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Evaluation of supporting document completeness in outpatient claims to prevent BPJS claim returns at charitas Hospital Palembang

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ABSTRACT

This study examined the completeness of outpatient claim documents and how it affected the return of claims by the national health insurance agency at Charitas Hospital Palembang. Incomplete documents often delay claim verification and lead to financial loss for healthcare providers. The research used a quantitative approach and analyzed 206 outpatient claim files submitted between February and June 2025. Data were collected through observation checklists and structured questionnaires distributed to administrative staff. The findings revealed that most returned claims were caused by missing laboratory or radiology results, incomplete referral documents, and inconsistent medical records. Statistical analysis showed a strong correlation between document completeness and the frequency of returned claims. Factors such as coordination between hospital units, staff competence, and the effectiveness of hospital information systems were found to significantly influence the completeness of claim files. The study concluded that improving internal communication, enhancing staff training, and optimizing electronic record systems can reduce the risk of claim rejection and improve financial sustainability.

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INTRODUCTION

In a national health system driven by universal coverage, such as Indonesia's Jaminan Kesehatan Nasional (JKN), the effectiveness of health financing relies heavily on the accuracy and completeness of claim documentation submitted by healthcare providers (Santiasih, Simanjorang, & Satria, 2022), (Ramadanis, Yuliza, & Gusrianti, 2024). For hospitals working closely with BPJS Health—the national insurance agency—claim submission is more than just administrative work; it is the financial lifeline that supports their daily operations and ensures sustainability of service delivery (Zulaikha, 2019), (Cantika, 2023).

However, managing outpatient claims remains a persistent challenge. Delays in submitting supporting documents, incomplete medical records, and inconsistencies in clinical data often lead to claim returns (Sorensen, 2024). These administrative bottlenecks not only burden hospital staff, particularly those in medical records and finance departments, but also disrupt hospital cash flow, reduce operational efficiency, and potentially compromise the continuity of patient care (Mega & Pratiwi, 2019; Zahra, 2023).

Charitas Hospital Palembang, as one of the referral hospitals in South Sumatra, has experienced an increasing trend in outpatient claim rejections due to documentation issues. Preliminary observations show that many of these rejections stem from incomplete referral letters, delayed diagnostic results, or misaligned coding between clinical and administrative data (Rahayu & Prasetyo, 2019).

Several studies have identified factors such as poor coordination between hospital units, inadequate staff training, lack of standard operating procedures, and underutilization of hospital information systems as major contributors to claim rejection (Santoso et al., 2020; Arifin, 2022; Arikusnadi, 2020). Additionally, the absence of integrated electronic medical records has been linked to increased risks of document inconsistency and data loss during the claim process (Sittig & Singh, 2015; Menachemi & Collum, 2011).

Despite the growing body of literature, much of the existing research tends to focus on inpatient claim processing or generalized claim administration challenges, leaving outpatient claims underrepresented in scholarly discussions (IQBAL, 2022), (Ahdinur, Semiarty, & Fahmy, 2021). This study seeks to fill that gap by focusing specifically on the completeness of outpatient claim documents and how that completeness directly affects claim return rates at Charitas Hospital Palembang (Zahro, 2024), (Vionita & Khairunnisyah, 2024).

To address this problem, the research applies a structured quantitative approach to assess the level of document completeness and identify the most influential factors associated with claim rejections. Data are gathered from actual outpatient claim files and hospital administrative staff, providing both empirical and contextual insights.

The novelty of this study lies in its localized analysis and targeted emphasis on outpatient services, which remain relatively underexplored despite their significant contribution to patient volume and hospital revenue. By focusing on real-world issues in an active hospital setting, this research contributes practical recommendations that could inform hospital policies, optimize internal workflows, and support broader efforts to strengthen Indonesia’s health financing system through more efficient claims management (KARS, 2021; WHO, 2021).

RESEARCH METHOD

This research used a quantitative descriptive design with a cross-sectional approach to evaluate the completeness of outpatient claim documents and their impact on BPJS claim returns at Charitas Hospital Palembang. A quantitative method was chosen because it allows the researcher to measure, analyze, and interpret numeric data objectively, ensuring that patterns and correlations can be statistically tested (Creswell, 2018).

Research Design and Subjects

The study focused on 206 outpatient BPJS claim files submitted during February to June 2025 that had experienced return or rejection due to incomplete documentation. In addition to file analysis, data were also collected from administrative staff through structured questionnaires. The selection of documents was conducted using purposive sampling, focusing on files that met the criteria of incompleteness in supporting elements such as laboratory results, referral letters, and diagnostic documentation (Sekaran & Bougie, 2019).

Research Procedure

The course of this study was conducted in five major stages, as illustrated in Figure 1: (a) Preparation Phase: Identifying the research topic, designing the instrument, and obtaining permission from the hospital and ethical clearance. (b) Sampling Phase: Selecting claim documents and administrative staff that meet the inclusion criteria. (c) Data Collection Phase: Gathering data through checklists and Likert-scale questionnaires. (d) Data Processing Phase: Validating, coding, and inputting data into SPSS for analysis. (e) Analysis and Interpretation: Conducting descriptive and inferential statistical analysis to determine key influencing factors.

Presents the sequential stages of this research, structured to provide clarity on how the study was conducted from start to finish. The flow begins with the Preparation Phase, which involved setting the research objectives, designing instruments, and obtaining ethical approval. This was followed by the Sampling Phase, where outpatient claim documents and administrative staff were selected using purposive criteria.

Next, the Data Collection Phase focused on gathering claim document data and responses from staff using checklists and questionnaires. In the Data Processing Phase, the collected data were validated, coded, and statistically processed using SPSS. Finally, the Analysis and Interpretation Phase enabled the researchers to derive insights, assess correlations between variables, and formulate conclusions. This structured flow ensures the research maintains scientific rigor and transparency at every step.

Instrumentation and Data Collection

Two main instruments were used: (a) A document checklist to assess the completeness of the claim files (e.g., identity, diagnostic codes, lab/radiology attachments, referral documents). (b) A questionnaire using a 5-point Likert scale to measure administrative staff perceptions regarding coordination, system support (SIMRS), and their competence.

The instruments were tested for validity using Pearson Product Moment and reliability with Cronbach's Alpha. Items with a correlation coefficient > 0.3 and alpha value > 0.7 were considered acceptable (Fryer & Dinsmore, 2020).

Data Analysis Technique

The analysis was performed using descriptive statistics to summarize the level of document completeness and multiple linear regression to identify how factors such as accuracy, coordination, information systems, and staff competence affect claim returns. The regression model used is presented below:

$$Y=a+b1X1+b2X2+b3X3+b4X4+b5X5+e$$

Where:
Y : BPJS claim return
$X1$: Document accuracy
$X2$: Coordination between units
$X3$: SIMRS utilization
$X4$: Staff competence
$X5$: Claim submission flow
e : Error term

Statistical tests included t-tests (partial effect), F-tests (simultaneous effect), and R^2 to measure the strength of the model. The significance level was set at $p < 0.05$.

Ethical Considerations

The research adhered to standard ethical principles. Written consent was obtained from all staff participants after being informed about the study's purpose and confidentiality assurances. All data were anonymized and used solely for academic purposes (Cronje, 2020).

RESULTS AND DISCUSSIONS

This study analyzed 206 outpatient BPJS claim files submitted by Charitas Hospital Palembang between February and June 2025. The objective was to assess document completeness and identify major factors contributing to claim returns. The results were classified into key themes: causes of claim return, document compliance, and influencing internal factors.

Most Common Causes of Claim Return

Analysis showed that the majority of claim returns were associated with missing or incomplete supporting documents. As presented in Figure 2, the most frequent issue was incomplete laboratory results (52 cases), followed by missing referral letters (43 cases), diagnosis mismatches (38 cases), incomplete SOAP notes (32 cases), and unattached radiology reports (29 cases).

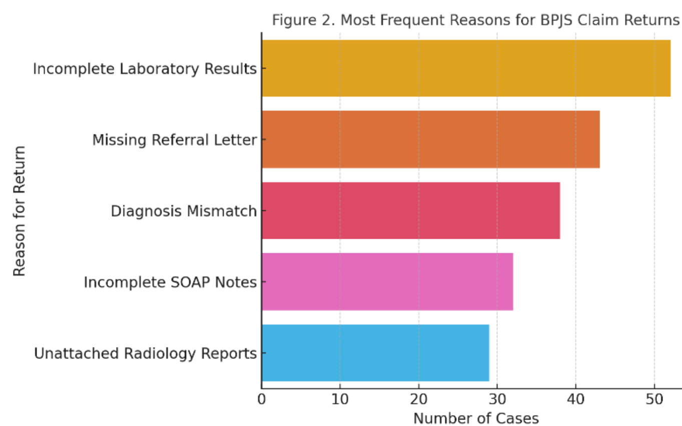

Figure 1. Most frequent reasons for BPJS claim returns

These findings highlight recurring administrative problems that can delay financial reimbursement from BPJS. The dominance of incomplete lab results and referral letters suggests a gap in interdepartmental coordination and document tracking systems. These problems are consistent with previous findings that emphasize the need for standardized document handling and more robust internal audits (Ananda & Fitri, 2021).

Document Compliance Level

Out of the 206 claim files examined, only 41.7% met full documentation standards, while the remaining 58.3% were returned for correction. This low compliance rate reflects either a lack of familiarity with BPJS claim requirements or insufficient support from hospital information systems. Several staff admitted they were unaware of updated claim submission guidelines or lacked access to complete patient data at the time of documentation.

The absence of integrated access between polyclinic units, laboratory, radiology, and medical records was cited as one of the major reasons why critical attachments were often delayed or missed. This reinforces the importance of SIMRS (Hospital Management Information Systems) integration across service units.

Staff Competence and System Utilization

A survey of 20 administrative staff revealed that only 35% had received formal training on BPJS claim procedures in the past year. Moreover, only half of them reported high confidence in using the hospital's claim submission system. The lack of routine technical guidance and training has been shown to correlate with low documentation accuracy and slower verification processes (Fryer & Dinsmore, 2020).

In addition, staff stated that the current SIMRS platform often experiences delays or outages, especially during peak submission hours. This not only hinders timely uploads of documents but also creates risks for data loss or misfiling, contributing further to claim rejection rates.

Implications for Hospital Management

The findings of this study indicate a clear need for process redesign and staff development. Interventions such as structured document validation before submission, enhanced use of electronic alerts for missing files, and regular capacity-building programs for administrative staff could significantly reduce return rates.

Furthermore, by addressing the issue of cross-unit coordination and improving system interoperability, hospitals like Charitas can enhance both financial performance and service efficiency. These changes are not merely technical—they reflect a shift toward a more accountable, responsive, and integrated health service model.

CONCLUSION

This study successfully confirmed the initial hypothesis stated in the introduction—that the completeness of outpatient claim documents significantly affects the likelihood of BPJS claim returns. Based on the analysis of 206 claim files at Charitas Hospital Palembang, it was evident that missing laboratory results, incomplete referral letters, and diagnosis mismatches were among the dominant causes of claim rejection. These findings demonstrate that administrative quality and inter-unit coordination play a crucial role in supporting smooth and timely claim submission.

Moreover, low staff competence and the limited use of integrated information systems were identified as internal factors that weaken documentation processes. This study not only provides a clearer understanding of the obstacles hospitals face in outpatient claim processing but also offers actionable insights for policy improvement and staff development.

Looking ahead, the research holds promising implications for broader applications in other hospitals facing similar challenges. Future studies could explore the use of digital checklist tools, claim prediction systems using artificial intelligence, or evaluate the long-term financial impact of claim return reduction strategies. By embracing systematic improvements, hospitals can strengthen their operational resilience and better serve patients under the national health insurance framework.

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