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The Effectiveness of Health BPJS Claim Discrepancies Against Health Service Standards in Indonesia

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Abstract

This study aims to evaluate the effectiveness of the *Badan Penyelenggara Jaminan Sosial* (BPJS) health system in addressing claim discrepancies in relation to health service standards in Indonesia. As a social security administration agency, BPJS Health faces various challenges concerning claim discrepancies, which can impact the quality of healthcare services provided to the community. Health insurance claims refer to submissions made by healthcare facilities to BPJS for reimbursement of healthcare service costs. These claims are submitted collectively on a monthly basis, accompanied by supporting documents. Upon submission, the claims undergo a verification process conducted by BPJS Health verifiers, whose role is to assess the accuracy and completeness of the administrative accountability for services provided to patients. Following claim verification, the insurer at the healthcare facility receives one of four claim status outcomes: eligible claim status, ineligible claim status (pending), post-claim verification status, or disputed claim status. This study employs a normative juridical research method, involving the collection and analysis of primary, secondary, and tertiary legal materials. The findings reveal several factors contributing to claim discrepancies, including hospitals' and healthcare professionals' limited understanding of claim procedures, as well as inefficiencies in BPJS Health's monitoring and evaluation system. The study also highlights that claim discrepancies often have a negative impact on patient satisfaction and the overall quality of healthcare services. To enhance the effectiveness of the BPJS Health claims system, improvements are needed, including systematic reforms, increased dissemination of information, targeted training programs for healthcare workers, and the strengthening of monitoring and evaluation mechanisms. These measures will contribute to improving the efficiency and reliability of healthcare services in Indonesia.

Keywords*: Health BPJS, health service standards, effectiveness, Indonesia*.

Introduction

Health is a fundamental human right and an essential aspect of life. It is also a basic necessity for individuals to live properly and productively. Good health enables individuals to perform daily activities efficiently and contribute to societal progress through innovation. Given its crucial role in daily life, a well-regulated healthcare system is necessary to ensure both quality and cost control.

As the highest governing body in Indonesia, the government is responsible for safeguarding public health and providing high-quality healthcare services to the community. The success of national development can serve as an indicator of a country's progress, with public welfare being a key measure of governmental effectiveness. Welfare encompasses access to fundamental necessities, including education and healthcare. The government's primary duty in improving public welfare - particularly in healthcare - is mandated by Article 34, Paragraph (3) of the 1945 Constitution of the Republic of Indonesia (UUD 1945), which states that: "The state is responsible for the provision of health care facilities and decent public service facilities" (Safroni, 2012).

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For the first time, the government issued Regulation No. 1 of 1968 (Pramana, 2023) on the Amendment and Addition to Government Regulation No. 12 of 1967 (State Gazette of 1967 No. 24, Supplement to State Gazette No. 2833), which regulated the salary structure for civil servants in Indonesia. This regulation led to the establishment of the Health Maintenance Fund Organizing Agency (BPDPK), responsible for managing the healthcare services of civil servants (PNS), pension recipients, and their families.

Subsequently, the government introduced Government Regulation No. 22 of 1984 on Health Maintenance for Civil Servants, Pension Recipients, and Their Families, alongside Government Regulation No. 23 of 1984 on the establishment of Public Company (Perum) Husada Bhakti (PHB). This development resulted in a transformation of BPDPK's status. Initially operating as an agency under the Ministry of Health, BPDPK was restructured into a state-owned enterprise (BUMN) under the name Perum Husada Bhakti (PHB).

In 1992, PHB underwent another transition, becoming PT ASKES (Persero), following the issuance of Government Regulation No. 6 of 1992, which formally changed its status from a public company to a limited liability company (Persero). PT ASKES (Persero) later introduced the Commercial Askes program, expanding its healthcare services to employees of state-owned enterprises (SOEs/BUMN). Eventually, the government enacted Law No. 40 of 2004, which established the National Social Security System (SJSN) as a comprehensive framework for broader social security coverage in Indonesia.

As stated in the Preamble of the 1945 Constitution, the implementation of the National Social Security System (SJSN) is one of the key pillars for improving public welfare. The SJSN framework regulates five types of social security programs, as outlined below (Mundiharno, 2012):

- Medical Coverage Program
- Employment Accident Risk Insurance
- Retirement Benefit Plan
- Pension Insurance
- Death Insurance

According to the SJSN Law, the National Health Insurance Program (JKN Program) is a social security initiative jointly established by the government and society to ensure comprehensive health coverage for all Indonesians, enabling them to lead healthy, productive, and prosperous lives. This program functions as a social security scheme that covers healthcare expenses and guarantees access to essential medical services. The JKN Program provides extensive health benefits, including health promotion (promotive), disease prevention (preventive), treatment (curative), and rehabilitation (rehabilitative), along with access to medications and medical equipment. These services are administered through a managed care approach, ensuring both quality control and cost optimization.

The Social Security Organizing Agency (BPJS) was initially formed as part of State-Owned Enterprises (SOEs/BUMN) and was responsible for implementing the aforementioned programs. Subsequently, on November 25, 2011, the government further enhanced the national health insurance system through the enactment of Law Number 24 of 2011 concerning BPJS (Social Security Organizing Agency). This regulation facilitated the implementation of a health insurance program with affordable premiums while expanding healthcare access to all Indonesians.

BPJS Health participants are classified into two main categories based on funding sources:
- Contribution Assistance Recipients (PBI): These participants consist of economically disadvantaged individuals who receive government-issued membership cards and are exempt from paying monthly contributions. Their healthcare costs are subsidized by other participants and government assistance.
- Non-PBI Participants: These participants register individually or as a family and are required to pay monthly premiums based on their chosen class.

There are three classes of BPJS Health participants, each with different premium rates:
- Class I: IDR 80,000 per month
- Class II: IDR 51,000 per month
- Class III: IDR 25,000 per month

The BPJS Health card can be used 14 days after registration or upon the issuance of a virtual account.

Effective July 1, 2020, the BPJS Health premium rates were officially increased for PBPU (Self-Employed Participants) and BP (Non-Workers). The new contribution rates are as follows:
- Class I: IDR 150,000 per month
- Class II: IDR 100,000 per month
- Class III: IDR 42,000 per month

However, the government continues to subsidize IDR 16,500 per month for Class III participants, reducing their out-of-pocket payment to IDR 25,500 per month (Hedrik, 2013).

Following the enactment of Law Number 24 of 2011, the government rebranded PT Askes Indonesia (Persero) as BPJS Kesehatan, which officially began operations as the Health Social Security Organizing Agency on January 1, 2014.

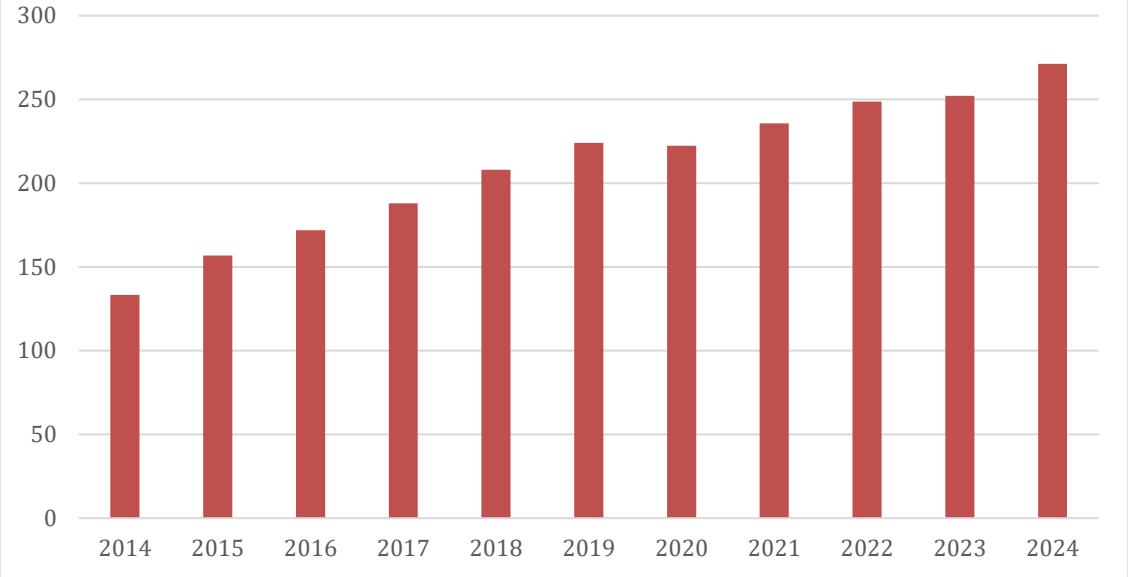
As part of its innovations, BPJS Kesehatan launched Mobile JKN on November 15, 2017, in Jakarta, aiming to enhance accessibility and efficiency in healthcare administration. The Mobile JKN application, available on both the App Store and Google Play Store, allows BPJS participants to manage their membership, access administrative services, and submit complaints efficiently.

The Mobile JKN platform enables participants to:
- Modify their JKN-KIS membership status
- Access administrative services using information and communication technology (ICT)
- Perform self-service administrative activities anytime and anywhere

Common documents required for BPJS Health-related processes include:
- Participant registration forms
- Participant data update forms
- Family cards (*Kartu Keluarga*)
- Identity cards (KTP)
- Referral letters for medical treatment

According to BPJS Kesehatan President Director Ali Ghufron Mukti, as of May 10, 2024, the JKN Program has 271.2 million participants, covering approximately 97% of Indonesia's population (STATISTIK, n.d.).

Tabel 1.1.
JKN Membership



The table above illustrates the annual increase in the number of BPJS Health participants, suggesting a growing public awareness of the importance of healthcare. High community participation in this policy is also supported by the provision of healthcare facilities. Ensuring equitable distribution of these facilities is crucial, as their availability significantly impacts the delivery of healthcare services across different regions - not only in urban areas but also in rural and remote locations that are difficult for the government to reach.

As stipulated in the UN Declaration of Human Rights (1948) and ILO Convention No. 102 (1952), the Republic of Indonesia administers social security programs to ensure that its citizens can meet their basic living needs. Several factors contribute to the reluctance of many individuals to enroll in BPJS Health services, including:

- Inefficiencies in BPJS Kesehatan's clinical services
- The classification disparities between Contribution Assistance Recipients (PBI) and Non-PBI participants
- Extensive medical benefits offered without cost-sharing

To address these issues, the government plans to replace the Class I, II, and III system in BPJS Health services with the Standard Hospitalization Class (KRIS) system. Under this new system, contribution amounts for participants may change. Health Minister Budi Gunadi Sadikin has indicated that the government is considering the implementation of a unified contribution rate scheme. However, he emphasized that this scheme is still under review, particularly concerning its impact on Class II and III participants. The changes to the BPJS Health class system are outlined in Presidential Regulation Number 59 of 2024. According to this regulation, the government aims to implement the KRIS system nationwide by June 30, 2025, with tariff adjustments to take effect no later than July 1, 2025 (Aji, 2024).

Contribution revenue plays a vital role in ensuring the sustainability of the JKN program and the overall welfare of the Indonesian population. The revenue from contributions is influenced by two key factors (Candrawila, 2001):

1. *Ability to Pay (ATP)* – This reflects participants' financial capacity to contribute, which is closely linked to Indonesia's economic conditions. Economic policies that expand market access and encourage productivity in goods and services directly impact ATP. Additionally, monetary stability, education and healthcare quality, and other economic well-being indicators also affect ATP.
2. *Willingness to Pay (WTP)* – This refers to participants' readiness to pay for healthcare coverage based on perceived value and necessity.

Given these factors, the government must subsidize health insurance costs for individuals who cannot afford to contribute.

However, BPJS Health claims frequently encounter issues that contradict Indonesian healthcare standards. These problems may arise due to:

- Inadequate documentation
- Administrative procedural errors
- Other systemic challenges

Based on these concerns, the research problem can be formulated as follows:

1. How do BPJS Health claims align with Indonesian healthcare service standards?
2. What factors contribute to discrepancies in BPJS Health claims, and how do these affect service delivery in Indonesia?

Research Methodology

Research is a scientific activity that involves analysis and construction and is conducted consistently, methodologically, and systematically. This study employs normative legal research, which entails the collection of primary, secondary, and tertiary legal materials. Four problem-solving models can be utilized to address the formulated legal issues, namely:

- Statutory approach
- Conceptual approach
- Comparative approach
- Historical approach

These approaches can be applied as needed depending on the research context.

This study adopts a descriptive qualitative research design, as the author seeks to examine the implementation of BPJS Health claim procedures. Through this approach, the author aims to assess the effectiveness and inconsistencies in the claim procedures in relation to Indonesian health service standards. The primary objective of this research is to explain the phenomenon through comprehensive and in-depth data collection (Sunggono, 2012).

Furthermore, data collection is essential to obtaining reliable materials, information, and factual evidence. This study utilizes library research, which involves searching for, identifying, and analyzing relevant literature, including books, articles, laws and regulations, jurisprudence, and scholarly writings related to the research subject. Once collected, the data is systematically analyzed to derive meaningful conclusions.

Results and Discussion

According to Handayani, the obligation to ensure service quality focuses on maintaining quality assurance in health services. Similarly, Sutoto stated that service quality encompasses a series of healthcare activities based on appropriate medical standards and procedures, ensuring the

delivery of high-quality health services from both the provider's perspective and patient satisfaction.

Health problems arise due to multiple factors, including the cost of healthcare and treatment. High medical expenses often make it difficult for people, particularly those in rural areas, to access necessary health services. In addition to financial constraints, the distance to healthcare facilities serves as another barrier to access. As of March 2023, the percentage of people living in poverty stood at 9.36%, reflecting a 0.21 percentage point decrease compared to September 2022 (F. Agiwahyuanto, 2014).

The government holds the responsibility of providing adequate healthcare services and public facilities. Under this mandate, it is obliged to fulfill the healthcare needs of its citizens. To enhance healthcare accessibility, the government has introduced a national health social security system under the BPJS Health (Badan Penyelenggara Jaminan Sosial Kesehatan or Social Security Organizing Agency for Health).

The BPJS Kesehatan is a legally established entity responsible for administering Indonesia's national health insurance program. It officially commenced operations on January 1, 2014. Participation in this program is mandatory for all Indonesian citizens as well as foreign nationals who have been employed in Indonesia for at least six months and have made the required contributions.

BPJS Kesehatan classifies its participants into two main categories, namely: (Kesehatan, n.d.)

- *Recipients of health insurance contribution assistance*

Recipients of Health Insurance Contribution Assistance (PBI) are individuals classified as poor and underprivileged, as defined by the SJSN Law, with their insurance contributions fully covered by the government under the National Health Insurance (JKN) Program. The government determines PBI participants through official policies and regulations. Additionally, individuals with permanent total disabilities and those deemed incapable of earning a living are also eligible for PBI. Permanent total disability refers to physical and/or mental impairments that prevent an individual from engaging in any form of employment. The assessment of such disabilities must be conducted by an authorized medical professional.

- *Non-PBI health insurance*

Participants who do not qualify for PBI are categorized into the following groups:

1. Wage-earning workers and their family members
   This group comprises individuals who receive a salary, wage, or other forms of remuneration for their work. Wage earners are those employed by an employer, which may be an individual, business entity, legal entity, or government institution responsible for employing civil servants and paying their salaries. Wage-earning workers include:
   - Government employees
   - Members of the Indonesian National Armed Forces (TNI)
   - Members of the Indonesian National Police (POLRI)
   - State officials
   - Non-civil servant government employees, including Non-Permanent Employees, Honorary Employees, Special Staff, and others whose salaries are funded by the State Budget (APBN) or Regional Budget (APBD)
   - Private sector employees
   - Other workers who meet the criteria of wage earners.
2. Non-wage workers and their family members

Non-wage workers are individuals who work independently or operate a business at their own risk. This group includes:

- Self-employed individuals or those working outside a formal employment relationship.
- Other workers who meet the criteria for non-wage earners.

3. Not workers and their family members
   Non-workers refer to individuals who are not employed but have the financial capacity to pay National Health Insurance (JKN) contributions. This category includes:
   - Investors
   - Employers
   - Pension recipients
   - Veterans
   - Pioneers of independence
   - Other individuals who meet the criteria for non-wage earners

   The eligible family members of participants include:
   - One legal spouse (husband or wife) of the participant.
   - The participant's biological children, stepchildren, and/or legally adopted children, provided they meet the following criteria:
     - They are unmarried and do not have their own source of income.
     - They are either under 21 years old or under 25 years old if they are still pursuing formal education.

The maximum number of family members covered under BPJS Health is five (5), including the primary participant. If a participant has more than five dependents, they may enroll additional family members by paying extra contributions. Enrollment in BPJS Health is mandatory for all Indonesian residents, regardless of whether they already have private health insurance. Individuals who are not registered as BPJS Health participants must bear the full cost of medical care, which can be prohibitively expensive. By 2019, BPJS Health membership had achieved universal coverage across Indonesia, implemented in stages to ensure nationwide enrollment (Sulastono, 2006).

The implementation of Law Number 24 of 2011 on the Social Security Administering Body (BPJS) is set to proceed following the finalization of supporting statutory regulations, such as Government Regulations or Presidential Regulations. As of January 1, 2014, the National Health Insurance program has been administered by BPJS Health under the Regulation of the Health Social Security Administering Body Number 1 of 2024, which revokes Regulation Number 2 of 2020 concerning procedures for guaranteeing refraction and eyeglass services in primary health facilities under the Health Insurance Program.

In preparation for the implementation of BPJS Health, several measures are being undertaken, including the formation of cross-ministerial and institutional teams and working groups within the Ministry of Health. These efforts aim to develop activity plans and coordination strategies to facilitate the institutional and programmatic transformation of health insurance.

In addition to institutional and programmatic preparations, readiness is being assessed from both the demand and supply sides. On the demand side, preparations include determining contribution amounts and securing funding, both from the government for Contribution Assistance Recipient (PBI) participants and from workers and employers for non-PBI

participants, with accurate and transparent information. On the supply side, resource calculations and planning focus on healthcare facilities and infrastructure, the availability of medicines and medical equipment, and the adequacy of healthcare professionals.

A. BPJS Health Claims are based on Indonesian Health Service Standards.

The aim of establishing SJSN is to provide social security to all Indonesian people, in accordance with the Instruction of the President of the Republic of Indonesia Number 1 of 2022 concerning Optimizing the Implementation of the National Health Insurance Program. A person's income will not decrease or disappear if circumstances change, such as illness, accident, loss of job, retirement, or entering old age. This ensures that a person can still meet all their important needs. Several social security administering bodies are responsible for the national social security system. (Astutik, 2017)

To ensure the social security system runs well, the Health Social Security Administering Body (BPJS Health) has become the official legal entity responsible for administering social health security for the entire population of Indonesia. Comprehensive health services in accordance with medical needs and in accordance with medical standards are known as providing health insurance. Health services are provided in health facilities to promote, prevent, curative and rehabilitate. This effort is carried out by the government, regional government, and/or the community. BPJS Health participants have two types of services. The first is BPJS PBI (Contribution Assistance Recipients), which are Jamkesmas participants. The second is BPJS PBI or non-PBI, which includes health insurance, social security, premiums, civil servants, TNI, Polri and wage earners in accordance with Law no. 24 of 2011.

The Social Security System (SJSN) was established to provide comprehensive social security for all Indonesian citizens, in line with Presidential Instruction Number 1 of 2022 on Optimizing the Implementation of the National Health Insurance Program. The system ensures that an individual's income does not decrease or disappear due to unforeseen circumstances, such as illness, accidents, job loss, retirement, or aging. This allows individuals to continue meeting their essential needs. Several social security administering bodies are responsible for managing the national social security system (Astutik, 2017).

To ensure the effective implementation of the social security system, the Health Social Security Administering Body (BPJS Health) serves as the official legal entity responsible for administering national health insurance for all Indonesians. Comprehensive health services provided under BPJS Health must adhere to medical standards and cover preventive, promotive, curative, and rehabilitative healthcare. These services are delivered through government, regional authorities, and community healthcare providers. BPJS Health participants are categorized into two groups:

- BPJS PBI (Contribution Assistance Recipients) – Individuals receiving government-subsidized health insurance, including *Jamkesmas* participants.
- BPJS Non-PBI – This category includes individuals covered by health insurance, social security schemes, premium-based programs, and formal wage earners, such as civil servants, military personnel (TNI), police officers (POLRI), and private-sector employees, as stipulated in Law No. 24 of 2011.

BPJS Health: Tasks and Functions

BPJS Health has several key responsibilities (R, 2023), including:

1. Participant Enrollment – Registering and managing participant data to ensure proper inclusion in the program.
2. Contribution Collection – Collecting payments from participants and employers to sustain the health insurance system.
3. Government Financial Assistance – Managing financial aid received from the government for specific participant categories.
4. Fund Management – Ensuring the effective allocation and utilization of social security funds to maximize participant benefits.
5. Data Management – Maintaining participant records and ensuring the accuracy of social security program data.
6. Claims Disbursement – Processing and reimbursing healthcare costs according to program policies.
7. Public Information and Awareness – Providing updates and information on the implementation of the National Health Insurance (JKN) Program to participants and the public.

BPJS Health Claims Process

A health insurance claim refers to a submission made by a health facility to BPJS Health to request payment for healthcare services provided to insured patients.

Returned Claims

Returned claims refer to submitted claims that BPJS Health has verified but cannot process due to missing or incomplete documentation. These claims may require further confirmation before approval, leading to delayed payments. BPJS Health must coordinate with healthcare facilities to resolve such issues.

Claims Submission and Verification

Health facilities submit BPJS health claims monthly, and they must provide complete supporting documents. Claims are processed manually using the INA-CBGs software, which classifies medical cases for payment determination. BPJS Health verifiers assess the claims to ensure accuracy, completeness, and compliance with administrative and medical standards before approving reimbursement (Yustina, 2012). There are two types of claims:

- First-Level Health Facilities
  - Claim submission form (FPK) in three (3) copies.
  - Soft copy of service data for health facilities using the P-Care application or other BPJS Health applications (for PMI/UTD) or a manual service recapitulation for facilities that have not yet adopted the P-Care application.
  - Original receipt with sufficient stamp duty.
  - Proof of service signed by the participant or a family member.
  - Additional supporting documents required for each claim.
- Advanced Health Facilities
  - Claim submission form in three (3) copies.
  - External soft copy of the application.
  - Original receipt with sufficient stamp duty.
  - Proof of service signed by the participant or a family member.
  - Additional supporting documents required for each claim.

Emergency Services in Health Facilities Collaborating with BPJS Health
The administration of claim submission follows the same procedures as the collective claim process for health services at First-Level Health Facilities and Advanced-Level Health Facilities.

Emergency Services at First-Level Health Facilities Not Collaborating with BPJS Health (Herlambang, 2018)
- BPJS Health guarantees emergency services at first-level health facilities that do not collaborate with BPJS Health, in accordance with the applicable emergency criteria.
- Claims must be submitted collectively by health facilities to BPJS Health no later than the 10th of the following month. Health facilities must not charge patients.
- Claims should be submitted to the BPJS Health Branch Office or Regency/City Operational Office collectively every month, with general administrative documents, including:
  1. Service Recapitulation, consisting of:
     - Patient's name
     - Identity number
     - Patient's address and telephone number
     - Disease diagnosis
     - Treatments provided
     - Date of admission and discharge
     - Billing amount per patient
     - Total bill amount
  2. Copy of BPJS Health participant identity
     - Rates for emergency services at non-collaborating health facilities are equivalent to those at similar health facilities in the region, ranging from Rp. 100,000.00 to Rp. 150,000.00 per case.

Emergency Services at Advanced-Level Health Facilities Not Collaborating with BPJS Health (Megawati, 2016)
- BPJS Health guarantees emergency services at advanced-level health facilities that do not collaborate with BPJS Health, in accordance with the applicable emergency criteria.
- Costs for emergency services at non-collaborating health facilities follow the INA-CBG's package for the equivalent hospital cost group in the area, with no additional fees charged to patients.
- Health facilities without an official class designation must use INA-CBG's class D health facility rates.
- Claims must be submitted collectively by health facilities to BPJS Health no later than the 10th of the following month, in both:
  - Soft copy (from the applicable Ministry of Health INA-CBG's application output)
  - Hard copy (supporting claim documents)
- For health facilities unable to submit soft copies, claims must be manually entered at the nearest BPJS Health office.
- Claims should be submitted to the BPJS Health Branch Office or Regency/City Operational Office collectively every month, with general administrative documents, including:
  - Service Recapitulation, consisting of:
    - Patient's name
    - Identity number
    - Patient's address and telephone number
    - Disease diagnosis
    - Treatments provided

    - Date of admission and discharge
    - Number of hospitalization days (if applicable)
    - Billing amount per patient
    - Total bill amount
  - Copy of BPJS Health participant identity

Claim Submission and Payment Processing
- Pending BPJS claim files can delay claim payments to health facilities, potentially causing financial losses and delays in medical service payments, which may impact the quality of health services.
- Health facilities must submit claims regularly by the 10th of each month.
- BPJS Health is required to process payments within 15 working days from the receipt of complete claim documents at the BPJS Health Branch Office or Regency/City Operational Office.
- Patients registering for BPJS services (outpatient or inpatient) must provide a referral letter from a first-level facility. This referral letter helps determine the appropriate treatment based on the patient's condition and medical history.

Claim Verification and Expiry Period
- Verifiers must ensure that the diagnosis and procedures match the ICD-10 and ICD-9 CM coding guidelines in the INA-CBG technical manual (Nur Fadilah Dewi).
- In special cases, the Quality Control and Cost Control Team may request additional medical records from the health facility.
- Claim Expiry Limits (Erlia Safa Maulida, 2022):
  - Collective claims (for government and private health facilities, both first-level and advanced-level) must be submitted within two (2) years from the date of service.
  - Individual claims must be submitted within two (2) years from the date of service, unless otherwise specified.

B. Effectiveness of discrepancies between BPJS health claims and health service standards in Indonesia.

Health Services and BPJS Health Claims Processing

Health services aim to address, correct, and normalize health issues or deviations in society by fulfilling the needs of individuals and community groups. The demand for health services continues to increase alongside improvements in education levels and socio-economic conditions. Consequently, enhancing the effectiveness of healthcare delivery and optimizing the role of healthcare personnel remain critical challenges. (Hendra Rohman, 2021)

Health facilities are institutions that provide comprehensive healthcare services, including outpatient, inpatient, and emergency care (RI Minister of Health Regulation No. 3 of 2020). Health facilities that collaborate with BPJS Health can submit claims for reimbursement, provided they meet the eligibility criteria. For advanced healthcare service facilities (FKRTL), the INA CBG payment system is used, which categorizes diagnoses and procedures based on clinical similarity and resource utilization. Procedures are then grouped according to severity levels.

Several factors hinder the BPJS Health claims process, including:
- Participants failing to provide the necessary BPJS administrative documents.
- Delays in doctors completing and submitting medical resumes.

- Errors in entering diagnosis and treatment codes.
- Insufficient support from relevant units.
- Lack of adequate software systems.

A common issue faced by BPJS Health is the limited length of stay (LOS) for patients. Additionally, BPJS Health only reimburses generic medications, referrals from primary healthcare centers can be challenging, and discrepancies in coding verification between BPJS Health and healthcare facilities often cause delays in fund disbursement. Collaboration between medical personnel and coders is essential to minimize claim rejections and improve claim processing efficiency. Proper documentation of patient data in service recapitulation files, medical resumes, and diagnoses ensures smoother claim submissions.

Medical Coding Standards and Claim Verification

Medical record coders must understand international coding standards and procedures as outlined in the International Classification of Diseases (ICD-10). Healthcare professionals should exercise caution when completing medical resumes and submitting claims, as incomplete or incorrect diagnosis codes are among the primary reasons for claim rejections. Claim delays often stem from inadequate coder knowledge and unclear diagnosis documentation. Coding inaccuracies rank among the top factors affecting claims, often resulting from a lack of familiarity with ICD-9-CM or ICD-10-CM coding guidelines.

According to Minister of Health Regulation No. 28 of 2014 in conjunction with Minister of Health Regulation No. 3 of 2020, which outlines guidelines for the implementation of the National Health Insurance (JKN), the final stage of the claim process involves verifying claim documents. This verification ensures that BPJS Health funds are utilized effectively and efficiently. BPJS Health verifiers review submitted claims, confirm their validity, and determine the final reimbursement amount. Healthcare facilities then submit billing reports to the BPJS Health branch office.

The implementation of E-Klaim and V-Klaim facilitates claim processing and administration. Following claim verification, healthcare facilities receive one of the following four claim statuses (Devi Anyaprita):

- Eligible Claim Status
  The claim has been accepted and processed successfully.
- Ineligible or Pending Claim Status
  The claim is on hold due to incomplete or missing documents from the healthcare facility.
- Post-Claim Verification Status
  A discrepancy is found between claim data and service records, requiring revisions even after payment has been made.
- Dispute Claim Status
  A disagreement regarding clinical services or treatment requires resolution by a professional organization through the Dispute Claim Settlement Team at the Ministry of Health.

Pending Claims and Financial Implications

Pending claims (Bustami, 2011) refer to claims that remain unresolved due to disputes between BPJS Health and healthcare facilities over coding or medical policies. Resubmissions are allowed within a maximum of six months. However, claim rejections disrupt financial flows in healthcare facilities, as BPJS Health cannot process new payments until previous claims are settled. Government healthcare facilities that treat a high volume of BPJS patients may face financial losses due to discrepancies in claim reimbursements and service costs. Coding errors

significantly impact reimbursement amounts since claim payments depend on the diagnosis codes submitted to the INA-CBGs system. Incorrect coding can lead to substantial financial losses. (Imbalo Pohan, 2007)

To mitigate claim rejections, healthcare facilities strive to ensure that medical records and inpatient claim files meet all necessary requirements. In accordance with Minister of Health Regulation No. 26 of 2021, which provides guidelines for INA-CBGs implementation in health insurance, healthcare facilities aim to complete BPJS Health evaluations within one week at the latest.

Conclusion

The discrepancies between BPJS Health claims and health service standards in Indonesia indicate that significant challenges remain in the implementation of this program. The effectiveness of BPJS Health claims is often hindered by procedural and administrative barriers. Complex claims processes, strict documentation requirements, and insufficient training for medical and administrative staff contribute to high rates of claim denials and delays. These issues highlight the need for simplified claims procedures and improvements in data quality and medical documentation across healthcare facilities.

The lack of effective monitoring and evaluation by BPJS Health regarding the implementation of health service standards, coupled with the suboptimal use of technology, are key factors contributing to claim discrepancies. Inadequate supervision makes it difficult to ensure that healthcare facilities comply with established standards, while inefficient technology hampers the efficiency and transparency of the claims process. This underscores the importance of enhanced monitoring and the adoption of more advanced information technology solutions to address these challenges.

To improve the effectiveness of BPJS Health claims and ensure compliance with health service standards, several key measures should be taken:

- Simplifying claim procedures to make them easier for healthcare facilities to understand and follow.
- Enhancing medical recording and documentation systems to ensure that all claims are supported by accurate and complete data.
- Strengthening monitoring and evaluation mechanisms to ensure healthcare facilities comply with service standards.
- Adopting advanced information technology to automate and streamline the claims process, enhancing transparency and data accuracy.
- Improving communication and collaboration between BPJS Health and healthcare facilities to resolve emerging issues efficiently.

By simplifying procedures and leveraging technology, the effectiveness of BPJS Health claims can be significantly improved, leading to better healthcare services in Indonesia that align with established standards.

To enhance efficiency in claims submission and reduce the likelihood of inappropriate, pending, or disputed claims, it is essential for all healthcare facilities in Indonesia to prioritize the timely and complete collection of required documents. To minimize errors in data entry for submitted claims, personnel responsible for inputting information into the INA-CBG system should exercise greater caution. Additionally, increasing the number of coding officers at each healthcare facility would help ensure accuracy and efficiency in claims processing.

Healthcare facilities are also encouraged to conduct benchmarking activities to facilitate knowledge-sharing among staff responsible for medical records, documentation, and claim resubmissions. These efforts, particularly in handling and returning inpatient claim files, will contribute to a more efficient claims process and reduce administrative burdens on healthcare providers.

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