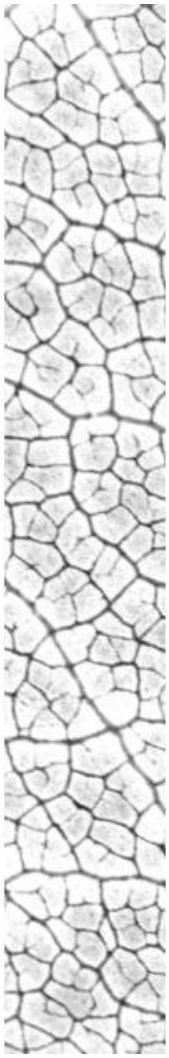

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Factors affecting potential overpayment claim of government health insurance in naval hospital

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Abstract
Background: There are the potential overpayment claims performed by hospital. The aims of the study were to find out what the factors causing potential overpayment.
Methods: This study was descriptive analytic to all document after audited by internal oversight unit for national health insurance (BPJS). The population was all claim documents after audited by internal audit BPJS in 2018.
Results: The results showed that there were 3881 (1.33%) potentially overpaid documents found during 2018. The value of overpayment was approximately IDR 4,066,938,800 (1.18%) of total claim BPJS in 2018. Factors affecting overpayment claim of BPJS insurance were: readmission, double billing for inpatients and outpatients on the same day, differences in perception of diagnoses and procedures in coding, different classes of care with patient rights, billing of died patient, and chemotherapy patients.
Conclusion: The potential for overpayment can be resulted from both hospital and BPJS sides associated with difference of perception.

Keywords: health insurance, claim document, claim audit, potential overpayment

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INTRODUCTION

Social health insurance literacy is the measure of one's knowledge and confidence to find, evaluate, and choose the most suitable health plans by considering their financial and health conditions (or their family), and maintain the plan after the registration. Individuals with low social health insurance literacy face more challenges in accessing social health insurance services and consequently low social health insurance (Nisa' & Sari 2019). BPJS is an agency in Indonesia that is a public legal entity, non-profit state owned by and responsible to the Government, and responsible for the National Health Insurance (JKN). On 1 January 2014, BPJS came into effect. Participants of BPJS Health program are divided into 2 groups of new participants and the transfer of the previous program, the Health Insurance, Public Health Insurance, the Indonesian Armed Forces, the Police, and the Workers' Social Security (Rahman et al. 2015).

Problems also emerge in developed countries with the introduction of the JKN: the number of vulnerable citizens, the weak wage capacities and the growing number of non-formal employees in the industry. One of the difficulties in applying the new JKN in Indonesia is the contradictions in the allocation of gross income to the overall expense to be paid to support participants in public health. Data from BPJS Health reveal that only 50.19% of active BPJS members in Indonesia paid dues in 2015 (Palutturi et al. 2018). BPJS states that the realization number of back-referral by the end of 2015 was 34.05% (401,848 out of 1.18 million participants with chronic diseases according to the types of diseases classified in the back-referral program). This causes an increase in hospital claim submissions. By the end of 2017, BPJS Kesehatan had experienced a deficit of 4.4 trillion (Esti, Sandra, & Witcahyo 2019). In serving BPJS participant patients, the hospital submits billing claims for the cost of patient care which is performed collectively and billed to the Healthcare BPJS every month. This process is especially important for the hospital as the reimbursement of treatment costs of BPJS Kesehatan participant patients. Facilities partnering with Healthcare BPJS submit claims every month regularly no later than the 10th of the next month, enclosing the required documents that must be completed in accordance with the Healthcare BPJS verification procedure (Supriadi 2018; Maikasuwa, et al. 2017).

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After claims have been submitted, the subsequent processes are purification, verification, and feedback on the billing claims. The next stage is the payment process in accordance with the Minutes of Claim Verification. However, following the payment of claims, a claim audit is conducted to check for overpayments for the claims. The claim audit is conducted by BPJS once a year and effective retroactively for one year of previous service. An audit is also conducted independently by the internal verifier of Healthcare BPJS every current month after claims have been paid (Kesehatan 2014). The claim audit finds potential overpayments to be reconfirmed by Healthcare BPJS to the hospital. Consequently, the hospital must return the excess in the form of a discount for the next claim. This causes troubles in regard to budget and hospital operating cost.

Hospitals are a labor-intensive health care organization (Ajenjo et al. 2010). Dr Ramelan Naval Hospital Surabaya, East Java, Indonesia or commonly known as RSAL Surabaya is a hospital owned by TNI AL. However, Dr. Ramelan Naval Hospital is not limited to family members and/or retired soldiers; it is also open to the general public. Patients visiting Dr. Ramelan Naval Hospital consist of 90% BPJS participants and 10% general and partner patients. This study aimed to find out what the factors causing potential overpayment.

METHODS

This study was quantitative in nature, with analytical survey. The populations in this study were all BPJS claim files in 2018, amounting to 254.669 files. Samples taken were Healthcare BPJS audit result files that has been approved by BPJS internal verifiers to Dr Ramelan Naval Hospital Surabaya, East Java, Indonesia, amounting to 3.881 files. After a review and confirmation with the doctors and related officers, they were then reconfirmed to Healthcare BPJS in response to the hospital. Examination and verification were reperformed for files approved as overpayment potentials.

There were several cases in the procedure of action that found differences between the hospital and the Healthcare BPJS because Healthcare BPJS conducted an audit based on a digital claim verification system, while the clinician felt that the procedure was carried out. The characteristics observed in this study are Claim Value, Confirmation Value, and Payment Refund. These three characteristics are seen based on existing several types of cases, including double claim, readmission, perception difference in treatment coding and class, dead patient claim, and chemotherapy.

Table 1. Number and Types of Claim Audit Cases in 2018

Case Types	Number of Cases	%
Double claim	615	15.8
Readmission	12	0.3
Perception difference in treatment coding & class	209	5.4
Dead patient claim	1	0.02
Chemotherapy	3.044	78.48

Table 2. The Number of Claim Audit Cases and Approved Cases

Case Types	Case Number	Number of Approved Cases	Number of Unapproved Cases
Double claim	615	615	0
Readmission	12	10	2
Perception difference in treatment coding & class	209	206	3
Dead patient claim	1	1	0
Chemotherapy	3.044	1122	1922

RESULTS

Based on **Table 1**, chemotherapy cases dominate with 78.48% out 3,881 total audit claim files. The second place was the inconsistency of double claim billing of inpatients and outpatients with 15.8%, the confirmation of difference in diagnose perception and treatment class in the third place with 5.4%, followed by readmission with 0.3%, and the last was one case of dead patient billing (0.02%).

Table 2 shows that for double claim and dead patient billed, Healthcare BPJS and RSAL Dr. Ramelan agree that both cases are a subject of overpayment and the hospital must return the excess. For the readmission case, out of 12 cases of audit findings, 2 cases were rejected, and 10 cases were approved. For difference in coding perception, 3 cases were rejected, and 206 cases were approved for the return of the excess of the payment. Many cases were rejected for chemotherapy case with 1922 cases.

Table 3 shows that the potential for overpayment in 2018 is IDR 8,419,398,800, and the biggest overpayment potential is found in chemotherapy cases with 81.75% or equal to IDR 4,274,964,600. Other overpayment potential cases were diagnosis confirmation, procedures and care class with 15.93% (1,332,496,700). It was smaller than the number for inpatient and outpatient double claim, but it had higher payment value. The value of inpatient and outpatient double claim and care class was 1.58% (IDR

Table 3. Claim Value, Confirmation Value and Payment Refund Value 2018 Claim Audit

Description	Claim Value	Confirmation Value	Payment Refund Value	%
Double claim	133,266,600	133,266,600	133,266,600	100.00
Readmission	69,439,600	9,471,500	59,968,100	86.40
Difference in diagnosis perception, procedures and care class	1,332,496,700	68,023,900	1,264,472,800	94.90
Death	1,656,600	1,656,600	1,656,600	100.00
Chemotherapy	6,882,539,300	4,274,964,600	2,607,574,700	37.90

133,266,600). The next was readmission cases with 0.82% or equal to IDR 69,439,800, and lastly, one dead patient case with 0.02% (IDR 1,656,600).

Double Claim of Inpatients and Outpatients

The reasons for this are several problems that arise in the process of BPJS claim requirements for inpatients, including BPJS claim documents not being filled out completely, lack of proof of service, incomplete evidence of supporting examinations, the discrepancy between operational reports and medical resumes, the discrepancy of procedures written on the medical resume with the ones on the proof of service, and consequently, billing claims are made twice. The main claim on every 10th after 80% of SEP hospitalizations have been reached, and the remainder as a follow-up inpatient claim is billed on every 20th.

The IT system in Healthcare BPJS is unable to detect the double claim at file verification stage since the outpatient claim is not filed at the same time alongside the inpatient claim. This results in the payment of claims that are not in accordance with the provisions of the episode of care, i.e., the payment of outpatient claims which are part of the inpatient claim that should be billed as an episode of inpatient care. In an effort to overcome the above condition, an application assistance system was developed to detect double claims, and outreach was conducted to outpatient entry officers. Thus, outpatient SEPs were combined with inpatient SEPs in patients treated from polyclinic or from emergency rooms.

Readmission

There is a billing in inpatient case with a potential for readmission tendency. This happens when a patient readmits days after being released presenting conditions similar to the prior admission. Out of 12 cases (0.3%), from total audit files, two cases were rejected since the second diagnosis differs from the first diagnosis of the previous admission.

The IT system of BPJS only detects readmission potential if a patient is re-hospitalized on the adjacent date for the month. For example, a patient is admitted on 28 June and released on 8 July, then they are readmitted on 10 July. Seen from the INA CBGs, first and the second admission have different codes. The INA CBG code for the first admission is K-4-10-II and for the second admission is U-4-10-1. A review needs to be performed to determine whether the second condition is similar to the first condition at admission. The hospital needs to conduct an elucidation and communicate with the doctors in charge of the patients so that prior to releasing a patient an examination is redone and complete records are taken as evidence that the patient is eligible to be discharged.

Diagnosis, procedure and care class confirmation

There is a diagnosis coding mismatch of ICD X and ICX IX coding rules with INA CBGs. Out of 209 (5.4%) audit files, only six (2.8%) cases were rejected. Some diagnoses or procedures in coding must be adjusted. The billing claim files must be included to support the diagnosis, for example, the diagnosis of anemia must be strengthened with laboratory and transfusion results or the diagnosis of DHF with shock syndrome needs to include signs of shock. The same also applies to supporting radiological examination, the complete evidence of the results of radiological examination must be included to support the enforcement of the diagnosis. Differences in the calculation of the use of ventilators also cause differences in ICD IX coding.

Coding skills are very important, as is communication and outreach with doctor so that all actions and evidence of services are tailored to what is on the medical resume. This coding understanding is a quite crucial problem because there are no standard rules, there is only local understanding. Thus, if there is no agreement between the hospital and Healthcare BPJS, then the problem will be brought to the Clinical Consideration Council where the settlement time can be overly long. In the case of care class, the potential for excess in claims occurs in patients who are declassed because the appropriate class corresponding to their rights is full, so that patients are billed based on the class of care not based on patient rights. This error is caused by the lack of carefulness of officials in inputting data so that billing is not in accordance with the regulations of care class. Improvements must be made so that the treatment class is rewritten in the code that has been written by the coders according to the maintenance class.

Dead patients

There was one inpatient case that is admitted on 4 July 2018 and on 6 July 2018, and the patient died. However, on 2 August 2018, there was an outpatient claim filing for the patient. This happens because before the patient died, he underwent CT scan supporting examination but the radiology department was late in submitting the radiology examination claim documents which should have been part of the inpatient claim, resulting in a service bill for a participant who had died in the previous service. Delay in submission of supporting document file will result in double claim. Elucidation is needed so that the supporting documents that are part of the claim documents are not billed separately. BPJS has actually made an effort by inputting in the system the discharge status of dead patients by entering a death certificate and locking the BPJS system for participants who died.

Chemotherapy

Radiotherapy services at RSAL Dr Ramelan are carried out mostly as inpatients. Healthcare BPJS raised

a question whether it is possible for this chemotherapy service to be carried out on an outpatient basis, thereby necessitating clinical confirmation pathway. In this chemotherapy case there were 3,044 (78.48%) cases and after a review of clinical protocols and the use of chemotherapy drugs given to patients, it was found that not all cases of chemotherapy can be performed on an outpatient basis. Based on Permenkes No. 76/2016 on Guidelines of INA CBGs in Chapter 3, for services in the form of ongoing procedures or therapy in outpatient services, such as radiotherapy, chemotherapy, medical rehabilitation, psychosocial rehabilitation, blood transfusion and dental services, the applicable episodes are on a per visit basis.

After the review, 1,922 (63,14%) cases were not eligible for outpatient service, citing patient conditions as the reason, where the use of more than one type of chemo drugs must be performed > 6 hours, thus, patients still require hospitalization. There were 1122 (36.86%) files of chemotherapy patients who did require hospitalization. Guidelines for chemotherapy from the related collegiums were just put in order on August 2019 as the basis for outpatient and inpatient chemotherapy services.

Claim Value, Confirmation and Payment Refund Value

After reconfirmation, RSAL Dr. Ramelan and Healthcare BPJS agreed that for double claims and dead patients, 100% of the potential for overpayment was billed. A total of 94.9% were cases of different perceptions in the coding of diagnoses and procedures with a return value of IDR 1,264,472,800. This coding ability needs special attention because the percentage of overpayment is quite large even though the value is smaller than chemotherapy cases. 37.9% (IDR 2,607,574,000) of chemotherapy cases are accepted as an overpayment case, while the other 62.1% are rejected because chemotherapy patients still need hospitalization. 86.4% (59,968,100) of readmission cases are accepted. The total reimbursement value of the original claim is IDR 8,419,398,800 and after re-verification, an overpayment of IDR 4,066,938,800 (48.3%) was found.

Causes, Development and Supervision

The claim audit result above is caused by both parties. There is a weakness in Healthcare BPJS's claim file digital application control system at purification and verification processes. Many regulatory changes often occur without preceded by elucidation. This has an impact on services that lead to overpayments. Potential fraud can occur because of pressure and opportunity. The BPJS program is not yet fair for the hospital. This is a potential cause of fraud. The provision of one day one polyclinic and one hospital can cause service fragmentation. BPJS tariffs perceived as disproportionate to the services provided will harm hospitals and trigger potential fraud in readmissions.

DISCUSSION

Factors affecting overpayment claim of BPJS insurance were: readmission, double billing for inpatients and outpatients on the same day, differences in perception of diagnoses and procedures in coding, different classes of care with patient rights, billing of died patient, and chemotherapy patients. The hospital itself needs to improve the competence of coders and doctor discipline in documenting service procedures into medical resumes and the completeness of supporting files as part of claim collection documents and elucidation and communication to doctor related to the understanding of service regulations (Greiner & Knebel 2003). Improved monitoring and evaluation of the anti-fraud team needs to be improved. Policies, guidelines, SOPs in good service governance are needed to create an anti-fraud culture and sound business practices. Sanctions must be given to service personnel if they deliberately commit a fraud. Quality control and cost control must always be monitored in order to create bureaucratic reform in public services including hospitals (Bel & Esteve 2020). Injustice in geographical, educational and domestic economic differences must be reduced by enhancing JKN policy and other policies linked to the success of JKN's implementation (Nasution, Mahendradhata, & Trisnantoro 2019). Utilization of information technology with e-claims at RSAL Dr. Ramelan that is still in process is expected to help minimize the potential for overpayment. It is also expected that this will increase orderliness in the process of completing claim documents so that the claim collection process will be faster and the findings on the claim audit will be reduced so that the potential for overpayment will not become an obstacle in the hospital's procurement and operational planning process.

Policymakers recognize increasingly that government purchasing can improve regulatory efficiency and improved quality, as government payment-based facilities are incentives to respond. In the meantime, other advocates suggest that federal funds should be used for funding public facilities to minimize access costs for the underprivileged. Common purchasing criticisms include being unstrategically reasonable to increase quality or lower costs; being complex could increase administrative costs, and being able to remove resources from public facilities from the integration of private suppliers (Lagomarsino et al. 2012). In addition to growing inefficiencies from adverse selection through cost management benefits, game ability and fairness, we understand that the regulatory authorities have goals. A Medicare Advantage program indicates that programs which are more reliable and

consistent for insurance plans are more desirable as policies are built to increase profits. For the rationing of services to matter, predictability is the level to which enrollees can predict the future use of a service. Unless consumers can anticipate their use of a service, selective rationing cannot influence their plan choices. Due to its impact on revenues received by a plan for registering an individual, risk adjustment and other system features affect the plan's incentive to ration predictiveness (Layton & Ellis 2018).

Furthermore, each of the nine countries surveyed tend to develop practices and procedures iteratively. PhilHealth has announced plans to discourage copayments from being levied by the public hospitals, and the number of lawsuits submitted by disadvantaged people has risen by 50 percent since 2007. The Ghanaian scheme works to better identify and enroll the underprivileged. India is piloting primary care benefits by RSBY and the Kenya National Hospital Insurance Fund. However, the difficult relationship between domestic politics, international donor demand, financial reality and organizational viability poses problems for system design and execution which can achieve all objectives. Tradeoffs are inevitable. As countries of all levels world over aspire to pursue sustainable health, we are inspired by the initiatives of these nine developed countries which are challenging, nonetheless (Lagomarsino et al. 2012).

JKN program has opened access of inpatient utilization in both the government and private hospitals nationwide. This condition is one of the effects of the implementation of the mandate of the Social Security Act and the Act of BPJS which states that all citizens shall be a participant of JKN program (Shihab et al. 2014). The National Health Insurance Program significantly affects economic growth. National Health Insurance greatly influences the Human Development Index. National Health Insurance does not affect the level of poverty. National Health Insurance does not affect the overall level of poverty (Ginting et al. 2018). There must be ongoing communication between BPJS and hospitals to find technical solutions related to services to claim billing to minimize the potential for claim returns. Oversight and activities of RSAL Dr. Ramelan's fraud team must be improved by elucidating regulations, understanding coding rules and quality services with cost control. Improved IT systems, both from hospitals and Healthcare BPJS, will help in identifying the claim file to avoid reverification. Hospital revenues are a crucial element in hospital management. The impact of this overpayment will result in revenue uncertainty (Aprillia, Cicilia, & Pertiwi Sergius 2015). In the hospital, capacity planning relates to ensuring a balance between the quality of health care provided and the costs provided. In a plan, it involves predicting the specific quantity and attributes of the resources that will be needed to provide health care services at a certain level of quality and cost (Pardede et al. 2019). Hospital planning, procurement, and operational processes will be disrupted because they do not meet the revenue targets projected in the business plan of the hospital budget. With its status as regional public service, RSAL Dr. Ramelan is demanded to improve service quality, which will lead to improved performance. If the revenue or revenue target in the hospital budget is not met due to a refund in the form of deductions in subsequent claims, this will affect the operational performance of the hospital.

CONCLUSION

The most cases found in this claim audit are chemotherapy, differences in diagnoses perceptions, and action procedure cases. This claim refund will affect the performance and operation of the hospital. It takes combined efforts from both parties, Healthcare BPJS and the hospital.

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