
Factors Causing Pending BPJS Health Claims For Inpatient Services At Waled Regional Hospital In The Third Quarter Of 2025

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Abstract

Pending BPJS Kesehatan claims remain a significant obstacle to hospital financing as they can disrupt cash flow and service continuity. This study aims to analyze the factors causing pending BPJS Kesehatan claims for inpatient services at Waled Regional Hospital in the third quarter of 2025. The study used a descriptive quantitative design with a retrospective cross-sectional approach. The population and sample consisted of 908 pending claim files using a total sampling technique. The research instrument was a checklist, while data analysis was conducted descriptively using frequency distribution and percentages. The results showed that the most common cause of pending claims was the coding aspect at 41.9%, followed by the medical aspect at 35.0% and the administrative aspect at 23.1%. In the administrative aspect, the most dominant problem was the mismatch of care classes. In the medical aspect, the main cause was neonatal asphyxia that did not meet the TKMKB criteria. In the coding aspect, the most common problem was inaccurate diagnosis codes or those that needed to be adjusted to clinical data based on verification BPJS. In conclusion, pending claims at Waled Regional Hospital are multidimensional and interrelated, thus requiring strengthening clinical documentation, coding accuracy, and integrated administrative verification.

Keywords: *Claims Administration, BPJS Health, Medical Coding, Pending Claims, Inpatient Care.*

INTRODUCTION

The National Health Insurance (JKN) program has been a key instrument of health financing reform in Indonesia since its launch in 2014, aiming to expand access to services, reduce household financial burdens, and strengthen equity in health care. In recent years, JKN's challenges have shifted beyond expanding coverage to include efficient claims management, as verification delays and pending claims can disrupt hospital cash flow and reduce operational efficiency. Recent findings indicate that pending claims persist in various healthcare facilities and are influenced by administrative factors, coding issues, and the completeness of clinical evidence. This issue remains both scientifically and practically relevant in the context of JKN's sustainability.

In the context of regional hospitals, this issue becomes increasingly important because most inpatient services rely on JKN funding and require accurate, complete, and timely claims documentation. A study at Prof. Dr. R. Soeharso Orthopedic Hospital in Surakarta showed pending outpatient claims of 5.02% in the third quarter of 2023 and 2.04% in the fourth quarter of 2023, with administrative aspects being the dominant cause. Meanwhile, research at Waled Regional Hospital showed fluctuating numbers of pending inpatient claims in the third quarter of 2025, with 194 cases in July, 400 in August, and 314 in September, indicating that this problem is dynamic and cannot be understood solely as a routine administrative issue.

Based on the state of the art, previous studies consistently show that pending BPJS/JKN claims are closely related to three main groups of factors: incomplete administration, inaccurate diagnosis or procedure coding, and a lack of supporting evidence or medical records. Research on hospitals in Central and West Java found that errors in primary diagnosis coding, incomplete therapy documentation, and incomplete administrative files were the most common causes of pending claims. Other studies confirmed that BPJS verifiers and unprepared internal hospital documentation were often the causes of returned files. These findings align with the research report you cited, which states that pending claims can account for up to 25% of claims data and impact a hospital's financial stability.

However, previous research results still show variations in the dominant patterns of pending claims. In some hospitals, administrative aspects are the primary factor, while in other studies, BPJS

coding or verification factors are more prominent, indicating that organizational context, hospital type, human resource quality, and claims workflow can significantly influence the problem profile. Another limitation is the differences in study designs, some qualitative, some retrospective, and some focusing only on outpatient care or coding aspects. Therefore, they do not fully describe the characteristics of pending inpatient claims in a regional hospital with a high service load such as Waled Regional Hospital. Thus, the existing empirical evidence is insufficient to explain how the combination of administrative, medical, and coding factors work together to produce pending claims in the context of Waled Regional Hospital.

This research gap highlights the need for a more specific analysis of pending BPJS Kesehatan claims for inpatient care at Waled Regional Hospital during July–September 2025, specifically to identify the administrative, medical, and coding factors that contribute to pending claims. This research is important because regional hospitals face dual demands: maintaining service quality while ensuring timely claims processing to ensure continuity of care. Scientifically, this study contributes to enriching the literature on the determinants of pending claims in the context of inpatient care at regional hospitals in Indonesia. Practically, the results can serve as a basis for improving claims flow, strengthening medical documentation, increasing coding accuracy, and developing more targeted management interventions.

Considering the complexity of the problem, this study aims to analyze the factors causing pending BPJS Kesehatan claims for inpatient services at Waled Regional Hospital during July–September 2025 in a descriptive and focused manner, thus producing a sharper empirical picture than previous studies that tended to separate administrative, clinical, and coding aspects. The novelty of this study lies in its focus on inpatient care at a regional hospital with JKN-dominated claims characteristics, the use of the most recent quarterly period in 2025, and its emphasis on mapping specific and contextual causal factors. This study's position is not simply to repeat previous findings, but rather to strengthen the evidence base for improving claims governance that is more efficient, accountable, and oriented towards the sustainability of healthcare services.

RESEARCH METHODS

This study employed a descriptive quantitative approach with a retrospective cross-sectional design. The descriptive quantitative approach was chosen because it focused on objectively describing the factors causing pending BPJS Kesehatan claims for inpatient care without intervening on the variables studied. The cross-sectional design was used because data were collected and analyzed within a specific observation period, while the retrospective design was applied because the data source came from documents of previous claims. Methodologically, this design aligns with the characteristics of descriptive research, which aims to systematically, factually, and accurately portray phenomena based on real-world conditions, as commonly described in quantitative research methodology literature. In this study, the analysis focused on three groups of factors causing pending claims: administrative factors, medical factors, and coding factors. Therefore, the results are expected to provide a comprehensive picture of the pattern of inpatient claims problems at Waled Regional Hospital.

The study was conducted at the inpatient BPJS Kesehatan claims management unit at Waled Regional Hospital, Cirebon Regency, West Java. The study location was selected based on Waled Regional Hospital's position as a regional hospital with a high volume of JKN patients and a crucial role in inpatient referral services, making the claims verification and settlement process a crucial component in ensuring service continuity. The operational timeframe for the study was January 2025, using pending claims data from July to September 2025. This period was deemed relevant because it represented a quarter that showed fluctuations in pending claims and provided sufficient data for descriptive analysis. Therefore, the unit of analysis for this study was inpatient claims documents that had reached pending status during the observation period.

The population in this study was all pending BPJS inpatient claims data at Waled Regional General Hospital during the period of July to September 2025, amounting to 908 claim files. The entire population was sampled using a total sampling technique, because the number of units studied was limited and all met the criteria as research objects. The use of total sampling is appropriate in retrospective descriptive research when researchers want to obtain a comprehensive picture of the phenomenon being studied without reducing the representativeness of the data. In addition, selecting the entire population as a sample also minimizes selection bias and strengthens the accuracy of the descriptive results obtained, especially when the characteristics of the pending claims observed are specific to one period and one service unit. Thus, the study sample consisted of 908 medical record documents of BPJS Kesehatan inpatients who experienced pending claims during the study period.

The research variables were pending BPJS Kesehatan inpatient claim files, reviewed across three main factors: administrative, medical, and coding. The operational definition of each variable was measurable and readily observable through a checklist. Administrative factors were defined as incomplete or inconsistent administrative claim documents with BPJS Kesehatan regulations, such as incomplete documents, errors in SEP data input, and participant identity discrepancies. Medical factors referred to incomplete or inconsistent clinical data in inpatient medical records, such as unclear hospitalization indications, mismatched diagnoses with procedures, and inadequate clinical documentation. Coding factors included inaccurate diagnosis or procedure coding according to applicable coding standards, including errors in diagnostic code selection, procedural coding errors, unbundling or bundling issues, and incorrect sequencing. All variables were measured on a nominal scale with yes and no categories, facilitating the grouping and frequency analysis process.

The instrument used in this study was a checklist compiled based on administrative, medical, and coding factors in pending claim files. The data analyzed were secondary data, namely BPJS Kesehatan confirmation data for inpatient services from July to September 2025. The use of secondary data was chosen because this study did not aim to conduct primary patient measurements, but rather to review existing and verified claim documents. The checklist serves as a systematic tool to ensure each file is reviewed consistently based on the same indicators, thereby increasing observation accuracy and reducing inter-file assessment variation. In the context of medical records and claims management research, such an instrument is relevant because it allows researchers to identify sources of pending claims in a structured manner based on documented administrative, clinical, and coding aspects.

Data collection techniques were conducted through secondary data review by examining pending claim documents and BPJS confirmation results using a prepared checklist. After the data was collected, the data was processed through editing, coding, and categorization stages so that the data was ready for analysis. Editing was carried out to check the completeness and consistency of the data, coding was carried out to convert categorical data into a numerical form that could be processed, and categorization was carried out to group the results based on the factors causing the pending claims. The data analysis used was descriptive analysis, specifically frequency distribution and percentages, to describe the number of pending claims based on each causal factor. The results of the analysis were then interpreted descriptively to provide meaning to the patterns of pending claims found. This approach is in accordance with the objectives of descriptive research, which emphasizes systematic fact-finding without conducting inferential hypothesis testing.

The research procedure was carried out in three stages: preparation, implementation, and final. In the preparation stage, the researcher identified the problem, conducted a literature review, developed a checklist, and collected secondary data from the hospital claims unit. In the implementation stage, the data obtained were processed through editing and coding, then analyzed descriptively to identify patterns causing pending claims based on administrative, medical, and coding factors. Furthermore, in the final stage, the analysis results were interpreted, compiled into a research report, and presented to relevant parties. Ethically, this study maintained the confidentiality of patient data, obtained permission from the hospital, did not disrupt routine service activities, and presented data honestly and accountably. With this process, this study is expected to produce a valid empirical

picture of the factors causing pending BPJS Kesehatan claims for inpatient services at Waled Regional Hospital.

RESULTS AND DISCUSSION

Identification of Pending BPJS Health Claim Data at the Waled Regional Hospital Inpatient Facility in 2025

Table 1. Pending BPJS Inpatient Claims Data for 2025

Month of Service	Number of Claims Submitted	Number of Pending Claims	Percentage
January	1,529	446	29.17%
February	1,310	263	20.08%
March	1,334	279	20.91%
April	1,474	437	29.65%
May	1,512	407	26.92%
June	1,359	242	17.81%
July	1,326	194	14.63%
August	1,329	400	30.10%
September	1,324	314	23.72%
October	1,421	177	12.46%
November	1,125	267	23.73%
December	1,290	253	19.61%
Total	16,333	3,679	-

Based on Table 1, there were 16,333 inpatient claims filed in 2025, 22.34% of which were pending. The highest percentage of pending cases occurred in August 2025, at 30.10%. For a more in-depth analysis, the study focused on the third quarter of 2025, with a total of 908 pending cases: 194 in July (14.63%), 400 in August (30.10%), and 314 in September (23.72%).

Identification of Administrative Factors Causing Pending Inpatient Claims at Waled Regional Hospital

Table 2. Pending Claims Based on Administrative Aspects at Waled Hospital in the Third Quarter of 2025

Pending Claims Based on Administrative Aspects	Amount	Percentage (%)
Yes	210	23.1%
No	698	76.9%
Amount	908	100%

Table 3. Overview of Pending Claims Identification from Administrative Factors at Waled Hospital in the Third Quarter of 2025

No	Question Items	Yes (1)	No (0)	Amount	Percentage (%)
1	Are there any incomplete radiology documents? (only impressions/results without radiologist expertise/signature)	31	179	210	14.8%
2	Are there any readmissions (<30 days, same diagnosis) that have not been combined into one claim episode?	61	149	210	29%
3	Are there any incomplete or missing reports/action sheets? (operative reports, pleural punctures, intubations, etc.)	4	206	210	1.9%
4	Is there a CPPT that is not attached to the claim file?	7	203	210	3.3%
5	Was the claim submitted as an inpatient treatment when it should have been an outpatient treatment or was it not in accordance with the type of service? (STT <4 cm / Pro PCI / indicated as outpatient)	21	189	210	10%
6	Are there any KLL (Traffic Accident) chronological letters that are missing or not appropriate?	2	208	210	0.9%
7	Is there a Down Score sheet that is not attached to the neonatal claim file?	36	174	210	17.1%
8	Are there any other incomplete administrative documents that cause the claim to be returned?	8	202	210	3.8%

9	Was there an error in the SEP data input? (SC patient admitted without proper referral procedures / without documented evidence of emergency)	40	170	210	19%
10	Are there any other SEP data discrepancies? (JR synchronization, supplemental claims, PCI claims as outpatient, etc.)	4	206	210	1.9%
11	Is there a mismatch in care class?	96	116	210	45.7%
Total		308	-	210	-

Based on Table 3, the most dominant administrative factors were mismatched care classes (45.7%) and readmissions that were not combined into a single claim episode (29%). Other factors appeared in smaller proportions, such as SEP input errors (19.0%), unattached neonatal down score sheets (17.1%), radiology results without expertise (14.8%), and claims that did not match the type of service (10%). The lowest-ranking factor was missing KLL letters (0.9%).

Identification of Medical Factors Causing Pending Inpatient Claims at Waled Regional Hospital
Table 4. Pending Claims Based on Medical Aspects at Waled Hospital in the Third Quarter of 2025

Pending Claims Based on Medical Aspects	Amount	Percentage (%)
Yes	318	35%
No	590	65%
Amount	908	100%

Table 5. Overview of Pending Claims Identification from Medical Factors at Waled Hospital in the Third Quarter of 2025

No	Question Items	Yes (1)	No (0)	Amount	Percentage (%)
1	Are there any indications of hospitalization that are not clearly documented in the medical record / no ER assessment sheet?	43	275	318	13.5%
2	Are there any cases of GEA/mild-moderate dehydration indicated for outpatient care according to the 2025 National TKMKB?	11	307	318	3.4%
3	Is there a diagnosis of neonatal asphyxia that does not meet the TKMKB criteria? (Downe Score/AGD/CPAP not met, or billed separately from the mother)	88	230	318	27.7%
4	Is there a diagnosis of pneumonia/bronchopneumonia that does not meet the IDAI PPM criteria? (no culture/microbiology results, or radiological findings are inconsistent)	50	268	318	15.7%
5	Is there a CPAP installation without a Blood Gas Analysis (AGD) examination?	25	293	318	7.9%
6	Is there neonatal hypoglycemia that does not meet the 2025 TKMKB criteria? (GDS \geq 47 mg/dL)	10	308	318	3.1%
7	Are there any diagnoses of Dengue Fever/DF that do not meet the diagnostic criteria? (IgG/IgM negative, platelet counts are inconsistent)	9	309	318	2.8%
8	Is there Neonatal Jaundice that does not meet the criteria? (bilirubin value does not meet the established threshold)	5	313	318	1.6%

9	Is there incomplete monitoring of shock management? (no urine output monitoring / fluid loading records not appropriate to body weight)	34	284	318	10.7%
10	Are there any mandatory supporting examinations not included? (sputum culture, EEG, TCM TB, Tubex Typhoid, ABG, etc.)	69	249	318	21.7%
11	Is there evidence of special procedures/actions that are not documented in the CPPT or do not match the billing?	43	275	318	13.5%
12	Is there any ventilator/ABD documentation that does not comply with TKMKB provisions? (incomplete recording as of the date of service)	5	313	318	1.6%
13	Was there any other incomplete/inconsistent clinical documentation in the medical record that caused the claim to be returned?	75	243	318	23.6%
Total		467	-	318	-

Based on Table 5, the most dominant medical factor was neonatal asphyxia that did not meet the TKMKB criteria, at 27.7%. Other factors appeared in smaller proportions, particularly inadequate clinical documentation (23.6%) and missing or inappropriate mandatory supporting examinations (21.7%). The lowest proportions were neonatal jaundice and ventilator or ABG documentation that did not meet the TKMKB requirements, each at 1.6%.

Identification of Coding Factors Causing Pending Inpatient Claims at Waled Regional Hospital

Table 5. Pending Claims Based on Coding Aspects at Waled Hospital in the Third Quarter of 2025

Pending Claims Based on Coding Aspects	Amount	Percentage (%)
Yes	380	41.9%
No	528	58.1%
Amount	908	100%

Table 6. Overview of Pending Claims Identification from Coding Factors at Waled Hospital in the Third Quarter of 2025

No	Question Items	Yes (1)	No (0)	Amount	Percentage (%)
1	Was there a re-selection of the Principal Diagnosis (DU) based on the verification results, where the DU code did not reflect the diagnosis that consumed the most resources during treatment?	100	280	380	26.3%
2	Were there any diagnosis codes that were inappropriate or unnecessary based on the verification results, because they were not supported by clinical data or supporting examinations?	95	385	380	25%
3	Was there a non-specific viral infection diagnosis code used based on the verification results, so that a more specific code based on clinical data should have been used?	66	314	380	17.4%
4	Was there an inaccurate diagnosis code based on the verification results, requiring correction or replacement based on the patient's clinical condition?	119	261	380	31.3%
5	Were there errors in selecting other diagnosis codes based on the verification results that resulted in the claim being returned?	91	289	380	23.9%

6	Were there any ventilator or endotracheal tube (ETT) procedures coded separately based on the verification results, even though they were included in the primary procedure according to applicable regulations?	20	360	380	5.3%
7	Were there any procedure coding errors based on the verification results, where the code used did not correspond to the procedure performed?	6	374	380	1.6%
8	Are there any diagnosis or procedure codes that are coded separately based on verification results, even though they should be bundled into the main code according to coding rules?	15	365	380	3.9%
Total		512	-	380	-

Based on Table 7, the most dominant coding factor was inaccuracy of the diagnosis code or the need to be adjusted to clinical data based on the BPJS verification (31.3%). Other factors included re-selection of the primary diagnosis based on the BPJS verification (26.3%), unnecessary diagnosis codes or codes that did not meet clinical criteria based on the BPJS verification (25%), and errors in selecting other diagnosis codes based on the BPJS verification (23.9%). Smaller proportions were found in less specific coding of viral infections based on the BPJS verification (17.4%), separately coded ventilator or ETT procedures based on the BPJS verification (5.3%), unbundling based on the BPJS verification (3.9%), and errors in coding other procedures based on the BPJS verification (1.6%).

Identification of Pending Claims Data Distribution in Inpatient Services in the Third Quarter Based on Causal Aspects

Table 7. Distribution of Pending Inpatient Claims by Month and Aspect at Waled Regional Hospital in the Third Quarter of 2025

Month	Total Pending	Administrative Aspects	Aspect Medical	Aspect Coding
July	194	34 (17.5%)	76 (39.2%)	84 (43.3%)
August	400	106 (26.5%)	138 (34.5%)	156 (39.0%)
September	314	70 (22.3%)	104 (33.1%)	140 (44.6%)
Total Q3	908	210 (23.1%)	318 (35%)	380 (41.9%)

Based on Table 8, coding factors were the most common cause of pending claims, accounting for 380 of the 908 cases in Q3 2025. The number of pending claims fluctuated, with 194 cases in July, 400 in August, and 314 in September. Furthermore, 1,287 issues were identified as the cause of pending claims, indicating that a single claim can have more than one contributing factor.

Table 8. Recapitulation of the Distribution of Pending Problems per Aspect in Inpatient Services at Waled Regional Hospital in the Third Quarter of 2025

Pending Aspects	Number of Issues Identified	Number of Files (N)	Percentage (%)
Administration	310	908	34.1%
Medical	467	908	51.4%
Coding	512	908	56.4%

Based on Table 9, in the third quarter (July-September 2025), the coding aspect was the most common factor causing claims delays, with 512 issues, or 56.4%. Next came medical issues, with 467 issues, or 51.4%, and administrative issues, with 310 issues, or 34.1%. These issues all came from the 908 claims files analyzed. The greater number of issues than files indicates that a single claim file may contain more than one issue, causing delays in the process.

Discussion**Identification of Pending BPJS Health Claim Data at the Waled Regional Hospital Inpatient Facility in 2025**

The study results showed 908 pending BPJS Kesehatan inpatient claims at Waled Regional Hospital during the third quarter of 2025, with a fluctuating pattern: 194 cases in July, 400 in August, and 314 in September. This condition aligns with increasingly stringent BPJS verification and indicates the dynamic nature of pending claims. Pending claims are billing files that have been suspended due to incomplete or inaccurate data or because there is information that needs to be confirmed with the hospital, which can hinder hospital payments and cash flow.

Identification of Administrative Factors Causing Pending Inpatient Claims at Waled Regional Hospital

Based on the research results, administrative factors contributed to 210 pending cases, or 23.1% of the total 908 cases. The most dominant sub-factor was mismatched treatment classes, with 96 cases (44.8%), followed by readmissions that had not been combined into a single claim episode, with 61 cases (29%). Other factors included errors in SEP data input, incomplete supporting documents such as neonatal down scores, CPPT, and radiology results, and mismatched service types, with a smaller proportion. Overall, these findings indicate that administrative issues at Waled Regional Hospital are quite diverse and require strengthening internal verification and completeness of files before claims are submitted.

Identification of Medical Factors Causing Pending Inpatient Claims at Waled Regional Hospital

Based on the research results, medical aspects were the second largest cause of pending cases, with 318 cases, or 35% of the total 908 cases. The most dominant sub-factor was neonatal asphyxia that did not meet the TKMKB criteria, with 88 files (27.7%), followed by inadequate clinical documentation, missing mandatory supporting examinations, and pneumonia or bronchopneumonia that did not meet the IDAI PPM criteria. Overall, these findings indicate that pending cases in the medical aspect are primarily triggered by discrepancies between clinical documentation, supporting evidence, and BPJS Kesehatan verification criteria.

Identification of Coding Factors Causing Pending Inpatient Claims at Waled Regional Hospital

Based on the research results, coding aspects were the biggest cause of pending cases with 380 cases or 41.9% of the total 908 files. The most dominant sub-factor was inappropriate diagnosis codes that needed to be adjusted to clinical data based on the BPJS verification, amounting to 119 files (31.3%), followed by re-selection of the main diagnosis based on the BPJS verification (26.3%), unnecessary diagnosis codes or codes that did not meet clinical criteria based on the BPJS verification (25%), and errors in selecting other diagnosis codes based on the BPJS verification (23.9%). In general, these findings indicate that the main problem lies in the accuracy of interpreting clinical data into diagnosis and procedure codes, so that it is necessary to improve coder competence, more complete clinical documentation, and better coordination between coders and verifiers.

Identification of Pending Claims Data Distribution in Inpatient Services in the Third Quarter Based on Causal Aspects.

The study results show that pending BPJS Kesehatan inpatient claims at Waled Regional Hospital in the third quarter of 2025 occurred in three areas: administration, medical, and coding. Coding was the leading cause, followed by medical and administrative aspects. The consistent dominance of coding in July, August, and September indicates that the pending issue is systemic and requires ongoing intervention.

In detail, in terms of administration, the most prominent issues were mismatched treatment classes and readmissions. In terms of medicine, neonatal asphyxia did not meet the TKMKB criteria and inadequate clinical documentation. In terms of coding, there were inaccurate diagnosis codes and reselection of the primary diagnosis. These findings confirm that the quality of clinical documentation, coding accuracy, and administrative completeness are interrelated and all influence the occurrence of pending claims.

Furthermore, the number of issues found in each aspect exceeds the total number of files because a single claim can contain more than one pending cause. This indicates that pending claims are multidimensional, and therefore cannot be resolved in a piecemeal manner. Strengthening medical documentation, improving coding competency, and improving integrated claims administration are necessary to sustainably reduce pending claims.

CONCLUSION

This study concludes that pending BPJS Kesehatan inpatient claims at Waled Regional Hospital during the third quarter of 2025 were multidimensional, with coding factors as the most significant contributing factor, followed by medical and administrative factors. Key findings indicate that the most prominent issues were inaccurate diagnosis codes, reselection of the primary diagnosis, neonatal asphyxia that did not meet the TKMKB criteria, and inconsistencies in treatment classes and readmissions that had not been combined into a single claim episode. Practically, these results emphasize the need to strengthen internal verification, complete clinical documentation, and improve coder competency so that claims can be processed more accurately and timely.

This study's limitations lie in the data coverage, which only covered one hospital and the third quarter of 2025. Therefore, the results cannot be generalized to all hospitals or to a longer period. Furthermore, this study used retrospective data, making it highly dependent on the completeness of available documentation. Future research is recommended to expand the observation period, involve several hospitals with different characteristics, and incorporate analytical or qualitative approaches to better understand organizational factors, staff competency, and the claims verification process.

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