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FACTORS CAUSING PENDING CLAIMS AT SULTAN THAHA SAIFUDDIN REGIONAL HOSPITAL

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ABSTRACT

Pending claims are delays in the payment of billed debts aimed at preventing financial disruption. Unresolved claims can interfere with and complicate hospital cash flow, as well as hinder the settlement of hospital obligations. The purpose of this study was to determine the factors causing pending BPJS Health claims in inpatient services at Sultan Thaha Saifuddin Regional General Hospital, Tebo. This research employed a quantitative design with a cross-sectional approach and was analyzed using univariate and bivariate data. The results and conclusions of the study showed that out of 361 claim files, 138 files (38.2%) experienced pending status. The identified factors causing pending claims included inaccurate diagnostic coding (20.8%), incomplete claim documents (16.3%), and unclear diagnostic writing (2.8%). To prevent recurring inpatient pending claims, it is expected that coding officers will be more thorough in entering diagnostic codes into the INACBG's application, pay greater attention to the completeness of claim documents and clarity of diagnosis writing, as well as participate in training and seminars related to coding and diagnostic establishment.

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1. INTRODUCTION

The National Health Insurance (JKN) is a nationwide health insurance program whose financing, membership, health services, implementing agencies, and organization are determined by the government (State Secretariat of the Republic of Indonesia, 2024). The payment method implemented by hospitals under the JKN program uses a prospective payment method, namely payment for health services whose rates are known before the services are provided. In Indonesia, this prospective payment method is known as Casemix INA-CBGs (Indonesian Case Base Groups), which group diagnoses and procedures based on similar or

identical clinical characteristics and resource utilization. The grouping is performed using grouper software (Happy Putra et al., 2023).

The INA-CBGs payment system in hospitals requires a file verification process. Before claims are submitted to BPJS Kesehatan, a BPJS verifier conducts a verification process to verify the accuracy of the administrative accountability of services provided by the health facility to maintain service quality and cost efficiency for BPJS Kesehatan participants. The verification process begins with the healthcare facility preparing claim documents. BPJS Kesehatan verifiers then verify the membership administration, service administration, health service verification, and verification using INA-CBG's software. BPJS Kesehatan then approves the claim and makes payment for files deemed eligible. However, files deemed ineligible must be returned to the hospital for confirmation of claimability (Pengauan et al., 2025). According to Astuti and Tirto (2022), pending claims are claims returned for which there has been no agreement between BPJS Kesehatan and the hospital regarding coding or medical procedures. Incomplete or inappropriate requirements require revision by casemix officers, in accordance with the 2014 Claim Verification Technical Guidelines. Requirements submitted to BPJS Kesehatan will undergo a verification process and must meet three verification criteria: participant administration verification, service administration verification, and three health service verification aspects. A BPJS claim is a request for medical expenses for BPJS patients by a hospital to BPJS Kesehatan. This is done collectively and billed to BPJS Kesehatan monthly. To receive these costs, the hospital must submit supporting documentation as a requirement for submitting a claim. Completeness of the JKN claim application documentation is crucial for a smooth reimbursement process. Delayed or pending claims are caused by incomplete medical records and inaccurate diagnosis and procedure codes. Inaccurate diagnosis and procedure codes are caused by differing perceptions between hospital coders and BPJS verification officers. Inaccurate diagnosis and procedure codes influence the determination of INA-CBG claim rates and result in inaccurate INA-CBG rates. Pending claims impact cash flow to the hospital and disrupt claim payments.

A survey conducted in April 2025 found several pending claims by BPJS Kesehatan that were not yet eligible for claim processing and were delayed due to incomplete requirements, such as radiology and laboratory results. There are 107 pending claims. The file revealed that one of the reasons for the pending inpatient claims was a case of incomplete supporting documentation during diagnosis management, resulting in BPJS Kesehatan inpatient care not being paid (pending claim).

2. METHOD

This research is a quantitative research with a cross-sectional design. The study was conducted on July 14, 2025 – completed in the medical records room of Sultan Thaha Saifuddin Tebo Regional Hospital. The population in this study was all inpatient claim files from January to March 2025, totaling 1744 files. The sample used by the author in this study was based on the Slovin method, namely 361 samples. The sampling technique in this study was Simple Random Sampling, namely a sampling technique from population members that was carried out randomly without considering the strata in the population.

3. RESULTS AND DISCUSSION

3.1. Univariate Analysis

1. Distribution of pending claims frequency

claim file	f	%
pending	138	38.2
Not Pending	223	61.8
Total	361	100.0

Based on the table above, it shows that of the 361 medical records of outpatients, 138 (38.2%) medical records were pending, and 223 (61.8%) were not pending for inpatients at Sultan Thaha Saifuddin Tebo Regional Hospital in 2025.

2. Frequency Distribution of Diagnostic Code Inaccuracy

Inaccurate Diagnostic Code	f	%
correct	286	79.2
incorrect	75	20.8
Total	361	100.0

Based on the table above, it shows that from 361 medical records of inpatients, 75 (20.8%) of the diagnosis codes were incorrect, and 286 (79.2%) were correct for inpatients at Sultan Thaha Saifuddin Tebo Regional Hospital 2025.

3. Frequency Distribution of Incomplete Claim Files

Incomplete Claim Files	f	%
Complete	302	83.7
Incomplete	59	16.3
Total	361	100.0

Based on the table above, it shows that of the 361 medical records of inpatients, 59 (16.3%) claim files were incomplete, and 302 (83.7%) claim files were complete for inpatients at Sultan Thaha Regional Hospital.

4. Frequency Distribution of Ambiguity in Diagnostic Writing

Ambiguity in Diagnostic Writing	f	%
Clear	351	97.2
Unclear	10	2.8
Total	361	100.0

The table above shows that out of 361 inpatient medical records, 10 (2.8%) had unclear claim files, and 351 (97.2%) had complete claim files for inpatients at Sultan Thaha Saifuddin Tebo Regional Hospital in 2025.

3.2. Bivariate Analysis

3.2.1. The Relationship Between Inaccurate Diagnostic Codes and Pending Claims

Inaccurate Diagnostic	Pending	%	Not Pending	%	Total	%	P
Incorrect	75	100.0%	0	0.0%	75	100.0%	
Correct	63	22.0%	223	61.8%	286	100.0%	0.000

Total	138	38.2%	223	61.8%	361	100.0%

The table above shows that of the 138 pending medical record files, 75 (100%) were inaccurate. The results of the statistical test (chi-square) obtained a p-value of 0.000 (p<0.05), indicating a relationship between inaccurate diagnosis codes and pending claims.

3.2.2. The Relationship Between Incomplete Claim Files and Pending Claims

Incomplete Claim File	**Pending**	**%**	**Not Pending**	**%**	**Total**	**%**	**P**
incomplete	59	100.0%	0	0.0%	59	100.0%	
complete	79	26.2%	223	61.8%	302	100.0%	0.000
Total	138	38.2%	223	61.8%	361	100.0%	

The table above shows that pending claims due to incomplete claim files are 59 (100%) higher than non-pending files (0%). The results of the statistical test (chi-square) obtained a p value of 0.000 (p <0.05), meaning there is a relationship between incomplete claim files and pending claims.

3.2.3 The Relationship Between Unclear Diagnosis Writing and Pending Claims

Unclear Diagnosis Writing	**Pending**	**%**	**Tidak Pending**	**%**	**Total**	**%**	**P**
unclear	10	100.0%	0	0.0%	10	100.0%	
clear	128	36.5%	223	61.8%	351	100.0%	0.000
Total	138	38.2%	223	61.8%	361	100.0%	

The table above shows that pending claims due to unclear diagnosis writing are 10 (100%) higher than files that are not pending (0%). The results of the statistical test (chi-square) obtained a p value = 0.000 (p <0.05), meaning there is a relationship between unclear diagnosis writing and pending claims..

Discussion

Frequency Distribution of Pending Claims

Pending claims are claims or healthcare services that have not been approved for payment by the BPJS Kesehatan due to a disagreement between BPJS Kesehatan and the hospital. Pending claims can also be defined as claims that have been verified but have not yet been paid by the primary care provider due to incomplete documentation, administrative, medical, inaccurate coding, and other issues submitted by the hospital (Ministry of Health, 2020). According to researchers, the causes of pending claims include payment from the healthcare facility that does not match the requested information, incomplete claim documentation, and inaccurate diagnosis codes, which result in a pending claim. Consequently, there are files pending from BPJS Kesehatan to the hospital, and there are files received from BPJS Kesehatan from the hospital.

Frequency Distribution of Inaccurate Diagnosis Codes

According to researchers, one of the causes of pending claims is inaccurate diagnosis codes. This is due to discrepancies between the hospital and the BPJS Kesehatan verifier, and inaccurate code entry by the coder. Inaccurate diagnosis codes are crucial issues that medical records personnel must address. Medical record coding must be carried out with great care to produce accurate codes. Diagnosis coding by coders at Sultan Thaha Saifuddin Tebo Regional Hospital was performed inaccurately and did not comply with ICD-10. This was also due to disagreements between the hospital and the BPJS (Social Security Agency) resulting in inaccurate codes, resulting in pending claims from BPJS to the hospital. To mitigate this, coders or verification officers should carefully review the codes they have created and follow BPJS regulations. This ensures the

codes are accurate and precise, and BPJS officers can validate the codes to prevent pending claims and impact hospital payment rates.

Frequency Distribution of Incomplete Claim Files

The importance of complete documentation when submitting a BPJS claim at a hospital includes a recapitulation of services and supporting patient files, including a Participant Eligibility Letter (SEP), a medical resume written by a doctor, a statement of diagnosis, both the initial diagnosis upon admission and the final diagnosis upon discharge, determined by the responsible doctor, and other required supporting documentation (Oktamianiza, O., Reza, I.A., & Novita, 2022). These documents must be completed by the hospital before being submitted to BPJS Kesehatan to obtain reimbursement for patient costs during treatment in accordance with the Indonesia Case Base Groups (INACBG's) rates (Valentina, & Halawa, 2018). According to researchers, pending claims are caused by incomplete claim files, namely procedures not attached during the claim process, such as missing supporting lab results, radiology results, ultrasound results, and others, doctor signatures, and incomplete BPJS requirements. The incomplete files found in the study originated from inpatient medical records. Inpatient medical records are a crucial factor in BPJS Kesehatan claims. This can result in pending claims. Therefore, it is crucial for staff to check the completeness of medical records and ensure BPJS Kesehatan claim requirements are met, which will ultimately result in appropriate financing and treatment specifications.

Frequency Distribution of Unclear Diagnosis Codes

The clarity and accuracy of disease codes play a crucial role in hospitals, including facilitating the classification of the top ten most common diseases for reporting to the health office and the Ministry of Health. The International Statistical Classification of Diseases and Related Health Problems (ICD-10) provides guidelines for coding diagnoses to ensure correct and precise coding. According to the authors, the cause of unclear diagnosis codes during coding is the inability of coding staff to read doctors' handwriting, which is often difficult to read. The writing of the diagnosis is unclear or illegible and precise, cursive writing and abbreviations in writing the main diagnosis will make it difficult to code the main diagnosis so that the medical records officer needs to look for information related to the clearer writing of the diagnosis on other sheets, if they do not find a clearer writing of the diagnosis, the medical records officer must confirm with the doctor concerned.

The Relationship between Inaccurate Diagnosis Codes and Pending Claims

Based on research (Yohana Fransiska Nanjo et al., 2022) entitled "Analysis of the Effect of Inaccurate Diagnosis and Procedure Codes for Inpatients Under National Health Insurance on Rates at Wanga Regional General Hospital in Denpasar City," bivariate analysis using the chi-square test revealed 90 (68.2%) inaccurate codes, with a p-value of 0.000, indicating a relationship between inaccurate codes and pending claims. Coding inaccuracy is a form of discrepancy in the diagnosis of diseases and behaviors included in specific categories in the ICD-10 and ICD-9 CM. Medical professionals treating patients or identifying primary conditions must make a diagnosis to ensure accurate diagnostic codes, which will serve as the basis for calculating morbidity data. Available medical records must be used by coders to determine the diseases and procedures to be coded. For accurate classification, complete medical records are required (Hatta, 2011).

The Relationship Between Incomplete Claim Files and Pending Claims

A study by Ayu Fiska Putri et al., entitled "The Relationship Between Completeness of Claim Requirements and Claim Approval by BPJS Verifiers at Dr. Soeradji General Hospital," found a relationship between the completeness of inpatient BPJS claim files and claim approval by BPJS verifiers at Dr. Soeradji General Hospital, Tirtonegoro, Klaten. These documents are mandatory for hospitals before submitting to BPJS Kesehatan (Healthcare Social Security Agency) to obtain reimbursement for patient care costs in accordance with the Indonesia Case Base Groups (INA CBGs) rates (Valentina & Halawa, 2018). According to the researchers, a statistical test showed a $P < 0.05$, thus accepting Ha, indicating a relationship between incomplete claim files and pending claims. This significantly impacts operational work, particularly the claims process.

The Relationship Between Incomplete Claim Files and Pending Claims

The chi-square test yielded a p-value of 0.000 ($P<0.05$), indicating a relationship between incomplete claim files and pending claims. Based on research (Maisharoh et al., 2020) on the Relationship between Clarity and Accuracy of Disease Diagnosis Writing and Accuracy of ICD-10 Diagnosis Coding at the Perlompek Kerinci Community Health Center, 95 inpatient medical records showed that 55 of the unclear diagnoses were inaccurate, while 42.2% were correct. The statistical test yielded a p-value of 0.000 ($p<0.05$), indicating a significant relationship between the accuracy of diagnosis writing and the accuracy of diagnosis coding. This study is in line with (Maisharoh et al., 2023) regarding the Relationship between Completeness and Clarity of Writing Diagnosis Actions with the Accuracy of Medical Action Codes, It was found that more than half of

the unclear and precise writings were more legible writings, namely 58 (81.7%). Based on the statistical test conducted by the researcher, the p-value was obtained = 0.000 which means (P ≤ 0.05), so there is a relationship between the clarity of writing diagnoses and the accuracy of coding medical actions**.**

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4. CONCLUSION

Based on research conducted by researchers at Sultan Thaha Saifuddin Tebo Regional Hospital, 138 (38.2%) pending claims were caused by inaccurate diagnosis codes, unclear diagnosis writing, and incomplete claim files, pending claims due to inaccurate diagnosis codes numbered 75 (20.8%) due to discrepancies between coders and the BPJS, incomplete claim files numbered 59 (16.3%) due to missing supporting documentation, such as laboratory results, and radiology results, during the claim process, unclear diagnosis writing numbered 10 (2.8%) due to unclear and illegible diagnosis writing, there was a correlation between diagnostic inaccuracy and pending claims at Sultan Thaha Saifuddin Tebo Regional Hospital from January to March 2025 (p-value = 0.000 (p<0.05), there was a correlation between incomplete claim files and pending claims at Sultan Thaha Saifuddin Tebo Regional Hospital from January to March 2025 (p-value = 0.000 (p<0.05), there was a correlation between unclear diagnosis writing and pending claims at Sultan Thaha Saifuddin Tebo Regional Hospital from January to March 2025 (p-value = 0.000 (p<0.05).

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