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Coding Accuracy in The Return of Inpatient BPJS Claims at Ajibarang Regional General Hospital

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Abstract
The decline in hospital revenue caused by pending claims remains a major challenge for hospitals. Many hospitals have experienced a decrease, particularly in operational income. Pending claims also affect the health services provided to the community and have an impact on the overall quality of public health. This study aims to determine the coding accuracy of inpatient BPJS claim returns at Ajibarang Regional General Hospital. This research employs a descriptive qualitative design. The population consists of inpatient medical records with pending claims from November 2024, with a total sample of 205 medical records, selected using total sampling. Data were collected through a review of original hospital data sources, and the findings were analyzed to determine the frequency distribution of the causes of pending claims. The results of the study on 205 pending claims showed that the inaccuracy in determining the main diagnosis was 3.41%, inaccuracy in determining diagnosis codes was 29.27%, incompleteness of patient medical record documents was 67.32%, and the highest occurrence of pending claim incompleteness was found in the Internal Medicine Polyclinic (42.44%). It is recommended that the hospital improve staff accuracy and competence through training to reduce the occurrence of pending claims.

***Keywords**: Coding Accuracy, Pending Claims, BP JS*

INTRODUCTION

The Indonesian government has implemented the Universal Health Coverage (UHC) program, which aims to ensure that the entire population is covered by the national health insurance scheme, BPJS Kesehatan. This program is committed to providing adequate access to healthcare services without causing financial hardship (Setyowati K, 2022). BPJS Kesehatan is responsible for managing and verifying all claim submission processes. A claim is an official request made by hospitals to BPJS Kesehatan to obtain compensation for the healthcare services they have provided. Healthcare facilities must complete the available claim forms and submit them to BPJS Kesehatan to receive payments in accordance with the standard tariffs determined in the Indonesian Case Based Groups (INA-CBGs) system (Fahreza et al., 2023).

The management of claims highly depends on the completeness of data within medical records. Medical records are a collection of information in document form, which includes patient identity, physical examination results, laboratory findings, diagnoses, and all medical procedures and treatments received by the patient. This information covers inpatient, outpatient, and emergency services (Tofan et al., 2022). A current phenomenon in Indonesia is that many hospitals are experiencing a decline in operational revenue. This issue warrants serious attention because it has a substantial impact on healthcare facilities; when a hospital's income decreases, it affects the healthcare services provided to the community and influences overall public health quality (Wayan et al., 2023).

Research conducted by Syifa Mukaromah (2024) reported a financial decline in RSUD Kota Bandung due to pending claims, which caused delays in payments and the distribution of medical service fees. This finding is supported by the study of Farhansyah et al., (2024) which stated that Hospital X experienced a decrease in cash flow caused by claim payment issues,

leading to financial losses due to discrepancies between healthcare service costs and the amount reimbursed through claims.

Pending claims are not a new issue in Indonesia, as many hospitals continue to face obstacles in BPJS Kesehatan claim processing (Yunita N et al., 2025). Pending claims refer to a condition in which the periodic monthly submission of claims to BPJS Kesehatan does not meet the required document completeness (Yusuf et al., 2022). If hospital claims are continuously delayed, the reimbursement process for BPJS patient services will also be postponed. Since the expenses incurred are not matched by the amount received, this situation disrupts hospital cash flow. Consequently, hospital financial stability is affected, which may interfere with payments for medical services provided by doctors and other healthcare workers (Fadilah, 2023).

The decline in hospital revenue caused by pending claims remains a challenge. Therefore, to prevent ongoing issues, research is needed to identify the factors contributing to pending claims, particularly focusing on the accuracy of principal diagnosis determination, completeness of medical record documentation, and accuracy of diagnostic coding. Findings from a study at RSI Sultan Agung Semarang revealed that claim returns due to diagnostic code accuracy consisted of 19% accurate and 81% inaccurate cases. One major cause of inaccurate diagnostic coding was the lack of complete supporting examination results. Additionally, inconsistencies were found between the types of medical procedures stated in operative or anesthesia reports (Amalia et al., 2023).

Preliminary findings at RSUD Ajibarang in January 2025 showed the occurrence of BPJS inpatient claim returns for the November 2024 period. Out of a total of 1,509 inpatient claims submitted, 205 claim documents were categorized as pending. Based on this background, the researcher is interested in conducting a study entitled “Coding Accuracy in the Return of BPJS Inpatient Claims at RSUD Ajibarang.”

METHODS

Type of Research

This study employs a descriptive method with a qualitative approach to determine the coding accuracy of returned BPJS inpatient claims at Ajibarang Regional General Hospital.

Time and Location of the Study

The study was conducted in October 2025 at Ajibarang Regional General Hospital. Data collection was carried out using a checklist form and interviews with casemix officers responsible for disease coding.

Population and Sample

The population in this study consists of pending inpatient claim files from November 2024, totaling 205 files. The sample size used in this research is 205 medical record documents. The sampling technique applied is total sampling.

Data and Research Instruments

Data collection in this study utilized both primary and secondary data sources. Primary data were obtained through a checklist form used to assess the accuracy of medical record documents. Secondary data were collected through interviews with respondents or informants to support the primary data.

Data Analysis Technique

This study uses a qualitative approach with data analysis based on checklist forms containing the criteria “accurate” or “inaccurate.” The checklist data were processed to generate results in percentage form. In addition, interviews were conducted as supporting data to strengthen and provide explanations for the obtained percentages.

RESULTS AND DISCUSSION

Accuracy of Principal Diagnosis Determination

The research findings related to the accuracy of principal diagnosis in 205 inpatient medical records with pending claims are presented as follows.

Table 1. Frequency Distribution of Principal Diagnosis Accuracy

Accuracy of Principal Diagnosis	Frequency	Percentage (%)
Inaccurate	7	3,41%
Accurate	198	96,59%
Total	**205**	**100%**

Based on Table 1, the frequency distribution of principal diagnosis accuracy shows that out of 205 samples, 3.41% of the medical records were categorized as inaccurate due to incorrect determination of the principal diagnosis. Inaccuracy in assigning the principal diagnosis occurs when the placement of primary and secondary diagnoses does not comply with ICD-10 coding rules. If coders encounter difficulties or discrepancies with the general coding guidelines when assigning diagnostic or procedural codes, they are required to clarify the information with the attending physician. If clarification cannot be obtained from the Primary Responsible Physician (DPJP), coders may apply the reselection rules MB 1 through MB 5 to re-evaluate and select the correct principal diagnosis (Permenkes No. 26, 2021).

The findings at Ajibarang Regional General Hospital indicate that the most frequent errors in determining the principal diagnosis occurred in cases of Atrial Fibrillation and Flutter. Document reviews revealed that these diagnoses should not have been assigned as the principal diagnosis but rather as secondary diagnoses, as they appeared as consequences of an underlying condition, specifically heart failure. According to the Regulation of the Minister of Health of the Republic of Indonesia No. 26 of 2023 on Medical Record Management, a secondary diagnosis is a diagnosis that accompanies or occurs concurrently with the principal diagnosis and may take the form of comorbidities or complications. In this context, Atrial Fibrillation and Flutter represent complications arising from heart failure and therefore should be coded as secondary diagnoses, not principal diagnoses.

Based on these findings, the researcher concludes that the inaccuracy of principal diagnosis assignment occurred because coders were insufficiently meticulous when reselecting diagnostic codes according to the MB 1 to MB 5 rules and the coding agreements established between BPJS Health and the Ministry of Health. This issue is attributed to the limited time available for completing BPJS claim processing. Coders are often confronted with a large volume of claim documents and strict deadlines, resulting in suboptimal coding processes. These conditions may reduce coders' concentration and lead to errors in determining the appropriate principal diagnosis.

Accuracy of Disease Diagnostic Code Assignment

The observations conducted on 205 inpatient medical records with pending claims yielded the percentage of diagnostic coding accuracy as presented in the table below.

Table 2. Frequency Distribution of Diagnostic Code Accuracy

Accuracy of Diagnostic Coding	Frequency	Percentage (%)
Inaccurate	60	29,27%

Accurate	145	70,73%
Total	**205**	**100%**

Based on Table 2, which shows the frequency distribution of diagnostic code accuracy, it can be seen that of the 205 samples, 29.27% of the medical records were categorized as inaccurate due to incorrect diagnostic coding. Inaccuracy in diagnostic coding occurs when the assigned code does not comply with the standard classification rules (Fakhrur & Elystia, 2022). The diagnostic coding process in hospitals uses the ICD-10 (International Statistical Classification of Diseases and Related Health Problems, Tenth Revision), which has been mandatory since the issuance of the Decree of the Minister of Health of the Republic of Indonesia No. 50/MENKES/SK/I/1998 on the international statistical classification of diseases. Therefore, all diagnoses and laboratory results documented in patient medical records must be accurately and correctly coded (Agnes Jeane, 2022).

Based on the findings at Ajibarang Regional General Hospital, it was identified that errors still occur in the assignment of diagnostic codes, particularly in cases of a history of old stroke. Document review revealed that this diagnosis should have been coded using I69.3 (Sequelae of cerebral infarction), but in several records, it was instead coded as I63.9 (Cerebral infarction, unspecified). According to ICD-10 Volume 2 guidelines and the Minister of Health Regulation No. 26 of 2023 on the Administration of Medical Records, the code I63.9 is used for acute stroke events currently occurring, whereas I69.3 is applied for sequelae or residual effects of previous stroke events. Therefore, using I63.9 for old stroke cases is inaccurate as it does not reflect the patient's actual clinical condition.

Based on the research findings, the researcher concludes that inaccuracies in diagnostic coding occurred due to a lack of agreement between hospital coders and BPJS Health, particularly differences in interpretation regarding the meaning of diagnostic codes and medical procedures. Coders stated that they had applied coding based on the international standards and coding guidelines currently in effect; however, the results often did not align with the criteria or standards applied by BPJS Health. This discrepancy may lead to inconsistencies in determining both diagnostic and procedural codes, ultimately affecting the validity of claims submitted. These findings align with Afifah et al. (2024) who reported that inaccuracies in diagnostic coding within BPJS claims occur due to differing perceptions between BPJS Health officials and hospital coders. These differences arise from variations in interpreting diagnoses written in patient medical records and translating them into ICD-10 codes. Coders rely on internationally recognized coding rules, while BPJS Health often applies specific internal policies in determining diagnoses used as the basis for claim reimbursement. Similarly, Tuzzahra et al. (2024) stated that inaccuracies in diagnostic coding occur due to changes in claim audit reports, which may be revised periodically according to BPJS Health policies, leading to differences in understanding and implementing claim regulations.

Completeness of Patient Medical Record Files in Pending BPJS Inpatient Claims

The research findings related to the completeness of patient medical record documents in BPJS pending claim data for 205 inpatient medical records are presented as follows.

Table 3. Frequency Distribution of Medical Record File Completeness in Pending BPJS Inpatient Claims

Completeness of Diagnosis Documentation	**Frequency**	**Percentage (%)**
Incomplete	138	67,32%
Complete	67	32,68%
Total	**205**	**100%**

Based on Table 3, which displays the frequency distribution of medical record completeness, it is shown that of the 205 samples, 67.32% of the medical records were categorized as incomplete. Incomplete medical record documents refer to conditions in which required files or administrative components needed for claim submission are not fulfilled in accordance with applicable regulations (Feby et al., 2024). BPJS claims must be submitted in complete form according to the requirements established by BPJS Health (Aryani et al., 2025). Field observations revealed that many medical record documents remain incomplete. These incompletions include several important aspects, such as insufficiently specific examination results, absence of medical indications for inpatient care, lack of documented special management during treatment, and the omission of incident chronology in accident cases. These findings indicate that the process of completing and verifying medical records has not fully met the required completeness standards as mandated by relevant regulations. According to the Regulation of the Minister of Health of the Republic of Indonesia No. 26 of 2023 on Medical Record Management, each medical record must be completed accurately, thoroughly, in a timely manner, and in a legally accountable way.

Based on the research findings, the researcher concludes that incomplete medical record documentation occurs due to insufficient discipline among healthcare providers in documenting clinical information, limited attention to detail among staff when checking document completeness, and weak coordination between related units. Physicians and nurses often fail to complete medical summaries, procedure notes, or supporting examination results, causing the information documented in medical records to fall short of the standards required for claim submission.

Coverage of Pending Claim Incompleteness by Clinic at Ajibarang Regional General Hospital

The analysis of 205 inpatient medical records with pending BPJS claims shows that incomplete medical record documentation was present, with the distribution of incompleteness categorized by outpatient clinics as follows:

Table 4. Frequency Distribution of Pending Claim Incompleteness by Clinic

Polyclinic	Frequency	Percentage (%)
Internal Medicine	87	42,44%
Obstetrics	31	15,12%
Pediatrics	24	11,71%
Surgery	16	7,80%
Cardiology and Vascular Medicine	14	6,83%
Neurology	10	4,88%
Orthopedics	9	4,39%
Urology	7	3,41%
Pulmonology	7	3,41%
Total	**205**	**100%**

Based on the findings, incomplete medical record documentation is the most significant factor contributing to pending inpatient claims at Ajibarang Regional General Hospital. From the 205 documents examined, most incomplete records were found in the Internal Medicine Clinic, with a percentage of 42.44%. This high percentage indicates that the Internal Medicine Clinic contributes the largest proportion of pending claims compared with other clinics.

The highest occurrence of incomplete documentation in pending claims was identified in the Internal Medicine Clinic. This situation is caused by the large number of supporting documents and medical management records that were not attached during the BPJS claim submission process. Missing documents—such as laboratory results, radiology reports, and medical procedure notes—prevent claims from being optimally verified, thereby increasing the risk of being marked as pending. Additionally, the high rate of incompleteness in this clinic is influenced by a significantly large patient volume, as internal medicine cases constitute the highest number of visits at Ajibarang Regional General Hospital. The heavy workload of physicians and administrative staff increases the likelihood of omissions in document attachment during claim preparation.

CONCLUSION

The conclusions drawn from the research conducted at Ajibarang Regional General Hospital are as follows:

1. The inaccuracy in determining the principal inpatient diagnosis was found to be 3.41% of the 205 medical record documents reviewed.
2. The inaccuracy in assigning diagnostic codes for inpatient cases amounted to 29.27% of the total 205 documents.
3. The incompleteness of patient medical record files in pending BPJS inpatient claims was 67.32% of the 205 documents.
4. The highest proportion of incomplete documentation in pending claims was observed in the Internal Medicine Clinic, accounting for 42.44% of the total cases.

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