

## Evaluation of BPJS Health Administration in Reducing Pending Claims at the Buton District Hospital BLUD in 2025

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### A B S T R A C T

*The BPJS Health claim administration system plays a vital role in supporting the continuity of healthcare financing in hospitals; however, the high number of pending claims indicates persistent implementation challenges. This study aims to evaluate the effectiveness of the claim administration system at BLUD RSUD Kabupaten Buton, focusing on timeliness, procedural compliance, document completeness, and barriers affecting claim submission. The research applied a descriptive qualitative approach through interviews, observations, and document reviews involving five key informants directly engaged in the claim process. The results show that although standard operating procedures have been established, their implementation remains inconsistent across units, leading to submission delays. Issues of document completeness and accuracy are still prevalent due to weak internal validation. Systemic barriers were also identified, including limited human resources, inadequate inter-unit coordination, technical disruptions, and the absence of optimal periodic evaluations. Several improvement efforts have been introduced, such as document simplification, routine evaluations, and the establishment of a coordination team. Nevertheless, these efforts have not yet addressed the need for comprehensive system restructuring. In conclusion, the claim administration system at BLUD RSUD Kabupaten Buton functions but remains suboptimal, requiring improvements in procedures, human resource capacity, and cross-unit coordination to reduce pending claims and enhance service efficiency.).*

### PENDAHULUAN

Hospitals are key institutional actors in the health system, with a mandate that is not limited to curative and preventive care, but also includes the education of health professionals and the advancement of medical science through research. (WHO, 2020). Within the framework of national regulations, hospitals are required to provide comprehensive services, ranging from outpatient care, inpatient care, to emergency units.. (Rizky, 2020). All of these functions are supported by medical records that serve a dual purpose: as clinical archives, legal instruments, and administrative bases in the construction of healthcare financing. (Kusumawati, 2019).

Within the framework of the implementation of the National Health Insurance (JKN), hospital claims are positioned as an essential financial mechanism for the continuity of health service financing. The validity of claims requires procedural compliance and document integrity, because even the slightest deviation can result in the return of files or delays in payment realization. (Supriadi & Rosania, 2019). For hospitals with a majority of JKN participants as patients, delays in claim disbursements have a direct impact on cash flow pressure and have the potential to disrupt operational continuity. (Halawa, 1018).

Recent literature identifies a number of determinants of barriers in claims administration, including diagnosis code mismatches, administrative verification inconsistencies, and insufficient supporting documentation. (Ningsih, Santoso, & Prasetyo, 2022). (Kusumawati, 2019) emphasizes that internal verifiers play a strategic role in controlling document quality to reduce the accumulation of pending claims. However, observations at the Buton District Hospital BLUD in March 2025 revealed an average backlog of around 100 claims per month, particularly in outpatient dental services and inpatient cases where there was a discrepancy between the diagnosis code and clinical findings. This situation reflects procedural inconsistency

Health claims administration can be defined as an operational relationship that bridges the provision of medical services with financial compensation from funders. (McLaughlin & Kaluzny,

2018). In the context of public administration, efficiency is reduced to two benchmarks: temporal accuracy and procedural discipline, which determine the smooth running of the claims mechanism. The dimension of organizational effectiveness focuses on the achievement of institutional goals through procedures that are reliable, appropriate, and in accordance with service quality standards. (Cameron & Whetten, 2019). serves as the backbone of verification, while the risk management approach (Hopkin, 2018) enables the identification and mitigation of potential administrative disruptions. Improvement efforts can take two forms: Kaizen, which focuses on gradual, continuous improvement, and Business Process Reengineering (BPR), which emphasizes a comprehensive restructuring of the claims process. (Imai, 2018; Hammer & Champy, 2019).

Based on this framework, an evaluation of the effectiveness of the BPJS Kesehatan claims administration system at the Buton District Hospital BLUD is significant. Delays in cash flow not only cause fiscal instability for the institution, but also erode service quality through disruptions in the availability of medicines, medical devices, and remuneration for health workers. (Jannah & Hariyati, 2020). Therefore, this study aims to examine the sources of administrative inefficiency, assess claim performance based on the principles of efficiency and effectiveness, and formulate improvement schemes that are not only remedial but also preventive, based on public administration theory, health information systems, and risk management.

## METHODE

This study is placed within a qualitative descriptive framework, not merely as an attempt to inventory procedures, but as an interpretive effort to uncover the organizational logic that supports the administration of BPJS Kesehatan claims at the Buton District Hospital BLUD. This approach was chosen based on the awareness that the issue of claim delays cannot be explained solely through statistical measures, but requires an understanding that is directly related to institutional routines, administrative documents, and latent norms that shape work patterns. Informants were selected using a purposive technique, considering their strategic position and practical authority in the claim management cycle, namely claim administration officers, medical record officers, BPJS verifiers, the head of the finance department, and the service manager who also coordinates the treatment room. Their testimonies were not treated as separate individual voices, but as intertwined perspectives within a broader institutional discourse.

Fieldwork was conducted in March–April 2025 by combining three complementary techniques: (1) situational observation of the claim management process and interdepartmental interactions; (2) dialogic interviews aimed at eliciting interpretive explanations, not just superficial opinions; and (3) document tracing that followed the flow of claims through registers, forms, and standard formats. Throughout the process, researchers functioned not only as passive data collectors, but also as key interpretive instruments that were responsive to field dynamics and sensitive to emerging new signals.

The analysis stage referred to the interactive framework of Miles, Huberman, and Saldana. (Sugiyono, 2013). However, it is treated as a recursive cycle in which reduction, configuration, and conceptualization occur simultaneously, rather than linearly. The validity of the findings is maintained through layered triangulation across sources, techniques, and time frames, so that the research results are not only empirically valid but also conceptually robust.

## RESULTS & DISCUSSION

### Evaluation of Timeliness and Procedures

Empirical exploration of the effectiveness of the BPJS Kesehatan claim administration system at the Buton District Hospital BLUD was conducted through focused interviews with claim administration officers, medical record officers, BPJS verifiers, and service managers. This interaction process did not merely collect descriptive information, but also reconstructed the operational dynamics that occur in daily practice. From these conversations, patterns of interconnection were identified between the implementation of claim procedures and the Standard Operating Procedures (SOP) framework, the frequency of recurring delays, systemic and technical obstacles, and assessments of the degree of time efficiency achieved.

**Table 1.** Synthesis of Interviews on the Effectiveness of the BPJS Health Claim Administration System

| No | Question | Answer | Informan |
|----|----------|--------|----------|
|----|----------|--------|----------|

|   |                                                                               |                                                                                                                                                                                                                                                |                                               |
|---|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| 1 | What is the flow or stages of the BPJS Health claim process at this hospital? | "The process begins with the unit filling in the service data, followed by the creation of claim files, verification by us, and then uploading to BPJS e-claim. However, sometimes the documents from the unit arrive late or are incomplete." | Claims Administration Officer (June 30, 2025) |
| 2 | Have all claim procedures followed the established SOP?                       | "The SOP for claims is clear, but its implementation has not been consistent. There are often delays in filling out forms and formats that do not meet standards."                                                                             | Medical Records Officer (June 30, 2025)       |
| 3 | How often do delays occur in the claim submission process?                    | "Delays often occur, especially at the end of the month when patient volume increases. The average delay can be 3 to 5 days from the ideal schedule".                                                                                          | Service Manager (June 30, 2025)               |
| 4 | What are the factors causing delays in the claim process?                     | "We receive documents for verification, but 30% of them have to be returned due to coding errors or incomplete documentation."                                                                                                                 | Verifikator BPJS (30 Juni 2025)               |
| 5 | How would you rate the time efficiency of the claim administration process?   | "Ideally, verification should be completed within a day if the documents are complete. But in reality, many documents need to be revised, so efficiency drops dramatically."                                                                   |                                               |

Sumber: Data Terolah, 2025

The findings of the interviews indicate a gap between procedural design and operational reality. Although the claims mechanism has been stipulated through SOPs, practices in the field show inconsistencies: documents from service units are often submitted late, while the error rate in coding reaches around 30%, resulting in repeated returns of files. The accumulation of these issues causes an average time deviation of 3–5 days from the (Cameron & Whetten, 2019). Compliance with procedures is not merely a formality, but a fundamental indicator of the effectiveness of public bureaucracy. Therefore, the failure to maintain consistency in SOPs at this hospital can be seen as a key variable underlying the delay in the claims process.

**Table 2.** Results of Pending Claim Timeliness Evaluation Observations

| Observed Aspects          | Observation Indicators              | Assessment Criteria | Field Notes                                                           |
|---------------------------|-------------------------------------|---------------------|-----------------------------------------------------------------------|
| Claims submission process | Claim process flow according to SOP | Yes                 | The process follows SOPs, but is not yet consistent across all units. |
| Claim processing time     | Completion time                     | Currently           | On average, 3–5 days, excluding additional revisions                  |
| Accuracy between stages   | Accuracy of document input          | Late                | Document input and delivery often run behind schedule                 |
| Procedural compliance     | Internal validation                 | No                  | Many validation steps have been skipped.                              |

Sumber: Data Terolah, 2025

Direct observation in the field not only serves to verify the results of interviews, but also reveals the dynamics of inconsistencies in the implementation of procedures. Although the claims process is framed by Standard Operating Procedures, practices between units show clear disparities. The internal validation mechanism, which should be the last safeguard before a claim is submitted, is often overlooked, allowing administrative errors to continue to the BPJS verification stage. This situation shows that the existence of formal procedures does not automatically guarantee orderly implementation, because administrative effectiveness is essentially determined by consistency of implementation, not merely by the clarity of written rules. (Supriadi & Rosania, 2019).

### Assessment of Document Completeness and Accuracy

The completeness and accuracy of documents is not merely an administrative requirement, but a determining factor that regulates the effectiveness of the BPJS Kesehatan claims system. Every gap in the form of an incomplete form, ambiguous diagnosis code, or delayed medical summary acts as a small friction that slows down the entire verification mechanism. The financial consequences cannot be underestimated, as delays in claim disbursement directly affect the liquidity and stability of hospital cash flow. (Kusumawardhani & Pratama, 2021).

Field findings show that document problems often stem from three crucial points: (1) slow and fragmented medical resume filling practices at the clinician level, (2) imprecise diagnosis coding, which creates potential for verification disputes, and (3) administrative errors in formats that should be standardized. In addition, the lack of alignment between digital data and physical archives creates an information paradox, while weak cross-unit coordination increases the likelihood of invalid data passing through to the external verification stage. (Ningsih, Santoso, & Prasetyo, 2022)

This series of findings is synthesized in the following table as a structured representation of in-depth interviews regarding the completeness and accuracy of documents supporting claims..

**Table 3.** Synthesis of Interviews on the Completeness and Accuracy of Documents Supporting Claims in the BPJS Health Administration System

| No | Question                                                                                              | Answer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Informan                                                                                           |
|----|-------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| 6  | What documents must be attached when submitting a BPJS claim?                                         | Required documents include SEP, patient medical records, INA-CBGs forms, supporting examination results such as laboratory and radiology reports, referral letters, and internal verification forms. All documents must be complete and dated according to the date of service.<br>“Documents include patient identification, initial assessment sheet, medical summary, nursing actions, supporting examination results, and medical consent form. All must be signed by authorized medical personnel.” | Claims Administration Officer (July 1, 2025)<br>Medical Records Officer (July 1, 2025)             |
| 7  | To what extent are the documents completed by each service unit?                                      | The completeness of documents varies. Outpatient clinics tend to be more organized, while emergency rooms and inpatient wards are often late or lack attachments. Many files are returned for completion.<br>Some units are quite organized, but there are incomplete documents due to staff rotation or patient overload. Medical resumes are often unsigned or lab results are not printed.                                                                                                            | Claims Administration Officer (July 1, 2025)<br>Petugas Rekam Medis (1 Juli 2025)                  |
| 8  | Is there a validation or re-checking process for documents before they are sent to BPJS?              | There is an internal validation process to check the completeness and accuracy of the INA-CBGs form against the resume, as well as the signature. If it is incomplete, it is returned to the relevant unit.                                                                                                                                                                                                                                                                                              | Claims Administration Officer (July 1, 2025)                                                       |
| 9  | How do you assess the accuracy and suitability of the data in the supporting documents for the claim? | Medical diagnoses are checked for consistency with claim codes. Inconsistencies are still frequently found. Approximately 20–30% of claims need to be revised each month.                                                                                                                                                                                                                                                                                                                                | BPJS Verifier (July 1, 2025)                                                                       |
| 10 | What is the impact of incomplete or inaccurate documents on the claims process?                       | Incomplete documents cause claims to be delayed. If revisions are not made immediately, claims will be delayed and payments will be late.<br>“The impact is significant on hospital cash flow. Delayed claims mean delayed income, affecting financial stability.”                                                                                                                                                                                                                                       | BPJS Claims Administration Officer (July 1, 2025)<br>Head of the Finance Department (July 1, 2025) |

Sumber: Data Terolah, 2025

These interview findings were confirmed through direct observation of administrative claim documents, as presented in the following table.

**Table 4.** Synthesis of Observations on the Completeness and Accuracy of Claim Documents

| Observed Aspects               | Observation Indicators    | Assessment Criteria | Field Notes / Comments                                                      |
|--------------------------------|---------------------------|---------------------|-----------------------------------------------------------------------------|
| Claim administration documents | Completeness of documents | No                  | Medical resume is incomplete, laboratory results are not attached.          |
|                                | Akurasi isi dokumen       | No                  | There are errors in diagnosis coding and data inconsistencies.              |
|                                | Internal validation       | No                  | Inconsistent validation, many files are submitted without initial checking. |

Sumber: Data Terolah, 2025

Field observations reaffirmed the issues previously revealed through interviews, namely the fragility of internal validation mechanisms and the inconsistency of unit compliance with document completeness standards. This phenomenon shows that the obstacles are not only technical in nature, but also cultural, related to medical record-keeping discipline and sporadic cross-unit coordination patterns.

Thus, the necessary transformation cannot rely solely on administrative corrections, but requires systemic strengthening that instills documentation discipline and restructures coordination channels to ensure the reliability of the claims system.

### Identifying Obstacles in the Claims Administration System

Although the procedural framework for administering BPJS Kesehatan claims at the Buton District Hospital BLUD has been established with reference to official regulations and operational protocols, the reality of its implementation still shows signs of dysfunction. The disruptions that arise are heterogeneous and occur at both the intra-organizational and extra-organizational levels. Empirically, the most obvious patterns of deviation are delays in document flow, disharmony between manual archives and digital databases, a shortage of operational personnel, and technical anomalies in the information system. (Putri & Adiprasetyo, 2020).

In addition, there is fragmentation in coordination between units that has not been systematically bridged, while the use of digital technology is still partial and has not achieved full integration. The accumulation of these factors prolongs the latency of claim settlements and reduces the degree of administrative efficiency. (Wahyudi & Hidayat, 2023). Interviews with informants also confirmed that these obstacles were not merely operational in nature, but also reflected structural problems that required comprehensive reconstruction. A detailed summary of the obstacles is presented in the following table.

**Table 5.** Synthesis of Interviews on Barriers in the BPJS Health Claim Administration System

| No | Question                                                                                                                                           | Answer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Informan                                                                                                                                                                                                                             |
|----|----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 11 | What are the main obstacles encountered in the BPJS claim administration process at this hospital?                                                 | <p>“The obstacles include delays in document submission from service units, discrepancies between physical and digital documents, limited human resources, and technical disruptions to the e-claim system.”</p> <p>“Delays in filling out resumes by doctors, lack of coordination between teams, and changes in BPJS document requirements that are not always communicated.”</p> <p>“Inaccurate coding of diagnoses and procedures, lack of understanding of document content by service units, and limited verification time.”</p> <p>“Delays in data and document collection, as well as the lack of an integrated system between units, have led to miscommunication.”</p> <p>“High workload, lack of training in claims administration, staff turnover, and errors in filling out documents.”</p> | <p>Claims Administration Officer (July 3, 2025)</p> <p>Medical Records Officer (July 3, 2025)</p> <p>BPJS Verifier (July 3, 2025)</p> <p>Kepala Bagian Keuangan (3 Juli 2025)</p> <p>Service Manager/Head of Room (July 3, 2025)</p> |
| 12 | Have there been any claims that were put on hold due to procedural errors or incomplete data?                                                      | <p>“There are often delays due to missing documents or errors in filling out the INA-CBGs form. Failure to follow SOPs is also a cause.”</p> <p>Very often, mainly due to diagnostic code errors, date discrepancies, and unsynchronized documents. Files may be returned multiple times.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <p>Claims Administration Officer (July 3, 2025)</p> <p>BPJS Verifier (July 3, 2025)</p>                                                                                                                                              |
| 13 | Are there any obstacles arising from the information technology system, such as applications or data integration between departments?              | <p>“There are obstacles in the form of disruptions to the e-claim system, slow networks, and a lack of integration between systems, meaning that some processes are still manual.”</p> <p>“Often, medical record applications are not directly connected to the claims system. Data must be re-entered, increasing workload and the risk of errors.”</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p>Claims Administration Officer (July 3, 2025)</p> <p>Medical Records Officer (July 3, 2025)</p>                                                                                                                                    |
| 14 | How would you rate the coordination or communication between the service, medical records, finance, and verifier departments in claims management? | <p>“Coordination between units is still sectoral. There is no systematic cross-unit monitoring, so the claims process is prone to delays.”</p> <p>“Coordination is ongoing but not yet optimal. Miscommunication still occurs frequently, especially regarding schedules and document revisions.”</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <p>Head of Finance (July 3, 2025)</p> <p>Claims Administration Officer (July 3, 2025)</p>                                                                                                                                            |

| No | Question                                                   | Answer                                                                                                                                                                                                        | Informan                                                                      |
|----|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| 15 | In your opinion, what is the main cause of pending claims? | “Incomplete documentation, errors in filling out INA-CBGs forms, and discrepancies in diagnosis codes and service dates. In addition, weak consistency in the implementation of SOPs was also a major cause.” | Summary of responses from BPJS Claims Administrator & Verifier (July 3, 2025) |

Sumber: Data Terolah, 2025

Furthermore, empirical observations in the field confirm the existence of previously identified obstacles, particularly in the technological and coordination spheres.

Table 6. Observation Results of Identifying Obstacles in the Claims Administration System

| Aspect                       | Category                               | Description                                                                        |
|------------------------------|----------------------------------------|------------------------------------------------------------------------------------|
| Claims administration system | Form filling errors / data duplication | Occurred – INA-CBGs forms are often incorrect in terms of actions and rates.       |
|                              | Technical obstacles                    | There is – The e-claim system is slow, the network is unstable.                    |
|                              | Coordination barriers                  | Visible – Communication still relies on verbal channels and is not yet systematic. |
|                              | Response to obstacles                  | Slow – Confirmation takes a long time, follow-up is often delayed.                 |

Sumber: Data Terolah, 2025

The correlation between the interview and observation results shows that the obstacles that arise cannot be reduced to mere technical errors in filling out documents. Instead, they are a manifestation of structural problems in the claim management architecture. Human resource competency deficits, dissonance between information platforms, and fragmented coordination across units reveal that the inefficiencies of the claim administration system are systemic. (Ningsih, Santoso, & Prasetyo, 2022) Therefore, the necessary improvements cannot be limited to procedural adjustments, but must involve a comprehensive reconstruction that touches on managerial foundations and digital infrastructure.

### Recommendations for Improving the Claims Administration System

The findings from the interviews indicate that although the BPJS Kesehatan claim administration system at the Buton District Hospital BLUD formally operates in accordance with the procedural framework, the reality of its implementation is still overshadowed by a number of obstacles that undermine its operational effectiveness. (Ningsih, Santoso, & Prasetyo, 2022). On that basis, the informants formulated strategic recommendations aimed not only at technical aspects, but also at structural dimensions. These recommendations included intensifying cross-unit coordination, augmenting human resource capacity, maximizing the use of digital technology, and institutionalizing continuous training for officers involved in the claims mechanism. (Ningsih, Santoso, & Prasetyo, 2022)

Table 7. Observation Results and Recommendations for Claim Improvements

| Observed Aspects           | Observation Indicators                 | Assessment Criteria | Field Notes / Comments                                                               |
|----------------------------|----------------------------------------|---------------------|--------------------------------------------------------------------------------------|
| System improvement efforts | Changes to procedures/document formats | Terlihat            | There have been changes to the checklist and resume format.                          |
|                            | Implementation of routine evaluations  | Yes                 | Evaluation meetings were held, but not uniformly across all units.                   |
|                            | Improvement initiatives                | Ada                 | The coordination group and special staff assignment for claims have begun operating. |
|                            | Application of Kaizen / BPR principles | Yes                 | Kaizen is underway, but BPR has not been fully implemented.                          |

Sumber: Data Terolah, 2025

The synthesis of interviews and observations shows that the required improvements cannot be limited to procedural adjustments alone, but must extend to the structural and organizational realms. The long-term agenda necessitates the renewal of SOPs, the integration of interoperable information platforms, and the strengthening of a continuous cross-unit evaluation culture. With this orientation, the claims administration system has the potential to transform from a mere instrument for fulfilling technical formalities into a proactive, efficient, and adaptive managerial tool for contemporary healthcare dynamics. (Puspaningsih, Santoso, & Ramadhan, 2022)

## CLOSING

Based on the results of research conducted through in-depth interviews, direct observation, and data analysis on the BPJS Kesehatan claim administration process at the Buton District Hospital BLUD, it can be concluded that the effectiveness of the claim administration system is at a level that is “functional but not yet optimal.” Timeliness and claim procedures still face obstacles, even though the workflow is in accordance with standard operating procedures (SOP). Inconsistent implementation between units causes delays in claim submissions. In terms of documentation, completeness and accuracy remain major obstacles, as most files are returned for correction due to errors in filling out the INA-CBGs form, diagnosis code discrepancies, and data inconsistencies. Other systemic obstacles were also found, such as limited human resources, lack of coordination, technical disruptions to the e-claim system, and weak routine evaluation mechanisms, all of which have a direct impact on the high number of pending claims.

However, internal improvements have been made, including through periodic evaluations, the use of document checklists, simplification of medical resume formats, and the formation of cross-departmental coordination teams. However, these measures are still partial and have not touched on comprehensive restructuring, so the improvements made have not had a significant impact on reducing pending claims or improving the efficiency of the claims administration system. Thus, the research objective of identifying the effectiveness of the BPJS Kesehatan claim administration system at the Buton District Hospital BLUD can be answered by stating that the system has been running in accordance with formal regulations, but its effectiveness is still limited and requires more comprehensive improvements.

The limitations of this study lie in the scope of the data, which only covers a specific period, and the limited number of informants interviewed, so that the results do not fully represent the entire range of claim issues in hospitals. Furthermore, this study only focuses on administrative aspects without further exploring external factors such as national BPJS policies and health regulation dynamics. Therefore, future studies are expected to expand the scope of informants, use quantitative data on the number of pending claims longitudinally, and add analysis of external factors that also influence the effectiveness of claim administration.

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