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Analysis of Individual Characteristics of Employee's Performance at Regional Hospital dr. Soebandi Jember on the Case of BPJS Inpatient Pending Claim

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A B S T R A C T

JKN program is mandatory social health insurance for all Indonesian citizens. JKN claims are submitted monthly by the hospital to reimburse the service fee provided to its participants. Pending claims occur because the submitted claims still get confirmation from the Social Security Administrator for Health. In March–May 2021, 234 pending claims were found out of 1934 total submitted inpatient claims by RSD dr. Soebandi Jember. This incident cannot be separated from the performance of claim officers. According to Gibson's theory, performance could be influenced by individual variables. This study aims to analyze the determinants of inpatient pending claims based on individual characteristics. This research a qualitative using depth interviews, observation, and documentation. The result shows pending claims caused by an unmatched ability of coders and physicians in charge of the patients, the implementation of internal verification has not been maximized and different perceptions regarding claims regulation between coders and BPJS verifiers. To solve the problem, an in-charge officer for the completeness of medical records in each inpatient room is needed, implement one-stop administration system, increase the understanding and accuracy of coder, and communicating with BPJS to equalize claims regulation perceptions.

Kata kunci:

BPJS Kesehatan
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A B S T R A K

Program JKN merupakan asuransi kesehatan sosial yang bersifat wajib bagi seluruh penduduk Indonesia. Klaim JKN ditagihkan setiap bulan oleh rumah sakit untuk mendapatkan pergantian biaya atas pelayanan yang telah diberikan kepada pesertanya. Pending klaim terjadi akibat klaim yang telah diajukan masih mendapat konfirmasi dari BPJS Kesehatan. Jumlah pending klaim rawat inap RSD dr. Soebandi Jember pada bulan Maret-Mei 2021 ditemukan sebanyak 234 klaim (12,23%) dari total pengajuan 1914 berkas. Kejadian pending tidak terlepas dari kinerja pegawai yang terlibat dalam pengajuan klaim. Kinerja menurut teori Gibson dapat dipengaruhi oleh variabel individu. Penelitian ini bertujuan untuk menganalisis determinan kejadian pending klaim BPJS rawat inap berdasarkan variabel karakteristik individu. Jenis penelitian yaitu kualitatif dengan teknik pengumpulan data wawancara mendalam, observasi, dan dokumentasi. Hasil penelitian determinan pending klaim rawat inap disebabkan adanya ketidaksesuaian kemampuan dan keterampilan petugas koding dan DPJP, pelaksanaan verifikasi internal belum maksimal, dan terdapat perbedaan persepsi terkait regulasi klaim antara koder dengan verifikator BPJS. Upaya

perbaikan masalah tersebut yaitu perlunya penanggung jawab kelengkapan kuantitas pengisian rekam medis di setiap ruang rawat inap, penerapan sistem one stop administration, peningkatan pemahaman dan ketelitian petugas koding, melakukan komunikasi dengan BPJS untuk menyamakan persepsi regulasi klaim.

INTRODUCTION

The National Social Insurance System (SJSN) is evidence of the Indonesian government's performance in completing some basic health needs for all people and that's implemented in the National Health Insurance (JKN) program. JKN uses social health insurance mechanisms required for all Indonesian people and they contributed by paying regular contributions (Kementerian Kesehatan RI, 2014a). JKN programs are organized by Health Social Security Administrator (BPJS Kesehatan) following the law of the Republic of Indonesia number 24 of 2011 and have been operating since January 1, 2014.

The JKN Program until September 2021 has covered 226,3 million participants (83,5%) and the target cover 98% of all people, as established in National Long Term Development Plan (RPJMN) IV 2020-2024 (Bappenas, 2019). And the existence of the JKN program is expected to give the easiest way to facilitate all people to access health facilities and reduce the cost of health expenditures from their pocket (Out of Pocket). JKN is a form of Indonesia commitment as one of the member World Health Organization (WHO) to achieve Universal Health Coverage (UHC) (Baltussen et al., 2017).

Health services for the JKN participant are provided by Health Service Provider (PPK) which are divided into First-Level Health Facilities (FKTP) and Advanced Referral Health Facilities (FKRTL). The hospital as an FKRTL if corporate with BPJS Kesehatan, can submit claim bills collectively to BPJS Kesehatan to reimburse health service fee that has been provided to its participants at least on the 10th of the following month. BPJS Kesehatan should pay claim bill at least 15 days on weekdays since the complete claim document is received (Kementerian Kesehatan RI, 2014a).

The hospital before submitting a claim should complete administration requirements such as SEP (Participant Eligibility Letter), the detail of hospital bills, medical resumes, and a recapitulation of services listed in medical records, etc. Then, BPJS Kesehatan verified the claim document that has been submitted and the result of the verification is explained in Verification Result Report (BAHV). The document deemed appropriate will be approved for claims, while those whose payments are pending will be returned to the hospital for repair (BPJS Kesehatan, 2014). The result of a preliminary study at Health Service Fee Claim Management Installation (IPKBPK) RSD dr. Soebandi Jember in August 2021, according to the BAHV, there were pending claims from the BPJS verifier that need to be confirmed for both outpatient and inpatient documents for March-May 2021, which are shown in table 1:

Table 1
Pending Claim File Recapitulation RSD dr. Soebandi Jember March - May 2021

Month	Claimed Document BPJS Outpatient			Claimed Document BPJS Inpatient		
	Amount	*Pending*	%	Amount	*Pending*	%
March	3974	68	1,71%	674	97	14,39%
April	3756	82	2,18%	625	60	9,60%
May	3333	66	1,98%	615	77	12,52%
Total	**11063**	**216**	**1,95%**	**1914**	**234**	**12,23%**

Source: IPKBPK RSD dr. Soebandi Jember 2021

From the data above, total submission of BPJS claims in the service month March – May 2021 out of 11063 outpatient claims submitted, there are 216 files (1.95%) with pending claims status. Meanwhile, the total of submission inpatient claims is 1914 files with 234 documents (12.23%) still having pending claim status. It can be shown that the percentage of inpatient BPJS claims returns (pending claims) is greater than outpatient claims with the highest claims occurring in March 2021 are 14.39%.

There are several field problematic factors that are suspected to be involved in causing pending claim inpatient of BPJS such as individual characteristics in terms of the abilities and employee skills in handling the BPJS claim process. The result of an interview with one of IPKBPK's RSD dr. Soebandi Jember employee explained that there is still an incomplete claimed requirement in the item filled on the medical resume. It is supported by Viatiningsih (2018) research, the doctor does not know about the deadline to fill out the medical resume after the patient was an outpatient and the deadline for claim payment before its expired.

Based on the statement of the claims officer, the impact of the inpatient pending claimed document submitted by RSD dr. Soebandi Jember to BPJS is increasing workload, the working time for an employee exceeds the working limit, and the disbursement of claim funds is not on time. The large number of the claimed document returned by BPJS can be harmful to the hospital because it was slowed the process of claimed payment, and it will make the hospital cash flow disrupted. Harnanti, (2018) explained that the delays of claimed submission can be difficult for hospital operational

activity which are the ability of medicine, medical equipment, and the payment of employee intensive that can be impacted hospital services to the patient.

The incident of BPJS inpatient pending claim related to employee performance which can be influenced by various factors. The fluency of the submitted claim of BPJS Kesehatan in
RSD dr. Soebandi Jember is determined by employee performance in registration counter officer in making SEP, claim administration employee related with checking the completeness of the claim requirements, the coding officer who in role to determining the disease and medical procedure codification, also the activities of INA-CBGs group which determines service bill, internal verifier officer that have to verify a final claim document before being deposited to BPJS Kesehatan, besides that physician in charge of the patients (DPJP) have a role in the completeness of medical resume as also determining the accuracy of primary diagnosed and secondary diagnosed.

Gibson *et al., dalam* Priansa (2018) describe the factor that could affect performance such are individual variables, organization variables, and psychological variables. Individual variables such as the ability and skills of employees are the primary factor that influences employee performance. Meanwhile, background and demographics have a strong impact on individual performance are education and work experience. By the description above, the researchers interested to do the research with the title "Analysis of Individual Characteristics Employee Performance of RSD dr.Soebandi Jember on the Claimed Pending Incident of Inpatient BPJS"

RESEARCH METHOD

The research type that the writer used is qualitative research with the purpose of analysing individual characteristics on employee performance in RSD Dr.Soebandi Jember in an incident of pending claim of inpatient BPJS. The study of individual characteristics referring to performance theory by Gibson et al., (1985) includes the ability and the skills of employees involved in the implementation of claims submission, background, and demographics such as education and work experience.

Research Subject

The subject of this study is the employee that has a role in the implementation of inpatient claims, it consists of two patient registration officers, one physician in charge of the patients (DPJP), and IPKBPK officers consisting one of inpatient claim document administrator officer, two coding officers and INA-CBGs inpatient grouping, and one hospital internal verifier.

Data Collection

Data collection methods in this study are taken by in-depth interviews, observation, and documentation at the time of research. Data collection was carried out of 4 months starting from June – September 2022.

Data Analysis

This research uses qualitative data analysis by presenting the results of in-depth interviews, observation, and documentation. The result of data collection is presented while comparing to the theory of performance acted by the officers involved in the processing of inpatient claim submission. The officer's performance refers to individual characteristics which consist of ability and skills, background education, and work experience

FINDINGS AND DISCUSSIONS

Analysing the ability and skills performance

Performance is the work achieved by an employee while doing their task based on their skills, work, opportunity, experience, and time which is suitable with criteria and standard company (Hasibuan, 2017). Abilities and skills are the main influence on individual performance and behaviour. The ability has a definition as a characteristic from innate or can be learned well so an individual can complete their work. Meanwhile, skills are activities that are related to their task and used at the right time (Gibson et al., 1985).

It is important for an officer that involved in claim submission process have good ability and skills to prevent pending claims causing either by the incomplete requirement or there is submission that's not match with the rules of verification claims. The existence of returned claim document by BPJS Kesehatan can prejudice the hospital. Because it will slow the reimbursement process which can make the hospital's cash flow disturbed. The implementation of the claimed process from completing the requirement until being claim submitted process to BPJS Kesehatan in
RSD dr.Soebandi Jember started with patient registration until managing administration and preparing the claim document by IPKBPK.

The ability and skills of the Patient Administrate Registration Officers

Minister of Health Regulation Number 28 of 2014 explains there are some procedures that the patient should pass to get health services in Advanced Referral Health Facilities (FKRTL), which are related to the inpatient administration process to complete the admission document requirement. One of the competencies that patient administrator officers should need to have is knowing and can complete the requirements to register BPJS inpatients, and also be able to make a SEP. The admission officer at RSD dr.Soebandi Jember has understood and can request the completeness of the registration document requirements for BPJS inpatients to patients who want to get inpatient services.

There are the required administrations that must be requested by the admissions officer at the RSD dr. Soebandi Jember to patient/registrant of hospitalized BPJS patient. The required document is an ID Card/Family Card/National Health Insurance (JKN) Card, Hospitalization Warrant (SPRI) from the outpatient department or Emergency Room (IGD), and a referral letter from First-Level Healthcare Facilities if the patient transferred from outpatient care to receive inpatient services or referral letter from other hospitals if the patient referred to RSD Dr. Soebandi Jember, also addition requirement for certain cases according to the provisions of the Health Insurance program. The requirements needed for the administrative registration process are in line with

Lewiani's (2017) statement, the registration of hospitalized patient requires an ID Card/National Health Insurance (JKN) Card/Family Card, and is also accompanied by a hospitalize statement letter because these requirements used as authentic evidence of the patient whether the patient is registered member of Health Social Security Administration or not.

Admission officers in carrying out the registration process for inpatient BPJS patients in addition to having to complete patient registration requirements also require an understanding of the diagnosis that will be inputted into the v-claim application to make SEP, because there are several diagnoses and health services are not covered by Health Social Security Administrator. Based on interviews and with informants, admissions officers have understood the types of services that can be covered by Health Social Security Administrator as stipulated in the Presidential Regulation of the Republic of Indonesia No. 82 of 2018.

Obstacles encountered when researchers conducted interviews with admissions officers at RSD dr. Soebandi Jember there is still a Participant Eligibility Letter (SEP) which cannot be issued within 3x24 hours because the patient has not completed all the registration requirements for inpatient BPJS. The officer at the registration counter, if at the time of registration the patient still does not bring the complete requirements, an Information and Education Communication (KIE) will be given to take care of the completeness of the registration requirements, so that inpatients can get health services using the national health insurance program with processing time to complete all requirements no more than 3x24 hours.

The most important completeness of the claim file obtained at the registration section is a printout of the Participant Eligibility Letter (SEP) because this is one of the claims requirements that will be submitted to the Health Social Security Administrator (BPJS Kesehatan) Jember Branch office. SEP must be owned by every BPJS patient who will receive health services at the hospital as a sign that the participant is administratively a valid claim, and is an official patient guaranteed by the Social Security Administrator of Health. Participants must complete the administrative requirements for issuing SEP within 3x24 hours of working days after being hospitalized or before going home/dying/being referred if the treatment is less than 3x24 hours, and the National Health Insurance (JKN) participant card must be in an active state. If up to the specified time, the patient cannot show the identity number of the JKN participant or the registration requirements of the Health Social Security Administrator patient cannot be fulfilled, the patient is declared a general patient or switches to using other health insurance outside BPJS Kesehatan.

The ability and skill of the Inpatient Claims Requirement Administrative officer

The claim administrator officer conducted the management of claimed submission administration after the patient does the registration process and after they have finished receiving medical services. After the patient is discharged, the claim document has to be sent to Health Service Fee Claim Management Installation (IPKBPK). In this step, the complete claimed requirement becomes more complex, not only relate to the requirement document of patient registrative administration but it was included all the documents that are needed for the claim submission requirement. The transmission of claimed documents by the inpatient administration room officer to IPKBPK RSD Dr. Soebandi Jember is currently implemented in the less paper system in some of the treatment wards.

The transmission of the claimed document from wards that have implemented the less paper system consists of two types of transmission such as physical claim document (SEP, medical resume, and billing) also with online transmissions such as the result of a scanned form of inpatient employment letter, billing, and all the supportive evidence that given to patients through the "AjaXplorer" application which is an online-based storage media drive by RSD dr. Soebandi Jember. Meanwhile, if there are wards that have not implemented the less paper system, the ward admin will transmit all of the claimed requirement documents to IPKBPK. This is also related to research from Winarti dan Sukmawati (2022), inpatient administration officers in RSUD X Bandung Regency have implemented scanning claimed document requirements uploaded in Nextcloud.

The inpatient claim document administrator officers in working their duties have appropriate abilities and skills already. After the claim file is received by the IPKBPK section, the claims administration officer will check the completeness of the requirements that must be attached when submitting a claim and check the filled of the claim document following the requirement of claimed submission that needed by IPKBPK RSD dr. Soebandi Jember also refers to the guidelines of BPJS Kesehatan in 2014. The fact that founded at IPKBPK according to the informant's statement, there is still incompleteness in requirement documents that would be used for claims submission, it is shown when uploading the claim requirement document in "AjaX" application or even the document transmitted to the IPBK section from the ward after the inpatients get discharged. If there are incomplete documents, the officer will return the document to the inpatient room to be revised and completed within 3x24 hours on weekdays.

If there is an incomplete claimed document, it can cause delays in the claim management process by hospital claims officers. Although it does not affect the timeliness of submitting claim documents to BPJS Kesehatan, the incomplete claim requirement can lead to potential claim returns as there are still supporting evidence form that has not been attached when submitting this claim. Nuraini et al., (2019) explain if there is an incomplete required file, that file will be returned so it can harm the hospital because it slows down the claim payment process. It is also in line with the research from Nikmah et al., (2021) one of the caused delays in claiming document are they are not the police report sheet for the accident patient and the document about an indication of inpatient.

The ability and skills of Inpatient Coding and grouping INACBGs Officers

The implementation of the claim submission after passing the check for completeness of the files, there are case-mix coding activities and inputting claim data on the INA-CBGs application to carry out the grouping process. Where is the input of claim data and coding activities for claims submission at RSD dr. Soebandi Jember was carried out by a case-mix coding officer. The officer will input the claim data into the INA-CBGs application (e-claim version 5.6). The INA-CBGs application is a patient data entry device that is used to group claim rates based on data obtained from the medical resume.

The results of interviews and observations showed that officers had understood and were able to enter claim submission data in the INA-CBGs application but there was

still a discrepancy between data recordings entered in the e-claim and v-claim applications. The existence of inaccuracies or confirmation codes as well as discrepancies in the e-claim data recording with the v-claim is one of the causes that can lead to the return of the claim file that has been submitted.

Corresponding data recorded in the SEP with the INA-CBGs application is very important because if there is inappropriate data it will cause purification failure and pending claims will occur. The existence of a bridging system between v-claim with e-claim will reduce pending claims in participant administration caused by purification failure (Susanto, 2021). However, that statement does not apply to RSD dr. Soebandi Jember, despite this hospital already implementing the bridging system, there are still pending claims because they do not pass the purification. Therefore, the data entry officer of INA-CBGs applications needs to be careful and re-checking so there is no difference in data recorded in e-claim and v-claim so that there is no pending caused by not passed purification.

The process of coding officer in the claim submitted also has a responsibility in choosing the diagnosis code and procedure code that is appropriate for the accuracy with ICD-10 and ICD-9CM version 2010. The interview result shows there are so many discrepancies in the ability and skills of coding officers and inpatient grouping. It is supported by a revision sheet by the BPJS verificatory that there is a pending claim caused by code confirmation. The existence of a code confirmation to the coding officer happened due to:

a. Inaccuracies code determination,

Inaccuracies or inappropriate diagnosis codes and procedure codes have a big impact on the claimed process with the case-mix system (INA-CBGs). Inaccuracy code can make an incompatibility in the reimbursement cost of INA-CBGs grouping in the implementation of claims so it occurs delays in claims payment (Huffman in Widyaningrum, 2015). One of the reasons there is returned claim document to RSD Dr. Soebandi Jember is that there is an inappropriate code officer in doing the coding process and inputting the INA-CBGs system. There is a human error, which is the writing code that is inverted so the pending claim happens because the code did not match the diagnosis in the medical resume. This thing also related to Kusumawati dan Pujiyanto (2020), the inaccuracy of the code officer makes the ICD code inputted in National Casemix Center (NCC) system often exchanging, the example like an inputted code is 99.06 but actually, the code is 99.60.

b. There are differences in understanding perception of implementing the coding rules,

The returned claim document based on the aspect of coding can be caused by differences in perception between BPJS Kesehatan verifier with the coder officer in a healthcare facility. Sulaimana et al., (2019) stated that the returned claim document happened because there are different perceptions between the BPJS verifier with the coders regarding the interpretation of the applicable rules of coding, which caused disagreements of code. The different perceptions in RSD dr.Soebandi Jember happened because there is a misunderstanding of the coding rules by the use of additional code, combination codes, and omit codes.

c. Removal code request,

The BPJS verifier can confirm regarding unmatched disease code and the procedure code given by the coder to have an explanation of the evidence against the claim being billed. The code removal request can be caused by a mismatch code that is inputted into the INA-CBGs application with the resource and supporting evidence. Inputted diagnoses in the submitted claim should be the diagnoses that clinical and recorded in the patient medical record.

Confirmation BPJS verifier regarding the requested removal code is also caused by the inputted code are the symptom from the patient main diagnosis, so it does not need to be in a separate code. Secondary diagnoses criteria according to Minister of Health Regulation Number 26 of 2021 are complication conditions or comorbid by the patient. Therefore, inputting the coding process must pay attention to code rules from the ICD guide, code criteria rules following claim regulation and agreement, also the availability of support evidence that supported the diagnosis or procedure code.

d. Request for change of position of primary and secondary diagnosis code.

The return of the pending claim documents that have been checked by the BPJS Kesehatan verifier to RSD dr. Soebandi Jember, one of the reasons is confirmation of the accuracy of code position in main and secondary diagnosis code. The accuracy of position in main and secondary diagnosis will determine the accuracy of code main and secondary diagnosis, so it influences the grouping cost of INA-CBGs. If there is an incorrect code position of the main and secondary diagnosis, the BPJS Kesehatan verifier has the right to confirm with the hospital.

Megawati dan Pratiwi (2016), the factors that affected the cost of INA-CBGs are the main and secondary diagnosis (comorbidities or complications), severity, age, and intervention given to the patient. The determination of code by the coding officer should be correct with the diagnosis that is written on the medical resume. The coding officer cannot change the diagnosis position because only the doctor's profession can change those positions. The selection of main and secondary diagnoses positions can be changed by looking at the most resources given during the treatment and with approval from the physician in charge of the patients.

The ability and skills of the Internal Verifier

The internal verifier in the claim process has the role of final checking the completeness of the claim file and the suitability of the coding that has been carried out by the coding officer and grouping INA-CBGs before the claim file is submitted to the social security administrator of health. The internal verifier will analyze the accuracy of the claim file, both from the administrative, coding, and medical aspects in accordance with the rules of claim submission. IPKBPK internal verification officer RSD dr. Soebandi Jember has understood and is able to verify the inpatient claim file. In addition, the submission of claims to the BPJS every month doesn't exceed the deadline for submitting claims and has exceeded the minimum submission target required by BPJS Health. In accordance with the Cooperation Agreement (PKS) between BPJS Kesehatan and RSD dr. Soebandi Jember Number 289/KTR/VII-07/1221, the limit for submitting a

claim is a maximum of every 15th of the following month with a minimum claim submission standard of 75% of the number of SEPs issued, if there are still files that cannot be sent to BPJS according to the schedule for the month of submission, the file becomes a follow-up claim that can be submitted in the following month.

Although regular submissions have obedient with the submission due date and exceeded the minimum target required by BPJS Health, the inpatient BPJS claim verification by RSD Soebandi Jember's internal verifier still cannot be implemented optimally because there is no daily target so it can cause a buildup of claim document that must be completed at the end of the month. Although it does not affect the date of submission of claims and the minimum number of claims submission limits, if the internal verifier does not carry out further checks on the accuracy of placing the primary and secondary diagnoses, can lead to potential pending claims. Therefore, it is better for the claim officers of RSD dr. Soebandi Jember needs to make daily targets so that the available time management in the claim file processing process can be better, so it can improve the quality of claim submission results and reduce the number of pending claims returns that have been submitted.

The ability and skills of the Physician in Charge of the Patients (DPJP)

A physician in charge of patients has an important influence on the claim submission process in the JKN era, where they play a role in the completeness of filling out medical records and the accuracy of establishing the main diagnosis and secondary diagnosis. Decree of the Minister of Health Number 129 of 2008 concerning Minimum Service Standards for Hospitals explains that a medical record is said to be complete when the medical record has been filled in completely by a physician within <24 hours after completing outpatient services or after an inpatient is decided to go home including the patient's identity, history, plan care, implementation of care, follow-up and resume.

Abilities and skills DPJP RSD dr. Soebandi Jember shows that DPJP the ability and skill of the doctor in charge of the patient at RSD dr. Soebandi Jember indicated that they are competent in completing the medical record, but there is still the document that has not been filled in completely within <24 hours after the patient's discharge. The incomplete filling of medical records occurs because the doctor was not with the hospitalized patient after finished receiving all treatment and allow to be discharged so the recording is not carried out by the doctor in charge of the patient (DPJP) but is carried out by other Professionals Care Provider / PPA (doctors, nurses, nutritionists, pharmacists). In addition, DPJP has not been able to complete medical records due to the doctor was busy and many patients should be in service or even there are so many surgery schedules. This is similar to the conditions that occurred in the research of Rohman, et al (2011) in Maryani (2016), the factors causing the incomplete filling of the main diagnosis on the medical resume were due to the doctors being on duty, patients wanting to get discharged by own Request (APS), a large number of patients need to get treated by doctors, high workload, and medical records that have been distributed to another department.

The incidence of pending inpatient claim documents at RSD dr. Soebandi Jember is also determined by the doctor's performance related to the accuracy of determining the main and secondary diagnoses. The pending claim by the BPJS verifier occurs because there are differences in determining the main diagnosis. The diagnosis that is already made by the DPJP is not a diagnosis that consumes the largest resources. According to the interview result with DPJP, it was explained for claims purposes, sometimes doctors need to change the order of primary and secondary diagnoses according to the largest resources given to patients. In the necessity of claim submission, the main diagnosis is a diagnosis that is selected based on the condition that consumes the most resources (Kementerian Kesehatan RI, 2021).). This is not always in line with the concept of the main diagnosis in the clinical realm, the main diagnosis refers to the pathophysiology which is the basis of the case of the disease suffered by the patient and can move dynamically according to the development of the patient's condition, and also based on the scientific concepts (Indawati, 2019).

Analyzing The Educational Background

The factor that can affect productivity or performance is the level of education. Simanjuntak (1985) in Saputra (2018) explained that the higher of employee's educational background either formal or informal, it will be easier to obtain, receive, and develop their knowledge, so the employee can improve their performance. Therefore, the level of education for an employee in claim submission must be in accordance with the educational qualification required so the claim activity goes well and reduces the pending claim.

The educational background of some RSD dr. Soebandi officers involved in the process of claim submission are not suitable with the educational qualification of healthcare worker, for example, the educational background of the patient registration officer is a Bachelor of Economics and for inpatient claimed document administrator is an officer whose high school graduated. The law of the Republic of Indonesia Number 36 the Year 2014 Article 9 Paragraph (1) explained the minimum education qualification for health officers is a 3-years diploma in Health, one of them is a graduate of an Associate in the medical record and health information management, except the physicians (doctor, dentist, medical specialist, and dental specialist).

The need to obtain and increase employee knowledge to support their performance is not only obtained by education formally. As explained by Notoatmodjo in Syaadah (2017), increasing knowledge is not only obtained by formal education but can be obtained by non-formal education. There is a step that can be taken by the hospital if there is a difference in the level of final education by a healthcare worker, which is by giving the facility for the employee to improve their skills (Saputra, 2018). This has also been applied by RSD dr. Soebandi Jember, the informants involved in the implementation of the claim have all received socialization, seminar, and training both from the internal hospital and external from BPJS Kesehatan Jember.

Analyzing Work Experience

Work experience has an important role for the employee when they do their task in an organization. Work experience is a performance by an officer that is obtained from their working experience. The longer a person's working period, the more knowledge that worker gains about the work they do (Sedarmayanti, 2017). Working experience in this research related to how long the working experience as an admission officer and installation officer of RSD dr. Soebandi Jember.

The officer involved in submitting inpatient claims has a position time ≥ 3 years, the longest tenure of the informant

is owned by an internal verifier employee that has been working for 14 years, meanwhile, the shortest work period is the inpatient claim document administrator that has been working in 3 years. Manabung dkk., (2018) explained that tenure can have a positive influence if that is increasing the officer's skills in working their duties as the length of the work period increases. Besides, there is also a negative side to tenure, the employee will easily feel bored.

The experience that the officer gained while working at RSD dr. Soebandi Jember affects the implementation of inpatient claim submission, before, the officer stil didn't know and still had to adapt how the work system is applied, and with work experience, the new knowledge will increase and develop. This has a positive impact on hospital services and it is expected to minimize the incidence of pending claims.

CONCLUSION AND RECOMMENDATION

The conclusion of the result by analyzing the individual characteristics of employee performance at Regional Hospital dr. Soebandi Jember on the case of BPJS inpatient pending claim:

1. The ability and skill of the patient registration employee and claim document administrator match with the competence for the claim submission, the ability of the physician in charge of the patients to select the main diagnosis for claims purposes is not appropriate, and the ability of the claim coding officers is inaccurate in determining the code also have a difference in perception related claim regulation between coder with verifier of BPJS Kesehatan, and internal verification has not been implemented optimally.
2. The educational background of the officers involved in the processing of inpatient claim submission at RSD dr. Soebandi Jember matches the health worker's minimum education qualifications. Although, there is a registration officer with a Bachelor of Economics and a patient administration officer from high school, do not affect their performance because they already have training or socialization.
3. the employee in this research has worked for ≥ 3 years, and this work experience of the claims officers has a positive impact, the officers are more understanding and more proficient in their tasks related to fulfilling the requirements of claim submission.

The suggestion that can be used to improve those problems for RSD dr. Soebandi Jember, is explained below:

1. coding and grouping officers of INA-CBGs need to improve their knowledge of claim regulations, increase accuracy in coding, and confirm to the inpatient ward officer about examination results from the healthcare services facility that referred the patient or check the history of previous supporting examination results that may be able to support the diagnosis and current claim submission;
2. Officers that have the responsibility to handle the problem of the completeness of medical records and supporting evidence for claim submission purposes is necessarily needed in each inpatient ward;
3. Activating the one-stop administration system so claim document did not accumulate at the end episode;
4. Communication/discussion and coordination with BPJS Kesehatan to equalize the perception of existing claims regulation is needed.

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