

Health Insurance (BPJS-Kesehatan) late payment for hospital inpatient claims - a case study in West Sumatra

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Abstract

Purpose: Claim pending is a major problem faced by Hospitals in the universal coverage (JKN) era in Indonesia. The delay is believed due to incomplete claim requirements submitted by the hospital. This study aims to explore contributing factors of late payment of inpatient BPJS claims at the Government hospitals in terms of input and process. **Method:** This was qualitative research. Data was collected through semi-structured interviews, observation, and document review. Content analysis was applied in data analysis. **Results:** Component input contributing to claim pending were case-mix team, human resources, and standard operational procedures. Component processes were medical resume filling, the accuracy of coding, and internal verification process. **Conclusion:** Many factors contributed to the hospital claim pending at the level of input and process. All the factors together influenced the accuracy of the inpatient service claim. Any effort to improve the factors could prevent the claim delay.

Keywords: BPJS Health; claim; late payments; claims hospital; claims pending

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INTRODUCTION

The Law No. 40 of 2004 states that the National Health Insurance System (JKN) is part of the National Social Security System, which is a compulsory social health insurance for meeting primary health needs of its member, managed by the Health Social Security Administering Body (BPJS Kesehatan). BPJS Kesehatan is a legal entity responsible for providing national health insurance for all Indonesians in all levels of health care services, from primary to tertiary care [1]. Hospitals are health care facilities that provide secondary and tertiary services to BPJS Kesehatan members, via a tiered referral system from primary care facilities. Services provided by the hospitals are paid using the INA-CBGs payment method [2,3].

Technical Guidelines (Juknis) of BPJS Kesehatan states that hospitals have to submit service claims to BPJS Kesehatan for the payment of services that they provided. The submitted claim must meet the requirements for being processed and paid. If there is an incomplete or unsuitable file, it will return to the hospital or health facilities [4]. Studies identified some factors that contributed to claim pending were incomplete medical resumes, inaccuracies in coding, misplaced diagnoses, and input errors [5-7].

Delay in claim payment affects hospital cash flow and impacts the quality of service, especially on the dimensions of safety and comfort of services for BPJS Kesehatan participants. BPJS patients' dissatisfaction with health services, which in turn affect the number of visits [8]. Five indicators have the lowest Average

Value (NRR) that affect service satisfaction, including service speed, clarity of information provided by service officers, justice, environmental comfort, and service safety [9]. In addition, Murtiana (2016) found that there is a relationship between administrative services, doctors, nurses, infrastructure, and the hospital environment and patient satisfaction [10].

Claim pending was also faced by hospitals in West Sumatra. A Regional General Hospital (a type B government hospital) had 3% to 21% of its inpatient services claim were delayed in 2018. The highest percentage occurred in May, 131 files from 633 files, (21%), and the lowest was in January 15 files (3%). Our preliminary study found 30 claim files were pending in December that year. The delay in payment of claims affected the hospital cash flow and impacted service quality and patient satisfaction. This study aimed at exploring factors contributing to BPJS inpatient claim pending using the lens of system theory, i.e. input and process components.

METHODS

This study was conducted in a government type B hospital (regional hospital) in West Sumatra. This qualitative study applied semi-structured interviews, observation, and document review for data collection. Informants were selected purposively. There were seven [7] informants participating in this study, consisting of the hospital director, head of medical service, head of treasury and verification section, internal hospital verifier, inpatient coder, and doctor in charge of patients (DPJP).

The system theory was applied in exploring the phenomena of claim pending. Input components were policies, human resources, infrastructure, Standard Operating Procedures (SOP). Process components were filling out medical resumes, coding by coders, and verification of claims files by internal verifiers). The interviews used a tape recorder and notebook to obtain complete information. Besides semi-structured interviews, researchers conducted observations and reviewed documents. We observed the process by directly observing the claim submission process, starting with evaluation of the completeness of the medical resume filled out by the DPJP, and the coding and verification process by the internal verifier in the case-mix section of the hospital. The pending claim documents were also examined by the researchers for gaining more understanding of the pending.

The data analysis technique applied in this research was a content analysis technique, which is to compare the research data with existing theories in the literature review, and the data is analyzed immediately

after the interview to avoid errors that may arise, applying triangulation of sources and triangulation of methods.

RESULTS

Many factors contributed to the hospital claim pending at the level of input and process. Component input contributing to claim pending were the governance of case-mix team, human resources, and standard operating procedures. Component processes were medical resume filling, the accuracy of coding, and internal verification process.

The governance of case-mix team

Hospitals need a case-mix team for helping them in managing INA-CBGs claims. Our study found that an ineffective governance of this team contributed to the problems of the inaccuracy of claims resulting in claim pending. We identified that unclear position of the case-mix team in the hospital organization structure is one example of the ineffective governances. Both services and finance department of the hospital rejected the team to be part of them. As a result, there was an absence of a leadership role. The absence of the leader's role (person in charge) caused unclear job descriptions, monitoring, and evaluation process.

"Job description is not clear" (Inf3)

"We haven't done any monitoring and evaluation in the case-mix section. Who is responsible? Who is overseeing their work? Are they doing correctly or not? We can't figure it out yet" (Inf2)

"There should indeed be an evaluation carried out by the hospital. However, the problems are the absence of a person in charge of the case-mix section" (Inf1)

Furthermore, it was identified that the unclear position of the case-mix team was a result of an incompatibility of the hospital's organizational structure with the amount of activities it must carry out. The hospital in which this research was conducted has undergone a service development into a provincial hospital (type B), but the organizational structure of this hospital has not been adjusted to the changes. The case-mix team did not have a separate place in the organizational structure and was only included into other units in this case the service unit and then the financial unit. If we analyze the function of the case-mix team, they need a separate unit because their duties require coordination of several units including services, finance, and medical records. According to

Government Regulation Number 18 of 2016 concerning Regional Apparatus, the hospital was waiting for a presidential regulation to change its organizational structure.

"So actually this is like this, we are a type B hospital. It means the volume of work is already a lot, but our structure is still Type C, so we are a thin structure with a fat work volume. Indeed, the discussion regarding this structure is not yet clear. Organization in the bureau, if we change the structure, we cannot do it alone. We only propose to the provincial organizational bureau. If it doesn't continue yet, there is no. We just accept it. There are still discussions for 3 or 4 provincial hospitals, not yet finished; maybe there are related regulations that must be waited for related to government regulation (PP). So it's just being discussed now" (inf2)

Human Resources

The case-mix team consists of coders, internal verifiers, grouping officers, and claim file completeness officers who coordinate with each other. However, to file a claim does not escape the role of a doctor as a service provider who is in charge of completing a medical resume as a condition for submitting claims to BPJS Kesehatan.

Participants indicated that factors that contributed to the effectiveness of case-mix team work to prevent pending claims were the number of personnel compared to the number and complexity of files, clarity of job descriptions, competency in INA-CBGs and a working culture of attention to detail. We found that the perceptions of the case-mix team and management regarding the adequacy of manpower had a potential to differ. This difference in perception needs to be discussed and found a common ground so that the work of the case-mix team can run effectively and efficiently.

"In terms of quantity, we've had enough, no need to add, now how to work professionally, if they are not professional it is useless" (inf1)

"The number of by internal verifier is two people, in my opinion, it is not enough" (inf4)

Competence is a person's ability to perform specific tasks, consisting of knowledge, skills, and work attitudes. Interviews with coders who graduated with a medical records diploma and worked at the hospital for eight years revealed that they had a sufficient understanding of the process of coding for the INA-CBGs. Inaccuracies or errors in coding resulted from a lack of work accuracy and differences in

perceptions in determining the diagnostic code with the BPJS Kesehatan's claim verification officers. The inaccuracies or errors in coding could be identified by the internal (hospital) verification officer and then corrected. Unfortunately, it seems that the internal verification process did not work well in this government hospital due to lack of skills resulting from lack of training.

"I have been a verifier for one year, at first I was the head of the emergency room, because there were many pending problems. I was appointed as a verifier, I did not understand what I did, I asked the top person (Management) he said just do it. Later you will find out for yourself. My understanding of ICD is still lacking" (inf4).

The hospital management has not been able to respond or comment on the competence of the case-mix team because there has never been an assessment and evaluation. This was due to the absence of a person in charge of the team.

Standard Operating Procedure (SOP)

The case-mix staff lamented the absence of standard operating procedure (SOP) that could guide every related system component in preparing a complete claim. There were unclear tasks and responsibilities of each parties involved as well as coordination among them. This condition made the case-mix team "we are here to work based on instinct" (inf5).

They often got medical records written with the absence of diagnosis or incomplete explanation of management procedures that had been conducted. Unfortunately, there was no guidance on procedure to solve this problem, i.e. How to ask the doctor in charge to complete the medical record and how long the time was allocated.

"SOP, claim, not there, guidance for a complete claim file is not available, we are here to work single-handed" (inf4)

"SOP, no, we are here to work based on instinct. I started to work in August, was just told to work, we just worked on instinct, there was no diagnosis made, so we predict. When the claim is pending, we analyze ourselves its' causes, oh, maybe because of this, we just predict" (inf5)

The participants' experiences showed that the availability of the SOP is important in preparing BPJS claims to prevent the claim pending. The SOP needs to include standards of a complete claim, preparation and correction procedure, as well as tasks and

responsibilities of each party involved. Participants mentioned that the absence of the SOPs was due to the absence of a person in charge or case-mix team leadership.

Completing Medical Resume by the DPJP

Interviews with physician in charge (DPJP) showed that busyness and workload, as well as obedience and compliance of the DPJP in filling out medical resumes influenced the completeness of the resumes. The obedience and compliance which in turn was determined by the DPJP's understanding of the importance of a complete resume.

"I have limited time, especially surgery, operating theater, polyclinic, lotstofill, sometimes I forget to write, hurry. If all doctors know, and should know if the resume of medical treatment must be filled completely, then obedience can be improved." (inf6)

The interview above indicated that the DPJPs were not informed appropriately on the importance of the complete medical resume for BPJS claim and minimum standard of a complete claim.

The Accuracy of Coding

The interview data showed that effective communication and team work between coder and internal verifier had significant impact on the accuracy of the claim. A SOP that could enable communication and teamwork would be helpful. They had to work collaboratively on checking each other and discussing differences in perceptions and problems that arise in completing the claim. Unfortunately, due to the absence of the SOP, they just did their own work without any discussion. The coder coded the diagnoses written on the medical resume sheet and INA-CBG verification without seeing and assessing the entire patient's medical record because checking for completeness of the medical resume was the task of the internal verifier. On the other hand, the internal verifier checked the completeness of the supporting documents of the claim without paying attention to the accuracy of code inputted by the coder.

"If the claim has been checked by internal verifier, then a coder gave the code. He or she doesn't need to see the entire record any more. He or she just need to code. Sometimes, coders code first before the internal verifier, then the internal verifiers do their job to check the completeness of the claim. We are working here, not based on SOP" (inf7)

In addition, the participants lamented the DPJPs' hand writing on medical records, which is difficult to

read, as another obstacle in the coding process. The coders often predicted the DPJPs' handwriting without reconfirming it because there was no guide on how to contact the DPJPs.

Checking for the completeness of documents by the internal verifier

Hospital management explained that the formation of the hospital's internal verifier team aimed to evaluate the claim file's completeness and the diagnosis' appropriateness with supporting resources before the claims were being submitted to the BPJS Kesehatan. However, from interviews with the internal verifier officers, it seemed that they had doubts about their working procedures and standards. They lamented the absence of clear job description and guidance, the lack of training in verifying BPJS claims according to the standards requested by the BPJS Kesehatan, and the absence of monitoring and evaluation as well as feedback on their works. As a result, they "work based on instincts" (inf5).

"The person who gave us the tasks should explain what our work is. This is not. We are appointed as verifiers, but we don't know exactly what to do. We work based on our thoughts. We think that we have to assess the accuracy of submitting claims based on the rationalization of the disease's course (anamnesis), diagnosis and management, analyzing pending claims, correcting pending claims that occur with DPJP, facilitating claim submission. We do not know if we are doing our work right or not. When we feel tired, we stop. We do not have working target." (inf5)

Similar to the problems faced by the coders, the DPJPs' unclear handwriting was also an important problem for the internal verifier officers.

DISCUSSIONS

The roles of input

Our data indicated that the governance of the case-mix team was important for the effectiveness of the team in preparing the INA-CBGs claim. The case-mix team had to have its own space within the hospital management structure, and the hospital regulation had to support the establishment of this team. The case-mix team should be strengthened through effective leadership, competent staff and positive working culture including teamwork and attention to detail. An effective leadership could ensure the clarity of job descriptions, increase the effectiveness of communication and coordination, ensure the implementation of monitoring and evaluation activities, as well as increase motivation.

Our findings support theories on leadership. Leaders are people who can move their members to achieve organizational goals. The existence of an effective leader is necessary for an organization. An organization's success depends on its leaders' role in managing organizational resources and optimally carrying out all organizational activities [2]. One of the important roles of a leader is to determine job descriptions for each component within the organization and manage interaction and collaboration. Alfiansyah, et al (2018) found that the absence of job descriptions and coordination are factors contributing to the BPJS inpatient claims pending in a private hospital in East Java [11].

Furthermore, our findings indicated that the government regulation on public hospitals had a potential to hinder the organization of hospital structures that supported the effectiveness of the case-mix teams. The management structure of a public hospital was determined by the type of the hospital and it took time to adjust the structure to the type of hospital and its workload. Thus, compared to private hospitals, public hospitals had more rigid regulation on managing its structure. In our study, the hospital had been type B which had a higher workload than type C. Unfortunately, it had to wait for a government regulation to rearrange its structure. Since 2019, the government regulation on public hospitals has been more flexible by giving an authority for the hospital directors to manage its organizational structure [12].

An effective structure is important for an effective function of an organization. The organizational structure manages the relationship between employees and their duties and functions for achieving goals of the organization. The structure is important for the clarity of positions, responsibilities, and job descriptions [2]. Thus, there is a need to change the organizational structure of the hospital in which this study took place and discuss it again by equalizing perceptions and commitments related to the case-mix person in charge because with the role of the leader in the case-mix team, POAC (Planning, Organization, Actuating, Controlling) activities can be carried out properly. Tasks and division of tasks, compiling the case-mix SOP, monitoring and evaluation can be carried out, communication and coordination between subordinates and superiors or other related departments can run well.

Our study proved that even though the number of case-mix team members was sufficient, the absence of job descriptions affected the hospital's claim submission process. Pattisahusiwa (2013) found that the implementation of an effective job description could significantly improve process performance,

namely the well-defined authority, responsibilities, working conditions, work facilities, and work output standards [13]. Human resources are the most valuable assets in an organization that function as movers, thinkers, planners to accelerate organizational goals. In the context of empowering human resources, it is necessary to have clear authority to not cause doubts in every activity (14). A part from the quantitative aspect, human resources must be competent in doing work. Job competence is the work ability of each individual, including aspects of knowledge, skills, and working attitudes following established standards [15].

Moreover, our study showed that working attitudes of coders in terms of attention to detail or working accuracy also determined the claim acceptability. In fact, knowledge on INA-CBGs, ICD-10 and ICD-9-CM was not sufficient to ensure the absence of error or inaccuracy in coding. Coding inaccuracy by coders, however, could be corrected by the internal verifiers. Unfortunately, the internal verifiers in this setting lamented that they had lack of training on INA-CBGs, ICD-10 and ICD-9-CM, resulting in lack of skills and knowledge. Kusumawati (2019) argued that internal verification doctors could reduce the number of inpatient claims pending due to coding errors. She identified the causes of coding errors were incomplete medical resume, lack of accuracy in coders, lack of knowledge of coders, inequality of information related to coding and unloading of claim files, accompanied by the sufficiency of the number of coders. The internal verification doctors must understand the coding rules for ICD-10 and ICD-9-CM, and BPJS-Kesehatan regulations [16].

There was a significant correlation between resource variables and the implementation of the JKN policy regarding INA-CBGs claims, the lower the quality and quantity of the resources, the worse the implementation of the JKN policy. On the contrary, the quality of the JKN policy implementation would increase as a result of the increase of quantity and quality of the resources [17]. In order to achieve the organizational goals, the management must look at the ability (competency) of employees and the placement of employees in accordance with the demands of the position in an organization, meaning that the capabilities possessed by the employee has to meet a condition that the right man is in the right place [2].

Based on interviews and observation, the case-mix section in this hospital did not yet have a Standard Operating Procedure (SPO) as a guideline or reference for officers in filing BPJS inpatient claims, ensuring the completeness of the claim file, and maintaining the accuracy of coding by the coders. The absence of the SPO had an impact on the flow of claim submission

files that were not properly sequential and coordinated. Several studies had proven that the absence of the SPO could have an impact on the incompleteness of the claim file, causing delays in payment of claims [6,11,18].

The Standard Operating Procedures (SOPs) are guidelines or references for carrying out tasks and work in accordance with the function of the job. The SOP describes all operational activities carried out with the aim that the work is performed correctly. By implementing the SOP, the organization's operations will be more efficient, both in terms of time, process, manpower and operational costs [19].

The roles of process

Our study showed that more than a half of the pending claims were due to incomplete medical resumes written by the DPJPs. The incompleteness, as identified by our study, was due to the doctor's busyness, workload, and obedience or compliance as a health care provider.

The poor quality of coding is caused by incompleteness of documentation of patient information within the medical record. Thus, the diagnosis and medical/ surgical procedures taken are not well supported with data [20]. The Indonesian Ministry of Health regulation number 76 year 2016 states that a DPJP has an obligation to write primary and secondary diagnosis based on ICD-10 and ICD-9-CM, and he or she has to write a complete medical resume for documenting management and procedure received by patients during their hospitalization [21]. The incompleteness of filling out the medical resume will affect the claim process to BPJS Kesehatan and impact hospital cash flow and hospital services quality. Utami et al. (2016) found the relationship between the medical resume completeness and the payment timeliness of claims [22].

Furthermore, our study identified that coders had to read the entire patient medical record for improving coding accuracy. By reading the entire record, the coder could identify the most accurate INA-CBGs' code for the service provided for patients. Hence, a non-sequential flow of BPJS patient claims in the case-mix section increased the INA-CBGs code's inaccuracy. The suggested flow should be: the patient files were submitted to the medical record officer to check the completeness of the medical record file, then the files were submitted to the internal verification officer to check the completeness of the medical resume and its supporting resources. After that, the coders code the diagnoses on the medical resume sheet and the INA-CBGs verification sheet. However, it was often that the coders provided a diagnostic code on the

medical resume and INA-CBGs verification sheet without reviewing the entire medical record file, then the hospital's internal verifier carried out an examination. This practice was potentially that the codes chosen by the coders were not well supported with data and documents available within the medical record, because the record had not been evaluated by the internal verifier for its completeness.

Karimah et al. (2016) found that the inaccuracy of the diagnosis code for an acute gastroenteritis was caused by the coder's coding process, which only looked at the main diagnosis without looking the entire medical record, i.e. the history, documentation of supporting examinations and then diagnoses written by the DPJP [23]. Windari et al. (2016) identified 25.33% inaccurate codes for delivery cases because coders missed in evaluating the medical records for mother's condition, mode of delivery, and baby's condition (single alive, single died, twins) [24].

In addition, our study indicated that coders had difficulties in reading diagnosis and medical records written by doctors due to the DPJPs' unreadable handwriting. As a result, it was often that the coders guessed the information stated on the records because there was unclear SOP in making confirmation to the DPJPs. Pertiwi (2019) identified that coding accuracy was determined by three components, i.e. doctors, coders, and collaboration. The doctors (the DPJPs) resources that affected coding accuracy included readable handwriting, completeness of written diagnostic information, compatibility of diagnosis built with the main diagnostic criteria. Coders' components were coders' knowledge and skills in coding with the INA-CBGs, ICD-10 and ICD-9-CM, coders' working accuracy and coders' understanding on medical terminology written by the DPJPs. A collaboration between the DPJPs and the coders was important through effective communication [25].

Finally, our study showed that similar to the coders, the internal verifier had to have sufficient understanding of the INA-CBGs, ICD-10 and ICD-9-CM. This understanding is important for their tasks in evaluating the completeness and accuracy of the BPJS claims. The internal verifier had to take into account the INA-CBGs rules, ICD-10 and ICD-9-CM principles in the evaluation process. Unfortunately, the internal verifier staff in our study had never got any training for this and had no clear job description and guidance. Ningtyas (2019) found that there was no difference in the accuracy of the main diagnosis code of delivery cases before and after verification by the hospital internal verifier. In other words, the internal verifier activities had no impact on improving the accuracy of coding. This was because the internal verification

process only evaluated the claim file's completeness by comparing the diagnosis and managements written by the DPJPs and supporting information and documents available, without considering principles of INA-CBGs, ICD-10 and ICD-9-CM [26].

CONCLUSION

Component input contributing to claim pending were the organization structure of case-mix team, human resources, and standard operating procedures. Component processes were medical resume filling, the accuracy of coding, and internal verification process. The main concepts contributing to these factors were leadership, the importance of SOPs and work training, and team work consisting of communication and collaboration. All the factors together influenced the accuracy of the inpatient service claim. Any efforts to improve the factors could prevent the claim delay.

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