E-ISSN: 2986-559X, P-ISSN: 2986-6103
DOI: https://doi.org/10.38035/gijtm.v1i3
Received: 29 July 2023, Revised: 15 August 2023, Publish: 12 September 2023

Completeness of Delivery and Accuracy of Delivery Diagnosis Code On The Smooth Verification of BPJS Claims in Hospital

Nofri Heltiani[1], Lolli Nababan[2], Liza Putri[3]
[1] STIKES Sapta Bakti, Bengkulu, Indonesia, nofrihelti11@gmail.com
[2] STIKES Sapta Bakti, Bengkulu, Indonesia, lollynbb@gmail.com
[3] STIKES Sapta Bakti, Bengkulu, Indonesia, lizaputri363@gmail.com

Corresponding Author: Nofri Heltiani

Abstract: The completeness of the files and the accuracy of the diagnostic code have an important role in the smooth verification of claims and are the basis for the approval of fee billing by BPJS to Hospitals. From the results of initial observations of 10 samples of claim files for delivery cases submitted to BPJS, it was found that 4 (40%) files passed verification and 6 (60%) files were pending due to incomplete claim files such as no supporting reports and DPJP signatures and coding information which are not in accordance with BPJS Health, resulting in delays in the claim payment process which causes material losses for the Hospital. The purpose of this study was to determine the completeness of the file and the accuracy of the delivery diagnosis code for the smooth verification of BPJS claims. this type of research is observational with a descriptive design. The population in this study was 137 files with 58 samples taken by simple random sampling which were processed univariately using a frequency distribution. The results of the study were claim files for complete and smooth delivery cases 31(53%), complete claim files but not smooth verification 22(38%) and incomplete claim files and not smooth verification 5(9%), while the delivery diagnosis code was accurate and smooth verification 31(53%), diagnostic codes accurate but verification not smooth 5(9%) and diagnostic codes inaccurate and verification not smooth 22(38%). It is recommended that the Hospital should make efforts to improve the accuracy of the diagnostic code through training, monitoring and regular evaluation to minimize the occurrence of claim returns.

Keywords: Delivery Completeness, Accuracy of Delivery Diagnostic Code, Smooth BPJS Claim Verification.

INTRODUCTION

The Government of Indonesia has implemented the National Health Insurance Program (JKN) since 2014. This program aims to ensure that people receive health services in a fair

and equitable manner using a prospective financing system. The JKN program is organized by the Social Security Agency, hereinafter referred to as BPJS [1].

Health financing is very important in the implementation of JKN. BPJS as the organizer of the JKN program is obliged to finance health services [2]. According to the Regulation of the Minister of Health of the Republic of Indonesia Number 36 of 2015 [3], a claim is an application for payment of health service fees from the hospital to BPJS, before a claim application is approved the claim file must be verified first by the BPJS verifier.

Regulation of the Minister of Health of the Republic of Indonesia Number 28 of 2014 [4], states matters that affect the BPJS claim process, namely the claim file is incomplete, the claim content is not appropriate and the file submission time is too long. Completeness of files for inpatients includes complete medical record information that must be signed by the doctor in charge of health services. In addition to the completeness of the files, things that affect the smoothness of the BPJS claim process are the suitability of the code between claim sheets (BPJS) and medical resumes (hospitals). The resulting diagnosis and action codes must comply with the ICD-10 and ICD-9-CM.

According to the Ministry of the Republic of Indonesia of 2008 concerning Technical Guidelines for Claims Administration and Verification of the Community National Health Insurance Program, the complete documents for filing claims are referral letters, examinations, diagnostic support services and medical procedures that are authorized by the doctor in charge. Based on the Regulation of the Minister of Health of the Republic of Indonesia Number 903/Menkes/Per/2011 [5], if one of the requirements is missing or the items are not filled in completely it will result in the success of the claim process.

The smooth verification of claims submitted to the BPJS is influenced by the completeness of administration and the accuracy of the diagnosis and action codes between claim sheets (BPJS) and medical resumes (hospitals) in accordance with ICD-10 and ICD-9-CM, completeness of claim file requirements and completeness of information which must be signed by the Doctor in Charge of the Patient (DPJP). In documenting medical records, diagnosis and action codes on ICD-10 and ICD-9-CM are one of the important data used as a reference in determining the amount of health service costs. Medical records must be coded with reliable, correct and complete results and carried out in a timely manner so that they can be used for medical record decision making [6].

Based on a preliminary survey at the Bengkulu Hospital, it is known that the number of patient visits based on the Service and Nursing Section Annual Report Data (2021) has increased every year, but in 2020 Indonesia is facing the Covid-19 pandemic which has caused patient visits to decrease significantly. Delivery cases are one of the 15 biggest cases handled each year. This can be seen from the data for the last three years, namely in 2019 the number of visits was 272 patients with 64 (24%) failed purif claim files, in 2020 the number of visits was 87 patients with 27 (31%) failed purif claim files, and in 2021 the community began adapted to the Covid-19 pandemic so that patient visits increased by 137 (64%) patients.

From the results of initial observations of 10 samples of medical record files for delivery cases submitted to the Bengkulu Branch of Health BPJS, it was found that 4 (40%) of the files submitted to BPJS passed verification and 6 (60%) of the files were pending due to incomplete claim files (no patient supporting reports and no signature of the Doctor in Charge of the Patient (DPJP)) and coding information (related to diagnoses and the code entered on the medical resume was not in accordance with BPJS Health) with details 3 files had to be added the code of delivery action, 1 wrong code file in the 4th character and The 2 files were incorrectly coded because the code from BPJS differed from the code on the medical resume which was seen based on the results of supporting examinations, of the 6 medical record files which experienced purif failure, one of the cases was that a sectio

cesarean patient experienced post-partum bleeding placenta coded (O72.1) but on the results of the operation report the amount of hemoglobin < 500 cc so it could only be coded as delivery with normal anemia, the code can be recognized as post-partum bleeding if the amount of hemoglobin is > 500 cc so the claim file is returned by the BPJS verifier to the Hospital for correction.

Completeness of claim files and accuracy in coding a disease and action is very important because it is related to the smooth verification of BPJS claims and financing of health services, both self-paid and BPJS expenses. Based on the results of interviews with casemix officers, it was found that the files returned by the BPJS verifier were caused by the absence of patient support reports that supported the enforcement of the diagnosis by the DPJP and the code made by the coder on the medical resume sheet when verifying claims by Referral Benefit Guarantee (PMR) officers turned out to be the difference with the code from the BPJS verifier. The coder has coded according to the diagnosis written by the doctor. However, in the results of verification of BPJS claims during the coding analysis using the Venika application, several codes were found that were inaccurate and did not comply with BPJS regulations and minutes so that the files were pending and returned to the health facility for repair. This is in line with research which says that the cause of the claim file being returned several times is due to incorrect coding information. The completeness of the claim file and the accuracy of the code are the main requirements in order to pass verification [7].

Returning claim files has an impact on hospitals because it slows down the claim payment process which can cause material losses [8]. In addition, losses from the hospital as a result of claims submitted failing purif due to inaccurate diagnosis codes will also affect the quality of the medical record unit and the workload of officers will increase. Therefore, before a claim is submitted to BPJS it is very important to re-evaluate by the hospital's internal verifier for the accuracy of the code, the completeness of the claim file requirements and the completeness of the documentation before being submitted to BPJS so that claims are not returned and are directly verified by BPJS.

Given the frequent occurrence of pending during the process of verifying former claims for labor cases because there were no patient support reports that supported the enforcement of the diagnosis by the DPJP and the diagnosis codes were inaccurate because the diagnosis of labor cases differed from other disease diagnosis codes and was more detailed, so errors often occurred in writing the code. diagnosis by the coder, apart from that besides that the hospital does not yet have an internal evaluator to audit before the claim files are sent to BPJS, therefore an effort is needed to analyze the smooth verification of BPJS claims for delivery cases at Bengkulu Hospital.

METHODS

This type of research is observational with a descriptive design. The population in this study were 137 delivery case files submitted to BPJS in 2021 with a sample of 58 files taken by simple random sampling. The instruments used in this study were observation sheets, ICD-10 and interview guidelines to observe the smoothness of claim verification seen from the completeness of the files and the accuracy of the code.

The research was conducted by observing the completeness of the BPJS claim file for delivery cases at the hospital. Observations focused on knowing the completeness of the claim file and the accuracy of the diagnostic code, then the observations were classified into 2 categories, namely the completeness of the file being complete and incomplete, the accuracy of the diagnostic code being accurate and inaccurate and the smoothness of claim verification being passed verification and pending. The results of the observations were processed univariately using the frequency distribution.

RESULTS AND DISCUSSION

Completeness of Claim Files for Childbirth Cases

The results of observing the completeness of claim files for delivery cases revealed that the number of complete claim files was 53(91%) while those that were incomplete were 5(9%).

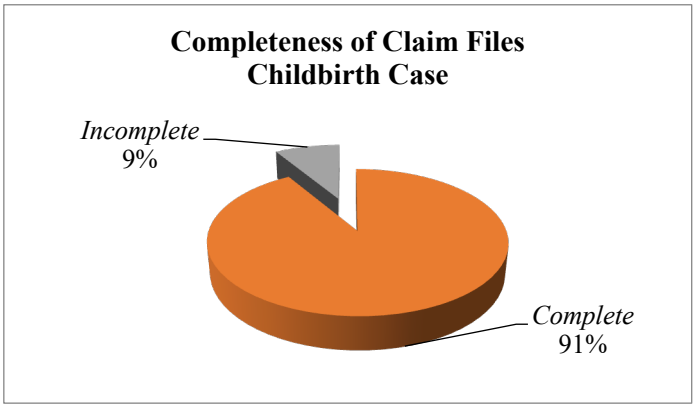

Figure 1. Completion of Claim Files for Childbirth Cases

The incompleteness of the accident case claim file was caused by the absence of supporting reports, no medical resumes and no DPJP signatures as described in the following table:

Table 1. Incomplete Claim Files for Childbirth Cases

No.RM	Category	Information
05-22-xx	Patient Reports	There is no patient support report in the labor case claim file submitted to BPJS
06-35-xx	Patient Reports	There is no patient support report in the labor case claim file submitted to BPJS
07-70-xx	Medical Resumes	There is no medical resume sheet in the labor case claim file submitted to BPJS
09-22-xx	Medical Resumes	There is no DPJP signature on the claim file medical resume
09-33-xx	Medical Resumes	There is no DPJP signature on the claim file medical resume

The completeness of the claim files based on the results of observations and interviews with the person in charge of inpatient casemix is known that the files needed for submitting BPJS claims include Participant Eligibility Letters (SEP), individual patient reports, patient support reports, medical resumes, JKN verification forms (INA-CBG's), certificate (hospitalization order, emergency letter, referral letter) and patient identity (KTP and BPJS card). Incomplete claim files submitted to BPJS from the results of the study it was found that 2 files had no patient support reports, 1 file had no medical resume and 2 files had no DPJS signature on the medical resume.

Based on the results of observations and interviews with the person in charge of the inpatient casemix, the incomplete claim file was caused by the absence of a supporting examination report and medical resume and the absence of the DPJP's signature on the medical resume, this was due to not checking the completeness of the claim file by the section officer. assembling and lack of re-checking by the coder and inputting INA-CBG's data in the casemix section.

Incomplete claim documents, especially in supporting files or patient support files which are part of the completeness of documents and claim procedures due to the lack of attention and understanding of officers towards the completeness of medical record

documents [9]. This is one of the causes of returning claim files because based on the 2004 BPJS Health Claim Verification Technical Guidelines it is explained that the BPJS verifier has the right to make conformations to officers if there is no evidence, the claim is returned to the hospital to be completed or repaired [8].

Lack of supporting sheets and medical resumes will have an impact on the accuracy of the code to be enforced, the legitimacy of billing and calculation of patient care costs because the supporting sheets are proof that the patient has performed additional services and will cause the file to be unclaimed and must be returned for completion. In line with Pitaloka & Ningsih (2021), the completeness of the claim file is a consideration for the smooth process of the BPJS claim, such as not attaching supporting report sheets to the BPJS claim requirements file for inpatients, while cases of diagnosis of the action or procedure carried out require a supporting report so that the verifier BPJS requests completeness by returning the claim file [10].

According to the Regulation of the Minister of Health of the Republic of Indonesia Number 269/Menkes/Per/III/2008 Article 4 paragraph (2) [11], the signature of the DPJP has an important role in payment of claims, because the signature is a sign of document authenticity and an absolute requirement for submitting claims regulated in the cooperation contract agreement between hospitals and BPJS. Legally the signature on the medical resume is the validity of the medical resume.

The completeness of patient file documentation shows the accuracy of guarantees provided by BPJS. However, in submitting BPJS claims, incomplete documentation was found, such as incomplete patient claim files along with the diagnosis and signature of the DPJP. The signing of the medical resume sheet is very important as a sign of the validity and approval of the treating doctor for the contents of the medical resume [12]. The absence of a signature on the medical resume makes the claim files unable to be grouped so that BPJS claims can be delayed and returned to the hospital to be completed. Delays and returns of claim files cause delayed claim payments and decreased hospital cash flow, affecting hospital operational funds because almost 90% of hospital patients are BPJS patients [13].

The patient's medical record file is a very important factor in BPJS claims. The completeness of this patient file shows the accuracy of the guarantee provided by BPJS. The BPJS claim officer must check the completeness of the claim file to ensure that BPJS provides the right financing and according to the specifications for the types of treatment [14].

Accuracy of Delivery Diagnostic Codes

The results of observing the accuracy of the delivery diagnostic codes revealed that the number of accurate diagnostic codes was 36(62%) while 22(38%) were inaccurate.

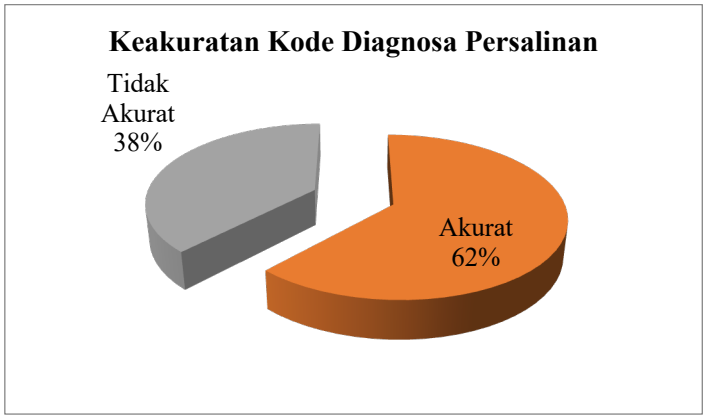

Figure 2. Accuracy of Delivery Diagnostic Codes

The inaccuracy of the birth diagnosis code is caused by the wrong number of characters, wrong Complication Of Delivery (O00-O99)/Mother's code, wrong Method Of Delivery (O80.0-084.9)/action code as described in the following table:

Table 2. Inaccurate Delivery Diagnostic Codes

No.RM	Claim Submission Code	Verification Results	Passed Verification Code
Incorrect Number of Character Code			
07-85-xx	O14	The diagnosis of preeclampsia was not explained but only coded as preeclampsia so it was incomplete for the 4th character.	O14.9
09-20-xx	O42	Incomplete Diagnosis Code on the 4th character, namely (.9) for the unspecified category.	O42.9
09-29-xx	O06	Diagnosed complete uncomplicated abortion but coded abortion only.	O06.9
Wrong Complication Of Deliver/Mother's Code			
05-21-xx	O64.1	Inappropriate reselection of the main diagnosis, namely presbo, while the main diagnosis should be stage II.	O63.1
07-04-xx	O72.1	Coded as postpartum haemorrhage but on the results of the supporting report the amount of bleeding was <500cc so that it could only be coded as ordinary anemia.	O99.0 D64.9
07-71-xx	O99.5	Pregnant women with shortness of breath but based on the results of supporting reports from BPJS verifiers are not included in the category of pregnant with shortness of breath. So the code for complications of shortness of breath must be deleted, and the code must be changed to a normal pregnancy code without complications.	O80
07-77-xx	O14.0	The code from the hospital is the code for eclampsia but from the BPJS verifier it does not include eclampsia.	O11
08-39-xx	O42.0	Premature rupture of membranes less than 24 hours but coded premature rupture of membranes more than 24 hours.	O42.1
08-64-xx	O14.0	Diagnosed with moderate preeclampsia but diagnosed with hypertension before and during pregnancy.	O11
08-95-xx	O99.0	No complication code written for pneumonia	O99.0 J12.9
08-96-xx	O32.1	The code from the hospital is the code for pregnancy with the location of the baby being breech but because the condition of the mother at the time of delivery can be identified so that action is taken.	O64.1
09-11-xx	O14.0	Diagnosis on medical resume is severe preeclampsia but coded as moderate preeclampsia.	O14.1
09-36-xx	O14.1	The code from the hospital is the code for severe preeclampsia but in supporting reports it turns out that there is an increase in proteinuria during pregnancy so it is coded O11.	O11
09-41-xx	O48	The code from the hospital is the code for post-term pregnancy but from the normal pregnancy BPJS verifier.	O80.9
Wrong Method Of Delivery / Delivery Action Code			
06-33-xx	O82.9	Based on the diagnosis, the delivery should have been carried out in an emergency because the mother's condition had complications but was coded as an unspecified delivery.	O82.1
07-44-xx	O84	Delivery of twins, one was done by sectio caesarean and one was normal but coded as multiple delivery without explanation.	O84.8

09-15-xx	O83.1	Method of delivery other breech delivery but coded on the medical resume of spontaneous breech delivery.	O80.1
09-19-xx	O82.9	Delivery with an emergency, namely there are complications during pregnancy but coded as unspecified sectio caesarea delivery.	O82.1
09-20-xy	O82.9	Delivery by caesarean section, in which previous deliveries were also carried out by sc, so the code used is delivery by elective caesarean section.	O82.0
09-21-xx	O82.9	Based on supporting reports, namely sectio caesarean emergency but coded sectio caesarean unspecified.	O82.1
09-24-xx	O82.9	Sectio caesarean delivery with emergency but coded sectio caesarean is not explained.	O82.1
09-31-xx	O82	Delivery by caesarean section is not explained but is coded for delivery by caesarean section only, not coded for the 4th character so it is less specific.	O82.9

Based on observations and interviews with the person in charge of the inpatient casemix, it was found that when determining the code, the coding officer found it difficult to read the doctor's writing in the form of unclear writing of the diagnosis enforced by the doctor, so he had to clarify with the DPJP, however, doing the clarification often took quite a long time because the DPJP's schedule was not always in the hospital. The coding officer contacts the DPJP when the DPJP has a schedule at the hospital so to carry out coding the coding officer must look at the history of treatment, medication, symptoms on the anamnesis sheet and physical examination. In line with Susanti's research (2018) which said that when determining for BPJS claims the coding officers found difficulties related to diagnoses enforced by doctors and abbreviations that were difficult to understand, so coding officers had to clarify with doctors, and when the clarification process was not successful, coding officers used the MB1-MB5 Rule to reselect or reselect the main diagnostic code [15].

In addition, in the process of determining the diagnosis code, the coding officer only codes by looking at the diagnosis without reading the results of supporting reports and medical resumes that support the diagnosis. Ningtyas, et al (2019) in his research said that the information needed to support the accuracy of the diagnosis code for labor cases includes a resume (discharge summary) sheet which functions to find out the diagnosis made by a doctor, laboratory examination results sheets function to find out certain conditions in patients, sheets radiographic examination results (USG) serve to determine the condition of the fetus, informed consent and operation reports [16][17].

This is in line with the results of Alik's research (2016) which stated that the inaccuracy of coding obstetric diagnoses was caused, among other things, by the writing of the diagnosis that was unclear and less specific, the doctor's writings were difficult to read and used abbreviations making it difficult for the coding officer to set the code and the coding officer often did not read the complete medical record such as (not reading supporting reports, anatomical pathology results, operating sheets) but only looking at the diagnosis in the outgoing summary (medical resume) [16].

According to Meilany (2018) the factor of accuracy in giving a diagnosis code is the result of medical supporting examinations. The completeness of the results of supporting medical examinations affects the accuracy of giving a diagnosis code because it can be used as supporting information if the diagnosis determined by medical personnel is unclear or incomplete [18]. The code can be declared correct if it is in accordance with the ICD-10 and ICD-9-CM based on a diagnosis supported by supporting information such as laboratory results and anatomical pathology results [19].

In addition, the factor that influences the accuracy of giving the diagnosis code is the completeness of filling in medical information. In the Regulation of the Minister of Health of

the Republic of Indonesia Number 27 of 2014 [20] Chapter IV part H it is explained that the complete contents of the medical record written by the doctor will greatly assist the coding officer in providing the diagnosis code and the correct action or procedure. This is in line with Wariyanti's research (2014) which states that the completeness of medical information and the accuracy of medical record documents is very important, if the medical information in a medical record document is incomplete then the resulting diagnosis code will be incorrect [21].

Diagnostic codification must be complete and precise according to ICD-10 directives. The accuracy of diagnosis and action codes greatly affects the quality of statistical data and payment of health costs with the casemix system. In the case of giving birth at Hospital X Bengkulu City, it can be seen in table 1 that there were 22 inaccuracies in the delivery code, causing purif failure which resulted in delays in paying BPJS claims to the hospital.

In line with the research of Gifari & Ariyanti (2019) determining an incorrect diagnosis code can be a problem so that BPJS claims cannot be paid because they violate the provisions set by BPJS. If this continues to occur, the further impact that will be seen is a decrease in hospital revenue which will decrease and will have an impact on hampered hospital operations [22].

The impact that will occur from the inaccuracy of the delivery code will affect the cost of care and medicines used/consumed and affect the process of submitting claims to BPJS. In line with Ayu's research (2012), the impact of discrepancies in coding a diagnosis will affect claims for treatment costs, hospital administration and the quality of services available at the hospital [23]. According to Alik (2016) in his research he said that the accuracy of enforcing the diagnosis code affects the cost of health services to be provided, this can cause losses to the hospital because payment of claims based on INA-CBG's is determined from the coding results set by the coding officer [16].

Completeness of Claim Files and Accuracy of Delivery Diagnostic Codes for the Smooth Verification of BPJS Claims

Table 3. File Completeness and Accuracy of Delivery Diagnostic Codes Against the Smoothness of BPJS Claim Verification

Criteria	Smooth BPJS Claim Verification				Total
	Fluent		Not Smooth		
	n	%	n	%	
Completeness of Claim Files					
Complete	31	53	22	38	53
Incomplete	0	0	5	9	5
Accuracy of Diagnostic Codes					
Accurate	31	53	5	9	36
Not Accurate	0	0	22	38	22

Source: Processed Secondary Data, 2022

Based on table 3, it is known that claim files for delivery cases were complete and smoothly verified 31(53%), claim files were complete but verification was not smooth 22(38%) and claim files were incomplete and verification was not smooth 5(9%), while delivery diagnosis codes were accurate and verification was 31(53%), diagnostic codes were accurate but verification was not smooth 5(9%) and diagnostic codes were inaccurate and verification was not smooth 22(38%).

Based on observations and interviews with the person in charge of inpatient casemix, he said that the completeness of the claim file and the accuracy of the diagnostic code were factors that influenced and approved the billing of verification fees by BPJS to the Hospital so that health service costs that had been incurred would be paid on time by BPJS and would

have an impact good for the Hospital because it does not experience difficulties in operational costs or suffer losses. This is in line with the results of research by Gifari, M & Ariyanti, F (2019) which said that the completeness of medical information and the accuracy of the diagnosis code were factors that influenced BPJS claims to be approved for billing verification fees by BPJS-Health to hospitals [22].

Siswati and Pratami [24] argue that in the claim process, the accuracy of the officers is required and vice versa, repeated reviews are carried out before being submitted to BPJS so that the claim verification process runs smoothly without any rejection or delay of claims. In line with Santiasih et al [25] that pending claims can occur due to incomplete or incomplete filling of items in the patient's medical record, such as incompatibility of diagnoses on medical resumes, incompatibility of therapy given with the diagnosis established by DPJP.

CONCLUSION

The completeness of the claim file and the accuracy of the diagnostic code have an important role in the smooth running of the claim verification and become the basis for the approval of billing verification fees by the BPJS to the Hospital so that the service fees that have been incurred will be paid on time by the BPJS and will have a good impact on the Hospital because there are no difficulties in operational costs or incur a loss.

REFERENCE

Suprapto S, Malik AA. 2019. *Implementasi Kebijakan Direksi pada Pelayanan Kesehatan Badan Penyelenggara Jaminan Kesehatan (BPJS).* J Ilm Keseh Sandi Husada, 2019, 7(1), 1-8.

Salim DLF. 2020. *Aksesibilitas Pembiayaan Kesehatan dalam Program Jaminan Kesehatan Nasional.* Lex Soc. 2020, 8(4).

Kementerian Kesehatan RI. Peraturan Menteri Kesehatan No. 36 Tahun 2015 Tentang Pencegahan Kecurangan (Fraud) dalam Program Jaminan Kesehatan pada Sistem Jaminan Sosial Nasional.

Kementerian Kesehatan RI. Peraturan Menteri Kesehatan No. 28 Tahun 2014 Tentang Pedoman Pelaksanaan Program Jaminan Kesehatan Nasional.

Kementerian Kesehatan RI. Peraturan Menteri Kesehatan Republik Indonesia Nomor 903/Menkes/Per/2011 Tentang Pedoman Pelaksanaan Program Jaminan Kesehatan Nasional Masyarakat

Oktavia, N. 2017. Gambaran Faktor-Faktor Yang Berpengaruh Terhadap Ketepatan Kode Diagnosa Pasien Jiwa dengan Skizofrenia Pada DRM Rawat Inap Ruang Murai B di RSKJ Soeprapto Bengkulu. *Jurnal Manajemen Informasi Kesehatan (Health Information Management)*, *2*(2), 10–14.

Made, I., Adiputra, S., Luh, N., Devhy, P., Intan, K., & Sari, P. (2020). Gambaran Ketepatan Kode ICD-10 Kasus Obstetri Triwulan 1 pada Pasien Rawat Inap di RSUD Sanjiwani Gianyar. *Jurnal Manajemen Informasi Kesehatan Indonesia*, *8*(2), 2337–2585.

Irmawati, I., Kristijono, A., Susanto, E., & Belia, Y. (2018). Penyebab Pengembalian Berkas Klaim Badan Penyelenggara Jaminan Sosial (BPJS) Pasien Rawat Inap ditinjau dari Syarat-Syarat Pengajuan Klaim di RSUD R.A Kartini Jepara. *Jurnal Rekam Medis dan Informasi Kesehatan*, *1*(1), 45.

Malonda, T. D., Rattu, A. J. M., & Soleman, T. 2015. Analisis Pengajuan Klaim Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan di RSUD Dr . Sam Ratulangi Tondano. *Jikmu*, *5*(5), 436–447.

Pitaloka, S & Ningsih, N. 2021. *Penyebab Pengembalian Berkas Klaim Badan Penyelenggara Jaminan Sosial (BPJS) Pasien Rawat Inap Ditinjau dari Syarat-Syarat Pengajuan Klaim di Rumah Sakit TK 02.07.02 Lahat.* Cerdika: Junal Ilmiah Indonesia,

Vol.1 No.12, Desember 2021.

Peraturan Menteri Kesehatan Republik Indonesia Nomor 269/MENKES/PER/III/2008 Tentang Rekam Medis.

Novita, M. 2016. *Analisis Pencairan Klaim Badan Penyelenggara Jaminan Sosial di Rumah Sakit Umum Daerah Dr. Achmad Mochtar Bukittinggi Tahun 2014*. Universitas Andalas.

Pitaloka, S & Ningsih, N. 2021. *Penyebab Pengembalian Berkas Klaim Badan Penyelenggara Jaminan Sosial (BPJS) Pasien Rawat Inap Ditinjau dari Syarat-Syarat Pengajuan Klaim di Rumah Sakit TK 02.07.02 Lahat.* Cerdika: Junal Ilmiah Indonesia, Vol.1 No.12, Desember 2021.

Rahmatiqa, C., Sulrieni, I. N., & Novita Sary, A. 2020. Kelengkapan Berkas Rekam Medis Dan Klaim Bpjs Di RSUD M.Zein Painan. *Jurnal Kesehatan Medika Saintika*, *11*(1), 11.

Hamid. 2013. *Hubungan Ketepatan Penulisan Diagnosis Dengan Keakuratan Kode Diagnosis Kasus Obstetri Gynecology Pasien Rawat Inap di RSUD. Dr. Saiful Anwar Malang.* Program Studi Kesehatan Masyarakat Fakultas Ilmu Kesehatan Universitas Muhammadiyah Surakarta.

Ningtyas, N. K., Sugiarsi, S., & Wariyanti, A. S. 2019. Analisis Ketepatan Kode Diagnosis Utama Kasus Persalinan Sebelum dan Sesudah Verifikasi pada Pasien BPJS di Rsup Dr. Soeradji Tirtonegoro Klaten. *Jurnal Kesehatan Vokasional*, *4*(1), 1.

Susanti, M. E. 2018. Tinjauan Peran Koder Untuk Klaim BPJS Kesehatan Dalam Pelaksanaan JKN Di RSU Darmayu Ponorogo. *Global Health Science*, *3*(3), 245–251

Alik, A. T. N. 2016. Hubungan Ketepatan Kode Diagnosa Obstetric Terhadap Kelancaran Klaim Bpjs Di Rsud Sawerigading Kota Palopo Sulawesi Selatan. *Indonesian of Health Information Management Journal*, *4*(1), 1.

Meilany, L. 2018. *Hubungan Pengetahuan dan Kesesuaian Pemeriksaan Klinis Dengan Ketepatan Kode Diagnosa. RSKD : M*akassar

Kementerian Kesehatan RI. Peraturan Menteri Kesehatan No. 27 Tahun 2014 Tentang Petunjuk Teknis Sistem Indonesian Case Base Groups (INA CBG's).

Indawati, L. 2019. *Analisis Akurasi Koding pada Pengembalian Klaim BPJS Rawat Inap di RSUP Fatmawati Tahun 2016.* Jurnal Manajemen Informasi Kesehatan Indonesia, 7(2), 113.

Wariyanti, A. S. 2014. Hubungan Antara Kelengkapan Informasi Medis Dengan Keakuratan Kode Diagnosis Pada Dokumen Rekam Medis Rawat Inap Di Rumah Sakit Umum Daerah Kabupaten Karanganyar Tahun 2013. *Kesehatan Masyarakat*, 13.

Gifari, M & Ariyanti, F. 2019. *Analisis Persetujuan Klaim BPJS Kesehatan pada Pasien Rawat Inap.* Jurnal Ilmu Kesehatan Masyarakat 2019 Vol.8 No.4 Hal 156-166.

Siswati & Pratami SL. 2015. *Hubungan Ketepatan Pemberian Kode Diagnosa dan Tindakan Terhadap Persetujuan Klaim BPJS.* J INOHIM, 3, 1-9

Santiasih WA, Simanjorang A, Satria B. 2021. *Anaslisis Penyebab Pending Klaim BPJS Kesehatan Rawat Inap di RSUD Dr.RM Djoelham Bonjai.* Jurnal Healthe Technol Med, 7(2), 1381-94.