

Dynamics of BPJS Kesehatan Claims Resulting from Differences in the Interpretation of Healthcare Claims Verification: A Perspective on Legal Certainty and Justice

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ABSTRACT

Delayed and rejected claims remain persistent challenges in the implementation of Indonesia's National Health Insurance (JKN) program, particularly in inpatient healthcare services. One contributing factor is the difference in interpretation between the professional judgment of medical personnel and the administrative verification conducted by BPJS Kesehatan during the claims verification process. This study employed normative legal research using statutory and conceptual approaches to examine the implications of such differences from the perspectives of legal certainty and justice. The analysis was based on legislation, legal literature, and previous studies concerning the BPJS Kesehatan claims system, professional medical judgment, legal certainty, and justice. The findings demonstrate that differences in interpretation may arise in establishing diagnoses, supporting diagnostic examinations, medical coding, and determining claim eligibility. Consequently, healthcare services considered medically necessary based on professional judgment may not necessarily be recognized as eligible for reimbursement under the BPJS Kesehatan claims system. These differences contribute to delayed and rejected claims, creating legal uncertainty regarding healthcare facilities' entitlement to reimbursement while also raising concerns of justice due to the imbalance between administrative compliance and the legitimate interests of healthcare facilities. The study argues that a clearer mechanism for resolving differences in interpretation during claims verification is necessary to strengthen legal certainty and promote justice within the implementation of the National Health Insurance (JKN) program.

INTRODUCTION

Health is a constitutional right of every citizen, as guaranteed under Article 28H paragraph (1) of the 1945 Constitution of the Republic of Indonesia. As a manifestation of the state's responsibility to fulfill the public's right to health, the government established the National Social Security System through the National Health Insurance Program (Jaminan Kesehatan Nasional/JKN). The JKN program is administered by Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS Kesehatan) as a public legal entity responsible for ensuring access to healthcare services for the Indonesian population.

In practice, the JKN claims system has not yet operated optimally. Throughout 2024, BPJS Kesehatan delayed claim payments amounting to IDR 5.92 trillion across approximately 3.69 million cases. In addition, the Indonesian Hospital Association (Perhimpunan Rumah Sakit Seluruh Indonesia/PERSI) reported that approximately 15% of hospital claims experienced payment delays. This situation not only imposes financial burdens on hospitals but also has the potential to affect patients' access to and the quality of healthcare services. The magnitude of these delayed claims indicates that issues surrounding BPJS Kesehatan claims extend beyond mere administrative matters and reflect the complexity of the claim verification process and the assessment of the eligibility of healthcare services provided by healthcare facilities.

Within the National Health Insurance (JKN) system, BPJS Kesehatan is authorized to conduct claim verification as part of the mechanism for controlling healthcare financing funded by the National Social Security Fund. This authority is intended to ensure that healthcare services provided by healthcare facilities comply with the applicable regulations and are eligible for coverage under the JKN program. Nevertheless, in practice, the claim verification process frequently gives rise to differences in interpretation between the professional judgment of medical personnel and the administrative verification conducted by BPJS Kesehatan, which may result in delayed or rejected claims. Therefore, it is important to examine whether the current claim verification mechanism provides sufficient recognition of the professional judgment of medical personnel without undermining the principle of accountability in healthcare financing under the JKN system. The existing mechanism has the potential to create legal uncertainty for healthcare facilities, as healthcare services may have been provided based on the professional judgment of medical personnel, while their eligibility for reimbursement remains subject to dispute during the claim verification process. Furthermore, rejected claims may also give rise to concerns of justice, as the financial burden of healthcare services is ultimately borne by healthcare facilities despite the services having been provided to insured patients.

Previous studies have primarily examined delayed and rejected BPJS Kesehatan claims from the perspectives of administrative procedures, diagnostic coding, and claims management. However, studies specifically analyzing differences in interpretation between the professional judgment of medical personnel and BPJS Kesehatan administrative verification from the perspectives of legal certainty and justice remain limited. Against this background, this study aims to analyze how such differences in interpretation during the BPJS Kesehatan claim verification process contribute to delayed and rejected healthcare claims, as well as to examine their implications for the principles of legal certainty and justice.

METHOD

This study employed a normative legal research method using a statutory approach and a conceptual approach. Legal materials were obtained through library research and consisted of

primary, secondary, and tertiary legal sources related to the implementation of the National Health Insurance (JKN) program, the BPJS Kesehatan claims verification mechanism, the professional judgment of medical personnel, and the principles of legal certainty and justice. The legal materials were then analyzed qualitatively through legal interpretation and conceptual analysis to examine the implications of differences in interpretation arising during the BPJS Kesehatan claim verification process from the perspectives of legal certainty and justice.

RESULT AND DISCUSSION

1. Legal Framework for BPJS Kesehatan Klaim Verification

The implementation of the National Health Insurance (JKN) program forms part of Indonesia's National Social Security System and is administered by BPJS Kesehatan as a public legal entity. Under the JKN program, healthcare services are delivered through healthcare facilities that have entered into cooperation agreements with BPJS Kesehatan in accordance with the applicable laws and regulations.

Hospital healthcare services are reimbursed under the Indonesia Case Base Groups (INA-CBGs) system, which adopts a prospective payment system, while the reimbursement rates are determined in accordance with government regulations. Following the provision of healthcare services, hospitals submit claims to BPJS Kesehatan in accordance with the applicable administrative procedures. BPJS Kesehatan subsequently verifies the administrative documents, diagnoses, supporting diagnostic examinations, and medical coding to determine the eligibility of claims for reimbursement.

During the verification process, BPJS Kesehatan assesses whether the submitted claim complies with the applicable administrative and medical requirements to determine its eligibility for reimbursement. Where non-compliance with the applicable regulations is identified, the claim may be returned to the healthcare facility for revision, placed on pending status, or rejected. It is at this stage that differences in interpretation between the professional judgment of medical personnel and the administrative verification conducted by BPJS Kesehatan are most likely to arise.

2. Differences in the Interpretation of Healthcare Services between Medical Personnel and BPJS Kesehatan Administrative Verifiers

In medical practice, physicians exercise professional authority to conduct history taking, perform physical examinations, determine the need for supporting diagnostic examinations, establish diagnoses, and prescribe appropriate treatment based on the patient's clinical condition in accordance with professional standards and standard operating procedures. Accordingly, decisions concerning diagnosis, indications for hospitalization, and medical interventions constitute the professional judgment of medical personnel, which forms the basis

for medical record documentation and the submission of healthcare claims under the National Health Insurance (JKN) program. By contrast, within the JKN financing system, BPJS Kesehatan verifies claims based on the applicable administrative requirements and claims verification guidelines. These differing approaches may give rise to differences in interpretation between the professional judgment of medical personnel and the administrative verification conducted by BPJS Kesehatan, as healthcare services are provided based on each patient's individual clinical condition, whereas administrative verification is conducted in accordance with predetermined requirements and verification guidelines.

A study by Agiwahyunto et al. reported that 36 pediatric bronchopneumonia claims (9.63%) were rejected by BPJS Kesehatan because the physicians' diagnosis of pneumonia was considered inconsistent with the INA-CBGs verification guidelines and was not supported by chest radiographic findings indicative of bronchopneumonia. In contrast, Hagaman et al. found that 21% (22 of 105) of patients with a clinical diagnosis of pneumonia had negative chest radiographs at the time of their initial presentation.

Similar findings were reported in a study conducted at Sebelas Maret University (UNS) Hospital. The study found that delayed claims were not solely attributable to coding errors but were also associated with differences in perception between hospital personnel and BPJS Kesehatan regarding the adequacy of supporting clinical evidence required to establish a diagnosis. Consequently, insufficient supporting clinical evidence led BPJS Kesehatan to question the diagnostic codes submitted by the hospital during the claims verification process.

Differences in interpretation may also arise in the coding of diagnoses and medical procedures. A study conducted at Pandan Arang Regional General Hospital found that 18% of diagnosis codes were inaccurate, resulting in delayed claims. The identified inaccuracies included incorrect code selection, reselection of the principal diagnosis, and the inappropriate use of combination codes. These findings suggest that the clinical information documented by physicians in medical records must subsequently be translated into the administrative coding system used under INA-CBGs. It is during this translation process that differences in interpretation may arise and ultimately influence the outcome of the claim verification process.

Rohman et al. found that the primary factors contributing to delayed claims were inaccurate medical coding (43%), diagnoses that did not meet the applicable verification criteria (34%), and incomplete claim documentation (23%).¹⁸ To reduce the occurrence of delayed claims, the study recommended strengthening communication and coordination with the attending physicians, providing coding training, and improving the dissemination of claims-related procedures to the units involved in the claims process. The need to enhance coordination with attending physicians indicates that the claim verification process extends beyond administrative compliance and also depends on the adequacy of clinical documentation and the physicians' clinical judgment.

The above studies demonstrate that the differences in interpretation between healthcare facilities and BPJS Kesehatan extend beyond administrative compliance and involve clinical diagnosis, supporting diagnostic examinations, clinical documentation, and medical coding. While physicians establish diagnoses and determine appropriate medical management based on their professional judgment and patients' clinical needs, BPJS Kesehatan verifies claims against administrative requirements and applicable claims verification guidelines. These differing approaches may result in returned claims for revision, delayed claims, or claim rejections, ultimately affecting the financing of healthcare services under the National Health Insurance (JKN) program.

3. Analysis of Differences in Interpretation from the Perspectives of Legal Certainty and Justice

The above studies demonstrate that differences in interpretation between the professional judgment of medical personnel and the administrative verification conducted by BPJS Kesehatan may arise at various stages of the claims process, including the establishment of diagnoses, the fulfillment of supporting diagnostic examination requirements, medical coding, and the determination of claim eligibility for reimbursement. Such differences not only result in claims being returned for revision or placed on pending status but, in certain cases, also lead to claim rejections despite healthcare services having already been provided to patients.

These circumstances raise important legal questions regarding how such differences in interpretation should be assessed from a legal perspective. BPJS Kesehatan administrative verifiers are required to perform claim verification in accordance with the applicable legal and regulatory framework governing the National Health Insurance (JKN) program. On the other hand, medical personnel exercise professional authority to establish diagnoses and determine appropriate medical treatment based on patients' clinical conditions. Accordingly, it is necessary to examine the relationship between compliance with positive law and the realization of justice in the BPJS Kesehatan claims verification process.

According to Hans Kelsen, law constitutes a system of valid norms that is binding upon all legal subjects. The validity of a legal act is determined by its conformity with the applicable legal norms rather than by considerations of morality or justice. Accordingly, the law must be applied in accordance with the norms established by the legal system.

In the context of BPJS Kesehatan claims verification, the positivist approach to law is reflected in the obligation of administrative verifiers to assess claims in accordance with the applicable laws and regulations, claims verification guidelines, and the INA-CBGs framework. Accordingly, decisions to delay or reject claims due to non-compliance with administrative requirements essentially constitute the implementation of positive legal norms governing the financing mechanism of the National Health Insurance (JKN) program.

From the perspective of legal positivism, BPJS Kesehatan administrative verifiers may be regarded as acting in accordance with the applicable legal norms, as claim verification is based on compliance with the legal and administrative requirements established under the National Health Insurance (JKN) program.

Although the actions of BPJS Kesehatan administrative verifiers may be justified under the applicable positive law, they do not necessarily reflect substantive justice for all parties involved in the implementation of the National Health Insurance (JKN) program. Physicians may have established a diagnosis and provided healthcare services based on the patient's clinical condition and professional judgment; however, such diagnoses may subsequently be considered insufficient to satisfy the applicable verification criteria because they are not supported by the diagnostic examinations or other clinical evidence required under the claims verification process.

This situation raises concerns of justice because healthcare facilities have already committed substantial resources, including medical personnel, medicines, medical supplies, and operational costs, to provide healthcare services to patients, yet reimbursement may be delayed or denied due to differences in the assessment of the evidentiary basis supporting the diagnosis. In other words, although healthcare services have been duly provided to patients, healthcare facilities are not necessarily guaranteed reimbursement for the services rendered.

According to John Rawls, justice is founded upon the principle of *justice as fairness*, which requires that all parties within a legal system be treated fairly and proportionately. Within the context of the National Health Insurance (JKN) program, BPJS Kesehatan has a legitimate obligation to ensure the accountability of public health insurance funds through the claims verification mechanism. At the same time, healthcare facilities also possess a legitimate interest in obtaining reimbursement for healthcare services rendered in accordance with professional standards and the applicable legal and regulatory framework.

From Rawls' perspective of justice, a claims verification mechanism should not be exclusively oriented toward protecting the interests of BPJS Kesehatan as the administrator of the National Health Insurance (JKN) fund but should also give due consideration to the legitimate interests of healthcare facilities as providers of healthcare services. Where differences in interpretation regarding diagnoses and supporting diagnostic examinations result in delayed or rejected claims without an adequate mechanism for resolving such disagreements, the balance between the legitimate interests of the parties may be undermined.

In addition to raising concerns of justice, these circumstances also give rise to issues of legal certainty. Healthcare facilities cannot always predict with certainty whether the claims they submit will be approved, delayed, or rejected due to differences in the interpretation of medical evidence and claim eligibility. According to Jan Michiel Otto, legal certainty is not determined solely by the existence of clear legal rules but also by their consistent application and their ability to provide predictability for legal subjects. Differences in the interpretation of

the sufficiency of medical evidence and claim eligibility may therefore undermine legal certainty by creating uncertainty regarding the fulfillment of the rights and obligations of the parties within the National Health Insurance (JKN) system.

Accordingly, the issues identified in this study extend beyond questions of compliance with positive law and the realization of justice. They also concern legal certainty in the legal relationship between BPJS Kesehatan and healthcare facilities in the administration of the National Health Insurance (JKN) program.

CONCLUSION

This study demonstrates that delayed and rejected BPJS Kesehatan claims may arise from differences in interpretation between the professional judgment of medical personnel and the administrative verification conducted by BPJS Kesehatan in assessing diagnoses, supporting diagnostic examinations, medical coding, and claim eligibility. Such differences may result in healthcare services that are considered medically necessary and appropriate by medical personnel not necessarily being recognized as eligible for reimbursement under the BPJS Kesehatan claims system.

From the perspective of legal certainty, these circumstances create uncertainty regarding healthcare facilities' entitlement to claim reimbursement, as the outcome of the verification process largely depends on the interpretation of the medical evidence submitted. From the perspective of justice, delayed and rejected claims may give rise to an imbalance in the protection of the legitimate interests of BPJS Kesehatan and healthcare facilities, as healthcare services have been provided in accordance with patients' medical needs, yet reimbursement is not necessarily guaranteed. Therefore, a mechanism capable of minimizing differences in interpretation during the claims verification process is required to promote legal certainty and justice in the implementation of the National Health Insurance (JKN) program.

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