ANALYSIS OF PENDING BPJS KESEHATAN CLAIMS BASED ON THE DONABEDIAN FRAMEWORK IN A PRIVATE HOSPITAL

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Abstract

Pending claims withhold hospital revenue and disrupt liquidity, yet prior studies have generally been short in duration and examined only one or two contributing factors. This study analyzed BPJS Kesehatan claim submissions using the Donabedian framework over 47 months in a class C private hospital. A quantitative-dominant mixed-methods design was applied. Secondary data on all claims from January 2022 to November 2025 (total sampling, 124,716 claims) were extracted from the hospital management information system, V-Claim, and Casemix unit archives, analyzed descriptively and longitudinally, and triangulated with in-depth interviews with three key informants, which were analyzed thematically. A total of 13,539 claims (10.9%) were pending, withholding IDR 8,067,510,900 (12.4% of the total submitted claim value), and no rejected claims were recorded. The Process dimension accounted for 85.8% of pending causes, dominated by coding inaccuracy (77.4%), most of which involved episode-of-care merging rules for repeat visits; the Structure dimension accounted for 29.3%. The trend was non-linear: 24.7% (2022), 2.0% (2023), 11.3% (2024), and 9.1% (2025). Interviews identified discharge summary completeness and the absence of a dedicated internal verifier as strategic issues. Pending claims were concentrated in the Process dimension but were rooted in clinical documentation quality within the Structure dimension.

Keywords: *Coding Accuracy, Donabedian Framework, Hospital Management, Pending Claims.*

A. INTRODUCTION

The Universal Health Coverage (Jaminan Kesehatan Nasional/JKN) program represents a major component of Indonesia's efforts to achieve universal health coverage and is implemented within the national social security framework established by Law Number 40 of 2004 on the National Social Security System and Law Number 24 of 2011 on the Social Security Administering Body (Badan Penyelenggara Jaminan Sosia/BPJS). The scale of financing managed through the program makes the effectiveness of healthcare reimbursement increasingly important for both the sustainability of the national health insurance system and the financial stability of healthcare providers. In 2025, BPJS Kesehatan paid approximately IDR 201 trillion in healthcare claims, illustrating the substantial financial volume moving through the national reimbursement system. Within this context, hospital claim submission represents a critical link between the provision of healthcare services and the realization of institutional revenue. The quality, accuracy, and timeliness of claims therefore have implications that extend beyond administrative compliance, as weaknesses in the claim process may delay the conversion of delivered healthcare services into realized hospital revenue and increase the resources required to resolve problematic claims.

For hospitals contracted with BPJS Kesehatan, claim management constitutes a complex organizational process involving clinical documentation, administrative preparation, coding, verification, information systems, and coordination among multiple professional units. A claim that cannot be immediately approved may be classified as pending and returned to the hospital for clarification, correction, or completion before reimbursement can be realized.

Consequently, pending claims create a dual burden: they increase the administrative workload associated with reviewing and resubmitting claim files while simultaneously delaying the receipt of revenue for services that have already been provided. Previous research has shown that delays in BPJS claim processing may disrupt hospital cash flow and potentially affect service continuity (Rohman et al., 2021), while inaccurate diagnosis coding has been associated with reduced hospital revenue under the INA-CBGs payment system (Maryati et al., 2021). The financial significance of pending claims therefore suggests that claim management should be regarded as part of hospital financial and operational management rather than as a purely technical activity performed by medical-record or Casemix personnel.

The complexity of claim management is reflected in the diverse causes of pending claims reported in Indonesian hospitals. Previous studies have identified incomplete claim files, inaccurate coding, insufficient supporting examinations, and insufficient evidence of therapy as important contributing factors (Maulida & Djunawan, 2022). Similarly, a fishbone analysis at Dr. Kariadi General Hospital identified staff carelessness, data-entry errors, and incomplete diagnosis-supporting information in discharge summaries as prominent causes of pending inpatient JKN claims (Sahir & Wijayanti, 2022). In outpatient services, differences in the interpretation of ICD-10 diagnosis codes between hospital coders and BPJS Kesehatan verifiers have also been identified as an important source of pending claims (Afifah et al., 2024). Other studies have emphasized the role of diagnosis accuracy and coding precision in returned or pending claim files (Amalia et al., 2023; Oktamianiza et al., 2024). Taken together, these findings indicate that pending claims are unlikely to result from a single point of failure. Rather, they may emerge from a chain of interdependent activities in which the quality of clinical documentation and administrative preparation influences coding and verification, which subsequently determines whether a claim can proceed to payment without further correction.

This issue has become increasingly relevant in the context of the national transition toward the Indonesia Diagnosis Related Groups (iDRG) system. The national trial of iDRG coding procedures began with the October 2025 service month, introducing a more detailed approach to case classification than the existing Indonesia Case Based Groups (INA-CBGs) framework (Ministry of Health of the Republic of Indonesia, 2025). The iDRG approach incorporates comorbidities, complications, and severity in greater detail through a more extensive coding structure, thereby increasing the importance of complete and clinically consistent documentation. During the trial period, iDRG coding procedures were implemented through the E-Klaim application while the amounts reimbursed to hospitals continued to follow the INA-CBGs tariff scheme (Ministry of Health of the Republic of Indonesia, 2025; Ministry of Health of the Republic of Indonesia, 2021). Although the transition does not in itself establish a causal relationship with pending claims, it creates a changing operational environment in which weaknesses in clinical documentation, coding, and verification may become increasingly consequential. Hospitals therefore need to understand not only the immediate causes of pending claims but also the organizational conditions that enable such problems to occur and persist.

Despite the growing body of research on BPJS Kesehatan claim problems in Indonesia, important limitations remain in the existing evidence. First, previous studies have generally examined relatively short observation periods, ranging from several months to approximately one year, which limits the ability to identify longer-term patterns, recurring fluctuations, or the sustainability of improvements in claim performance (Ivana et al., 2025; Kusumawati & Pujiyanto, 2020). Second, much of the existing research focuses on specific contributing factors, such as coding accuracy, documentation completeness, administrative problems, or information-system issues, without sufficiently integrating these factors across the different stages of the claim-management process. Third, although previous studies have established the

potential financial consequences of delayed and inaccurate claims, the financial value of pending claims has rarely been examined simultaneously with the operational causes that generate them. These limitations are important because the most visible cause recorded during claim verification may not necessarily represent the underlying organizational condition responsible for the problem. A coding discrepancy, for example, may be an immediate process-level problem, while the underlying cause may lie in incomplete clinical documentation or inadequate internal verification. Understanding this distinction is essential for developing interventions that address root causes rather than merely correcting individual claims after they have become problematic.

The Structure-Process-Outcome framework developed by Donabedian (1988) provides a relevant conceptual perspective for addressing this complexity. Donabedian proposed that quality should be understood through three interconnected dimensions: Structure, referring to the resources, organizational arrangements, and conditions within which activities are performed; Process, referring to what is actually done during the delivery of services; and Outcome, referring to the results generated by those structures and processes. Although originally developed for assessing the quality of healthcare delivery, this framework offers a useful basis for examining hospital claim management because the claim process similarly depends on the interaction between organizational conditions, operational activities, and resulting outcomes. In the context of BPJS Kesehatan claims, structural conditions may include the completeness of medical records, administrative arrangements, information-system readiness, staffing, and internal control mechanisms; process factors may include coding accuracy and diagnosis–procedure concordance; while outcomes may be reflected in claim status, delayed reimbursement, and the financial value of claims that remain pending. Applying the framework in this manner makes it possible to examine pending claims as a system-level management issue rather than simply as an isolated coding or administrative problem.

The present study therefore aims to analyze BPJS Kesehatan claim submissions based on the Donabedian framework in a class C private hospital over a 47-month period from January 2022 to November 2025. Specifically, the study maps the contribution of structural and process dimensions to pending claims, examines longitudinal patterns in claim status and associated financial value, and explores the underlying causes from the perspective of personnel directly involved in claim management. By combining longitudinal quantitative evidence from hospital claim records with qualitative accounts from implementing staff, the study seeks to clarify the relationship between the causes recorded at the claim-processing level and the organizational conditions underlying those causes. This approach is expected to provide a more comprehensive understanding of pending claims by identifying not only which factors contribute to claims remaining unresolved, but also how structural conditions may influence process performance and ultimately affect the timeliness and financial realization of hospital reimbursement.

B. LITERATURE REVIEW

1. Pending BPJS Kesehatan Claims

Previous studies have shown that pending BPJS Kesehatan claims are caused by multiple factors related to the completeness and accuracy of claim documentation. Maulida and Djunawan (2022) identified incomplete claim files, inaccurate coding, insufficient supporting examinations, and insufficient evidence of therapy as the main causes of pending inpatient claims. Similarly, Sahir and Wijayanti (2022) found that staff carelessness, data-entry errors, and incomplete diagnosis-supporting information in discharge summaries were important contributors to pending inpatient JKN claims. These findings indicate that pending claims cannot be attributed solely to the claim submission stage, as problems may originate from earlier stages of clinical documentation and administrative preparation.

Coding accuracy is one of the most frequently identified factors in pending or returned claims. Indawati (2019) reported that coding accuracy was an important determinant of returned BPJS inpatient claims, while Amalia et al. (2023) confirmed the importance of diagnosis-code accuracy in the return of inpatient claim files. More recently, Oktamianiza et al. (2024) identified diagnosis-related problems and diagnosis-code accuracy as important causes of pending claims. In outpatient services, Afifah et al. (2024) found that differences in the interpretation of ICD-10 diagnosis codes between hospital coders and BPJS Kesehatan verifiers were a major cause of pending claims. Collectively, these findings suggest that coding problems are closely related to the quality of information available in the medical record and to the interpretation of claim requirements during the verification process.

2. Donabedian Framework in Claim Management

The Donabedian Structure-Process-Outcome framework provides a useful perspective for integrating these different factors. Donabedian (1988) conceptualized healthcare quality through three interconnected dimensions. Structure refers to the conditions and resources that support service delivery, Process concerns the activities through which services are provided, and Outcome represents the results generated by those structures and processes. The framework emphasizes that adequate structure provides the foundation for effective processes, which subsequently influence outcomes.

In the context of BPJS Kesehatan claim management, the Structure dimension can be represented by the availability and completeness of medical records, administrative readiness, information-system support, and organizational arrangements for claim verification. The Process dimension encompasses coding accuracy and diagnosis–procedure concordance, which directly influence whether submitted claims meet verification requirements. The Outcome dimension can be reflected in the status of submitted claims and the financial value withheld because claims remain pending. This adaptation allows claim problems to be examined as an interconnected management process rather than as isolated administrative errors.

The relationship between Structure and Process is particularly relevant to coding accuracy. Although coding is classified as a process-level activity, its accuracy depends substantially on the completeness of clinical information documented beforehand. Incomplete diagnoses, supporting examination results, comorbidities, complications, or treatment information can limit the coder's ability to assign appropriate codes. This is consistent with the findings of Maulida and Djunawan (2022) and Sahir and Wijayanti (2022), which identified incomplete documentation and supporting information as important causes of pending claims. Therefore, improving coding performance may require interventions at the structural level, particularly improvements in the quality and timeliness of medical record completion.

3. Financial Impact and Longitudinal Claim Performance

Pending claims also have financial implications for hospitals because claims that remain unresolved represent revenue that has not yet been realized. Previous research has linked delays in BPJS claim processing with disruption to hospital cash flow (Maimun & Rifqi, 2020; Rohman et al., 2021). Maryati et al. (2021) further demonstrated that diagnosis-coding errors could reduce hospital revenue under the INA-CBGs payment system. These findings indicate that claim management should be evaluated not only from the perspective of the number of problematic claims but also from the financial value associated with them.

However, previous studies have generally examined pending claims over relatively short periods and have tended to focus on specific contributing factors (Kusumawati & Pujiyanto, 2020; Ivana et al., 2025). Such approaches provide useful information about immediate causes but may not capture fluctuations in claim performance over several years.

Longitudinal analysis is therefore important to determine whether improvements in claim management are sustained or whether pending claims recur after temporary improvements.

Based on the existing literature, three main gaps can be identified. First, relatively few studies examine pending claims over an extended observation period. Second, previous studies tend to examine individual causes without integrating structural and process factors within a single framework. Third, the financial value of pending claims has received less attention than the frequency of pending cases. The present study addresses these gaps by applying the Donabedian framework to a 47-month dataset, mapping pending claims according to Structure and Process dimensions, examining longitudinal patterns, and assessing the associated financial value. The qualitative component further complements the quantitative findings by exploring the operational factors underlying the observed patterns.

C. METHOD

This was an observational study with a quantitative-dominant mixed-methods approach. The quantitative component used a retrospective longitudinal design based on secondary data, whereas the qualitative component consisted of in-depth interviews intended to explain the root causes underlying the quantitative findings.

The study was conducted from July to August 2026 at a class C private general hospital in East Java, hereafter referred to as Hospital X in accordance with a confidentiality agreement. The hospital has been operating for more than 15 years, holds Paripurna (highest-level) accreditation, has 101 beds, and is supported by 42 specialist physicians across 18 specialties, with a total workforce of 237. During the data period, the hospital used the INA-CBGs scheme and began participating in the national trial of iDRG coding procedures in the E-Klaim application with the October 2025 service month.

The study population comprised all BPJS Kesehatan claims submitted by Hospital X for services from January 2022 to November 2025, including verified outpatient and inpatient claims. Total sampling was applied, yielding 124,716 claims. The unit of analysis for cause mapping was the individual claim, whereas the unit of analysis for trend presentation was the observation month (47 months). December 2025 data were excluded because they were not yet complete at the time of data collection. Informants for the qualitative component were selected by purposive sampling and comprised the JKN coordinator, the medical records coordinator, and a coder/Casemix officer.

Secondary data were extracted using a structured extraction sheet from three sources: the Hospital Management Information System (Sistem Informasi Manajemen Rumah Sakit, SIMRS), the BPJS Kesehatan V-Claim and E-Klaim applications, and the Casemix unit's monthly recapitulation archives. Data were cross-verified across sources and then cleaned through checks for duplication, completeness, and inter-variable consistency. Pending causes were classified by tagging each pending claim according to the pending reason recorded in the verification archive and mapping it to five categories aligned with the Donabedian dimensions: medical record completeness, administrative accuracy, and information system readiness in the Structure dimension; and coding accuracy and diagnosis–procedure concordance in the Process dimension. A single claim could have more than one pending reason; therefore, the sum of proportions across categories may exceed 100%.

Quantitative analysis was descriptive and longitudinal, covering the frequency distribution and proportion of claim status by month and year, the distribution of pending cause categories, the decomposition of each dimension's contribution, the withheld financial value, and a descriptive comparison between the INA-CBGs period and the early iDRG period. Data were processed using SPSS version 25 and Microsoft Excel. In-depth interviews used a semi-structured guide developed based on the three Donabedian dimensions, were conducted after the quantitative analysis was completed, and were analyzed thematically.

The study received ethical approval from the Research Ethics Committee of the Faculty of Medicine, Universitas Muhammadiyah Surabaya, and official permission from the Director of Hospital X. The data used were aggregate recapitulations without patient identifiers, and the hospital's identity was anonymized in all reporting.

D. RESULTS AND DISCUSSION

Over the 47-month observation period, Hospital X submitted 124,716 BPJS Kesehatan claims. Of these, 111,177 claims (89.1%) were approved for payment and 13,539 claims (10.9%) were pending. No rejected claims were found throughout the study period. The withheld financial value reached IDR 8,067,510,900, or 12.4% of the total submitted claim value of IDR 65,052,565,450. The annual summary is presented in Table 1.

Table 1 Distribution of Claim Status and Financial Impact by Year

Year	Claims Submitted	Approved (%)	Pending (%)	Pending Value (IDR)	% of Value
2022	23,289	17,535 (75.3)	5,754 (24.7)	4,221,143,600	32.1
2023	33,795	33,108 (98.0)	687 (2.0)	719,961,100	4.3
2024	42,848	38,011 (88.7)	4,837 (11.3)	2,081,405,600	9.5
2025*	24,784	22,523 (90.9)	2,261 (9.1)	1,045,000,600	7.9
Total	**124,716**	**111,177 (89.1)**	**13,539 (10.9)**	**8,067,510,900**	**12.4**

**2025 data cover January–November.*

Table 1 shows a non-linear trend. The proportion of pending claims dropped sharply from 24.7% in 2022 to 2.0% in 2023, rose again to 11.3% in 2024, and then declined moderately to 9.1% in January–November 2025. The highest spike occurred in September 2024, when pending claims reached 52.7% in a single month. Throughout the four years of observation, there was not a single year in which all of the hospital's claims were paid in full.

Another finding is that, over the entire period, the proportion of withheld value (12.4%) was higher than the proportion of withheld cases (10.9%). This pattern was observed in 2022 and 2023 and reversed in 2024 and 2025; overall, it indicates that pending claims tended to have a higher average value than claims that passed verification.

The mapping of pending reasons in the Structure dimension is presented in Table 2. This dimension contributed to 3,966 pending claims, or 29.3% of all pending claims, with incomplete medical records as the largest contributor.

Table 2 Distribution of Pending Claim Causes in the Structure Dimension

Indicator	Number of Claims	% of Total Pending
Medical record completeness	2,278	16.8
Administrative accuracy	1,688	12.5
Information system readiness	0	0.0
Structure subtotal	**3,966**	**29.3**

No pending claims were recorded as being caused by information system problems. This finding was further explored in the qualitative component.

The distribution of causes in the Process dimension is presented in Table 3. This dimension was the largest contributor, accounting for 11,620 claims, or 85.8% of all pending claims.

Table 3 Distribution of Pending Claim Causes in the Process Dimension

Indicator	Number of Claims	% of Total Pending
Coding accuracy	10,481	77.4
Diagnosis–procedure concordance	1,139	8.4
Process subtotal	**11,620**	**85.8**

Note: a single claim may have more than one pending reason; therefore, the sum of proportions across all categories in Tables 2 and 3 exceeds 100%.

Further examination showed that most cases in the coding accuracy category involved the application of episode-of-care merging rules to repeat visits rather than errors in diagnosis code selection in the narrow sense. The internal verification indicator had no separate pending

reason category because it conceptually serves as a control mechanism for the other four categories.

During the iDRG trial period (October–November 2025), the mean proportion of pending claims was 7.79%, lower than the monthly mean of 12.20% in the preceding period. Because the observation period covered only two months and the trial did not change claim amounts, this finding is preliminary and cannot be interpreted as an effect of a change in the payment scheme.

Qualitative findings in the Structure dimension showed that all three informants consistently identified medical record completeness, particularly discharge summaries, as the stage that most frequently generated pending claims. The medical records coordinator stated that attending physicians' (Dokter Penanggung Jawab Pelayanan, DPJP) compliance with completing medical records fully and on time remained a challenge, while the coder emphasized that medical record completeness strongly determined their ability to assign accurate codes. Regarding administration, the JKN coordinator identified problems including unissued participant eligibility letters (Surat Eligibilitas Peserta, SEP), referral diagnoses that did not support the services provided, and mismatched participant identity data. Regarding information system readiness, informants considered the SIMRS–V-Claim integration to be functioning well without significant technical problems, consistent with the absence of this cause category in the secondary data.

In the Process dimension, the coder identified that the main barriers to coding accuracy stemmed from incomplete diagnoses and supporting examination results, as well as procedure code entry errors that prevented diagnoses from being grouped. Diagnosis–procedure mismatches were considered relatively rare because they were always confirmed manually through the medical record or directly with the attending physician. The medical records coordinator noted that the documentation of comorbidities and complications in discharge summaries remained incomplete. Regarding internal verification, the JKN coordinator revealed that the hospital did not yet have a dedicated internal verifier; this function was temporarily performed by the Patient Services Manager and the head of JKN affairs.

In the Outcome dimension, the JKN coordinator reported that the dominant causes of pending claims over the past two years were inpatient referral cases and repeat visits by chronic patients within a single month. Pending claims were considered likely to affect the hospital's ability to meet operational obligations, including payments for medicines, medical devices, and service fees, with the settlement cycle following the BPJS Kesehatan service level agreement of 14 days after a claim is declared complete. Triangulation across the three informants yielded two strategic issues: discharge summary completeness as a cross-dimensional root cause and the absence of a dedicated internal verification function.

The main finding of this study is that pending claims were concentrated in the Process dimension (85.8%), yet their root cause lay in the Structure dimension. At first glance, the concentration in the Process dimension points to coder competence, but qualitative triangulation revealed a different picture: the coder stated that the greatest obstacle was not coding knowledge but incomplete diagnoses and supporting results in the medical records. This finding is consistent with the study at Dr. Kariadi General Hospital, which identified incomplete diagnosis-supporting information in discharge summaries as the main cause of pending claims (Sahir & Wijayanti, 2022), and with findings at Universitas Airlangga Hospital, where incomplete files and insufficient evidence of therapy were two of the four main causes (Maulida & Djunawan, 2022).

This pattern is consistent with Donabedian's (1988) postulate that good structure is a prerequisite for effective processes and that outcomes cannot be improved without first improving the underlying structure and processes. The practical implication is clear: interventions targeting only coding training may be ineffective if discharge summary

completeness is not improved first. Previous studies identifying coding accuracy as the main determinant of returned claim files (Amalia et al., 2023; Indawati, 2019) should therefore be interpreted in light of the quality of the documentation underlying the coding process.

The second noteworthy finding is the predominance of episode-of-care merging issues in repeat-visit cases, which accounted for the largest share of cases administratively recorded as coding inaccuracies. As the informants noted, not all repeat visits were errors; some reflected legitimate medical needs of chronic patients. This indicates room for differing interpretations between the hospital and BPJS Kesehatan verifiers, consistent with the finding that differing interpretations of diagnosis codes between hospital coders and verifiers cause pending outpatient claims (Afifah et al., 2024). Such nuances cannot be captured by quantitative data alone and support the use of a mixed-methods approach in claims management research.

The third finding concerns the non-linear trend. The decline in pending claims from 24.7% in 2022 to 2.0% in 2023 shows that substantial improvement is achievable when operational controls are optimized. However, the subsequent rise to 11.3% in 2024, peaking at 52.7% in September 2024, indicates that this improvement was not institutionalized. Within the Donabedian framework, this suggests that improvement occurred at the process level without reinforcement of the supporting structure, so performance declined again when management attention waned. The absence of a dedicated internal verification function is the most plausible structural explanation for this lack of sustainability. Without a screening mechanism embedded in the organizational structure, claim quality control depends on individual attention and is vulnerable to changes in workload and staff turnover.

The fourth finding concerns the financial dimension. Over the entire period, the proportion of withheld claim value exceeded the proportion of withheld cases, driven mainly by 2022 and 2023, meaning that pending claims tended to be of higher value than claims that passed verification. For hospital management, this implies that monitoring pending claims based solely on case counts may underestimate the actual financial risk. The withheld value of IDR 8.07 billion over four years represents working capital that was unavailable when needed, even though it was not lost in accounting terms. Delayed claim payments have been reported to disrupt hospital cash flow (Maimun & Rifqi, 2020; Rohman et al., 2021), but the asymmetry between value exposure and case exposure has received little attention in the previous literature.

The absence of rejected claims distinguishes the study site from several previous reports. All problematic claims remained eligible for payment after correction, so the issues faced concerned cash flow efficiency and administrative burden rather than permanent revenue loss. Nevertheless, the resubmission workload constitutes a real indirect cost that was not measured in this study.

The findings on information system readiness showed convergence between the secondary data and the interviews. This differs from several studies that identified information system desynchronization as a major barrier and suggests that barriers to claims are specific to each hospital's context. Readiness in the V-Claim era does not automatically carry over to the iDRG era, given that the iDRG E-Klaim application has different technical specifications.

In the context of the gradual transition to iDRG, the findings of this study carry a clear warning. The iDRG system demands far more complete documentation of comorbidities and complications than INA-CBGs, because these elements determine case grouping and, upon full implementation, tariff amounts (Ministry of Health of the Republic of Indonesia, 2025). It is precisely in this area that the greatest weakness of the study site was identified, namely the recording of secondary diagnoses without consistent documentation of therapy in discharge summaries. The gap between the coding unit's readiness, considered adequate, and clinical documentation readiness, considered inadequate, may become a source of new problems in the iDRG era if not anticipated.

This study has several limitations. It was conducted in a single institution, so generalization should be made with caution. The cause categories were derived from classifying verifiers' notes and may overlap. This study also did not statistically test the relationship between the Structure and Process dimensions and claim status because, in the available data structure, the cause categories are constituent components of pending claims themselves; correlation or regression tests would therefore reflect arithmetic rather than empirical associations. Valid testing of such relationships would require measuring medical record completeness and coding accuracy independently of claim status through audits of a random sample of all claims. In addition, the causes of year-to-year performance shifts could not be fully explained, the iDRG-era observation period covered only two months, and the resolution time and resubmission success rate of pending claims were not measured.

E. CONCLUSION

From January 2022 to November 2025, 10.9% of the 124,716 BPJS Kesehatan claims at Hospital X were pending, with a withheld financial value of IDR 8,067,510,900, or 12.4% of the total submitted claim value, and no claims were rejected. The Process dimension was the largest contributor to pending claims (85.8%), dominated by coding inaccuracy largely related to episode-of-care merging rules, while the Structure dimension contributed 29.3%, with incomplete medical records as the main contributor. Although the problem was quantitatively concentrated in the Process dimension, qualitative triangulation showed that medical record completeness, particularly of discharge summaries, was the cross-dimensional root cause. The non-linear trend, with a sharp improvement in 2023 that was not sustained, indicates that claim control has not been institutionalized and still depends on episodic management attention.

The hospital is advised to prioritize strengthening attending physicians' compliance with discharge summary completion through regular feedback mechanisms and management policy support, with an emphasis on documenting comorbidities, complications, and therapy in preparation for the iDRG system, and to establish a dedicated internal claim verification function so that claim quality control shifts from the individual level to the system level. Pending claims should be monitored using indicators based on financial value rather than case counts alone. Future studies should conduct multicenter validation, measure resolution time and resubmission success rates, and perform independent audits of medical record completeness and coding accuracy on a random sample of all claims.

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Surat Edaran Menteri Kesehatan Nomor HK.02.02/MENKES/936/2025 tentang uji coba nasional penerapan Indonesia Diagnosis Related Groups (iDRG)