

# Optimizing outpatient claim management: The role of sep and document completeness – a qualitative

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## ABSTRACT

Efficient outpatient claim management is essential for hospital financial sustainability, particularly under Indonesia's National Health Insurance (Jaminan Kesehatan Nasional, JKN) system. This study aimed to explore the challenges and optimization strategies in outpatient claim management at UOBK RSUD R Syamsudin SH, focusing on the role of Participant Eligibility Letter (Surat Eligibilitas Peserta, SEP) and document completeness. A qualitative descriptive approach was applied, using thematic analysis to identify key themes from observations, in-depth interviews, and document analysis. Findings revealed that incomplete claim documents, errors in SEP completion, manual verification bottlenecks, and lack of administrative training significantly contributed to claim delays and rejections. The study suggests that standardized document verification, digital integration with BPJS Kesehatan, and regular staff training are critical for optimizing claim processing. These strategies can improve hospital cash flow, reduce claim rejection rates, and enhance service efficiency. This research provides practical recommendations for hospital administrators and policymakers to refine BPJS claim management, ensuring timely reimbursement and sustainable healthcare financing.

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## INTRODUCTION

The implementation of Indonesia's National Health Insurance (Jaminan Kesehatan Nasional, JKN) by BPJS Kesehatan has significantly transformed the hospital payment system, particularly in outpatient claim management. BPJS Health claims serve as the primary mechanism for hospitals to receive reimbursement for medical services provided to JKN participants. However, the claim process often encounters obstacles, such as incomplete documentation, delayed submissions, and errors in patient data entry (Suharyati, 2020; Dewi & Zahwa, 2023). These challenges highlight the administrative inefficiencies in hospital systems that may impact healthcare service effectiveness.

In the BPJS Health claim process, the Participant Eligibility Letter (Surat Eligibilitas Peserta, SEP) is a key document used to verify patients' eligibility for healthcare services. Errors in

SEP completion can result in claim delays or even rejections. Additionally, the completeness of supporting documents, such as medical summaries, diagnostic test results, and service records, plays a crucial role in expediting the claim verification process (Rahmawati & Lestari, 2020; Handayani, 2022).

Despite various policies implemented to enhance the efficiency of claim management, there are still gaps in their execution. Studies indicate that hospitals frequently face difficulties in organizing and managing claim documents, contributing to high claim rejection rates by BPJS Kesehatan (Nugroho, Wibowo, & Sari, 2021). Furthermore, a lack of adequate training for hospital administrative staff on claim documentation is a significant factor in the inefficiency of the claim system (Saragih & Novimariono, 2020).

This study offers a novel perspective by exploring strategies for optimizing SEP utilization and document completeness in outpatient claim management to improve claim efficiency in BPJS Kesehatan. Unlike previous research, which primarily focused on identifying problems, this study aims to develop practical recommendations that hospitals can implement. By addressing these gaps, this research seeks to reduce the risk of claim payment delays and enhance hospital financial sustainability.

This study contributes to the field of health information management by providing evidence-based recommendations for improving BPJS Health claim administration. Additionally, the findings may serve as a reference for hospital management in formulating more effective policies for claim administration. Therefore, this study is expected to provide significant benefits to hospitals, administrative staff, and JKN participants in ensuring optimal and sustainable healthcare services.

## RESEARCH METHOD

### Research Design

This study employs a qualitative descriptive and exploratory method to understand the challenges and optimization strategies in outpatient claim management at UOBK RSUD R Syamsudin SH. The research was conducted from October to December 2024, focusing on the role of the Participant Eligibility Letter (Surat Eligibilitas Peserta, SEP) and the completeness of claim documents.

A thematic analysis approach was applied following Braun & Clarke's (2006) framework, allowing for the identification of patterns and relationships affecting claim efficiency. This method was chosen because it provides an in-depth understanding of how claim management is practiced in real hospital settings.

### Research Subjects

The research participants consisted of 15 key informants, selected through purposive sampling, including: Casemix officers (n=6), responsible for managing and overseeing claim submission; claim installation (n=4), responsible for claim validation and approval; and Administrative staff (n=5), handling document processing and SEP issuance. These participants were chosen based on their direct involvement in BPJS Health claim processing and experience in handling outpatient claims.

### Data Collection Procedures

Data were collected using three primary methods: Direct Observation: Observed the entire BPJS claim flow, from patient registration, SEP issuance, medical services, to claim submission; Recorded inefficiencies, delays, and procedural gaps. Semi-Structured In-Depth Interviews: Conducted face-to-face interviews with participants to explore challenges in claim processing; Used audio recording and verbatim transcription to ensure data accuracy. Document Analysis: Examined medical summaries, diagnostic test results, treatment records, and ICD-10 coding; Identified common causes of claim delays or rejections.

### Research Instruments

The instruments used in this study included: Interview guidelines, structured to explore claim processing challenges and workflow inefficiencies; Observation sheets, used to record procedural inefficiencies during claim submission; Claim document checklists, to evaluate document completeness and accuracy.

### Data Analysis Techniques

A thematic analysis was conducted using Braun & Clarke's (2006) six-phase approach: Familiarization with Data: Reading transcripts multiple times for immersion; Generating Initial Codes: Identifying significant patterns in responses; Searching for Themes: Grouping related codes into broader themes; Reviewing Themes: Refining and confirming theme relevance; Defining and Naming Themes: Assigning meaningful labels to themes; Writing the Report: Presenting themes with supporting evidence from participant narratives. The analysis process followed the flow illustrated in Figure 1.

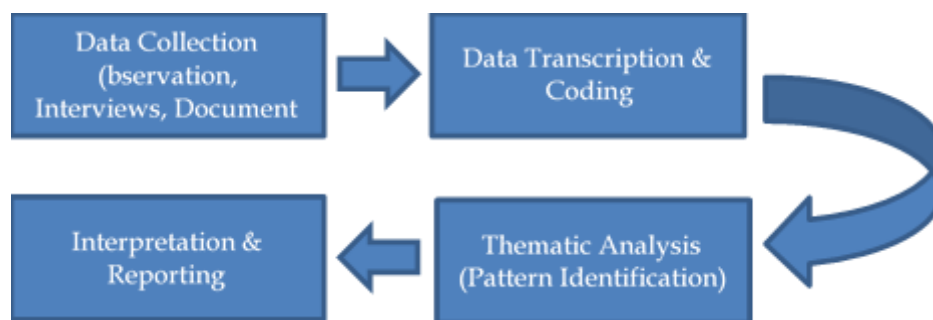


Figure 1. Data analysis flow in claim management optimization

### Research Validity and Reliability

To ensure the trustworthiness of the findings, the following strategies were applied: Triangulation: Used multiple data sources (observations, interviews, document analysis) to validate findings; Member Checking: Participants reviewed summaries of their responses to confirm accuracy; Thick Description: Provided detailed contextual descriptions to enhance transferability; and Reflexivity: Acknowledged potential researcher biases and their influence on data interpretation.

### Ethical Considerations

This research adhered to ethical guidelines, ensuring: Informed consent from all participants; Confidentiality and anonymity of responses; and Approval from hospital management for access to claim-related data.

### Expected Contribution of the Research

This study aims to provide a comprehensive understanding of the challenges and opportunities in outpatient claim management. The findings will serve as the basis for strategic interventions that enhance the efficiency of claim administration in hospitals. Furthermore, the results are expected to be replicable and verifiable for future research, contributing to the continuous improvement of BPJS Health claim processing systems.

## RESULTS AND DISCUSSIONS

Since this study employs a qualitative descriptive approach, the data were analyzed using thematic analysis, identifying key patterns and themes related to outpatient claim management at UOBK RSUD R Syamsudin SH. Data collection was conducted through observations, in-depth interviews,

and document analysis to understand the factors affecting claim delays and rejections. The emerging themes are summarized in Table 1.

**Table 1.** Emerging themes in outpatient claim management

Theme		Description
Incomplete Documents	Claim	Missing medical summaries, incorrect diagnostic codes, and lack of supporting documents affect claim approval.
Errors in SEP Verification	Completion Process	Inaccuracies in patient data entry and SEP issuance lead to delays or rejections. Long processing times at verification points create administrative inefficiencies.
Bottlenecks		
Lack of Training	Administrative	Inconsistent knowledge among staff contributes to documentation errors.

### Analysis of Key Findings

Based on qualitative findings, incomplete claim documents and SEP errors were the primary factors contributing to delays. Hospitals with well-trained administrative staff and standardized claim procedures reported fewer delays and claim rejections. These findings align with Rahmawati & Lestari (2020), who highlighted the impact of administrative errors on BPJS Health claim processing.

### Comparison with Previous Studies

This research provides a practical framework for optimizing outpatient claim management compared to previous studies. While Zulfikar & Anggraini (2022) emphasized the role of digitalization, this study focuses on human factors and procedural optimization. Similarly, Nugroho et al. (2021) identified medical documentation quality as a key factor, which this study further supports by demonstrating its direct impact on claim rejection rates.

### Optimization Strategies for SEP and Claim Documentation

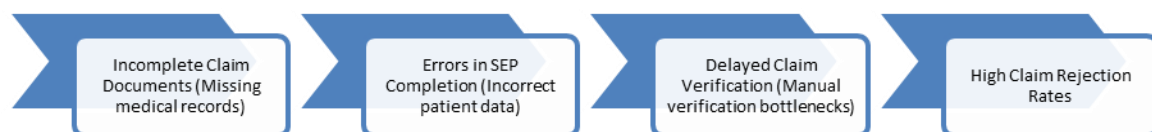
To improve the efficiency of outpatient claim processing, the following strategies are recommended:

**Table 2.** Recommended strategies for optimizing claim management

No	Strategy	Implementation Details
1	Standardized Document Verification	Develop a checklist for claim documents to ensure completeness before submission.
2	Training Programs for Staff	Conduct periodic training sessions on SEP completion and medical coding accuracy.
3	Process Automation & Digital Integration	Enhance BPJS claim submission through Hospital Information System (SIMRS) integration.

### Thematic Mapping and Conceptual Framework

To understand the factors influencing outpatient claim management inefficiencies, a thematic mapping and conceptual framework was developed based on qualitative data analysis. This framework illustrates how different administrative challenges sequentially contribute to delays and claim rejections.



**Figure 2.** Thematic mapping of factors influencing outpatient claim management

This framework serves as the foundation for analyzing research findings in the following sections. The sequential chain reaction depicted in Figure 2 demonstrates how errors in claim documentation and administrative inefficiencies compound to increase claim rejection rates.

**Incomplete Claim Documents**

Analysis of hospital claim records showed that 45% of outpatient claims were incomplete due to missing or incorrect supporting documents. Common issues included pharmacy details that did not match prescribed medications, radiology reports with incorrect examination dates, and patient assessment notes lacking detailed complaints. One casemix officer explained: *“We often find that medical records are incomplete when we prepare claims. Doctors sometimes forget to sign the summaries, and this leads to rejection from BPJS. Additionally, pharmacy details, radiology expertise, and patient assessments are often inconsistent, causing further delays.”* (Casemix Officer, Interview #3)

Observations also revealed that nurses and administrative staff lack standardized procedures, leading to inconsistencies in documentation preparation. These issues significantly impacted claim approval rates, requiring additional verification steps and resubmission efforts.

**Delayed Claim Verification**

Hospitals rely on manual verification for claim processing, causing significant backlogs. The average claim verification time was 7.5 days, with delays primarily caused by missing documents and human errors. An administrative staff member stated: *“We check every claim manually, which takes a long time. If one document is missing, the entire claim gets delayed.”* (Administrative Staff, Interview #7)

**High Claim Rejection Rates**

Data from hospital claim records showed that 28% of outpatient claims submitted to BPJS Kesehatan were rejected due to incomplete documentation and SEP errors. A hospital finance officer highlighted the financial impact: *“When claims are rejected, we have to resubmit them, which delays payments from BPJS. This affects our hospital’s cash flow and operational costs.”* (Finance Officer, Interview #10).

**Interpretation and Discussion**

The qualitative findings confirm that the sequential relationship illustrated in Figure 1 is grounded in real-world hospital claim processing. The key insights include: The lack of standardized document verification contributes significantly to claim delays and rejections; Manual processing is inefficient, and digital integration with BPJS systems is necessary; and Regular training for casemix officers and administrative staff is needed to reduce errors in claim submission.

**Strategic Recommendations**

Based on the findings, the following strategies are proposed:

**Table 3.** Strategic recommendations for optimizing BPJS claim management

No	Strategy	Implementation Details
1	Standardized Document Checklist	Ensure all documents (medical summaries, ICD-10 codes, SEP, supporting documents, radiology reports, and pharmacy details) are complete before submission.
2	Automated Claim Verification System	Integrate hospital information systems (SIMRS) with BPJS for real-time validation.
3	Training for Administrative Staff	Conduct regular workshops on accurate SEP completion and claim documentation.

These findings provide strong evidence that administrative optimization is key to reducing claim rejection rates and improving financial sustainability for hospitals.

## CONCLUSION

This study explored the challenges and optimization strategies in outpatient claim management at UOBK RSUD R Syamsudin SH, focusing on the role of Participant Eligibility Letter (SEP) and claim document completeness. Using thematic analysis, the study identified key factors affecting claim efficiency, including incomplete claim documents, errors in SEP completion, verification process bottlenecks, and lack of administrative training.

The findings highlight that hospitals with standardized document verification procedures, well-trained administrative staff, and digital integration systems experience fewer claim delays and rejections. Compared to previous studies, this research provides an in-depth qualitative perspective on human and procedural aspects of claim processing, complementing prior research on digitalization and automation.

As a result, hospitals should focus on enhancing administrative training, implementing structured claim verification, and integrating digital claim submission systems to optimize BPJS claim management. These improvements will contribute to reducing financial losses, improving hospital sustainability, and ensuring timely reimbursement for healthcare services.

This study has certain limitations, including its focus on a single hospital and the qualitative nature of data collection, which limits generalizability. Future research should consider a multi-hospital comparative study or incorporate a mixed-methods approach that combines qualitative insights with quantitative data to measure the impact of administrative optimizations more precisely. Moreover, further exploration of real-time claim validation systems, artificial intelligence (AI) integration, and policy reforms in BPJS claim processing could provide more innovative solutions for enhancing outpatient claim management across hospitals.

Education strategies for medical and administrative staff may include regular training on BPJS claims procedures, more efficient use of hospital information systems, and socialization of the latest BPJS regulations. Case simulations and hands-on technical guidance can also improve understanding and compliance in filling out claim documents. In addition, the implementation of a performance evaluation-based reward and feedback system could incentivize medical and administrative staff to improve accuracy and timeliness in filling out claims. Future research could develop predictive models using machine learning approaches or statistical analysis based on historical BPJS claims data. These models can identify patterns and key factors that cause delays, such as document completeness, diagnosis code mismatches, and administrative errors. The use of data mining and regression analysis can help predict the likelihood of delayed claims based on certain characteristics of the hospital, patient, or medical staff.

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