Analysis of Pending BPJS Claims among Inpatients at RSUP dr. Johannes Leimena Ambon

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Abstract
Pending claims refer to delays in the payment process of BPJS Kesehatan claims due to administrative, medical, or coding discrepancies. High rates of pending claims affect hospital cash flow and service efficiency. This study aimed to describe the pending claims of BPJS Kesehatan for inpatients at RSUP dr. Johannes Leimena Ambon in 2025 based on their characteristics and causative factors. This quantitative study used a descriptive design with a total sampling of 1,588 pending claim documents from 2025. Data were collected using observation checklists and analyzed descriptively. The results showed that 19% of the total 8,206 claims were pending. The main administrative cause was incomplete referral documents (65%). In the medical aspect, incomplete patient progress notes (64%) were dominant. In coding, the use of non-specific diagnosis codes (92%) was the primary issue. In conclusion, pending claims at this hospital remain high and are driven by systemic issues across administrative, medical, and coding sectors.

Introduction

A pending claim occurs when healthcare service claim documents, submitted by a healthcare facility to a payment guarantor such as BPJS Kesehatan, encounter delays or returns because they fail to meet administrative or technical requirements, thereby stalling the payment process. The status of a pending claim reflects inefficiencies in claim management, which directly impacts hospital cash flow and healthcare service performance (Mulyani et al., 2024).

Research indicates that inaccurate diagnostic coding and incomplete documentation contribute significantly to the emergence of pending claims in healthcare facilities. For instance, a study at Universitas Sebelas Maret Hospital reported that approximately 11.3% of delayed files were caused by inaccurate diagnostic codes during the 2023 research period (Bella et al., 2024). Furthermore, a study of 1,143 files at Islamic Hospital Jakarta Pondok Kopi in 2023 noted that administrative factors accounted for 46%, coding for 50%, and medical aspects for 4% of the primary causes of pending claims (Mulyani et al., 2024). Another study in the Indonesian Journal of Health Information reported that diagnostic discrepancies, incomplete documents, and administrative issues influenced the percentage of delayed claims in hospitals that same year (Haq & Werdani, 2025).

The scale of the pending claim problem in Indonesian hospitals remained significant throughout 2024 (Maharani et al., 2025). A study at Nirmala Suri Hospital reported that pending claim cases reached 8.58% of total inpatient claim submissions in the first semester of 2024. The distribution of causal factors included administration (39.4%), service standards (33.2%), and coding accuracy (27.4%). Research at RS X Cirebon in the third quarter of 2024 showed that out of 1,418 files, 93 were pending cases involving coding, medical, and administrative aspects (Haq & Werdani, 2025). Similarly, research at Bhayangkara Hospital Pekanbaru recorded that 38.2% of 361 files held a pending status, with inaccuracies in diagnostic codes at 20.8% and incomplete documentation at 16.3% (Dewi & Novarini, 2025). Another study at Kartika Husada Setu showed that 79.4% of pending claims resulted from medical indication mismatches, 16.2% from inaccurate coding, and 4.4% from incomplete documentation. These results demonstrate that factors influencing pending claims include diagnostic code inaccuracies, incomplete files, and the alignment of medical indications with guarantor requirements (Situmorang et al., 2025).

The pending claim process begins at the patient service stage, followed by the completion and verification of medical records by the hospital, the diagnostic and procedural coding process, and finally, submission to BPJS Kesehatan or other guarantors. Inconsistencies at any of these stages can lead to claims being returned or delayed for revision, resulting in payment

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delays for the hospital. A study at Islamic Hospital Jakarta Pondok Kopi in 2023 showed that out of 1,143 pending claim reports, the dominant factors were inaccurate diagnostic coding (50%) and administration (46%) (Mulyani et al., 2024). UNS Hospital also noted that 11.3% of total pending files were due to diagnostic code errors, illustrating a strong correlation between clinical data inaccuracies and claim delays (Bella et al., 2024). Other studies suggest that suboptimal internal verification processes also create bottlenecks in claim submissions, thereby prolonging the pending status (Dewi & Novarini, 2025).

Although previous research has examined various causes of pending claims across several hospitals, most studies remain partial and fail to provide a comprehensive profile of pending claim characteristics within the context of Type A or regional referral hospitals. This includes the distribution of causal factors by service unit, submission timing, and the impact on internal hospital management (Bella et al., 2024; Haq & Werdani, 2025). While some studies propose integrating information systems and enhancing coder competence to reduce pending rates, few have comprehensively analyzed pending claims in referral healthcare facilities (Situmorang et al., 2025).

Research at Bhayangkara Hospital Pekanbaru linked administrative and coding factors to pending status but did not provide a detailed overview of claim characteristics (Kryandhari et al., 2025). Other studies have shown the relational percentages between causal factors but have yet to explain how these relationships affect overall claim management performance (Dewi & Novarini, 2025). The lack of research regarding pending claims in referral hospitals in Eastern Indonesia, specifically at RSUP dr. Johannes Leimena Ambon, highlights the need for an empirical study to generate accurate local data as a basis for claim system improvement policies.

A preliminary study at RSUP dr. Johannes Leimena Ambon in the fourth quarter of 2025 revealed that approximately 19% of total inpatient claims submitted were pending. The distribution of causes included incomplete documentation (35%), coding errors (30%), administrative discrepancies (20%), and internal verification delays (15%). These preliminary findings indicate that pending claims remain a challenge in the management of documentation and claim administration. These issues potentially affect operational cash flow and the quality of hospital administrative services. Consequently, this provides the rationale for this research: to identify the profile of pending claims at RSUP dr. Johannes Leimena Ambon based on their causes and characteristics.

Methods

This study employs a descriptive design with a quantitative approach to illustrate the status of pending BPJS Kesehatan claims for inpatient services at RSUP dr. Johannes Leimena Ambon in 2025. The study utilizes secondary data derived from pending claim documents, which are analyzed descriptively through frequency distributions and percentages. The research was conducted at the Medical Records and BPJS Claim Management Unit of RSUP dr. Johannes Leimena Ambon from January to April 2026. The population consists of all inpatient BPJS claim files from 2025. Using a total sampling technique, all claims with pending status were included as the research sample.

The research variable is the BPJS pending claim, defined as a claim that cannot be processed due to inconsistencies or incomplete documentation. Measurement is categorized based on the type of cause, namely: administrative factors, completeness of medical records, and coding accuracy. The research instrument consists of an observation sheet (checklist) covering claim identity, pending characteristics, and causal factors. Data collection was performed through direct recording from claim documents. The instrument has undergone expert judgment by professionals specializing in claim management.

Data analysis is performed descriptively through the stages of editing, coding, tabulating, entry, and cleaning using Microsoft Excel. This study also adheres to ethical principles, including the absence of coercion, confidentiality of identity and data, and ensuring no risk to patients as the study utilizes secondary data.

Results and Discussion

The analysis showed that of the 1,588 pending files, coding factors represented the most specific issues with the highest impact on claim rejection.

Table 1. Distribution of Pending Claim Factors at RSUP dr. Johannes Leimena Ambon (2025)

Pending Factor	n	%
Administrative		
Incomplete referral documents	482	65%
Data discrepancy with BPJS system	234	32%
Delay in claim submission	20	3%
Medical		

Pending Factor	n	%
Incomplete patient progress notes	243	64%
Incomplete medical resume	87	23%
Missing supporting test results	42	11%
Missing primary diagnosis	5	1%
Coding		
Non-specific diagnosis codes	360	92%
Inconsistency between diagnosis and action	18	5%
Inaccurate action codes	10	2%
Inaccurate diagnosis codes	5	1%
Total Pending Cases	**1588**	**100%**

The 19% pending rate indicates systemic issues in claim management. Administrative factors were dominated by incomplete referral documents (65%), reflecting weak coordination between primary health facilities and the hospital. Medically, the high rate of incomplete progress notes (64%) indicates low compliance of medical staff with documentation standards. Coding issues were primarily driven by non-specific diagnosis codes (92%), suggesting a need for increased competency among coders or better communication between doctors and coders. These findings highlight that pending claims are a systemic problem requiring integrated solutions across administrative, medical, and coding units.

The total number of pending claims, amounting to 1,588 cases out of 8,206 (19%), indicates a significant issue in claim management at RSUP Dr. Johannes Leimena Ambon. This figure is relatively high compared to the efficiency standards expected by BPJS Kesehatan, which prioritizes "ready-to-pay" claims that require no administrative or medical corrections. The Ministry of Health emphasizes that claim accuracy and completeness are prerequisites for payment. This condition suggests a discrepancy between field practices and prevailing regulations (Permenkes, 2023).

Monthly distribution shows sharp fluctuations in pending claims, peaking in May (256 cases) and November (184 cases). This phenomenon can be linked to workload theory, which posits that an increase in service volume leads to a decline in administrative and documentation quality if not balanced with adequate resources. Studies indicate that high workloads contribute to medical documentation errors, underscoring the need for human resource management that is adaptive to service surges (Linda, 2017; Syukur et al., 2018).

The highest total volume of claims occurred in November (888 claims), yet this did not directly correlate with the highest number of pending claims. This imbalance suggests that pending factors are influenced not only by claim volume but also by the quality of claim management. The Hospital Act mandates that hospitals provide high-quality and effective services, including the administrative aspects of financing (Kemenkes RI, 2009)

The dominance of administrative factors in pending claims confirms that the claim administration system is not yet optimal. Incomplete referral documents accounted for 65%, indicating weak coordination between primary healthcare facilities and the hospital. Permenkes No. 71 of 2013 regarding Healthcare Services under JKN stipulates the importance of tiered referrals as the basis for claims; this discrepancy reflects a failure in service integration (BPJS, 2021).

Furthermore, the 32% discrepancy between administrative data and the BPJS system highlights issues with health information system (HIS) interoperability. HIS theory identifies system integration as the key to successful health data management. Research by the WHO (2018) also emphasizes the importance of interoperability in improving claim efficiency, suggesting that digitalization has not yet been fully optimized (WHO, 2025).

Conversely, the 0% rate of incomplete Patient Eligibility Letters (SEP) and patient identity mismatches indicates that the initial verification process is functioning well. This suggests that the front-office system is relatively effective, but problems arise during the subsequent stages of document management.

In the medical aspect, incomplete patient progress notes were the largest factor (64%). This reflects low compliance among medical personnel regarding documentation standards. The Permenkes on Medical Records asserts that every medical action must be documented completely and accurately; such incompleteness poses potential legal and financial risks (Permenkes, 2023).

Incomplete medical resumes (23%) point to weaknesses in discharge planning and final patient documentation. Clinical governance theory states that documentation is an integral part of service quality. Research shows that incomplete documentation is directly correlated with increased claim rejections (Dewi & Novarini, 2025; Mandia, 2023).

While the absence of primary diagnoses (1%) and the unavailability of supporting test results (11%) are statistically smaller, they remain crucial. Without a clear diagnosis, the system cannot determine the INA-CBG's tariff. Evidence-based medicine requires every

diagnosis to be supported by clinical evidence; inconsistencies here render claims unverifiable (Wirdah et al., 2025).

Regarding coding, the use of non-specific diagnostic codes reached 92%, making it the most dominant issue. This indicates low coder competence or a lack of communication between physicians and coders. Technical guidelines for the INA-CBG's system emphasize the necessity of coding precision (Permenkes, 2023).

Discrepancies between diagnostic codes and medical records (1%), as well as inappropriate procedure codes (3%), indicate inconsistencies between clinical and administrative data. Data quality theory identifies accuracy and consistency as primary indicators of data quality (Amar, 2023). Inconsistencies between diagnosis and procedure (5%) also signal potential fraud or clinical misinterpretation, which BPJS Kesehatan monitors through verification mechanisms to prevent claim irregularities (BPJS, 2021).

Conclusion

This study concludes that the pending claim rate at RSUP dr. Johannes Leimena Ambon reached 19% in 2025, driven primarily by incomplete referral documents, clinical progress notes, and the use of non-specific diagnosis codes. It is recommended that the hospital strengthens its internal multi-layered verification system prior to submission and conducts regular ICD-10 coding workshops for both physicians and coding professionals.

Study Limitation

This study has several limitations that should be considered when interpreting the findings. First, the research used a descriptive quantitative design based solely on secondary data from pending claim documents, which limited the ability to explore causal relationships between variables in depth. Second, the study was conducted only at RSUP dr. Johannes Leimena Ambon, so the findings may not fully represent the characteristics of pending claims in other referral hospitals or healthcare settings in Indonesia. Third, the analysis focused on administrative, medical, and coding factors documented in claim files, without direct interviews or observations involving coders, physicians, verifiers, or BPJS officers; therefore, some underlying organizational or human resource factors may not have been captured comprehensively. Fourth, the accuracy of the results depended on the completeness and quality of hospital claim records, which may contain documentation bias or recording inconsistencies. Finally, this study did not evaluate the financial impact, turnaround time, or effectiveness of corrective interventions related to pending claims, so further analytical and longitudinal studies are recommended to provide a broader understanding of claim management performance.

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References

Amar, R. (2023). Prosedur BPJS dan Klaim BPJS. Fakultas Kedokteran Universitas Baiturrahmah.

Bella, C. R., Pratama, A., & Abidin, A. Z. (2024). Gambaran Penyebab Pending Claim BPJS Kesehatan Akibat Ketidaktepatan Kode Diagnosis di Rumah Sakit Universitas Sebelas Maret (UNS). Jurnal Rekam Medik & Manajemen Informasi Kesehatan, 2(2), 7–17. https://rammik.pubmedia.id/index.php/rmik/article/view/47/19

BPJS. (2021). Panduan Praktis Administrasi Klaim Fasilitas Kesehatan BPJS Kesehatan.

Dewi, A., & Novarini, M. (2025). Factors Causing Pending Claims at Sultan Thaha Saifuddin Regional Hospital. In Journal of Medical Records and Information Technology (JOMRIT) (Vol. 3, Number 2). https://jurnal.syedzasaintika.ac.id/index.php/jomrit

Haq, M. A., & Werdani, K. E. (2025). Analisis Penyebab Pending Klaim Berkas BPJS Kesehatan Pasien Rawat Inap di Rumah Sakit Nirmala Suri. PREPOTIF: JURNAL KESEHATAN MASYARAKAT, 9(1), 765–774. https://doi.org/10.31004/prepotif.v9i1.41201

Kemenkes RI. (2009). Undang-Undang No. 44 Tahun 2009 Tentang Rumah Sakit.

Kryandhari, C. A., Hatta, Gemala R, & Istiqlal, H. (2025). Analisis Faktor-Faktor yang Mempengaruhi Tingkat Pending Klaim Bpjs Kesehatan di RS Bhayangkara Pekanbaru Periode Semester 1 Tahun 2024. Jurnal Manajemen Dan Administrasi Rumah Sakit Indonesia (MARSI), 9(3), 305–310. https://doi.org/10.52643/marsi.v9i3.6632

Linda, S. E. (2017). Hubungan antara Beban Kerja dan Pendidikan Perawat dengan Kualitas

Dokumentasi Keperawatan di Ruang Rawat Inap RS Pelabuhan Jakarta Tahun 2001. Jurnal Kesehatan, 1(2), 22–40.

Maharani, S. D., Bhakti, A., Rahmawati, F. D., & Haryanto, Y. (2025). Tinjauan Pending Klaim BPJS Rawat Inap di RS X Cirebon Pada Tahun 2024. Manajemen Informasi Kesehatan, 209–218.

Mandia, S. (2023). BPJS Verification Pending Claim Case Accuracy Diagnostic Codes Inpatients. Jurnal Kesehatan, 14, 136–140. https://doi.org/10.35730/jk.v14i2.889

Mulyani, S., Sonia, D., Putra, D. H., & Yulia, N. (2024). Analisis Pending Klaim BPJS Kesehatan Pasien Rawat Inap Di Rumah Sakit Islam Jakarta Pondok Kopi Tahun 2023. Sehat Rakyat: Jurnal Kesehatan Masyarakat, 3(3), 140–152. https://doi.org/10.54259/sehatrakyat.v3i3.3021

Permenkes. (2023). Standar Tarif Pelayanan Kesehatan Dalam Penyelenggaraan Program Jaminan Kesehatan. BN 2023 (35): 30 Hlm; Jdih.Kemkes.Go.Id.

Situmorang, B. A., Aziz, A., & Hutapea, F. (2025). Analysis of Factors Causing Pending BPJS Health Claims for Inpatients at Kartika Husada Setu Hospital in 2024. International Journal of Business, Law, and Education, 6(1), 549–555. https://doi.org/10.56442/ijble.v6i1.1051

Syukur, A., Pertiwiwati, E., Setiawan, H., Studi, P., Keperawatan, I., Kedokteran, F., & Lambung, U. (2018). Hubungan beban kerja dengan dokumentasi asuhan keperawatan. Nerspedia, 1(2), 164–171.

WHO. (2025). Universal health coverage. https://www.who.int/health-topics/universal-health-coverage#tab=tab_3

Wirdah, W., Soewondo, P., & Kartika Dewi, E. (2025). Analisis Klaim Pending BPJS Kesehatan di RSUD Pasar Minggu Tahun 2024. COMSERVA: Jurnal Penelitian Dan Pengabdian Masyarakat, 5(2). https://doi.org/10.59141/comserva.v5i2.3234