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A Position Analysis of BPJS Claims Administration Officers and Verifiers (Case Study: Jambi Province Regional Mental Hospital)

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ABSTRACT

The high coverage rate of handling partially rejected claim financing reaching 7.34 percent of the total 19,476 cases in the Outpatient Unit of the Jambi Provincial Mental Hospital (RSJD) in 2022, is closely related to the quality of human resources (HR) in this case, the claims officer and the suitability of what is done with the job description, job specifications and standard operating procedures (SOP) that have been made. This study aimed to analyze the position of administrative officers and claim verifiers in the outpatient unit of the Jambi Provincial Mental Hospital. This research used a qualitative method. Information was collected through in-depth interviews with eight informants, observation, and document review. Test validity by triangulating sources, techniques, and data. The results showed that officers already knew the claims administration and verification procedures. The claim administration SOP in this case, the RJTL claim submission SOP and the monthly reporting SOP have not been outlined in a decision letter for the coding SOP. However, it has been outlined in a decision letter but has not been adequately socialized to the officers concerned. The SOP for claim verification has not been outlined in a decision letter and still refers to the technical guidelines for claim verification issued by BPJS Health. It is still found that the delegation of tasks and the number of verification officers not following the calculation of workload and standards set are obstacles in implementing administration and verification of claims in the Jambi Province RSJD outpatient department.

1. Introduction

The National Health Insurance (JKN) is a health insurance program for citizens and a foundation for Indonesia's Universal Health Coverage (UHC) (Perdana et al., 2022). The JKN program provides equal rights to access resources in the health sector. It obtains safe, quality, and affordable health services to ensure the welfare of all Indonesian citizens so that they can produce well without having to fall into poverty when they fall ill (Ariyanti & Gifari, 2019).

Hospitals have a strategic function as health facility that collaborates with the BPJS Health and spearhead advanced health services. They must carry out quality medical duties and obligations to the community (Indarwati & Phuoc, 2018). The implementation of hospital

functions is primarily determined by human resources (HR) owned. This is important because the core of organizing quality hospital functions can be seen from the involvement of professionals in the hospital (Romaji & Nasihah, 2018). In addition, the hospital's operation will be optimal if every health worker can work under hospital service and professional standards (Lester, 2014).

The high coverage rate of handling partially rejected claim financing at the Jambi Province Regional Mental Hospital (RSJD) reached 7.34% of 19,476 cases, with a total cost difference of Rp.233,787,700 in 2022. In this case, handling partially rejected claims can be in the form of shares not under procedures or claims with costs not covered by BPJS Health (Ariyanti & Gifari, 2019). In other words, there is a gap between the verification of claim files from the Jambi Provincial RSJD and BPJS Health verification regarding the cost of services covered. Therefore, there is a difference in payment from the results of the claim verified by BPJS Health. The high number of pending claims for BPJS patients in 2022 is an unfavorable record for the performance of the Jambi Province Regional Mental Hospital. In contrast to treatment in inpatient units with relatively longer treatment days, in outpatient units where most of the health services provided are completed on that day, if there is a coding error or incomplete file for handling claims, it will be difficult to contact the patient or repeat the coding. This could result in a high coverage rate of partially rejected claims.

The existence of the above problems, as revealed by the head of the outpatient and inpatient section of the Jambi Provincial RSJD, around 75-80% of claims are rejected partly due to reasons for mismatching diagnostic coding, incomplete files, and double claims, where this is closely related to the quality of human resources in this case, namely claims officers and the suitability of what is done with job descriptions, job specifications and standard operating procedures (SOPs) that have been made.

In research conducted by Maulida & Djunawan (2022), it was found that the lack of completeness in submitting claims by providers caused claims to be delayed or could not be processed. Meanwhile, regarding coordination in submitting claims, it is necessary to apply skill standardization (job specifications), standardize procedures and hold scheduled communication between agencies (Nomeni et al., 2020). This research aims to obtain in-depth information about the analysis of the position of claims administration officers and BPJS verifiers and the determinants that influence it, especially in the outpatient unit of the Jambi Provincial Hospital.

2. Method

This descriptive research uses a qualitative approach that aims to obtain in-depth information about the analysis of the position of BPJS claims administration officers and verifiers in the outpatient unit of the Jambi Province RSJD. The data collected is primary data from in-depth interviews and secondary data from reports or related documents in the Jambi Province RSJD. The theory used in this study is a modification of J. Ghorpade's job analysis theory (Graham-Moore & Ghorpade, 1989). The informants in this study were eight people, consisting of the head of the inpatient and outpatient section, the head of the service quality improvement and HR development section, the BPJS health center verifier, the hospital internal verifier, and the claims administration officer in the outpatient unit of the Jambi Province RSJD.

3. Result and Discussion

3.1. Knowledge

Notoatmodjo in Ridwan et al., (2021), suggests that knowledge results from knowing, which occurs after people perceive a particular object. Knowledge generally comes from sensing that arises through the five human senses. When connected to Bloom's knowledge dimensions, knowledge consists of four things, namely: factual, conceptual, procedural, and metacognition knowledge (Arievitch, 2019).

Accordingly, knowledge in the Jambi Province RSJD outpatient unit is included in the procedural knowledge section on how to carry out claim administration procedures in the outpatient department. Knowledge dramatically influences whether or not the implementation of job analysis. When associated with Ghorpade's job analysis theory Graham-Moore & Ghorpade, (1989), knowledge is an important variable that determines the job analysis process and affects officer performance. Therefore, increasing officers' knowledge of the work procedures they must perform is crucial.

The results showed that most officers were aware of procedures regarding claims administration and claim verification related to the requirements for completeness of claim files, coding provisions, and data purification. This is by the interview quotes from several informants as follows:

> *"... claim files that must be completed for outpatient care include a Participant Eligibility Letter or SEP, proof of service that includes a diagnosis, and a doctor's DPJP. Coding provisions follow the coding guidelines in the INA CBGs Technical Guidelines version 4.1, which can be downloaded from the Ministry of Health website. Data purification includes SEP No., Participant Card Number, and SEP Date..."* **(HA)**

The factors of age and length of service do not significantly affect the knowledge of administrative officers about claims administration procedures in the outpatient unit of the Jambi Provincial Hospital. Educational background plays a more significant role in influencing officers' knowledge of claims administration procedures when compared to age and length of service. Then in another study conducted by Kurniawati, (2022), suggested that the level of education can affect a person's thinking patterns. When a person's level of education is high, the person's way of thinking is broader.

Implementing claims in the outpatient unit of the Jambi Provincial Hospital is closely related to officers' knowledge regarding the fixed procedures or SOPs used as a reference in implementing these claims. With knowledge of systems or SOPs, officers understand their respective duties and what to do so that the work process can be carried out and achieve the expected results (Putri et al., 2020).

3.2. Claim Administration and Verification SOP

In an agency or organization, internal agency standard procedures must be followed by the agency as a benchmark in carrying out activities to ensure consistency and systematic work processes to achieve mutual commitment (Pradani et al., 2017). Standard Operating Procedures (SOP) are guidelines or references for carrying out tasks or work under

government agencies' functions and performance assessment tools based on technical, administrative, and procedural indicators under work procedures, work procedures, and work systems in the work unit concerned.

According to the Regulation of the Minister of State Apparatus Empowerment No.35 of 2012 by Menpan RB, (2012), standardization of work processes / SOPs can be divided into two types, namely: Technical SOP, which is a standard procedure that is very detailed and technical in nature and administrative SOP which is a legal procedure intended for organizational types of work. An essential stage in preparing SOPs is conducting system analysis, work procedures, task analysis, and work procedure analysis (Taufiq, 2019).

Based on the results of field observations and document review, there was no SOP for file inventory for claims administration in the outpatient unit of the Jambi Provincial RSJD because for administration in the outpatient department, both coding and returning medical record files and claim files in the outpatient unit poly. This is by the excerpt from the in-depth interview with the informant below:

> *"... we don't have an inventory of files. Every day after finishing all the patient's lists, we return them to the Medical Record. Nothing is stored in the Poly..."* **(PJA)**

> *"... for file inventory and internal monthly reporting for the hospital, I don't think it has been officially issued as far as I know. We were just taught by previous seniors..."* **(KN)**

Realizing the importance of SOPs in the implementation of work in an agency and from the results of the research, it was found that there are still claims administration SOPs that have not been outlined in a decision letter or the preparation stage, such as the SOP for submitting claims and monthly reporting. However, there are others that already exist and have been outlined in a decree by the hospital director but have not been adequately socialized to the officers concerned.

To improve administrative staff performance, especially in the outpatient unit, the hospital director needs to establish a Decree (SK) on guidelines for preparing SOPs related to the technical implementation of claims administration. With the establishment of the SOP, it is hoped that the suitability of the performance of the work process, especially in the clarity of the claims administration process, includes the clarity of the responsible work unit to achieve smooth operational activities. And with the SOP, the performance of the outpatient team can be evaluated measurably. Then for SOPs that already exist but have not been adequately socialized to the officers concerned, such as the coding SOP, the socialization needs to involve the head of the work unit. Socialization starts from the bottom to the top so that no more staff do not know the flow of coding procedures.

3.3. Job Description

A detailed job description is needed so that each officer's activities can be well organized. Job descriptions must consider six qualifications: systematic, clear, concise, precise, principled, and accurate (Krisnawati & Bagia, 2021). After conducting in-depth interviews, it is known that the job description of claims administration officers in the Outpatient Unit is to check claim files, code, submit claims, and monthly reporting. The following informant statement quote illustrates this:

"... the description of my duties is just that, after finishing coding, I check the completeness of the claim file and the validity of the SEP. Everything is not given to Ms. Ade to be claimed..." **(PJA)**

The implementation of claims administration activities by administrative officers in the outpatient unit is still partly found to delegate tasks in carrying out claims administration activities to other officers who are not in that position. As well as not implementing efforts to develop most of the human resources of claims administration officers related to implementing employment patterns and personnel qualifications. Meanwhile, most have been carried out under applicable procedures and technical instructions in implementing claim verification activities by verifiers in the outpatient unit. This is reinforced by evidence of the results of researchers' observations in the field in Table 1.

Table 1. Observation of claim verification

No	Type of Activity	Implementation		Description
		Yes	No	
1	Checking the completeness of the claim file			Implemented
2	Inventory of claim files			Implemented
3	Verification of diagnoses, procedures, coding etc.			Implemented
4	Verification of cost calculations based on hospital rates and INA-CBGs system			Implemented
5	Daily recap of claims data			Implemented
6	Monthly claims data recap			Implemented
7	Monthly claims verification reporting			Implemented
8	Monthly reporting submission			Implemented
9	Feedback from BPJS Health			It's there but can't be shown
10	Evaluation by supervisors			No evaluation from superiors during the research

Source: Primary Data, 2022

The results of a previous study stated that it is necessary to update job descriptions by reviewing job descriptions, evaluating competencies regularly, and increasing training and development programs for position holders so that there is not too large a competency gap (Alvianitasari et al., 2018).

3.4. Job Specification

According to the Head of the Civil Service Agency Regulation No. 12/2011 by BKN RI (2011), job specifications are defined as the qualifications that must be met to perform a job or position holder. Job requirements include rank/grade, education, courses/training, work experience, work knowledge, work temperament, work interest, etc.

The obstacles faced by the outpatient unit of the Jambi Provincial RSJD from the results of the study found that there were still officers in the outpatient department who had the lowest education at the high school level (SMA) and the most increased education, namely strata one (S1) with a long span of service and varied age composition. Therefore, it is necessary to standardize officers' knowledge through training or socialization in carrying out work. The requirements for the minimum education level of verifier officers, namely at least

diploma three (D3) and preferably S1 if further examined and compared to the facts in the field that verifier officers in the outpatient unit have an S1 computer education background, are not appropriate when associated with the job description of claims officers in the outpatient department, especially in the coding and verification process which requires curative and medical knowledge specifications. It is a criticism from researchers that formal education for verifiers in the outpatient unit is at least D3 nursing and preferably S1 nursing or other health workers who already have a curative and medical knowledge base and expertise to minimize errors in the implementation of claim verification.

Because there is only one staff member in charge of verifying outpatient claims while the number of cases per day is large, it requires accuracy in verifying claim cases. The number of claims verifiers in the outpatient unit, in reality, is not under the standards needed for the joint decision of the Minister of Health and Head of BKN No.48/Menkes/SKB/2014 which states that type C hospitals must have two professional medical record verifiers (Kemenkes RI, 2014).

3.5. RJTL Claims

The problems with BPJS claims, as described in the study, are not new, even long before PT Askes changed its name to BPJS Health (Hafiz et al., 2020). In recent years, the implementation of Jamkesmas with an INA-DRG-based case-mix system (which later changed its name to INA CBGs) has caused many problems in various hospitals. This impacted revenue from reimbursement claims submitted to the government, sometimes rejected or unpaid. Although it has not caused hospitals to go out of business as in America at the beginning of the implementation of case-mix, it has caused problems in hospitals, especially in government hospitals. When compared to the number of partially rejected claims in the previous year, which did not exceed 7%, and among other government hospitals in Jambi City, the percentage of somewhat dismissed claims in the outpatient unit of the Jambi Provincial RSJD with a figure of 7, 34% of the total 19,476 cases in 2022 was the highest and significant figure.

Previous research found that the problems faced in submitting BPJS Health claims in coordination and teamwork, late submission and incomplete documents, and the absence of a billing system caused delays in claim payments (Santiasih et al., 2022). In line with this research in the outpatient unit of the Jambi Provincial Hospital, claims were rejected due to incomplete files, incompatibility of diagnoses, inappropriate coding, and the expired referral letter date. To reduce the shortage of claim files, namely by conducting repeated coaching to claims officers in the outpatient unit, supervising the implementation of claims administration and verification to ensure file completeness, and providing practical manuals regarding the claims administration and verification process aimed at officers related to claims administration and validation in the outpatient department.

4. Conclusion

Most administrative officers already know the procedures regarding claims administration, in this case, checking the completeness of files, coding, submitting claims, and knowledge of monthly reporting procedures. Age and service length did not significantly affect officers' knowledge of claims administration procedures. Verifiers already know the methods for claims verification, including verification of membership administration, assurance of service administration, and use of verification software. The claims administration SOP, in this

case, the RJTL claim submission SOP and monthly reporting SOP, have not been outlined in the form of a decision letter. Although the SOP for coding has been outlined as a decision letter, it has not been adequately socialized to the officers concerned. Implementing administrative activities and verifying claims in the outpatient unit has mainly been carried out under the job description and application procedures. However, tasks are still delegated to other officers, not in that position. The number of claims verification officers in the outpatient unit is not under the workload calculation and established standards.

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