suri Sukoharjo Hospital provides inpatient services for general patients and BPJS. In collaboration with BPJS since the beginning of the National Health Insurance program in 2014. Based on the results of a preliminary survey conducted with observations and interviews in the Casemix section of the Nirmala Suri Sukoharjo Hospital, researchers obtained data on the number of BPJS inpatients at the Nirmala Suri Sukoharjo Hospital in 2020 and the number of BPJS claims for inpatients who are pending monthly from January to December.

Based on the data above, pending BPJS claims for inpatients at Nirmala Suri Sukoharjo Hospital in 2020 occurred every month, as many as 685 pending claims (12.56%) of the 5,451

BPJS claims for inpatients submitted that year. The data can be seen in more detail in the following figure:



Source: Data from Casemix Hospital Nirmala Suri Sukoharjo, 2020

Based on interviews with claims officers in the casemix section, it is known that pending BPJS claims will have an impact on reducing hospital cash inflow. The accuracy of BPJS claims is the submission of the cost of treating BPJS participants by the hospital to the BPJS health which is carried out collectively and billed to the BPJS health every month no later than the 10th of the following month. If at the time of filing BPJS claims there are often pending claims, it can have an impact on hospital revenues.

RESEARCH METHOD

The type of research used in this research is descriptive research. This study describes the causes of pending BPJS claims for inpatients at Nirmala Suri Sukoharjo Hospital in 2020. The variables used in this study include Implementation of BPJS claims for inpatients, Classification of pending BPJS claims for inpatients, Factors causing pending BPJS claims for inpatients and Efforts to settle pending BPJS claims for inpatients. Samples were taken from the entire population, namely the total number of BPJS claims for inpatients who were pending in 2020 at the Nirmala Suri Sukoharjo Hospital with a total of 685 claims. Observations were made through direct observations on the implementation of BPJS claims for inpatients in the Casemix section at Nirmala Suri Sukoharjo Hospital. Interviews were conducted with the head of the Cesemix section and BPJS claims officers for inpatients at Nirmala Suri Sukoharjo Hospital regarding the implementation of BPJS claims for inpatients, classification of pending BPJS claims for inpatients, factors causing pending BPJS claims for inpatients, efforts to resolve pending BPJS claims for patients hospitalization at Nirmala Suri Sukoharjo Hospital in 2020.

RESULT AND DISCUSSION

A. Classification of Pending BPJS Claims for Inpatients

1. Coding

   BPJS claims for inpatients who are pending at the Nirmala Suri Sukoharjo Hospital in 2020 with coding classifications amounted to 231 claims out of a total of 685 pending claims. Based on the research, the following results and amounts were obtained :

Table 1 Classification of Pending Claims Coding

No	Result	Amount
1.	Coding for spontaneous parturition with the help of the code O83.9	98
2.	Coding for curettage action 69.02	19
3.	Code Z03.8 because the diagnosis has not been established	20
5.	The diagnosis of heart failure has signs of pulmonary oedema using the code I50.1	13
6.	Coding combination code for HT with ARF and CHF which is I13.2	19
7.	Coding for multiple births, babies born are coded only 1	2
8.	Coding for the main diagnosis in accordance with the resume and support or focus of treatment	30
9.	The CKD is because DM uses code E11.2	24
	TOTAL	231

Permenkes No. 27 of 2014, coding is the activity of providing codes for primary and secondary diagnoses in accordance with ICD-10 and providing procedure codes in accordance with ICD-9-CM. Coding is very decisive in the prospective financing system which will determine the amount of fees paid to the hospital. The source of data for coding comes from medical records, namely data on diagnoses and actions or procedures contained in the patient's medical resume. The accuracy of coding diagnosis and procedures greatly affects the grouper results in the application of INA-CBGs (PMK No. 27 of 2014).

The coding classification at Nirmala Suri Sukoharjo Hospital there are 231 claims out of a total of 685 pending claims during 2020. The most cases occurred in the coding statement for spontaneous parturition with the help of the code O83.9 as many as 98 claims explaining the code O83.9 for spontaneous parturition with the help of the code O83.9 Assisted single delivery, unspecified which means single delivery with unspecified assistance, previously the hospital proposed the code O83.8 Other specified assisted single delivery which means single delivery with other specified assistance, case coding for curettage explains the correct code is 69.02 Dilation and curettage following delivery or abortion because the 4th character is lacking, the code previously submitted is code 69.0 Dilation and curettage of uterus. For the case of coding code Z03.8 because the diagnosis has not been confirmed, it explains that if the diagnosis is not established or is still suspect, then use the code Z03.8 Observation for other suspected diseases and conditions. For cases where skin biopsy results are coded 86.11, if the patient's file contains skin biopsy results, the code 86.11 Biopsy of skin and subcutaneous tissue is added. In the case of a heart failure diagnosis, if there are signs of pulmonary oedema, the code I50.1 Left ventricular failure is used, the code previously proposed was I50.9 Heart failure, unspecified.

In the case of coding, there is a combined code for HT with ARF and CHF, namely I13.2, explaining that the code for the diagnosis of hypertension with ARF and CHF can be coded with the combination code I13.2. Hypertensive heart and renal disease with both (congestive) heart failure and renal failure. For the case of multiple birth coding, babies born who were coded only 1 were coded for healthy twins, only one was not coded for both. For cases of coding, the main diagnosis is in accordance with the resume and the supporting or treatment focus explains the coded diagnosis must be in accordance with the state of the resume and the results of the examination or treatment given. For the case of CKD due to DM using the code E11.2, if the diagnosis of CKD is caused by DM, it is coded E11.2 Non-insulin-dependent diabetes mellitus with renal complications. The results of this study are in line with research conducted by (Amir et al, 2020) in his research on the Identification of Causes for Returning Inpatient BPJS Claims at the Bahteramas Regional General Hospital, Southeast Sulawesi Province in 2020. In the results of the study, if there is an error in the coding process, the effect is direct. to BPJS claims. Usually the claims submitted are not claimed or may not be paid. There can be an incorrect claim rate, which has an impact on the hospital's profit and loss.

2. Completeness of Diagnostic Support

The classification of completeness supporting the diagnosis is 181 claims out of a total of 685 pending claims.

Table 2 Completeness of Diagnostic Support

No	**Result**	Amount
1.	AFI examination results for the enforcement of Oligohydramnios	17
2.	PA examination results for cancer enforcement	2
3.	Blood test results for the establishment of Epistaxis	1
4.	Urine test results for UTI	18
5.	ECG results for heart failure	32
6.	Spirometry test results for COPD	14
7.	Litmus test results for KPD enforcement	30
8.	Results of blood tests for the establishment of sepsis	3
9.	Pneumonia blood test results	7
10.	Treatment for diagnosis	56
11.	Management at DPJP	2
	TOTAL	181

Supporting reports are an important requirement in submitting BPJS claims. Thus, patients who perform supporting services must be included or attached with evidence of supporting reports so that the range of additional costs that must be billed to the BPJS can be seen. The incompleteness of patient support reports in the requirements for submitting BPJS claims for inpatients will result in the BPJS verifier asking for completeness by returning BPJS claims (Linda and Rita, 2016).

In the classification of the completeness of diagnostic support, there are 181 claims out of a total of 685 pending claims during 2020. Most of the cases occurred in the treatment information for the diagnosis as many as 56 claims explained that the BPJS verifier asked for confirmation of several diagnoses in the patient, so therapy or drug administration was given at most. by the doctor to focus on which diagnosis. For the management of the DPJP, the diagnosis and services provided are focused on the service provider or specialist doctor in charge of the patient. For other information on the

classification, the results of supporting examinations are used to establish a diagnosis. For example, in the case of completeness of supporting diagnoses, cases of completeness of supporting the diagnosis of PROM or premature rupture of membranes are asked to add by showing the results of the red litmus test. If the amniotic fluid comes out, the paper will turn blue, which can confirm the diagnosis of PROM. The results of this study are in line with research that has been carried out by (Amir et al, 2020) in their research on the Identification of Causes for Returning Inpatient BPJS Claim Files at the Bahteramas Regional General Hospital, Southeast Sulawesi Province in 2020. In filing a claim at the Bahteramas Hospital it was found that there was no report support. In addition to supporting reports, the absence of a therapeutic protocol at diagnosis also affects the return of the claim file.

3. Readmission

The classification of readmission is 145 claims out of a total of 685 pending claims.

Table 3 Readmission

No	Result	Amount
1.	Indicated readmission	145
	TOTAL	145

Readmission is that in a certain period the patient gets inpatient health services at the hospital more than once. In the readmission classification, there are 145 claims out of a total of 685 pending claims during 2020. Readmisi occurs if one patient in one month experiences 2 inpatient services at the hospital with the same or different diagnosis from the BPJS verifier asking for confirmation of the 2 claims submitted at one month with the same patient identity. The results of this study are in line with research conducted by (Linda and Rita, 2016) in their research on the Factors Causing Return of Files for Claims Requirements for BPJS Inpatients at PKU Muhammadiyah Hospital Yogyakarta. complete, it is known that the items that cause the BPJS claim to be returned are, among others, Treatment Class, SEP Number, Date of Entry, Primary Diagnosis, Secondary Diagnosis, Procedure, and INA CBG's.

4. Confirm diagnosis

The classification of Confirm diagnosis is 50 claims out of a total of 685 pending claims.

Table 4 Confirm diagnosis

No	Result	Amount
1.	Confirm diagnosis	50
	TOTAL	50

According to Permenkes No. 27 of 2014 the main diagnostic criteria is the final diagnosis chosen by the doctor on the last day of treatment with the criteria for using the most resources or the longest day of care. Secondary Diagnosis is a diagnosis that accompanies the main diagnosis at the time of admission or that occurs during an episode of care. Errors in diagnosis can lead to claim disputes that affect the claim process. Errors in diagnosis can lead to pending claims that affect the claim process (Permenkes No. 27 of 2014).

In the classification of confirmation of the main diagnosis, there are 50 claims out of a total of 685 pending claims during 2020, which means that the BPJS verifier asks for confirmation whether the secondary diagnosis is also the primary diagnosis, if so, it can be coded with one code or a combination code. If not, then the primary and secondary

diagnoses are coded separately. The results of this study are in line with research conducted by (Linda and Rita, 2016) in their research on the Factors Causing Return of Files for Claims Requirements for BPJS Inpatients at PKU Muhammadiyah Hospital Yogyakarta. complete, it is known that the items that cause the BPJS claim to be returned are, among others, Treatment Class, SEP Number, Date of Entry, Primary Diagnosis, Secondary Diagnosis, Procedure, and INA CBG's.

5. Confirm the baby is billed class 3
   The classification of confirm the baby is billed class 3 is 28 claims out of a total of 685 pending claims.

Table 5 Confirm the baby is billed class 3

No	Result	Amount
1.	Healthy sectio caesarea baby billed for class 3	18
2.	Babies treated non-class paid class 3	10
	TOTAL	28

BPJS Health claims are submissions for the treatment of BPJS participants by the hospital to BPJS Health, carried out collectively and billed to BPJS Health every month (Ardhitya, 2015). The payment system made by BPJS Kesehatan to FKRTL is in the form of Indonesia Case Base Groups' Tariffs (INA-CBGs). Indonesian-Case Based Groups Tariff, hereinafter referred to as INA-CBGs Tariff, is the amount of claim payment by BPJS Health to FKRLT for service packages based on grouping of disease diagnoses and procedures (PMK No. 52 of 2016). BPJS care class is a class of patients in obtaining health services with different contributions, benefits, and room facilities.

In the confirmation classification of babies billed for class 3, there are 28 claims out of a total of 685 pending claims during 2020. This classification of babies who are billed for class 3 occurs when the baby at registration is given class 3 while the mother has a nursing class not class 3, the baby should have an inpatient class following his mother. The results of this study are in line with research conducted by (Linda and Rita, 2016) in their research on the Factors Causing Return of Files for Claims Requirements for BPJS Inpatients at PKU Muhammadiyah Hospital Yogyakarta. complete, it is known that the items that cause the BPJS claim to be returned are, among others, Treatment Class, SEP Number, Date of Entry, Primary Diagnosis, Secondary Diagnosis, Procedure, and INA CBG's

6. Indications of completion and referrals
   The classification of Indications of completion and referrals is 8 claims out of a total of 685 pending claims.

Table 6 Indications of completion and referrals

No	Result	Amount
1.	Indications for hospitalization and referral have not been listed on the resume	8
	TOTAL	8

In the classification of indications for referral and indications for hospitalization, there are 8 claims out of a total of 685 pending claims during 2020. Indications for referral and indications for hospitalization occur if they are not listed on the resume, which means the Doctor in Charge of the Patient has not written the indication for referral and indication for hospitalization on the patient resume sheet. The results of this study are

in line with research conducted by (Irmawati et al, 2018) in their research on the Causes of Returning Claims Files by the Social Security Administering Body (BPJS) for Inpatients. often do not check service evidence that includes diagnoses and procedures before inputting INA-CBGs data, resulting in incomplete patient care supporting files.

7. Resume is not clear

   The classification of Resume is not clear is 17 claims out of a total of 685 pending claims.

Table 7 Resume is not clear

No	Result	Amount
1.	Resume is not clear	17
	TOTAL	17

A medical resume is a summary of the course of a patient's illness who is sent home by DPJP and given when he returns home. The medical resume is prepared by the DPJP in accordance with the format applicable at the hospital. The patient's medical resume is one of the requirements in submitting BPJS claims for inpatients. When the officer scans the patient's medical resume file, it is seen again that the writing has been read clearly or not so that the verifier has no difficulty in reading.

In the unclear resume classification, there are 17 claims out of a total of 685 pending claims during 2020. An unclear resume means that the readability of the writing on the resume is less legible or the scanned resume sheet is unclear. The results of this study are in line with research conducted by (Irmawati et al., 2018) in their research on the Causes of Returning Claims Files by the Social Security Administering Body (BPJS) for Inpatients. diagnosis resulting in incomplete patient care support files.

8. Traffic Accident Cases

   The classification of Traffic Accident Cases is 6 claims out of a total of 685 pending claims.

Table 8 Traffic Accident Cases

No	Result	Amount
1.	Traffic accident cases unchecked	4
2.	Traffic accident cases have not entered the verification data	2
	TOTAL	6

In the classification of traffic accident cases, there are 6 claims out of a total of 685 pending claims during 2020. Traffic Accidents have not been checked, which means that there is no police report showing the case was a traffic accident. For cases of traffic accidents, verification data has not been entered, which means that the claim officer is asked to confirm with the raharja service because the data has not been verified and usually experience delays due to the case processing process. The results of this study are in line with research conducted by (Irmawati et al., 2018) in their research on the Causes of Returning Claims Files by the Social Security Administering Body (BPJS) for Inpatients. often do not check the evidence of services that include diagnoses and procedures before inputting INA-CBGs data, resulting in incomplete patient care supporting files.

9. SEP data

   The classification of SEP data is 4 claims out of a total of 685 pending claims.

Table 9 SEP data

No	Result	Amount
1.	SEP file is not in the attachment	1

2.	Incorrect treatment class, diSEP 2 ditxt 3	1
3.	The SEP date is different from the patient's date of admission	1
4.	The way the patient goes home is not appropriate, the SEP died in the txt with the doctor's approval	1
	TOTAL	4

In the classification of SEP data, there are 4 claims out of a total of 685 pending claims during 2020. SEP data errors such as the SEP file do not exist because the SEP file has not been scanned, the class of care does not match in SEP 2 in the txt 3 and the way the patient goes home is not appropriate, the SEP dies at above the doctor's approval because the officer entered incorrectly in the application system, the SEP date is different from the patient's entry date, this occurs because the BPJS membership active status on the patient's entry date is not active and is active again the next day, the SEP date printed is different from the patient's entry date. The results of this study are in line with research conducted by (Linda and Rita, 2016) in their research on the Factors Causing Return of Files for Claims Requirements for BPJS Inpatients at PKU Muhammadiyah Hospital Yogyakarta. complete, it is known that the items that cause the BPJS claim to be returned are, among others, Treatment Class, SEP Number, Date of Entry, Primary Diagnosis, Secondary Diagnosis, Procedure, and INA CBG's.

10. Coinciding with other hospitals
    The classification of Coinciding with other hospitals is 2 claims out of a total of 685 pending claims.

Table 10 Coinciding with other hospitals

No	Result	Amount
1.	Coinciding with other hospitals	2
	TOTAL	2

In the concurrent classification with other hospitals, there are 2 claims out of a total of 685 pending claims during 2020. The concurrent intersection with other hospitals is if the patient on the same day gets service at the hospital then is referred and gets service at another hospital on the same day. same. The results of this study are in line with research conducted by (Irmawati et al., 2018) in their research on the Causes of Returning Claims Files by the Social Security Administering Body (BPJS) for Inpatients. often do not check the evidence of services that include diagnoses and procedures before inputting INA-CBGs data, resulting in incomplete patient care supporting files.

11. The Softfile Doesn't Exist Yet
    The classification of The softfile doesn't exist yet is 3 claims out of a total of 685 pending claims.

Table 11 The softfile doesn't exist yet

No	Result	Amount
1.	The softfile doesn't exist yet	1
2.	The scanned support file is not complete	2
	TOTAL	3

In submitting BPJS claims, patients are required to submit online which includes softfile files. In the classification of the softfile file, there are no 3 claims out of a total of

685 pending claims during 2020. It is incomplete if the softfile actually exists but the file does not exist on that date but is entered in the file on another date. The results of this study are in line with research conducted by (Irmawati et al., 2018) in their research on the Causes of Returning Claims Files by the Social Security Administering Body (BPJS) for Inpatients. diagnosis resulting in incomplete patient care support files.

12. Chronology of events

The classification of chronology of events is 2 claims out of a total of 685 pending claims.

Table 12 Chronology of events

No	Result	Amount
1.	Self-harm or not	1
2.	Confirm the race in the patient's work or not	1
	TOTAL	2

In the chronological classification of events, there are 2 claims out of a total of 685 pending claims during 2020. The chronology of events from the BPJS verifier asked to ensure that the incident experienced was an act of self-harm. . The results of this study are in line with research conducted by (Irmawati et al., 2018) in their research on the Causes of Returning Claims Files by the Social Security Administering Body (BPJS) for Inpatients. often do not check the evidence of services that include diagnoses and procedures before inputting INA-CBGs data, resulting in incomplete patient care supporting files.

13. Confirm the patient goes home

The classification of confirm the patient goes home is 2 claims out of a total of 685 pending claims.

Table 13 Confirm the patient goes home

No	Result	Amount
1.	Check the patient's discharge date	1
2.	Confirm the return time is more than 6 hours or not	1
	TOTAL	2

In the confirmation classification of patients going home, there are 2 claims out of a total of 685 pending claims during 2020. Confirmation of patients going home occurs if the date of entry and exit of the patient shows less than 6 hours, it means that the patient has received outpatient services, if more than 6 hours, the patient gets service inpatient. The results of this study are in line with research conducted by (Irmawati et al., 2018) in their research on the Causes of Returning Claims Files by the Social Security Administering Body (BPJS) for Inpatients. often do not check the evidence of services that include diagnoses and procedures before inputting INA-CBGs data, resulting in incomplete patient care supporting files.

14. Confirm gestational age

The classification of Confirm gestational age is 6 claims out of a total of 685 pending claims.

Table 14 Confirm gestational age

No	Result	Amount
1.	Confirm gestational age	6
	TOTAL	6

In the classification of confirmation of gestational age, there are 6 claims out of a total of 685 pending claims during 2020. Confirmation of gestational age from the BPJS verifier asks how old the patient is to confirm the diagnosis and the accuracy of the code. The results of this study are in line with research conducted by (Irmawati et al, 2018) in their research on the Causes of Returning Claims Files by the Social Security Administering Body (BPJS) for Inpatients. often do not check service evidence that includes diagnoses and procedures before inputting INA-CBGs data, resulting in incomplete patient care supporting files.

B. Factors Causing Pending Claims BPJS Inpatients

Pending claims are claims that are returned by the BPJS Kesehatan verifier to the hospital for revision which can later be re-submitted. Factors causing the pending claims of BPJS inpatients at Nirmala Suri Sukoharjo Hospital in 2020 include:

1. Diagnostic support equipment

Patient Support Report is a report on the results of additional services for patients who perform additional services. If the supporting report does not exist or is incomplete in submitting the BPJS claim requirements to the BPJS verifier, it will be returned to be completed or attached. Lack of Support Sheets will affect the validity of billing and calculation of patient care costs because the supporting sheet is proof that the patient has performed additional services (Linda and Rita, 2016).

The factor causing the pending BPJS claims for inpatients at the Nirmala Suri Sukoharjo Hospital in 2020 regarding the completeness of supporting diagnoses is because in the patient's medical record file, the results of the diagnostic supporting examination are not available. So it is in accordance with the statement (Santiasih et al, 2021) in his research regarding the Analysis of the Causes of Pending BPJS Health Inpatient Claims at Dr. RM Djoelham Binjai Hospital that the pending claims of BPJS inpatients occur due to incompatibility or incomplete filling of items in filling out medical records. patients, such as a discrepancy between the diagnosis and the medical resume, then the therapy given is not in accordance with the existing diagnosis that has been made by the doctor in charge of the patient regarding the completeness of the claim file between the hospital's internal verifier and the BPJS Health verifier also affects pending claims.

2. The doctor's writing is not clearly legible

Coding is the activity of providing codes for primary and secondary diagnoses according to ICD-10 and providing procedure codes according to ICD-9-CM. Coding is very decisive in the prospective financing system which will determine the amount of fees paid to the hospital. The source of data for coding comes from medical records, namely diagnosis and action/procedure data contained in the patient's medical resume. The accuracy of coding diagnosis and procedures greatly affects the grouper results in the application of INA-CBGs (PMK No. 27 of 2014).

The factor causing the pending BPJS claims for inpatients at the Nirmala Suri Sukoharjo Hospital in 2020 regarding doctors who are not clearly legible causes the coder to not be able to read the writing on the patient's resume sheet so that it can

result in giving a diagnosis or action code. So in accordance with the statement (Nurmalinda, 2017) in his research regarding the Evaluation of the Inaccuracy Level of Giving Diagnostic Codes and Causing Factors at Hospital X East Java, the causative factors include the readability of the diagnosis. Doctors as medical record makers must establish a clear diagnosis. However, at X Hospital, East Java, 214 inpatient medical record files were still unreadable.

3. App system update

   INA-CBGs is one of the patient data entry tools used to group rates based on data from medical resumes. The INA-CBGs application is one of the patient data entry tools used to group rates based on data from medical resumes. The INA-CBGs application has been installed in hospitals that serve JKN participants, which is used for JKN is INA-CBGs 4.0. To use the INA-CBGs application, hospitals must have a hospital registration code issued by the Directorate General of Health Efforts, then the INA-CBGs software will be activated for each hospital according to the hospital class and regionalization (PMK No. 27 of 2014).

   Factors causing pending BPJS claims for inpatients at Nirmala Suri Sukoharjo Hospital in 2020 regarding slow application system updates to submit claims online and the system experiencing errors can cause input errors in the claim process. So according to the statement (Enoch and Kuswanto, 2020) in his research regarding the Analysis of the Causes of Pending BPJS Health Claims at the Bhayangkara Hospital Yogyakarta, it was found that the pending claim factor based on the machine factor was the infrastructure used in BPJS claims, such as computers, both seen from hardware and software.

C. Efforts to Resolve Pending Claims of BPJS Inpatients

Efforts to settle pending BPJS claims for inpatients in 2020 at the Casemix Section of the Nirmala Suri Sukoharjo Hospital have revised what needs to be repaired and reviewed according to the existing SPO seen from the minutes of the agreement then for matters that need to be confirmed back to service providers or related units. So in accordance with the statement (Santiasih et al, 2021) in his research regarding the Analysis of the Pending Causes of BPJS Health Inpatient Claims at Dr. RM Djoelham Binjai Hospital, it was found that the efforts made by the Hospital regarding the problem of returning the inpatient claim file BPJS Health carried out an evaluation to reduce the incidence of incompleteness claim file, starting from always communicating all existing problems and coordinating from each related section and improving the performance of each section, following regulations properly and also reminding each other.

The officers are guided and have implemented the SOP for filing a revised claim for BPJS Health. SPO regarding submission of BPJS Health revised claims with No. document 007/SPO/RSNS/I/2022 as follows:

1. Casemix Officers receive Minutes of Handover (BAST), Minutes of Verification Results (BAHV), and Minutes of Return, as well as Excel Recapitulation of revised claim files.
2. The Casemix officer reviews the Excel Recapitulation which contains the revised claim data.
3. Casemix officers review the revised claim file both outpatient and inpatient. The claim file review is adjusted to the physical examination and supporting examination.
4. Casemix officers provide confirmation answers regarding the revised claim in the Excel file in the RS confirmation column.
5. The process of re-submission on the E-claim application:

a. Casemix officers open a revised claim on the E-claim application according to the patient's SEP number or RM number.
b. Casemix Officer performs “Claim Re-edit”.
c. If there is no coding change in the diagnosis and or action, the casemix officer will regroup.
d. If there is a coding change in the diagnosis and or action, then the coding is changed first and then regrouped.
e. Casemix officers re-finalize and send online all claim files both outpatient and inpatient.

6. The Casemix officer completes the lack of documents that support the response to the confirmation of the claim revision.
   5. Casemix officers submit and send revised claims to BPJS Health the same as the main claim submission process.

CONCLUSION

The implementation of BPJS patient claims at the Nirmala Suri Sukoharjo Hospital has been implemented and has implemented the existing SOPs. The requirements for submitting a claim at the Nirmala Suri Sukoharjo Hospital are in accordance with the Regulation of the Minister of Health of the Republic of Indonesia Number 28 of 2014. Classification of pending BPJS claims for inpatients at Nirmala Suri Sukoharjo Hospital, including: coding, supporting diagnostics, readmission, confirmation of diagnosis, confirmation of billed baby for class 3, indications for concurrent and referral, unclear resume, traffic accident cases, data SEP, concurrently with other hospitals, no softfile file, chronology of events, confirmation of patient discharge, confirmation of gestational age. Factors causing pending BPJS claims for inpatients at Nirmala Suri Sukoharjo Hospital in 2020 include completeness of medical record documents, clarity of doctor's writing, and application system updates. Efforts to settle pending BPJS claims for inpatients have revised what needs to be repaired and reviewed according to the existing SPO seen from the minutes of the agreement, then for things that need completeness, coordination and confirmation back to service providers or related units such as units medical records and registration, inpatient installation, emergency department, cashier unit, and pharmacy installation.

It is better for the officer when scanning the patient's medical resume file to review whether the writing has been read clearly or not so that the verifier has no difficulty in reading. When submitting a claim, it is better if the completeness requirements such as supporting diagnosis enforcement are completed first or given a time limit for collection from the relevant unit, so as to minimize the number of claims returned by BPJS. Coordinate with related units such as medical records and registration units, inpatient installations, emergency units, cashier units, and pharmacy installations regarding matters that affect pending claims so that they do not happen again. Coders should require updating of knowledge and the latest rules related to coding rules or BPJS Health rules and it is necessary for the coder and grouper to be thorough in the coding and input process. The hospital should make an electronic medical record so that every doctor's or professional care provider's writings can be read clearly.

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