Implementation Of Poac Management (Planning, Organizing, Actuating And Controlling) In An Effort To Reduce The Number Of Pending Claims For Inpatient Bpjs In The Hospital

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ABSTRACT

Problems with pending claims in hospitals are mostly caused by incomplete files and discrepancies in the accuracy of diagnosis codes. UNS Surakarta Hospital is known to find around 50-300 BPJS Inpatient claim files pending every month. This study aims to determine management in an effort to reduce the number of pending claims for inpatient BPJS patients in hospitals. This type of research is descriptive qualitative, with a cross sectional approach. The subjects of this research include claims coordinators, coders, internal verification officers and medical committee members (doctors). The research object is the claim file for Trimonths 4 of 2023. The instruments used are interview guidelines, observation guidelines, checklists. The research results showed that of the 2289 claim files submitted, 168 files (7.34%) were pending, which were divided into 3 factor classifications, namely Medical Aspects 62 files (36.90%), Administrative Aspects 57 files (33.93%) and Coding Aspect 49 files (29.17%). The process of handling pending claims based on planning, organizing, actuating and controlling aspects is still not running optimally. This is caused by the lack of clear division of job descriptions and the absence of SOPs related to handling pending claims which are only manifested in official notes, in general evaluations are still carried out based on cases but not based on users which causes there to be no rewards and punishments for officers who do not comply. It would be better for hospitals to prepare SOPs for filling out BPJS claim requirements files, and make clear job desk divisions, especially the BPJS coding section, and implement Inpatient RME immediately.

KEYWORDS: Pending Claims, Causal Factors, POAC Management

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INTRODUCTION

Indonesia uses a prospective payment system for the payment method for health services at Advanced Referral Health Facilities (FKRTL). The prospective payment method is known as case-based payment (casemix). The casemix system is a grouping of diagnoses and procedures carried out using grouper software or the INA-CBGs system (Government of the Republic of Indonesia. 2016). The INA-CBG's payment model organized by BPJS in Hospitals must go through the claim stage. BPJS will verify the claim approval and pay for documents that are eligible for the claim, but documents that do not meet the claim requirements must be returned to the hospital for confirmation so that they are categorized as pending claims (Sander A, et al. 2022)

The problem of pending claims in hospitals is mostly caused by incomplete files, the accuracy of the diagnosis code or differences in perception of the diagnosis code from the hospital with the code from the BPJS verifier, lack of time to complete claims against the claim target, failure of data connection to the database due to system disruptions in the Jasa Raharja application, lack of supporting examinations and lack of therapy evidence, no SOP regarding inpatient BPJS claims, there are several scan files that are unclear and often experience internet network disruptions so that claim submissions are hampered (Agiwahyuanto, et al. 2022, Kusumawati and Pujiyanto. 2020, Santiasih, et al. 2021, Manurung J, et al. 2020, Sander A, et al. 2022, Maulida E and Djunawan A. 2022, Kurnia E and Mahdalena. 2022, Sari I and Rukmini. 2022, Rohman H. 2021, Syafitri E, and Novita D. 2021). The quality of diagnostic coding is one of the factors that greatly influences INA-CBG's claims (Oktamianiza, Reza I. 2022, Oktamianiza, et al. 2022, Yastori. 2021, Muroli C. 2020). In supporting the smooth process of inpatient claims, integration is needed between the INA-CBG's application and other management processes in SIMRS, and has an SOP for resolving pending claim problems (Nabila S F, et al. 2020)

Based on the results of previous research at Deli Serdang Hospital in 2018, precisely starting from February, data was obtained that there were 1167 pending BPJS inpatient claim files from 4268 visits. If nominalized, the 1167 files are worth IDR 6,697,738,100 (Manurung J, et al. 2020). The second study at RSBT Karimun in January - September 2022, the number of pending claims totaled IDR 1,537,233,700 from 1,353 cases (Fitriani Y, Hidayat B. 2023). Based on the results of a preliminary survey at the UNS Surakarta Hospital, which is one of the advanced health care facilities that has collaborated with BPJS Kesehatan in the Surakarta Branch area. The large number of patients using BPJS indicates the large number of claims submitted to BPJS Kesehatan. Based on data at the UNS Surakarta Hospital, the claim submission activity from the hospital to BPJS Kesehatan experiences pending claims every month, an average of 200 claim files. This results in pending claim costs of 3-6 billion each year. Pending claims result in the amount of claims paid by BPJS being smaller than the initial claim submission. This has an impact on hospital cash flow and causes problems with hospital operational costs because almost 90% of hospital patients are BPJS Kesehatan patients. If it continues and for a long period of time, it will cause liquidity problems for the hospital (Listiyawati, Wijayanti R A. 2022, Pratama A, et al. 2023). The return of incomplete requirement files from the BPJS provider to the medical records department makes officers work twice, so that this condition causes an increase in the workload of medical records officers (Nuraini N, et al. 2019).

Proper claim implementation requires good management from each service provider for the sustainability of health services in hospitals in the JKN era. Good management is always carried out with good planning. Terry (2006) states that in achieving a target (a good claim process) planning, organization, actuating, and controlling can be used through the utilization of human resources and other resources. As in a Hospital, good

management is needed to control all resources to improve the quality of Hospital services by optimizing existing management so that it can reduce the number of pending BPJS claims for inpatients. This management optimization can be in the form of compiling or revising existing SOPs related to submitting BPJS Health claims to inpatient units and SOPs for verifying the completeness and accuracy of the contents of inpatient claim files so that they can be used as guidelines for officers in implementing BPJS Health claims at inpatient units in hospitals (Mayori E, et al. 2022). Based on the background, the research formulates the problem of how to implement planning, organization, actuating, and controlling management in an effort to reduce the number of pending claims for BPJS inpatients at UNS Surakarta Hospital in order to improve the quality of service.

RESEARCH METHOD

This type of research is descriptive qualitative using a Cross Sectional approach. This study examines the strategy in handling pending claims for inpatient BPJS patients at UNS Surakarta Hospital in Quarter 4 of 2023 using the POAC method. The subjects of the study were the Head of the Guarantee Section (Doctor), Head of the Guarantee Room (Medical Records), Internal Verifier (Nurse) and BPJS Coder Officer (Medical Records). The object of the study was the file of pending claims for inpatient BPJS patients in Quarter 4 of 2023 at UNS Surakarta Hospital. The variables of this study include the Process of submitting inpatient claims to BPJS Kesehatan at UNS Surakarta Hospital, the Number and percentage of pending inpatient claims in Quarter 4 of 2023 at UNS Surakarta Hospital, and Management analysis using planning, organization, actuating, and controlling in the process of handling pending claims for inpatient BPJS patients. The instruments used were interview guidelines, observation guidelines, and voice recorders. Data processing includes Collecting, editing, coding, Classification, Tabulating, and data presentation. Data analysis uses descriptive analysis by describing the data that has been collected and processed, then presented in the form of tables and diagrams.

RESULT AND DISCUSSION

Based on the results of interviews with the Head of the Guarantee Room and Internal Verifier (Claim Evaluator) and observations in the guarantee section for the flow and procedures for BPJS Inpatient claims at UNS Surakarta Hospital as follows:

The inpatient claim process is still carried out manually, starting with the collection of medical record files from the medical records section. After that, the scanning process for various required documents is carried out, namely SEP, inpatient order letter, diagnosis certificate from the ER if the patient is admitted through the ER, medical resume, supporting examination results, operation report if any, delivery report, proof of ventilator use if used, and death certificate if the patient dies. The scanned documents must be complete.

After scanning, the coding officer enters the data into SIMRS via the bridging menu, then E-Claim, then selects the date of treatment. Patient data is searched by name or medical record number. The type of hospitalization and treatment class are automatically filled in according to the SEP, while the choice of patient admission method, use of ventilator with incubation and excubation hours, and the patient's discharge method whether approved by the doctor, referred, died, or at their own request must also be inputted. The total cost of

treatment is automatically calculated by SIMRS based on the actions that have been inputted by the related unit during hospitalization.

At the coding stage, the officer fills in the code according to the diagnosis from the DPJP and the largest resources. The officer must also ensure that the diagnosis matches the ICD and the claim report from BPJS, or related laws. After the coding process is complete, the data is saved, and the claim is updated. After that, there is a grouper process that is automatically sent from SIMRS to E-Claim.

Claims can be printed individually on individual sheets that include patient identity, BPJS participant number, medical record number, SEP number, admission and discharge dates, discharge method, type of treatment, CBG code, and claim rate. This CBG code and claim rate are automatically issued based on the inputted data. After that, the process of merging or combining several files is carried out, namely merging individual sheets, resumes, supporting documents, and billing from the cashier. The merged files are stored in the claim folder per month, then stored in the folder per return date with the file name in the form of the last three digits of the SEP number.

Before submitting a claim, a manual checklist is carried out to match the files to be submitted for claim to the data in the folder and in E-Claim. Next, several files from E-Claim are downloaded, consisting of .txt files, encrypted, unencrypted plus details, and excel recaps. These files will be attached with the claim submission letter. Before submitting a claim, the .txt file is uploaded to V-Claim for digital validation. If there is invalid data, it must be corrected first until all data is declared valid. After that, the claim is submitted and will be verified by the external BPJS verifier. The verification process takes a maximum of 14 days after submission, and the claim submission must be made no later than the 15th of the following month. The first claim submission must cover at least 90% of the SEP issued in the month submitted, otherwise the hospital's compliance value will decrease.

After verification, a Verification Result Report will be issued containing the number of claims that are eligible, ineligible or revised, and disputed. Then, a Claim Submission Form (FPK) is created based on the number of eligible claims and their nominal value. If there is a reduction Report (BA), namely the results of an audit with BPJS that has been agreed upon, such as a code replacement that can reduce the nominal claim, the difference between the first submission and after the code replacement will be recorded in the reduction BA, then the nominal claim that is eligible will be reduced by the reduction BA and a receipt will be made. The hospital will receive funds according to the receipt.

The first claim submission is a regular submission, while the second submission is for revision and follow-up. An ineligible claim is a claim that is returned by BPJS during the first submission. An ineligible claim can occur if the claimed service SEP is assessed as one series between outpatient and inpatient care, so that one of them is assessed as ineligible. The revised claim submission is submitted around the 20th-25th of the following month. A dispute is a claim that has not been agreed upon by BPJS and the hospital. Disputes are also used to avoid expired claims, with a time limit of 6 months from the service.

In its implementation, the claim flow and procedures implemented at UNS Surakarta Hospital are in accordance with the existing SOP. In submitting claims, there has never been a delay because the Head of the Guarantee Room always communicates with external parties of BPJS regarding the tolerated time limit, and so far it has never exceeded the time that has been set. The obstacle found when submitting a claim is the regulation that the

number of claims must be at least 88%-90% of the number of SEPs in that month, so if there are still some documents found to be incomplete, the claim file is still submitted, causing the possibility of the claim being returned because it is not feasible (pending claim). The results of this study are in line with (Santiasih, et al. 2021) that the BPJS Health claim administration procedure for inpatient services at Dr. R.M Djoelham Binjai Hospital runs according to the existing Standard Operating Procedure. All informants know the flow of the BPJS claim administration process procedure, which starts from the registration location, continues to the doctor in charge of the patient, recapitulation of medical records, continued with the billing process, then checked by the verifier, then inputted by the coding officer, and finally the scanning process to be sent to BPJS.

Based on the research results in Quarter 4 (October-December) of 2023, the pending data on BPJS Inpatient Claims at UNS Surakarta Hospital are as follows:

Table 1. Pending Data on BPJS Inpatient Claims Quarter 4 of 2023

Month	**Number of Inpatient Claims**	**Number of Pending Claims**	**Percentage (%)**
October	780	50	6,41
November	789	55	6,97
December	717	63	8,79
Total	2289	168	7,34

Based on these data, it can be seen that the number of claims in Quarter 4 of 2023 was 2289 claim files submitted, of which 168 claim files (7.34%) were pending or ineligible. Based on these results, it can be concluded that the number of pending claims increased every month in Quarter 4 of 2023, which can be illustrated using the following graph:

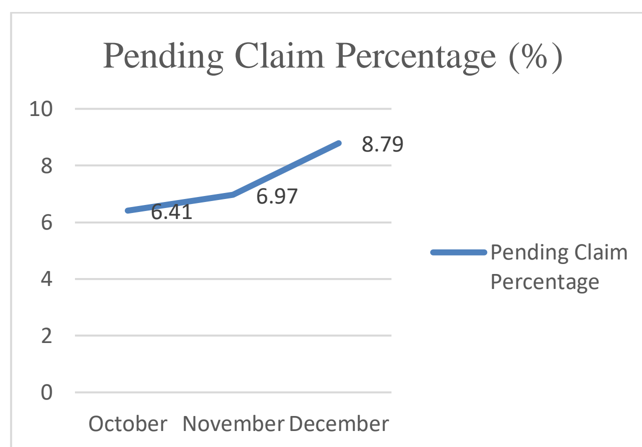

Figure 1. Pending Claim Percentage

Factors causing pending BPJS Inpatient claims based on the results of interviews with the BPJS Inpatient Claims Coordinator and the Hospital Internal Verifier The causes of pending claims can be divided into three main aspects: administration, coding, and medical. In the administrative aspect, during the scanning process, it is usually ensured that the documents are complete. However, if there are incomplete documents and the submission time is urgent, the claim is still submitted first. If the claim is then considered pending, the deficiencies are then completed. Another example is a problem related to the class of care. For example, if a patient is treated in class 2 but is inputted as class 3, the claim will be pending. In the coding aspect, a problem that often occurs is in cases of pneumonia with COPD where the case can be coded in combination. However, if the COPD

in question is acute exacerbation of COPD where the code used is J44.1, then there is no combination code between pneumonia and acute exacerbation of COPD. However, BPJS requires both to be coded into one code, namely J44.0, which causes the claim to be pending. In the medical aspect, an example that is often encountered is the case of pneumonia. Based on the Minutes (BA), pneumonia can be coded if there is a positive chest X-ray result plus at least two clinical symptoms. However, BPJS requires that pneumonia must be in accordance with the National Clinical Management Guidelines (PNPK) on pneumonia. This inconsistency can also cause the claim to be considered pending. Based on BPJS Inpatient Claims data in Quarter 4 of 2023, it can be classified as follows:

Table 2. Factors Causing Pending BPJS Inpatient Claims for Quarter 4 of 2023

Factors Causing Pending Claims	Number	Percentage (%)
Administrative Aspect	57	33,93
Coding Aspect	49	29,17
Medical Aspect	62	36,90
Total	168	100

Based on the table, it can be seen that the highest cause of pending claims is the Medical Aspect factor with 62 files (36.90%), then the Administrative Aspect with 57 files (33.93%) and the Coding Aspect with 49 files (29.17%). It can be seen in the following graphic image:

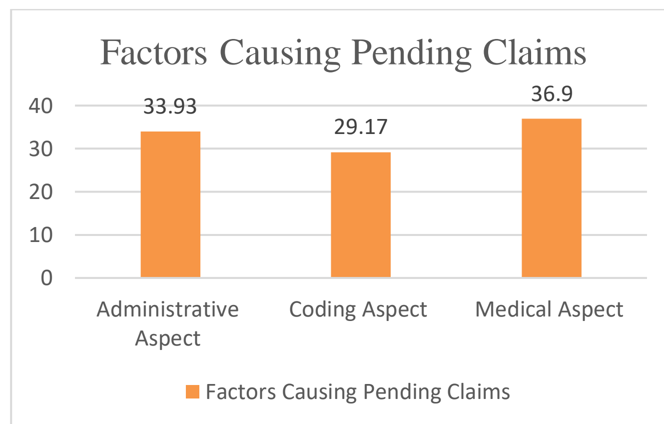

Figure 2. Pending Claim Percentage

These results are in accordance with previous research, that the implementation of inpatient file claims at RSUD dr Rasidin Padang still has several obstacles. One of the obstacles is the completeness of the form information and the completeness of supporting results (Oktamianiza, et al. 2022). Supporting reports for inpatient services are an important requirement in submitting BPJS health claims at Airlangga University Hospital. Thus, inpatients who undergo supporting services must include or attach evidence of supporting reports so that the range of additional costs that must be billed to BPJS Kesehatan can be known (Maulida E, Djunawan A. 2022). The most common reason for refunds is because the diagnosis is not supported by management and supporting results with a percentage (66%), this reason can occur due to 2 things. Lack of supporting results or therapy processes, and differences in perception between the hospital and BPJS (Sander A, et al. 2022).

This is in accordance with the results of previous studies, that the accuracy of the diagnosis code (validity) can affect the smoothness and approval of INA-CBG's claims where the chances of smoothness and approval of claims with the correct diagnosis code

are higher than diagnoses with incorrect codes, while the reliability factor affects the process of determining and providing diagnosis codes. In addition, the quality of diagnosis coding is also one of the causes of INA-CBG's claim disputes. This shows how crucial/important the quality of diagnosis coding is in the field of health financing, especially INA-CBG's claims in hospitals (Syafitri E, and Novita D. 2021).

These results are also in line with previous studies which stated that the highest causal factors were the percentage of inaccurate coding 43%, incomplete files 23% and diagnoses that did not meet the criteria 34%. The efforts made were to provide a coding training assignment letter, approach the DPJP and conduct socialization to all parts directly involved in handling patients. (Rohman H, et al. 2021). The problems found from the research conducted were (1) Inaccuracy in coding and actions that had been given to patients, (2) Inconsistency in filling in or inputting patient data, (3) No SOP regarding inpatient BPJS claims, (4) There were several scans that were unclear, (5) Frequent internet network disruptions (Sari I and Rukmini. 2022).

These results are in accordance with previous studies showing that the return of BPJS Kesehatan inpatient claim files at Dr. R.M. Djoelham Binjai Hospital occurred due to inconsistencies or incomplete filling in of items in filling in medical records, errors by officers in the input process. The impact of incomplete BPJS claim files is the occurrence of pending claims, pending claims themselves have an impact on late payment of medical services which has an impact on the performance of hospital employees, thus affecting the quality of hospital services. Then the cash flow of the Hospital is also disrupted because the payments that should have been claimed are not as they should be (Santiasih, et al. 2021). The incomplete files found in the study came from inpatient medical record files. Inpatient medical record files are a very important factor in BPJS Kesehatan claims at Airlangga University Hospital. The completeness of these inpatient medical files indicates the accuracy of the provision of guarantees by BPJS Kesehatan. Therefore, it is important for officers to check the completeness of medical records and ensure that the BPJS Kesehatan claim requirements have been met, which can later provide financing appropriately and in accordance with the specifications of the types of care. (Maulida E, Djunawan A. 2022). To minimize the number of claim refunds, it is necessary to create a complete checklist of BPJS Health claim files. (Agiwahyuanto, et al. 2022), (Kusumawati, and Pujiyanto. (2020).

Management analysis using POAC (planning, organization, actuating, and controlling) in the process of handling pending BPJS claims for inpatients.

1. Planning

The implementation of planning in handling pending BPJS claims for inpatients at UNS Surakarta Hospital based on interviews with respondents (Head of Guarantee Section, Head of Guarantee Room and Internal Verifier) can be seen from the data on pending claims cases that exist every month. After submitting a claim, there will be a pending confirmation from BPJS. From this confirmation, we can see what the cases are. If the case has been reviewed, there are things that need to be discussed with other fields such as the service field, supporting field or with related doctors.

With the service field, data collection is usually carried out on pending claim file cases according to information from the BPJS verifier. From the results of this decision, we may hold a meeting with DPJP, or make a circular or official memo, and make requirements according to confirmation, such as if there are certain files that are incomplete, then we discuss them with the relevant unit to be completed according to request. We do not always agree with what is confirmed by BPJS. For example, if there is a pending case from the medical side, we first discuss it with the relevant doctor (DPJP)

through the Medical Staff Commission (KSM), if it turns out that the BPJS request is seen from the applicable regulations, then we explain to BPJS if we are in accordance with the existing regulations. So we don't always immediately agree. If there are indeed deficiencies from the medical side, for example, BPJS asks for an open or detailed explanation of the patient's supporting examination results for certain cases, if it does not violate the medical, we follow the BPJS request.

There are pending cases from BPJS that are cases that do not exist or are lacking, then we add and adjust them, but there are also cases that actually already exist and we just need to confirm with BPJS. Next, we report again from the results that we have answered whether there is a decrease in the nominal, which cases have a decrease in the nominal, then we provide information to the relevant field that from the agreement to answer pending claims that have been made previously, which ones are not included or not appropriate, then when submitting the next claim, it does not need to be submitted again.

When there is a case that needs to be discussed, such as a recurring pending case with the same error, then the pending claim data will be analyzed and prepared because of what, how much, and how much the nominal amount is, which will then be discussed to decide on a solution. We group this pending data this month according to what is pending and then next month we avoid the error so that there is no more pending. So we continue to appeal to the DPJP if errors are still found in the same case every month. The Hospital follows more revisions made by the BPJS external verifier if it is indeed a rule or not a medical problem, but if it is a medical problem, the doctor who treats the patient knows the patient's condition better so they do not always agree if it is a medical problem.

This planning is grouped based on cases that are adjusted to the nominal amount of the claim, with related units starting from the IGD, medical support labs, wards, medical rehabilitation, and others. So all related parts are informed at the time of the first meeting, wait for it to be decided whether the results use a service note or continue with the next meeting, for example only specifically per case according to KSM. The results of the special meeting will produce improvements or confirmations, including system improvements, creating new forms or file improvements, flow improvements, according to the case. If a pending case is found with the same case, it is necessary to appeal again to the service sector. Ask again about the obstacles experienced by DPJP, if the doctor or user is forgotten or does not know, it means being reminded, informed and asked what the cause is, what obstacles are discussed and solutions are sought every month. If the coding aspect is changed, we adjust the revision from BPJS and applicable regulations.

If the understanding of each coder is different, we carry out a common perception which is carried out by meeting internally in the guarantee section or discussing it in the WA group. Adjusting the case every month. The obstacles found by coders are usually not being able to read the doctor's writing, the clarity of the resume such as the completeness of supporting information greatly supports coders to be able to code correctly and accurately. This is in accordance with the results of previous studies related to the implementation of disease diagnosis codes which are still constrained due to resumes that do not match the status, lack of supporting anamnesis data, and the placement of the main diagnosis and secondary diagnosis is not right, the implementation of the revision of pending claims takes several days to the doctor in charge of the patient (DPJP). In addition, coders still have difficulty reading the doctor's diagnosis, which affects the quality of the code and has an impact on pending claims (Oktamianiza, et al. 2022).

From the administrative aspect, completeness of medical records is very much needed in submitting claims, in terms of the composition of the medical records it is complete but in terms of claims it may not be because several casemix forms are needed to submit claims, such as chronology attachments, resumes must meet medical and coding

rules regulations, there must be anamnesis, supporting examinations, which actually already exist but have not been written on the resume sheet in the CPPT. If the requirements for filling in the coding and medical rules according to the general Minutes have been circulated but are not included in the SOP, they are only circulated in the form of official notes, because BPJS claim regulations often change

Based on the results of this study, the researcher provides recommendations If there are new regulations, an SOP can be made, not just a circular. Such as the SOP for the completeness of JKN claims and the SOP for the completeness of other insurance claims. Here, if there is a new regulation or the results of the pending claim evaluation have been circulated but in the form of an official note, it has not been included in the SOP. This is in accordance with the results of research by Santiasih, et al. (2021), Planning activities include creating a special SOP for filling out BPJS claim requirement files and regulations such as clearer and more structured job descriptions, then socializing the SOP or other regulations to all officers who handle BPJS claim requirement files (BPJS hospital verifiers, team of doctors, team of nurses and BPJS coder/medical records team). Hold regular meetings at least once a week for each officer who handles BPJS Health claim requirement files. Also in line with research by Nabila S F, et al. (2020) Regarding Implementation, namely the claim process seen from the existing flow has been in accordance with the applicable SOP and in the analysis of the process related to Evaluation, namely holding regular meetings or monthly meetings.

2. Organization

Based on the interview results, it can be seen that the HR needs have been met, but for our jobdesk there is no one specifically for pending, specifically for regular, specifically for coding. But we already have a team that handles pending outpatient and inpatient care separately. There is also an audit team. There are 14 officers but 3 officers work on inpatient BPJS claims, 2 of whom are medical records personnel and 1 internal verifier with an Ns education. and the others work on outpatient care. Officers not only handle BPJS claims but also claims from other insurance. One officer can handle 2 insurances, the main BPJS and one other insurance. The internal verifier here, in addition to handling BPJS health claims, also handles Jasa Raharja. Some outpatient officers hold BPJS employment, some hold Admedika, and some hold Taspen. In addition, there are also those who handle claims for medical devices, ambulances, and blood bags. So there is still overlap for the jobdesk.

Based on the results of the analysis, the researcher recommends that the job description division be clearer, so that officers can also focus more on carrying out their duties. For example, for BPJS coders, a separate team of officers is formed who only carry out the task of coding diseases and actions for claim cases, because a coder requires high concentration, so special officers are needed who only handle coding. This is in accordance with the results of research by Santiasih, et al. (2021), Furthermore, determining the target of which organizations are responsible for carrying out tasks regarding filling in BPJS Health claim requirement files. The targets are the control team, namely the nursing team, the doctor team, Coders or medical records, along with BPJS hospital verifiers who have their respective expertise according to their duties. Identifying resources in the process of managing BPJS claim requirement files for inpatients such as integrated computers to facilitate the INA CBG's process, BPJS claim requirement file sheets, and other supporting results. These results are also in accordance with previous research related to Organization, namely the need to create job descriptions, especially for coding officers. Making job descriptions, especially for coding officers at RSUPN dr. Cipto Mangunkusumo so that they can help manage existing human resources and coding officers can understand the boundaries between the tasks they have (Nabila S F, et al. 2020)

3. Actuating (Implementation)

For the implementation carried out by UNS Surakarta Hospital in handling pending claim cases, it has been carried out according to the established planning. If the planning has been carried out but there are still pending claim files with the same case or when BPJS returns the document for confirmation there is a difference in nominal value, that is the question of why this can happen. The case is discussed between the finance and service sectors first, then the meeting is continued by inviting the relevant DPJP according to the pending case and the solution is agreed upon. It is more coordinated and discussed. We have a routine meeting every month, later we will discuss what is the cause of the new pending or audit findings and others, then we agree on the solution. If after confirmation the nominal value remains, it means it has been running well, just confirm it with BPJS. Our report only goes as far as the claim value changes or remains the same, we have not dissected what the shortcomings are, where, by whom (the user) who made the mistake repeatedly.

From the coding aspect in its implementation, if a revision is found from BPJS, it will be answered and worked on according to the revision. As much as possible, maintain the initial coding with a strong basis so that there are no changes to the code so that there is no decrease in the claim rate. The pending claim is sent in excel format, later we will answer according to the questions there as best we can first. If it can be answered then it is answered, but if further discussion is needed, then we make an agreement or hold a meeting first because there is a risk of a reduction in the claim rate and it could be detrimental to the hospital so it is necessary to agree on the answer first. In an internal evaluation meeting, for example when there is a coding case that is still wrong, then during the internal evaluation meeting the correct code will be discussed. In addition, there is also annual training from the HR field. The impact that occurs if there is a pending claim at the hospital is a decrease in the claim value. When submitting a revision, it is always attempted to maintain the initial coding. If it cannot be maintained, the claim can be considered unworthy or paid but the nominal amount decreases. The impact on officers is an increased workload because they have to work on revising the pending claim. The impact is that the hospital's income is clearly reduced because the submission is so much but there is a pending so much so that only so much is received. Then it could be that it is not paid because no agreement is found then disputed and it turns out that the dispute is rejected so it is not paid. So, it is related to hospital income because pending claims almost always lead to a reduction in claim costs.

In the implementation stage, here the researcher recommends conducting an analysis of users who cause the most pending claims, so it is not only per case that causes a decrease in the nominal claim but specifically to the user who causes it, for example DPJP who does not comply with the service note that has been circulated and causes pending claims in the same case. A report card is held per DPJP or KSM every month, and there are rewards and punishments for officers. So that it motivates officers to complete the claim requirements, both from the medical, coding and administrative aspects. The researcher recommends the implementation of Electronic Medical Records for inpatient care to minimize incomplete filling in the patient's medical record, making it easier for officers to prepare the requirements for claim submission files. The implementation of this EMR will also reduce the difficulty of coders in reading the doctor's writing, so that they can determine the correct and accurate diagnosis and action codes.

This is in line with previous research which states that the efforts made by Dr. Soedirman Kebumen Hospital regarding the problem of delayed BPJS Health claims, are improving the quality of human resources, especially coding officers, by holding training and socialization regarding policy updates related to claims. Optimization of activities by

creating SOPs related to claims in order to minimize the occurrence of pending claims. The hospital always conducts evaluations to reduce the incidence of returning claim files, starting from always communicating existing problems and coordinating with each related section and improving the performance of each section, following regulations properly and also reminding each other (Pratama, 2023).

4. Controlling (Supervision)

Supervision from our pending side, we get an assessment every month. From there we continue to see the number of pending, what are the cases. For supervision in terms of value, there is but from the financial sector because we only see the number of pending. If it is still in process, then we work together with other departments that provide services, for example, if there are forms that are not yet available, then we complete them first. Controlling when the patient is still an inpatient, so the files are not here yet. Above that, there is a controlling team that anticipates when the patient is treated with what diagnosis, how much the claim will be. Then also prepare, for example, if the patient is treated with what diagnosis, what supporting documents must be completed.

Every time there is a new regulation, we convey it when there is an update. For general regulations, we convey it to everyone when there is an update. Then when there is a new case, such as if there is case A and case B, later we will convey the new regulation to the related unit only, case A is conveyed to unit A, case B is conveyed to unit B. So we only convey it to those concerned. We convey the new regulation when there is a meeting and we make a circular. The results of the meeting will be made into a memorandum regarding the case that was discussed and the agreed provisions. The memorandum is made by the finance department and then issued by the service department signed by the hospital director. The memorandum will be socialized to the relevant DPJP from the case that occurred and the memorandum will be the basis for future services.

To supervise the evaluation of pending claims, meetings are scheduled every month. There are three levels of meetings, level one meeting with the head of the department, level two meeting with the related internal department, level three we meet with cross-sectors that are different from our department, for meetings at levels 1,2,3 are incidental, then level 4 is a meeting from the head of finance with other heads of departments and all staff below him, for meetings at level 4 it is already scheduled.

Based on the results of the analysis of supervisory activities at UNS Surakarta Hospital, it has been well scheduled. Researchers recommend that there be more supervision of officers or users who cause claim files to be pending personally, not only in general, in order to increase officer compliance. In achieving a target (good claim process) can use planning, organization, actuating, and controlling through the utilization of human resources and other resources. Based on this opinion, activities in the Hospital actually require good management to control all human resources and other resources to improve the quality of Hospital services. One of them is management needed in organizing all activities for the BPJS Health era process. This study is in line with Nuraini N, et al (2019), The process of handling pending claims based on the aspects of planning, organizing, actuating, and controlling is still not running well. This is due to the absence of job details and job descriptions, lack of motivation from the leadership, and no clear leadership supervision schedule. Prepare an operational work plan in the process of filling in BPJS claim requirement files, create a detailed arrangement of work and job descriptions in managing the filling in of BPJS inpatient claim requirement files, prepare SOPs to facilitate communication between officers, and prepare a leadership supervision schedule to make it easier for staff to report information that must be reported.

CONCLUSION

The research object is the claim file for Trimonths 4 of 2023. The instruments used are interview guidelines, observation guidelines, checklists. The research results showed that of the 2289 claim files submitted, 168 files (7.34%) were pending, which were divided into 3 factor classifications, namely Medical Aspects 62 files (36.90%), Administrative Aspects 57 files (33.93%) and Coding Aspect 49 files (29.17%). The process of handling pending claims based on planning, organizing, actuating and controlling aspects is still not running optimally. This is caused by the lack of clear division of job descriptions and the absence of SOPs related to handling pending claims which are only manifested in official notes, in general evaluations are still carried out based on cases but not based on users which causes there to be no rewards and punishments for officers who do not comply. It would be better for hospitals to prepare SOPs for filling out BPJS claim requirements files, and make clear job desk divisions, especially the BPJS coding section, and implement Inpatient RME immediately.

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