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Factors Causing Pending Claims BPJS Health Inpatient Use Improving Claim Quality At Welas Asih Regional Hospital

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ABSTRACT

BPJS Kesehatan claims are a crucial component of the continuity of hospital services, yet pending claims are still common. This study aims to identify the factors causing pending inpatient claims at Welas Asih Regional Hospital and understand the obstacles in the claims submission process. The main problems include incomplete supporting documents, mismatched diagnoses, and verification challenges from BPJS. The study used descriptive qualitative methods through interviews, observations, document reviews, and analysis of 521 pending claim files. The results indicate that the largest causes of pending claims stem from BPJS verification (57.39%) and coding (28.60%), while administrative issues account for only a small portion. Good internal coordination between units allows most claims to be resolved without escalation to BPJS. The study concluded that improving the completeness of medical records, coding training, understanding regulations, and reviewing multiple documents are effective strategies to reduce pending claims and increase the efficiency of the BPJS claims process at Welas Asih Regional Hospital.

Keywords : BPJS claims, pending, inpatient, coding, BPJS verification

INTRODUCTION

As the national health insurance provider, BPJS Kesehatan plays a strategic role in ensuring access to healthcare services for all Indonesians. A crucial aspect of BPJS operations is the management of inpatient claims, where hospitals, as service providers, are required to submit complete, accurate, and procedurally correct claim documents. However, in practice, many claims remain pending, hampering the payment process and potentially leading to inefficiencies in hospital management.
Pending claims can be caused by various factors, including incomplete medical documentation, coding errors, and internal administrative constraints. Previous research has shown that coding errors and incomplete documentation are the dominant factors influencing the BPJS claims process (Syahputri et al., 2024; Setiawan et al., 2025). Furthermore, coordination between hospital units and interaction with BPJS also play a crucial role in expediting or delaying the claims process (Putri et al., 2023).

In theory, BPJS Kesehatan claims management can be explained through the Public Administration System Theory, which emphasizes the need for an effective information system, inter-unit coordination, and clear work procedures to ensure smooth administrative processes. In the hospital context, this theory is relevant because BPJS claims are part of the interconnected financial management and patient care systems. An effective administrative system is key to ensuring smooth claims processing, increasing patient satisfaction, and maintaining the sustainability of hospital operations.

In addition to internal hospital factors, BPJS regulations and mechanisms also influence claim status. The INA-CBG regulations, which guide coding and claims, require high accuracy. Mistakes in coding diagnoses and procedures can result in claims being returned or delayed, increasing the administrative burden on hospital staff (Rahayu et al., 2020). This emphasizes that the competence of claims officers and an understanding of BPJS regulations are crucial in reducing the number of pending claims.

Previous research has shown that suboptimal claims management not only impacts hospital efficiency but can also undermine patient trust in hospital services and the National Health Insurance (JKN) system. Putri et al. (2022) emphasized that late claims can impact a hospital's relationship with the National Health Insurance (BPJS), including potential administrative fines or delayed claims payments. Therefore, improving internal processes is a strategic step to maintain hospital performance and the quality of patient care.

Based on these conditions, an in-depth analysis is needed to understand the causes of the high number of pending inpatient claims at Welas Asih Regional Hospital. Through this study, researchers sought to identify the factors causing the pending claims, both those originating from the hospital's internal processes and from the external verification mechanisms of BPJS Kesehatan. The results of this analysis are expected to provide an objective overview of weaknesses in the claims submission process and areas requiring improvement. The research findings will form the basis for developing strategic recommendations, such as improving staff competency, improving internal SOPs, optimizing coordination, and strengthening the completeness of supporting documents. Therefore, this research is expected to not only contribute to improving the efficiency and accuracy of the claims process at Welas Asih Regional Hospital but also provide broader benefits for the development of BPJS claims management in other healthcare facilities.

RESEARCH METHODS

This study uses a descriptive qualitative approach aimed at obtaining a comprehensive overview of the BPJS inpatient claims submission process at Welas Asih Regional Hospital and the factors that lead to pending claims. This approach was chosen because it allows researchers to obtain in-depth information through direct explanations from parties involved in claims management. The main

informant in this study was purposively selected, namely the Head of Casemix at Welas Asih Regional Hospital, because he has comprehensive knowledge of the claims process, frequently encountered obstacles, and corrective measures taken to address pending claim files.

Data collection was conducted through in-depth interviews, direct observation, and document review, including medical resumes, INA-CBG files, supporting findings, and claims correction communication records between the hospital and the BPJS. In addition to primary data, this study also utilized secondary data in the form of 521 pending claim files obtained from official hospital reports. This data was analyzed to determine the patterns, distribution, and categories of causes of pending claims.

All data obtained was then analyzed through data reduction, data presentation, and conclusion drawing, resulting in a comprehensive understanding of the research problem. To ensure data validity, this study employed triangulation techniques, comparing and confirming information from interviews, observations, and document reviews to ensure consistency, accuracy, and reliability. This method is expected to provide a clear picture of the factors causing pending claims and serve as a basis for improving the BPJS claims process at Welas Asih Regional Hospital.

RESULTS

A qualitative analysis of 521 pending inpatient claim files at Welas Asih Regional Hospital revealed that the main obstacles stemmed from BPJS verification and coding, followed by administrative issues. The majority of pending claims required clarification regarding medical evidence, diagnostic accuracy, and the completeness of supporting documentation, such as radiology and laboratory results. Medical records are usually complete because they are reviewed by a supervising physician before being sent to the coders, but human error remains possible, especially if the files go directly to the coding unit.

Table 1. Factors Influencing the Number of Pending Inpatient Claims at Welas Asih Regional Hospital

Pending Category	Number of Files	Percentage (%)
Administrative	43	8.25
Encoding	149	28.60
BPJS Verification	299	57.39
Not feasible	23	4.41
Blank	6	1.15
Total	**521**	**100**

Notes: The percentage is calculated from a total of 521 pending claim files.

An interview with the Head of Casemix confirmed that internal coordination between coders, supervising physicians, DPJPs, and nurses occurred in a hierarchical manner, allowing many issues to be resolved without escalating to BPJS. External communication with BPJS focused on specific officials to maintain clarity and consistency. Pending claims were generally revisable, resulting in Welas Asih Hospital recording a 0% dispute rate, demonstrating the hospital's ability to resolve differences internally. These findings underscore the importance of effective internal coordination, meticulous document verification, and enhanced coding capacity to streamline the inpatient claims process.

DISCUSSION

The analysis showed that the majority of pending claims at Welas Asih Regional Hospital were caused by BPJS verification (57.39%) and coding (28.60%), while administrative issues contributed 8.25%. This confirms that claim barriers are not only administrative in nature, but also related to the accuracy of medical data and proper coding. Many pending claims require clarification regarding medical evidence, the appropriateness of diagnoses, and the completeness of supporting documents such as radiology and laboratory results. Although medical records are generally complete due to verification by the supervising physician before being sent to the coding unit, human error is still possible, especially if the files go directly to the coding unit.

Internal coordination at Welas Asih Regional Hospital is hierarchical and systematic. The control unit reviews medical documents and supporting documentation, then forwards the files to the coding unit for coding. The controlling physician plays a crucial role in ensuring that diagnoses, procedures, and supporting documentation are accurate before submission to the BPJS. The coders then code based on the verified data. This coordination system has proven effective in reducing internal errors and minimizing escalation of issues to BPJS.

Furthermore, internal communication between coders, supervising physicians, DPJPs, and nurses runs smoothly. Nurses and administrative staff are also crucial in ensuring all supporting documentation is complete and that the number of claim files matches the data recorded in the system. This coordination ensures that most pending claims can be corrected and ultimately validated. Consequently, Welas Asih Regional Hospital recorded a 0% dispute rate, demonstrating the hospital's ability to resolve claim discrepancies internally without external involvement.

From a technical perspective, human errors in coding still occur, such as combinations of codes that should be described separately or interpretations of diagnoses that differ from standard codes. However, these errors can be corrected through revisions and used as material for internal evaluation. Furthermore, the

web-based SIMRS system significantly simplifies access, document management, and claims file tracking compared to the previous desktop system.

In terms of supporting documentation, radiology and laboratory results often present challenges due to the time required to read and the lengthy waiting lists. This impacts the completeness of claim documents and can lead to pending claims, even if the medical record is complete. Therefore, coordination with the nurse and supervising physician is crucial to ensure all documentation is available before submitting a claim.

The corrective measures implemented include improving the completeness and quality of medical records, enhancing coding competency through regular training, understanding the latest regulations, and checking supporting documents before submitting claims. This approach is expected to reduce pending claims, expedite the claims process, and ensure payment in accordance with BPJS regulations, particularly for class 3 patients, who make up the majority.

Overall, these findings emphasize that the smooth processing of BPJS inpatient claims relies heavily on effective internal coordination, thorough document verification, and adequate coding and administrative capacity. By strengthening these aspects, Welas Asih Regional Hospital can minimize pending claims, expedite the claims process, and improve hospital administrative efficiency.

CONCLUSION

Based on a qualitative analysis of 521 pending inpatient claim files at Welas Asih Regional Hospital, the primary causes of pending claims were BPJS verification and coding, while administrative issues contributed less. Effective internal coordination between coders, supervising physicians, DPJPs, and nurses proved to be a crucial factor in resolving pending claims, allowing most claims to be resolved internally without escalation to BPJS, as reflected in the 0% dispute rate. Although human errors in coding and supporting documentation still occurred, these errors were minimized through multiple checks, internal revisions, and regular evaluations.

Implemented improvement measures, such as increasing the completeness and quality of medical records, routine coding training, understanding the latest regulations, and checking supporting documents before submitting claims, have proven effective in reducing the number of pending claims and expediting the submission process. By strengthening internal coordination, document verification accuracy, and coding capacity, Welas Asih Regional Hospital can improve hospital administrative efficiency, streamline claims processes, and enhance the quality of care for patients, particularly class 3 patients who make up the majority of claims.

BIBLIOGRAPHY

Inap, R., Rumah, D., Setiawan, AP, Setiatin, S., & Nuraeni, YA (2025). Analysis of the Causes of Delays in BPJS Health Patient Claims. 10(2), 220–229.

Indawati, L. (2019). Analysis of Coding Accuracy in BPJS Inpatient Claim Returns at Fatmawati General Hospital in 2016. Indonesian Journal of Health Information Management, 7(2), 113. https://doi.org/10.33560/jmiki.v7i2.230

Pratama, A., Fauzi, H., Nur Indira, Z., & Purnama Adi, P. (2023). Analysis of Factors Causing Pending Inpatient Claims Due to Medical Record Coding at Dr. Soedirman Regional General Hospital (RSUD) Kebumen. Imelda Scientific Journal of Health Recording and Information (JIPIKI), 8(1), 124–134. https://doi.org/10.52943/jipiki.v8i1.1225

Putri. (2025). Analysis of Inhibiting Factors in Submitting Inpatient BPJS Claims at Majenang Hospital in 2023. 17(1), 101–115.

Putri, FA, & Dhamanti, I. (2025). Analysis of Factors Causing Pending BPJS Health Claims for Inpatients in Hospitals: A Literature Study. Tambusai Health Journal, 6(1), 764–772. https://doi.org/10.31004/jkt.v6i1.40923

Rahayu, N., & Sari, I. (2023). The Effect of Completeness of Patient Medical Resumes on BPJS Health Claim Submissions at Cicendo Eye Hospital, Bandung. Health Information: Research Journal, 15(2), 1–10.

Rismawati, D., & Sari, I. (2021). Completeness of BPJS Files in an Effort to Accelerate BPJS Outpatient Claims at Cirebon Harbor Hospital. Journal of Health Research" SUARA …, 12 (November), 63–67. http://forikes-ejournal.com/ojs-2.4.6/index.php/SF/article/view/1561

Sakinah, A., & Yunengsih, Y. (2021). Analysis of the Completeness of BPJS Inpatient Medical Resumes. Tambusai Health Journal, 2, 70–77.

Sari, I., & Ganesha, PP (2022). The Effect of Completeness of Inpatient Care Requirements on Claim Delays at Majalaya Regional Hospital. 6(1), 14–20.

Syahputri, FA, Khairani, K., Gurning, FP, Islam, U., Sumatera, N., & Deli, K. (2024). Analysis of Factors Causing Pending BPJS Claims. Journal of Public Health, 12(October), 339–355.

Utami, T., Maryati, W., Ahmad, H., Prodi, D., Medik, R., Universitas, K., Bangsa, D., Prodi, D., Medik, R., Universitas, K., & Bangsa, D. (2025). Number of Pending Claims for Inpatient BPJS Patients in Hospitals. : : Infokes: Scientific Journal of Medical Records and Health Informatics, 15(1), 30–41.