



# The Impact of BPJS Health Post-Claim Refunds on Hospital Administrative Services

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**Abstract:** A high rate of post-claim refunds indicates challenges in the claims administration process, including incomplete documentation, administrative errors, and inconsistencies with BPJS Kesehatan verification standards. These issues may delay claim payments and affect hospital financial and operational performance. This study aimed to analyze the impact of post-claim refunds on hospital administrative services. This study employed a qualitative descriptive approach. Data were collected through in-depth interviews, observations, focus group discussions, and document reviews. Data were analyzed using the interactive model of Miles and Huberman, which consists of data reduction, data display, and conclusion drawing and verification. The results showed that post-claim refunds from BPJS Kesehatan have significant implications for hospital administrative services. Delays in claim reimbursement disrupt cash flow, reduce financial liquidity, and complicate budget planning. Furthermore, the refund process increases administrative workload, requires intensive coordination among hospital units, and may delay the procurement of facilities, payment of service incentives, and other operational activities. These conditions can affect administrative efficiency and the continuity of healthcare services. In conclusion, post-claim refunds have substantial impacts on hospital administrative and financial management. Strengthening claim verification procedures, improving documentation quality, and enhancing coordination among related units are necessary to minimize refund occurrences and support the sustainability of hospital services.

**Keywords:** BPJS Kesehatan; Claim refund; Financial management; Healthcare services; Hospital administration.

## Introduction

The National Health Insurance Program (Jaminan Kesehatan Nasional/JKN) is a strategic initiative aimed at ensuring equitable access to healthcare services for all Indonesians. The program is financed through participant contributions and government subsidies for eligible populations, while healthcare services are delivered through healthcare facilities that collaborate with BPJS Kesehatan. As the administrator of JKN, BPJS Kesehatan is responsible for managing membership, verifying claims, processing payments, and maintaining the sustainability of the national health financing system (Nurlianti et al., 2024).

The effectiveness of the JKN financing system is strongly influenced by the quality of claims administration, as inaccurate documentation, coding errors, and inefficient administrative processes may lead to delayed payments and increased pending claims, thereby affecting financial flow and system performance (Arifin & Puspitasari, 2024; Mathar et al., 2025; Paramarta et al., 2025). Accurate and timely claim management is essential because claims constitute the primary reimbursement mechanism for healthcare facilities under the JKN scheme (Donneli, 2026). In general, most BPJS claims are categorized as eligible, indicating that the submitted documents comply with administrative and medical verification requirements (Regina & Fauzi, 2024; Septian & Nurjayanti, 2025). This

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condition reflects the ability of healthcare facilities to meet BPJS Kesehatan standards and maintain orderly claim administration (BPJS Kesehatan, 2021). However, claim returns or refunds still occur due to incomplete documentation, coding inaccuracies, administrative errors, and discrepancies identified during the verification process (Sari & Hidayat, 2023).

Several studies have highlighted challenges in health insurance claim management. Research conducted in Tanzania found that documentation discrepancies, coding errors, delayed submissions, weak hospital management, and limited staff understanding of claim procedures were the main causes of claim denials (Fulla et al., 2025). The study emphasized the importance of staff training, strengthening verification systems, and improving administrative governance to reduce claim problems (Regina & Fauzi, 2024; Utami et al., 2025). Similarly, a report by Permier Inc (2025) revealed that claim adjudication, denial management, and appeals processes generated an estimated annual administrative cost of USD 25.7 billion for healthcare providers in the United States. The report recommended greater use of digitalization and automation to improve efficiency in claims management (Premier Inc., 2025). Administrative inefficiencies in claim processing have also been reported to affect hospital financial performance and service sustainability (Sadhu et al., 2023).

A preliminary study at the West Nusa Tenggara Provincial General Hospital (RSUP NTB) identified a substantial number of refunds related to Post-Claim Verification (VPK) and Claims Administration Audit (AAK). Based on an interview with an Internal Verifier at the Health Financing Guarantee Installation, 3,262 refund cases were recorded in July 2024, with a total value of IDR 6,224,634,500. This figure indicates recurring challenges in claim administration, particularly regarding document completeness and compliance with BPJS Kesehatan verification standards. Such conditions may delay reimbursement and create operational and financial pressures on healthcare facilities. Delays in claim payments have been reported to disrupt hospital cash flow, affect budget planning, and reduce operational flexibility in service delivery (Tarigan et al., 2022).

The novelty of this study lies in its focus on the implications of post-claim refunds for hospital administrative services, an area that has received limited attention in previous research. Understanding these implications is important because refund processes may increase administrative workload, prolong claim settlement, disrupt financial planning, and require additional coordination among hospital units (Mathauer & Dale, 2017). Therefore, this study aims to analyze the impact of post-claim refunds on hospital administrative

services. A qualitative approach was employed because it enables an in-depth exploration of the perceptions, experiences, and interpretations of key actors involved in the claims management process, thereby providing a contextual understanding of the issue and potential improvement strategies (Denzin, 2018).

## Method

### *Research Time and Location*

This research was conducted at the West Nusa Tenggara Provincial General Hospital. The research period lasted one month, from December 1, 2025, to December 31, 2025, which included the licensing process, data collection, and validation of interview results.

### *Research Design*

This research uses a qualitative descriptive approach. Data were obtained through interviews, observations, group discussions, and document analysis, resulting in a contextual and holistic understanding of the situation under study (Creswell \* Poth, 2018).

### *Research Informants*

Informants in this study were selected using purposive sampling. Informants were divided into two categories: key informants and supporting informants. Key informants are those with direct knowledge and in-depth experience regarding the topic being studied. Supporting informants are those who provide additional information but may not have the same depth or influence as key informants. Informants were selected based on four categories: Hospital Financial Management involved in the JKN post-claim reimbursement process; Claims Management Team; Hospital Services and Support Division; BPJS Kesehatan (Social Security Agency for Health).

### *Research Instruments*

Data were collected using research instruments in the form of interview guides, documents or archives, field notes, and audio/visual recording devices.

### *Data Analysis*

Data analysis was conducted using the interactive model of Miles and Huberman (1994), which includes three main stages: data reduction, data presentation, and drawing and verifying conclusions. According to Miles and Huberman, the data collection process in qualitative research is not a stand-alone stage but rather a cyclical and interactive process, consisting of data reduction, data presentation, and drawing and verifying conclusions. During data collection, researchers

interacted directly with participants through interviews, observations, and document analysis to obtain in-depth information about the phenomenon being studied. The collected data was then immediately and continuously analyzed to identify relevant patterns, themes, and meanings.

## Result and Discussion

### Interview Results

#### Administrative Services

Based on interviews with 16 informants, post-claim refunds were perceived as affecting hospital administrative services, particularly financial management, procurement activities, facility maintenance, and operational continuity. Several informants stated that claim refunds did not directly stop healthcare services but created operational constraints due to delays in claim reimbursement.

*"Claims refunds do not stop services, but they disrupt operations, medical procurement, equipment maintenance, and maintaining optimal service quality." (IRS-1)*

*"Procurement, facility maintenance, and service development programs are the most impacted, often delayed or adjusted due to cash flow disruptions." (IRS-5)*

Informants explained that delays in claim payments affected hospital liquidity and created uncertainty in financial planning. These conditions influenced budget allocation, procurement processes, and operational expenditures.

*"Delays in BPJS claims disrupt hospital liquidity, affecting salary payments, medication, operations, budgets, medical equipment, and patient care." (IRS-2)*

*"Post-claim refunds create revenue uncertainty, disrupt operations, medical procurement, equipment maintenance, and facility targets, but hospitals maintain their targets through budget control." (IRS-2)*

Several participants from supporting units reported that refund claims affected the availability of operational budgets, particularly for laboratory materials, medical consumables, and maintenance activities.

*"Post-claim refunds have impacted the operational budget constraints of supporting units, which impacts the procurement of materials." (IRS-5)*

*"Claim refunds cause delays in the procurement of medical support facilities, potentially hampering the smooth operation of services if not anticipated." (IRS-5)*

Overall, informants indicated that although healthcare services continued to operate, claim refunds increased administrative workloads, delayed procurement activities, complicated budget management, and required continuous adjustments to maintain service quality.

#### Strategy and Mitigation

Informants identified several strategies implemented by the hospital to reduce claim refunds and minimize their operational consequences. These strategies included strengthening internal verification, improving coding accuracy, enhancing inter-unit coordination, implementing digital systems, and improving communication with BPJS Kesehatan. Hospital management emphasized the importance of policy support and internal control mechanisms.

*"Top management establishes strategic policies, strengthens internal verification, improves coding competency, and encourages cross-unit coordination." (IRS-1)*

*"Claims verification is expected to be consistent, BPJS hospital communication strengthened, and VPK feedback clear, supporting sustainable JKN financing." (IRS-1)*

Internal verifiers highlighted their role in ensuring document completeness and compliance with BPJS regulations before claims submission.

*"As an Internal Verifier, I ensure that BPJS documents, procedures, and claim data are complete and comply with regulations to prevent refunds and financial risk." (IRS-7)*

*"We are tightening internal verification, improving coordination with the DPJP and nurses, and conducting regular evaluations of previous claim findings." (IRS-6)*

Informants also emphasized the importance of improving documentation quality, coding accuracy, and administrative capacity through training and routine monitoring.

*"The main obstacles are incomplete or unclear medical records, misunderstandings of codes, or changes in BPJS regulations, so regular training and coordination with the medical team are necessary." (IRS-8)*

*"Strategies include coding audits, coder training, coordination with physicians, and an integrated*

*information system for accurate and smooth claims.” (IRS-8)*

Digitalization and standardized administrative procedures were repeatedly identified as important mitigation measures.

*“Hospitals need to ensure complete documentation in accordance with the Cooperation Agreement (PKS) and Minutes of Agreement. They need to use checklists, digitize systems, and train staff to reduce data errors.” (IRS-12)*

*“Clear BPJS guidelines and a better digitalization system are needed to reduce errors, expedite verification, and minimize claim refunds.” (IRS-11)*

From a financial perspective, several informants reported implementing adaptive budgeting and liquidity management strategies to anticipate delayed claim payments.

*“We implement flexible budget planning, provide buffers for specific items, monitor periodic revenue realization, and strengthen coordination between finance and claims units to anticipate potential claims returns.” (IRS-3)*

*“We addressed this refund by deducting the current month's main claim, so as not to disrupt ongoing operations.” (IRS-1)*

Overall, interview findings suggest that reducing post-claim refunds requires an integrated approach involving management commitment, stronger internal verification, improved documentation quality, staff competency development, digital system utilization, and effective coordination between hospitals and BPJS Kesehatan.

## Discussion

### Administrative Services

Research results show that post-claim refunds have far-reaching consequences for hospital administrative services. Claim refunds not only cause delays in disbursement of funds but also increase administrative workload through document correction, re-verification, data reconciliation, and cross-unit coordination. This situation demonstrates that the BPJS claims management system is an integrated process involving clinical services, medical records, coding, internal verification, and financial administration. When discrepancies occur in any of these components, the entire claims administration chain is impacted.

This finding supports research by Puspitasari et al., (2024) and Yuliani et al., (2024), which states that the quality of clinical documentation from supporting units

such as laboratories and radiology directly influences the validity of medical records and the accuracy of claims. In the context of this research, claim refunds are generally not only caused by simple administrative errors but also related to the quality of clinical information that forms the basis for determining diagnoses and coding INA-CBGs. Thus, refund claims can be understood as an indicator of discrepancies in information between service units that are not yet optimally integrated.

This problem is further complicated when hospitals do not have information systems capable of integrating service data in real time. Research Shriver et al., (2020) demonstrated that integration between laboratory, radiology, and electronic health record (EHR) systems can improve documentation accuracy and expedite the internal verification process. These findings are relevant to the results of this study, which showed that document correction processes due to refunds often take longer because clinical data is spread across several different work units. This situation indicates that refund claims are not solely a BPJS verification issue but also reflect the maturity level of the hospital's information system.

In addition to information system factors, the effectiveness of administrative governance is also a determining factor. (Maimun et al., 2025) found that unclear SOPs and incomplete documents were the main causes of claim delays. These findings align with this study, which showed that claim refunds often require repeated document tracing processes because not all staff share a common understanding of BPJS Kesehatan requirements. This indicates that the quality of administrative governance is determined not only by the availability of regulations but also by the consistency of their implementation across all service units.

From an organizational perspective, the impact of refund claims extends beyond the administrative aspect. The results of this study indicate that delays in claim payments impact hospitals' financial flexibility in meeting operational needs. These findings are consistent with research by (Pradani et al., 2025; Regina & Fauzi, 2024), which showed that late claims can hamper the procurement of drugs, medical consumables, facility maintenance, and budget planning. Therefore, refund claims can be viewed as a factor linking administrative aspects to the sustainability of healthcare services. The higher the refund rate, the greater the potential disruption to hospital operational stability.

The findings of this study also align with an international study conducted by (Mtei, 2023) in Tanzania. That study found that documentation errors, coding errors, and weak claims governance were the main causes of health insurance claim rejections. The similarity of patterns between Indonesia and Tanzania suggests that claims administration challenges are a

common systemic issue in social insurance-based healthcare financing schemes. Furthermore, a report by Premier Inc. (2025) showed that problematic claims correction and resolution processes incur significant administrative costs for hospitals. This suggests that refund claims are not merely a matter of administrative compliance but also have significant economic implications for the efficiency of healthcare organizations.

Based on these results, this study provides insight into the potential use of post-claim refunds as an indicator of hospital claims governance performance. The high number of refunds indicates gaps in the clinical documentation process, inter-unit coordination, and internal verification systems that need to be improved to increase the effectiveness of administrative services and the sustainability of hospital financing.

### *Strategy and Mitigation*

Research findings indicate that mitigating refund claims requires a systemic and multidimensional approach. Strategies focused solely on document improvement after a claim is returned are insufficient to sustainably reduce the frequency of refunds. Therefore, strengthening human resources, information systems, internal verification mechanisms, and management support is necessary.

One of the most widely recommended strategies in the literature is improving the competency of claims and coding officers. Research (Fulla et al., 2024) demonstrated that ongoing training can reduce administrative and coding errors, which are the primary causes of claim rejections. In the context of this research, improving competency is crucial because BPJS Kesehatan regulations continue to evolve, requiring adaptability from all officers involved in the claims process.

In addition to human resource competency, digitalizing information systems is a strategy that has a significant impact on the efficiency of claims management. Research (Oktoriani et al., 2025) shows that INA-CBGs coding errors remain a dominant factor in claim refunds. Therefore, integrating a digital verification system that allows for automatic data checking before claims submission can reduce the risk of administrative errors. This finding is supported by research by (Setiyadi et al., 2025; Wurster et al., 2024) showed that document digitization can improve data accuracy, accelerate the verification process, and reduce duplication of administrative work.

Another factor proven to be influential is the presence of internal verifiers. Research Hasibuan et al., (2025) found that internal verifiers can reduce the proportion of pending claims by checking administrative completeness, validating coding, and

evaluating documentation before files are submitted to BPJS Kesehatan. Similar results were also reported by (Yunawati et al., 2025), who emphasized that a comprehensive internal verification process can reduce the risk of file returns and improve the quality of submitted claims. In this study, the presence of internal verifiers serves as a quality control mechanism that bridges hospital administrative needs with BPJS verification standards.

However, the success of mitigation strategies does not depend solely on technical aspects. Management support is a determining factor in the successful implementation of all claims management policies. Research by (Herawati et al., 2025; Regina & Fauzi, 2024; Zalukhu & Permanasari, 2025) showed that hospitals with strong management commitment had lower refund rates due to clear internal policies, continuous training, and more effective cross-unit coordination. These findings suggest that refund claims should be positioned as a strategic organizational issue, not simply an administrative issue.

Overall, these studies demonstrate that reducing refund claims requires an integrated approach that includes improving human resource competency, digitizing information systems, strengthening internal verifier functions, and establishing accountable claims governance. This approach not only has the potential to reduce refund rates but also increases administrative efficiency, maintains hospital financial stability, and supports the sustainability of healthcare services within the National Health Insurance (JKN) system.

### **Conclusion**

Post-claim refunds have significant implications for hospital administrative services. Delays in refunds disrupt liquidity, strain cash flow, and impact budget planning and the institution's financial stability. Operationally, this situation increases administrative workloads, increases the need for cross-unit coordination, and potentially hinders the procurement of facilities, payment for services, and maintenance of service quality. Although medical services continue to operate, post-claim refunds require hospital management to make strategic adjustments to ensure operational continuity and maintain service quality.

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**Author Contributions**

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**Conflicts of Interest**

The authors declare no conflict of interest.

**References**

- Arifin, M., & Puspitasari, R. (2024). Evaluating the role of diagnostic accuracy on health insurance claims in Indonesian hospitals. *Journal of Health Services Research and Policy*, 29(3), 200–212. <https://doi.org/https://doi.org/10.1177/13558196241011234>
- Creswell, J. W. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage Publications.
- Donneli, E. (2026). Insurance claim settlement delays and their consequences for service quality and financial management. *Journal of Economic, Business & Accounting Research*, 3(2), 131–146. <https://doi.org/https://doi.org/10.61511/jembar.v3i2.2026.2034>
- Denzin, N. K., & Lincoln, Y. S. (Eds.). (2018). *The SAGE handbook of qualitative research* (5th ed.). SAGE Publications.
- Fulla, R., Basinda, N., Tupa, T., Chilipweli, P., Kapesa, A., Konje, E. T., Morona, D., & Mshana, S. E. (2025). Patterns and Mitigation Strategies for Rejected Claims Among Health Facilities Providing Services for the National Health Insurance Fund in Mwanza, Tanzania. *In Healthcare*, 13(1), 1–17. <https://doi.org/Tanzania.Hhttps://doi.org/10.3390/healthcare13030320>
- Fulla, R., Basinda, N., Tupa, T., Chilipweli, P., Kapesa, A., Konje, E. T., & Mshana, S. E. (2024). Patterns and mitigation strategies for rejected claims among NHIF-accredited hospitals. *Healthcare*, 13(3), 320. <https://doi.org/https://doi.org/10.3390/healthcare13030320>
- Hasibuan, A. K., Girsang, E., & Nasution, S. L. R. (2025). Performance evaluation of internal verifier in reducing pending inpatient claims of BPJS Kesehatan at Muhammadiyah Hospital North Sumatra 2022. *Contagion: Scientific Periodical Journal of Public Health and Coastal Health*, 7(2), 343–361. <https://doi.org/https://doi.org/10.30829/contagion.v7i2.25036>
- Herawati, P., Gurning, F. P., Islam, U., Sumatera, N., Islam, U., & Sumatera, N. (2025). Analisis Implementasi Total Quality Management Dalam Penurunan Pending Klaim Bpjs Kesehatan Pada Pelayanan Rawat Inap Di Rumah Sakit X Kabupaten. *Indonesian Journal of Health Science*, 5(4), 660–670. <https://doi.org/file:///C:/Users/limlo/Downloads/1575+IJHS.pdf>
- John W. Creswell, J. W., & Cheryl N. Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage Publications.
- Mathauer, I., & Dale, E. (2017). *Strategic purchasing for universal health coverage: Key policy issues and questions*. World Health Organization. <https://www.who.int/publications/i/item/strategic-purchasing-for-universal-health-coverage>
- Maimun, N., Natassa, J., & Ulfa, H. M. (2025). Prosedur klaim BPJS kesehatan pasien rawat jalan guna menunjang pelayanan kesehatan di rumah sakit. *Jurnal Ilmu Kesehatan Masyarakat*, 13(1), 39–4. <https://doi.org/https://doi.org/10.35328/kesmas.v13i1.2673>
- Mathar, I., Woro, O., Handayani, K., & Widowati, E. (2025). Analysis Of The Need For The Development Of A Misconduct Prevention System On National Health Insurance ( Jkn ) Claims At Hospital X \*. *Procedia Environmental Science, Engineering and Management*, 12(3), 1015–1030. <https://doi.org/https://ijhp.net/index.php/IJHP/article/view/341/464>
- Mtei, G. (2023). Determinants of rejected claims in a national health insurance scheme (evidence from Tanzania). *International Journal of Environmental Research and Public Health*, 20(19), 7009.
- Nurlianti, I., Winarti, S., Sujatmiko, P., & Mahadewi, E. P. (2024). Analysis of Fraud in National Health Insurance in Indonesia: A Literature Review. *International Journal of Health and Pharmaceutical (IJHP)*, 5(3), 476–484. <https://doi.org/https://doi.org/10.51601/ijhp.v5i3.341>
- Oktoriani, E. N., Rosarini, A., & Lubis, I. A. (2025). Analysis of ICD-9-CM coding accuracy in the reimbursement claim process for INA-CBGs compliance. *Proceeding International Conference of Innovation Science, Technology, Education, Children and Health.*, 5(1), 584–597. <https://doi.org/https://doi.org/10.62951/icistech.v5i1.215>
- Paramarta, V., Setyaji, D. T., & Guterres, A. D. (2025). Optimizing BPJS Claims Management: an Analysis of Submission Accuracy, Administrative Process Efficiency and its Impact on Hospital Financial Sustainability. *Orfai Journal*, 1(1), 8–13.

- <https://doi.org/https://doi.org/10.54443/morfa.i.v5i1.2513>
- Pradani, E. A., Lelonowati, D., & Sujianto, S. (2025). Peran manajemen rumah sakit dalam pengendalian klaim BPJS Kesehatan. *Jurnal Medicoeticolegal Dan Manajemen Rumah Sakit*, 1(1), 22–31. <https://doi.org/https://doi.org/10.18196/jmmr.6134>
- Puspitasari, S., Hidayat, A. D., & Pangestuti, A. (2024). Analysis of the Accuracy of Diagnosis and Action Codification with Reconfirmation of BPJS Inpatient Patient Claims for the January-April Period of 2024 at SLG Kediri Hospital. *Procedia of Engineering and Life Science*, 7(1), 29–37.
- Premier Inc. (2025, February 24). *Claims adjudication costs providers \$25.7 billion – \$18 billion is potentially unnecessary expense. Premier Inc.*
- Regina, P. S., & Fauzi, H. (2024). Completeness of Medical Record Files and The Timeliness of BPJS Claims on Inpatients With Bronchitis Cases at Purwokerto Islamic Hospital. *Regina, P. S., & Fauzi, H. (2024). Completeness of Medical Record Files and The Timeliness of BPJS Claims on Inpatients With Bronchitis Cases at Purwokerto Islamic Hospital*. 6, 241–245., 6(1), 241–245. <https://doi.org/https://doi.org/10.21070/pels.v6i1.1952>
- Sadhu, A. K. R., Palaparthi, H., Thota, S., Saini, V., & Ahmad, T. (2023). The Financial Transformation of Healthcare Through AI-Driven Claims Management. *European Economic Letters*, 13(5), 2054–2064. <https://doi.org/https://www.eelet.org.uk/index.php/journal/article/view/2603>
- Sari, N. W. A. A., & Hidayat, B. (2023). Analisis Faktor Penyebab Klaim Pending Pelayanan BPJS di Era JKN. *Medicina*, 54(1), 5–9. <https://doi.org/10.15562/medicina.v54i1.1203>
- Septian, I. W., & Nurjayanti, D. (2025). Factors Causing Delays in BPJS Health Inpatient Claims at Dr . Harjono S Regional General Hospital in Ponorogo Regency. *Jurnal Rekam Medis Dan Informasi Kesehatan Indonesia*, 2023(2), 46–54. <https://doi.org/https://doi.org/10.62951/jurmi.ki.v4i2.101>
- Setiyadi, A., Sumitra, I. D., Hardyanto, C., & Reza, D. (2025). KOMPUTA : Jurnal Ilmiah Komputer dan Informatika Model Sistem Digitalisi Dokumen Akreditasi untuk Mendukung Proses Validasi Oleh Asesor Menggunakan Metode Ekstraksi Transformasi dan Load Accreditation Document Digitalization System Model to Support The Va. *Komputa: Jurnal Ilmiah Komputer Dan Informatika*, 14(2), 1–9. <https://doi.org/10.34010/komputa.v14i2>
- Shriver, E. M., Pine, K., & Bohman, E. (2020). Maintenance of the Anophthalmic Socket. In T. E. Johnson (Ed.), *Anophthalmia* (pp. 129–137). Springer International Publishing. [https://doi.org/10.1007/978-3-030-29753-4\\_11](https://doi.org/10.1007/978-3-030-29753-4_11)
- Tarigan, I. N., Lestari, F. D., & Darmawan, E. S. (2022). Kesehatan Nasional Oleh Bpjs Kesehatan Di Indonesia : Sebuah Scoping Review. *Jurnal Ekonomi Kesehatan Indonesia*, 7(2), 108–123. <https://doi.org/https://doi.org/10.7454/eki.v7i2.6136>
- Utami, Y. T., Maryati, W., & Ahmad, H. (2025). Optimalisasi manajemen dalam upaya menurunkan angka pending klaim pasien BPJS rawat inap di rumah sakit. *Jurnal Ilmiah Rekam Medis Dan Informatika Kesehatan*, 15(1), 4185. <https://doi.org/https://doi.org/10.47701/infoke.s.v15i1.4185>
- Wurster, F., Beckmann, M., Cecon-stabel, N., Dittmer, K., & Jes, T. (2024). The Implementation of an Electronic Medical Record in a German Hospital and the Change in Completeness of Documentation : Longitudinal Document Analysis Corresponding Author : *JMIR Medical Informatics*, 12(1), 1–11. <https://doi.org/10.2196/47761>
- Yuliani, N., Noor, H. L., & Maryati, W. (2024). Quality of Medical Record Documentation Affects Accuracy of Diagnosis Codes in InaCBGs Claims in Hospitals. *Indonesian Journal of Global Health Research*, 6(5), 3237–3242.
- Yunawati, N. P. L., Aridayana, I. P. M., Faidah, N., & Murcittowati, P. A. S. (2025). Analysis of verification aspects associated with the return of BPJS Health claims for inpatients at RSU Surya Husadha Denpasar. *Procedia of Engineering and Life Science*, 7(1), 16–22. <https://doi.org/https://doi.org/10.21070/pels.v7i0.2093>
- Zalukhu, L. A., & Permanasari, V. Y. (2025). Scoping Review: Factors Causing Claim Pending in Indonesian Hospitals. *Jurnal Health Sains*, 6(9), 252–262. <https://doi.org/https://doi.org/10.46799/jhs.v6i9.2679>