

DISPUTE ANALYSIS OF CLAIMS FOR PATIENTS WITH COVID-19: A CASE STUDY AT HOSPITAL X CLASS B IN BANTUL REGENCY

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Abstract. The Indonesian Government established referral hospitals for COVID-19 as an effort in combating the pandemic. Referral hospitals for COVID-19 submit their services' claims to the Ministry of Health. Hospital X in Bantul experienced challenges in submitting COVID-19 claims and underwent claim disputes which caused delays in payment process. This research aimed to explore the factors that led to the disputes over the COVID-19 claims. This descriptive research was conducted with a qualitative approach, using in-depth interviews and observations. The additional descriptive analysis used secondary data COVID-19 claim dispute file reports from 2020. The results showed that the highest criteria of disputed claims at Hospital X were the criteria for non-compliant guaranteed participants, incomplete claim files, non-compliant comorbid diagnoses, and identities that did not comply with the provisions. The causes of the disputes over claims for patients with COVID-19 included inaccurate history taking, differences in regulation perceptions between the provider and payer, PCR results were not provided, and doctors had a lack of understanding regarding the technical guidelines for COVID-19 claims. In addition, there were technical problems faced by the hospital during the process of submitting claims, including regulations were changed frequently, errors in applications, incomplete medical resumes, and unreadable doctors' writings. Disputed claims did not affect the hospital cash flow, yet delayed the payment process to health workers, which might harm the quality of services.

Keywords: dispute claim, COVID-19, cash flow, hospital, Indonesia

Abstrak. Upaya Pemerintah Indonesia dalam penanggulangan COVID-19 adalah dengan menetapkan rumah sakit rujukan pandemic ini. Rumah sakit rujukan COVID-19 dapat mengajukan klaim ke Kementerian Kesehatan. Rumah Sakit X di Bantul dalam mengajukan klaim COVID-19 mengalami kendala dan adanya kasus *dispute* klaim yang menyebabkan proses pembayaran klaim tertunda. Penelitian ini bertujuan untuk menganalisis faktor-faktor yang menyebabkan *dispute* klaim COVID-19. Jenis penelitian ini merupakan penelitian deskriptif dengan pendekatan kualitatif, dengan wawancara mendalam dan observasi, ditambah analisis deskriptif menggunakan data sekunder yaitu laporan berkas *dispute* klaim COVID-19 tahun 2020. Hasil penelitian menunjukkan bahwa kriteria tertinggi *dispute* klaim di Rumah Sakit X adalah kriteria peserta jaminan tidak sesuai, berkas klaim tidak lengkap, diagnosa komorbid tidak sesuai ketentuan, dan identitas tidak sesuai ketentuan. Penyebab *dispute* klaim pasien COVID-19 disebabkan karena ketidaktepatan anamnesis, perbedaan persepsi, hasil PCR tidak terlampir, kurangnya pemahaman DPJP mengenai juknis klaim COVID-19. Kendala dalam proses pengajuan klaim adalah regulasi yang mengalami perubahan, aplikasi eror, kelengkapan rekam medis lebih dari 2 x 24 jam, ketidaklengkapan resume medis, dan tulisan dokter yang tidak dapat dibaca. Dispute klaim tidak berdampak pada permasalahan cash flow rumahsakit, tapi menunda pembayaran jasa medis dan perawat, dan dapat menurunkan kualitas layanan.

Kata Kunci: klaim dispute, COVID-19, arus kas, rumah sakit, Indonesia

INTRODUCTION

The World Health Organization (WHO) announced the Corona Virus Disease 2019 (COVID-19) as a

global pandemic on March 11, 2020. All countries have been affected by this novel coronavirus disease. As the number of COVID-19 cases continued to increase, the Government of Indonesia

issued a Decree from the Minister of Health of the Republic of Indonesia Number HK.01.07/Menkes/104/2020 that COVID-19 is a certain emerging infectious disease that causes outbreaks and public emergencies, and it is mandatory to enact countermeasures that require financing.(1)

In response to the COVID-19 pandemic, the Indonesian government issued the Decree from the Minister of Health, numbered HK.01.07/Menkes/275 of 2020. This decree designated 132 hospitals located in every province of the country as referral hospitals for the management of certain infectious diseases. The purpose of this measure was to ensure that there were sufficient medical facilities with the necessary resources to manage COVID-19 cases and other infectious diseases.(2)

People infected with COVID-19 can get health services, such as laboratory tests, radiology, and hospitalization if the patient has co-morbidities or with special assistance. The state bears healthcare costs for patients infected with COVID-19 through social insurance.(3) One of the Indonesian government's strategies in dealing with this pandemic is the waiver of COVID-19 patient fees, based on Minister of Health Regulation 59 of 2016, that patients with certain emerging infectious diseases are exempt from financing.(4)

Hospitals that treat patients with COVID-19 can apply for reimbursement of costs following statutory provisions. Claim costs for patients with COVID-19 are regulated in the Decree of the Minister of Health of the Republic of Indonesia Number Hk.01.07/Menkes/446/2020 concerning Technical Instructions for Claiming Reimbursement for COVID-19 Patient Services. Those hospitals providing services for patients infected with COVID-19 can submit claims to the Ministry of Health through the Director General of Health Services. The patient care costs that can be claimed are outpatients and inpatients with the criteria of suspected patients, probable patients, and confirmed COVID-19.(5)

Hospitals have faced challenges in submitting claims for COVID-19-related expenses, leading to a significant number of disputes. A report from the Social Health Insurance Administration Body (BPJS Kesehatan) revealed that, as of October 2021, the agency had received a total of 1,345,970 COVID-19 claims, amounting to IDR 72.3 trillion. After verification, 933,708 claims were deemed appropriate, with a total cost of IDR 50.5 trillion, representing 79.07% of all claims. However, 170,335 claims, or 14.42% of the total, were disputed, with a cost of IDR 9.9 trillion.

Additionally, there were 72,248 pending claims, representing 6.12% of all claims, with a total cost of IDR 3.4 trillion. These challenges in processing claims have added to the burden faced by hospitals as they work to manage the impacts of the COVID-19 pandemic.(6)

Hospital X is one of the hospitals that obtained an Operational Permit and has been designated as a type B hospital in Bantul Regency. It has been designated as a referral hospital for managing certain emerging infectious diseases based on the Decree of the Governor of the Special Region of Yogyakarta Number 61/Kep/2020.(7) While dispute claims also occurred at Hospital X, the increasing number of patients with COVID-19 being treated at Hospital X also increased the filing of COVID-19 claims. However, delays followed this in the payment of claims due to the disputed claims. The delay in paying COVID-19 claims may significantly impact contributing income to hospitals during this pandemic.

From April to July 2020, Hospital X submitted 138 claims and 83 were disputed. The disputed claim costs were IDR 7,557,420,000. The value was large enough to cause potential losses for COVID-19 claims submitted by the hospital and may have affected the financial flows at Hospital X. To understand and mitigate the disputed claims, this research aimed to explore the main factors that led to the disputed claims.

METHODS

This descriptive research was conducted with a qualitative approach. Qualitative research was used to obtain data regarding the causes of disputed claims by patients with COVID-19. The research design was a case study to dig deeper into the causes of disputed claims. Data were collected through in-depth interviews, and claim file data in 2020.

This research was conducted at Hospital X Class B (a COVID-19 referral hospital) located in Bantul Regency, Special Province of Yogyakarta. The determination of research subjects was selected based on specific criteria. The research subjects who were the primary data sources in this research were Isolation Room Administrative Officers (1 person), Medical Recorder (1 person), COVID-19 Claim Coder (1 person), Claim Person in Charge (1 person), general practitioners (2 people), Doctors in Charge of Patients (2 people), Chief Treasurer (1 person), BPJS Kesehatan Verifier (1 person), and Head of the Health Service Division (1 person). The process of data analysis used content analysis techniques to discuss the management of claims that caused disputes over claims by patients with

COVID-19. Questions were asked openly, then analysis and classification of the answers given were done based on the data.

This research was conducted based on research ethics considerations, and its implementation was conducted after obtaining research approval. The permission in the form of Ethical Clearance issued by the Medical and Health Research Ethics Committee of the Faculty of Medicine, Public Health and Nursing, Universitas Gadjah Mada, Yogyakarta, Indonesia, with a letter-number KE/FK/0172/EC/2022.

RESULTS AND DISCUSSION

Causes of Disputed Claims of Patients with COVID-19 at Hospital X Class B in Bantul Regency

Based on secondary data from the 2020 report of verification result, the COVID-19 claim at Hospital X has two verification results: an appropriate claim and a disputed claim. The following is the claim file data submitted by Hospital X.

Table 1. Report of verification result data of COVID-19 claims at Hospital X Class B, Bantul Regency, 2020

Month	Claim Submitted	Approved	%	Disputed	%
April	37	14	39%	23	62%
May	49	13	27%	36	73%
June	21	10	48%	11	52%
July	31	18	49%	13	42%
August	42	22	52%	20	48%
September	91	14	15%	77	85%
October	28	12	43%	16	57%
November	61	44	72%	17	28%
December	83	44	53%	39	47%
Total	443	191	43%	252	57%

Source: Report of Verification Result 2020.

There were 443 filed claims by Hospital X. Of the 443 claim files, there were 191 claims approved (43%) and 252 files were disputed claims as much as 57%.

Based on the 2020 Report of Verification Result data, there are four criteria for the highest COVID-19 disputed claims at Hospital X. The following describes the criteria for a COVID-19 disputed claim at Hospital X:

Table 2. Criteria for the highest disputed claims at Hospital X, Bantul Regency in 2020

No.	Dispute Criteria	Number of Files	%
1.	The criteria for participants in the COVID-19 guarantee do not comply with the provisions	187	74.2
2	Incomplete file	27	11.0
3	Comorbid diagnoses are not in accordance with the provisions	17	7.0

4	Identity does not comply with the provisions	11	4.4
Total		242	96.6

Based on secondary data and the results of interviews, the highest cause of disputed claims involved the inaccuracy in enforcing suspected diagnoses that were not in accordance with the provisions of the Decree of the Minister of Health technical guidelines for COVID-19 claims.

The large number of patients admitted to isolation facilities at Hospital X has led to inaccuracies in history-taking and physical examinations. With only a few general practitioners on duty, doctors at the hospital have had to work quickly and with limited information provided by patients and their families. In some cases, patients or their families were unaware that they had been in contact with individuals who had tested positive for COVID-19, which further complicated the situation. These challenges are reflected in the results of hospital staff interviews:

"We are the doctors on duty for the COVID-19 emergency room and the ward. In one team, sometimes consists of 2 or 3 people."

So, this is a difficulty for the assessment. Sometimes, the patient also does not realize that his activities can have positive results....” (DUI)

Another cause of disputed claims was differences in the perceptions of the Doctor in Charge of Services and the verifier, where the Doctor in Charge of Services only made a diagnosis based on clinical circumstances. Meanwhile, the Decree of the Minister of Health verifier and provisions require evidence of fever, other symptoms, contact, and travel history to make a diagnosis. If the Doctor in Charge of Services does not reflect compliance with this information, then the verification process will become a disputed claim, followed by a re-confirmation procedure. This situation is shown in the results of the following interviews:

“...so just write down according to what is available such as the results of a physical examination, more just the clinical situation. There are patients with typical symptoms of COVID-19 but the PCR is negative, so we give COVID-19 therapy, and the patient recovers.” (Doctor in Charge of Services 1)

The second criterion for the COVID-19 claim dispute was an incomplete claim file. Supporting claim files was very influential in the process of verifying claims and the success of COVID-19 claims. The terms of completing the claim files were the duty of the isolation room administration officer, but in the results of the verification, there were still incomplete files causing a disputed claim at Hospital X. The incomplete forms were the results of the first polymerase chain reaction (PCR) test and the results of supporting tests that support the diagnosis, such as D-dimer.

Disputed claims for COVID-19 also happened because the files were incomplete due to referral patients, where sometimes the referring hospital forgot to attach the PCR results and laboratory supporting examinations. Even though at Hospital X, a PCR test was repeated, the Verifier still asked for the first PCR result. This is seen in the results of the following interviews:

“ Sometimes lab results from outside are referral patients, now patients come for referrals, but they don’t bring their lab results, it has to be uploaded.” (Administrator)

The third criterion for disputed claims for patients with COVID-19 at X Hospital was comorbid diagnoses that do not comply with the provisions. It

was due to an understanding of the related policy for claims that the doctor in charge must understand. It is not only the claims officers who know it since all those related to claims must follow the Decree of the Minister of Health technical guidelines for claims. Based on secondary data and interview results, there were doctors in charge of the patient who wrote incomplete medical resumes and differences in doctors' perceptions regarding comorbid diagnoses of COVID-19. This issue is reflected in the results of the following interviews:

“like a lack of therapy writing, sometimes there are some Doctors in Charge of the Patient who don’t write....” (RM)

“...The comorbid that is often written about is pneumonia, even though pneumonia is not included in the Decree of the Minister of Health...” (VRS)

“Then for others, maybe this is a comorbid diagnosis, but in the treatment process, there is no term for special treatment...” (VBPJS)

“What kind of comorbidities but there are no supporting examinations.” (PJK)

The fourth cause for the disputed claims for COVID-19 patients at X Hospital was because the identity did not comply with the guidelines. The highest cause was because the National Identity Number did not match the data in the Indonesian Civil Registry. This is seen in the results of the following interviews:

“There was a National Identity Number that was the same as the identity, but yesterday there was also a mistyped identity” (KK)

“National Identity Number problem, it's only a few, madam” (VRS)

“Administratively, it's National Identity Number's fault.” (PJK)

The process of verifying the COVID-19 claims for identity data uses an Indonesian identity card or national identity number. However, there were some inaccurate national identity numbers, due to typing errors. In entering claim data, accuracy becomes very important.

Obstacles Faced by Hospital X in Submitting Claims for Patients with COVID-19

Human Resources

Although there was only one coder, it was still considered sufficient. The coder does coding and

data entry, as well as matching the number of files submitted with the inputted files, assisted by a scan officer. While the isolation room administrator is responsible for completing the claim file for patients with COVID-19, in this case, an administrator was deemed sufficient even though there were many claim file requirements that must be completed. This situation is seen in the following interview results:

"In my opinion, the claim officer is enough."
(PJK)

"The claim officer is quite adequate, even if it's by reducing other parts of the service and assisted by volunteers." (KBY)

Policies and Standard Operating Procedures (SOP)

Hospitals have relied on the Decree of the Minister of Health's technical guidelines for COVID-19 claims as a reference when submitting claims for patients with the disease. However, these technical guidelines have been amended multiple times, causing confusion among hospital staff. Interviews with staff members have revealed that they struggled to keep up with the guidelines' changes, making it challenging to submit accurate claims for COVID-19-related expenses. This highlights the need for clear and consistent guidelines to ensure that hospitals can effectively manage the costs associated with treating patients with COVID-19.

"It changes back and forth, so sometimes that's what makes us experience problems because the regulations are out now but apply in the past." (KK)

"There are rules that are not applied in the same way as before." (VRS)

Facilities and infrastructure

Facilities and infrastructure function to simplify and speed up the claim submission process. The facilities and infrastructure that support the claims submission are computers, printers, and scanners. All of these work facilities are available in the isolation administration room and in the case-mix unit. There were 14 computers, 14 printers, five scanners, and one photocopy machine for the case-mix unit. It is discussed in the following interview results:

"Basically, the facilities and infra

structure are adequate, such as computers and printers that already exist" (ADM)

Technology

Hospital X faced some technical problems in submitting claims. For example, there were unstable network problems and application errors because many referral hospitals upload claim files during working hours, so uploading claim files becomes disrupted. As a result, the coder has to work on them outside of working hours. This is seen in the results of the following interviews:

"Sometimes the file is unreadable, it's credit, so we failed to send it. That's why I used to work overtime and stay here, that's it." (KK)

Medical Record Completeness

Another obstacle found in the completeness of the medical record was that the Doctor in Charge of Services did not directly fill in the medical resume. When a patient was allowed to leave the hospital, the Doctor in Charge of Services should immediately complete a medical resume, but the facts in the field are that the Doctor in Charge of Services completes a medical resume two days or more after the patient is allowed to go home. This is because medical specialists have many patients and are only willing to fill out resumes at the polyclinic, which has a practice schedule that is only three times a week. This is discussed in the results of the following interviews:

"If there are not many patients, we have to take them to the poly, and it usually takes a long time." (ADM)

"The room administrator returns the status here, mostly around 2x24 hours, because they are waiting for the doctor's resume and they only photocopy the file, when it's finished, it's returned here." (RM)

Collection of Claim Files

Claim files were expected to be completed one day after the patient was discharged. This approach helped BPJS Kesehatan to collect the files on time. However, there were obstacles related to the process of collecting the COVID-19 claim files at Hospital X, including incomplete medical resumes written by doctors and Integrated Patient Development Records that were not in accordance with the patient's condition. This is seen in the results of the following interview:

"Yes, if there are still missing files, for example like a resume, the doctor's writing is lacking...., the Integrated Patient Development Records are out of sync from start to finish" (ADM)

Coding and Data Entry Provision

Hospital X continues to rely on paper-based medical records, which means that coders must manually enter data into the E-claim application for coding purposes. The code assigned by the coder must match the primary diagnoses and actions documented by the doctor in the medical records. Fortunately, the coders at Hospital X have not experienced any major issues with coding and data entry because they have a strong understanding of the Decree of the Minister of Health's technical guidelines for COVID-19 claims. This was confirmed in recent interviews with staff members at the hospital. However, the continued use of paper-based records highlights the need for hospitals to transition to more efficient and reliable electronic systems:

"If the coding is correct, it's because the coding is all the same." (VBPJS)

Verification of Claims of Patients with COVID-19

Another obstacle of the BPJS Kesehatan Verifier during the process of verifying the claim file of Hospital X was the doctor's writing which was unclear and illegible. This is because Hospital X still uses manual medical records, although it is known that the doctor's writing greatly influences claims. In responding to this, the Social Health Insurance Administration Body verifier will confirm information in advance with the hospital, as seen in the results of the following interview:

"There is an unclear doctor's writing" (VBPJS)

The Impact of the Dispute Claims of COVID-19 on the Hospital Cash Flow

During the COVID-19 situation, service utilization decreased at Hospital X. This was because people were worried about being infected with COVID-19 when they came to the hospital. Hospital X also limited the number of patients and opening time. From this situation, the income of Hospital X decreased. However, from the revenue side, Hospital X revenue increased. It is because payments for services in 2019 were paid in 2020, and Hospital X received grants to provide services to COVID-19 patients. This is seen in the results of interviews and secondary data as follows:

"From the reception side, there was a decline, on the revenue side in 2020 it was rather high because there was payment for services in 2019. It was paid in 2020. As for

expenses, it is clear that in 2020 there has been an increase....." (BP)

Based on the data from the Verification Results Reports, from a total of 443 claim files submitted from April to December 2022, there were 252 dispute claims with a total claim of as much as Rp. 17,823,434,000, which is a very large amount that might affect the financial flows of Hospital X.

Based on the results of the interviews, the impact of dispute claims at Hospital X caused a delay in payment of incentives or services for doctors or other health staff related to patients with COVID-19, as seen in the results of the following interviews:

"The incentive is delayed; the impact is more incentive..." (PJK)

"...For us personally it doesn't really affect us, because we get aid funds and goods grants.... So actually, the impact of the dispute is more on the incentives to retreat ..." (BP)

"Does not really affect cash flow, because the percentage of disputes is relatively low." (KBY)

The impact of the disputed claims of patients with COVID-19 did not really affect hospital cash flow, even though the value of the disputed claims was quite large. This happened because Hospital X received grants and in-kind contributions. However, the impact of disputed claims has caused a delay in paying for the services of doctors, nurses, and other health staff from the promised date.

The Criteria for Participants in the COVID-19 Insurance Do Not Comply with the Provisions

One of the causes of the disputed claim at X Hospital was that written indications and diagnoses did not match the technical guidelines for COVID-19 claims, and it was as many as 187 files (74.2%). It included an incomplete initial medical assessment. Meanwhile, the Decree of the Minister of Health verifier and provisions require evidence of fever, other symptoms, contact history, and travel history to make a diagnosis. If the Doctor in Charge of Services does not reflect this, then the verification process will become a disputed claim, followed by a re-confirmation procedure. Previous research showed that the highest number of disputed claims for COVID-19 in hospitals in Indonesia was because claims did not comply with the guidelines (37.03%).(8)

The initial patient assessment aims to understand the patient's condition and the treatment to be given and establish a diagnosis. The patient's initial assessment consists of the patient's identity and anamnesis results, including a history of current or past illness, physical examination, and medical support.(11) Indications for diagnosing patients suspected of COVID-19 were based on the Decree of the Minister of Health 238 and 446 of 2020. Suspected cases are if the patient has symptoms of fever, cough, runny nose, weakness, headache, muscle aches, nausea/vomiting, diarrhea, a history of fever above 38 degrees, anosmia, travel history, and contact history.(5)

Filling out the initial assessment is the responsibility of the general practitioner. In order to minimize the inaccuracy of the history and speed up the history-taking process, Hospital X has created a COVID-19 screening form that only needs to be filled in with a tick. Despite the existence of the form, the inaccuracy of diagnosis still occurs. The hope is that, before the claim file is uploaded, the internal verifier checks again whether it is following the Decree of the Minister of Health technical guidelines for COVID-19, and if it is not following the claim file, it is returned to the doctor to be completed first.

Incomplete claim file

Supporting claim files is needed in processing claims verification. The terms of completing the claim file are the duty of the administrator of the isolation room. But in the results of the verification, there were still incomplete files causing a disputed claim at Hospital X. Some incomplete result forms involve the first PCR result and the results of supporting examinations that support the diagnosis, such as D-dimer. Previous research at UI Hospital showed that the disputed claim was dominated by incomplete swab and rapid test results, different return times from swab results, and incomplete comorbid support.(9)

Based on the technical guidelines for claims of patients with COVID-19, the criteria for guaranteed patients with COVID-19 are confirmed, suspected, and probable patients. Criteria for COVID-19 inpatients must undergo a reverse transcription-polymerase chain reaction (RT-PCR) examination on the first and second day of treatment, then take another swab on the seventh day.(5) Sometimes, the PCR results and laboratory support were not attached because the patient comes from another hospital or referral patient, where the results are not given to the referral-receiving hospital. To avoid this, cooperation is needed, such as the doctor in charge of the Emergency Room and isolation room administrator reminding each other if there are referral patients and efforts from Hospital X's case-

mix team to make a checklist of claim file requirements. Therefore, when the files are collected, it is complete and following the technical guidelines for the COVID-19 claim.

Comorbid diagnoses are not following the provisions

Healthcare providers are required to document all services provided. These records are written in the medical record. Based on our study, another cause of the dispute claims for patients with COVID-19 at Hospital X was comorbid diagnoses that did not comply with the provisions accounting for as much as 7%. This was due to the Doctor in Charge of Services wrote the incomplete medical resumes, especially in the diagnostic examination section, as well as differences in doctors' perceptions regarding comorbid diagnoses of COVID-19.

The reason for the rejection of the claim is the supporting evidence of an incomplete diagnostic examination (9). The description of the highest dispute criteria in Indonesia based on BPJS Kesehatan data in Ambarwati's research in 2020 was a comorbid diagnosis that does not comply with the provisions as much as 5.4%.(8)

Doctors are healthcare providers who are required to diagnose and provide medical care to patients, and all of these actions are fully documented.(10) Incomplete and non-specific documentation will result in coding inaccuracies and disputed claims.

Based on the technical guidelines for the COVID-19 claim, a comorbid diagnosis is a patient who has a previous chronic illness that will aggravate the COVID-19 disease. Comorbid diagnoses include immunocompromised disease, heart disease, diabetes mellitus, asthma, hypertension, kidney disease, tuberculosis, HIV, and others.(5)

The orderly administration of claims is not enough to attach claim support files, but must be in accordance with the patient's condition and claim regulations. The medical resume must include all healthcare providers and be in accordance with the patient's condition. The completeness of the medical resume is the responsibility of the Doctor in Charge of Services but the doctor on duty can also assist in completing the medical resume. In addition, the medical record department must also ensure whether the forms in the medical record are complete or incomplete. In order for the completeness of the medical record and the success of the claim, the Doctor in Charge of Services must adhere to patient handling guidelines or SOPs.(9,11) In overcoming problems at Hospital X, it is necessary to monitor and always confirm with the doctor in charge of the patient before the claim file is submitted.

Identity does not comply with the provisions

The identity used in the COVID-19 claim is an Indonesian Identity Card, Family Card, or a letter from the village administration for Indonesian citizens, and a passport for foreign citizens. The fourth highest disputed claim criteria at Hospital X was because the identity did not comply with the provisions. The national identity number showed it did not match the civil registry data, leading to disputes claims for patients with COVID-19 at Hospital X, even though the number was small. This happened due to an error in inputting the membership number, the coder made several mistakes in typing the National Identity Number, causing the identity to be incorrect or unverified in Civil Registry, or the wrong and unverified.

National Identity Number which caused a dispute claim.

One of the causes of pending claims at the hospital is the inaccuracy of coders. These errors can occur because the number of files is very large, so the coder is working on coding and inputting data in a hurry.⁽¹²⁾ One alternative to prevent this from happening at Hospital X is that the internal verifier needs to re-check the data entered by the coder.

Responding to the events and causes of dispute claims of patients with COVID-19 that occurred at Hospital X, the head of the case-mix team records the causes of the dispute and takes direct action. For example, if the patient care days are too long, the officer claims that COVID -19 has immediately cut the treatment day. Then, they should provide direction to officers related to COVID-19 claims, such as the Head of the Isolation Room, the isolation room administrator, the head of the general practitioner, and also the laboratory staff. These briefings are not routinely done. Briefings are only conducted if there is a high dispute incident. But in that briefing, the Doctor in Charge of Services was not included. The Doctor in Charge of Services should have been included.

The Process of Submitting a COVID-19 Claim at Hospital X

The process of submitting a COVID-19 claim for reimbursement costs starts with the hospital submitting a claim by completing claims supporting documents, filling in patient data, and uploading files through the e-claim application until the COVID-19 claim is verified by Social Health Insurance Administration Body.⁽⁵⁾ In the case of submitting a COVID-19 claim, Hospital X experienced five obstacles, namely the claim regulations or technical instructions which had changed several times, causing the case-mix team to

be confused and overwhelmed in following these changes.

The technical guidelines for Covid-19 have been updated several times, including the Decree of the Minister of Health 238 for 2020, the Decree of the Minister of Health 46 for 2020, the Decree of the Minister of Health 4434 for 2021, the Decree of the Minister of Health 4718 for 2021, and the latest Decree of the Minister of Health 5673 for 2021. The changes of technical guidelines for Covid-19 claims aim to facilitate the process of claims, but in fact, there are still disputed claims and hospitals are confused between the issuance of new regulation and the applicable regulation.

The integrated claim files for patients who are still comorbid, they need treatment. This situation is confusing. Such as, Patients from the isolation room are then transferred to the regular ward, the claim files must be separate.

The problem of criteria for Covid-19 patients not complying with the provisions still occurs, although it's not as much as in 2020. Whereas, the latest regulation states that confirmed patients can be proven with the positive PCR and positive antigen results. However, in the verification process, the Verifier asks for a history of fever above 38 degrees, travel and contact. Then, not all symptoms are found in this suspected patient. When the patient comes to the hospital, symptoms such as fever do not appear.

The technical guidelines for Covid-19 claims state that the Ministry of Health will make payments within 3 working days after receiving BAHV from Social Health Insurance Administration Body with a down payment of 50%. But in fact, the The hospital accepts payments for up to 4 months and the down payment given is below 50%.

There is a regulation regarding technical documents for COVID -19 claims, which aims to regulate the claim process in a trusted, transparent and smooth manner. The regulations regarding technical guidelines for COVID claims have changed five times so it made Hospital X overwhelmed to adjust them. Ideally, the existence of a new policy should be accompanied by the efforts of policymakers (Ministry of Health and the public health Officer) to socialize it. In this case, the Ministry of Health had done some socialization, although it was not been able to realize a common perception and technical understanding of claims between hospitals and the Social Health Insurance Administration Body.⁽⁸⁾

The second obstacle in the process of submitting a COVID-19 claim at Hospital X is the e-claim application, namely, an application error occurs

during working hours, which causes the coder's performance to be disrupted.

One of the claims management challenges lies in the technical challenges, namely software that takes a long time to read instructions in the claims process.(13) Another obstacle in the implementation of claims is the unpreparedness of the application and the system for resubmitting revisions to disputed claims, where claims that have been submitted are not readable in the e-claim system, so the hospital has to re-upload the file.(8)

For claims for patients with COVID-19 at Hospital X to still be submitted in a timely manner, the claims officer decided to work on filing claims outside of working hours or in the afternoon until late at night, because at night the e-claim application runs smoothly.

Another obstacle to the process of submitting a COVID-19 claim at Hospital X was that the process of completing medical records takes a long time, which is more than 2 x 24 hours. So, it does not match the quality indicators of medical records at Hospital X. This is because doctors have many patients. and the practice schedule is only three times a week.

Factors that affect the completeness of medical records for more than 24 hours are medical specialists who tend to have a pile up of the medical resumes. This is because they have many patients in the polyclinics and surgeries so doctors are exhausted and do not have time to fill out the resumes in a timely way.(14)

Medical records involve documents that contain a patient's medical history. The contents of the inpatient medical records at least contain the patient's identity, results of anamnesis, physical examination, supporting examinations, treatment or action, discharge summary. One of the benefits of medical records is it can be used as a basis for paying health care costs.(15)

Based on the medical record quality indicators that are guided by Minister of Finance Regulation 129 of 2008, medical record completeness should be ensured within 24 hours after completion of service and for returning inpatient medical record files within 2 x 24 hours.(16)

The SOPs regarding the completeness and return of medical records at Hospital X already exist. But medical specialists do not apply them properly. In this case it is hoped that monitoring and evaluation should be done once a month and medical specialists who complete inpatient medical records according

to the quality indicator that is 1 x 24 hours will be rewarded.

The fourth obstacle in the process of submitting a COVID-19 claim at Hospital X is the collection of claim files for patients with COVID-19, the completeness of the claim files at Hospital X done by the administrator of the isolation room, and the collection of claim files both hardcopy and softcopy. Obstacles in file collection are mostly incomplete medical resumes written by doctors. An incomplete medical resume written by a doctor will result in the return of the claim file.

Completeness of the supporting requirements for submitting a COVID-19 claim include the medical resume, treatment room description, laboratory results, radiology results, other supporting results, prescriptions for drugs or medical devices, billing, and etc.(5)

The quality of medical records is influenced by the knowledge of doctors, but good knowledge does not always ensure optimal medical record filling. This happens because doctors have a high workload, and lack of support from hospitals and lack of communication.(17) The existence of incomplete medical resumes at X Hospital requires supervision from the Head of Health Services Division and the medical committee.

The claim file submitted by the hospital is then subjected to a verification process by the Social Health Insurance Administration Body to determine whether the claim file is eligible to be paid or not. Claim verification is a procedure for testing the correctness of health care fee claims submitted by the hospital and if there is a resume that is not accompanied by an examination, then the claim will be returned to the hospital for confirmation.(12)

In verifying the claim files from Hospital X, the verifier experienced a problem, namely a medical resume that was difficult to read because Hospital X still used conventional medical records. The handwritten medical resumes make it difficult to read, resulting in errors in the claim report.(18) To reduce medical resumes where doctors' handwriting are unclear and unreadable, it is hoped that Hospital X will implement electronic medical records.

Impact of Hospital X's Cash Flow

At the beginning of the COVID-19 pandemic, the hospital limited patient visits and did not have operations except during emergencies which caused the hospital's income to decrease. Financial problems were also compounded by the disputed claims of patients with COVID-19 which caused payment delays. These problems disrupted

hospital's cash flow and had other impacts, namely providing COVID-19 service infrastructure, such as negative pressure isolation rooms and medicines that require large funds. Then, the cost of health care increased, due to the rearrangement of services in hospitals, namely the separation of infectious and non-infectious patient care services, patient screening, clean, healthy, safe medical services and increased digitization of hospital services. These can delay the payments to providers of drugs and medical devices, and salaries of health workers which will result in decreased performance.(8,18,19)

Even though Hospital X experienced a decrease in the number of patient visits and had many disputed claims for patients with COVID-19, it did not really affect the cash flow at Hospital X, because Hospital X received assistance funds for healthcare for patients with COVID-19 and received substantial goods grants. Not all hospitals experienced financial problems during the COVID-19 pandemic. In some areas, there are hospitals experiencing greater revenue for treating patients with COVID-19 and getting resource assistance.(19)

CONCLUSIONS

Hospital X faced several challenges in submitting claims for patients with COVID-19, including inaccurate patient history, differing perceptions between providers and payers, missing PCR and laboratory results for referral patients, a lack of understanding of technical guidelines for COVID-19 claims by the doctor in charge of services, and typos in national identity numbers.

The frequent changes to claim regulations also posed a significant challenge for Hospital X, which struggled to keep up with the updates. In addition, there were technical issues, such as e-claim application errors that resulted in delayed completion of claim data, incomplete medical resumes, inaccurate patient records, and unreadable resumes.

Despite these challenges, Hospital X has managed to maintain its cash flow without significant disruption from disputed claims related to COVID-19. Nonetheless, the hospital needs to address these issues and ensure that patients receive the care they need while managing costs effectively. Improving the accuracy of patient history, and ensuring adherence to technical guidelines are all critical steps that Hospital X can take to streamline the claims submission process and deliver high-quality care to patients with COVID-19.

RECOMMENDATIONS

To minimize dispute claims and expedite payment of claims at X Hospital, it is crucial to establish regular monitoring and evaluation processes in collaboration with the case-mix team, medical specialists, general practitioners, heads of rooms, and the finance department. One effective step towards this goal is to implement an electronic medical record system to eliminate errors resulting from illegible handwriting. Additionally, incentives and penalties for doctors who submit their medical resumes on time or late can encourage timely submission.

Furthermore, X Hospital and the Social Health Insurance Administration Body must work together to coordinate COVID-19 claims and facilitate quick payments. It is also recommended that the Ministry of Health closely monitors disputed claims that arise in hospitals to ensure prompt and accurate resolution. By implementing these measures, X Hospital can minimize the occurrence of claim disputes and expedite payment, resulting in improved patient care and financial stability.

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