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Analysis of Factors Causing Pending Claims for Inpatient JKN Patients Using the Fishbone Diagram Method Approach at Hospital X

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ABSTRACT

Since the implementation of the National Health Insurance (JKN) program as of January 1, 2014, the profile of hospital patients has undergone many shifts, which are currently dominated by BPJS Kesehatan guarantee patients, this means that the largest health financing comes from BPJS Kesehatan claim payments. Claim files that do not meet the requirements will be returned to the hospital, this will have an impact on reduced claim payments. Preliminary study at the hospital. X found that the number of pending claims for hospitalization for the month of January to March 2025 reached an average of 18.1% of files. This study aims to analyze the factors that cause the pending claims of hospitalization of JKN patients in hospitals. X with the fishbone diagram method approach. This research is qualitative, data collection using secondary data, observation, interviews, and document review. The results of this study show the causes of pending claims from the man factor: quality and quantity of coding, material factors: incomplete files (machine): lack of scanner equipment and process factors (method): SOP and regulations related to inadequate coding. The root causes of the problem include a lack of number, education and training of coder officers, lack of claim file filters, lack of number and quality of scanners and incomplete and not updating SOPs and regulations related to coding activities.

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INTRODUCTION

BPJS as the implementation of the JKN Program which has been going on for more than 10 years, as of April 30, 2025, shows that it has succeeded in attracting 278,658,723 participants or 98.9% of the total population of Indonesia (BPJS Kesehatan, 2025), it is natural if the patient profile in the hospital is currently dominated by BPJS Kesehatan guaranteed patients. In addition, at least 2700 hospitals or 82.4% of hospitals have collaborated with BPJS Kesehatan, which means that there are 2700 hospitals, either privately owned or government-owned, whose main income comes from the payment of BPJS Kesehatan claims. Health financing in hospitals is obtained from the payment of claims by BPJS Kesehatan for health services provided to participants (Ministry of Health of the Republic of Indonesia, 2016).

Hospitals submit claims collectively to BPJS Kesehatan a maximum of every 10th of every month. The claim process begins with the coder entering patient data into the INACBG application for each patient, then the claim file is sent electronically to BPJS Kesehatan. BPJS Kesehatan will purify and verify, files that pass verification will be made a Minutes of Verification Results (BAHV) a maximum of 10 days from the date of receipt of the file, then make a payment a maximum of 15 days from the date of making the BAHV. On the other hand, files that do not pass verification will experience a pending claim, this file will be returned to the hospital for correction and billed again the following month. Pending claims result in the number of claims paid by BPJS Kesehatan being smaller than the amount submitted by hospitals, this has a wide impact, including delays in the payment of employee salaries, payments for doctors' medical services, payments for vendors of drugs and consumable medical materials, limited logistics supplies including patient nutrition, and even disruption of hospital maintenance costs.

The following is data on the number of BPJS Kesehatan guaranteed inpatients for the period January to March 2025 at RS.X.

Table.1. Data on the Number of Hospitalized Patients Guaranteed by BPJS Kesehatan for the Period of January to March 2025

Moon	BPJS	Non-BPJS	Total	BPJS Ratio
January	858	128	986	87,0 %
February	821	115	809	85,8 %
March	856	120	800	85,0 %

Source: Secondary Data of the First Quarter Report of 2025

Based on table 1, it is known that the number of inpatient visits is dominated by BPJS Kesehatan guaranteed patients, which reach more than 85% of the total inpatient visits every month. The large number of BPJS patient visits has a big influence on the hospital's revenue. X, good governance is needed to maintain payment continuity so as not to interfere with hospital operational costs. Ellis & McGuire (1990) stated that the national system (JKN) applies tariff restrictions or pending claims, then hospitals will experience a decrease in revenue**,** especially hospitals that rely heavily on JKN patients.

Table.2. Data on the Number of Pending Claims for Hospitalization of BPJS Health Guarantee Patients for the Period of January to March 2025

Moon	Total Claims	Approved	Dipending	Rasio Pending
January	858	701	157	18,3 %
February	821	694	127	15,5 %
March	856	680	176	20,6 %
			Flat - Flat	18,1%

Source: Secondary Data of the First Quarter Report of 2025

Based on table 2, it is known that the number of pending hospitalizations claims for the period from January to March 2025 averaged 18.1% of the total files sent to BPJS Kesehatan. Late payment due to this pending claim will result in disrupting the hospital's cash flow which has an impact on delaying costs for hospital operations, if this situation continues and for a long period of time, it will cause liquidity problems for the hospital and distress or financial vulnerability. Financial vulnerability in non-profit organizations is caused by the fact that their income is not well diversified, the income earned is highly dependent on the main source of income, low administrative costs, and does not have a surplus during financial turmoil (Omar, 2013). Delays in submitting claims have an impact on hampered hospital operational activities such as delays in the availability of medicines, medical devices, and employee incentive payments, thus affecting the quality of health services (Harnanti, 2018). Not only that, the performance of the hospital. X also decreased due to not being able to meet the Key Performance Indicators set by the hospital owner (Corporate) where based on the Director's Decree number 020/AVM/SK/DIR/III/2022, the limit for pending claims for bills to BPJS Kesehatan has been set at a maximum of 5% on average.

Based on the above background, the researcher is interested in analyzing the factors that cause the pending claim of hospitalization of JKN patients by using the fishbone diagram approach in the hospital. X. The application of the fishbone diagram will have an effect on determining the strategy for solving the problem of pending claims in the hospital. X, then the researcher submitted a study entitled "Analysis of Causative Factors of Pending Claims for JKN Patients with the Fishbone Diagram Method Approach at RS.X".

METHODOLOGY

This study uses a qualitative method, where the researcher focuses on observation and in-depth and comprehensive understanding of the phenomenon of pending claims in hospitals. X. The researcher delved deeper into the main problem of each element to secondary data, namely feedback pending claims, Minutes of Verification Results (BAHV), Verification Results Report (LHV), and 1st quarter of hospital pending claim report. X period from January to March 2025. The data collection technique uses interview sheets, observations and analysis of related documents. The research informants were 6 people consisting

of 6 coder officers. The object of this study is the inpatient claim file for the period from January to March 2025 while the data analysis uses a qualitative method, carried out by selecting, sorting and organizing data collected from interview results, field observation records, and analysis of related documents, so as to get a complete picture and an in-depth understanding, meaning in the form of new findings that are descriptive.

LITERATURE REVIEW

Pending claims are part of the performance assessment at the hospital. X at the central level (corporate) is one of the assessments in the Key Performance Indicator (KPI), where the pending claim target is set not to exceed 5%. To achieve this goal, the hospital is assisted by the casemix team, the performance of the hospital is determined one of which is from the performance of the unit (team casemix) and the performance of the individual (coder officer), so it can be said that the performance of this hospital is a reflection of the performance of the coder officer, this is in accordance with what was conveyed by Campbell (1993) who stated that performance is the goal of the organization by hiring someone to do something and do it well, Likewise, Ivancevich (2015) explains that performance is the result achieved from what an organization or company wants.

To find the root of the problem that causes the failure to achieve hospital performance, many methods can be used, one of which is the fishbone diagram method. A quality assurance expert from Japan, Dr. Kaoru Ishikawa, for the first time introduced the fishbone diagram / cause and effect diagram method to find the root cause of a quality-related problem. The application of fishbone diagrams can identify the potential cause of a problem (Kusnadi, 2008). A fishbone diagram is a visual aid in the form of fish bones that displays the relationships between various causal factors that contribute to a particular problem, which is a causal relationship. Problems will be broken down and described into several categories of elements, namely human resources (man), money (money), materials (material), equipment (machine), process (method). All of these elements are then analyzed to find the root cause of the problem.

The human factor affects performance through many aspects, ranging from education, training, working period, and the adequacy of the number of workers according to the existing workload. Education and training have a linear contribution to performance, the higher the education and training, the greater the productivity, Becker (1964) said that education and training is an investment in "human capital", which increases the skills, knowledge and productivity of individuals. Barney (1991) stated that education is a valuable and scarce internal resource of the organization, educated staff become a competitive advantage in producing superior performance. Bandura (1986) also states that learning through training includes observational learning, self-efficacy and reinforcement, emphasizing that when staff have acquired new skills, their self-efficacy will increase to apply what they have learned so that it will increase performance. In addition, the adequacy of the number of employees or staff affects the performance of individuals or groups, this is because the workload will be evenly distributed according to the ability of the staff, on the other hand,

if there is a shortage, the workload of each employee will exceed his ability, in his book Big School Small School, Baker (1964) conveyed the theory of understaffing, namely When the number of individuals in a setting is less than needed, everyone tends to take on more roles and responsibilities. This can increase individual participation and a sense of responsibility, but it can also potentially lead to burnout and decreased performance if the load is too heavy, as well as overstaffing, whereas if the number of individuals exceeds the need, some people may not have a clear role, which can lead to decreased motivation and performance. In addition, the working period is also related to performance, the longer working period is more exposed to procedures and training so that the understanding will be better and performance is easier to achieve, Blau (1964) stated that the working relationship is based on the principle of reciprocity, employees with a longer working period feel more committed because they have received a lot from the organization, and in return it improves performance, so Hackman (1976) states that the longer a person is in a job, the deeper his understanding of the characteristics of the job (skill variation, task identity, autonomy, feedback), which can improve motivation and performance.

The money factor plays an important role where limited cash flow in hospitals will affect the fulfillment of operational costs which will have an impact on delays in the payment of salaries and medical services, this will erode the motivation of the coder and make the coder not focus on carrying out their duties, as a result pending claims will increase, and so on like a vicious circle if not addressed immediately. In the Two-Factor Theory introduced by Herzberg's (1959) it is explained that salary, incentives, and working conditions are hyegenic factors, when these factors are met, the staff will feel satisfied and can focus on motivating factors, namely responsibility and work performance. Likewise with the theory of Expectancy presented by Victor Vroom (1964) where a person's motivation to perform certain actions is determined by 3 things, namely the belief that the effort made will produce good performance (expectancy), the belief that good performance will produce good rewards (instrumental), the individual's attraction to the reward (valence) where motivation is a multiplication of the 3 factors, So that if there is a delay in salary, it will certainly reduce the motivation of the coder officer and have an impact on reducing their focus in carrying out their duties.

The material factor in the context of this study is how the coder ensures that all claim files have met the requirements. Incompleteness of the file becomes an obstacle in billing to BPJS Kesehatan, because the file will be returned to the hospital to be completed again through the pending claim process, this is in accordance with the Thory of Constraints (TOC) by Eliyahu M. Goldratt & Jeff Cox (1984) which states that each system has one or more constraints so that it needs to be identified and managed properly. The relevance of file completeness is an important constraint in the coding and billing process, even though the coder already has high flying hours will still be an obstacle if the claim file is incomplete.

The equipment (machine) factor ensures the availability of the facilities and infrastructure needed by the coder to achieve the targets given by the

company, here management/company support is needed to prepare the infrastructure facilities needed by the coder to do the job well, this is in accordance with the theory of Job Demands-Resources (JD-R) by Bakker & Demerouti (2007) which states that the performance and welfare of employees are influenced by the balance between job demands and available resources (job resources), what is meant by resources here are facilities and infrastructure of work tools, the fulfillment of resources will help coders to carry out their duties well, minimize stress and increase motivation at work. Donabedian (1966) also said that one of the things that affects the quality or performance of staff is the structure, where this structure represents human resources, facilities and infrastructure.

The process factor (method) is described as the availability of adequate SOPs and regulations for coders to do their work well, this is in accordance with the Organizational Process Theory presented by Robbins & Coulter (2012), which explains that a well-documented work process will increase the efficiency, consistency and accuracy of task execution. SOPs and guidelines that are unclear, will interfere with the process and output performance, in this case the claim approved by BPJS Kesehatan, this is in accordance with the General System Theory conveyed by Ludwig (1968) where the organization is seen as a system and work methods are part of the operational process.

RESEARCH RESULTS

Identifying the Man Factor

Identify the Number of HR Availability

Management of hospital claims. X is carried out by the casemix team, which requires adequate human resources / officer support both in quantity (quantity) and quality in order to achieve the performance targets set by the corporate. The current available casemix personnel data are 2 internal verifiers and 6 coders. However, based on the results of the document search, it is difficult to conclude the availability of the number of casemix personnel, whether it is in accordance with the calculation of the existing workload, because there is no planning of personnel needs based on workload analysis, this is supported by interviews with informants, here are the quotes:

> "*It has been more than 3 years that no manpower needs have been planned, if there is a shortage of manpower, it will be assisted by personnel from other temporary units, even though the number of inpatients continues to increase along with the addition of hospital capacity in the last 3 years,*" he said.
> *(1 report)*

Educational Identification

Regulation of the Minister of Health of the Republic of Indonesia Number 55 of 2013 concerning the Implementation of Medical Record Work, stipulates that the implementation of medical recorder work is carried out by graduates of Associate Experts in Medical Records and Health Information. From the search of personnel documents, only 2 or 33.3% of the coder officers met the educational requirements, 4 or 66.7% of them had an inappropriate educational background,

namely from 2 graduates of SMK/SMA, 1 graduate of Diploma in Accounting Information Systems and 1 graduate of Diploma in Management. So it can be concluded that 66.7% of the coder officers at the hospital. X has not met the educational requirements.

Identification of Training

Based on the results of the review of personnel documents, it was found that in the last 3 years only 1 coder officer or 16.7% had participated in coding training, and 5 coder officers or 83.3% had not received a coding training, this was strengthened by the interview of one of the coder officers, here is an excerpt:

> "*Since the last 3 years, there has never been any coding training both internally and externally, even though many regulations have changed*".
> *(2 report)*

So it can be concluded that 83.3% of the coder officers at the hospital. X has not received training both internally and externally in the last 3 years.

Identify the Tenure

From the results of the review of personnel documents, it was found that all coder officers or 100% have had a working period of more than 3 years. So it can be concluded that the working period of all coder officers at the hospital. X has exceeded 3 years, enough time to gain skills and adapt to the work environment.

Material Factor Identification

From the results of the search for claim feedback documents from BPJS Kesehatan, it was found that pending claims caused by incomplete file problems were obtained at 4.8% in the 1st quarter of 2025, where this file problem consisted of incomplete files of 91% (20 documents), scans of unreadable files of 4.5% (1 document) and corrupted files that could not be opened by 4.5% (1 document). Incomplete files are the main cause, including the lagging of related files such as anatomical pathology results, surgery reports, KLL chronology, flowsheets and fluid balances. The lagging of files can occur due to the lack of careful filtration of documents before the documents are sent to BPJS Kesehatan, this is reinforced by the results of an interview with one of the coder officers, along with the quote.

> "*Document filtration activities are carried out by 1 document control staff, but in the implementation, there are still many documents that do not exist, the coder officer does not focus on filtering documents because they are more focused on entering data into INACBG's application*".
> *(3 report)*

Money Factor

Identification of Operational Costs

If you look at the value of the money, during the 1st quarter of 2025 there will be Rp. 2,719,496,500 or an average of 24.17% of the total value of claims submitted, of course this is a big problem for hospitals to meet their operational needs, including the payment of salaries, medical services, medicines, etc. The coder was also affected by the late payment of salary, this was confirmed from the interview of one of the coder officers, the following excerpt:

> "*Pending claims make us worried, because there have been several delays in salary payments and split salary payments.* "
> (*4 report*)

Equipment Factor (Machine)

Identification of Printer Facilities

From the results of observation, it was found that there are 5 scanners available to handle outpatient and inpatient claim files, based on the results of an interview with one of the coders the number of scanners is considered sufficient, but if one of them is damaged, there is no backup scanner, so you have to borrow another unit. In addition, the officer complained that the scan results were often unclear, so the officer had to roll over the scan of the file, as follows:

> "*We think the scanner is sufficient, but if there is a problem we have to borrow from other units that also need the tool, special backup has not been provided*".
> *(5 report)*

Factor Process (Method)

Coding SOP Identification

The results of observation and document review were obtained from the fact that the SOP is available but not complete, and the SOP is more than 3 years old. The availability of SOPs makes it easier for officers to carry out their duties and responsibilities. So, it can be concluded that the SOPs needed by the coder officer are incomplete and do not update according to the latest regulations.

Identify Coding Guidelines

The results of observation and document review found that hospitals have provided JKN guidelines but have not been revised for more than 3 years, while there are many dynamics of changes in regulations related to JKN, such as TKMKB Recommendations at the central and regional levels, Minutes of Agreement, and other laws and regulations, which are a reference for coders to codify correctly. Although the coders get external documents, they admit that sometimes they still lack understanding of the existing coding rules, here is an excerpt:

> "*The documents of BA or TKMKB results can be obtained from bpjs but we have difficulties in understanding them*".
> *(6 report)*

DISCUSSION

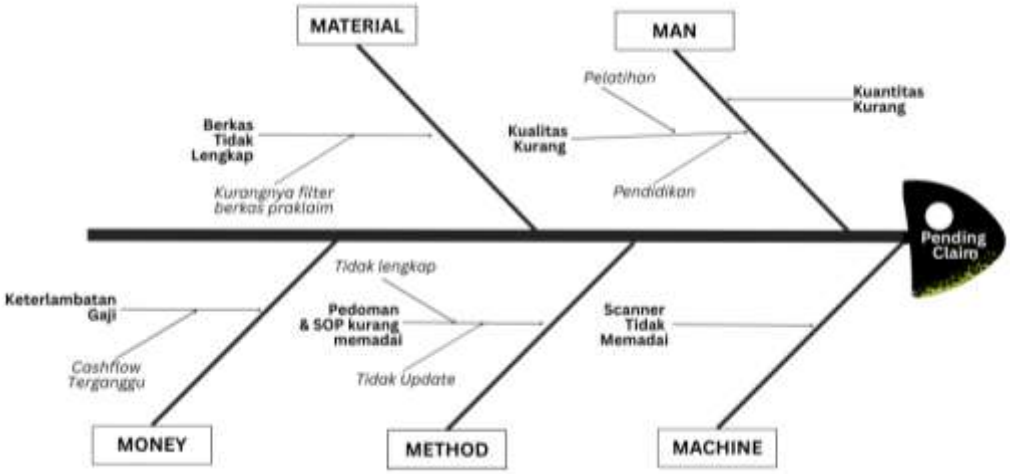

Figure 1. Diagram Fishbone

Analysis of the causes of pending claims for hospitalization of JKN patients in hospitals. This X uses the fishbone diagram method. Based on figure 1, it is found that the problem of pending claims at the hospital. X is influenced by 5 factors, namely the human factor, the material factor, the machine factor and the process factor, and the money factor.

The root of the problem causing pending claims from human factors can be grouped into 2, namely related to the quality of human resources and the quantity of human resources. The quality of human resources is associated with the education and training of coder officers. It can be concluded that the coder officer at the hospital. X has not met the educational requirements of a coder, namely a graduate of the Associate Expert in Medical Records and Health Information, because there are only 2 out of 6 coder officers who meet the educational requirements. The educational background of the coder officer has a great impact on the implementation of claims, it is hoped that with the appropriate background, the coder can carry out accurate codification according to his science so that it can prevent pending claims, this is in accordance with research conducted by Indrawati (2019) which said coders with inappropriate education have a high risk of producing inaccurate codes. The coding inaccuracy of 68% at the Kagok Health Center is due to the fact that the coding officers do not have a background in medical record education (Irmawati and Nazillahtunnisa, 2019).

The skills of coders play an important role in claims management, where skilled and dexterous coders are needed to complete tasks quickly and accurately according to the specified targets. The skills of the coder can be obtained from a number of coding trainings both internally and externally. Coding training also contributes to officers in improving their understanding of coding both in terms of selecting the right code and understanding of coding rules, so as to minimize errors. This study found the fact that only 1 coder or 16.7% had participated in coding training. The impact of officers not getting adequate coding training both

internally and externally, causes the resulting coding results to be inaccurate. It is necessary to conduct training for coding/casemix officers to further improve knowledge about the quality and accuracy of medical record data, especially BPJS Kesehatan claim data (Endah & Fadhila, 2024). The inaccuracy of the coding results is due to the coding officers never participating in the training (Windari & Kristijono, 2016). On the contrary, the more training given to officers has a great effect on improving their performance, accurate coding (Mandey & Sahangggamu, 2014).

In terms of the quantity of coder officers at the hospital. X, only 2 coder officers stated that it was not enough, but did not know how many shortages there were coder officers, this was because the analysis of manpower needs had not been updated since 3 years ago. The lack of coders will increase the workload of coders and will have an impact on the inaccuracy and accuracy of the ICD 10 and ICD 9 CM codes that are given, causing pending claims, this is in accordance with a study conducted by Fadillah & Harry (2024) which states that the lack of medical records personnel of 30 people but the available 18 people causes a high workload. The fulfillment of medical record officers in accordance with their respective job descriptions will provide maximum service (Nuraini, 2015). Factors The number of claims that are not offset by sufficient human resources can cause officers to be exhausted and become less focused in carrying out their duties (Rohman et al., 2017). In addition, the Decree of the Minister of Health of the Republic of Indonesia number HK.01.07/MENKES/1596/2024 TKRS Standard 9 states that "Each unit head plans and reports the needs of staff and resources such as rooms, equipment and other resources to the hospital leadership to meet the services according to the needs of the patient", meaning that the Head of Unit who oversees the coder officer has the obligation to plan the needs of the staff (coder officer) proposed to the Director of the House sick, which is updated at least once a year or as appropriate sooner according to the needs of the unit.

The length of a person's service life is related to increased work experience, better understanding of organizational culture and increased adaptability and problem solving. The longer the working period, the more coding experience they have, especially in solving complex coding cases, showing better productivity, having an increased level of skills, knowledge and analytical ability in carrying out coding activities, so that the resulting coding has a high level of accuracy. The accuracy of code by coders with a service life of ≥ 3 years, is worth more accuracy than the accuracy of code generated by coders with a service life of < of 3 years (Jannah, 2015). This is in accordance with the research of Indawati, (2019) who states that coders that have a longer working period produce more accurate code. The results of this study show that the working period of all coder officers at the hospital. X has fulfilled the working period of more than 3 years, so the working period is not the root cause of the problem in the human factor (man).

The root cause of the problem is the material factor, namely the incompleteness of the files, which accounted for 91% of the total files that experienced pending claims in the 1st quarter of 2025. The incomplete file is due

to the absence of related files in the file sent to BPJS Kesehatan, such as anatomical pathology results, surgery reports, chronological KLL, flowsheets and fluid balances, where the lagging of these files is due to the lack of filter running in the process of fulfilling the completeness of the claim file. Claim files that are declared complete after going through several stages of verification will proceed to the payment process by going through a certain administrative process. Verification is the process of checking and verifying the correctness of claims submitted by hospitals related to patient care costs. This verification ensures that the claim complies with applicable terms and procedures.

BPJS will carry out three stages of verification, the first is the verification of the administration of participation, namely ensuring that the BPJS card and membership data including SEP and NIK numbers are in accordance with it, the second is service verification, which is to ensure the completeness and accuracy of claim files such as medical resumes, supporting results both laboratory, radiology and other files, the last is verification of medical data and diagnosis, namely to ensure that the diagnosis listed has been in accordance with medical examinations and procedures have been carried out correctly (BPJS Kesehatan, 2018). Claim files that do not pass verification will be returned to the hospital (pending claim) to be completed again, this is in line with the results of research conducted by Rohman et al., (2017) which stated that the claim material factor is still found to be incomplete in the claim file submitted to the BPJS office so that the claims submitted to the BPJS office have a pending claim and research conducted by Nuraini & Wijayanti (2018) which states that there is still incompleteness in filling out the BPJS claim requirements file for inpatients resulted in the disbursement process being delayed.

Likewise, a study conducted by Fani et al., (2024) which said that the pending BPJS Kesehatan claim file was due to incomplete files. There is still incompleteness in filling out the inpatient BPJS claim requirement file, resulting in a delay in the disbursement process (N Nuraini and Wijayanti, 2018). RS. X should filter files accountably by applying a file checklist, so as to ensure that all files have been fulfilled, in addition to that it can also be done by implementing Electronic Medical Records which facilitate a checklist of file completeness in the Casemix module, so that officers can automatically add additional files beyond the general files needed.

The root cause of the problem of the equipment (machine) factor is the unavailability of an adequate number of scanner machines. RS. X has not used Electronic Medical Records, especially for inpatient services, therefore it still uses physical files or manual medical records, with many files that must be scanned, the coder needs a sufficient and reliable scanner machine, in the sense that it is enough to carry out all scanning activities and can reliably produce clear scans. One inpatient has at least 10 files that must be scanned and made into one file, the file consists of SEP and inpatient plan letter from the vclaim application, individual patient claim file from INACBG's application, medical resume, action or surgery report, supporting examination results, hospitalization order from doctor, patient details and receipts and other supporting files if needed. The number of BPJS Kesehatan guaranteed inpatients in a month can reach more than

800 patients, so it can be concluded that at least 8000 files per month must be scanned by officers to complete the BPJS Kesehatan guaranteed inpatient claim documents. Unclear file scan results will experience a pending claim, this is in accordance with research conducted by Erlia & Achmad (2022) which states that incomplete medical record files of inpatient patients, including unclear scan results, is the main factor in the return of claims by BPJS Kesehatan.

The unclear results of the scanned BPJS claim file cause difficulties in the verification process, which results in pending claims and disrupts the hospital's cash flow (Larasaty, 2023). RS. X can also solve the problem of unclear scan results by implementing Electronic Medical Records in inpatient installations, this will cut the file scanning process which takes time and effort, coders can download all files from the electronic medical record application integrated in SIMRS, thus increasing efficiency, this is in line with the research conducted by Novita et al., (2023) where the use of EMR in BPJS claim filing has proven to be effective if and has a positive impact on the quality of the claims submitted, as can be seen from the absence of claims that reached more than 90%, showing that the claim process is becoming more efficient.

The root cause of the problem of the process factor (method) is the incompleteness and non-updating of SOPs and guidelines related to codification. In this context, SOPs and guidelines serve as a reference to reduce task ambiguity, increase accuracy, and lower the risk of error. The SOP provides standard steps in coding according to the rules of ICD-10, ICD-9 CM, and also serves as a bridge to reduce variations in perception, working methods and subjectivity in work. SOPs are the desired work guidelines and work processes that must be carried out for certain purposes, SOPs are very important as guidelines or standardization of steps to complete a job that can reduce the occurrence of errors. The incomplete availability of SOPs causes confusion, multiple interpretations, inconsistencies in work and directly decreases performance, this is in accordance with research conducted by Nunik & Rani (2024) which shows that inaccuracy of diagnosis codes, incompleteness of supporting information results, and incompleteness of claim files are factors that cause the return of claim files, this emphasizes the importance of SOPs that regulate the completeness and accuracy of files claim. Likewise, guidelines such as governance guidelines, coding guidelines, PNPK and Recommendations from TKMKB also need to be updated, so that the selection of coding is in accordance with the latest rules, so that it can prevent pending claims.

Both SOPs, management guidelines, coding rule guidelines, PNPK and Recommendations from TKMKB in addition to needing to be completed, updated also need to be socialized to the coder officer, and the coder officer must be trained in implementing it, not only that to ensure that the SOPs, management guidelines, coding rule guidelines, PNPK and Recommendations from TKMKB can be carried out Utilization Review pending claims, the extent of compliance of the coder in implementing it. The results of the review of the verification feedback document from BPJS Kesehatan show that there is a difference in perception in understanding the coding rules of ICD 10 and ICD 9 CM and regulations related to codification between coders and BPJS Kesehatan verifiers,

regulations related to codification activities including PNPK, Guidelines/Consensus on Disease Management and Recommendations of the Quality Control and Cost Control Team (TKMKB). This can be proven from the feedback document from the BPJS Kesehatan Verifier, where the difference in perception reached an average of 83.82% of the total pending claim files in Q1 of 2025.

CONCLUSIONS AND RECOMMENDATIONS

Based on the results of research conducted at the Hospital. X regarding the analysis of the factors that cause pending claims for JKN patients with the fishbone diagram method approach, it can be concluded that the factors that cause pending claims, include man, material, machine and method factors. Meanwhile, the root causes of pending claim problems include inappropriate education for coder officers, lack of training, lack of number of coder officers, lack of filters in completing files, unavailability of adequate scanners, and incomplete and not updated SOPs, related guidelines, and disruption of hospital cashflow.

Managerially, this research is important for hospital management. X to make the following strategic improvement efforts:

a. Improving the manpower formation of coder officers in accordance with the provisions of applicable regulations, namely graduates of Associate Experts in Medical Records and Health Information, providing both internal and external coding training for each coder officer and making plans for the needs of coder personnel according to the latest hospital needs.
b. Filtering claim files in accordance with the checklist, monitoring and evaluating the implementation of the checklist periodically until the target of file incompleteness determined by the hospital is achieved.
c. Accelerating the implementation of Electronic Medical Records integrated with SIMRS for time and effort efficiency, cutting photocopying and scanning of documents totaling thousands of files, as well as bridging with INACBG's application to prevent input errors and time efficiency in calculating cost groups before being input to INACBG's application.
d. Complete and update SOPs, governance guidelines, coding guidelines, PNPK and Recommendations from TKMKB, conduct socialization and training on their understanding and implementation and conduct periodic monitoring and evaluation to assess compliance with these rules.
e. Preparing bailout funds to help operational costs, and in parallel actively utilizing monthly claims reviews, carrying out follow-up results of review utilization by making continuous improvements until the target is achieved.

FURTHER STUDY

This study has limitations because the sample is not relevant to the current government policy where all health facilities are required to carry out Electronic Medical Records including in inpatient installations, the challenges in the future are the need to conduct research taken from hospitals that have implemented

Electronic Medical Records, whether the classic problems above still occur or there are new problems that can potentially cause pending claims.

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