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Completeness of BPJS Kesehatan Outpatient Claims at RSD Idaman Banjarbaru

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ABSTRACT
Background: The completeness of BPJS Kesehatan outpatient claims is essential for hospital claims management under the National Health Insurance (JKN) Program. Incomplete administrative requirements, diagnosis and procedure codes, and medical documentation may contribute to pending claims and delayed reimbursement. This study aimed to describe the completeness of BPJS Kesehatan outpatient claims at RSD Idaman Banjarbaru based on these components.
Methods: This quantitative study used a retrospective descriptive design at the JKN Unit of RSD Idaman Banjarbaru from July to September 2025. The population consisted of 386 pending outpatient claim files, with 196 selected using the Slovin formula and purposive sampling. Data were collected using a structured checklist and analyzed using univariate analysis, presented as frequencies and percentages. Patient confidentiality and anonymity were maintained.
Results: Of 196 pending claim files, 167 (85.2%) had complete administrative requirements and 29 (14.8%) were incomplete. Complete diagnosis and procedure codes were found in 71 files (36.2%), while 125 (63.8%) were incomplete. Complete medical documentation was found in 176 files (89.8%), while 20 (10.2%) were incomplete. Common deficiencies included missing control and referral letters, incomplete diagnosis and procedure codes, and incomplete supporting medical documentation.
Conclusion: Claim completeness differed across components. Incomplete diagnosis and procedure codes were the most frequent deficiency, followed by administrative requirements and medical documentation. Improving claim document completeness is important to support effective hospital claims management.

INTRODUCTION

The management of BPJS Kesehatan claims is a critical component of hospital claims management under Indonesia's National Health Insurance (JKN) program. The completeness of administrative requirements, diagnosis and procedure codes, and supporting medical documentation is essential to ensure successful claim verification and timely reimbursement. From the perspective of health information management, high-quality clinical documentation and standardized clinical coding are fundamental for producing reliable health information, supporting reimbursement systems, and improving the efficiency of hospital claims management. Conversely, incomplete documentation and coding may delay claim processing, increase

administrative workload, and affect hospital financial performance (Davis, J., & Shepheard, 2024;Shepheard, J., & Groom, 2020).

As the utilization of healthcare services under the JKN program continues to increase, hospitals are required to submit a growing number of BPJS Kesehatan claims. The increasing claim volume places greater demands on the claim verification process and may contribute to a higher number of pending claims when submitted claim files do not meet BPJS Kesehatan verification requirements. Pending claims occur because of incomplete or inconsistent claim information, resulting in delays in reimbursement and reducing the efficiency of hospital financial management (Nuraini, N., et al,. 2019).

Previous studies have identified several factors associated with pending BPJS Kesehatan claims. Agiwahyuanto, F., Anjani, S., & Stacey (2021) reported that incomplete administrative documents, such as referral letters and other supporting documents, frequently resulted in returned claims. Pratama, et al. (2023) reported that incomplete diagnosis and procedure codes were associated with pending hospital claims. These findings indicate that deficiencies in claim documentation remain a persistent challenge in BPJS Kesehatan claim management.

Although previous studies have identified factors associated with pending BPJS Kesehatan claims, they have primarily focused on determining the causes of pending claims rather than comprehensively describing the completeness of outpatient claim files. Furthermore, evidence regarding the completeness of BPJS Kesehatan outpatient claims in regional hospitals in South Kalimantan remains limited despite the increasing number of pending claims. Unlike previous studies, this study provides a comprehensive description of outpatient claim completeness by evaluating three key components simultaneously: administrative requirements, diagnosis and procedure codes, and medical documentation. This comprehensive approach is expected to provide evidence that supports improvements in hospital claim management and the BPJS Kesehatan claim verification process.

RSD Idaman Banjarbaru is a regional public hospital in South Kalimantan that collaborates with BPJS Kesehatan in providing healthcare services. According to data from the hospital's JKN Unit, 386 outpatient claim files were classified as pending between July and September 2025. The most frequently identified deficiencies included incomplete control letters, incomplete diagnosis and procedure codes, and incomplete supporting medical documentation.

Therefore, this study aimed to describe the completeness of BPJS Kesehatan outpatient claims at RSD Idaman Banjarbaru based on administrative requirements, diagnosis and procedure codes, and medical documentation.

METHODS

This study employed a quantitative method with a retrospective descriptive design. The study was conducted at the National Health Insurance (JKN) Unit of RSD Idaman Banjarbaru from July to September 2025. The study population consisted of 386 pending BPJS Kesehatan outpatient claim files. The sample size was calculated using the Slovin formula with a 5% margin of error, resulting in a total sample of 196 claim files. Purposive sampling was applied based on predetermined inclusion and exclusion criteria. The inclusion criteria comprised BPJS Kesehatan outpatient claim files with pending status recorded between July and September 2025 that were available for review at the JKN Unit. Claim files with incomplete records, duplicate files, or files that were inaccessible during data collection were excluded from the study. Data were collected through structured observation of claim files using the BPJS Kesehatan claim completeness verification checklist routinely implemented at RSD Idaman Banjarbaru. The data collection process was conducted systematically by identifying eligible claim files, reviewing each file using the checklist, recording the findings, and verifying the completeness of the collected data before analysis. This study evaluated three variables: administrative completeness, coding completeness, and medical documentation completeness. Administrative completeness was defined as the completeness of claim administrative requirements, including the Participant Eligibility Letter (SEP), patient identification, control letter, referral letter, outpatient clinic information, and document legibility. Coding completeness was defined as the completeness of diagnosis and procedure codes documented in the claim files. Medical documentation

completeness was defined as the completeness of supporting clinical documents, including the medical summary, proof of medical services, medical rehabilitation form (when applicable), and the signature of the physician responsible for patient care. Each variable was classified as either complete or incomplete according to the BPJS Kesehatan claim verification standards implemented at RSD Idaman Banjarbaru. The research instrument consisted of the BPJS Kesehatan claim completeness verification checklist routinely used by RSD Idaman Banjarbaru as part of its operational claim verification process. Therefore, additional validity and reliability testing was not conducted because the checklist had been adopted as the hospital's standard operational instrument for claim verification. Data were analyzed using univariate analysis and are presented as frequencies and percentages. This study received ethical approval from the Research Ethics Committee of STIKES Intan Martapura (Approval No. 135/KE/YBIP-SI/XII/2025). As this study used secondary data obtained from outpatient claim files, patient identities were anonymized by replacing all personal identifiers with unique codes. All data were kept confidential and used exclusively for research purposes in accordance with established research ethics principles.

RESULTS

A total of 196 pending BPJS Kesehatan outpatient claim files at RSD Idaman Banjarbaru from July to September 2025 were included in this study.

Table 1. Completeness of Administrative Requirements in BPJS Kesehatan Outpatient Claim Files (n = 196)

Variables	Category	F	%
Administrative aspect	Complete	167	85,2
	Incomplete	29	14,8

Source: Primary data, 2026

Table 1 shows that most BPJS Kesehatan outpatient claim files had complete administrative requirements (85.2%), whereas 14.8% were incomplete. The most frequently identified deficiencies involved missing control letters and referral letters, which may delay the claim verification process.

Table 2. Completeness of Diagnosis and Procedure Codes in BPJS Kesehatan Outpatient Claim Files (n = 196)

Variables	Category	F	%
Coding aspect	Appropriate	71	36,2
	Inappropriate	125	63,8

Source: Primary data, 2026

Table 2 indicates that 63.8% of the claim files contained incomplete diagnosis and procedure codes, while only 36.2% had complete coding. This finding demonstrates that coding completeness was the most frequently identified deficiency among the three assessed components and represents an important issue in the BPJS Kesehatan claim verification process.

Table 3. Completeness of Medical Documentation in BPJS Kesehatan Outpatient Claim Files (n = 196)

Variables	Category	F	%
Medical document aspect	Complete	176	89,8
	Incomplete	20	10,2

Source: Primary data, 2026

Table 3 shows that 89.8% of the claim files contained complete medical documentation, whereas 10.2% were incomplete. The most common deficiencies were incomplete medical summaries and incomplete proof of medical service forms.

Overall, the findings indicate that the completeness of administrative requirements and medical documentation was relatively high. However, the completeness of diagnosis and procedure codes remained the main deficiency identified among pending BPJS Kesehatan outpatient claim files. This finding highlights the need to improve the completeness of coding documentation to support a more efficient claim verification process and reduce pending claims.

DISCUSSION

This study found that most BPJS Kesehatan outpatient claim files at RSD Idaman Banjarbaru fulfilled the required administrative requirements, with 167 of 196 claim files (85.2%) categorized as complete. Nevertheless, 29 claim files (14.8%) remained administratively incomplete, primarily because of missing control letters, referral letters, incomplete patient identification, and illegible supporting documents. Although the proportion of incomplete administrative documents was relatively small, these deficiencies contributed to pending claims by delaying the verification process and requiring claim revisions before reimbursement could be processed.

Administrative completeness is the initial requirement in the BPJS Kesehatan claim verification process because it determines whether a claim is eligible for further assessment. According to Kryandhari, C. A., Hatta, G. R., & Istiqlal (2025), complete administrative documentation facilitates efficient claim verification and reduces the likelihood of claim rejection or delayed reimbursement. Similarly, the Technical Guidelines for BPJS Kesehatan Claim Verification (Kemenkes R.I., 2014) state that incomplete claim files must be returned to hospitals for correction before verification can proceed. BPJS Kesehatan (2014) also stated that claim verifiers have the authority to return incomplete claim files to hospitals for revision before further processing. Therefore, even minor administrative deficiencies may increase administrative workload, prolong claim processing, and affect hospital financial management.

The remaining administrative deficiencies identified in this study may indicate inconsistencies in document preparation and internal verification before claim submission. Because claim files are prepared through collaboration among physicians, nurses, medical record officers, and claim verification staff, ineffective communication or inadequate document checking may result in missing administrative requirements. Putri and Nugroho (2022) explained that the claim submission process requires administrative documents processed by casemix officers after healthcare services have been completed. Strengthening internal verification procedures and improving coordination among healthcare professionals may therefore reduce administrative deficiencies and improve claim processing efficiency.

The findings are consistent with those reported by Agiwahyuanto, F., Anjani, S., & Stacey, (2021), who identified incomplete administrative documents as one of the leading causes of returned BPJS Kesehatan claims. Likewise, Nuraini, N., et al. (2019) reported that incomplete claim documents delayed reimbursement because claims had to undergo revision before approval. Maimun (2024) also emphasized that outpatient claims can only proceed to the verification stage after all administrative requirements have been fulfilled. Similarly, (Triatmaja, A. P., et al (2022) and Maulida, E. S., & Djunawan (2022) demonstrated that incomplete administrative documents contribute to pending claims, delayed reimbursement, and disruptions to hospital financial management. Irmawati (2018) in Lutfia (2024) also stated that incomplete administrative documents are among the major causes of returned outpatient claim files. Santiasih, W. A., Simanjorang, A., & Satria (2022) further reported that incomplete or inappropriate claim documentation, including inconsistencies between diagnoses, medical resumes, and therapies, contributed to pending claims and delayed reimbursement. Collectively, these findings highlight the importance of maintaining administrative completeness to ensure an efficient and timely claim verification process.

Among the three components evaluated, coding completeness represented the most prominent deficiency. Of the 196 outpatient claim files reviewed, 125 files (63.8%) contained

incomplete diagnosis and procedure codes, whereas only 71 files (36.2%) had complete coding. This finding indicates that incomplete coding remains the primary challenge in BPJS Kesehatan outpatient claim management at RSD Idaman Banjarbaru and is likely to be a major contributor to pending claims.

Diagnosis and procedure codes are fundamental components of the Indonesian case-based payment system (INA-CBGs), as they determine reimbursement for healthcare services. Consequently, incomplete coding may prevent claim verification, require repeated revisions, and delay claim reimbursement. Kryandhari, C. A., Hatta, G. R., & Istiqlal (2025) explained that complete clinical documentation is essential for producing complete diagnosis and procedure codes and ensuring the quality of health information. Similarly, Pratama et al., (2023) identified incomplete coding as one of the principal causes of pending BPJS Kesehatan claims.

The predominance of incomplete coding observed in this study may reflect organizational and systemic challenges rather than individual performance alone. Document review indicated that incomplete procedure codes and coding revisions requested by BPJS Kesehatan verifiers were the most frequently identified deficiencies. These findings suggest that coders may encounter difficulties when clinical documentation is incomplete, inconsistent, or lacks sufficient detail to support code assignment. Previous studies have similarly demonstrated that incomplete physician documentation limits coders' ability to assign complete diagnosis and procedure codes, thereby increasing the likelihood of pending claims (Ulhamdiati & Iqbal, 2024; Yulia, 2023).

In addition to documentation quality, workload and limited processing time may also contribute to incomplete coding. Hospitals are required to submit a large volume of BPJS Kesehatan claims within specified reporting periods, requiring coders to maintain both efficiency and compliance with ICD-10, ICD-9-CM, and INA-CBGs coding standards. Under these circumstances, insufficient time for document review and code verification may increase the risk of incomplete coding. Amanda, R., & Sonia (2023) reported that incomplete diagnosis coding may result in discrepancies in INA-CBGs reimbursement, requiring claim revision before approval. Likewise, Kamalia, F dan Indawati (2024) explained that diagnosis documentation that does not adequately support ICD-10 coding standards may create difficulties during claim verification.

The present findings are further supported by Rahmah et al,. (2025) and Ivana, Romodon, Hakim, & Al,. (2025). who reported that insufficient clinical information and incomplete diagnostic documentation frequently contributed to pending claims. These findings indicate that improving coding completeness requires not only competent coders but also comprehensive clinical documentation prepared by physicians. Hospitals should therefore strengthen collaboration between physicians and coders, conduct routine coding audits, and provide continuous education on clinical documentation and coding standards. Because coding completeness represented the greatest deficiency identified in this study, interventions targeting this component are likely to have the greatest impact on reducing pending BPJS Kesehatan claims and improving the efficiency of hospital claim management.

The findings showed that 176 of 196 outpatient BPJS Kesehatan claim files (89.8%) contained complete medical documentation, whereas 20 files (10.2%) were classified as incomplete. This result indicates that medical documentation at RSD Idaman Banjarbaru generally complied with the documentation requirements for BPJS Kesehatan claims. Nevertheless, incomplete medical summaries, missing proof of medical services, and unsigned documents by the physician responsible for patient care were still identified and contributed to pending claims.

Complete medical documentation provides objective evidence that healthcare services have been delivered appropriately and supports the claim verification process. Medical records constitute the primary source of clinical information used by BPJS Kesehatan verifiers to determine whether the submitted claim is consistent with the services provided. Consequently, incomplete documentation may delay claim verification because additional clarification or document revision is required before reimbursement can be approved.

The remaining deficiencies observed in this study suggest that documentation quality depends not only on individual compliance but also on the effectiveness of documentation procedures within the hospital. Medical documentation is prepared collaboratively by physicians, nurses, and other healthcare professionals; therefore, incomplete documentation may reflect inadequate coordination, insufficient supervision, or variations in documentation practices. Strengthening compliance with medical record completion standards and implementing periodic documentation audits may improve the quality of supporting documents submitted with BPJS Kesehatan claims.

The findings are consistent with Amran (2021), who emphasized that complete medical records support healthcare delivery, legal protection, and reimbursement processes. Likewise, Agiwahyuanto et al. (2021) reported that incomplete supporting documentation frequently resulted in returned BPJS Kesehatan claims. Maulida, E. S., & Djunawan (2022) also highlighted the importance of supporting examination reports and treatment documentation in determining claim validity. Furthermore, Dewi, N. F., & Zahwa (2023), Ivana et al., (2025), and Rahmah et al,. (2025) reported that incomplete clinical documentation and insufficient supporting evidence contributed to pending claims because verifiers were unable to confirm the appropriateness of the services provided. These findings reinforce the importance of maintaining complete medical documentation to support timely claim verification and reimbursement.

This study demonstrates that the completeness of BPJS Kesehatan outpatient claims is determined by three interrelated components: administrative requirements, coding completeness, and medical documentation completeness. Although administrative requirements and medical documentation were generally complete, coding completeness emerged as the most prominent deficiency. This finding suggests that improvements in hospital claim management should prioritize strengthening coding practices while maintaining the quality of administrative verification and clinical documentation.

The predominance of incomplete coding indicates that pending claims are influenced not only by technical errors in code assignment but also by broader organizational factors, including documentation quality, communication among healthcare professionals, workload, and internal quality assurance systems. Since diagnosis and procedure codes are generated from clinical documentation, improving coding completeness requires collaborative efforts involving physicians, coders, medical record officers, and claim verification staff rather than focusing solely on coder performance.

These findings support previous studies by Nuraini, N., et al (2019) and Oktamianiza, Rahmadhani, Yulia, & Putri (2021), which demonstrated that pending BPJS Kesehatan claims are commonly associated with incomplete administration, coding deficiencies, and incomplete medical documentation. Similarly, Andi Karisma et al,. (2024) emphasized that effective standard operating procedures (SOPs), clear task distribution, and strong interprofessional communication are essential for producing complete claim documentation and minimizing pending claims.

From an operational perspective, pending claims may adversely affect hospital financial sustainability because delayed reimbursement disrupts cash flow and increases administrative workload due to repeated claim revisions. Therefore, hospitals should implement continuous quality improvement strategies, including routine internal claim audits, periodic training on BPJS Kesehatan claim requirements and coding standards, strengthened pre-submission verification procedures, and continuous monitoring of claim completeness. These strategies may improve claim quality, reduce pending claims, and enhance the efficiency of hospital claim management.

This study provides practical evidence regarding the completeness of BPJS Kesehatan outpatient claims at a regional public hospital in South Kalimantan. However, this study was limited to a descriptive analysis conducted in a single hospital and did not examine causal relationships between claim completeness and pending claim outcomes. Future studies are therefore recommended to employ analytical designs involving multiple healthcare facilities to

identify organizational, human resource, and system-related factors influencing pending BPJS Kesehatan claims. Such evidence would provide stronger support for developing effective strategies to improve hospital claim management under Indonesia's National Health Insurance program.

CONCLUSION

This study provides evidence that the completeness of BPJS Kesehatan outpatient claims at RSD Idaman Banjarbaru was generally satisfactory in terms of administrative requirements and medical documentation. However, the completeness of diagnosis and procedure codes remained the most prominent deficiency and was identified as the primary issue associated with pending claims. These findings highlight that improving coding completeness, together with maintaining complete administrative requirements and medical documentation, is essential to enhance the efficiency of the BPJS Kesehatan claim verification process and support timely reimbursement.

From a practical perspective, hospitals should strengthen collaboration among healthcare professionals involved in claim management. Physicians should ensure comprehensive and timely clinical documentation, coders should improve the completeness of diagnosis and procedure coding in accordance with applicable coding standards, and claim verification officers should reinforce pre-submission verification to identify incomplete claim files before submission to BPJS Kesehatan. Implementing routine coding audits, continuous staff training, and periodic evaluations of claim completeness may further reduce pending claims and improve hospital claim management.

This study was conducted using a retrospective descriptive design in a single regional hospital; therefore, the findings may not be generalizable to other healthcare settings. Future studies are recommended to employ analytical or multicenter research designs to investigate organizational, human resource, and system-related factors influencing pending BPJS Kesehatan claims, thereby providing stronger evidence for developing effective strategies to improve hospital claim management under Indonesia's National Health Insurance program.Authors' Contribution Statement: Hasanudin contributed to the conceptualization of the study, data collection, data processing, and data analysis. Saharudin contributed to supervision, methodological review, interpretation of the findings, and manuscript revision. Mustafa contributed to methodological input, academic review, drafting, and critical revision of the manuscript. Dedi Mahyudin Syam contributed to academic input, validation of the analysis, and refinement of the manuscript content. Fitri Handayani contributed to the literature review, manuscript editing, and final manuscript review.

Authors' Contribution Statement

Siti Tanzilah: Conceptualization, Investigation, Data curation, Data collection, Formal analysis, and Writing – Original Draft. Melinda Restu Pertiwi: Methodology, Supervision, Validation, Interpretation of findings, and Writing – Review & Editing.

Conflicts of Interest

The authors declare that they have no competing interests in relation to this study or its publication. There are no financial, personal, professional, institutional, or other relationships that could reasonably be considered to have influenced the research process, analysis, interpretation, or presentation of the findings. The study was conducted independently, with efforts made to ensure objectivity and maintain the academic integrity of the research.

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