DOI: https://doi.org/10.38035/ijphs.v3i3

Classification of Inpatient Pending Claim Factors in the RSB Sartika Asih EMR Transition

Sali Setiatin[1], Naila Salsabila Jamilah[2]
[1]Politeknik Piksi Ganesha, Bandung, Indonesia, email: salisetiatin@gmail.com
[2]Politeknik Piksi Ganesha, Bandung, Indonesia, email: nailaslsbl33@gmail.com

Corresponding Author: nailaslsbl33@gmail.com[2]

Abstract: BPJS claims are the submission of all BPJS patient care costs by healthcare facilities to BPJS. However, the submission of claims may be delayed by the BPJS verifier depending on various factors. This study was conducted at Bhayangkara TK II Sartika Asih Hospital using data on pending inpatient claims from November 2024 to January 2025. The study employed a descriptive, retrospective approach. Non-probability sampling was used to select the entire population. The analysis revealed 327 pending claim files by BPJS. The objective of the research was to identify the factors that caused pending claims during the Electronic Medical Record (EMR) transition period. Data were collected through document analysis and interviews. It was found that the BPJS claims process was not fully EMR-based, resulting in pending claims. Three main factors contributed to this issue: non-compliance with service standards (73%), coding rules (15%), and administrative completeness (11%). These factors disrupt hospital cash flow due to delays in fund disbursement and increase staff workload. To reduce the number of pending claims, it is necessary to routinely evaluate claim data by increasing coordination between related units and promoting compliance with PPK CP to prevent similar mistakes

Keyword: Factors Claim Pending, Transition, EMR, Inpatient.

INTRODUCTION

In Law No. 17 of 2023 hospitals are facilities for individual health services in a complete manner. Individual health services in full through promotive, preventive, curative, rehabilitative, and or peliative services by providing inpatient, outpatient and emergency services (Presiden RI, 2023). Plenary services can be achieved with good medical record quality, with good medical record quality services, one of the hospital's obligations in Government Regulation (PP) No. 47 of 2021 is to make, implement, and maintain health service quality standards in hospitals as a reference in serving patients .(Peraturan Pemerintah, 2021)

All health service activities in hospitals provided to patients during the treatment period must be documented in medical records. Medical record services are one of the supports to maintain the quality of service in the hospital to be plenary, medical record services include

when patients enter starting from registration, processing patient data, storing patient data, reporting, data, to claiming patient fees (Rekam et al., 2024). Electronic medical records (EMR) are medical records made using an electronic system intended for the implementation of medical records with the implementation consisting of at least, patient registration, EMR distribution, clinical information filling, EMR information processing, data entry for financing claims, EMR, EMR quality assurance and transfer of EMRcontent (Permenkes No. 24, 2022). Which is expected to replace manual medical records because EMR is considered more efficient which affects the quality of service (Latipah et al., 2021). Also with the aim of increasing the effectiveness of medical records because EMR can facilitate and accelerate the acquisition of information access (Aulia & Sari, 2023). All health care facilities are required to be electronic-based because they see the development of the times that are all based on digitalization. In filling in medical record data, medical record officers are required to fill in data completely, accurately and on time for each patient. Because one of the success of claims for health financing is the completeness of medical record documents. However, currently not all hospitals have implemented the entire medical record flow using EMR, as well as in the Bhayangkara TK II Sartika Asih Hospital which is still in the transition period to EMR.

EMR transition is a process of moving the patient health information processing recording system from a manual system to a digitized system. Especially at Bhayangkara TK II Sarika Asih Hospital, the implementation of Electronic Medical Records in the BPJS claim flow is still in the hybrid phase. Hybrid is a combination of a combination of manual medical records (paper) with the use of EMR (Asgiani et al., 2024). In the sense that this hybrid phase patient data is still physically documented and some have been digitally recorded with a computer system, this is a hospital step in the transition from manual medical records (papers) to electronic systems gradually. Because there are still some obstacles so that the EMR process in total requires a long time to improve better infrastructure.

Hospitalized patients are patient care services by health workers according to a diagnosis, or for a certain reason, which are kept for at least one day until the doctor's recommendation to be discharged because the patient's condition has improved or is healthy again .(Tugiman & Basri, n.d.)

BPJS (Badan Penyelenggara Jaminan Sosial) Is a legal entity formed to provide JKN (Jaminan Kesehatan Nasional) which is a health program for the community. BPJS is obliged to pay health care facilities for all treatment services that have been carried out to BPJS participants (Ibrahim et al., 2024). Claims are demands or bills for compensation for services that have been provided, thus BPJS claims are demands for compensation for services provided through responsible health workers (Antonius Artanto EP, 2018). In the 2018 BPJS regulation on claim administration, it is explained that claims are demands for payment for health services that have been provided to participants by health care facilities that cooperate with BPJS (BPJS Kesehatan, 2018). The BPJS claim process requires accuracy because the claim process is continuous with the provisions of the INA-CBGs guidelines, where BPJS only covers costs that are included in the INA-CBGs package and in accordance with clinical guidelines. INA-CBGs System (Indonesian Case-Based Group) Is a system used for the BPJS claim process, the INA-CBGs system applies payment in a prospective manner. INA-CBGs (Case Based Groups) guidelines in the implementation of health insurance the process of determining the tariff starts from the patient leaving the hospital (Kementerian Kesehatan Republik Indonesia, 2021). Prospective payment or also known as casemix (case based payment) is a payment system to hospitals where the tariff has been determined, based on the grouping of diagnoses and actions. The basis for grouping INA-CBGs with a codification system of diagnoses and actions that become service outputs by referring to ICD-10 for codifying diagnoses and ICD-9 for codifying actions.

Pending claims are claim files that are returned by BPJS health if the claim file does not meet the requirements and does not pass verification with this the hospital is required to re-check and re-complete the pending file (Maulida & Djunawan, 2022). In the BPJS claim process, not all BPJS claims are approved by the verifier from the BPJS, so there will be pending claims, where the BPJS returns the inappropriate claim file to the hospital. Therefore, the author's aim by raising the title "Classification of factors causing pending claims in the RME transition at Bhayangkara TK II Sartika asih Hospital" is to analyze what are the classification of factors causing pending claims in the RME transition at Bhayangkara TK II Sartika Asih Hospital.

This research is in line with research conducted by Julia et al (2024) with research on the Causes of Return of BPJS Inpatient Claims Quarter 1 Year 2024 at RSI Sultan Agung Semarang found that the cause of pending claims is inaccurate diagnosis codes, incomplete supporting documents and differences in perceptions with BPJS perivators (Rizki et al., 2025). Also in line with research conducted by Endah et al (2024) who examined the Pending Factors of Inpatient Claims at Qim Batang Hospital in 2022 from this study it was found that (68.11%) pending claims were due to coding aspects due to inaccurate coding errors, code reselection, and double coding, from the results of this study training is needed to improve coder skills (Widaningtyas et al., 2024). from these findings it is found that each hospital has factors that cause various pending claims as well as at the Bhayangjara TK II Sartika Asih Hospital.

METHOD

This journal research uses descriptive research with a retrospective approach. Descriptive research is research by describing a phenomenon systematically. This research also focuses on providing a description of an object or phenomenon without explaining the relationship between variables with the aim of making a description of the description or painting systematically factual and accurate about the phenomenon under study (Susanti, 2018). This research with a retrospective approach is research in the form of observing an event that has occurred or past with the aim of finding factors related to the cause (Sugiyono, 1967). Therefore, retrospective approach description research is a type of non-experimental research that is only aimed at describing a phenomenon based on past data.

Data collection techniques with documentation / archival studies, namely by reviewing using BPJS pending claim documents for the period November 2024 to January 2025, data collection by involving one casemix officer who is directly involved in the BPJS claim process and one inpatient coder officer as a respondent for in-depth interviews regarding the BPJS claim process at Bhayangkara TK II Sartika Asih Hospital. The sample collection technique with Non Probability Sampling technique where the sample is selected is the result of the entire population of pending claims November 2024 to January 2025. This research data is processed by collecting, editing, tabulating carried out with descriptive analysis and processed and the results are presented in the form of tables and graphs with the aim of being easy to understand.

RESULT AND DISCUSSION

Implementation of BPJS Claims in the Electronic Medical Record Transition at Bhayangkara TK II Sartika Asih Hospital.

From the results of interviews with one casemix employee, namely as an inpatient coder at Bhayangkara Hospital TK Sartika asih, it was found that the flow of inpatient BPJS claims with the application of RME starts from the patient entering the list by bringing a

letter of introduction to hospitalization and then inputted into SIMRS (Hospital Management Information System) and the beginning of making SEP (Participant Eligibility Letter) inpatient, after the inpatient service is completed or the patient goes home then administrative verification is carried out, also called Billing, namely administrative checking by officers with the following requirements:

A. Main Requirements
1. SEP
2. SPRI must be complete
3. Medical resume must be complete
4. Triage (specifically for emergency room patients)

B. Additional Requirements
1. Operation Case (Operation Report)
2. Odontectomy case (Panoramic result, operation report)
3. Trauma / injury / accident cases other than ASABRI traffic accidents, BPJS TK (From the chronology must be in accordance with the medical resume)
4. Obstetric cases (SHK, OBGYN Triage if the patient enters the emergency room)
5. Ventilator cases (Ventilator Resume)
6. TB cases (SITB sheet)
7. Jasa Raharja cases (Refusal letter / underwriting of Jasa Raharja)
8. ASABRI case (ASABRI guarantee letter)

After billing for verification, the files that pass are sent to casemix with automatic input by SIMRS and the physical file (paper) is sent to the casemix room by the inpatient admin for further internal medical file verification, as well as coding according to the rules of ICD 10 and ICD 9 cm. Internal medical file verification is carried out by the medical file verifier of the casemix unit and is also carried out by the coder. Based on the results of the interview, internal medical file verification is the process of rechecking and evaluating claim files by competent medical personnel to assess whether the medical actions performed are in accordance with the patient's clinical indications and in accordance with standard procedures. The internal file verification procedure at this hospital is in accordance with the general procedure according to BPJS health regulation No. 2 of 2018 concerning claim verification procedures stipulates that for medical file verification, health facilities must prepare:

1. Complete claim documents according to the type of service (inpatient, outpatient, ICU etc.),
2. Authentic medical data signed by the DPJP (Doctor in Charge of the Patient),
3. Supporting documents for service results that are in accordance with the provisions of the INA-CBG code,
4. Minutes of referral or referral back if needed.

After verification of medical files, files that do not pass medical file verification will be returned to the room to be asked to be completed while files that pass verification are then scanned, the meaning of scanning here is downloading the files needed from virtual claims, namely downloading supporting files according to the criteria and conditions with the diagnosis. Downloaded files from virtual claims are put together in one filing folder. Complete files are then uploaded to VIBI (Virtual INA-CBGs) in text (txt) format and other files to JKN Drive. After uploading, billing minutes will appear. The BPJS will carry out a verification process for 20 working days from after the file is sent to the BPJS, after which it

will appear with a statement that the claim is eligible to be paid directly for disbursement to the hospital and with the pending claim category, it will be returned to the hospital.
From the results of the researcher's interview with the casemix officer, it was found that the flow of BPJS inpatient claims was still not fully using RME, still transitioning between manual to electronic but already hybrid. Therefore, this raises several factors why claims are pending by BPJS.

Classification of factors causing pending claims at Bhayangkara TK II Sartika Asih Hospital.

Based on the results of the analysis of factors causing pending claims with a three-month time frame, namely November 2024 to January 2025 as follows:

Table 1 percentage of factors causing pending claims in November 2024

NO	Category	Number	Percentage
1	Service Standar	21	55%
2	Coding Rules	5	13%
3	Completeness Administration	12	32%
	Total	38	100%

The results of the analysis of factors causing pending claims in November are: 55% service standards, 13% coding rules and 32% administrative completeness. From table I in November the overall result of pending claims is 38 pending files, the November pending results analyzed are the results of the remaining claim files that have been resubmitted for BPJS claims.

Table 2 percentage of factors causing pending claims in December 2024

No	Category	Number	Percentage
1	Service Standar	17	53%
2	Coding Rules	6	19%
3	Completeness Administration	9	28%
	Total	32	100%

The results of the analysis of factors causing pending claims in December are: 53% service standards, 19% coding rules and 28% administrative completeness. From table II in December the overall result of pending claims is 32 files. Where the files analyzed are the result of the remaining claim files that have been resubmitted for BPJS claims.

Table 3 Percentage of factors causing pending claims in January

No	Category	Number	Precentage
1	Service Standar	203	80%
2	Coding Rules	37	14%
3	Completeness Administration	17	6%
	Total	257	100%

The results of the analysis of factors causing pending claims in January are: 80% service standards, 14% coding rules, 6% administrative completeness. From table III in January the overall result of pending claims is 257 files.

From the results of the analysis of the three tables above, namely during the period November 2024 to January 2025 that there were 327 pending claim files returned to the hospital, it was found that the factors causing claims in the RME transition at Bhayangkara TK II Sartika Asih Hospital were classified into three causal factors, namely the 73% service standard factor, 15% coding rules,

and 11% administrative completeness. these three causal factors are what every month become a factor in pending claims at Bhayangkara TK II Sartika Asih Hospital. Can be seen in the following diagram:

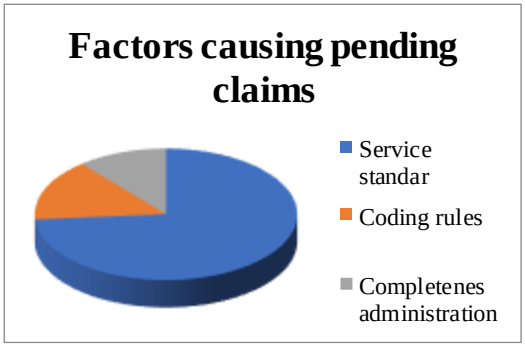

Figure 1 Factors causing pending claims for the period November 2024 - January 2025

Based on Figure 1, it is known that the biggest factor causing pending claims is the standard of service factor, the second is the coding rules and the third is the completeness of the administration. The three factors causing pending claims are continuous with how the implementation of RME at Bhayangkara TK II Sartika Asih Hospital is still in transition.

It is known that the results of the interview, namely the implementation of BPJS claims, are still in the transition and hybrid process, so the results of the analysis show that of the 327 pending claim files, the factors causing pending claims can be classified, namely service standards, coding rules and administrative completeness.

1. Service Standards

   Service standards in the analysis results are the factor with the largest percentage of pending claims in the period November 2024 to January 2025. Service Standards are a series of procedures and requirements that must be met by officers from the start of the patient registering, getting services or actions until the patient goes home. from the results of the analysis of pending claims due to standard factors, the most examples of cases are.
   Example 1:
   "Submission of claims is not appropriate, treatment in Bhayangkara 1A class 3 but billed in class 2" this case example occurs because in Bhayangkara Hospital TK II Sartika Asih in one room has several classes Example: Bhayangkara room: rooms 1A, 1B, 1C, 8A, 8B, 8C (class 3), rooms 6A, 6B, 7A, 7B (class 2), rooms 2-5, 9-11 (class 1). This causes a pending mismatch between the class of service and the class when submitting a BPJS claim due to human error, from the results of the interview this can be caused by officers lack of focus, so from the files that are pending due to the example of the case must be re-evaluated and corrected by the officer concerned and then submitted again for BPJS claims. Example 2:
   "claim submission is not in accordance with the indication of hospitalization billed outpatient"
   with an example of an Odontectomy case of at least 2 and even more than 2 teeth submitted for an inpatient claim, if less than two then it must be billed outpatient. So from this pending case it must indeed be billed to outpatient because according to the 2019 agreement BA odontectomy matrix records for inpatient cases are carried out more than 2 impaction tooth elements.

2. Coding Rules

The factor of pending claims due to coding rules is the second most common factor from the analysis results. Basically, the coding rules for patient diagnoses are carried out by coders and must be in accordance with the ICD 10 and ICD 9 cm coding rules. Misplacement of primary and secondary diagnoses is also one of the factors of non compliance with coding rules, the placement of primary and secondary diagnoses is differentiated based on the largest and most performed resources and the cause of the patient being hospitalized (Kusumawati & Pujiyanto, 2020). According to the results of interviews, factors with the category of coding rules can occur due to inaccurate coding of diagnoses, coders do not focus when there is a merge code, which is a rule where there are diagnoses suffered by patients but with certain rules must be an integrated code and code reselection that is not in accordance with health criteria, examples of coding rules factors that are suspended by BPJS at Bhayangkara TK II Sartika Asih Hospital, for example. Example 1:

"Amputation of the toe is inputted as ankle amputation"

Pending cases like this can occur because the coder is less careful, where the classification of the amputation code must be in accordance with the procedure given if the toe is amputated then the action code must be amputation of the toe, if the input is ankle amputation then the INA-CBGs rate is also different. Therefore, it is returned by the BPJS verifier to be revised again according to the correct rules. Conton 2:

"Recoding I11.0 with I11.9"

For examples of cases like this occur when the placement of the diagnosis is not in accordance with the support, the explanation of code I11.0 is hypertensive heart disease with (congestive) heart failure, namely hypertension with congenital heart failure, while the definition of code I11.9 is hypertensive heart disease without heart failure, namely hypertension disease not accompanied by heart failure. From this case example, why the BPJS verifier returned the file because the diagnosis code submitted by the claim did not have supporting support for the category of heart disease, namely echocardiogram or echocardiography. So the BPJS verifier returns with the direction that the code must be changed to I11.9, and the hospital must revise the appropriate code so that the claim can be submitted again to the BPJS.

The factors returned by the BPJS verifier to the hospital because of the coding rules are not all due to coder errors, the following are excerpts from interviews with coder officers at Bhayangkara TK II Sartika Asih Hospital:

"Pending cases due to coding rules are not solely due to coder errors, but the BPJS verifier ensures and asks again whether the coding is in accordance with the proposed diagnosis and support, while the diagnosis code is correct."

3. Administrative Completeness

The administrative completeness factor also greatly influences the occurrence of pending claims, from the results of interviews with officers the administrative completeness aspect includes at least SEP, Hospitalization Order (SPRI), medical resume, proof of service and other supporting files in accordance with the diagnosis and procedures performed. Because the Bhayangkara TK II Sartika Asih Hospital is still transitioning to RME and hybrid so that the previous treatment history is still in the form of paper, so that it triggers why claims are pending due to administrative incompleteness, administrative completeness is very influential for the smooth submission of BPJS claims. In the administrative completeness factor, the most pending cases are incomplete medical support files, example 1:

"There is no Echocardiography supporting attachment for CHD (Congenitah Heart Disease), which is congenital heart disease".

This case example can occur because there is a disturbance during manual scanning, for supporting echocardiogram and echocardiography the electronic form is not yet in SIMRS, therefore it must be scanned manually by the officer, the following is an explanation from the respondent:

"For the example of this case, the patient is an old patient, and for supporting Echocardiography already exists but is still in the form of a papper because the validity period of echocardiography is 1 year, therefore it must be scanned manually, at the time of the manual scan the hospital has scanned the supporting results but it could be that during the scan an error occurred, so the support that was scanned manually was not scanned properly and this would cause the supporting file to be missing when sent for BPJS claims ".

This is in accordance with the BA agreement.

Impact of Pending Claims for Bhayangkara TK II Sartika Asih Hospital

Impact on Hospital revenue, cash flow flaw, payment for BPJS claims is by prospective method, which will be paid at the end or after the service is carried out, if the service has been carried out and the file submission is returned then it hinders disbursement and payment becomes late or not on time, and will affect financial stability so that it can cause disruption of pharmaceutical supplier payments, delay the purchase of new medical devices due to having to revise the file again and submit a claim again for the disbursement of financial inflows to the hospital, it will also have an impact on officer performance because pending continues to accumulate it will cause an increased workload to revise files and submit claims again. Pending claims not only affect the financial administrative aspects of the hospital, but also affect the quality of service.

Evaluation and Suggestions for Reducing Pending Claims with the Same Case

With the flow of BPJS claims at Bhayangkara TK II Sartika Asih Hospital which is still in the RME transition where there are still some files that are still manual, then officers between units must be able to be more careful with each other, it requires more effective coordination between officers related to pending claims to be improved, officers involved in the implementation of BPJS claims, namely inpatient admin, billing officers, doctors in charge (DPJP) internal verifiers, inpatient coders, and all casemix officers related to submitting BPJS claims. The following are evaluations and suggestions for reducing pending claims with the same case:

1. Analyze pending claims data regularly

By analyzing the results of pending claims regularly, it can be identified what causes are usually pending, pending analysis is by collecting data on claims that have not been approved, grouping the reasons why the file is pending, for example: incomplete documents or support needed for claims. This must be coordinated with all related units so that it can be revised if there is incompleteness.

2. Socialization to officers

In general, this socialization is related to PPK CP (Clinical Pathway) compliance, which is a clinical guide that must be carried out by health care facilities, usually for health

workers and general practitioners and specialists, then socialization to coder officers that the coding can be used if there is support that matches the coding.

3. Internal verification

Before entering the coding stage, the file must first be verified by an internal verifier with the aim of rechecking the completeness of the document, to check that the diagnosis and support are aligned for coding and also to provide input for the coder when there is a diagnosis condition that still has no definite support for coding so that the officer immediately completes the supporting documents.

CONCLUSION

From the results of this study, it can be obtained identification related to the classification of factors causing pending claims in the electronic medical record transition at Bhayangkara TK II Sartika Asih Hospital, namely that the flow of implementing BPJS claims is still in the RME transition period where there are still some files that are still in the form of pepper or also called hybrid and this is one of the triggers for pending claims, there are four factors causing pending claims, namely service standards as much as (73%), coding rule factors as much as (15%) and administrative completeness factors as much as (11%). The impact of pending claims at Bhayangkara TK II Sartika Asih Hospital causes the hospital's financial stability to decrease which causes a decrease in the performance of officers due to increased workload because pending claims not only affect the financial administrative aspects of the hospital but also affect the quality of service in the hospital. Then the evaluation to reduce pending claims with the same case is: routine analysis of pending data, socialization to officers related to the flow of pending claims, internal verification is carried out first before coding.

All units related to the implementation of BPJS claims are expected to be more coordinated between their units because the implementation of claims is closely related and also affects the success of submitting claims to the BPJS, the success of BPJS claims not only affects the financial stability of the hospital but also affects the quality of service in the hospital.

REFERENCES

Antonius Artanto EP. (2018). *Faktor-Faktor Penyebab Klaim Tertunda BPJS Kesehatan RSUD Dr. Kanujoso Djatiwibowo*. *4*, 122–134.

Asgiani, P., Sari, R. Y., Purwanti, E., & Suryaningsih, Y. (2024). Manajemen Rekam Medis dalam Mendukung Alih Media Medis Rekam Elektronik di RSUD Nyi Ageng Serang. *Jurnal Pengabdian Masyarakat Bangsa*, *1*(11), 2971–2975. https://doi.org/10.59837/jpmba.v1i11.614

Aulia, A.-Z. R., & Sari, I. (2023). Analisis Rekam Medis Elektronik Dalam Menunjang Efektivitas Kerja Di Unit Rekam Medis Di Rumah Sakit Hermina Pasteur. *INFOKES (Informasi Kesehatan)*, *7*(1), 21–31. https://doi.org/10.56689/infokes.v7i1.1028

BPJS Kesehatan. (2018). *Peraturan BPJS Kesehatan Nomor 7 Tahun 2018 tentang Pengelolaan Administrasi Klaim Fasilitas Kesehatan dalam Penyelenggaraan Jaminan Kesehatan*. *1712*.

Ibrahim, M. M., MAULANA, A. F., ANWAR, H. S., BILQIS, I., NURJAYANTI, T. P., MUNAWAROH, W., & MILADIYAH, Z. (2024). Faktor Penyebab Pending Klaim Bpjs Kesehatan Pasien Rawat Inap Di Rumah Sakit. *MEDICORDHIF Jurnal Rekam Medis*, *11*(2), 57–62. https://doi.org/10.59300/mjrm.v11i2.124

Kementerian Kesehatan Republik Indonesia. (2021). Peraturan Menteri Kesehatan Republik

Indonesia Nomor 26 Tahun 2021 Tentang Pedoman Indonesian Case Base Groups (INA-CBG) Dalam Pelaksanaan Jaminan Kesehatan. *Handbook*, 1–56.

Kusumawati, A. N., & Pujiyanto. (2020). Faktor-Faktor Penyebab Pending Klaim Rawat Inap di RSUD Koja Tahun 2018. *Cdk-282*, *47*(1), 25–28.

Latipah, T., Solihah, S., & Setiatin, S. (2021). Pengaruh Rekam Medis Elektronik Terhadap Peningkatan Efektivitas Pelayanan Rawat Jalan di Rumah Sakit X. *Cerdika: Jurnal Ilmiah Indonesia*, *1*(10), 1422–1434. https://doi.org/10.36418/cerdika.v1i10.215

Maulida, E. S., & Djunawan, A. (2022). Analisis Penyebab Pending Claim Berkas BPJS Kesehatan Pelayanan Rawat Inap Rumah Sakit Universitas Airlangga. *Media Kesehatan Masyarakat Indonesia*, *21*(6), 374–379. https://doi.org/10.14710/mkmi.21.6.374-379

Peraturan Pemerintah. (2021). *Peraturan Pemerintah Nomor 47 Tahun 2021 tentang Penyelenggaraan Bidang Perumahsakitan*. *086146*.

Permenkes No. 24. (2022). Peraturan Menteri Kesehatan RI No 24 tahun 2022 tentang Rekam Medis. *Peraturan Menteri Kesehatan Republik Indonesia Nomor 24 Tahun 2022*, *151*(2), 1–19.

Presiden RI. (2023). Undang-Undang Republik Indonesia Nomor 17 Tahun 2023 Tentang Kesehatan. *Undang-Undang*, *187315*, 1–300.

Rekam, P., Elektronik, M., & Rsud, D. I. (2024). *FAKTOR PENYEBAB PENDING KLAIM BPJS RAWAT INAP DENGAN*. *3*, 406–417.

Rizki, J. N., Sari, A. A., & Suprihatin, E. (2025). *Penyebab Pengembalian Klaim BPJS Rawat Inap Triwulan 1 Tahun 2024 di RSI Sultan Agung Semarang*. *6*(2), 156–167. https://doi.org/10.25047/j-remi.v6i2.5853

Sugiyono. (1967). Metode Penelitian Kuantitatif, Kualitatif Dan R&D. In *Alvabeta. CV*. https://www.academia.edu/118903676/Metode_Penelitian_Kuantitatif_Kualitatif_dan_R_and_D_Prof_Sugiono

Susanti, L. (2018). Metode Penelitian Metode Penelitian. *Metode Penelitian Kualitatif*, *17*, 43. https://r.search.yahoo.com/_ylt=AwrKBHEDddFlR34y52jLQwx.;_ylu=Y29sbwNzZzMEcG9zAzMEdnRpZAMEc2VjA3Ny/RV=2/RE=1708254595/RO=10/RU=http%3A%2F%2Flilyasusanti.lecture.ub.ac.id%2Ffiles%2F2018%2F03%2FMODUL-METODE-PENELITIAN.pdf/RK=2/RS=Xgq.5PncjZ8jLQ0YRBdftMTrPp4

Tugiman, A., & Basri, A. (n.d.). *Sistem Informasi Pembayaran Rawat Inap Pada Rumah Sakit Xyz*. *2*(2), 59–67.

Widaningtyas, E., Putri Novinawati, F., & Asmorowati, A. (2024). Analisis Pending Klaim Bpjs Rawat Inap Di Rumah Sakit Qim Batang Tahun 2022. *Avicenna : Journal of Health Research*, *7*(1), 42–53. https://doi.org/10.36419/avicenna.v7i1.1028