Analisis Efektivitas Intervensi Verifikasi Internal terhadap Akurasi dan Optimalisasi Nilai Klaim BPJS Kesehatan pada Pasien Intensif di RS Hermina Bogor Tahun 2025-2026

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Abstrak

Latar Belakang: Sistem pembayaran klaim BPJS Kesehatan berbasis INA-CBGs menuntut ketepatan koding dan kelengkapan dokumentasi agar nilai klaim sesuai dengan kompleksitas pelayanan. Pasien intensif (ICU/HCU/NICU/PICU) memiliki kompleksitas klinis tinggi, biaya besar, dan risiko ketidaktepatan klaim yang lebih besar, sehingga rentan mengalami under coding dan klaim pending yang menurunkan pendapatan rumah sakit. RS Hermina Bogor mencatat kontribusi pendapatan BPJS lebih dari 50% pada 2025, namun peningkatan volume belum tentu sejalan dengan optimalisasi nilai klaim, sehingga diperlukan verifikasi internal yang efektif.
Metode: Penelitian ini menggunakan desain kualitatif dengan pendekatan studi kasus yang dianalisis menggunakan kerangka struktur-proses-outcome (Donabedian). Data dikumpulkan melalui wawancara mendalam dan focus group discussion (FGD) terhadap tenaga yang terlibat langsung dalam siklus klaim, dipilih secara purposive, serta telaah dokumen file klaim INA-CBGs dan rekam medis pasien intensif dengan selisih klaim negatif, khususnya kasus bronchopneumonia dan stroke iskemik. Penelitian dilaksanakan di RS Hermina Bogor pada Februari-Juni 2026. Untuk mengurangi bias hierarkis akibat relasi struktural peneliti, wawancara mendalam dilakukan oleh enumerator independen, sedangkan FGD dimoderatori langsung oleh peneliti; keabsahan data dijaga melalui triangulasi sumber dan metode.
Hasil: Penguatan verifikasi internal terbukti meningkatkan akurasi klaim secara signifikan. Akurasi gabungan kedua diagnosis naik dari 71,67% (2025) menjadi 93,62% (2026), sementara potensi tambahan klaim dari audit menurun dari 7,92% menjadi 0,95%, menandakan klaim semakin akurat sejak awal. Pada aspek struktur, dukungan manajemen dan teknologi (SIMRS, E-Klaim, digitalisasi pedoman koding) sudah memadai, namun masih terdapat keterbatasan pada kompetensi clinical-coding interface, beban kerja yang tidak mempertimbangkan kompleksitas kasus, serta bridging sistem yang masih manual. Pada aspek proses, verifikasi 2026 lebih proaktif (mingguan, dua tahap, berbasis risiko), namun efektivitasnya tetap bergantung pada kelengkapan dokumentasi medis DPJP yang menjadi hambatan struktural berulang.
Kesimpulan: Verifikasi internal di RS Hermina Bogor efektif sebagai kontrol mutu sekaligus alat optimalisasi nilai klaim BPJS pasien intensif. Permasalahan utama tidak hanya pada proses, melainkan pada aspek struktur, terutama kualitas dokumentasi klinis DPJP, kompetensi coder, dan integrasi sistem. Diperlukan pendekatan yang menekankan perbaikan dokumentasi sebagai upstream process, penguatan kompetensi SDM, SPO khusus pasien intensif, serta integrasi sistem informasi untuk meningkatkan optimalisasi klaim secara berkelanjutan. <hr /> Background: The INA-CBGs-based BPJS claim payment system requires coding accuracy and complete documentation so that claim values reflect the complexity of services provided. Intensive care patients (ICU/HCU/NICU/PICU) present high clinical complexity, high costs, and a greater risk of claim inaccuracy, making them prone to under coding and pending claims that reduce hospital revenue. Hermina Bogor Hospital recorded a BPJS revenue contribution exceeding 50% in 2025; however, increased volume does not necessarily translate into optimized claim values, underscoring the need for effective internal

verification. Methods: This study employed a qualitative case study design analyzed using the structure-process-outcome (Donabedian) framework. Data were collected through in-depth interviews and focus group discussions (FGDs) with personnel directly involved in the claim cycle, selected purposively, alongside document reviews of INA-CBGs claim files and medical records of intensive care patients with negative claim differences, particularly bronchopneumonia and ischemic stroke cases. The study was conducted at Hermina Bogor Hospital from February to June 2026. To reduce hierarchical bias arising from the researcher's structural position, in-depth interviews were conducted by an independent enumerator, while the FGD was moderated by the researcher; data validity was maintained through source and method triangulation. Results: Strengthening internal verification significantly improved claim accuracy. Combined accuracy across both diagnoses increased from 71.67% (2025) to 93.62% (2026), while the potential additional claim value from audits declined from 7.92% to 0.95%, indicating that claims became more accurate from the outset. In terms of structure, management support and technology (SIMRS, E-Claim, digital coding guidelines) were adequate; however, limitations remained in the clinical-coding interface competency, workload that did not account for case complexity, and manual system bridging. Regarding the process, the 2026 verification was more proactive (weekly, two-stage, risk-based), yet its effectiveness still depended on the completeness of physician (DPJP) medical documentation, which remained a recurring structural barrier. Conclusion: Internal verification at Hermina Bogor Hospital effectively serves as a quality control mechanism and a tool for optimizing BPJS claim values for intensive care patients. The core challenges lie not only in the process but also in structural aspects, particularly the quality of DPJP clinical documentation, coder competency, and system integration. A systems-thinking approach emphasizing documentation improvement as an upstream process, strengthening of human resource competency, intensive-care-specific standard operating procedures, and information system integration is needed to sustainably enhance claim optimization.</p>