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RESEARCH ARTICLE

VERIFICATION MODEL OF BPJS CLAIM AT PRIVATE HOSPITALS TYPE C

***Mahendro Prasetyo kusumo**

Master of hospital management, Universitas Muhammadiyah Yogyakarta

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ABSTRACT

This study attempts to explain the process and mechanism of health service model claim with BPJS facility in private hospitals type C. Object of this study was medical record of BPJS patients at RS PKU Muhammadiyah Gampinghospital. This study was done in RS PKU Muhammadiyah Gamping. Emergency Department services at the hospital include OneDay Care and One Day Care Surgery services. An interesting finding in this study revealed that the verification process of BPJS claims by the verifiers at RS PKU Muhammadiyah Gamping has not run as expected because the verifiers were often not available atthe hospital and lack of similar perceptions among verifiers at RS PKU Muhammadiyah Gamping. The implementation of BPJS claim verification at RS PKU Muhammadiyah Gamping has not run well due to the medical personnel or doctor in charge of patient (DPJP) was incomplete in filling the medical record. The cause of non-compliance with BPJS claims at RS PKU Muhammadiyah Gamping wasthe incompatible codingorgroupingof diagnosis into INA-CBG's system. This is due to the lack of understanding on medical record at RS PKU Muhammadiyah Gamping that causes differences between INA-CBG's package with the verifier results of RS PKU Muhammadiyah Gamping.

INTRODUCTION

Public awareness on the importance of social protection assurance continues to grow in accordance to Law No. 40 Year 2004 on National Social Security System (SJSN) mandates that the social insurance for all the society including health insurance is through a social insurance administrator. The social insurance administrator has been regulated by Law No. 24 year 2011 on The Social Insurance Provider Agency (BPJS) consisting of BPJS of Health and BPJS of manpower. The health insurance program organized by BPJS of health has been implemented since Januari 1, 2014. The program then is called National Health Insurance (JKN). The national health insurance that is BPJS used managed care system therefore the claim is from public healthcare services, clinics or hospitals.

In implementing the hospitals' claim, the BPJS of health used INA CBG's application. The BPJS of health especially in the Referral Health Services Unit (MPKR) has verifier staffs responsible for ensuring or checking the hospitals' claims as well as verifying whether it is approved or not. The verifier staffs should have good understanding and ability related to ICD-10 for the diagnosis verification, ICD-9 CM for the verification on disease action and how to apply INA CBG's application in order to get the INA CBG's tariff which must be paid by BPJS of health. Furthermore, there is a provision in the claims management administration by BPJS of Health, namely BPJS of Health must pay the health facilities for services provided to PPK by no later than 15 (fifteen) working days since the claim documents are received in full at BPJS of Health Office.

Corresponding author:* **Mahendro Prasetyokusumo,
Master of hospital management, Universitas Muhammadiyah Yogyakarta.

One of the problems often found in many hospitals is the inconsistency of payment claims by BPJS of Health and the documents' completeness of administration claims. It is also found in PKU Muhammadiyah Gamping Hospital. One of the affecting matters of the inconsistency of BPJS claim payment is the disapproval of BPJS file by verifier because there is difference of opinion between verifier with RS PKU Muhammadiyah Gamping. The medical records of class 1 patients from Januari to September 2015 shows that there is a significant difference of tarrif between the PKU Muhammadiyah Gamping hospital and INA CBG's from BPJS. The average of tarrif difference from Januari to September 2015 is Rp 70,303,686.9. For the comparation, class II hospitalized patients' tarrif in PKU Muhammadiyah Gamping hospital and INA CBG's tarrif shows the significant difference. The average of tarrif difference exists both for the hospitalized and non-hospitalized patients. It causes the decrease of PKU Muhammadiyah Gamping profit as well as the disruption of hospital's operationat activites. This will lead to the unhealthy finances. The object of the study is the medical records of BPJS patients at PKU Muhammadiyah Gamping Hospital. The study was conducted at PKU Muhammadiyah Gamping hospital. The emergency services at the hospital are one day care and one day surgery.

Review of Literature

National Health Guarantee program (JKN) developed in Indonesia is a part of National Social Security System (SJSN) held through social insurance mechanism aimed to cover all Indonesia so they can fulfill the needs of health. This protection is given to everyone who has paid the bill or whose

bill is paid by the government. The scope of claim verification of BPJS is divided into Administration Claim verification and Health Service Verification where each is defined as:

1. Administration Claim Verification. It covers 2 main things; the documents of the claim and administration claim verification step. The documents of the claim that will be verified including Letter of eligibility (SEP), letter of service containing the diagnosis and procedures signed by the medical personnel or doctor in charge of patient(DPJP), therapy and special medication regimen protocols, health tools prescription (outside surgery procedure), health tools receipt (glasses, hearing-aid, etc), other supporting documents needed. While the claim documents for hospitalized case is hospitalized letter, eligibility letter, medical resume signed by DPJP, service letter containing diagnosis and procedures signed by DPJP, surgery report (if needed), therapy and special medication regimen protocols, health tools prescription (outside surgery operation), health tools prescription, other supporting documents needed. The steps of administration claim verification including;
   a. Membership Administration Verification: it observes the reliability between the documents including eligibility letter and the data input to INA CBG applications with other supporting documents.

1) Service Administration Verification: The important thing in prior detection of service administration is for INA CBG's severity level III, there must be an approval from Medical Committee.
2) The consistency between DPJP specialization and the diagnosis. For example, if there is a patient with heart attack diagnosis but the DPJP is an ophthalmologist, the medical resume needs to check.
3) The consistency between surgery procedures with operator specialization.For example, the report of appendectomy procedure by cardiologist operator needs further check. The consistency between types of hospital with doctors competencies at hospital. For example; craniotomy at type D hospital, CABG done at hospital that needs more check.Coding determined by coder is not unbundling. For example, Diabetes Melitus with Nephrophaty becomes Diabetes Melitus (Primer diagnoses) and Nephrophati (Secondary diagnosis). Pay attention to re-admission for similar diagnosis of disease, if a patients comes with similar diagnosis, do crosscheck with the history of previous record whether he came home in healthy condition, or discharge against medical advice (DAMA), or was sent to another hospital. If he was forced to come home, the treatment episode on re-admission is the continued bill of similar disease. In the special case of CMGs :
   a) Medical tools with surgical procedure: ensure the compliance of billing with medical resume, hospital billing, and surgical report.
   b) Outside surgical procedure: ensure the billing compliance with medical resume, hospital billing, medical tools prescription, receipt of medical tools.
   c) In the special case of drug: ensure the compliance between bill and medical resume, billing, and regimen (schedule and plan of drug delivery).

Things to consider in the Verification of Health Services:

1)Severity level according to type and competence of hospital.

2) Verifier must ensure the compliance of diagnosis and procedure on the bill coded 4) ICD 10 and ICD 9 CM (by looking at ICD 10 and ICD 9 CM book or the softcopy).
3) Note cases with special CMGs,i.e.:

a) Special drugs: Steptokinase, Deferiprone, Deferoksamin, Deferasirox, Human albumin.
b) Special procedure, for instances: Pineal tumor - Endoscopy, Pancreatectomy, etc. Doctor's certificate is required as operation description or report for special procedure performed.
c) Special investigations : CT Scan, Nuclear Medicine, MRI, Diagnostic and prosedur imaging on eye. Cases with special investigations have been completed with evidences of previous support services such as: MRI done after X-ray and CT Scan results, etc.
d) Special prosthesis : subdural grid electrode, cote graft, TMJ prosthesis, Liquid Embolic (for AVM), Hip Implant/knee implant. Note the compliance between primary diagnosis and procedure performed, e.g.: TMJ Prosthesis is performed for the case of temporomandibular os fracture or temporomandibular joint, treated by craniofacial ENT specialistor Oral Surgery.
e) Sub-acute group: hospitalized for 43 to 103 days and Chronic Group : hospitalized for 104 to 180. Adjust the patient's care period with recommendation to return home from DPJP at the last visite in the medical record. For cases with high-cost diagnoses, visit the care ward or customer visite. Make sure that the ADL assessment is done and convinced with customer visit.
f) Ambulatory package, for example: hemodialysis, radiotherapy, etc.

4) Cases of newborn babies with low birth weight (BBLR), ensure the weight is less than 2500 gramswith medical resume and see the birth certificate if necessary. Ensure the newborn baby who has no medical issues from a normal labor or section becomes one part with the labor billing.
5) Ensure that the unhealthy newborn baby from a normal or cesarean section becomes a separated bill from the maternal delivery.
6) At cases where diagnosis is confirmed, make sure that at the next visit diagnosis code Z (control) must be used.
7) Pay attention to patients of outpatient who then continue with inpatient care on the same day can only be billed as one episode of hospitalization. Scope of BPJS Claim Verification (BPJS Claim Verification Technical).
8) In claiming of payment to BPJS Kesehatan for health services that have been completed, Faskes (health facility) needs to consider how the verification process is done by BPJS Kesehatan. The verification process is done through several stages, i.e. by doing file checking and confirmation.File checking itself is an examination of the completeness of the file, entries in the file, costs submitted. As for verification through confirmation will be conducted if there are special findings that need to be explained. Here are how the examination is given and confirmation is made.
   a) File checking; examination that includes file completeness, entries in the file, and costs submitted. Things to consider :
   b) Entity Eligibility Letter (SEP) :

c) Legalized by BPJS Kesehatan Officer
d) SEP Number The identity issued in SEP (Card Number, Name, Date of Birth, RM Number, Addressed policlinic/treatment room). Compare the data in SEP, worksheet, and supporting file. The data in SEP must be exactly the same with those in the worksheet and the supporting file.
e) Ensure that outpatients enclose service evidences that include diagnoses and procedures and are signed by the DPJP.
f) Medical Resume :

1) Medical Record Number and Patient Identity (Name, Date of Birth,etc)
2) Date of Service (Date of Entryand Date of Return for Inpatient).
3) Primary Diagnosis, Secondary Diagnosis, and Procedure/Action.
4) Doctor In Charge of Patient (DPJP): clear name and signature.
5) Ensure the service date is the same with the date in SEP and in medical resume.
6) Ensure the identity in medical resume is the same with that in SEP.
7) Diagnosis written by DPJP in the medical resume is in accordance with coding specified by coder in INA-CBG's Application.
8) Procedures or actions performed are in accordance with the primary diagnosis and secondary diagnosis.
9) Patient's diagnosis code examination, procedure performed.
10) Medical service charge checking on diagnosis code and procedure inputted and comply with INA-CBG's code generated. To become a consideration on diagnosis with expensive costs and possibility of recurring billing.

To confirm in the case of something needs a special attention, confirmation can be done. This is done to obtain evidences or receive information on claims that receive attention, including:

a) Service administration confirmation; confirming the coder by requesting necessary supporting evidences, primary and secondary diagnosis, and procedure in the patient medical resume.
b) Administration confirmation of other claims, administration confirmation of CMG special evidences. On those previously mentioned confirmation stages, if no evidences are obtained then the claim is returned to the hospital claim officer for completion or correction.

11) Purification of data: purification serves to validate data output of INA-CBG's that are billed by the hospital to SEP issuance data. Data purification consists of No. SEP, Participant Card Number, and SEP Date. Steps in performing purification are as follows:
    a) Withdrawal of INA-CBG's data may use TXT file transfer or through WEB Service.
    b) Conducting administration verification process.
    c) Verifier matches bill worksheet with supporting evidences and hospital entry results.
    d) Verifier can view details of patient data by clicking row to be seen that will show data detail.
    e) Advanced verification process. Advanced verification with seven steps is carried out with discipline and orderly to avoid verification error and double claim potential. Advanced verification consists of :
    a) Double claim verification for two (or more) RITL services. This step is useful for viewing readmission cases or patients returned administratively only.
    b) Double claim verification of RJTL referred directly to RITL. In this case, the approved claim is the RITL claim. Thing that need to be considered by verifier is that patient with outpatient service in the morning and receive emergency (UGD) service in the afternoon and is referred to RITL, in this case, the morning service can be claimed but the UGD service in the afternoon cannot. There may be a case where a patient who has routinely performed hemodialysis at one time is hospitalized for a diagnosis not associated with the previous diagnosis, the time when the patient is hospitalized and must undergo hemodyalisis, the hemodyalisis outpatient services can also be claimed separately.
    c) Double claim verification for two (or more) RJTL services. RJTL receiving two or more services on the same day is possible to happen due to repeated data conversion or issuance of 2 or more SEP on the same day.
    d) Claim verification of INA CBGs code is potentially incorrect. This step filters out non-paying INA CBGs codes and requires further analysis, for instance: non-guaranteed cases, healthy born babies.
    e) Verification of diagnostic codes that is irrelevant with the applicable provisions, such as: infertility.
    f) Free inspection. This verification step is an examination for other reasons for cases which are not included in the category of previous steps but must be suspended for other reasons.
    f) Claim finalization,
    g) Verifier can view claims with pending status.
    h) Service feedbacks.

National Health Insurance Program (JKN) developed in Indonesia is a part of the National Social Security System (SJSN) which is organized through social insurance mechanism aims at ensuring that all Indonesian citizens are protected in the insurance system so that they can meet their basic needs of health. This protection is granted to everyone who has paid the fee or it is paid by the government.

Research Method

This research was a qualitative research study using a case study approach utilizing closed in-depth interviews as means of collecting the data. According to Sutopo (2006), an in-depth interview is a process of obtaining information about the BPJS claims model already running in PKU Muhammadiyah hospital Gamping by questioning directly between the interviewer and the respondents (the person interviewed), in which the interviewer and respondent involved in relatively long social life. The subject of this research were the specialist doctors, general doctors, nurses, RS BPJS team, RM Officers and BPJS Officers at PKU Muhammadiyah hospital Gamping. Whereas, the object of this research was the medical record. This research was done at PKU Muhammadiyah hospital Gamping on 2016 from January to April. The data collection technique used in this study was interview, documentation and participatory observation (Sugiyono, 2013).

The steps undertaken in this study generally included several stages as follow: preparation phase, the phase of collecting data (primary data and secondary data), the data management stage, and the stage of completion. The data collection techniques used were in-depth interviews of the informant and the documentation study (BPJS claims policy, SPO BPJS claims, BPJS claims report document, and observation). The observation techniques used were passive participations where the research was involved with the daily activities of the person being observed or used as a source of research data. In the analysis of the data, this research used qualitative data analysis techniques in which the obtained data from the results of the interview, FGD, observation and documentation were collected and grouped based on existing indicators, then it was also based on the facts and on critical thoughts to obtain the weighted results. The analysis performed by the researcher was presented in the form of tables, namely: data reduction, data presentation, drawing conclusion and verification, drawing conclusion by rethinking over during the writing, notes reviewing, reviewing and brainstorming as well as placing a copy of the findings in a set of another data.

RESEARCH RESULTS

The object of this research was the medical record of the patients in the PKU Muhammadiyah hospital Gamping. This research was done at PKU Muhammadiyah hospital Gamping on 2016 from January to April. The IGD service in a hospital is an outpatient services or a day surgical services (One Day Care/Surgery). However, the services could be said not running very well, as evidenced by seven of the respondents answered "proceeded" with the results of 58.33% and five respondents answered "not proceeded" with the result of 41.67%. Therefore, the results showed that of the VPK 1, VPK 2, VPK 3, and VPK 7 had been proceeded well, it could be seen from all respondents answered "agree" and obtained 100% results. On the number four of health service verification obtained the result that (33%) said “yes” that there was used the code "Z" as the primary diagnosis and disease conditions as the secondary diagnosis if a patient came for the health control with the same diagnosis and therapy as the previous visits, and (67%) said they“did not know.” On the number five of health service verification obtained the result (33%) that there was supporting evidence on the CMG's case and (67%) said they did not know. On the number six of health service verification obtained the result (33%) that said there were two conditions (primary and secondary) related to using one code of ICD 10 (67%) said they did not know. On the number seven of health service verification obtained the result (33%) said that there were separated codes used which were originally supposed to codify into one and (67%) said they did not know.

It showed that SIC 1, SIC 2, SIC 3, SIC 4, SIC 5, SIC 6, and SIC 7 on steps of claims files delivery went well and appropriate as the guideline listed, it was obtained 100% result. It showed that the INA CGB’s obtained the results of (33%) said it had carried out the data verification on the using of INA GBP’s software and (67%) said they did not know. On the number two of INA GBP’s software verification obtained the results of (33%) that the verifier did matching the worksheet Bill with the supporting evidences as well as the results of the hospital entry, while (67%) said they did not know. On the number three of INA GBP’s software verification obtained the results of (33%) that after completed the administration verification, an advanced verification was carried in order to avoid error and double claims and (67%) said they did not know. The results of the interview about the BPJS claims procedure of inpatient required two aspects from the hospital, namely the monitoring and evaluation procedures of BPJS claims and improving awareness, cooperation and responsibility of every profession in filling out medical resum. This was done to support the improvement of hospital services quality. The income from claims would able to run well and smoothly when the hospital was able to provide counseling to the DPJP according to BPJS’ formularium and the completeness filling in the medical record, then it could minimize the hospitallosses.

Then, should it be also knowledge improvement about the patient's diagnosis coding and intensive communication with the verifier and hospital BPJS medical record to support the quality improvement and hospital service particularly in the hospital budget, so that the PKU Muhammadiyah hospital Gamping continued to develop innovation and creation in improving their services. There were several obstacles in the process of implementing BPJS such as the discipline, time management, human resources, and the communication and the role of BPJS verifier in PKU Muhammadiyah hospital Gamping. All respondents felt that the communication between professions was still not done effectively because it took time and complicated to get maximum results.

While, as DPJP having so many patients with limited medical officers so that their discipline in filling the medical record were not good since they had not enough time to deal with it. In fact, especially in the medical record section, there were parts that were considered unnecessary repetition, such as the patient’s identity section and anamnesa resetting sheet, so most DPJP did not fill them. Furthermore, it needed special attention from the BPJS verifier in PKU Muhammadiyah hospital Gamping to be always available, for the confusion happened on the medical record officers if they wish to consult related to the medical record or patients who have BPJS insurance. Based on table 1 showed that the level of claims issues in PKU Muhammadiyah hospital Gamping was high. From the results of the interview, there wereseveral aspects of the problem at the PKU Muhammadiyah hospital Gamping hospital in terms of BPJS claims process. Until recently, PKU Muhammadiyah hospital Gamping hospital have yet to find the point of the problem of why the claim was always retrograde or the claims acquired was smaller than the filled claims. We can see from the table above, the highest problem obtained was on the doctor in charge of the patients which he did not complete in terms of filling in the medical record.

We can conclude, if the doctor in charge of the patients did not on time in filling the medical record, it wouldaffect in the time to obtain the claims. The next aspect was the hospital BPJS was not always available. In this case that the hospital verifierplayed as a mediator between hospitals andverifierof the Center.If the mediator did not available, then the access to the management of the claims becameobstructed. The next aspect was the lack of similarities between BPJS verifier’s perceptions. We can conclude that the person in charge in the field was a medical team that was the doctor in charge of the patient, in this case, the verifier sometimes did not understand

Table 1. BPJS claims problems level on RS PKU Muhammadiyah hospital Gamping

Code	Problems	Result
P.1	DPJP did not complete in filling in the medical record	33,33%
P.2	Hospital BPJS Verifierwas not always available	25%
P.3	The lack of similarities between perception of the BPJS verifier	25%
P.4	The rate of hospital acquired was smaller than the rate of claims filed	12,67%
P.5	Coding or Grouping the diagnosis to the Ina-CBG's system had effect on the outcome of the claim it brought	4%

Table 2. Problems level of BPJS claims

NO	PROBLEMS	RESULT
1	The difference of diagnosis between the hospital andverifier	4 (50%)
2	The carelessness of the registration section in selecting the patient who will enter	1 (13%)
3	The incomplete file filled out by the doctor	1 (13%)
4	The sub-specialist section which required high treatment affected the hospital cost	1 (13%)
5	Severalclaims cases which were not paid by BPJS	1 (13%)
6	There wereseveral underreasonable diagnosis from the BPJS platform	1 (13%)

the real conditions in the field, so it could result in a difference in terms of the claims, while the verifier was only following the available formulary. In addition to these three aspects above, there were other aspects that were also influential, i.e. the acquired rate of hospital was much smaller than the proposed rate of the hospital to the BPJS. It was highly connected with the issues to do with coding or grouping diagnosis, because if any coding or grouping included did not fit, then the claim it brought could be very small. In the era of the current BPJS, the hospitals are required to conduct the evaluation of the better services. Since the beginning of the patient come to the hospital, registration, then get the treatment from the medical health officer, until drugs that will be taken home. The cooperation of all parts of the hospital were indispensable, there was coordination of registration doing the initial screening by sorting out cases that can get services in the hospital, then got the treatment from the clinicians, in this case was from the doctors, were doctors had appropriate action in accordance with the needs of patients to appropriate treatment needed by the patient, alsothe pharmaceutical party then did theadjustingif the real drugs that patients needed was in accordance with the rights of patients. In addition, the medical record did preliminary screening or matching the patient's medical records if they were in accordance with the complaint, examination, diagnosis, and therapy given by the doctor to the patient, would have been in accordance with the BPJS requirements so that the medical medical record officers should always do crosscheck with the doctors.

The financial section was the party that determines or receives whether the difference occured onthe payment received or incurred losses at the hospital. It was seen through the hospital income with the claims presented to the BPJS, where the BPJS played as giver of insurance of most patients who came to the hospital. Later the financial section did evaluation so that the difference of payment could be obtained, be it from the difference in payments by the BPJS or because of other things caused the difference in the hospital income income. From the results of the interviews, it was obtained several different answers, both from the head of the BPJS, financial section, part of the medical record, and from the specialist doctors. Based on table showed that the level of claims issues in PKU Muhammadiyah hospital Gamping was high. From the results of the interview, there were several aspects of the problem at the PKU Muhammadiyah hospital Gamping hospital in terms of BPJS claims process. Until recently, PKU Muhammadiyah hospital Gamping have yet to find the point of the problem of why the claim was always retrograde or the claims acquired was smaller than the filled claims. We can see from table 4.13, the highest problem lied on the difference between the hospital's diagnosis with verifier. It happened because of the incomplete data filled in the form. So that the claims would not be accepted since they were not according to BPJS requirements. The next aspect was the carelessness of the registration section in selecting the patient who will enter. It would be fatally made the BPJS claims from the hospital being rejected since if patients in inpatient stated then the completeness of administrative files should be acquired. However, some patients from the beginning were not verified by the officers so that the claims to the BPJS could not be fully obtained. The next aspect was the incomplete file filled out by the doctor. Incomplete medical record file resulted in a claim which could not be obtained fully as the written diagnosis. The next aspect was the sub-specialist section which required high treatment which affected the hospital cost, this is a challenge for PKU Muhammadiyah hospital Gamping hospital because there were several subspecialist doctors who serve BPJS patients, so the need for standardization of treatment for patients treated by specialist doctors and subspecialist doctors, seeing that the PKU Muhammadiyah hospital Gamping is a C type hospital which BPJS cannot yet provide sub specialists treatments. The next aspect was the number of claims cases which were not paid by BPJS. This was the largest incident happened in almost all hospitals in cooperation with the BPJS insurance, this likely happen because of the incomplete medical resume filled by DPJP. The next aspect was there's a certain under reasonable diagnosis from BPJS, this also happen due to the incomplete medical resume filled by DPJP.

DISCUSSION OF THE RESEARCH RESULTS

1.BPJS Inpatients Document Mechanism

Polyclinic: Installation of outpatient or outpatient unit of polyclinic is a medical service place for outpatient also plays as the first gate to determine whether the patient needs further treatment (inpatient) or not, or whether the patient needs to be referred to other health services.

Emergency Unit (UGD): The Emergency Unit (UGD) is the 24 hour per day medical services place to serve patients who

experience a state of emergency. Because of the speed and accuracy of medical services, then it's often said that this medical service quality is a window of the overall hospital medical treatment quality. The images of 4.6 and 4.7 show that there was a flow of files received by the hospital for inpatient patients using the BPJS. It showed that patients who will be hospitalized in PKU Muhammadiyah hospital Gamping, their files were received by the room verifier for the verification process. Then after they verified the files and it was considered as complete, the files will be sent to the hospital claims verifier to do costing (cost calculation). After the costing process, the claims verifier would report to the medical record for coding (logging a disease suffered by using many diagnosis of the illness) and after that the files would be sent again to the BPJS claims verifier which was available in PKU Muhammadiyah hospital Gamping. If the claims verifier approved the files, then the data would be sent to the BPJS Center, and then would be checked whether the data were complete or not. If it was complete then BPJS from the financial section would pay out the claims to PKU Muhammadiyah hospital Gamping.

Based on technical verification of claims by 2014, there are four aspects of verification that must be completed to get a claim. Among them are the verification of membership administration, verification of administrative services, medical services verification, and verification using verification software. Of all these aspects, there was only one aspect becoming the problem in this research, namely the verification aspects of medical services especially in the UGD services which handled the one day medical services or surgical services of outpatient. Of the twelve respondents, there were five respondents who did not agree that the PKU Muhammadiyah hospital Gamping already did so and seven respondents agreed that PKU Muhammadiyah hospital Gamping was already doing so. The delay in the payment process from BPJS to PKU Muhammadiyah hospital Gamping. This condition happened since the BPJS was still checking all the claims of BPJS patients in PKU Muhammadiyah hospital Gamping. In addition, for the payment of the BPJS claims, it had to be reported first to the BPJS central office for the verification. Based on the results of intensive interviews with the BPJS verifier of the hospital, from the payment delay, BPJS was ready to fulfill the full payment in the next month, in the middle or in the last days of the month and it was already available the signed paper on this particular matter.

Obstacles and solutions related to the internal problems of the PKU Muhammadiyah hospital Gamping.

Starting from the first obstacles occurred in PKU Muhammadiyah hospital Gampingwhich the doctor in charge of the patient (DPJP) was not completely filling in the medical record. We know already that the DPJP are all the specialist as they have very tight schedule resulted in incomplete filling of the document because they have no time to do it. If it continues, it will affect the medical service of the hospital. In this case, it is often problematic in the patient home resume (RPP). The completeness of the RPP is also one of the indicators of the hospital medical services quality. A complete RPP document will streamline procedures so as to improve the efficiency. However, the RPP documents are very rarely to be completely filled so as it likely to be wasted. The incomplete RPP document is often called deficient RPP. Within the framework of BPJS Kesehatan (BPJS of Health) billing, the deficient RPP will only be a waste of time and resources. In addition, the RPP is actually a document which is essential for the continuity of services between health care providers. Research in various countries find the problem influencing the lack of quality of the RPP. Most of these problems are related to the document filling done by DPJP, either because of lack of time up to a lack of will. The deficient RPP document then returned to the DPJP by themedical record officers, once or more, until it is complete and can be codedin the reporting system or billing system of the payers. This inefficiency was in fact not necessary if the factors of deficient RPP can be recognized and intervened. The returns procedure of RPP to DPJP is lengthening the process of billing to the payers or the BPJS, so PKU Muhammadiyah hospital Gampingfelt the need to audit the completeness of this RPP. This problems included incompleteness of incoming and out coming diagnosis document, the lab results and the medical treatment of the patients. The solution of this problem is very easy as long as the corresponding role (DPJP) are willing and conscious to fill the complete medical record. If necessary, the director of the hospital can make a decision letter (SK) related to the obligation of the specialist doctors in filling the complete medical record and, with it, then DPJP will be more aware and understand how important the medical record filling for the benefit of the hospital or of personal interests.

After that, the next obstacle is on the availability of the BPJS verifier in the hospital as well as the lack of similarities of perceptions between the hospital verifier and BPJS verifier. This kind of problems was very crucial since it would affect to the delay of the claims payment as well as the amount of claims payment obtained. The first is the availability of the BPJS verifier in the hospital. Playing as the mediator between the hospital and the Central BPJS, the BPJS verifier in the hospital plays essential role, the unavailability of the verifier would affect the patients' claims unable to obtain. In the PKU Muhammadiyah hospital Gamping, the observation revealed that the BPJS verifier was usually unavailable with only 2-3 times a week which resulted in the hospital verifier facing more difficulties in dealing with the documents with the BPJS verifier in the hospital which would likely affect the hospital claims to continue to be delayed. The solution of this problem is that the hospital should communicate with central BPJS to provide personnel which will remain available at at the PKU Muhammadiyah hospital Gamping. The next obstacle is about the BPJS verifier's understanding was often not similar with the hospitals verifier's. This could affect the outcome of the claims obtained by the hospital. We need to understand that the verifier has different ability in dealing with medical things such as based on the interviews, there was a verifier who allowed to dothypoid diagnosis without examining the culture, but there was also a verifier who did not allow it. This was very important since the different understanding will resulted to the confusedness of DPJP in doing the medical treatment. Therefore, the same understanding between BPJS verifier in hospital with the hospital verifier on the medical treatment is very essential. To overcome it, the hospital in order to improve the proficiency of each verifiers in the hospital.

The next obstacle is the rate obtained from the hospital is smaller than the rate of claims filled. It is closely related to coding or grouping of the diagnosis to the INA-CBG's system,

because it will affect the outcome of the claim obtained. According to Aljunid (2014), the INA-CBG's Coding is based on the international classification system from WHO, where it cannot run without any good coding. The clinicians are responsible in choosing the major condition of the patients for the record as well as other conditions whenever medical treatment is provided. The main condition is defined as a final diagnosis of each episode of medical treatment which is used for the needs of nursing or special examination for patients. If there is more than one of such conditions, then the chosen condition as the main condition is the condition which is using the greatest resource which resulted in longer treatment needed by the inpatients. In this case, to specify the primary diagnosis is difficult. It is defined as the final diagnosis of the patients' condition at the end of the treatment period which resulted in the treatments or the examinations patients required. Determining the secondary diagnosis is including all diagnosis other than primary diagnosis in a period of treatment, or incurred as long as the patients are in treatment. In this case, the solution in coding diagnosis and procedure codes problem lies in determining the right INA- CBG's code for the maximum results in claims payment obtained. However, to ensure it goes well by coder in hospital, the hospital must ensure the quality of the management and if necessary, headed by a doctor and the medical auditor to improve efficiency and minimize the coding error on various levels.

Recommendations

There are several recommendations in this study as follow,

- The PKU Muhammadiyah hospital Gamping need to make a quick, precise, and efficient with the BPJS Kesehatan so that this problem will not happen again.
- The hospital management needs to support clinicians in particularly the DPJP to spur the complete medical record filling.
- The BPJS needs to set one BPJS verifier remained at PKU Muhammadiyah hospital Gamping to facilitate the verification related to the inpatient patients of PKU Muhammadiyah hospital Gamping
- Bthe next researcher should do the similar studies at other hospitals to seek out problems and find the solutions of the problems

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