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OPTIMIZING BPJS CLAIMS MANAGEMENT: AN ANALYSIS OF SUBMISSION ACCURACY, ADMINISTRATIVE PROCESS EFFICIENCY AND ITS IMPACT ON HOSPITAL FINANCIAL SUSTAINABILITY

Vip Paramarta[1]*, Deny Teguh Setyaji[2], Alexandra DeSousa Guterres[3]
[1,2,3] Universitas Sangga Buana Bandung, Bandung
E-mail: vip@usbypkp.ac.id [1]*, denyteguh94@gmail.com[2], aldesgguteres2022@gmail.com[3]

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Abstract

The National Health Insurance (JKN) system managed by BPJS Kesehatan aims to ensure access to health services for the community. However, the implementation of this program faces challenges in hospital claims management, including delays in claims submission and payment. This study analyzes the accuracy of BPJS Health claims submission by hospitals, the factors that affect the efficiency of claims administration, and the impact on hospital financial sustainability. The method used in this research is a qualitative method because researchers want to see the natural conditions of the object. The results showed that delays in claims occurred due to a long administrative process, errors in filling out documents, and limited knowledge of medical personnel in diagnosis codification. In addition, the claims payment process took up to 3 months and 10 days, causing financial pressure for the hospital. To overcome these problems, good coordination between health workers and coders, increased accuracy in recording medical data, and utilization of information technology are needed to accelerate claims verification. With an improved claims management system, hospitals can maintain financial stability and improve the quality of health services.

Keywords: ***BPJS Kesehatan, hospital claims, claims administration, financial management, health services.***

INTRODUCTION

The National Health Insurance System (JKN), managed by the Social Security Administration (BPJS) for Health, is one of the Indonesian government's strategic programs to ensure access to health services for all citizens. Since its launch in 2014, this program aims to create an inclusive and sustainable health system. However, its implementation faces various challenges, especially in the aspect of claims management that involves hospitals as the main healthcare providers. Through the BPJS Kesehatan arrangement, facilities can provide health services for patients who are BPJS Kesehatan participants without charging patients. Hospitals can submit claims for service costs for BPJS participants according to certain arrangements (Kosasih, 2022).

BPJS claims are submissions of patient care costs for BPJS Health participants made by the hospital and addressed to the BPJS Health. The submission is made collectively and billed monthly. The function of the claim is to submit the cost of treatment for BPJS participant patients from the hospital to the BPJS, which previously the patient's treatment costs were borne by the hospital. There are several documents that need to be considered in submitting claims, one of which is a medical resume with a diagnosis that refers to the Indonesia Case Base Groups (INA-CBGs) (Rahmatiqa, et al. 2021).

Hospitals as providers of health services for the community have the obligation to document patient data in the medical record system. In the context of BPJS Health financing, medical record documents are used to confirm diagnoses and actions taken by health service providers. The payment pattern of the National Health Insurance (JKN) to health care facilities uses a system that has been built by the Indonesian Ministry of Health, namely INA CBGs. The claim process starts from codifying the patient's diagnosis according to the International Classification of Diseases 10th or ICD 10 and the patient's actions according to the International Classification of Disease Clinical Modification 9th or ICD 9 CM. The hospital fee billing process must also submit documents as a condition for submitting claims (Santiasih, et al., 2022). The BPJS Health will verify the file by the BPJS verifier to test the truth and check the completeness of administrative responsibility for services provided to patients by health facilities in accordance with the Indonesian Minister of Health Regulation (Permenkes) No. 27 of 2014.

The BPJS Health claim submission process must fulfill various administrative and technical requirements in order to be accepted and paid according to the provisions. However, there are still many hospitals that experience problems in managing claims, either due to errors in filling out documents, non-compliance with standard provisions, or late submission. This inaccuracy in submitting claims can lead to a high number of rejected claims or delayed payments, thus hampering hospital cash flow and potentially disrupting health services for patients (Rahayu & Sugiarti, 2021).

In addition to the accuracy of claim submission, the efficiency of the administrative process is also a crucial factor in BPJS claim management. Claim procedures that involve various stages of verification and validation often take a long time, especially in hospitals with a high number of patients. Recording systems that are still manual or less integrated with the BPJS system are also factors that slow down the claims administration process. If not managed properly, these inefficiencies can lead to the accumulation of unresolved claims, increase the workload of hospital administration personnel, and potentially reduce the quality of health services (Puspaningsih, et al. 2022).

The impact of claim submission inaccuracies and administrative process inefficiencies not only affects the hospital's cash flow, but also its long-term financial sustainability. Hospitals that experience delays in payment of BPJS claims can experience significant financial pressure, especially in fulfilling operational needs such as payment of medical personnel salaries, procurement of drugs and medical devices, and maintenance of infrastructure. If this condition persists, it can affect service quality, increase the risk of financial deficits, and even threaten the sustainability of hospital operations. Therefore, optimizing BPJS claims management is an important step that must be taken by hospitals to ensure the accuracy of claim submission, improve the efficiency of administrative processes, and maintain hospital financial stability. This effort requires not only improving the hospital's internal system, but also good coordination with BPJS Health, increasing the capacity of administrative staff, and utilizing information technology in claims management

Based on the above background, the authors are interested in analyzing the accuracy of BPJS Health claim submissions by hospitals, identifying factors that affect the efficiency of the claims administration process, and evaluating the impact of claims management on hospital financial sustainability. Thus, it is hoped that hospitals can optimally carry out their role in providing quality health services to the community without being disturbed by financial constraints stemming from BPJS claim problems.

LITERATURE REVIEW

The BPJS Kesehatan program serves as an alternative to ensure the implementation of the National Health Insurance (JKN) for all Indonesian citizens. Through BPJS Kesehatan, the public can access healthcare services, and hospitals can claim reimbursement for the treatment costs of BPJS participants. The claim submission process is conducted collectively on a monthly basis, after which BPJS Kesehatan evaluates and approves claims that meet the required criteria. Claims with incomplete or incorrect documentation are returned to the hospital for verification and revision (Puspaningsih, et al, 2022).

In accordance with Law No. 40 of 2004 on the National Social Security System and Law No. 24 of 2011 on the Social Security Administering Body (BPJS), BPJS Kesehatan, as a public legal entity, is responsible for implementing the National Health Insurance (JKN) program for all Indonesians. BPJS Kesehatan is mandated to develop a healthcare service system, quality control mechanisms, cost control systems, and an efficient and effective healthcare payment system to ensure the sustainability of the JKN program (Suhadi, 2020).

METHOD

The method used in this research is a qualitative method because the researcher wants to observe the condition of the object naturally. The research instrument is the researcher themselves, who follows stages according to the rules or steps in collecting research data and information (Pahleviannur et a., 2022). The researcher chose a descriptive analysis approach derived from the study of scientific literature. Data collection was carried out by gathering literature sources on BPJS claims management, including submission accuracy, administrative process efficiency, and its impact on hospital financial sustainability, such as scientific journals, articles, official documents, and books. After that, the researcher selected the collected sources by carefully identifying them to obtain the most relevant data. Furthermore, the researcher analyzed and processed the obtained data regarding patterns and findings from previous studies to systematically and accurately describe and present the data.

RESULTS AND DISCUSSION

After searching and screening the references, the researcher divided the screening results into categories. As the findings are the core of this research, this step is the most important part of the systematic literature review. Table 1 below shows the results of screening the reference materials.

Researcher	Title	Methods	Results
(Suhadi, 2020)	Analysis of the Timeliness of Submitting National Health Insurance Claims at Hospitals	Qualitative research with a case study approach	The timeliness of submitting JKN claims is defined as the suitability of the time or date for hospitals when submitting JKN claims to the BPJS office based on the time set for the collection of health service claim files. The timeline for submitting JKN claims has been regulated in Permenkes number 28 of 2014 concerning Guidelines for Implementing the National Health Insurance Program which states that health facilities submit claims every month on a regular basis no later than the 10th of the following month.
(Puspaningsih, et al. 2022)	Evaluation of BPJS Health Claims Administration in Reducing Pending Claims	This type of research is qualitative with a phenomenological approach	The process of submitting hospital claims to BPJS Kesehatan has stages of verification of document integrity, service management and medical services, with the aim of maintaining service quality and cost efficiency in medical services. For BPJS Kesehatan participants, if in the verification process there is a discrepancy between the claim document and the provisions at the verification stage, the BPJS Health verifier will return the claim document to the hospital. Therefore, to prevent the impact of delayed claims from health and social security management institutions in hospitals, doctors must write a diagnosis certificate based on the results of the patient's examination and review the claim.
(Haryono & Budarsih, 2024)	The Effect of Delayed Payment of BPJS Health Claims on Awal Bros Hospital Services Pekanbaru	This research uses a triangulation method that is qualitative, retrospective, and purposive sampling.	The submission of claims is affected by the collection of administrative completeness files in the

			patient administration department, delays in file coding in the casemix unit, and the collection and delivery of claim files by the billing unit, with delays ranging from 7 to 45 days after due date. This affects the hospital's cash flow, so payment of crucial bills must be prioritized, which ultimately affects service quality. In conclusion, the delay in payment of BPJS claims impacts the effectiveness, efficiency, safety, optimization, convenience of health services, and welfare of staff. To overcome this, it is recommended to change the flow of sending BPJS Health claim files, improve coordination and communication between related units, and optimize service quality management and hospital receivables management.
(Maulida & Djunawan, 2022)	Analysis of the Causes of Pending Claim BPJS Health File Inpatient Services Universitas Airlangga Hospital	This research method is quantitative crosectional design	The causes of pending claims at Universitas Airlangga Hospital are due to 4 factors, namely: Incomplete files, inaccurate coding, lack of supporting examinations and lack of evidence of therapy.
(Syahira, et al. 2024)	Strategy for Optimizing National Health Insurance Claims at the Casemix Unit of Hospital "X" Blitar	This research was built with a descriptive qualitative approach and data collection was carried out by interviews and Focus Group Discussions (FGDs).	The prioritized strategies are those derived from SO (strength, opportunity), including improving the integration of hospital information systems with BPJS, effectively implementing BPJS technical guidelines in the coding and claim process, and utilizing BPJS responsiveness to accelerate claim settlement to increase the speed of the claim process.

The submission process in the implementation of BPJS Health claims is a claim administration process carried out using INACBG's, where claim payments are made based on the group of diseases suffered. INA CBG's can be done if you have done coding. According to Permenkes Number 27 of 2014, INA CBG's coding is the activity of providing main diagnosis codes and secondary diagnoses in accordance with ICD-10 and providing procedure codes in accordance with ICD-9-CM. Coding

determines the amount of fees paid to the hospital. After coding using INA CBG's coding, the BPJS claim process is then carried out. The claim procession is carried out to ensure that the costs of the Health Insurance program are used appropriately, so it is necessary to verify the claim (Suhadi, 2020).

Based on Permenkes Number 28 of 2014 concerning JKN implementation guidelines, after going through the entry and coding process, the last stage in submitting a claim is claim verification which aims to test the correctness of administrative accountability for services that have been carried out by health facilities. Verification of claim documents aims to ensure that the costs of the National Health Insurance program by BPJS Health are utilized in the right amount, on time, and on target. Verification of this claim will be carried out by the BPJS Health verifier. The verifier will verify the incoming claim file and determine the number of claims to be submitted and then a billing report will be made by the hospital which will be submitted to the BPJS Kesehatan branch office. Implementation of the BPJSKesehatan claim procession and claim administration process at the Hospital. The final result after claim verification is the claim status. There are three different types of claim status after the claim file is received by the insurance at the hospital, namely the status of eligible claims, the status of ineligible or pending claims and the status of disputed claims (Maulida & Djunawan, 2022).

Every hospital that cooperates with BPJS Kesehatan must follow a claim submission flow that involves various units, from the Patient Administration Unit, Casemix Unit, to the Billing Unit. The accuracy of claim submission is highly dependent on the smooth coordination between units and compliance with the time standards set by BPJS Kesehatan. However, this process often experiences obstacles that cause delays in submitting claims. For example, at RSAB Pekanbaru, the delay in claim submission can reach 2-3 months, which is caused by various factors in each related unit. In the Patient Administration Unit, incomplete files and delivery errors are the main obstacles, while in the Casemix Unit, delays in the coding and verification process also extend the duration of claim submission. In addition, the Billing Unit also faced obstacles in processing and compiling files according to BPJS procedures, which further slowed down the disbursement of claims by the hospital (Haryono & Budarsih, 2024).

Factually in the field, it is found that the factors causing the inaccuracy of JKN claim submission time by hospitals can be seen in terms of brain ware resources in terms of the availability of sufficient personnel, expertise / competence of personnel, workload, busyness of officers, and lack of officer training. In terms of software resources in this case there are application disruptions, the network is always congested, and the installation repair time is uncertain. From the Hard Ware side, computerized devices are damaged. From the patient's side, the completeness of the patient's file is missing or submitted late to the officer. If this condition continues to occur, it will hamper the submission of claims, claim payments will be delayed. The impact felt in hospital services is that services are hampered, low quality, hospital financial difficulties, patient satisfaction, low hospital performance, and the big impact that occurs is that the degree of health will not be realized. Efforts that must be made are the implementation of training, improvement of software systems, socialization to patients, supervision, coordination and teamwork between hospitals and BPJS on an ongoing basis (2020).

This is in line with research conducted by Haryono & Budarsih (2024) which says the factors that influence this delay are divided into two categories: internal factors and external factors. Internal factors include delays in sending claim files to BPJS Kesehatan, lack of communication between units involved in sending claim files, and incomplete claim files sent. External factors include the time-consuming claims verification process, system and financial problems at the central level, premium income to BPJS Kesehatan that is not proportional to claims payments, and budget deficits. Delays in sending claim files have a direct impact on the receipt of claim payments from BPJS Kesehatan. These delays affect cash flow, which in turn affects the hospital's budget allocation and planning policies. As a result, the quality of service quality in hospitals is affected in various dimensions, including competence, service effectiveness, safety, and service convenience.

Based on research conducted by Puspaningsih, et al. (2022) which evaluated the administration of BPJS health claims and found delays in the submission and payment of BPJS Health claims. The efficiency of the administrative process in claims management is highly dependent on how each of these units can work in a coordinated and timely manner. The delays that occur indicate that there are several administrative barriers that need to be improved, especially in terms of manpower, recording systems, and management of claim documents. Delays in claim payments from BPJS Kesehatan have a significant impact on financial cash flow, which has decreased dramatically. This cash flow disruption is characterized by the hospital's failure to fulfill its obligation to pay its counterparties' bills, resulting in financial instability.

One of the main impacts is the disruption of cash flow, where hospitals experience delays in receiving payments from BPJS so that income is not balanced with expenses. This condition results in delays in payment of medical personnel salaries, difficulties in purchasing medicines, and obstacles in fulfilling other operational needs. Hospitals that depend on BPJS claim payments as their main source of income must face the risk of prolonged financial deficits due to delays in fund disbursement, which in some cases can reach 9-10 months after the claim is submitted.

Delays in claim submission can also increase the hospital's debt burden. When cash flow is disrupted, hospitals are forced to seek alternative funding, such as taking out loans or delaying payments to drug and medical device suppliers. Delayed payments to vendors can have a wider impact because it causes supply limitations that lead to a decrease in the quality of health services for patients. If this condition persists in the long term, the hospital could potentially experience difficulties in establishing cooperation with suppliers and other service providers, which ultimately worsens its operational conditions. Not only that, the untimely submission of claims also hampers the hospital's budget allocation for facility development and improvement. Funds that should be used for purchasing new medical equipment, increasing service capacity,

or training health workers are delayed or even diverted to cover urgent operational needs due to slow claim payments. In the long run, this can hinder the hospital's growth and reduce its competitiveness in providing quality health services. With the growing financial burden of late claims submission, hospitals are also at risk of experiencing difficulties in maintaining financial stability, which could ultimately impact their operational sustainability.

Strategies for optimizing National Health Insurance (JKN) claims in hospitals can be done through improving information system integration, effectively implementing BPJS technical guidelines, and utilizing BPJS responsiveness in claim settlement. One of the main challenges in submitting claims is the lack of integration of hospital information systems with BPJS systems. To overcome this, hospitals can adopt technologies that enable real-time data exchange, such as API-based systems or centralized systems that ensure the completeness and accuracy of data prior to claim submission. With an integrated system, the possibility of delayed claims due to data errors can be minimized, thereby accelerating hospital cash flow and improving operational efficiency (Syahira, et al. 2024).

In addition, more effective implementation of the BPJS technical guidelines is essential to ensure the coding and claims process is in line with applicable regulations. Although staff in the Casemix unit are familiar with the existing procedures, regular training needs to be conducted to ensure they are always aware of the policy changes that are frequently updated by BPJS. Hospitals can conduct regular training for coders and administrative staff involved in claims, as well as provide internal guidelines containing a summary of BPJS technical guidelines as a daily reference. Thus, the risk of errors in coding and data entry can be reduced, so that claims are less likely to be rejected or require revisions that slow down the disbursement of funds.

Another strategy that can be implemented is to take advantage of BPJS's responsiveness in resolving pending claims. Hospitals can build a more effective communication mechanism with BPJS, such as forming a special team responsible for handling delayed claims and coordinating their settlement with BPJS. In addition, there needs to be regular meetings between the hospital and BPJS to discuss obstacles that often arise in the claims process and find more effective solutions. By improving this coordination, hospitals can reduce the number of delayed claims, accelerate payment disbursements, and ultimately maintain hospital financial stability.

CONCLUSION

The BPJS Health claim submission process is delayed by about 1-2 months. This is due to the lengthy process of submitting claims involving many units, with several stages repeated or carried out by several units. Delays in submitting claims are influenced by various factors that occur in related units. In addition, the BPJS Health claim payment process is also very long, reaching up to 3 months and 10 days. Some of the factors that cause pending BPJS Health claims in hospitals can be in the form of lack of coder knowledge, writing diagnoses that are difficult to understand / incomplete, and lack of completeness of recapitulation of services provided by the hospital due to the large number of BPJS patients that must be handled. Efforts to reduce the occurrence of pending BPJS Health claims should be between health workers and coders must go well, and for nurses and doctors to be more careful in writing patient data in the service recapitulation file, and health workers should be more careful when filling out medical resumes.

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