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OVERVIEW OF POST-CLAIM VERIFICATION AND ADMINISTRATIVE AUDIT OF NATIONAL HEALTH INSURANCE AT SURYA HUSADHA GENERAL HOSPITAL, DENPASAR

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ABSTRACT

Post-claim verification of JKN and administrative audit by BPJS is a checking and evaluation process carried out after a health service claim is submitted and paid by BPJS Kesehatan to review the claims that have been paid to ensure that they are in accordance with applicable provisions. RSU Surya Husadha Denpasar has undergone post-claim verification and JKN BPJS administrative audit, the results of post-claim verification and JKN administrative audit by BPJS can be in the form of claims that have been paid being verified and re-audited because there are several components in the claim submission that are lacking so that they fall into the category of claims that do not comply with the provisions. This can trigger a return of payments that have been paid by BPJS so that the hospital experiences losses in terms of financing. The research that has been conducted at RSU Surya Huasdha Denpasar uses a quantitative descriptive method with a total sampling of 259 post-claim verification files and JKN claim administrative audits. Based on the results of the research and discussion of the description of post-claim verification and JKN administrative audit at RSU Surya Husadha Denpasar, the results of the post-claim verification of the National Health Insurance carried out by BPJS at RSU Surya Husadha Denpasar showed that there were a total of 18 post-claim verification files for July - September 2023 that did not match the percentage of 6.9% and 214 files that matched the percentage of 93.1%. The files that did not match have been made into a post-claim verification report as the basis for compensation for deductions of excess claim costs that have been paid in the future. The results of the National Health Insurance claim administration audit carried out by BPJS Kesehatan at RSU Surya Husadha Denpasar showed that there were 15 claim administration audit files for July - September that did not match the percentage of 5.8% and 244 files that matched the percentage of 94.2%. The files that did not match have been made into a claim administration audit report as the basis for compensation for deductions of excess claim costs that have been paid in the future.

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1. INTRODUCTION

Hospitals are health service institutions that function to provide comprehensive health services to the community, including inpatient, outpatient, and emergency services. The success of hospitals in providing quality services is assessed by the level of patient satisfaction.

obtained through fast and precise services (Law No. 17 of 2023). In the era of National Health Insurance (JKN), hospitals are also required to be able to provide services in accordance with the provisions of the Social Security Administering Agency (BPJS) Health, which regulates the claim submission mechanism for health services provided to JKN participants.

BPJS Kesehatan is an institution established by the government to organize the JKN program, with the aim of providing equal access and health protection for all Indonesian citizens. In the process, hospitals serving BPJS Kesehatan participants must follow a series of claim procedures regulated through the INA-CBGs (Indonesian Case Based Groups) mechanism, where these claims will be verified by BPJS Kesehatan to ensure the accuracy of the data and compliance with applicable regulations.

However, it is not uncommon for there to be obstacles in submitting claims. These obstacles can trigger post-claim verification and administrative audits conducted by BPJS Kesehatan. This process is carried out to ensure that claims that have been paid are in accordance with the provisions. If any discrepancies are found, the hospital is required to return the claim payments that have been received, which of course can have a negative impact on hospital income.

Based on data from Surya Husadha General Hospital Denpasar during 2023, around 3-5% of the total claims submitted underwent a re-verification process and administrative audit by BPJS Kesehatan. This process can affect the hospital's cash flow and increase the administrative burden. Therefore, research is needed to understand the causes of post-claim verification and administrative audits, as well as to find solutions that can improve the efficiency of the claims process in hospitals.

This study aims to describe the post-claim verification process and JKN administrative audit at RSU Surya Husadha Denpasar. By understanding this process, it is expected that the hospital can identify areas that need to be improved in order to reduce the number of inappropriate claims and minimize financial losses due to claim refunds.

2. RESEARCH METHODS

2.1 Types of Research

This study uses a descriptive quantitative approach. The quantitative method was chosen because the purpose of this study was to measure and analyze claim data that had been verified and audited by BPJS Kesehatan. The descriptive approach was used to provide an overview of post-claim verification and JKN claim administration audit at RSU Surya Husadha Denpasar.

2.2 Data Collection Procedure

(1) Data Type

The data in this study were collected through observation and documentation methods. Observations were made by directly observing the post-claim verification process and administrative audit at RSU Surya Husadha Denpasar. The researcher used a checklist sheet containing a list of claims that had been verified and audited by BPJS. Documentation data was taken from the claim administration files stored by the hospital's Medical Records and Casemix section, as well as related documents relevant to the verification and audit process.

(2) Data Collection

The data in this study were collected through observation and documentation methods. Observations were made by directly observing the post-claim verification process and administrative audit at RSU Surya Husadha Denpasar. The researcher used a checklist sheet containing a list of claims that had been verified and audited by BPJS. Documentation data was taken from the claim administration files stored by the hospital's Medical Records and Casemix section, as well as related documents relevant to the verification and audit process.

3. RESULTS

This study examines 259 BPJS Kesehatan claim files at RSU Surya Husadha Denpasar for the period July to September 2023. Based on the results of post-claim verification and administrative audit, the results of the study can be presented as follows:

3.1 Post Claim Verification Results

Of the total 259 BPJS claim files verified by BPJS Kesehatan:
A total of 241 files (93.1%) were declared appropriate and did not require further action.
A total of 18 files (6.9%) were declared inappropriate, requiring corrective action and a claim refund.

Table 1. Results of BPJS Post-Claim Verification at RSU Surya Husadha Denpasar

Status Klaim	Frekuensi	Persentase (%)
Sesuai	241	93,1%
Tidak Sesuai	18	6,9%
Total	**259**	**100%**

The results of the study showed that the majority of claims submitted by RSU Surya Husadha were in accordance with the standards set by BPJS Kesehatan. Of the 259 files verified, only 6.9% were not in accordance. This inconsistency is likely caused by errors in filling in the diagnosis code, inconsistency of supporting files, or incompleteness of the submitted documents.
Claims declared inappropriate by BPJS Kesehatan cause hospitals to have to return the claim payments that have been received. This can affect the hospital's cash flow and increase the administrative burden in correcting claim files.

3.2 Claims Administration Audit Results

Of the 259 claim files that were audited administratively:
244 files (94.2%) were declared appropriate.
A total of 15 files (5.8%) were declared inappropriate and required further correction. Table 2.
Results of BPJS Claim Administration Audit at RSU Surya Husadha Denpasar

Status Audit Klaim	Frekuensi	Persentase (%)
Sesuai	244	94,2%
Tidak Sesuai	15	5,8%
Total	**259**	**100%**

The results of the administrative audit show that most claims (94.2%) meet the administrative requirements set by BPJS. However, there are still 5.8% of claims that do not comply with the provisions. This non-compliance has the potential to cause financial problems for the hospital, especially in terms of compensation for claims that have been paid.
Further analysis showed that inappropriate claims were generally related to inaccuracies in data entry, such as incorrect diagnosis and procedure codes or discrepancies between the documents submitted and the services provided.

4. CONCLUSION

4.1 Conclusion

Based on the results of the study on post-claim verification and audit of National Health Insurance claim administration at RSU Surya Husadha Denpasar, the following conclusions can be drawn:

Post-Claim Verification: Of the total 259 BPJS Kesehatan claim files submitted by RSU Surya Husadha Denpasar for the period July to September 2023, 93.1% of claims were declared appropriate, while 6.9% of claims were declared inappropriate. This inconsistency requires the hospital to carry out

refund of claims payments that have been received, which can have a negative impact on the hospital's cash flow.

Claim Administration Audit: From the results of the administrative audit, 94.2% of claims were declared in accordance with BPJS Kesehatan standards, while 5.8% of claims were not in accordance. Inappropriate claims must be corrected through a compensation mechanism, where the hospital returns the claim funds that have been paid.

Implications: Claim discrepancies, both in the post-claim verification process and administrative audits, are mostly caused by errors in filling in diagnosis codes, incomplete supporting documents, and inaccurate information submitted. This indicates the need for improvements in the claims submission system and administrative control in hospitals.

4.2 Suggestions

(1) For Hospitals

Improved Accuracy in Claim Submission: RSU Surya Husadha needs to strengthen its internal control system in the BPJS Kesehatan claim submission process. Before a claim is submitted, a thorough check needs to be carried out on the completeness of the documents and the accuracy of the diagnosis codes and medical procedures. This can reduce the number of inappropriate claims and the potential for refunds. Continuous Training for Administrative Staff: The hospital should provide regular training for staff in charge of submitting claims. This training should include filling out claim forms, coding diagnoses, and understanding BPJS administrative standards. Improving staff competency can minimize the possibility of errors in submitting claims.

Routine Evaluation of Claim Process: Hospitals need to conduct periodic evaluations related to claims that have been submitted and the results of BPJS verification. With evaluations, hospitals can identify errors that often occur and take corrective steps to prevent recurrence in the future.

Utilization of Technology for Claim Submission: RSU Surya Husadha can utilize a more integrated information technology system for the claim submission process. The use of special applications in managing BPJS claims can minimize manual errors and speed up the verification process and administrative audits.

(2) For Further Researchers

Further Research Development: This study focuses on post-claim verification and BPJS Kesehatan claim administration audit. Further researchers can expand the study by exploring other factors that influence claim non-compliance, such as the influence of hospital policies, the role of information technology, or a more in-depth analysis of frequently incorrect diagnosis codes.

Comparison Between Hospitals: To provide a broader picture, the next researcher can conduct a comparative study between several hospitals that are partners of BPJS Kesehatan. This comparison can reveal differences in claims management and strategies to reduce claims discrepancies in various hospitals.

Use of Qualitative Methods: In addition to quantitative research, the use of qualitative methods such as in-depth interviews with hospital administrative staff, BPJS verifiers, and patients can provide deeper insights into the obstacles and challenges in the BPJS claim submission process.

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