



## FACTORS AFFECTING CODING INACCURACY ON PENDING CLAIMS

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### ABSTRACT

In 2025, coding inaccuracies in National Insurance Health (NIH) inpatient claims at Sulianti Saroso Infectious Disease Hospital (SSIDH) significantly contributed to pending claims, negatively impacting the hospital's financial performance. This study aimed to identify the factors influencing coding inaccuracies on NHI pending claims. Using a mixed-methods approach with an explanatory sequential design, researchers analyzed 425 randomly selected NHI inpatient claim files. Chi-Square tests revealed significant relationships between pending claims and five variables: incomplete supporting data, differences in perception between coders and NIH verifiers, incomplete medical administration, incomplete medical resumes, and coding non-compliance (all with p-values of 0.000). Logistic regression analysis showed that differences in perception between coders and the SSAA verifier had the greatest impact, increasing the likelihood of pending claims by a factor of 1,789.5. Incomplete supporting data increased the likelihood by 1.1 times, while coder competence and experience increased it by 6.1 times. The study concluded that coding inaccuracy is primarily influenced by differences in perception between hospital coders and SSAA verifiers, followed by coder competence and incomplete documentation. To reduce pending claims, the study recommends improving coder training, standardizing communication protocols between hospitals and SSAA, and strengthening administrative completeness. These measures are crucial for enhancing claim accuracy and improving hospital financial outcomes.

Keywords: coding inaccuracy; inpatient; pending claims

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## INTRODUCTION

The National Health Insurance (NHI) is administered by the Social Security Administration Organization for Health, as regulated by Law Number 24 of 2011 concerning the Social Security Administration Agency (SSAA). The SSAA for Health claim process involves submitting healthcare service costs for SSAA-registered patients, which healthcare facilities collectively submit to SSAA for Health each month. SSAA for Health then verifies and approves these claims and proceeds with payment for files that meet the required criteria. Conversely, claim files that do not meet the requirements or are delayed (pending) must be returned to the healthcare facility for re-examination. If a claim is pending, it may disrupt the hospital's cash flow due to issues in the claim payment process (Nabila et al., 2020).

In implementing the NHI program, the payment mechanism for advanced-level healthcare facilities is regulated by the INA-CBGs system, in accordance with Presidential Regulation Number 12 of 2013 concerning Health Insurance, which was later amended by Presidential Regulation Number 111 of 2013. The tariff, effective as of January 1, 2014, was adjusted from the INA-CBGs Community Health Insurance rates and was established in the Regulation of the Minister of Health Number 69 of 2013 concerning the Standard Tariff for Health Services at Primary and Advanced-

Level Healthcare Facilities within the implementation of the National Health Insurance program (Kemenkes R.I., 2014).

Article 1 of Law Number 24 of 2011 concerning SSAA states that the Social Security Fund is a trust fund owned collectively by all participants. It consists of the accumulation of contributions and the results of their investment, managed by SSAA for the payment of benefits to participants and for the operational implementation of the Social Security program. This provision has an impact on the SSAA for Health claim payment system, where payments are made using the INA-CBGs package system, as well as for services outside the INA-CBGs package (BPJS Kesehatan, 2014).

The NHI claim process is a mechanism by which healthcare facilities partnered with SSAA for Health submit payment requests for medical services provided to NHI participants. This claim procedure plays a crucial role in determining the quality and efficiency of healthcare service delivery. However, various issues frequently arise during the claim process, particularly related to inaccurate diagnosis coding for NHI inpatient cases.

In the NHI claim management process, hospitals submit claims to SSAA for Health by preparing complete claim files with supporting documents in accordance with applicable regulations. These claims are then submitted through the claim application to the SSAA for Health. SSAA for Health then provides feedback in the form of verification results for the hospital's submitted claims, including administrative verification of participant eligibility. SSAA for Health conducts several types of verification, including administrative verification of participant eligibility, administrative verification of healthcare services, service verification, and digital verification using software (BPJS Kesehatan, 2014).

In practice, the success of the NHI program heavily depends on effective administrative processes, particularly in claim management (Bella et al., 2024a). The presence of pending NHI claims at hospitals indicates several obstacles in the administrative claims process, with incomplete medical records among the main factors contributing to inaccurate diagnosis coding. This often results in delays in SSAA claim payments. Delays in NHI claim payments can disrupt the hospital's cash flow (Tarigan et al., 2022).

The delay in NHI claim payments occurs not only in government-owned hospitals but in nearly all hospitals. Several private hospitals have reported the return of claim documents, indicating a delay in SSAA claim payments. A study conducted at Hermina Ciputat Hospital found that the return rate of inpatient claims from July to August 2018 was 9%, while for outpatient services it was approximately 0.001% (Supriadi and Rosania, 2019). Another study conducted by Valentina and Halawa at Imelda General Hospital for Indonesian Workers in 2018 found that from March to May 2018, 23.35% of claim documents were returned (Valentina and Halawa, M.N.S., 2018). Government-owned hospitals have also reported the same issue. The percentage of pending claims reported ranged from 2.5% to 47.7% (Alik, 2016; Valentina et al., 2022).

Pending claims generally occur in inpatient claims. Outpatient claim pending cases may also occur, although in smaller proportions, ranging from 0% to 10% (Susan et al., 2016); (Sabriyah, 2016) A study by (Ariyanti & Gifari, 2019) Tangerang Selatan City General Hospital found that 24.8% of claim documents had incomplete medical record information, and 1.2% of claim documents with incorrect primary diagnosis codes were not approved. Several previous studies have attempted to identify the causes of NHI claim returns to hospitals. Pending claims, both for outpatient and inpatient services, may result from administrative and coding errors. Another study found that factors associated with the return of NHI claims to hospitals include inaccuracies in determining the primary diagnosis and establishing secondary diagnoses in the medical record (Madakusuma et al., 2025)(Syahira et al., 2024) (Bella et al., 2024b)(Pratama et al., 2023);(Agiwahyunto et al., 2021)

Sulianti Saroso Infectious Disease Hospital, where over 90% of patients are NHI participants, has both coders and a hospital casemix team. The hospital's casemix team, consisting of general practitioners, is responsible for verifying the medical records of inpatients. The verified medical resumes are then translated into ICD-9-CM and ICD-10 diagnosis codes by coders, in accordance with applicable regulations. In this process, coders are assigned the task of coding diagnoses based on the medical resumes completed by the attending physicians.

However, the evaluation results for NHI claims at Sulianti Saroso Infectious Disease Hospital remained suboptimal. An evaluation conducted from late 2024 to early 2025 found that the pending claim rate ranged from 4% to 14% (across both inpatient and outpatient services). Of the total pending inpatient claims, approximately 80% to 90% were caused by inaccurate diagnosis and procedure coding. This poses a problem where the hospital's annual revenue target is 95 billion IDR, with a monthly target of 7–8 billion IDR. However, the actual revenue was 5.4 billion IDR in December 2024, 5.4 billion IDR in January 2025, 4.9 billion IDR in February 2025, and 4.9 billion IDR in March 2025, with an average monthly income of 3–5 billion IDR. NHI inpatient claims currently represent the largest source of revenue for Sulianti Saroso Infectious Disease Hospital. Therefore, the high number of pending inpatient claims caused by inaccurate diagnosis coding serves as the background for conducting this study (RSPI, 2025)

Therefore, it is necessary to evaluate coders individually. This background becomes the rationale for conducting this study, specifically to understand why there has been no improvement in financial performance as measured by the percentage of Verification Result Report acceptance at Sulianti Saroso Infectious Disease Hospital. Furthermore, the study aims to identify the factors that influence coders' performance quality.

Several previous studies have found that there are multiple factors affecting the quality of performance of verifiers/casemix personnel/human resources involved in the NHI claims process, such as demographic factors, knowledge, job satisfaction, infrastructure, training, and organizational support (Arikusnadi & Kadri, 2022); (Lutfiatun Nadibah Herman, Sustin Farlinda, Efri Tri Ardianto & Kes, 2020);(Putri et al., 2020); (Fauzan, 2022); (Niat et al., 2018). The implementation of claims management is expected to improve diagnostic coding accuracy, thereby increasing the likelihood of successful NHI claims. Therefore, the objective of this study is to analyze the factors influencing inaccurate diagnosis coding for pending NHI inpatient claims at Sulianti Saroso Infectious Disease Hospital.

Information on pending NIH inpatient claims at Sulianti Saroso Infectious Disease Hospital shows that the rates were 5.8% in December 2024, 14.3% in January 2025, 3.5% in February 2025, and 7.6% in March 2025. From the above pending inpatient claim data, it was found that inaccurate diagnosis coding accounted for 66.7% of pending claims in December 2024, 54.5% in January 2025, 70% in February 2025, and 81.8% in March 2025 (RSPI, 2025). This study examines factors associated with inaccurate diagnostic coding that lead to pending inpatient claims for NIH participants at Sulianti Saroso Infectious Disease Hospital in 2025 and delays in SSAA claim payments.

## **METHOD**

This study uses a mixed-methods approach, combining quantitative and qualitative methods. The design employed is a sequential explanatory design, beginning with the collection of quantitative data, followed by qualitative data to deepen the analysis results. The quantitative method used is an analytic observational study with a cross-sectional design. The study population was the NHI inpatient records at Sulianti Saroso Infectious Disease Hospital in December 2024 (326 records), January 2025 (306 records), February 2025 (299 records), and March 2025 (296), with a total of 1,227 records. Informants were 6 people, consisting of: 2 case mix doctors, 2 staff from the

Verification and Patient Insurance Installation, 1 Head of Medical Records Installation, and 1 Finance staff member.

The variables in the quantitative study include incomplete supporting data, differences in perception among coders, doctors, and SSAA verifiers, incomplete medical administration, coder competency and experience, incomplete medical resumes, and inaccurate or inconsistent coding. Chi-square tests were used to examine associations between categorical variables, and logistic regression was used to identify factors that significantly influence inaccurate coding. Qualitative data obtained from interviews and observations were analyzed thematically. The analysis process began with filtering and summarizing key information from interview transcripts and observation notes. Then, the data were presented in thematic narratives, grouping findings by main issues such as procedural obstacles, communication among staff, and technical factors in coding. This study has received ethical approval from the Sulianti Saroso Ethical Committee with the Number PP.07.01/D.XXXIX.14/71/1/2025

## RESULT

For the variable of incomplete supporting data, the "incomplete" category accounted for 60 cases (18.8%), while the "complete" category accounted for 365 cases (85.9%). It can be concluded that most data in this variable are complete, but 14.1% of claim documents still have incomplete supporting data. For the variable measuring differences in perception between coders and SSAA, "no difference" was observed in 352 cases (82.8%), while "difference" was observed in 73 cases (17.2%). It can be concluded that the majority of data for this variable showed no differences in perception (82.8%), while 17.2% still showed differences.

For the variable of completeness of medical administration, 69 records (16.2%) were categorized as "incomplete," while 356 records (83.8%) were categorized as "complete." Pada variabel Kompetensi dan Pengalaman koder, data kompetensi dan pengalaman coder yang "Kurang baik" sebanyak 101 berkas (23,8%), "Baik" sebanyak 324 berkas (76,2%). Dapat disimpulkan kompetensi dan pengalaman coder sudah baik namun masih ada yang memerlukan perbaikan. For the completeness variable, 98 records (23.1%) were categorized as "incomplete," while 327 records (76.9%) were "complete." It can be concluded that a considerable number of records still have incomplete medical resumes. For the variable of inaccurate/ inconsistent coding, 79 records (18.6%) were categorized as "inaccurate/ inconsistent," while 346 records (81.4%) were categorized as "accurate/consistent." It can be concluded that while the majority of the coding is already accurate and appropriate, many claim records still have inaccurate or inconsistent coding. For the variable of claim status, 94 records were categorized as "pending," and 331 records as "not pending." This means that, overall, there is still a significant number of pending claims.

Table 1.

Description of incomplete supporting data, differences in perception between coders and SSAA, completeness of medical administration, coder competency and experience, completeness of medical resumes, and coding inaccuracy (n = 425)

Variable	f	%
<i>Incomplete Supporting Data</i>		
Incomplete	60	14,1
Complete	365	85,9
<i>Perception Differences Between Coder and SSAA</i>		
No difference	352	82,8
Difference	73	17,2
<i>Completeness of Medical Administration</i>		
Incomplete	69	16,2
Complete	356	83,8
<i>Coder Competency and Experience</i>		
Poor	101	23,8
Good	324	76,2

Variable	f	%
<i>Completeness of Medical Resume</i>		
Incomplete	98	23,1
Complete	327	76,9
<i>Coding Accuracy</i>		
Inaccurate	79	18,6
Accurate	346	81,4
<i>Claim Status</i>		
Not Pending	331	77,9%
Pending	94	22,1%

The variable of incomplete supporting data has a significant effect on coding inaccuracy that leads to pending claims ( $p$ -value = 0.000), increasing the likelihood of a pending claim by 1.1 times compared to non-pending claims. The variable of perception differences between hospital coders and SSAA verifiers is considered to have a strong association with pending claims when ( $p < 0.05$ ), but no significant effect when ( $p > 0.05$ ). Multivariate analysis showed a significant relationship between SSAA-coder perception differences and pending claims ( $p = 0.000$ ), with pending claims 17.5 times more likely than those without differences. Coder competency and experience also significantly affect coding inaccuracy, resulting in pending inpatient NHI claims at Sulianti Saroso Infectious Disease Hospital ( $p$ -value = 0.000). These claims are 6.1 times more likely to be pending than those submitted with accurate coding.

Table 2.  
Bivariate Analysis

Variables	Claim Status f (%)		P value	OR (95% CI)
	Pending	Not Pending		
<i>Incomplete Supporting Data</i>				
Incomplete	58 (13,6)	2 (0,5)	0,00	265,03 (62,11-1130,95)
Complete	36 (8,5)	329 (77,4)		
<i>Perception Differences Between Coder and SSAA</i>				
No Difference	23 (5,4)	329 (77,4)	0,00	0,002 (0,000-0,009)
Difference	71 (16,7)	2 (0,5)		
<i>Completeness of Medical Administration</i>				
Incomplete	60 (14,1)	9 (2,1)	0,00	63,14 (28,81-138,38)
Complete	34 (8,0)	322 (75,8)		
<i>Coder Competency and Experience</i>				
Poor	82 (19,3)	19 (4,5)	0,00	112,21 (52,34-240,55)
Good	12 (2,8)	312 (73,4)		
<i>Completeness of Medical Resume</i>				
Incomplete	92 (21,6)	6 (1,4)	0,00	2491,67 (494,60 -12552,35)
Complete	2 (0,5)	325 (76,5)		
<i>Coding Accuracy</i>				
Inaccurate	79 (18,6)	0 (0)	0,00	23,07 (14,06-37,84)
Accurate	15 (3,5)	331 (77,9)		

Incomplete supporting data has a highly significant influence on the occurrence of pending claims. An Odds Ratio (OR) of 0.011 with a 95% Confidence Interval (CI) of 0.002–0.065 indicates that completeness of supporting data reduces the likelihood of pending claims by 1.1 times. A significant relationship was also found between perception differences and pending claims. An OR of 175.90 with a 95% CI of 32.40–954.79 indicates that differences in perception between coders and SSAA verifiers increase the likelihood of pending claims by 17.59 times. In other words, the greater the perception gap between the two parties, the higher the probability that claims will become pending.

Table 3.  
Multivariate Analysis

Variables	P value	OR	95% CI
Incomplete Supporting Data	0,000	0,01	0,00-0,07
Perception Differences between Coders and SSAA Verifiers	0,000	175,90	32,40-954,79
Coder Competency and Experience	0,000	0,06	0,02-0,20

## DISCUSSION

In the multivariate analysis, incomplete supporting data emerged as a significant factor influencing claim status, with an Odds Ratio indicating an effect on non-pending claims (OR = 0.011). This suggests that having complete supporting data can reduce the likelihood of pending claims by 1.1%. According to (Minasari et al., 2025). The completeness of supporting data is also a contributing factor to the pending claim status. This reinforces the finding that completing supporting documentation is one of the key elements in reducing the risk of pending claims. At General Haji Hospital Surabaya, incomplete claim files were also reported, specifically, the absence of attached supporting examination results, which affected the reimbursement process (Triatmaja et al., 2022).

Based on document observation, supported by in-depth interviews and quantitative data analysis, it can be concluded that incomplete supporting data affects coding inaccuracies. Document observation revealed that in the majority of cases (82.8%), no differences in perception were found between coders and BPJS; however, 17.2% of the samples showed differences in perception. Bivariate analysis showed a significant relationship between perception differences and the pending claim status ( $p = 0.000$ ), with an extremely low Odds Ratio (OR = 0.002), indicating a strong correlation. Furthermore, logistic regression analysis confirmed that this variable is significant, with an OR of 17.90, indicating that differences in perception between coders and SSAA verifiers increase the likelihood of pending claims by 17,90 times.

Document observations showed that 16.2% of medical administration records were incomplete, which was significantly associated with pending claims ( $p = 0.000$ , OR = 63.14). This confirms that complete and clear medical documentation facilitates verification and accelerates claim approval. Although the medical administration variable was removed from the multivariate model, the strong bivariate results indicate that it remains clinically and operationally important. Optimizing medical administration through internal Standard Operating Procedures that are aligned with SSAA guidelines is a key recommendation. From the interviews with all informants, it was stated that incomplete medical administration also contributes to pending claims. "Incomplete medical administration is one of the contributing factors to pending claims, as SSAA considers inaccurate diagnosis coding to result from such incompleteness." (Informan CM2)

Inpatient pending claims of SSAA for Health in 2023 at Islamic Hospital Jakarta Pondok Kopi were reported to be partly caused by administrative aspects (Sri Mulya et al., 2024). Based on document observations, supported by in-depth interviews and quantitative data analysis, it can be concluded that incomplete medical administration also contributes to coding inaccuracies, which, in turn, lead to pending claims.

Univariate results showed that 23.8% of coders had poor competency and experience, which had a significant impact on pending claim status ( $p = 0.000$ , OR = 112.211). Multivariate analysis also demonstrated a significant association between this variable and pending claims, with an OR of 0.061, indicating that greater coder competency and experience reduce the likelihood of pending claims by 6.1%. Coders who are careless, inexperienced, and have misperceptions cause coding errors (Ekawati et al., 2024). In line to (Dhamigus & Nurwahyuni, 2024) which states that coder competency and knowledge are important factors influencing pending claims.

The informants also strongly emphasized that ongoing experience and training are important to improve coder competency and expertise, as coders play a crucial role in ensuring coding accuracy. More experienced coders are better at identifying potential coding issues that can lead to pending claims (Alik, 2016), making regular training and focused work essential for improving coding quality. "It plays a big role. Coders with extensive experience in NHI coding claims definitely understand which parts are likely to be flagged as pending by SSAA," (Informant CM1).

Based on document observations, supported by in-depth interviews and quantitative data analysis, it can be concluded that coder competency and experience influence coding inaccuracies that lead to pending claims. A complete medical resume was found in 76.9% of the samples, with a significant relationship to claim status ( $p = 0.000$ ; OR 2,491.667), indicating that a complete medical resume is a crucial determinant of successful non-pending claims.

Although this variable was eliminated in the multivariate stage, bivariate findings, observations, and interviews with all informants indicate that the completeness of the medical resume is a critical aspect because it serves as the primary source of information for coders in determining the correct diagnosis codes. "A clear medical resume definitely contributes to accurate coding. If the medical resume is incomplete, coding is often inaccurate, which leads to pending claims by NHI and delays in payment," (Informant VPP1). Based on document observation, supported by in-depth interviews and quantitative data analysis, it can be concluded that incomplete medical resumes have a strong influence on coding inaccuracies that lead to pending claims.

Overall, the quantitative data, from univariate to multivariate analyses, strongly support the significant influence of incomplete supporting data, differences in perception between coders and SSAA, and coder competency on the pending claim status of NHI inpatient cases. Variables such as medical administration, completeness of the medical resume, and coding inaccuracy also play important roles from both bivariate and operational perspectives.

Observations and interviews with informants provided additional insights, reinforcing the understanding that regular training, strong team coordination, complete medical documentation, and alignment of internal SOPs with BPJS regulations are key to improving coding accuracy and reducing pending claims.

Therefore, strategic interventions targeting these variables are the main recommendations for hospital management to improve JKN claim performance. "Our pending inpatient claims at Sulianti Saroso Infectious Disease Hospital aren't that high in number, but yes, the main reason is often coding discrepancies. That doesn't necessarily mean our coders are always wrong, even though there are a few mistakes. Often, the issue is a difference in interpretation of the diagnosis codes between our coders and SSAA. We frequently hold meetings with SSAA after claims are marked pending, where we present our arguments to support the codes we've used, and many times SSAA eventually agrees, though sometimes we do have to accept the codes they assign," (Informant MR).

## **CONCLUSION**

This study found that the incompleteness of supporting data, differences in perception between hospital coders and SSAA verifiers, and the competence and experience of coders are the primary factors significantly affecting the occurrence of pending inpatient NHI claims at Sulianti Saroso Infectious Disease Hospital. Additionally, the completeness of medical administration and medical resumes also play important roles, although they may not always show statistical significance in multivariate analysis. Coding inaccuracies stemming from these factors are the main causes of pending claims. Therefore, improving medical documentation, providing coder training, and enhancing coordination between hospitals and SSAA are essential to reduce the number of delayed claims.

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