



ANALYSIS OF THE CAUSES OF PENDING BPJS HEALTH CLAIMS AT THE SPECIAL LUNG HOSPITAL TECHNICAL IMPLEMENTATION UNIT (UPTD) OF THE NORTH SUMATERA

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Abstract

The National Health Insurance (JKN) program, administered by BPJS Kesehatan (Social Security Agency for Health), is one of the government's efforts to ensure access to healthcare services for all. However, its implementation still faces various obstacles, one of which is pending claims. This study aims to analyze the causes of pending BPJS Kesehatan claims at the UPTD (Regional Government Hospital for Lung Disease Control) in North Sumatra Province and identify the dominant factors influencing the delay in claims settlement. This study used a descriptive quantitative method with secondary data obtained from BPJS Kesehatan claims reports and hospital financial data for the period January to July 2025. The data analyzed included the number of claims submitted, eligible claims, pending claims, and the categories of causes for pending claims. The results showed that the total number of claims submitted during this period reached 1,289 files, consisting of 1,224 outpatient claims and 65 inpatient claims. Of these, 77 claims (5.9%) were pending. The main cause of pending claims is the inconsistency of coding in class rates, 92.4% for outpatients and 82% for inpatients due to changes in hospital class rates, while the rest is caused by incomplete files and medical indications. Therefore, the right solution is to implement training activities to improve human resource competency. As a form of intervention, steps that can be taken are to develop Standard Operating Procedures (SOPs) for BPJS Kesehatan claims so that task implementation becomes more focused, uniform, and in accordance with applicable regulations to reduce the number of pending claims and improve hospital financial efficiency.

Keywords: BPJS Health, Pending Claims, JKN

Introduction

A national health insurance system is crucial worldwide to ensure everyone has equal access to healthcare services and reduce the significant financial burden on society. The World Health Organization (WHO) states that the sustainability of a public health insurance system depends on the efficiency of the claims and financing processes.[1]

Since 2014, Indonesia's national health policy has been based on the National Health Insurance (JKN), managed by the BPJS Kesehatan (Social Security Agency for Health). Technical regulations, such as Minister of Health Regulation No. 26 of 2021 concerning the INA-CBG Guidelines, have been established to govern the claims, verification, and payment processes. This regulation requires complete claim documentation as a prerequisite for payment by BPJS Kesehatan. However, in its implementation, several technical issues remain to be addressed. One such issue is the issue of delayed claims, which has attracted the attention of many hospitals and national researchers.[2]

In the BPJS Kesehatan claims system, the INA-CBG package rate can be applied to each hospital service. However, in reality, many hospitals experience delays or postponements in payments due to pending BPJS Kesehatan claims. This condition is known as a pending claim, which is a claim that has not been paid due to discrepancies between the submitted administrative, medical, and financing data [3]. This phenomenon has serious implications for hospital financial management, as delays in claim disbursement can disrupt cash flow and impact local revenue (PAD) achievement.

A nationwide study showed that pending claims are a recurring problem in many healthcare facilities. Research by Pratama et al., (2023) found that filling errors and incomplete documentation caused 11.6% of inpatient claims to be delayed at a national referral hospital. Meanwhile, Widaningtyas et al., (2024) at a private hospital in Bandung found that the main causes of delayed claims were incorrect diagnosis codes and procedures that did not comply with the INA-CBG.3 Syahputri et al., (2024) found that delays in document submission and incomplete examination result attachments caused 62% of file delays.

Human resources are another contributing factor, in addition to administrative factors. Research by Rahadatul et al., (2025) found that high workloads and lack of coding skills led to repeated coding errors. Conversely, one of the main factors causing verification delays was a lack of communication between the hospital's internal verification department and BPJS Kesehatan officers. A study by Zulkarnaen, (2025) demonstrated this. Differences in interpretation between the patient's treating physician (DPJP) and the verifier regarding the appropriateness of the procedure to the primary diagnosis were another frequent issue [9]

According to Hidayat et al., (2024), negligence by officers in completing paperwork and the ineffective use of a digital claims management system resulted in between 8 and 12 percent of claims being delayed in regional hospitals each month. This situation demonstrates the importance of information technology for an effective claims process. A study by Hardiyanti, (2023) showed that using a bridging system between the SIMRS (Sism) and the BPJS Kesehatan e-claim application could reduce the pending claim rate by up to 35 percent.

In terms of legislation, the government has issued several policies, such as Minister of Health Regulation No. 26 of 2021 and BPJS Kesehatan Circular Letter No. 021/2022 emphasize the importance of complete documentation and diagnostic validation based on ICD-10 and ICD-9-CM. However, implementation in the field has been suboptimal due to a lack of training for claims officers and an inadequate internal audit system [12]. A study conducted at Tebet Regional Hospital by Wulandari et al., (2024) found that the biggest problem was the time required to input electronic medical record data.

Several local studies in North Sumatra have also demonstrated similar issues. For example, a study conducted by Hutagalung et al., (2024) at Deli Serdang Regional Hospital found that of 4,212 inpatient claims, 11.3 percent were delayed due to incomplete claim documentation and mismatched diagnosis codes.

Pending claims that are not promptly resolved can impact hospital finances and service quality. According to Febriani, (2023), a ratio of pending claims to total bills exceeding 10% will reduce a hospital's ability to meet routine operational needs. This condition is increasingly evident in government hospitals that do not yet have Regional Public Service Agency (BLUD) status. Without flexible financial management, hospitals rely on rigid regional budget mechanisms, which can disrupt operational continuity due to delays in BPJS Kesehatan claim payments. The most obvious impact is a reduction in Regional Original Income (PAD) due to outstanding claims. Pending claims cannot be recognized as revenue until the verification and payment process is complete.

Based on the 2024 annual financial report of the North Sumatra Provincial Lung Specialist Hospital (UPTD), the initial target for Regional Original Revenue (PAD) from the healthcare sector was IDR 1.8 billion, but the target was not achieved. Of the IDR 1.8 billion PAD target, the actual

revenue only reached approximately IDR 998.5 million, or approximately 55.44% of the annual target (UPTD North Sumatra Provincial Lung Specialist Hospital 2025). Therefore, in August, the PAD target was lowered to IDR 800,000,000 to achieve PAD achievement of over 100%. The accumulation of pending claims resulted in some hospital revenue not being recognized in the same accounting period, impacting total hospital revenue and liquidity at the end of the fiscal year Hutagalung et al., (2024) Furthermore, the revenue structure of the North Sumatra Provincial Lung Specialist Hospital shows an imbalance between revenue sources from general patients and BPJS Kesehatan participants. According to the 2024 financial unit report, revenue from general services accounted for approximately 71.8% of total revenue, while BPJS Kesehatan participants only accounted for 28.2%. This situation was also influenced by the inpatient services not yet operating that year, so the majority of the hospital's revenue still came from outpatient services and supporting examinations. However, interviews with several patients indicated that they still chose to seek treatment at this hospital despite using paid general services. The reasons for this varied, ranging from the Lung Special Hospital's rates being more affordable than other hospitals, to time efficiency, and reluctance to process BPJS referrals because they considered it troublesome and time-consuming due to the long distance. This indicates that even though the JKN program has been running for more than a decade, the population seeking treatment at the Lung Special Hospital is still dominated by general patients who pay directly without insurance claims. However, in 2025, there had been an increase in revenue sources from BPJS Kesehatan participants, amounting to approximately 70.6% as of August. This indicates progress in BPJS Kesehatan claims at the North Sumatra Provincial Lung Specialist Hospital, due to the availability of inpatient services and the public's familiarity with the hospital, which has been operating for approximately two years.

Therefore, it can be concluded that the phenomenon of pending claims is a significant problem in the JKN system that must be evaluated contextually at each type of hospital. Specialist hospitals, such as the UPTD of the North Sumatra Provincial Lung Specialist Hospital, have different service characteristics than general hospitals because most diagnoses and procedures relate to pulmonary and respiratory diseases, which require specialized assessment of supporting examination results. This complexity can increase the likelihood of codification errors and document discrepancies.

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Method

This study uses a quantitative analytical method with a descriptive approach. The aim of this approach is to provide an objective overview of the reasons why BPJS Kesehatan claims are delayed at the UPTD Special Lung Hospital in North Sumatra Province. The primary objective of the study is to identify administrative and technical factors contributing to the delay in claims settlement. This also includes a breakdown of the number of claims based on the identified factor categories.

The data for this study comes from hospital PAD data and BPJS Kesehatan claims reports. The data analyzed included the number of claims submitted, the number of claims paid, the number of unpaid claims, and the reasons why claims could not be processed. To gain a better understanding of the phenomenon under study, the sampling method used was total sampling because all pending claims data during the study period were analyzed.

The results of the analysis are presented in the form of frequency distribution tables and percentages to show the proportion of each cause of pending claims, including medical indications, coding discrepancies, and incomplete files.

Results

The summary of BPJS Kesehatan claims data at the UPTD Special Lung Hospital in North Sumatra Province from January to July 2025 provides an overview of the number of claims submitted, the status of claim settlements, and factors causing claims to be delayed or postponed. This data serves as the basis for assessing the effectiveness of the claims administration process at the hospital, for both outpatient and inpatient services. To provide a more systematic overview of the trends and distribution of causes of delayed claims, all results are presented in tabular form.

Claims data is crucial for assessing a hospital's financial performance, as well as for assessing administrative efficiency. Hospital revenue realization and its ability to achieve regional revenue (PAD) can be directly impacted by the number of pending claims. Therefore, analysis of each table should not only consider the quantitative number of claims but also relate them to the broader management and financial context, as explained by Febriani, (2023) and Zulkarnaen, (2025), who stated that the accuracy and timeliness of claims significantly impact the stability of a hospital's operational cash flow.

This study also aims to demonstrate the level of preparedness and accuracy of human resources during the process of preparing, verifying, and submitting BPJS Kesehatan claims. Delayed claims are usually caused by technical errors such as coding errors, incomplete documents, and differences in perception between the patient's responsible physician (DPJP) and the verifier. Previous studies, such as those by Widaningtyas et al., (2024) and Rahadatul et al., (2025), also indicate that the increase in pending claims is influenced by a lack of internal validation and training of coders. Therefore, the purpose of the upcoming data presentation is to provide an empirical overview of the patterns and factors that cause claims to become pending at the North Sumatra Provincial Lung Specialist Hospital.

3.1 Table

Table 1 BPJS Health claim submission data for the UPTD Special Lung Hospital, North Sumatra Province

Month	Claim Submission		Total
	Outpatient	Inpatient	
Januari	128	4	132
Februari	132	8	140
Maret	143	8	151
April	169	6	175
Mei	164	9	173
Juni	184	9	194
Juli	303	21	324
Total	1.224	65	1289

Table 2. Pending BPJS Health Claim Data for the Special UPTD for the North Sumatra Provincial Lung Hospital

Month	Pending Claim		Total
	Outpatient	Inpatient	
Januari	5	1	6
Februari	4	0	4
Maret	6	1	7
April	8	0	8
Mei	11	4	15
Juni	4	2	6
Juli	28	3	31
Total	66	11	77

Table 3. Outpatient Claim Status Data for January-July 2025

No	Claim Status	Total	Percentage
1	Worthy	1158	94,6%
2	Pending	66	5,4%
Total		1224	100%

Table 4. Inpatient Claim Status Data for January-July 2025

No	Claim Status	Total	Percentage
1	Worthy	54	83,07%
2	Pending	11	16,92%
Total		65	100%

Table 5. Number of Pending Files for BPJS Kesehatan Outpatient Claims at the UPTD Special Lung Hospital, North Sumatra Province

Verification Aspect	Total	Percentage
Coding Mismatch	61	92,4%
File is Incomplete	5	7,6%
Medical Indications	0	0
Total	66	100%

Table 6. Number of Pending Files for BPJS Kesehatan Inpatient Claims at the UPTD Special Lung Hospital, North Sumatra Province

Verification Aspect	Total	Percentage
a	9	82%
File is Incomplete	1	9%
Medical Indications	1	9%
Total	11	100%

Discussion

Based on Table 1, the total number of BPJS Kesehatan claims submitted from January to July 2025 reached 1,289 files, consisting of 1,224 outpatient claims and 65 inpatient claims. The submission trend showed a significant increase, particularly in July with 324 files, an almost twofold increase compared to January. This increase indicates that utilization of services by JKN participants at Special Pulmonary Hospitals continues to increase, along with increasing public awareness of seeking treatment using BPJS and optimization of the pulmonary disease referral system. These results align with research by Widaningtyas et al., (2024) which states that increased utilization of JKN services also increases hospital claim volume each semester, especially at special referral hospitals. Furthermore, Pratama et al., (2023) also found that the increase in claims is directly proportional to the increase in the claims administration burden, which can trigger delays in the verification process.

Table 2 shows that the total number of pending claims for the January–July 2025 period reached 77 files, consisting of 66 outpatient claims and 11 inpatient claims. The highest number occurred in July with 31 pending claims, or 40% of the total pending claims for the seven months. This spike indicates that the increase in claim submission volume was not accompanied by the readiness of internal (94.6%) were declared verifiers to complete the additional workload. This condition supports the research findings of Syahputri et al., (2024), which explained that increasing the administrative burden without adjusting the number of staff led to verification delays and an increase in pending claims. Meanwhile, Rahadatul et al., (2025) also added that pending claims increased when there were no regular internal audits and weak supervision between units.

Based on Table 3, of the total 1,224 outpatient claims, 1,158 files (eligible for payment, and 66 files (5.4%) were pending. The high number of eligible claims indicates that most claim procedures comply with BPJS Kesehatan standards and Minister of Health Regulation No. 26 of 2021. However, although the number of pending claims is relatively small, this percentage still impacts the hospital's cash flow and PAD targets. These results align with Zulkarnaen (2025), who explained that pending claims below 10% are still considered reasonable, but if allowed to accumulate, they can reduce the hospital's financial efficiency. Furthermore, Febriani (2023) found that every 1% of pending claims directly impacts the delay in payment of service incentives and reduces the hospital's cash turnover rate.

Table 4 shows that of the 65 inpatient claims, 54 (83.07%) were deemed eligible for payment, and 11 (16.92%) were still pending. The percentage of pending inpatient claims was higher than that of outpatient claims, as the inpatient case verification process is more complex and involves more medical documents, such as CPPT, supporting findings, and treatment summaries. This finding aligns with research by Hidayat et al. (2024) which states that the complexity of inpatient claims increases the risk of pending claims due to the large number of verification attachments and secondary diagnosis input errors. Rabiulyati (2024) also emphasized that hospitals with specialist services tend to have higher pending claims rates than primary care hospitals due to greater variation in procedures and coding errors.

Based on Table 5, of the 66 pending outpatient files, 61 files (92.4%) were due to coding discrepancies, while 5 files (7.6%) were due to incomplete files, and no cases were found due to medical indications. This indicates that technical aspects in coding diagnoses and procedures are the dominant factor causing pending claims. These results are in line with research by Rahadatul et al. (2025) which showed that coding errors were the biggest cause of pending claims in pulmonary hospitals and referral hospitals, caused by coders' lack of understanding of INA-CBG code updates. Widaningtyas et al. (2024) also stated that double validation between SIMRS and BPJS e-claims often results in data discrepancies, especially if the hospital has not implemented a bridging system optimally.

Table 6 shows that of the 11 pending inpatient claim files, 9 (82%) were due to coding discrepancies, specifically in the hospital class rate. One file (9%) was due to incomplete documentation, and one (9%) was due to medical indications. This pattern is similar to outpatient claims, where coding errors were the most dominant cause. However, the emergence of medical indications indicates a difference in assessment between the patient's attending physician (DPJP) and the BPJS verifier regarding the appropriateness of the diagnosis and treatment. This finding aligns with a study by Zulkarnaen (2025) which stated that mismatched perceptions between DPJP and BPJS verifiers can lead to claims being postponed for clarification. Furthermore, Syahputri et al. (2024) also found that cross-unit communication and lack of coordination were factors contributing to the emergence of pending medical claims in type B and C hospitals in the Sumatra region.

Overall, the results of this study indicate that the problem of pending claims at the UPTD Special Lung Hospital of North Sumatra Province is mostly caused by technical factors in coding diagnoses and medical procedures, both in outpatient and inpatient services. Coding errors are the dominant cause, with a proportion above 80%, followed by incomplete administrative documents and differences in perception in the assessment of medical indications between the hospital and BPJS verifiers. This condition confirms that improving the quality of human resources, especially coders and internal verifiers, is a very crucial aspect in reducing the number of pending claims. This is in line with research by Rahadatul et al. (2025) and Zulkarnaen (2025) who found that strengthening the technical competence of claims officers through training and routine internal audits can accelerate the verification process and improve claim accuracy.

The findings of this study also demonstrate an indirect relationship between the level of pending claims and the achievement of hospital Regional Original Income (PAD). Delayed claim files result in some revenue not being realized in the current accounting period, thus hampering the achievement of

hospital financial targets. However, the increase in the proportion of BPJS participant claims in 2025 indicates significant progress in the effectiveness of claims submissions and increased public trust in hospital services. Efforts to improve the administrative system, digitize the claims process, and intensify coordination with BPJS Kesehatan are expected to minimize the potential for pending claims in the future. These findings support the research findings of Febriani (2023) and Hidayat et al. (2024), which emphasized that improving claims management systems and integrating information technology are key to hospital financial sustainability in the era of National Health Insurance.

Conclusion

Based on the results of research conducted at the North Sumatra Province Lung Specialist Hospital's Technical Implementation Unit (UPTD) for the period January to July 2025, it can be concluded that the pending claims rate for BPJS Kesehatan (Indonesian Health Insurance) is still moderate, at 5.4% for outpatient services and 16.9% for inpatient services. While these figures may seem small, delays in claims disbursement have a significant impact on hospital cash flow and the realization of Regional Original Revenue (PAD). The main factors causing pending claims are inconsistencies in diagnosis and medical treatment coding, with a proportion exceeding 80%, followed by incomplete documentation and differences in interpretation of medical indications between the patient's attending physician and the BPJS verifier. In general, outpatient claims demonstrate better administrative performance than inpatient claims due to the lower complexity of the verification documentation. This pending claims issue has been shown to contribute to low hospital PAD achievement, as pending claims cannot yet be recognized as revenue in the current period. However, the increase in the proportion of BPJS participant claims to 70.6% by 2025 indicates significant progress in the effectiveness of claims management and increased public trust in hospital services.

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