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Analysis of Factors Causing Pending BPJS Health Claims for Inpatients at Kartika Husada Setu Hospital in 2024

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Abstract
This study is motivated by the high number of pending BPJS Health claims at Kartika Husada Setu Hospital. Pending claims can disrupt the hospital's cash flow and potentially reduce the quality of healthcare services. The purpose of this research is to identify the factors causing pending BPJS Health claims for inpatient services at Kartika Husada Setu Hospital in 2024. This study employs a qualitative research approach with a retrospective design. Data were collected through in-depth interviews, direct observations, and document analysis. The informants included the hospital director, finance manager, service manager, head of the medical records unit, casemix staff, coder, and heads of inpatient wards. The findings indicate that the primary cause of pending claims is the mismatch in medical indications, accounting for 73 files (79.4%), followed by incomplete documentation in 4 files (4.4%), and inaccurate coding in 15 files (16.2%). The mismatch in medical indications often involves unmet emergency and inpatient criteria, as well as a lack of therapeutic evidence. Incomplete documentation is frequently found in medical summaries, while inaccurate coding results from differing interpretations between the hospital and BPJS Health verifiers. The hospital needs to enhance training for staff involved in the BPJS claims process, optimize the use of electronic medical record systems, improve coordination with BPJS Health verifiers, and establish a quality and cost control team. The implementation of these recommendations is expected to reduce the number of pending claims, thereby improving operational efficiency and the quality of healthcare services provided to patients.

Keywords:
Pending claims, BPJS claims, inpatient care

NTRODUCTION

The Indonesian government officially launched the National Health Insurance Program (JKN) on January 1, 2014. This program is administered by the Social Security Administration Agency for Health (BPJS Kesehatan), as regulated under Law No. 24 of 2011, with the objective of fulfilling the population's right to equitable access to quality healthcare services. Healthcare services under the JKN program are provided to individuals who either pay a monthly premium or have their contributions covered by the government (Noviatri & Sugeng, 2016). These healthcare services are delivered through various healthcare facilities, including hospitals.

The Indonesian Case-Based Groups (INA-CBGs) system is utilized to reimburse hospitals for services provided to JKN participants, whereby hospitals submit claims to BPJS Kesehatan. RS Kartika Husada Setu has partnered with BPJS Kesehatan since 2016 as an Advanced Referral Health Facility (Fasilitas Kesehatan Rujukan Tingkat Lanjutan/FKRTL). The hospital handles a significant number of BPJS-covered patients, averaging approximately 88.9% of total inpatient visits monthly. This implies that the hospital's main revenue stream stems from BPJS claims. However, not all claims submitted are approved by BPJS verifiers.

According to a field survey, the Casemix Unit—responsible for submitting collective billing claims for services provided to BPJS patients at the beginning of each month—reported a notable number of pending claims. Based on the monthly performance recap of the Casemix Team at RS Kartika Husada Setu in 2024, the

percentage of pending BPJS claims reached 13% in July, 18% in August, and 12% in October. These figures exceed the unit's performance indicator target, which aims for less than 10% of BPJS claims to remain pending. A particularly concerning issue is the sharp increase in pending claims in August 2024 (18%), and the causes behind the pending claims remain unidentified.

METHODS

This study aims to identify the factors contributing to pending BPJS inpatient claims. A qualitative research approach with a retrospective design was employed to examine past data patterns using in-depth interviews, document review, and analysis of informant responses to structured questions. The research was conducted in January 2025 at RS Kartika Husada Setu.

Research participants included the hospital director, medical and medical support service managers, finance manager, head of the medical records unit, Casemix team coordinator, coders, and head of inpatient wards. Data validity was ensured using source triangulation and method triangulation. Source triangulation was achieved by collecting information from various informants, while method triangulation involved interviews, observations, and review of secondary documents (Mudjia Raharjo, 2010).

RESULTS AND DISCUSSION

1. Respondent Characteristics

The analysis of respondent characteristics was conducted to understand the demographic and professional profiles of the informants. A total of 7 hospital personnel were interviewed. They were categorized based on gender, age, years of service, job title, and roles related to BPJS claim processing, as shown below:

Table 1. Characteristics of Respondents

No.	Gender	Age Range	Years of Service	Job Title	Role in BPJS Claims
1	Male	30–40	5 years	Casemix Coder	Data Coding & Submission
2	Female	28–35	4 years	Head of Medical Records	Document Verification
3	Male	35–45	6 years	Finance Manager	Financial Claims Evaluation
4	Male	38–48	7 years	Hospital Director	Strategic Decision-Making
5	Female	30–38	3 years	Inpatient Ward Coordinator	Documentation & Service Oversight
6	Male	32–40	4 years	Medical Services Manager	Clinical Verification
7	Male	33–42	9 years	Casemix Team Coordinator	Coordination & Supervision

Based on Table 1, the majority of informants were male and aged between 28 and 48 years. Their length of service ranged from 2 to 9 years, with each holding a critical role in the BPJS claims process at RS Kartika Husada Setu.

The gender distribution, dominated by males within the 28–48 age range, reflects general trends in healthcare administration, where decision-making roles are often male-dominated. Research by Sari and Hasan (2021) indicates that demographic factors, including gender, may influence administrative practices. Males often face distinct challenges compared to females when managing administrative tasks such as insurance claims.

This age group also represents a seasoned workforce with relevant experience in BPJS claims management. Supriyadi and Eko (2022) argue that both work

experience and age positively correlate with administrative efficiency, especially in navigating claim processes and regulations.

Respondents' tenure of 2–9 years suggests a sufficient level of experience, which is crucial for handling complex claims and adapting to changing administrative requirements. Aminah and Setiawan (2020) emphasize that longer work experience is frequently associated with greater speed and accuracy in claims administration.

Most respondents were healthcare professionals, whose roles are integral to the administrative and claims processes. According to Ratna and Anggraini (2021), healthcare personnel directly involved in documentation and service provision play a pivotal role in ensuring the smooth submission of claims, as they act as the first point of contact in documentation and verification.

Folland, Goodman, and Stano (2017) argue that administrative efficiency in healthcare services is influenced by factors such as work experience, educational attainment, and workforce demographics. Recent studies support this view, highlighting that experienced and well-educated medical staff are generally more competent in managing claims administration.

2. Input Analysis

a. Human Resources (HR)

Interviews, document reviews, and observations indicate that the human resources involved in BPJS claim submission at RS Kartika Husada Setu are sufficient in both quantity and competence. The workload is proportionally distributed according to patient volume.

b. Incentives

There are currently no specific incentives for managing pending claims. However, additional incentives are provided for staff working beyond regular hours to process claims. Recognition is given in the form of certificates for satisfactory performance, opportunities for training in claims management and updates in BPJS regulations, and provision of adequate work tools, including computers, internet access, and claim-supporting software.

c. Medical Records

Based on interviews and observations, the hospital's medical records system is partially digitized. Some documents still require scanning due to signature or legal documentation requirements. Documents such as informed consent forms and patient education sheets are scanned and uploaded to patient medical records.

d. Information Technology

The Khanza Hospital Information System (SIM RS Khanza) is integrated with the e-claim application, facilitating data extraction for further processing in the BPJS v-claim system. This integration significantly streamlines the claims submission workflow.

e. Standard Operating Procedures (SOPs)

Findings from interviews, observations, and document analysis confirm the existence of a comprehensive SOP for claims processing, which is implemented effectively by the Casemix team and covers all necessary aspects of the claims lifecycle.

Discussion

According to Dessler (2019), a positive perception reflects satisfaction with the performance of medical personnel, which should reduce the likelihood of delays in claim processing. From the perspective of human resource management theory, high-

quality human resources can reduce administrative errors and improve efficiency. However, several areas still demonstrate negative responses, such as the absence of specific incentives for cases where pending claims remain below 10%. This may impact motivation in managing the claims process.

In line with this, Laudon and Laudon (2018) highlight the importance of information systems in enhancing operational efficiency and minimizing delays. Limitations in technology, such as outdated or incompatible systems, can contribute to claim delays. Poor infrastructure may also slow down claim resolution and negatively affect overall service quality (Erlin et al., 2023).

Processes

a. Administrative Services

Triangulation from interviews, observations, and document analysis revealed that hospitals implement a verification system using national ID cards (KTP), BPJS health insurance cards, P-Care application, fingerprint scanning, or the FRISTA system. This indicates adherence to proper verification procedures. Patient registration is facilitated both online and onsite, enhancing access to healthcare services.

According to administrative theory, effective management of patient membership data is crucial for the smooth processing of claims (Griffin, 2017). Inaccuracies or delays in administrative data, such as membership status, can lead to postponed claim payments (Novia, Wilda, & Gusrianti, 2024).

b. Service Recapitulation

Triangulated data from interviews, observations, and document analysis revealed several issues in service recapitulation. These include challenges in determining criteria for inpatient care and emergency conditions for patients admitted via the emergency department (IGD), patient readmission cases, insufficient evidence of drug usage, surgical indications, and referrals made in less than 24 hours.

Service quality theory posits that poor service delivery can decrease patient satisfaction and slow down claim processing (Zeithaml et al., 2021). Moreover, administrative service theory suggests that efficient service management is essential to avoid errors and delays in claims (Zeithaml, Bitner, & Gremler, 2018).

c. Claim File Recapitulation

Based on triangulated findings, the research found that incomplete or erroneous claim files were still common. This supports previous studies by Erlia and Achmad (2022), which found that incomplete documentation, inaccurate coding, insufficient supporting examinations, and inadequate therapeutic evidence are major causes of pending claims in hospitals.

d. Recapitulation of Coding and Data Entry in INA-CBGs

Triangulation of interviews, observations, and document analysis indicated that issues in the recapitulation of coding and data entry for INA-CBGs contributed to inpatient pending claims. A total of 15 claim files (16.2% of total pending cases) were affected due to errors in this process.

Poor coding quality can delay the claim processing timeline. Coding quality theory indicates that substandard coding can negatively affect patient satisfaction and claim efficiency (Zeithaml et al., 2021). Inaccurate coding can also contribute to claim processing delays and administrative complications, consistent with findings by Muharom and Gunawan (2024).

Output

a. **Submitted Claim Output**

Based on interviews regarding the output of pending BPJS Health claims at Kartika Husada Setu Hospital, the findings show that the hospital is able to monitor the status of submitted BPJS claims through the BPJS Health v-claim system until the issuance of the Verification Result Report (*Berita Acara Hasil Verifikasi* or BAHV). The hospital conducts regular evaluations of pending BPJS claims to identify underlying causes and improve future claim processes.

These evaluations are carried out after the hospital receives feedback from BPJS Health, especially through BAHV, which serves as the primary basis for analysis and process improvement. The evaluation results are discussed during internal management meetings, and in certain cases, internal memos are issued to prevent the recurrence of similar claim issues in subsequent months.

Overview of BPJS Health Claim Verification Results at Kartika Husada Setu Hospital

Table 1. Percentage of Pending Inpatient BPJS Claims in 2024

Month	Inpatient Claim Submissions	Pending Inpatient Claims	Percentage of Pending Claims
January	590	28	4.7%
February	676	75	11.1%
March	776	58	7.5%
April	663	36	5.4%
May	689	70	10.2%
June	573	48	8.4%
July	588	67	11.4%
August	591	92	15.6%
September	529	55	10.4%
October	525	83	15.8%
November	540	63	11.7%
December	692	163	23.6%
Total	**7,432**	**838**	**11.27%**

Trends from BPJS Claim Verification Results:

a. **Inpatient Submission Trend**: The number of claim submissions ranged from 525 (October) to 776 (March). March recorded the highest number of submissions, while October had the lowest.
b. **Pending Inpatient Claims**: The highest number of pending claims occurred in December (163 cases), while the lowest was in January (28 cases).
c. **Pending Claims Percentage**: The highest percentage of pending claims was recorded in December (23.6%), with the lowest in January (4.7%).

Identification of Pending Claim Causes (August 2024 Sample)

To identify the causes of pending claims, the researcher conducted a sample analysis of data from the BAHV appendix for BPJS claims submitted in August 2024 (which had been finalized at the time of research). During this period, 92 out of 591 submitted inpatient claims (15.6%) were pending at the first submission.

Table 2. Causes of Pending BPJS Inpatient Claims at Kartika Husada Setu Hospital (August 2024)

Cause Category	Number of Claims	Percentage
Medical Indication	72	79.4%
Inaccurate Coding	15	16.2%
Incomplete Documentation	4	4.4%
Total	**91**	**100%**

Note: One file may have more than one issue; percentages are based on the most prominent cause per claim.

Detailed Breakdown of Claim Causes:

1. **Medical Indication (79.4%)**
   a. *Emergency Criteria and Inpatient Indication at ER*: The most significant cause, with 52 pending claims (56.5%), highlighting challenges in substantiating emergency conditions that justify inpatient care.
   b. *Insufficient Therapy Evidence*: 10 claims (10.9%) were pending due to inadequate therapeutic documentation.
   c. *Readmission*: 6 claims (6.5%) involved patients readmitted with similar complaints within the same claim period.
   d. *Referral Procedures*: 3 claims (3.3%) were due to referrals made before 24-hour treatment, which should have been classified as outpatient cases.
   e. *Surgical Procedures*: 2 claims (2.2%) required additional documentation detailing the chronology of the surgical intervention.
2. **Inaccurate Coding (16.2%)**
   a. *Incorrect Coding*: 6 claims (6.5%) were due to coding errors.
   b. *Discrepancies in Verifier Interpretation*: 9 claims (9.8%) resulted from differing interpretations between the hospital and BPJS Health verifiers, indicating a need for coding harmonization.
3. **Incomplete Documentation (4.4%)**
   a. *Incomplete Medical Summaries*: 2 claims (2.2%) were pending due to incomplete medical resumes.
   b. *Exceeded Waiting Time*: 1 claim (1.1%) was delayed due to waiting time violations.
   c. *Corrupted Softcopy Files*: 1 claim (1.1%) was affected by damaged electronic documents.

CONCLUSION

1. **Input Factors**

Several input factors contribute to the occurrence of pending claims. These include human resources, particularly errors in coding attributable to coders, as well as a lack of understanding among emergency room physicians, attending specialists (DPJP), and nurses regarding admission indications and emergency criteria. Regarding infrastructure, the hospital's digital-based management information system is considered adequate and is supported by appropriate technology and infrastructure to facilitate the claims process—from patient admission to discharge. However, user discipline is required to ensure that medical and supporting information is properly recorded in the electronic medical records.

2. **Process Factors**

Identified process factors that influence pending BPJS Kesehatan claims include: determining inpatient and emergency criteria for patients admitted through the emergency department, readmissions of inpatients, insufficient documentation of medication usage, indications for surgery, and referrals made in less than 24 hours. These issues account for 73 files or 79.4% of the total pending inpatient claims. Additionally, the process of coding recapitulation and data entry into INA CBGs contributes to 15 pending claim files or 16.2% of the total. In the claim documentation recapitulation process, errors or incomplete claim files accounted for 4 claim files or 4.4% of the total pending claims. In terms of membership administration, the hospital

implements a layered verification process to prevent potential misuse of healthcare coverage by unauthorized individuals.

3. Output Factors

Claims that do not meet the specified standards significantly impact BPJS Kesehatan by causing delays in claim payments. These delays can adversely affect hospital operations, lead to a decline in service quality, and ultimately reduce patient trust in the hospital.

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