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Analysis of Factors Causing BPJS Kesehatan Pending Claims Based on the INA-CBGs System at Hospital X

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Abstract: The National Health Insurance (JKN) program, managed by BPJS Kesehatan, implements the Indonesian Case-Based Groups (INA-CBGs) payment system for hospital service claims. The claims submission process still frequently encounters various obstacles, resulting in some claims being placed on hold and causing delays in payments to hospitals. This study aims to identify the factors causing BPJS Kesehatan claims to be pending under the INA-CBGs system at Hospital X. This study employs a qualitative method with a descriptive-analytical approach. Data were collected through in-depth interviews with medical records staff, coding staff, and claims staff, as well as through observation and a review of documentation regarding pending claims files. Data analysis was conducted using the Miles and Huberman model, which involves the stages of data reduction, data presentation, and drawing conclusions. The results of the study indicate that the most common causes of pending claims are readmission cases, discrepancies between supporting diagnostic documents and medical indications, and discrepancies in medical summaries. Inconsistencies in medical records result in the claim verification process requiring document corrections or additional documentation. The findings of this study are expected to serve as a basis for hospitals to evaluate and improve their management of BPJS Kesehatan claims so that the claims process can run more effectively and efficiently and support improvements in the quality of hospital service management.
Keywords: BPJS Kesehatan, INA-CBGs, Hospital Claims, Pending Claims, Medical Records.

INTRODUCTION

According to Government Regulation of the Republic of Indonesia Number 47 of 2021 concerning the Administration of Hospital Services, a hospital is an institution that provides comprehensive individual health services, encompassing inpatient, outpatient, and emergency care (Peraturan Pemerintah, 2021). Hospitals not only function as providers of health services but also as organizations obliged to ensure that the management of healthcare financing runs effectively and appropriately, particularly in implementing the National Health Insurance

(JKN) program through the BPJS Kesehatan claims system. Outpatient services represent one of the service categories with the highest number of visits, so the management of BPJS Kesehatan claims in this area requires administrative accuracy and complete medical documentation.

In the implementation of national healthcare services, the financing system plays a crucial role in ensuring the sustainability of hospital operations. In practice, however, various obstacles are still encountered, such as delays in claim payments, pending claims, and rejection of BPJS Kesehatan claims due to incomplete documents or inaccurate coding of diagnoses and procedures. These conditions can affect hospital cash flow and, in turn, the delivery of healthcare services. In Indonesia, healthcare financing is implemented through the National Health Insurance (JKN) Program managed by BPJS Kesehatan. As an advanced referral healthcare facility, hospitals submit service claims to BPJS Kesehatan using the Indonesian Case-Based Groups (INA-CBGs) system as the basis for determining healthcare service payments (Trisna et al., 2023).

The INA-CBGs system is a healthcare service grouping mechanism that classifies the final diagnosis along with the medical procedures resulting from the service provided. The INA-CBGs system is constructed based on the grouping of diagnoses and medical procedures using the International Classification of Diseases (ICD) standard as the basis for the BPJS Kesehatan claim payment process (Zalukhu & Permanasari, 2025). In other words, the INA-CBGs system is a prospective payment system that groups diagnoses and medical procedures into predetermined tariff packages.

Although the INA-CBGs system was designed to improve the efficiency and transparency of healthcare financing, its implementation in the field does not always run optimally. In practice, the submission of BPJS Kesehatan claims still faces a number of problems. One of the most frequently encountered problems is the occurrence of pending claims, a condition in which the claim file submitted by a hospital cannot yet be further processed because there are still discrepancies or incompleteness in the documents required by BPJS Kesehatan, whether in the administrative aspect, diagnosis coding, or the medical verification process (Unggul, 2025). In outpatient services, pending claims are often related to readmission cases, discrepancies between diagnostic supporting documents and medical indications, and inconsistencies in medical resumes.

In general, a research variable refers to anything that becomes the focus of observation in a study because it possesses variation in value and can be used to explain the phenomenon under investigation. In this study, the variables examined are the various factors that cause BPJS Kesehatan pending claims under the INA-CBGs system. These factors relate to various conditions that influence the claim submission and verification process, whether arising from administrative aspects, the completeness of medical record documents, the accuracy of diagnosis and procedure coding, or the claim verification process carried out by related parties.

Pending claims can be influenced by various factors, including inaccuracies in diagnosis or procedure coding, incompleteness of medical record documents, discrepancies in the content of medical resumes, and inaccuracies in data entry within the INA-CBGs system (Mandia, 2023). Pending claims have a significant impact on a hospital's financial condition because they can hinder cash flow and delay payment for healthcare services. In addition, a high rate of pending claims also reflects problems in claim management, particularly within the medical records and clinical coding units (Amin et al., 2026).

The issue of BPJS Kesehatan pending claims does not only affect financial aspects but also influences the effectiveness of hospital services (Maharani et al., 2025). Pending claims are generally caused by incomplete documents, errors in diagnosis and procedure coding, and discrepancies in claim verification results. Hospital X in the city of Bandung, as one of the referral hospitals, also continues to face pending-claim problems in the process of submitting

claims for JKN participants. Therefore, an analysis of the factors causing pending claims under the INA-CBGs system is needed as a basis for improving claim management and enhancing the quality of hospital services.

Based on the description above, this study focuses on identifying the various factors that cause BPJS Kesehatan pending claims under the INA-CBGs system at Hospital X in the city of Bandung. This study was conducted using a descriptive analytical approach by examining the BPJS Kesehatan claim submission process based on INA-CBGs through a review of claim documents, pending-claim data, and interviews with relevant staff.

Research on BPJS Kesehatan claims and the INA-CBGs system has been widely conducted, particularly research related to the accuracy of diagnosis coding and the completeness of medical records (Amin et al., 2026). However, most studies on BPJS Kesehatan pending claims have focused more on the accuracy of diagnosis coding and the completeness of medical documents, while administrative factors, workflow, and coordination between service units have not been comprehensively examined (Zalukhu & Permanasari, 2025). Therefore, the novelty of this study lies in a more comprehensive analysis of the factors causing BPJS Kesehatan pending claims under the INA-CBGs system, encompassing administrative aspects, medical aspects, and the claim management system implemented at Hospital X in the city of Bandung.

A hospital is a healthcare institution that provides comprehensive individual health services, encompassing inpatient, outpatient, and emergency care. Under Government Regulation Number 47 of 2021 concerning the Administration of Hospital Services, hospitals have the primary function of providing high-quality, safe, and sustainable healthcare services (Peraturan Pemerintah, 2021). Accordingly, hospitals not only play a role in delivering medical services to the public but also bear the responsibility of ensuring that healthcare services can be carried out optimally and sustainably.

In addition to performing its healthcare function, a hospital is also responsible for managing the healthcare financing system to ensure that its operations run smoothly. Effective and accountable financial management is an important aspect in supporting the implementation of the National Health Insurance (JKN) Program administered by BPJS Kesehatan. Consequently, the management of healthcare service claims to BPJS Kesehatan becomes an essential part of hospital management systems, as this process is directly related to the smooth financing of the healthcare services provided to patients.

According to Trisna (2023), the National Health Insurance (JKN) Program is a government program aimed at providing health protection guarantees for the entire Indonesian population through a national health insurance system managed by BPJS Kesehatan. As a public legal entity, BPJS Kesehatan is responsible for both administering and managing the health insurance program for all participants. Through the implementation of this program, the public is expected to gain easier, more equitable, and more assured access to healthcare services.

In implementing the JKN Program, hospitals, as advanced-level healthcare facilities, are obliged to submit claims to BPJS Kesehatan for the services provided to JKN participants. According to Ramadanis and Yuliza (2024), a BPJS Kesehatan claim is the payment submission process carried out by a hospital to BPJS Kesehatan in accordance with established procedures and provisions. This process involves several stages, starting from the collection of administrative documents and patients' medical data, the coding of diagnoses and procedures, through to the verification stage conducted by BPJS Kesehatan. Consequently, the accuracy and completeness of claim documents are of critical importance to ensure that the claim process runs smoothly and payments are made on time (Zalukhu & Permanasari, 2025). In outpatient services, claim documents include patient visit data, referral or control letters, medical resumes, supporting examination results, and the consistency of the diagnosis and medical procedures recorded in the INA-CBGs system.

According to Ramadanis and Yuliza (2024), the INA-CBGs system is used as a BPJS Kesehatan healthcare payment method by grouping patients' diagnoses and medical procedures into specific tariffs according to the level of service provided. The INA-CBGs system operates by grouping patients' diagnoses and medical procedures into specific tariff groups, which serve as the basis for BPJS Kesehatan claim payments (Zalukhu & Permanasari, 2025). This grouping process refers to international coding standards, namely the International Classification of Diseases, 10th Revision (ICD-10), for diagnoses, and the ICD-9 Clinical Modification (ICD-9-CM) for medical procedures.

Under the INA-CBGs system, each case group has a predetermined package tariff. This means that hospitals receive payment based on the assigned case group rather than on an itemized breakdown of individual service costs. Therefore, the accuracy of diagnosis coding, the appropriateness of medical procedures, and the completeness of supporting documents are important factors in the BPJS Kesehatan claim verification process (Maharani et al., 2025). Discrepancies in the diagnosis coding process or in the recording of medical data can affect the INA-CBGs grouping outcome and potentially lead to BPJS Kesehatan pending claims (Yulianti & Urrahmah, 2025). In outpatient services, the INA-CBGs system is used to determine the service package tariff based on the diagnosis and medical procedures provided during the patient's visit.

A BPJS Kesehatan pending claim is a condition in which a claim submitted by a hospital cannot yet be processed or paid by BPJS Kesehatan because of deficiencies or inconsistencies in the submitted claim file. This condition is temporary, meaning that the claim can still be processed once the hospital has made the necessary corrections or completed the required data.

In practice, pending claims frequently occur due to discrepancies between administrative data, patients' medical data, and the provisions applicable within the INA-CBGs (Indonesian Case Base Groups) system. This condition can hinder the claim payment process, which ultimately has the potential to affect hospital cash flow and financial stability. Furthermore, a high rate of pending claims may also indicate obstacles in claim management or in coordination among the units involved in the hospital's claim process (Zalukhu & Permanasari, 2025). In outpatient claims, pending claims can also occur due to incomplete supporting service documents, errors in inputting patient service data, or inconsistencies in follow-up visit scheduling within the BPJS Kesehatan system.

BPJS Kesehatan pending claims can be caused by various interrelated factors. From an administrative standpoint, pending claims generally occur due to incomplete or inaccurate claim documents, such as errors in patient identity data, discrepancies in the Participant Eligibility Letter (Surat Eligibilitas Peserta/SEP), or incomplete supporting documents that must be attached. Meanwhile, medical factors relate to the consistency between the diagnosis, the medical procedures performed, and the content of the medical resume with the service actually provided to the patient.

Studies conducted at other hospitals have similarly shown that incomplete medical resumes, inaccuracies in recording diagnoses and medical procedures, and staff members' limited understanding of the claim submission system are dominant factors frequently found in pending-claim files (Subastian et al., 2025). In addition, claim management aspects also contribute to the occurrence of pending claims, such as insufficient coordination among the units involved and suboptimal workflow in the claim submission process (Purwaningsing & Heryani, 2024). In outpatient services, factors causing pending claims can also be influenced by delays in entering service data, incomplete supporting examination results, and inconsistencies in patients' follow-up visit letters.

Various studies have shown that BPJS Kesehatan pending claims constitute a significant problem in Indonesian hospitals. Several studies have found that pending claims frequently occur due to incomplete claim documents and errors in the diagnosis and medical

procedure coding process. This condition requires claim files to be corrected or revised before they can be reprocessed by BPJS Kesehatan (Christy et al., 2024).

Other studies employing a qualitative approach have likewise noted that administrative and technical factors, such as incomplete or non-compliant completion of forms within the INA-CBGs system, are among the main causes of pending claims (Purwaningsing & Erwin, 2024). Based on these various research findings, it can be concluded that pending claims are not influenced by a single factor alone but result from the interrelationship of administrative factors, technical factors, and human resource factors involved in the hospital claim management process (Zalukhu & Permanasari, 2025).

Based on the theoretical review and the results of previous research, a conceptual framework can be constructed explaining that the occurrence of BPJS Kesehatan pending claims within the INA-CBGs system is influenced by several key factors, namely administrative factors, medical factors, and claim management factors (Zalukhu & Permanasari, 2025). Discrepancies or incompleteness in the data contained in claim files and medical resumes can cause claim documents to fail to meet BPJS Kesehatan's verification requirements, resulting in a pending claim status.

This conceptual framework subsequently serves as the foundation for conducting descriptive qualitative research, carried out through a review of BPJS Kesehatan pending-claim documents and interviews with staff involved in the claim management process. Through this analysis, the study is expected to identify the most dominant factors causing pending claims while providing insights that can serve as a basis for improving the claim management system at Hospital X in the city of Bandung.

METHODS

This study employed a qualitative research method with a descriptive approach. This approach was selected because the research aims to obtain an in-depth picture of the factors causing BPJS Kesehatan pending claims under the Indonesian Case-Based Groups (INA-CBGs) system at Hospital X in the city of Bandung. A descriptive qualitative design enables researchers to understand the claim submission process, workflow, and problems encountered based on actual conditions in the field (Harahap et al., 2024).

The study was conducted at Hospital X in the city of Bandung, specifically in the units directly involved in BPJS Kesehatan claim management, namely the medical records unit, the coding unit, and the claims unit. The research was planned to take place from April to June 2026, encompassing research planning, data collection and analysis, and report preparation.

The object of this study is the outpatient BPJS Kesehatan claim submission process with pending status under the INA-CBGs system at Hospital X in the city of Bandung. The scope of the object of study includes the completeness of medical resumes, the Participant Eligibility Letter (SEP), diagnostic supporting documents, supporting examination results, and INA-CBGs claim documents used in the verification process. This scope was determined to obtain information representing both the administrative and medical aspects as factors causing pending claims at the research site. The research subjects consisted of two medical records staff, two coding staff, and three claims staff directly involved in the BPJS Kesehatan claim management process (Ramadanis & Yuliza, 2024). This study also reviewed outpatient service claim files experiencing pending status to identify both administrative and medical obstacles in the BPJS Kesehatan claim submission process.

The type of data used in this study is qualitative data derived from primary data. Primary data were obtained through in-depth interviews with medical records staff, coding staff, and claims staff, as well as direct observation of the BPJS Kesehatan claim submission process (Kuncoro et al., 2025). Secondary data were obtained through documentation review of BPJS Kesehatan pending-claim files, medical resumes, claim reports, standard operating procedures (SOPs), and policies and guidelines related to the INA-CBGs system.

Data collection in this study employed several techniques, namely in-depth interviews, observation, and documentation review. Interviews were conducted in a semi-structured manner, enabling the researchers to explore in greater detail the obstacles encountered and the various factors contributing to the occurrence of BPJS Kesehatan pending claims. Observation was carried out by directly observing the workflow and claim management process, while documentation review was conducted to examine the completeness and consistency of pending-claim files (Putri & Novratilova, 2025).

Data analysis in this study was carried out qualitatively using the Miles and Huberman analysis model, which encompasses the stages of data reduction, data presentation, and drawing and verifying conclusions from the data obtained (Zulfirman, 2022). The data obtained were selected and focused on information relevant to the research objectives, then presented in narrative and tabular form to facilitate understanding, after which conclusions were drawn regarding the dominant factors causing BPJS Kesehatan pending claims under INA-CBGs (Putri & Novratilova, 2025).

To ensure the validity of the data obtained, this study applied source and method triangulation techniques, comparing information obtained from interviews, observation, and documentation review so that the data obtained could mutually support and confirm one another (Nurfajriani et al., 2024). In addition, confirmation was carried out with informants regarding the research findings to ensure the accuracy and consistency of the data obtained.

RESULTS AND DISCUSSION

Based on the results of the research conducted at Hospital X in the city of Bandung, it was found that the process of submitting BPJS Kesehatan claims under the Indonesian Case-Based Groups (INA-CBGs) system still faces several obstacles that lead to pending claims. A pending claim is a condition in which the claim file submitted by the hospital cannot yet be processed or paid by BPJS Kesehatan because of discrepancies or missing data that must first be corrected. This condition can slow down the claim payment process and indirectly affect the stability of the hospital's cash flow (Zalukhu & Permanasari, 2025).

Table 1. Outpatient BPJS Kesehatan Claim and Pending-Claim Data at Hospital X, January–March 2026

No	Month	Claims Submitted	Pending Claims	Pending (%)	Most Frequent Cause of Pending
1	January	15,451	999	6.47%	Readmission
2	February	14,197	832	5.86%	Diagnostic supporting documents not matching medical indications
3	March	13,947	848	6.08%	Inconsistency in medical resume
Total		43,595	2,679	6.15%	-

As shown in Table 1, the number of BPJS Kesehatan claims submitted during the January–March 2026 period totaled 43,595 claims, with 2,679 claims, or 6.15%, classified as pending. The highest pending-claim percentage occurred in January at 6.47%, while the lowest occurred in February at 5.86%. The most frequently identified cause of pending claims differed by month: readmission in January, discrepancies between supporting diagnostic documents and medical indications in February, and inconsistencies in medical resumes in March.

Based on interviews with medical records staff and claims staff at Hospital X in the city of Bandung, the most frequently identified causes of pending claims during the study period were readmission cases, discrepancies between diagnostic supporting documents and medical indications, and inconsistencies in medical resumes. These three factors were consistent with the results of the review of pending-claim documents for the January–March 2026 period.

Readmission cases were the most frequent cause of pending claims in January. According to the interview results, claims categorized as readmissions require further

verification by BPJS Kesehatan to confirm the appropriateness of the services provided to the patient. This additional verification process causes such claims to be delayed and require further clarification before they can be processed.

In February, the most dominant cause of pending claims was the discrepancy between diagnostic supporting documents and the medical indications stated in the claim file. According to the interviews, several files required re-examination because the attached supporting examination results did not fully support the submitted diagnosis. This condition led BPJS Kesehatan to request clarification or additional documentation before the claim process could proceed.

Meanwhile, in March, inconsistencies in medical resumes were the most frequently identified cause of pending claims. Incomplete medical resumes, or those that did not clearly describe the patient's condition and the procedures provided, required the claim verification process to undergo prior correction. Therefore, the completeness and consistency of medical resume content constitute an important aspect of the BPJS Kesehatan claim submission process.

Overall, the results indicate that the causes of BPJS Kesehatan pending claims at Hospital X in the city of Bandung during the January–March 2026 period were dominated by readmission cases, discrepancies between diagnostic supporting documents and medical indications, and inconsistencies in medical resumes. These three factors are interrelated and can affect the success of the claim verification process conducted by BPJS Kesehatan. Therefore, improvements are needed in the quality of medical documentation, the completeness of medical resumes, and the accuracy of preparing claim supporting documents to ensure a smoother verification process. With better management, it is hoped that the number of pending claims can be minimized, allowing the claim payment process to run more effectively and efficiently.

Based on the results of the research conducted at Hospital X in the city of Bandung, the process of submitting BPJS Kesehatan claims through the Indonesian Case-Based Groups (INA-CBGs) system continues to exhibit several obstacles that cause a proportion of claim files to be classified as pending. A pending claim is a condition in which the claim file submitted by the hospital cannot yet be further processed or paid by BPJS Kesehatan because discrepancies or incomplete data still need to be corrected beforehand. This condition has the potential to cause delays in the claim payment process, which can affect the hospital's cash flow, particularly when such occurrences are recurrent. The findings of several previous studies likewise indicate that pending claims remain a frequently encountered problem within the financing system of the National Health Insurance Program, as they can hinder the verification process, slow down claim settlement, and affect the smoothness of claim payments to hospitals (Klevina et al., 2026). Based on the research data, the most frequent cause of pending claims in January was readmission cases. The interview results indicate that readmission cases require additional verification because the patient received care again within a certain period, prompting BPJS Kesehatan to conduct a further review of the submitted claim. In February, the most dominant cause of pending claims was the discrepancy between diagnostic supporting documents and the medical indications recorded in the claim file. This condition required additional clarification during the verification process, delaying immediate processing of the claim. In March, inconsistencies in medical resumes were the most frequently identified cause of pending claims. Medical resumes that were incomplete or inconsistent with the diagnosis and medical procedures provided hindered the verification process and led to the return of claim files for correction.

The findings indicate that readmission cases are one of the important causes of BPJS Kesehatan pending claims. Readmission claims require a more in-depth verification process because BPJS Kesehatan needs to ensure that the services provided comply with applicable provisions. This additional verification process delays immediate claim processing,

potentially resulting in pending status. This finding is consistent with the study by Hariyanti and Cholifah (Hariyanti, 2024), which showed that readmission cases are one of the risks contributing to the occurrence of BPJS Kesehatan pending claims. That study explained that the additional verification process for readmission cases causes claim settlement to take longer, thereby requiring inter-unit coordination to minimize the occurrence of pending claims.

In addition, discrepancies between diagnostic supporting documents and medical indications are also a factor that frequently causes pending claims. Supporting examination results that do not corroborate the submitted diagnosis can raise doubts during the verification process. Therefore, the consistency between the physician's diagnosis and the attached supporting documents is of critical importance in the BPJS Kesehatan claim submission process.

Another factor identified in this study is inconsistency in medical resumes. This finding is consistent with the study by Khiko et al. (2024), which stated that the completeness of medical resumes plays an important role in the smoothness of the JKN claim submission process. Incomplete medical resumes require document correction during the verification process, thereby slowing down claim settlement. Medical resumes that are incomplete or that fail to clearly describe the patient's condition can make it difficult for verifiers to assess the eligibility of the claim. This condition results in claim files being returned for correction before they can be further processed. This finding indicates that the quality of medical documentation plays an important role in supporting the smoothness of the BPJS Kesehatan claim process.

These three factors play an important role in determining the smoothness of the claim verification process conducted by BPJS Kesehatan. In the final analysis, the study's novelty lies in demonstrating that, beyond the coding-accuracy and document-completeness issues emphasized in prior research, administrative coordination and workflow among the medical records, coding, and claims units are equally decisive in determining whether an outpatient BPJS Kesehatan claim is processed on time or placed on pending status.

CONCLUSIONS

Conclusion

Based on the results of the research on the factors causing BPJS Kesehatan pending claims under the Indonesian Case-Based Groups (INA-CBGs) system at Hospital X in the city of Bandung, it can be concluded that the claim submission process still faces various obstacles, resulting in a portion of claim files not being processed in accordance with applicable provisions. A pending claim is a condition in which the claim file submitted by the hospital cannot yet be processed or verified by BPJS Kesehatan because discrepancies or incomplete data still need to be corrected or completed before the claim process can proceed.

The results show that the most frequently identified causes of BPJS Kesehatan pending claims at Hospital X in the city of Bandung during the January–March 2026 period were readmission cases, discrepancies between diagnostic supporting documents and medical indications, and inconsistencies in medical resumes. Readmission cases require further verification by BPJS Kesehatan, causing claims to be delayed. Discrepancies between diagnostic supporting documents and medical indications necessitate additional clarification of the submitted claim files. Meanwhile, inconsistencies in medical resumes hinder the claim verification process because the medical information recorded is incomplete or inconsistent with the services provided.

It can therefore be concluded that these three factors influence the smoothness of the BPJS Kesehatan claim verification process at Hospital X in the city of Bandung. Consequently, improvement efforts are needed through enhancing the quality of medical documentation, the completeness of medical resumes, and the accuracy of preparing and

checking claim supporting documents prior to submission to BPJS Kesehatan. These efforts are expected to reduce the number of pending claims, enabling the claim submission and payment process to run more effectively and efficiently.

Limitations

This study has several limitations. The research was conducted at a single hospital (Hospital X) in the city of Bandung and covered only the January–March 2026 period for outpatient services, so the findings cannot yet be generalized to other hospitals or to inpatient claims. In addition, the study relied on a qualitative approach involving a limited number of informants (two medical records staff, two coding staff, and three claims staff), which may not capture the full range of perspectives involved in the claim management process. The findings should therefore be interpreted within the scope of the object, time period, and setting examined in this study.

Recommendations

Therefore, continuous improvement efforts are needed to reduce the occurrence of pending claims, including completing medical resumes in a detailed and consistent manner, re-checking the completeness and consistency of claim documents prior to submission, monitoring pending cases together with an analysis of their causes, and conducting periodic claim audits. Evaluation of BPJS Kesehatan claims should also be carried out every month after the claim submission process is completed. Other improvement efforts include increasing accuracy in completing claim documents, ensuring the completeness of medical resumes, improving accuracy in preparing claim supporting documents, and conducting routine evaluations of the identified causes of pending claims, so that the number of pending claims can be minimized.

Future research is recommended to broaden the scope of study to multiple hospitals and a longer observation period, including inpatient claims, in order to obtain a more comprehensive understanding of the factors causing BPJS Kesehatan pending claims under the INA-CBGs system.

Author Contributions

Both authors made significant contributions to this study, including research conceptualization, data collection, data analysis, interpretation of results, manuscript preparation, and critical revision of the manuscript. Both authors have read and approved the final version of the manuscript for publication.

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