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Analysis of Factors Causing Pending BPJS Health Claims at RSUD Mukomuko, Mukomuko Regency in 2024

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ABSTRACT

This study aims to analyze the factors contributing to pending BPJS Kesehatan claims at Mukomuko Regional General Hospital (RSUD Mukomuko), Mukomuko Regency, in 2024. A mixed-methods approach was employed, combining quantitative and qualitative methods to obtain comprehensive findings. Quantitative data were collected from 375 pending BPJS claim files, while qualitative data were obtained through in-depth interviews with 23 informants, including administrative staff, healthcare professionals, and other relevant stakeholders.
The results indicate that the primary causes of pending claims were incomplete documentation, coding errors, and issues related to compliance with service standards. The qualitative findings further revealed that limited understanding of BPJS regulations among hospital personnel and insufficient knowledge of claim coding procedures among claims officers significantly contributed to claim delays. In addition, challenges related to administrative processes and supporting infrastructure were identified as factors affecting the timely submission and verification of claims. This study recommends strengthening staff training programs, enhancing the capacity of hospital information systems, and improving supporting facilities and administrative processes to reduce the incidence of pending claims and improve the efficiency of claim management in the future.

Keywords: *BPJS Kesehatan claims, claim delays, claim management, hospitals, pending claims.*

INTRODUCTION

The implementation of the National Health Insurance Program (JKN) by the Social Security Agency (BPJS) Health is one of the main instruments in providing health protection guaranties for the entire Indonesian population. This program aims to ensure public access to quality, equitable, and sustainable health services thru an integrated health financing mechanism (BPJS Health, 2014). In its implementation, the Mukomuko Regional General Hospital (RSUD) plays a strategic role as a referral health facility providing services to JKN participants in Mukomuko Regency. According to data from the Central Statistics Agency of Mukomuko Regency, this hospital serves around 10,000 BPJS Kesehatan participants each year (BPS Mukomuko, 2022). The high number of visits by JKN participants makes the smooth process of claim submission and payment an important factor in maintaining the hospital's operational continuity. However, the effectiveness of this service is often hindered by structural financial constraints, namely the widespread phenomenon of claim payment delays or pending claims by BPJS Kesehatan (BPS Mukomuko, 2022). The issue of resolving the risk of pending claims at RSUD Mukomuko has become very urgent because the instant suspension of large amounts of liquidity disrupts the operational cash flow stability of the hospital (Permenkes, 2010). This financial obstacle, if left unaddressed, will directly trigger a negative multiplier effect, ranging from shortages of medication stock, stalled maintenance of medical equipment, to a drastic decline in the quality of clinical patient services (Permenkes, 2010).

Operational evaluations over time show that the management of claim administration still faces massive verification obstacles. Throughout 2023, RSUD Mukomuko recorded a total accumulation of significant delays, amounting to 1,155 pending claim cases with a nominal value reaching Rp3,878,701,870. The burden of administrative disputes is dominated by inpatient cases amounting to 810 cases (valued at Rp3,737,767,400) and outpatient cases totaling 345 cases (valued at Rp140,934,470). The handling pattern that has been in place at regional hospitals generally only focuses on reconciling numbers at the end of the fiscal year (reactive-retrospective), without any structured preventive mapping to dissect the

root causes of verification rejections at the upstream managerial level (BPS Mukomuko, 2022).

Although the financial losses due to claim delays are well-known, most previous studies often overlook detecting and isolating specific internal variables that trigger this systemic failure at the regional healthcare facility level (Thesis, n.d.). Conventional studies tend to blame the rigidity of the BPJS digital system or the delay of external verifiers, but overlook the real picture of the internal administrative competence of the hospital institution itself (Utami, Y. T., Akbar, P. S., Amelia, R., & Sari, 2024). In fact, the weak point of verification often stems from poor technical coordination between service divisions before the documents are sent (Triatmaja, A. B., Wijayanti, R. A., & Nuraini, 2022). To fill this research gap, this study offers a comprehensive triadic analysis concept by simultaneously integrating three main internal determinants, namely: the degree of completeness of administrative files, the accuracy level of medical diagnosis coding, and the consistency of compliance with hospital operational service standards.

This study aims to identify and analyze the factors causing pending BPJS Kesehatan claims in outpatient and inpatient services at RSUD Mukomuko, particularly based on the aspects of file completeness, coding accuracy, and compliance with service standards. The research results are expected to produce policy recommendations and operational strategies that are applicable for the management of RSUD Mukomuko in reducing the number of pending claims. Additionally, the findings of this study can serve as an empirical reference for other regional hospitals facing similar issues, as well as provide input for BPJS Kesehatan in strengthening a more effective, efficient, and sustainable claims management.

Literature Review

Hospital Financial and Receivables Management

Hospital financial management is a series of efficient governance of funds and financial resources aimed at maintaining business sustainability, optimizing the quality of patient services, and fulfilling the organization's social responsibilities (Permenkes, 2010). The success of this financial management is greatly influenced by receivables management, which is the amount of money that has not yet been paid by patients or insurance companies for the medical services provided. Effective receivables management plays a key role in maintaining cash flow stability to finance routine operations, medical staff payments, and facility procurement. Obstacles in the disbursement of receivables, especially third-party health insurance receivables such as pending claims, can significantly trigger budget deficits that threaten efficiency, disrupt service operations, and systematically cripple the hospital's financial liquidity (Irjaya, 2022; Poltekkes Tasikmalaya, 2022; Wijayanti, R. A., & Sugiartha, 2018).

National Social Security System and National Health Insurance

The implementation of health financing guaranties in Indonesia is based on Law Number 40 of 2004 concerning the National Social Security System (SJSN) and Law Number 24 of 2011 concerning the Social Security Organizing Agency (Health, 2014). The National Health Insurance (JKN) scheme managed by BPJS Kesehatan applies the principles of social insurance and a mandatory mutual cooperation ecosystem to provide socio-economic risk protection for the entire population (Kemenkes RI, 2013). In its implementation, healthcare services are divided into First-Level Health Facilities (FKTP) and Advanced Referral Health Facilities (FKRTL) (Health, 2014). Although this program expands medical accessibility, hospitals as Advanced Referral Health Facilities (FKRTL) often face delays in the disbursement of financing claims by BPJS Kesehatan, which directly impacts the disruption of the hospital's medical logistics supply chain (Mannanesia, 2022).

The Concept of Claim Submission and the Phenomenon of Pending Claims in BPJS

The administrative claim submission procedure is strictly regulated by BPJS Kesehatan Regulation Number 3 of 2017, which mandates three main stages: claim submission by healthcare facilities with supporting documents, verification of document compliance by BPJS verifiers, and claim payment settlement (BPJS Kesehatan, 2022). The phenomenon of pending claims occurs when the claim documents billed by hospitals are withheld from payment by verifiers due to non-compliance with administrative and regulatory validity principles (Irjaya, 2022). The factors underlying the occurrence of pending claims are grouped into two main dimensions:

1. Internal Hospital Administration Factors
   These include the incompleteness of medical record documents (such as the absence of the Participant Eligibility Letter or SEP, medical resumes, and action reports), errors in patient identity input, and inaccuracies in disease diagnosis coding (Maulida, E. S., & Djunawan, 2022).
2. Systemic and Bureaucratic

Factors These encompass weak coordination between the medical records division and the guaranty team, limitations in the competence and quantity of human resources managing claims, lengthy external verification processes, and challenges in integrating information technology into the claims application (Pratama, A., Fauzi, H., Nur Indira, Z., & Purnama Adi, 2023). The accumulation of pending claim files that are not promptly addressed responsively will multiply the burden of bad debts and reduce the overall operational performance efficiency of the hospital (Rahma Ardi Saputri, F., Nur Indira, Z., & Fauzi, 2022).

Analysis of Systems Management Theory in Claims Administration

To unravel the complexity of claims administration constraints, Systems Management Theory provides a comprehensive perspective that views hospitals as open system organizations consisting of subsystems that dynamically interact with each other (Permenkes, 2010). Referring to the fundamental thinking of Ludwig von Bertalanffy, the integrity of this organization is driven by a triadic dependency cycle that includes the components of input, process (throughput), and output.

In the context of JKN claim management at RSUD Mukomuko, this system theory cycle is operationalized as follows:

1. Input: This component includes the availability of operational resources based on the 5M elements (man, money, method, machine, material). This encompasses the competence of medical record coders, the availability of computers, the availability of JKN patient medical record files, and the clarity of regulations in the form of internal Standard Operating Procedures (SOP) related to the claim file preparation process (Nugroho, R., & Suryono, 2008).
2. Process (Throughput): This is the stage of technical transformation that begins when a patient registers, receives clinical services in outpatient or inpatient units, fills out the Integrated Patient Development Record (CPPT) by the doctor, issues the SEP, scans supporting documents, and finalizes the disease diagnosis coding using ICD-10 and ICD-9-CM classifications in the INA-CBGs e-Claim application (Nugroho, R., & Suryono, 2008).
3. Output: The final output of this system is a clean claim file that is ready to be sent and passes verification without rejection, thereby ensuring timely claim payment realization to secure the hospital's cash flow (Nugroho, R., & Suryono, 2008).

Based on the lens of this systems management theory, the phenomenon of pending claims in the output section is conceptualized not as a standalone failure, but rather as an indication of dysfunction, deviation, or procedural non-compliance occurring at the subsystem level in both the input and process stages (Poltekkes Semarang, 2022).

Factors underlying the occurrence of claim disbursement delays (pending claims) BPJS Kesehatan in the hospital environment has been explored in depth by several previous researchers thru an operational approach that focuses on the validity of administrative documents (Santiasih, W. A., Simanjorang, A., & Satria, 2021). Based on the study conducted by (Santiasih, W. A., Simanjorang, A., & Satria, 2021), the return of claim files for inpatients at RSUD Dr. RM Djoelham Binjai is predominantly triggered by the incompleteness of medical record document filling, errors in the data input process, and gaps or differences in understanding the standards of file completeness between the hospital's internal verifiers and BPJS Kesehatan verifiers. Similar administrative constraints were also found in the study (Djatiwibowo, K., Januari, P., & Ep, 2018) at RSUD Dr. Kanujoso Djatiwibowo for the period of January–March 2016, where delays in claim resolution were caused by incomplete patient medical resumes. The issue of document completeness occurred due to the absence of signatures from the Responsible Doctor for Patients (DPJP), which is technically suspected to be the result of the double burden carried by the case manager at the hospital. These two empirical findings consistently confirm that the meticulous performance of medical record administration at the upstream of service plays a crucial role in the smooth flow of financial cash at the downstream of the organization.

This condition is reinforced by the findings of (Kurnia, E. K., 2022) thru his research on inpatient patients at Hospital X during the first quarter of 2022. The study revealed that pending claims are not only sourced from the incomplete documents filled out by the DPJP but are also triggered by managerial limitations such as a shortage of human resources (HR) and the low level of formal education possessed by coding officers. The lack of qualifications has implications for the emergence of clinical discrepancies between the disease diagnosis and the medical therapy provided to the patient. The impact of this misalignment in medical record coding is in line with the analysis results (Manurung, J., Munthe, S. A., Bangun, H. A., & Putri, 2020) at RSUD Deli Serdang Lubuk Pakam in 2018. In his study, he found that the delay in fund disbursement was significantly caused by data discrepancies between the diagnosis codes set by the hospital's internal parties and the code assessment results determined by the BPJS

Kesehatan verifier. A series of empirical facts from previous researchers show that standardizing perceptions and enhancing the technical competencies of coding human resources are urgent instruments to reduce the hospital billing claim rejection rate.

Furthermore, the findings regarding the multi-complexity of administrative barriers were also confirmed by (Maulida, E. S., & Djunawan, 2022) in their research at Airlangga University Hospital related to inpatient service files. They explained that the phenomenon of pending claims occurs due to an accumulation of issues involving incomplete files, inaccurate coding, and a lack of clinical evidence attachments such as supporting examination results and patient medical therapy evidence. On the other hand, in addition to the factor of file accuracy, structural aspects and the work ecosystem also play a significant role in causing this delay. As explained by (Nabila, S. F., Santi, M. W., Tabrani, Y., & Deharja, 2020) thru their analysis at RSUPN Dr. Cipto Mangunkusumo, the coding constraints on inpatient medical records that lead to pending claims are indeed greatly influenced by the limitations of organizational capacity. These determining factors include a shortage of operational human resources, limited supporting facilities and infrastructure, and technical issues with the information technology system used for the claims process. The integration of all previous empirical studies further emphasizes the urgency of conducting a comprehensive system-based triadic analysis to untangle the complexities of JKN claim management at the regional healthcare facility level.

The interrelationship between these administrative variables is expanded (Kusumawati, A. N., 2020). her study on the factors causing pending inpatient claims at RSUD Koja in 2018. Their findings indicate that the delay in claims specifically originates from errors in the coding process, mistakes in the placement of primary and secondary diagnoses, and the incomplete filling of medical resume forms by healthcare personnel. To holistically summarize all the variations of these constraints, Hindun et al. (2023) conducted a large-scale scoping review on the factors causing the delay of BPJS Kesehatan claims for inpatients in various hospitals.

Based on the synthesis of the literature, (Hindun, H., Rahayu, S., & Koloi, 2023) mapped the spectrum of issues into several crucial dimensions, including coding inaccuracies, incomplete requirement files, and the absence of supporting examination results. In addition, obstacles are also triggered by the enforcement of diagnoses that do not meet clinical criteria, differences in the perception of diagnosis codes between coders and BPJS verifiers, discrepancies between diagnostic competencies and the doctor's area of specialization, and the incompleteness of medical resumes. From the macro management perspective, delays are also caused by the unavailability of Standard Operating Procedures (SOP) for claim management, the low level of knowledge among claim executors, limited facilities and infrastructure in the claims unit, and technical aspects such as input errors in the claims application. Various comprehensive findings from previous research serve as a strong empirical foundation for the researcher to delve deeper into the real conditions of claims management at RSUD Mukomuko.

The relevance of this research is reinforced by (Pratama, A., Fauzi, H., Nur Indira, Z., & Purnama Adi, 2023) thru their study on the factors causing delays in inpatient claims due to aspects of medical record coding at RSUD Dr. Soedirman Kebumen. Their analysis results confirm that pending claims are significantly triggered by differences in perception in determining diagnosis codes between the hospital's internal coding staff and BPJS Kesehatan verifiers, exacerbated by the lack of essential supporting clinical data for the enforcement of the diagnosis.

The condition of this technical regulatory misalignment is in line with the findings of Pranayuda et al. (2023) at Persahabatan General Hospital. In their study, (Pranayuda, B., Haryanti, I., Utomo, Y., & Madiistriyatno, 2023) identified that the obstacles in claim submission are rooted in the accumulation of traditional issues such as incomplete requirement documents, inaccuracies in coding, and a lack of supporting examination results. However, further, they also found another crucial variable, namely the low understanding of the claims team regarding the applicable Coding Agreement Minutes.

Another relevant study that reinforces the dimension of clinical and procedural communication constraints is the research by (Triatmaja, A. B., Wijayanti, R. A., & Nuraini, 2022) on the causes of delayed BPJS Kesehatan claims at RSU Haji Surabaya. The results of the study revealed that one of the main triggers for pending claims in the field is the technical obstacles of medical records, where officers have difficulty reading the diagnosis and action sheets due to the doctor's illegible handwriting. In addition to the issue of physical legibility, (Triatmaja, A. B., Wijayanti, R. A., & Nuraini, 2022) also

confirmed the inaccuracy in determining diagnosis and action codes, which stems from differing perceptions between hospital coding staff and BPJS verifiers, further exacerbated by incomplete claim requirement documents.

Furthermore, the characteristics of pending claims in specific units such as outpatient care are described in detail by (Rahma Ardi Saputri, F., Nur Indira, Z., & Fauzi, 2022) thru their analysis at RS X for the period of September 2022. He identified that the factors causing the delay in financing are multi-complex, including the complexity of the outpatient administration procedures, the integration of the outpatient flow with the hemodialysis unit, and the need for repeated confirmation of diagnosis coding or medical actions. In addition, obstacles also arise from specific clinical aspects such as the need for confirmation of drug dosage administration for thalassemia patients, and are exacerbated by the absence of internal Standard Operating Procedures (SOP) that specifically regulate the handling of delayed claims.

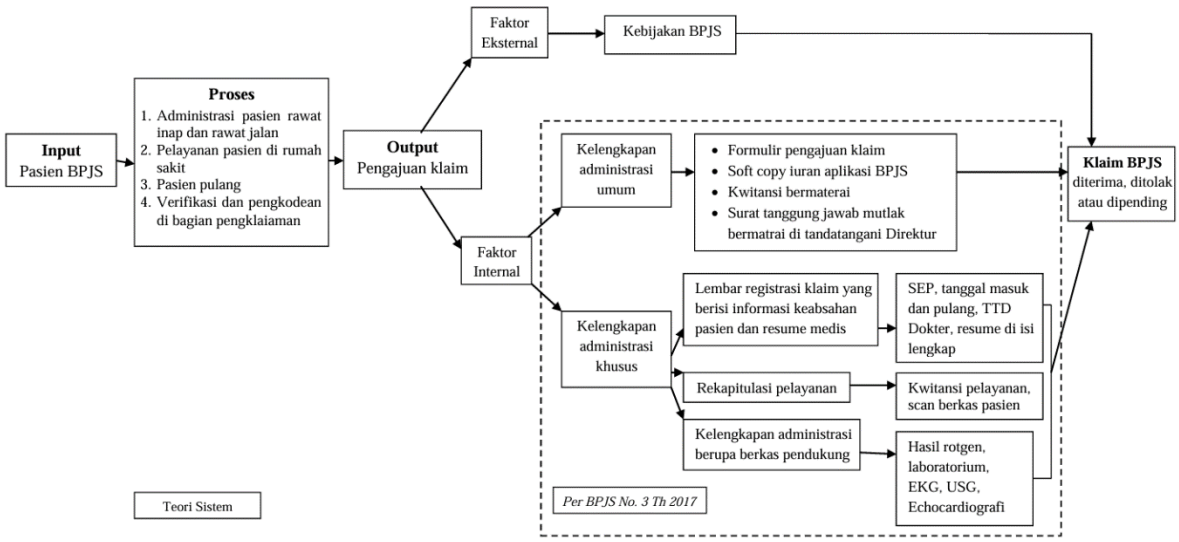
The exploration of these various obstacles was expanded by (Christy, J., Nengsih, Y. G., Sitorus, M. S., & Widyasari, 2024) thru their research on the factors causing the delay of BPJS Kesehatan claims for inpatients at RSUD Dr. Pirngadi Kota Medan in 2022. Their findings indicate that the suspension of claims is dominated by differences in perception regarding the filling of diagnoses between hospital INA-CBGs coders and BPJS verifiers. In addition to this misunderstanding, (Christy, J., Nengsih, Y. G., Sitorus, M. S., & Widyasari, 2024) also identified classic issues such as incomplete requirement documents, discrepancies between diagnoses and medical actions taken, mismatches between medication provided and clinical diagnoses, as well as infrastructure obstacles like slow hospital internet connections.

The combination of human error and systemic technical constraints aligns with the analysis results (Wijaya, 2023) regarding the return of inpatient BPJS Kesehatan claims at Nur Hidayah Hospital, Bantul Regency. In his study (Wijaya, 2023), it was explained that the main cause of claim file returns stems from the incompleteness of supporting documents, exacerbated by the inaccuracy of staff during internal verification and the absence of a file control checklist. On the other hand, technological and operational management factors also contribute, as evidenced by frequent errors in the e-claim application, unstable internet connections, and the behavior of staff who have not yet performed their service functions according to the standard operating procedures (SOP) established by management.

Comprehensively, the overview of the fourteen previous studies above empirically proves that the phenomenon of pending claims is the result of systemic dysfunction interconnected among the organization's subsystems. The study conducted at RSUD Mukomuko takes a strategic position to integrate all these variables into a triadic analysis to simultaneously dissect the issues of medical records, diagnosis coding, and compliance with service standards at the regional healthcare facility level.

Theoretical Framework

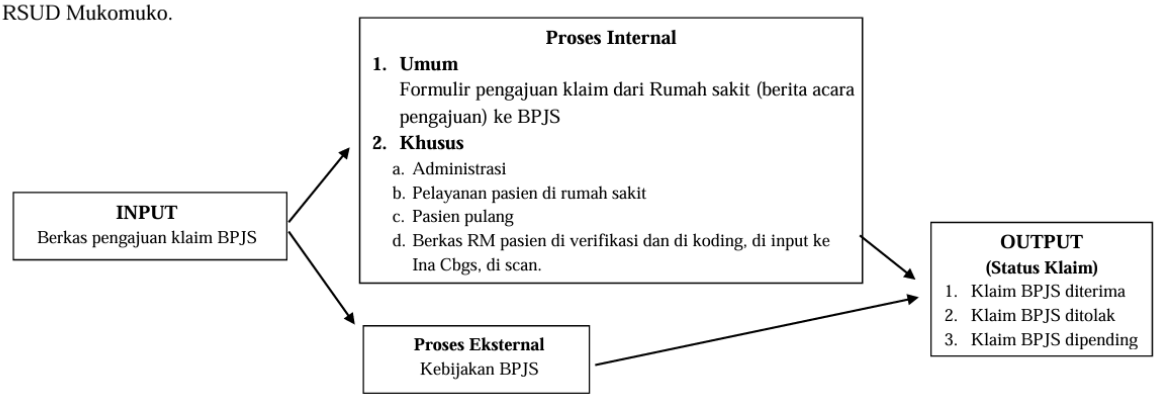
Kerangka teori ini menjelaskan tentang teori yang berkaitan dengan peneltian ini.



Based on the system theory framework, where the patient arrives and then undergoes the administrative process, patient service, and after being served, the patient goes home. Then, the patient's medical record and its completeness are submitted to the claims room, where they undergo verification, coding, scanning, input into the INA Cbds application, and the BPJS V claim application, becoming a claim file. The claim submission is influenced by external factors, namely BPJS policies, and internal factors regulated by BPJS regulation no. 3 of 2017, which includes general administrative completeness and special administrative completeness. All of this will culminate in the claim becoming a BPJS claim, which can be accepted, pending, or rejected.

Conceptual Framework

Sesuai dengan kerangka teori diatas maka kerangka konsep ini berkaitan dengan system pengklaiman yang ada di RSUD Mukomuko.



Berdasarkan kerangka konsep dari sistem pengklaiman di RSUD Mukomuko terdiri dari 3 konsep yaitu input, proses, dan output. Input yang terdiri dari berkas pengajuan klaim BPJS kesehatan. Selanjutnya Proses terbagi internal dan eksternal Dimana proses internal manjadi administrasi yang umum yaitu kelengkapan berita acara pengajuan klaim BPJS Kesehatan dan administrasi yang khusus seperti administrasi pasien, SEP, pelayanan pasien, pengisian RM, penerbitan kwitansi dan resep obat, pasien pulang, berkas RM serta berkas klaim diantar ke ruang RM, berkas RM diverifikasi, dikoding, di input ke INA CBGS, discan. Dan proses eksternal yaitu kebijakan BPJS terhadap klaim itu.Setelah semua kegiatan input dan proses dilakukan akan menghasilkan status klaim BPJS Kesehatan yang diolah oleh BPJS Kesehatan menjadi kalim BPJS yang diterima, ditolak atau dipending.

RESEARCH METHOD

This research is conducted at the Mukomuko Regional General Hospital (RSUD), Bengkulu Province. The timeline for conducting field research, data collection, and result visualization is scheduled to take place throughout 2024. In its implementation, this research applies a mixed methods approach (Creswell, J. W., & Creswell, 2018) with an explanatory sequential design. The quantitative approach is used in the first stage to identify and map the factors causing the most pending BPJS Kesehatan claims at RSUD Mukomuko during the period from January to June 2024. Next, a qualitative approach with a case study type is used in the second stage to deeply explore the mechanisms behind the delayed claims based on the priority issues identified in the quantitative data, where the main focus is to understand the phenomenon in the context of real-life situations (Yin, 2018). This combination allows researchers to depict real conditions in the field, comprehensively analyze the root causes of problems, and formulate adaptive solution recommendations for hospital management.

To unravel the complexity of administrative claim constraints, this research framework adopts the Systems Management Theory by mapping all internal variables into the input, process (throughput), and output cycle. On a macro level, this research dissects the triadic determinants, which include the degree of completeness of administrative files, the accuracy level of medical diagnosis coding (ICD-10 and ICD-9-CM), and the consistency of adherence to the Standard Operating Procedures (SOP) of hospital services, both in outpatient and inpatient installations. In addition, the analysis is also directed at

reviewing formal financing regulations and other external factors that influence the claims interaction between hospitals and BPJS Kesehatan.

Quantitative data were collected retrospectively from secondary documents in the form of medical records and summaries of pending National Health Insurance (JKN) patient claim files. Meanwhile, qualitative data were obtained directly thru in-depth interview techniques using purposive sampling methods with several key informants directly involved in the claims ecosystem, including medical record coders, the Casemix Team, the Responsible Doctor for Patients (DPJP), and the hospital management team. The collection of qualitative data was also reinforced thru field observations of the workflow of medical record documents and document reviews of internal regulations and Coding Agreement Minutes.

The data analysis technique in this study is conducted integratively thru three major stages, namely:

1. Quantitative Data Analysis using descriptive statistical analysis to calculate the frequency distribution and percentage of errors. Additionally, the analysis of the Financial Loss Potential Frequency Distribution (DFPKF) is applied to map the nominal amounts of withheld bills and rank the ratios of the highest administrative issue tendencies.
2. Qualitative Data Analysis applies content analysis and thematic analysis to reduce, categorize, and report crucial theme patterns that emerge from in-depth interview transcripts. This qualitative data is also presented in the form of an analytical narrative to provide detailed context regarding the reasons for procedural deviations.
3. Data Integration (Triangulation and Sequential Analysis): The validity of the findings is tested using method triangulation and source triangulation techniques. The researcher applied sequential analysis with a final validation type, where quantitative data in the form of error claim trends from the e-Klaim application was used to map patterns, which were then confirmed and clarified qualitatively based on arguments from coders, DPJP, and verifiers. Thru this alignment process, procedural dysfunctions in the organizational subsystems can be objectively and credibly unraveled.

RESULTS AND DISCUSSION

1) Quantitative Analysis of BPJS Kesehatan Claim Status

Based on medical record data and financial administration at RSUD Mukomuko throughout the period from January to June 2024, a total of 10,223 BPJS Kesehatan claims were recorded. The volume of these claims is divided into three main statuses determined by the verifier, namely eligible claims, ineligible claims (rejected), and pending claims (delayed). The distribution of claim status data during the first semester of 2024 is detailed in Table 1.

Table 1. Status of BPJS Health Claims at RSUD Mukomuko for the Period January–June 2024

Service	Worthy	Pending (Postponed)	Reject (Not Eligible)	Total
Inpatient Care	1.923	359	0	2.282
outpatient care	7.924	16	1	7.941
Total	9.847	375	1	10.223

The data presented in Table 1 shows that out of a total of 375 pending claim cases, the vast majority are contributed by the inpatient service cluster, amounting to 359 cases (95.7%). In contrast, the performance of claims in the outpatient service line shows a much more stable trend, with only 16 pending cases (4.3%) and 1 total rejection case.

2) Identification of the Root Causes of Pending

Claims Cumulatively, the failure to process claims resulting in a pending status at RSUD Mukomuko is triggered by three main determinant variables: administrative incompleteness, coding rule errors, and inconsistency in service standards.

a. **Inpatient Services:** Of the 359 pending files, coding errors accounted for the largest portion with 206 cases (57%), followed by administrative deficiencies with 147 cases (41%), and service standard inconsistencies with 6 cases (2%).
b. **Outpatient Services:** In contrast to inpatient services, the delay in 16 outpatient files was predominantly due to administrative deficiencies with 7 cases (44%), followed by coding errors with 5 cases (31%), and service standard issues with 4 cases (25%).

Discussion

The high number of pending claims at RSUD Mukomuko, particularly in the inpatient sector, indicates a systemic vulnerability in the hospital's internal administrative governance. The Director of RSUD Mukomuko emphasized that the reasonable tolerance limit for pending claims in hospital financial management ideally should be below 10%. When this figure significantly increases, the delay in the disbursement of claims funds from BPJS Kesehatan automatically hampers the smooth operational cash flow, which in turn risks disrupting the stability of drug procurement, medical equipment maintenance, and overall service quality.

1) Problem of Coding Rules, Habitual Coding Trap, and Perception Disparity
   Coding errors have proven to be the most dominant obstacle in the inpatient claim process at RSUD Mukomuko, with a contribution of 57%. This phenomenon does not stand alone, but rather intertwines with work patterns, limited competencies, and weak coordination.

   In-depth interviews with data entry staff and coders revealed that the most frequent coding errors causing delays are discrepancies between the inputted diagnosis or actions and the availability of supporting medical documents. The coding staff tend to practice coding based on the diagnosis sheet written by the doctor cumulatively (overcoding). For example, if a Patient Responsible Doctor (DPJP) writes four diagnoses at once in the medical resume, the coding staff will enter all four codes into the INA-CBGs application. However, on the other hand, supporting documents such as laboratory results, X-rays, or ultrasounds to support those four diagnoses are often not attached or even never conducted by the hospital.

   This practice directly hits the wall of verification by the BPJS Kesehatan. The BPJS verifiers emphasize that every code inputted into the INA-CBGs application must be clinically justified with authentic medical document evidence. The existence of this discrepancy has led to a sharp disparity in perception between the internal hospital coder and the combined BPJS verifier at the provincial level. The BPJS considers the coding to be excessive and not in line with the capacity of the facilities or the actual actions provided by RSUD Mukomuko as a type C hospital.

   Narratively, the root cause of the decline in coding accuracy lies in the aspect of human resources (HR). Based on the results of the workflow observation, the coding staff in the Casemix room were found to often create diagnosis codes not based on the latest BPJS technical regulations, but rather relying on memory, empirical experience, and a "habitual coding" record sheet. Official reference books such as ICD-10 for diagnosis and ICD-9 for medical procedures are only occasionally consulted. This situation is exacerbated by the stagnation of the competency refreshment program. The majority of claims staff admitted that they have not received any special training on coding national health insurance claims since 2018.

   This field fact aligns with the health information management theory from (LaTour, K. M., Maki, S. E., & Oachs, 2013) which states that coding accuracy is a highly dynamic key element, thus requiring continuous training for administrative staff to keep up with updates in health insurance operational standards. The coder's obstacles at RSUD Mukomuko also confirm a previous study by (Ulfa, H. M., Octaria, H., & Sari, 2017) which concluded that the quality of disease coding in hospitals is linearly correlated with the coder's capacity; the absence of systematic periodic training will multiply the risk of claim file returns by BPJS verifiers.

2) Deficit in Administrative Completeness: Double Burden on DPJP and Weak File Management
   The second factor that slows down the claim disbursement rate is the incompleteness of administrative documents, which recorded a rate of 41% for inpatient care and became the main cause for outpatient care at 44%. Vital documents such as discharge medical resumes, previous medical history, and attachments of X-ray, ultrasound, EKG, and blood transfusion results are often incomplete or omitted when the files are submitted.

   If we delve deeper thru the operational perspective of clinicians, this administrative deficit is rooted in the double burden faced by DPJP in the field. Thru in-depth interviews, the doctors complained about the situation where they had to handle a very high volume of patient visits in both the outpatient clinic and the inpatient ward. Amidst the time pressure, doctors are required

to perform two methods of medical record filling simultaneously: writing conventionally (manually) on paper sheets while also inputting data into the computer system.

This dual process, which is both conventional and digital, is felt as an administrative burden that consumes the doctors' medical time (administrative burnout). As a result, in order to maintain the speed of service and prevent the patient queue from getting longer, the attending physician is forced to fill out the medical resume hastily. The visual impact, as observed, shows that doctors' writing on medical resumes often consists of brief scribbles that are very difficult for claims officers to read (illegible handwriting). It is not uncommon, due to time constraints, for important points such as the patient's medical history and details of supporting examinations to be intentionally left blank because doctors assume these are not mandatory.

The impact of this incomplete filling pattern triggers a domino effect on the management of physical files in the claims room. Because many supporting documents are only searched for and completed after the patient has left (retrospective documentation), the risk of documents getting lost becomes very high. Direct observation in the Casemix room revealed a scene where newly delivered claim files were piled up on a special table without an adequate file security system, with the condition of documents in the treatment room appearing disorganized. This condition is prone to causing printed supporting files to get misplaced or lost in the pile, so when the internal verification team intends to process the file scans, the documents are declared incomplete.

This condition is highly relevant to the theory of hospital administration management by (Shortell, S. M., & Kaluzny, 2016), which emphasizes that the completeness and accuracy of documentation are the main foundations of efficient claims management. When documentation standardization fails to be applied consistently due to workload pressure, the reliability of the hospital's administrative system will automatically collapse. This phenomenon at RSUD Mukomuko also reinforces the findings of (Errisya, 2024), which prove that pending claims in hospitals are largely due to the incomplete filling of medical record items by DPJP, resulting from discrepancies in the clinical chronology between the therapy provided and the diagnosis in the medical resume.

3) Inconsistency in Service Standards: Absence of Internal SOPs and Cross-Unit Logistical Barriers
The third variable, although the percentage of pending cases is small (2% in inpatient care and 25% in outpatient care), reflects a fundamental weakness in the Method and Service Standardization aspects. Thru interviews with the claims staff, a shocking fact was revealed that the Casemix room at RSUD Mukomuko does not have a specific internal Standard Operating Procedure (SOP) that regulates the coding alignment between ICD rules and BPJS Kesehatan technical regulations. The officers have so far been operating solely based on the ICD-10 and ICD-9 pocketbooks without any locally agreed-upon guidelines.

The absence of local SOPs directly impacts the weak coordination and mobilization of logistics between service units in the hospital. One of the most concrete examples of method-related obstacles is found in the flow of delivering test results from supporting installations such as the Laboratory. Laboratory staff confirmed that they always complete sample examinations on time. However, problems arise downstream: the inpatient wards and outpatient clinics at RSUD Mukomuko are not equipped with operational printer facilities.

Due to the limitations of this equipment, ward nurses are forced to walk to the laboratory building to retrieve physical laboratory results, or laboratory staff must send them manually via WhatsApp. Due to the absence of a standardized and automated file submission system, these laboratory result sheets are often left in the room or only delivered after the main claim files have been assembled and sent to the Casemix room. The delay in file mobilization slows down the verification and scanning process in the claims department, causing the claim submission deadline (before the 10th of each month) to often be exceeded while the files are still incomplete.

This management analysis aligns with the theory of healthcare service quality developed by Donabedian (2003). He states that service quality is an integral unity of three components: structure (facilities/human resources), process (service activities), and outcome. At RSUD

Mukomuko, deficits in the structural component (such as damaged computer hardware, leaking claim room roofs, and the absence of printers in the room) directly impair the process component (delayed printing of results and document delivery), which ultimately leads to poor outcomes in the form of high rates of delayed hospital financial claims.

This operational condition also reflects the study by (Utami, Y. T., Akbar, P. S., Amelia, R., & Sari, 2024) at RSUD dr. Moewardi, which concluded that the management of pending claims cases without a clear handling SOP will only force the hospital to engage in reactive work such as exhausting revisions and re-confirmations downstream, instead of resolving issues from the upstream of service.

CONCLUSIONS

Based on the results of the explanatory sequential analysis and the discussion that has been presented, this study concludes that the phenomenon of pending BPJS Kesehatan claims at RSUD Mukomuko is the result of systemic dysfunction in the hospital's administrative governance. Throughout the period from January to June 2024, the accumulation of pending claim files reached 375 cases, with the inpatient cluster being the absolute contributor at 96% (359 cases) and the outpatient unit at 4% (16 cases). If deconstructed based on its triggering variables, these pending claim disputes are predominantly caused by non-compliance with coding standards (errors in coding) at 56% (206 cases), administrative file completeness obstacles at 41% (147 cases), and service standard discrepancies at 3% (6 cases). In the external dimension, this coding inaccuracy triggers a sharp disparity in perception between hospital coders and the BPJS Kesehatan, indicating a fragile alignment of tripartite regulations.

Thru the lens of systems management, the failure of verification at the output level is rooted in the structural weaknesses of the input and process phases in both service units. In the inpatient and outpatient units, the limitations in the quantity and quality of inputs are marked by the lack of formal training for coding officers and internal verifiers, as well as the absence of clear Standard Operating Procedures (SOP) regarding the mechanization of claim filing. This managerial deficit directly impacts the poor interaction process (throughput), where the claims process in the field runs unsynchronized and violates standard regulations.

The process of filling out medical records and clinical resumes is often delayed due to the high service load of the Patient Responsible Doctor (DPJP) in the polyclinic, which is exacerbated by the absence of quality control functions (repeated checks) by ward nurses. As a result, claim files tend to pile up after patients are discharged, and the digital coding process for e-Klaim INA-CBGs is ultimately forced to proceed based on habit and the subjective interpretation of coders without valid clinical records. This finding underscores the urgency of restructuring the claim management SOP, digitizing medical records, and periodically enhancing coder competencies to secure the financial liquidity and sustainability of service quality at RSUD Mukomuko.

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