Unnes Journal of Public Health 11 (2) (2022)

Unnes Journal of Public Health

http://journal.unnes.ac.id/sju/index.php/ujph

Patient's Claim Financing at Kariadi Hospital Semarang during the Covid-19 Pandemic

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Article Info

Article History:
Submitted November 2021
Accepted July 2022
Published July 2022

Keywords:
Financing, Patient Claim, Process

DOI
10.15294/ujph.v11i2.51664

Abstract

Findings on health status and condition of patients who came to Kariadi Hospital were classified into two categories comorbid and co-incident. For patient claims to be funded, an assembling process and case-mix coding are carried out for the submission process based on the results of checking the status and health conditions of comorbid and co-incident patients. This study is to know the process of financing the patient's claim at Kariadi Hospital Semarang during the Covid-19 pandemic. The research was conducted in a phenomenological descriptive qualitative manner with the data sources coming from primary informants. Sampling technique with the selection according to the criteria then conducted an interview. Content analysis was used to analyze the data. For Covid-19 patients with comorbidities, previously a claim was made for Covid-19 cases, and if the Covid-19 case was completed but the comorbidities persisted, the guarantor switched from the Ministry of Health to BPJS Health. In the process of financing a patient's claim at Kariadi Hospital Semarang during the Covid-19 pandemic there were two guarantees from the Ministry of Health and BPJS Health.

INTRODUCTION

The China Health Authority notified the World Health Organization (WHO) on December 31, 2019, of several cases of pneumonia of unknown etiology in Wuhan City, Hubei Province, central China. The subjects were reported on December 8, 2019, and many of the patients worked at or lived near the local Huanan Seafood Wholesale Market. However, other early cases had no exposure to this market (Lu et al., 2020). On January 7, a novel coronavirus, initially designated as 2019-nCoV by WHO, was isolated from a patient's throat swab (Hui et al., 2020). The Coronavirus Study Group (Lauxmann et al., 2020) renamed this pathogen severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and the disease coronavirus disease 2019 (Covid-19). As of January 30, 7736 confirmed and 12,167 suspected cases had been reported in China, with 82 confirmed cases found in 18 other countries (Burki, 2020). The SARS-CoV-2 outbreak was declared a Public Health Emergency of International Concern (PHEIC) by WHO on the same day (Burki, 2020). The mortality rate among patients admitted to hospitals ranged between 11% and 15% (Chen et al., 2020; Huang et al., 2020).

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Open Access
pISSN 2252-6781
eISSN 2548-7604

Covid-19 is a moderately infectious virus with a relatively high mortality rate, but the information in public reports and published literature is rapidly expanding (Harapan et al., 2020; Carducci et al., 2020; De Sousa, 2020; Han et al., 2021; Makki et al., 2020; Hui et al., 2020; Mousavi et al., 2020; Natsui et al., 2020; Alshabanah et al., 2021; Pung et al., 2020; Rahman et al., 2020; Suman et al., 2020; Yuvaraj, 2020; Han & Yang, 2020; van Doremalen et al., 2020). The reproductive number (R0) of Covid-19 is estimated by WHO to be 1.4 to 2.5, but other studies place it at 3.28 (Liu et al., 2020; Ong et al., 2020).

The government aims to ensure the fulfillment of basic public health needs through the National Health Insurance or known as *Jaminan Kesehatan Nasional or JKN* program, but the program was vulnerable to fraud due to changes in the health financing system from fee-for-service (out of pocket) to payment with the INA-CBG claim payment mechanism (Indonesia Case Base Group) for hospitals (Triastuti et al., 2019; Hartati, 2017)this program is also susceptible to fraud. Hospital as the Secondary Level Reference Facility that collaborates with the Social Security Agency (Badan Penyelenggara Jaminan Sosial/ BPJS. Premiums are payments made by the insured to the guarantor regularly up to the time specified as a substitute for the policy to ensure protection against a person's risk that may occur in the future. Every month, premiums are required for the insurer to meet the payment of healthcare. The National Health Insurance System (JKN) established in Indonesia is a social insurance scheme that enables anyone to obtain health care without financial hardship (Tarigan & Dondo, 2021).

Cases of Coronavirus Disease 2019 (Covid-19) showed a tendency to increase and spread rapidly throughout Indonesia. On May 26, 2020, the Indonesian Ministry of Health (Kemenkes) reported that the total confirmed cases had reached 23,165 cases, with 1,418 deaths (CFR: 6.1%) (Gugus Tugas Percepatan Penanganan Covid-19, 2020). A significant increase in Covid-19 cases occurred from December 2020 to January 2021. Data on December 5, 2020 recorded 563,680 confirmed cases with 17,478 deaths (CFR: 3.1%), with 466,178 recovered patients. The data on January 29, 2021 shows that there are 1,051,795 confirmed cases, 29,518 deaths (CFR: 2.8%), and 852,260 recovered cases (Kementerian Kesehatan RI, 2020a).

Covid-19 is a huge challenge for hospitals to reactivate disaster procedures as the main health care facility in handling Covid-19 patients. Hospitals need to improve clinical service management by preparing facilities and equipment according to standards. The cost of handling Covid-19 patients in hospitals is relatively high, because it requires a special isolation room, in addition to other expensive components of treatment costs such as antivirals, oxygen therapy, and intensive care with ventilators to treat severe and critical patients (Bartsch, 2020; Jati, 2020; Wiersinga, 2020).

All costs of treating Covid-19 patients are borne by the government- Minister of Health Regulation in Number 59 of 2016 concerning Exemption of Fees for Certain Emerging Infectious Diseases (PIE) patients. The financing for Covid-19 patients being treated can be claimed by the Ministry of Health through the Director-General of Health Services. To serve Covid-19 cases, the Ministry of Health has established 132 COVID-19 referral hospitals through the Decree of the Minister of Health Number HK.01.07/Menkes/275/2020 concerning the Designation of Referral Hospitals for the Management of Certain Emerging Infectious Diseases/COVID-19. In addition, to anticipate the escalation of Covid-19 patients, the Provincial Government has also designated 921 Covid-19 referral hospitals as of November 24, 2020 (Kementerian Kesehatan RI).

BPJS Health data on September 2, 2020, showed that the total claims submitted by hospitals were 103,519 cases for Rp. 6,336,426,538,300,-. Claims that have been verified by BPJS Health are 93,371 (90%) cases at a cost of Rp 5,539,856,881,100,-. Claims in the BPJS Health verification process are 10,696 claims (10%) at a cost of Rp.845.486.614,800 (BPJS Kesehatan, 2020b). Verification of hospital claims that have been made as many as 46,716 or 50.03% of claims are appropriate, with a cost of Rp. 3,250,143,479,600,-. The remaining 46,084 or 49.36% are disputed claims with a total cost of Rp 2,289,712,647,300 (BPJS Kesehatan, 2020b). Until the end of December 2020 the total claims submitted were Rp. 22,913,196,207,000, the amount that has been paid to the hospital is Rp. 14,526,648,658,510,- (63.3%) The remaining unpaid amounting to Rp. 8,386,547,548,490,- (36.6%) (Kementerian Kesehatan RI, 2020c).

The burden on hospitals treating Covid-19 patients is getting higher due to delays in payment of Covid-19 claims. Based on online data from hospitals as of September 1, 2020, the total number of Covid-19 patients treated by hospitals was 459,566 patients (Kementerian Kesehatan RI, 2020e). The Indonesian Private Hospital Association (ARSSI) noted that 40 to 60% of total claims for health services for Covid-19 patients at priva-

te health facilities had not been paid because the ministry's budget had not been disbursed. This has disrupted the cash flow of private hospitals (ARSSI, 2021). The reality of declining income, high operating expenses, and late claim payments ultimately have an impact on service continuity (Ambarwati, 2021; Tessema et al., 2021).

The problems of this research were the problem of claims for Covid-19 at the Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS Kesehatan), disputed claims for Covid-19 at the Ministry of Health, and the impact experienced by hospitals that provide Covid-19 services due to delays in payment of claims. The study aims to know about the process of financing the patient's claim at Kariadi Hospital Semarang during the Covid-19 pandemic.

METHOD

A phenomenological approach is used is descriptive qualitative research. Sources of primary data. Purposive sampling selection was used to select the quotations. The primary informants are the research informants. Informant's researches were Main Informant (MI) and Triangulation Informant (IT). Main Informant (MI) were Case-mix Coding Coordinator and The Covid-19 Handling Room Nurse Coordinator. Triangulation Informants (IT) were The Head of the Medical Record Unit and the Head of the Hospital Covid-19Handling Task Force. Techniques for gathering data using interviews. Data triangulation using source triangulation. Data analysis used content analysis. In this study, ethical clearance was carried out with the number 777/EC/KEPK-RSDK/2021 and the date March 17, 2021.

This study applies source triangulation in testing the validity of the data to obtain more accurate and credible data findings and interpretations by using sources other than the main data. The data collection technique used is through in-depth interviews. Sources of data in this study are primary and secondary data sources. Primary data sources in the form of interviews. The se-

Table 1. The Procedure for Patients to Enter through The ER (Emergency Room) and Polyclinic

Informants	Results
MI1	The procedure for patients to enter through the ER and polyclinic, if the patient uses BPJS Health still follows the procedure, and all of them must register online, except for emergencies in the ER. From the ER and Polyclinic, it is certain whether the patient needs to be hospitalized or not for all types of illness. And the determination of a clear diagnosis of Covid or not is the need for a Covid test, and this applies to patients who will be hospitalized.
MI2	The procedure flow for patients from admission to hospitalization and discharge is still the same, it's just that for inpatients, a rapid antigen is needed at Kariadi Hospital. When a patient comes, for example, a referral and has brought a Covid -free letter, he still has to be tested for Covid at this hospital. Then if it is clean from Covid, it can be treated together with other non-Covid patients, but if the antigen shows positive, then it needs to be confirmed with a PCR Swab Test and other supporting tests. Other supportive tests, it is also carried out on patients whose antigens are clean. And for patients who are diagnosed with Covid and have severe co-morbidities, they enter the eagle room 5B, and 6B.
TI1	The procedure flow is still the same, but there is a fundamental difference, namely the Covid test on patients who will be hospitalized, it will automatically add the medical record file. For the main diagnosis of Covid, it is the prerogative of the doctor on duty there with the existing provisions from the Permenkes and Perpres which were revealed to the Decree of the Director of Kariadi Hospital.
TI2	Patient care procedures at Kariadi Hospital are still the same, the only difference is that he is hospitalized, added with a swab test and other supporting tests. All tests were carried out at Kariadi Hospital even though the patient is a referral patient who already has a Covid-free certificate. To enforce the diagnosis of Covid or not, it is the doctor concerned, either the doctor on duty or the doctor in charge of the patient. If it's a severe case of Covid then it can be treated here (Kariadi Hospital) but if there is no ballast or accompanying and the patient is still able to survive, it is recommended to self-isolate with drugs according to doctors from Kariadi Hospital.

condary data source was is returned claim file for physiotherapy cases. The method of collecting data is in-depth interviews with snowball techniques (in-depth interviews and a rolling question system). The research instrument uses a list of interviews to explore and explore information related to the research objectives.

The data processing and analysis of this research were carried out using content analysis methods, namely: (1). Data collection, using in-depth interview techniques which were recorded and recorded using a camera and recorder, then the results would be recapitulated in a transcript of the interview results for each informant; (2). Data reduction, carried out by identifying the parts found in the data that have meaning when associated with the focus of the research problem followed by coding each data so that it can be traced where the data came from (coding) and grouped into parts that have similarities and looking for a link between one category and another (categorization); (3). Data verification and analysis presentation, carried out by reviewing the data obtained against the theory and the results of previous research to be presented in a narrative that is by the phenomenon under study; and (4). Concluding and in descriptive form, by comparing research questions with research results, research objectives, and theoretical concepts to conclude from research results.

RESULT AND DISCUSSION

Information for research informants:

MI 1 = Casemix Coding Coordinator

MI 2 = The Covid-19 Handling Room Nurse Coordinator

TI 1 = Head of Medical Record Unit

TI 2 = Head of the Hospital Covid-19 Handling Task Force

Patient registration procedure. Patients who come to the hospital must be clear at the beginning. At the beginning of the patient's admission, screening for symptoms of Covid was carried out (only for outpatient in all outpatient installations) by filling in the corona kariadi website.

The flow of care for patients who come through the outpatient installation or emergency room was a referral from a type D, C, or B hospital with a primary diagnosis of not Covid-19 (comorbid or co-incident convincing) and enforcement of the main diagnostic code. If the patient is a JKN and non-JKN patient.

Enforcement of the primary diagnostic code and secondary diagnosis frequently pays attention to the patient's medical resume. If the patient there is known to already have comorbid diseases such as DM, HT, heart, and others then there the patient is exposed to Covid, then the main diagnosis is Covid first to be resolved. The diagnostic code also follows from this, as for the writing by the doctor, it has also been based on the PMK 446/2020 rule which was revealed to the Hospital Director's Decree, and the SOP was also prepared by the Medical Committee and the Medical Services Division Director.

The process of screening patients who enter this hospital with indications of Covid-19 and with comorbid diseases and or co-incidence in

Table 2. The Flow of Care for Patients Who Come through The Outpatient Installation Or Emergency Room

Informants	Results
MI1	The guideline in the service of establishing a Covid diagnosis where there are comorbid and co-incident diseases is PMK 446 of 2020 is a rule where it is enforced that the patients being treated are Covid and non-Covid patients, even though there are conditions that accompany the disease. The flow of patient care is still the same as before, all patients who are hospitalized must be diagnosed with a test for Covid first. JKN and Non-JKN patients are treated the same, and referral patients are too. The comorbid conditions can be caused by Covid or a disease that already exists in the patient. To enforce the diagnosis code for a Covid patient with comorbid or co-incident, it must be seen from the patient's medical resume, how the doctor calls it, then the coder and case-mix coding follow.
MI2	Nurses do not have a problem with the flow of the medical record procedure; the point is that patients who enter and will be treated must be screened for Covid first. Patients who are treated with mild Covid-19 (without comorbidities or with controlled comorbidities, as well as signs of symptoms that can be treated immediately and are not physiologically burdensome) are advised to go for outpatient treatment under the control of the doctor in charge of the patient and treatment from the doctor.

Table 3. Enforcement of The Primary Diagnostic Code and Secondary Diagnosis

Informants	Results
IT1	For comorbid patients, it must be seen first, but if there is a patient with a co-incidence such as a broken bone patient, and when he enters the ER and is hospitalized there is an indication for Covid, then 2 claims will automatically be made which are coordinated with the doctor in charge first (there are 2 doctors in charge, namely Orthopedics and Pulmonary Specialist), as well as the main diagnosis for which a claim to the Ministry of Health about Covid is made, Covid; and the secondary diagnosis is a fracture, but the primary diagnosis used for claims to JKN is a fracture and the secondary diagnosis is Covid. This is already a standard rule, and the coding will also follow it. Likewise for patients with childbirth conditions.
IT2	I as the Coordinator of the Task Force, have provided and socialized to all medical service providers, that for writing the main medical diagnosis for patients who are confirmed to have Covid and where the patient also has comorbidities, the first thing to deal with is the Covid, but the comorbid drugs are still given by what is written in the proclamation. Therefore, if there is no ballast in comorbid with Covid, the patient is advised to self-isolate or centrally isolate. This is different if the patient is in severe condition when he comes with symptoms of Covid and his comorbidities become aggravating, then intensive care is necessary. For the diagnosis, it is clear that if the comorbid is a prolonged patient or the comorbid is obtained during the treatment process due to Covid, then Covid becomes the main diagnosis, and the comorbid becomes a secondary diagnosis. This is different from co-incidents and mothers giving birth, where there are 2 different claims and they must be handled immediately. In essence, the enforcement of a patient's medical diagnosis is based on the emergency or critical condition of the patient.

inpatient and outpatient services. The screening process was already running as mentioned above, for conditions where the claim process for Covid and non-Covid is clear from pmk 446/2020 as well. If a patient enters with a condition, for example, he is a referral because of a bone cancer case from one of the regional hospitals in central java and there the results of the Covid-19test are

Table 4. The Process of Screening Patients Who Enter The Hospital with Indications of Covid-19 and Comorbid Diseases and or Co-Incidence in Inpatients and Outpatients Services

Informants	Results
MI1	Patients who come for treatment will be checked first by a doctor at the poly or ER, then there will be known whether it is Covid or not, if it is Covid, the service and medical record data will go to Covid-19, and the main diagnosis is that then co-incidence to the comorbid disease. But if it's for example, bone cancer, then the Covid-19 is treated first while monitoring the complaints from the bone cancer, then if the Covid-19 has improved, further treatment for the bone cancer will be carried out if it does not start from 0 day for the DRM. In the case of giving birth, it is different, if parturition is parturition, then parturition is carried out and the Covid-19 treatment procedure is also.
MI2	The point of patient care is to follow medical instructions, if the patient comes in with various complaints, such as comorbid or co-incident, in principle what is the most urgent, the treatment is carried out there. If both are also urgent, then the 2 therapies are carried out. For the claim process, we from nursing were handed over to URM in charge of claims for both Covid and JKN.
TI1	For the problem of enforcing coding in such cases, it is also based on what was written and met by the doctor. In essence, the claim process in cases of Covid patients with comorbid or co-incident is to look at the status of the patient who is indeed the most urgent. Communication between case-mix and doctors is the most important thing to determine the diagnosis code so that it is not wrong, and the doctor also understands the claim process later.

negative, then he must be tested again at Kariadi Hospital and it turned out to be positive. So the main diagnosis is Covid, not bone cancer and the treatment is Covid first. So the treatment is the condition of his ttv or the complaint leads to Covid-19. If the patient never complains about the direction of Covid-19, but the biggest complaint is that the pain cannot walk and is referred to kariadi hospital because that is the main complaint, but how come the main diagnosis is Covid and the secondary diagnosis is bone cancer? Why is that?

Claims of patients admitted through the ER or referral are comorbid or co-incident cases. Claims follow suit. For example, the patient is a pregnant patient and is about to give birth, but during checks in the ER, the patient is confirmed to have Covid-19. So it was included in a co-incident, and the patient was a JKN patient. So for writing the main diagnosis code in JKN is the delivery and the secondary diagnosis code is Covid. However, for claims to the ministry of health regarding Covid issues, the main diagnosis code is Covid-19, and the secondary diagnosis code is parturition. Meanwhile, the treatment automatically goes hand in hand, so what is written in the CPPT (integrated patient progress record) report also does not go hand in hand. If the Covid-19case is not finished, even though the delivery has been completed, then the parturition case is closed, and the Covid-19 case continues to write its progress. When faced with cases of fractures, the same applies to cases of parturition. What is different is the comorbid cases, both comorbid obtained in patients when confirmed with Covid-19 or previously.

Table 5. Claims of Patients Admitted through The ER or Referral which are Comorbid or Co-Incident Cases

Informants	Results
MI1	In comorbid cases, for example, if a prolanis program patient (Hypertension or Diabetes Mellitus) has Covid-19, and also complains about his disease condition such as angina pectoris, then the main diagnosis is still Covid-19 and the secondary is angina pectoris and HT. There is still 1 claim, what happens if the patient for his Covid-19 problem has been completed, but the comorbidity has not been completed, then the Covid-19claim is closed or submitted, and continues to open for a claim with the main diagnosis being comorbid, but for the Covid-19 it does not need to be a secondary diagnosis.
MI2	For claims issues, nurses have no authority at all. But the point is that nurses carry out care by nursing standards that apply at Kariadi Hospital and everything is written in the DRM, especially the reporting on the patient's CPPT. The basic thing is that there is no double DRM, but 1 DRM, and when it arrives at the URM it becomes the authority there if 2 claims will be made. The most important thing is that all nursing services must be met.
TI1	The claim issue has been resolved by the coder and case-mix section. And all the guidelines are already in the SOP.
TI2	For claims, we already have a team. For the Covid-19 cases below, the case-mix team is divided directly. For JKN, there is already an INA-CBG's case-mix team, and the Ministry of Health's Covid-19 claims are under the direct supervision of the Medical Committee and are still carried out by URM friends in the case-mix section who are indeed assigned to the Covid-19 claims section. So that there is no overlap.

Input patient claims, the problem of inputting claims using the previously described system. That this is a case of Covid-19 with comorbid or Covid-19 with co-incident must be clear first.

Continuation of the claim process related to the number of claims in patients with the main case of Covid-19 with comorbidities and/or co-incidents. The problem with disbursing claims is the intelligence and skill of the case-mix or friends who have duties in the claims section. For comorbid or co-incident cases, there are terms of profit and loss. The basic thing is that patients who enter and are hospitalized must have a swab done, and the swab can be claimed and cannot. If the patient comes in with a negative swab result, the PCR swab cannot be claimed. What applies is the PCR swab. But if the PCR swab is positive, the result can be claimed. Then, to be able to be disbursed in Covid-19 conditions with cases of secondary diagnosis that exist in patients is very influential.

The number of claims for patients with the main Covid-19 case and those with comorbid or co-incident cases.

Table 6. Input Patient Claims

Informants	Results
MI1	If the case is a co-incident then it will automatically be entered 2 times, because the guarantor is different. If it is comorbid, then the claim is carried out separately and separately. Previously, a claim was made for the Covid-19 case, and if the Covid case was completed, but the comorbidities were still there, the guarantor would automatically switch from the ministry of health to BPJS health.
MI2	Nurses do not do this, all nursing action activities on patients are in 1 DRM, both electronic DRM and or manual DRM. In the claim process, nurses only know part of that, namely for Covid claims it is the guarantor of the Ministry of Health RI and for non-Covid-19 cases (JKN) it is BPJS Health.
TI1	Inputting claims follows the patient's DRM (patient condition) and different guarantors.
TI2	The patient's condition comes first. If a patient enters with a Covid-19 condition with a co-incident, it will automatically enter 2 times in the claim system, because the Ministry of Health-RI does not want to bear the costs of patients whose cases are outside of Covid-19, while BPJS Health and BPJS Manpower also do not want to. cover Covid-19 cases. This is different for the case of Covid-19patients with comorbidities, so automatically the main diagnosis is Covid-19 so that the claim can be liquidated and can cover all things that have not been covered by the financing.

Table 7. Continuation of The Claim Process Related to The Number of Claims in Patients with The Main Cases of Covid-19 with Comorbidities and/or Co-Incidents

Informants	Results
MI1	For example, if a patient enters with a bone cancer condition, then a Covid screening is carried out and if the result is positive, then it is entered into the comorbid section for bone cancer. While Covid-19 is the main diagnosis. The claim yield can be high. Even though the patient was only given 5 times PCR swab, chest X-ray, and basic treatment. No action has been taken for bone cancer. In terms of profit and loss, in Kariadi this should not be the case because its nature is to serve patients, and it is a government-owned hospital.
MI2	The problem of profit and loss claims, nurses have nothing to do with it.
TI1	Profits and losses are relative, but in daily life for those who take care of the claims section, the most important thing is to provide services according to the rules, and patients can be served perfectly. If there is a loss in 1 patient, there are still other patients who cover the loss. So for cases, it must be clear first whether comorbid or co-incident. This is the basis of everything.
TI2	The problem of claim losses has never been a barrier. The key is coordination between friends in the medical committee and URM friends who are in charge of the claims section for Covid and JKN. Because all the data is there.

In the ongoing Covid-19 claim process that there was a standard rule that always changes according to conditions if this hospital gets assistance in handling Covid-19.

Procedure flow for medical record data services in inpatient installation cases with comorbid patients and Covid-19 patients.

Table 8. The Number of Claims for Patients with The Main Covid-19Cases with Comorbid or Co-Incident Cases

Informants	Results
MI1 and 2, IT1 and 2	The amount varies depending on the patient's case.

Table 9. The Ongoing Covid-19 Claim Process

Informants	Results
MI1	Assistance from outside the Government (Philanthropy Party) will reduce the claimed factor for Covid cases. So it must be clear first.
MI2	We nurses don't know that.
TI1	The assistance will reduce the claimed factor for Covid-19 cases, it's already in the system.
TI2	The assistance reduces as long as it is recorded.

Table 10. Procedure Flow for Medical Record Data Services in Inpatients Installation Cases with Comorbid and Covid-19

Informants	Results
MI1	There will be no difference in claims. As long as the data is available and written, everything is clear.
MI2	Nursing data is also clearly written in the patient's DRM, and all data is recorded as one.
TI1	The data has been recorded as 1, so it is impossible to shift and affect the claim. And it is handled by a special team so that everything will be recorded and not cause any loss.
TI2	All data on comorbid or co-incident patients are clear.

Cases circulating in the community were related to patients who died due to Covid-19 even though the illness had been around for a long time.

Table 11. Cases Circulating in The Community were Related to Patients who Died due to Covid-19

Informants	Results
MI1	That's a matter of media, not so.
MI2	That's not the case with the media. All patients who enter the hospital have been tested, and if they are positive for Covid-19 then it is positive, and in the patient's medical resume that can be taken home by the patient's family also has explained the comorbid or co-incident.
TI1	It's a media issue, things that happen in the hospital are not like that.
TI2	The doctor has explained the details. If the patient dies and it is Covid, everything is in the patient's medical resume, and the nurse and doctor in charge of the patient have explained everything.

Patients who visit the hospital have an initial screening to test the symptoms of Covid-19 on visitors.

Table 12. An Initial Screening to Test The Symptoms of Covid-19 on Visitors

Informants	Results
MI1 and 2, IT1 and 2	Yes, it is mandatory, which is on the web. The ones who keep are the medical committee members.

Covid-19 tests and vaccines for officers.

Table 13. Covid-19 Tests and Vaccines for Officers

Informants	Results
MI1 and 2, IT1 and 2	Yes, there is. If the vaccine follows by the Government. Previously, tests were available and mandatory, now if anyone shows symptoms of Covid-19, they are asked to do a PCR swab test at Kariadi Hospital directly and isolated here.

The results of this study found that in Kariadi hospital there were Covid-19 patients with comorbidity or with co-incident. If patients were comorbid conditions, the claim was handled separately. If the patient's case was co-incident, it will be entered twice because the guarantor was different. Previously, a claim was made for the Covid-19 case, and if the Covid-19 case was completed but the comorbidities remained, the guarantor switched from the Ministry of Health to BPJS Health. The criteria in the claims regulation when implementing KMK RI Number 238 of 2020 were considered too strict; as a result, many claims could not be processed or did not pass verification because they did not comply with the provisions. At the beginning of the implementation of KMK Number 238 of 2020, there were problems with the low realization of the budget for claims for treating Covid-19 patients. This is due to the high number of disputed claims and the slow claim process due to the hospital being unable to comply with the provisions. Regarding the high number of dispute cases, BPJS Health has identified various obstacles, both in verifying and disputing Covid-19 claims in the field. These include, among others, during the administrative process due to a lack of completeness and/or clarity of the file and a lack of input for filling out the application. There are also potential auditor findings such as double claims, ICU or ventilators outside the hospital's capacity, inappropriate input coding, supporting files that do not match actual conditions, and sources of PPE and medicine donations from the government. The Covid-19 pandemic has implications for the continuity of hospital operations. Patient visits were greatly reduced, resulting in a significant decrease in hospital revenue and a decreased contribution margin. With the increase in the number of Covid-19 patients being treated in hospitals, more hospital operating costs have been absorbed for Covid-19 services.

Regulation of the Minister of Health Number 59 of 2016 concerning Exemption of Patient Fees for Certain Emerging Infectious Diseases, states that the financing for patients being treated with certain emerging infectious diseases can be claimed to the Ministry of Health through the Director-General of Health Services. Specifically, regarding Covid-19, it is regulated in the Decree of the Minister of Health of the Republic of Indonesia (KMK) number 238 of 2020 concerning Technical Instructions for Claims for Reimbursement of Services for Certain Emerging Infectious Disease Patients for Hospitals Providing Corona Virus Disease 2019 (Covid-19) Services which is set on 6 April 2020. This decision as a reference in the financing of Covid-19 services was later refined by the Decree of the Minister of Health number HK.01/07/MENKES/446/2020 which was set on July 22, 2020, and its contents adjusted the dynamics of the development of the management of Covid-19 patients.

The Covid-19 claim payment pattern is based on the INA CBGs rate which is given a top-up according to the length of treatment which is calculated as cost per day so that the financing is effective and efficient. Hospitals with documents according to the stipulated requirements, submit claims for reimbursement of costs for treating Covid-19 patients collectively to the Director-General of Health Services CQ. Director of Referral Health Services, and copied to BPJS Health as the verifier. Claims can be submitted by the hospital every 14 (fourteen) working days. BPJS Health then issues the Minutes of Verification of Payment of Claims for Service Bills no later than 7 (seven) working days after the claim is received by BPJS Health. The Ministry of Health, in this case, the Directorate General (Directorate General) of Health Services, will pay the hospital within 3 (three) working days after receiving the Report of Claim Verification Results from BPJS Health.

In the event of a dispute, the dispute claim data is sent to the RI Ministry of Health's dispute claim application through data integration from BPJS Health. The Directorate General of Health Services verifies and validates dispute claim data. Claim data that is appropriate or meets the requirements, followed by the payment process, if the claim data is not appropriate or does not meet the requirements, the hospital makes a revision which is inputted in the claim application of the Directorate General of Health and Safety.

Regulation is a measuring tool to ensure the verification process is accountable and transparent. The criteria in the claims regulation when implementing KMK RI Number 238 of 2020 were considered too strict, as a result, many claims could not be processed or did not pass verification because they did not comply with the provisions. At the beginning of the implementation of KMK Number 238 of 2020, there was a problem of low budget realization for claims for treating Covid-19 patients. This is due to the high number of disputed claims and the slow claim process due to the hospital being unable to comply with the provisions KMK number 446 of 2020 was issued on July 24, 2020, as a replacement for KMK number 238 of 2020 which was published 3 months earlier, April 2020. This latest KMK

is considered to make it easier for hospitals to implement Covid-19 claims because These various relaxation rules can simplify the claim process.

Despite this, the hospital is still experiencing confusion due to the change in regulations in just 3 months. Whereas ideally, the issuance of new policies should be accompanied by harder efforts from policymakers in conducting socialization. Socialization is an important aspect of the whole process so that a policy can achieve its objectives. The Ministry of Health, BPJS Health, and the Health Office have indeed carried out socialization with various related parties, the change of rules in a short time has not been able to realize a common perception and technical understanding of claims between hospitals and BPJS Health. This technical regulation set is considered incomplete because there are things that have not been accommodated in the explanation of the claim technical regulations, including; there are no detailed regulations regarding cases with suspected, confirmed, or probable status, and there is no detailed explanation of comorbid diseases and the coincidence of these two things causes a lot of differences in understanding between BPJS Kesehatan and hospitals, resulting in higher claim disputes (ARSSI, 2021).

Regarding the high number of dispute cases, BPJS Health has identified various obstacles, both in verifying and disputing Covid-19 claims in the field. These include, among others, during the administrative process due to lack of completeness and or clarity of the file as well as a lack of input for filling out the application. There are also potential auditor findings such as double claims, ICU or ventilators outside the hospital's capacity, inappropriate input coding, supporting files that do not match real conditions, as well as sources of PPE, and medicine donations from the government (PERSI, 2020). Administrative matters can be caused by the hospital's not yet optimal understanding of the technical instructions of the Indonesian Ministry of Health regarding submitting Covid-19 claims.

Other obstacles encountered in the implementation of claims include; (1). The unpreparedness of the Indonesian Ministry of Health dispute application. The system for resubmitting a disputed claim revision that requires revision is not clear, so it is difficult for hospitals to follow up, claims that have been submitted are not legible in the e-claim system, so hospitals must re-upload documents (ARSSI, 2021); (2). The number of MoH dispute claim verifiers assigned to verify is very limited, thus making the claim process even longer; (3). Problems that arise from the claim submission process from the hospital include unclear and/or incomplete hospital medical resumes, incomplete claim files, officers not understanding e-claims, incorrect input/entry menus in the application system, and hospitals who made a re-submission when the status was disputed from BPJS Health, causing a double claim; and (4). There is a mismatch of understanding between the hospital and BPJS Health in determining the comorbid criteria.

Facing the Covid-19 pandemic, governments in various countries are not ready to find effective ways to deal with the Covid-19 outbreak. Likewise, hospitals must be ready to serve new diseases for which there is no known treatment. In a short time hospitals are required to prepare special care facilities, and service procedures that are not carried out as before (Akreditasi, 2021). All parties are required to be able to quickly overcome this pandemic. The Covid-19 service financing policy for hospitals has also forced BPJS Health and the Ministry of Health to prepare an accountable claim payment process. Constraints that occur and problems that have been identified should be immediately followed up by each party to expedite the process of paying hospital claims (BPJS Kesehatan, 2020a). Many people believe that the JKN program can get all of its funding from the government or that it is free. This is one of the community polemics that cadres should be aware of because it gives the impression that the funding is not paid entirely by the government (Gustaman & Bachtiar, 2018).

The Ministry of Health's efforts to accelerate the settlement of Covid-19 claims include; (1). The Ministry of Health has been instructed to form a Dispute Claim and Claim Settlement Team (TPKD) in their respective regions through the Circular of the Director-General of Health and Safety No. JP.02.03/III/3602/2020 concerning Acceleration of Settlement of Claims and Dispute Claims for Covid-19 Services; (2). Forming a Dispute Claim Settlement Team; (3). Improve direct coordination between the Dispute Claims Settlement Team and related hospitals; (4). Coordinate with BPJS Health to improve the perception of equality regarding technical guidelines for Covid-19 claims between BPJS Health verifiers and hospitals in various regions; and (5). Improve e-claim applications and add dispute information on online hospitals dashboards.

The study has several limitations. First, this research did not account for the severity of the patient cases. As a result, the rise in per-case hospital charges could be attributed to changes in the severity of the patient's condition during the

pandemic. Second, this research data came from hospitals that voluntarily participated. More research was needed to determine external generalizability. Third, the research only looked at hospital charges that were claimed. Other payments, such as the compensation program for Covid-19 patients, were not included in the analyses.

CONCLUSION

In Kariadi hospital, there were Covid-19 patients with comorbidity or with co-incident. If patients were comorbid conditions, the claim was handled separately. If the patient's case was co-incident, it will be entered twice because the guarantor was different. Previously, a claim was made for the Covid-19 case, and if the Covid-19 case was completed but the comorbidities remained, the guarantor switched from the Ministry of Health to BPJS Health.

ACKNOWLEDGMENT

Thank LPPM Dian Nuswantoro University which has provided research funding.

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