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Factors Causing Delays in BPJS Health Inpatient Claims at Dr. Harjono S Regional General Hospital in Ponorogo Regency

Ike Wahyu Septian[1*], Dwi Nurjayanti[2]
[1-2]Sekolah Tinggi Ilmu Kesehatan Buana Husada Ponorogo, Indonesia
**Correspondence author: wahyuseptianiikke@gmail.com*

Abstract. *Pending inpatient BPJS Health claims pose a financial and operational challenge for hospitals. At RSUD Dr. Harjono S Ponorogo, 228 pending claims were identified in November 2024 out of 1,335 total claims. This issue was caused by incomplete supporting documents, coding errors, and non-specific medical diagnoses and procedures. This study used a descriptive qualitative approach through observation and interviews. The sample consisted of four claims officers and 228 inpatient pending claim files. The sampling technique used was purposive sampling. Data were analyzed through data reduction, presentation, and conclusion drawing. The study revealed several contributing factors: (1) Man lack of accuracy and training among staff; (2) Method suboptimal claim procedures; (3) Material incomplete supporting documents; (4) Machine information system disruptions; and (5) Money delayed claim payments. The primary causes of pending inpatient claims are incomplete medical documentation and inaccurate coding. Improvements are needed in staff training, claim procedures, and system integration between hospitals and BPJS Health.*

Keywords: *BPJS Health; Delays; Factors Causing; Health Inpatient Claims; Pending Claims.*

1. BACKGROUND

The National Health Insurance (JKN) program began in 2014. The JKN program is managed by the Social Security Administration Agency (BPJS), which is regulated by Law No. 24 of 2011. BPJS is a Social Security Agency established by the government to provide health insurance for the public. The National Health Insurance (JKN) is a public health program that provides healthcare services based on medical needs. BPJS will approve claims and pay for eligible documents, but unpaid documents must be returned to the hospital for review (Kurnia, 2022).

A BPJS claim is a collective submission of patient care costs by BPJS, billed to BPJS monthly, and the hospital is required to complete the BPJS claim documents before submitting them to BPJS to receive reimbursement for patient care costs (Herman, 2020). the BPJS Health verification process begins with the creation of the SEP, coding process, and BPJS Health claim entry, document scanning process, and claim document verification.

According to research by Fani et al. (2023), at Hospital X, there were 129 pending BPJS claims for inpatients in February-March 2023. According to research by Arif et al. (2023) at Sebelas Maret University Hospital (UNS), there were 183 pending BPJS claims for inpatients in August-October 2023 (Bella, C. R. 2024).

Based on a preliminary study at Dr. Harjono S General Hospital in Ponorogo District on May 20, 2025, conducted by researchers, there were 228 pending BPJS inpatient claims in November 2024 out of a total of 1,335 inpatient claim submissions. This occurred because the

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documentation was incomplete. Pending claims result in unpaid healthcare services by BPJS Health, leading to a decrease in hospital revenue and impacting operational activities within the hospital. The causes of pending claims include incomplete diagnostic supporting documents (76 files), coding that does not comply with applicable regulations (79 files), and incomplete, unclear, and nonspecific diagnostic and treatment descriptions from doctors (73 files).

The solution that can be implemented is to improve the referral process from community health centers to hospitals in accordance with the procedures determined by BPJS Health. Improving the quality of medical documentation to ensure completeness, coding accuracy, and the completeness of files and service evidence is expected to significantly reduce the number of pending claims, thereby stabilizing hospital revenue and ensuring uninterrupted operations. This prompted the researcher to choose the title "Factors Causing Pending BPJS Health Insurance Claims for Inpatient Care at Dr. Harjono S General Hospital in Ponorogo District."

2. THEORETICAL STUDY

BPJS Kesehatan can be defined as an affordable health insurance system that provides opportunities for people with limited financial means to independently pay for their healthcare costs, while for those who are unable to pay, the costs are covered by the government. With the existence of BPJS Kesehatan, it is hoped that all Indonesian citizens will have their healthcare needs met.

A claim is a claim made by a company against the insured based on a previously agreed contract and fulfilled by the insurance company. Therefore, the term "loss" is often used in the insurance world. In this case, the insurance customer acts as the insured, and the insurance issuer acts as the insurance company. An insurance claim is an insurance claim between the insurance company and the insured who pays a certain amount of premium to guarantee compensation payment. This claim can be confirmed due to the contractual arrangement.

Pending claims are the return of invoices due to the lack of agreement between BPJS Kesehatan and the Advanced Referral Health Facility regarding the regulations on coding and medical determination (dispute claim), and their resolution is carried out in accordance with the provisions of the applicable laws and regulations. The reasons for claim reimbursement include incomplete requirements or items not fully filled out, diagnostic discrepancies, and differences of opinion between hospital verifiers and BPJS Health verifiers (Zahra, A. V. 2024).

3. RESEARCH METHODOLOGY

This study uses a descriptive qualitative approach. This approach aims to describe in depth the factors causing delays in BPJS Kesehatan inpatient claims at Dr. Harjono S Regional General Hospital in Ponorogo Regency, with the researcher as the main instrument in the data collection and analysis process. This study focuses on the meaning, understanding, and interpretation of the situations observed in the field (Sugiyono, 2016). The subjects of this study consisted of four informants, including two coders, one doctor, and one verifier, who were selected using purposive sampling from 228 files because they were considered to have direct knowledge of the claims process and its problems. Data collection techniques included document observation and in-depth interviews. Structured interviews were conducted with claims officers to understand the claims process and its challenges. Observations involved directly observing the claims submission process and technical obstacles. The instruments used were interview guidelines and observation sheets.

Interview data were collected using semi-structured guidelines to explore informants' views on the BPJS Health inpatient claim submission process and claim management process. Validity and reliability testing were not detailed because the method used was qualitative, and the instruments were adapted to the field context. Data were analyzed using content analysis techniques, with steps of data reduction, data presentation, and conclusion drawing. This analysis aimed to identify patterns, themes, and relationships between the phenomena of factors causing BPJS Health inpatient claim delays at Dr. Harjono S General Hospital in Ponorogo Regency.

4. RESEARCH RESULTS

Based on an analysis using the 5M model (material, man, machine, method, money), observations, and interviews, the following causes were identified for the delay in BPJS Health inpatient claims at Dr. Harjono S Regional General Hospital in Ponorogo Regency:

Man Factor (Human Resources)

There are 12 staff members handling BPJS claims at Dr. Harjono S General Hospital, responsible for both outpatient and inpatient claims. Although the staff's competencies are adequate, the number of staff is insufficient to handle the high workload, leading to frequent delays and pending claims. The lack of regular training is also a challenge, especially when there are changes in the system or regulations. However, coordination among staff is good and conducted daily to ensure the claims process runs smoothly. Overall, the quality of human resources is adequate, but the quantity and regular training need to be improved.

Material Factors

Interviews and documentation show that in November 2024, there were 1,335 inpatient claim files submitted to BPJS Kesehatan. Of these, 228 files (30%) were pending, while 1,107 files (70%) passed verification and were claimed. In November 2024, out of the 1,335 inpatient claim files submitted, 228 files (30%) were pending. The main cause was discrepancies between the diagnosis in the medical records and the medical procedures and supporting documents. This made the verifiers doubt the administrative eligibility of the claims. Although the staff tried to compile the documents completely and on time, errors in content and incomplete documents still often occurred, thereby hindering the smooth processing of claims to BPJS Kesehatan.

Method Factors

The interview results showed that the BPJS Kesehatan claim submission process at Dr. Harjono S Regional General Hospital had been carried out in accordance with established procedures. The process began with medical records being collected by staff from the treatment room, which were then submitted to the insurance department. At this stage, staff checked the completeness of the documents, such as patient identity, diagnosis, medical procedures, and other supporting documents. The BPJS claim process at Dr. Harjono S General Hospital is carried out through a systematic process, starting from the collection of medical documents, completeness checks, coding, to internal verification before being submitted to BPJS. All staff understand and follow the applicable procedures. Verification is conducted to ensure data accuracy and prevent errors. Despite changes in BPJS regulations, the hospital strives to adapt to ensure the claim process remains smooth and compliant with regulations.

Machine Factors

The interview results indicate that technological aspects, particularly information systems, remain a challenge in the BPJS Health claim submission process at Dr. Harjono S Regional General Hospital. Currently, the Hospital Management Information System (SIMRS) is not yet fully integrated (bridged) with the Electronic Medical Record (ERM) system. Although previous efforts were made to bridge the older version of SIMRS, the implementation was not optimal, resulting in frequent data synchronization issues between systems. The BPJS claim process at Dr. Harjono S General Hospital is still hindered by technological challenges. SIMRS is not yet integrated with the Electronic Medical Record (EMR) system, so data synchronization often has problems. Additionally, the Ministry of Health's E-Claim system frequently experiences disruptions due to update processes, causing delays in claim submissions. Although the hospital's internet connection is stable and staff understand the

system, technical disruptions from external servers remain the primary obstacle to the smooth operation of the claims process.

Money Factor

The financial condition of Dr. Harjono S Regional General Hospital does not affect the BPJS claim submission process, as claims are still submitted on time according to the target. However, pending or unpaid claims can disrupt hospital operations because the funds are needed for service needs. The hospital does not have a specific budget for claims, but provides incentives to claims officers. Evaluations of pending and rejected claims are conducted regularly every month and quarter for future improvements.

Discussion

Human Factors

Based on the theory of Tarwaka et al. (2021), human workload factors are a set of tasks and jobs that must be completed by a person within a certain period of time. This is relevant to the condition of claims officers who face work pressure due to a lack of competent personnel with basic individual characteristics related to effective performance at work. Even if officers have the necessary competencies, these competencies will not be optimally applied due to high work pressure.

In this theory, an effective healthcare system depends on having a workforce with appropriate skills and a proportional number of staff. The shortage of human resources in healthcare administration, such as claims processing, directly impacts the quality of service.

Material Factors

Based on Azwar's theory (2022), material factors include all tools, facilities, and administrative and medical support documents required in the provision of services. Azwar emphasizes that the completeness and accuracy of medical documents such as medical records, surgical reports, and diagnoses significantly impact the smoothness of administrative processes, including BPJS claim submissions. If material documents do not meet standards, the organization's output in terms of efficient service delivery will be disrupted. In the context of claim management, discrepancies between diagnoses and procedures listed in supporting documents constitute a failure in document quality control.

Method Factors

Based on Handoko's theory (2020), method factors are systematic and structured ways or procedures for completing a task or activity. Good methods will help achieve work efficiency, reduce errors, and improve accuracy in work implementation. This theory emphasizes that hospital administration and the methods used in submitting claims must be

standardized, documented, and implemented consistently. The success of a healthcare system is not only determined by equipment or procedures but also by procedures. In submitting claims, an efficient method will speed up the process from document submission, coding, to verification.

Machine Factors

Based on the theory of Heizer, Render, and Munson (2020), machine factors greatly influence the efficiency and effectiveness of operational processes in organizations, including in the healthcare sector. Incomplete information systems, such as SIMRS that are not integrated with ERM, and disruptions to external systems such as E-Claims, are clear examples of inadequate technological infrastructure that can hinder workflows and directly impact administrative delays, including BPJS claims submissions. Interoperability of health information systems is a key element in improving the quality of services and administrative efficiency in hospitals. The lack of connectivity between the SIMRS and ERM systems reflects low interoperability, which ultimately disrupts bridging with external systems such as the Ministry of Health's E-Claim system.

Money Factor

Based on the theory of Robbins and Coulter (2021), the money factor is one of the most important organizational resources for supporting the planning, organizing, implementation, and control of operational activities. In the context of hospitals, the budget serves as the main pillar in maintaining the continuity of services, including administrative processes such as managing BPJS claims. Although BPJS claim submissions are not always directly affected by financial conditions, delays in claim fund disbursements can impact cash flow and operational stability in hospitals. Without smooth disbursement of funds, hospitals may face difficulties in meeting routine needs, such as procuring medications, paying honoraria, and maintaining facilities.

5. CONCLUSION AND RECOMMENDATIONS

Based on the results of research on the factors causing pending claims for BPJS Health inpatient care at Dr. Harjono S Regional General Hospital in Ponorogo Regency, it can be concluded that pending claims are caused by several main factors, namely incomplete supporting documents, coding discrepancies, and unspecific diagnoses or medical procedures. These factors stem from the 5M elements: lack of attention to detail and training of human resources (Man), suboptimal claim procedures (Method), information system disruptions (Machine), insufficient or inconsistent documentation (Material), and delayed claim payments

(Money). Therefore, it is necessary to enhance training for claims officers, review claim SOPs, and strengthen the information system to ensure that the claims process runs more accurately and efficiently. This study has limitations in terms of the scope of the institution and the limited observation period, so it is recommended that future research be conducted over a longer period or in several hospitals for comparison to expand the scope of data and the validity of the results.

It is recommended that hospitals improve training and supervision of claims management staff so that they are more thorough in compiling and verifying claim files. Hospitals are also advised to refine their claim submission procedures and improve the integration of their information systems with BPJS Kesehatan in order to minimize errors and delays. In addition, there needs to be regular evaluation of the completeness of documents and the accuracy of medical coding. This study has limitations in terms of time and location, so it is hoped that future research can be conducted in several hospitals with a broader scope to obtain a more comprehensive picture.

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