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Exploring the implications of national health insurance claim disputes for hospital cash flow in the fourth quarter: A qualitative study in Indonesia

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Abstract

Background: Claim disputes within Indonesia's National Health Insurance (JKN) system, administered by BPJS Kesehatan, represent a significant challenge in the healthcare reimbursement process. Unresolved or disputed claims may delay reimbursement to hospitals, potentially disrupting cash flow and affecting their financial stability.
Purpose: To analyze the impact of BPJS Kesehatan claim disputes on the cash flow of Hospital X during the fourth quarter of 2025.
Method: A qualitative descriptive case study was conducted. Data were collected through in-depth semi-structured interviews with two key informants, a hospital claim verifier and a finance officer, supplemented by a review of BAHV documents and claim dispute recapitulation records for the fourth quarter of 2025. Data were analyzed using the Miles and Huberman interactive model, comprising data reduction, data display, and conclusion drawing and verification.
Results: A total of 871 disputed claims valued at IDR 5,474,454,400 were identified. The disputes involved medical factors requiring further verification, discrepancies in diagnosis and procedure coding, and incomplete supporting documentation. Delays in resolving disputed claims were associated with delayed reimbursement and cash inflows, reduced availability of funds for hospital operations, and increased pressure on short-term liquidity.
Conclusion: BPJS Kesehatan claim disputes affected hospital cash flow through delays in reimbursement and reduced availability of operational funds. Strengthening internal claim verification, coding accuracy, documentation completeness, and coordination among relevant units may help reduce claim disputes and support stable hospital cash flow.

Keywords: BPJS Kesehatan; Cash Flow; Claim Dispute; Claim Verification; Hospital.

INTRODUCTION

Healthcare is a fundamental right of every citizen, and the government is responsible for ensuring the provision of high-quality, equitable, and sustainable healthcare services (Government of the Republic of Indonesia, 2023). The National Health Insurance (JKN) program is an integral component of Indonesia's social health insurance system, which aims to ensure access to healthcare benefits and provide financial protection for participants in meeting their basic healthcare needs (Government of the Republic of Indonesia, 2020). Administered by Health Social Security Administration Agency (BPJS Kesehatan), the JKN program is a major government initiative to promote equitable access to healthcare services. Within this system, hospitals function as referral healthcare facilities for JKN participants and receive reimbursement through a healthcare claim submission mechanism. Claims submitted by hospitals are subject to a verification process to assess the completeness and appropriateness of administrative requirements, healthcare services provided, and supporting documentation before reimbursement is approved and paid by BPJS Kesehatan (Errisya, 2022). Therefore, accurate and

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complete claim documentation is essential for facilitating timely reimbursement and supporting the financial sustainability of healthcare facilities.

Despite established claim submission and verification procedures, pending and disputed BPJS Kesehatan claims remain a persistent challenge for hospitals. Previous research reported that pending inpatient claims were primarily associated with coding, administrative, and clinical factors (Wirdah et al., 2025). These findings underscore the importance of coding accuracy, administrative completeness, and consistency between clinical documentation and claim requirements in facilitating successful claim reimbursement. Hospital cash flow is an essential component of financial management, as it reflects the hospital's capacity to meet financial obligations, finance routine operations, and maintain continuity of healthcare services. Adequate and timely cash inflows are necessary to support various operational expenditures, including the procurement of medicines and medical supplies, payment of employee salaries, maintenance of medical equipment, and other healthcare-related expenses. Consequently, delays or disruptions in claim reimbursement may negatively affect hospital liquidity and potentially compromise the continuity and quality of healthcare service delivery (Pramesti et al., 2022).

Although BPJS Kesehatan has established mechanisms for claim submission, verification, and reimbursement, claim disputes continue to occur in hospital settings. A claim dispute may arise when discrepancies or unresolved issues are identified during the verification process, requiring clarification or correction before the claim can be approved for payment. Such disputes may prolong the reimbursement process and delay the receipt of claim payments by hospitals. Beyond affecting the reimbursement cycle, prolonged claim disputes may adversely affect financial stability and operational efficiency, underscoring the importance of effective claim management within hospitals (Maharani et al., 2025). Delays in reimbursement associated with disputed claims may have substantial implications for hospital financial performance, particularly cash flow. When claim payments are delayed, funds that would otherwise be available to support operational activities may remain tied up in accounts receivable. This condition may reduce hospital liquidity and limit the availability of cash to meet short-term financial obligations. In particular, hospitals may experience difficulties in paying suppliers for medicines and medical devices, meeting salary obligations for healthcare professionals and other employees, and financing routine operational expenditures. Therefore, BPJS Kesehatan claim disputes may constitute an important factor associated with the financial stability and operational sustainability of hospitals (Ambarwati, 2021).

Previous studies have identified several factors associated with pending and disputed BPJS Kesehatan claims. Previous research found that pending claims were primarily associated with coding, administrative, and medical issues, with coding discrepancies being the most frequently reported factor (Maharani et al., 2025). These discrepancies were partly attributed to differences in interpretation between hospital coders and BPJS Kesehatan claim verifiers. Another study reported that pending claims were frequently associated with administrative problems and incomplete claim documentation. In addition, incomplete documentation, inaccuracies in diagnosis and procedure coding, and administrative deficiencies were identified as common factors associated with pending claims in hospitals (Amin et al., 2025; Mursyid et al., 2023). These findings are consistent with those of a previous study, which reported significant associations between coding inaccuracies, inadequate supporting examinations, insufficient evidence of therapy, and the occurrence of pending BPJS Kesehatan claims (Maulida & Djunawan, 2022).

A similar pattern was reported at a hospital in Medan, where a substantial proportion of submitted inpatient claim files were classified as pending or disputed (Valentina et al., 2023). The study also identified recurring facility and network constraints that further complicated the claim submission process. In a broader scoping review, coding inaccuracies, incomplete documentation, and medical-related issues consistently emerged as major factors associated with pending BPJS Kesehatan claims across hospitals in Indonesia (Zalukhu & Permanasari, 2025). Incomplete medical documentation may also result in claim files being returned to hospitals for correction or completion, thereby prolonging claim processing and potentially

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delaying reimbursement. Collectively, these findings indicate that the quality and completeness of clinical documentation, coding accuracy, administrative completeness, and coordination among healthcare professionals, coders, claim officers, and verifiers are important aspects of effective and timely BPJS Kesehatan claim processing.

From a financial perspective, delays in the settlement of disputed claims may have consequences beyond administrative inefficiencies. Previous research reported that delays in claim settlement may affect hospital financial conditions, particularly the availability and continuity of cash flows required to support routine operational activities (Ambarwati, 2021). When a substantial proportion of hospital revenue is derived from JKN reimbursements, delays in BPJS Kesehatan claim payments may place additional pressure on working capital and constrain the hospital's financial flexibility in meeting short-term obligations. Previous studies have predominantly focused on identifying factors associated with pending or disputed BPJS Kesehatan claims, including administrative deficiencies, coding inaccuracies, clinical issues, and incomplete medical documentation (Amin et al., 2025; Mursyid et al., 2023; Maharani et al., 2025). Another study found that documentation errors, coding inaccuracies, and non-compliance with insurer requirements were among the major factors associated with claim rejection in healthcare facilities covered by Tanzania's National Health Insurance Fund (Fulla et al., 2025). In Indonesia, post-claim refunds by BPJS Kesehatan may disrupt hospital cash flow, reduce liquidity, and complicate operational budget planning (Septina et al., 2025). However, empirical studies examining the financial implications of BPJS Kesehatan claim disputes, particularly their relationship with hospital cash flow, remain limited. This gap is important because claim disputes extend beyond administrative and reimbursement processes and may also affect hospital liquidity, financial management, and operational sustainability. Therefore, further investigation is warranted to examine the relationship between BPJS Kesehatan claim disputes and hospital cash flow. Accordingly, this study aims to analyze the relationship between BPJS Kesehatan claim disputes and hospital cash flow, with particular emphasis on delayed cash inflows, liquidity availability, and implications for operational sustainability.

RESEARCH METHOD

This study employed a qualitative research design using a descriptive case study approach to examine the implications of health social security administration agency (BPJS Kesehatan) claim disputes for hospital cash flow. The case study approach was selected to obtain an in-depth understanding of the claim management process, the factors contributing to claim disputes, the procedures for resolving disputed claims, and their implications for the timing and availability of hospital cash inflows. The study focused on BPJS Kesehatan claim disputes recorded during the fourth quarter of 2025 (October–December 2025). Data collection was conducted from April to May 2026 during the researchers Field Work Practice (PKL) at Hospital X.

Informants were selected using purposive sampling based on their direct involvement, responsibilities, and relevant experience in BPJS Kesehatan claim management and hospital financial administration. Two key informants participated in the study, BPJS Kesehatan claim verification officer and hospital finance officer. The informants were considered relevant because of their knowledge and practical experience regarding claim submission and verification, dispute resolution, reimbursement processes, and the financial implications of delayed claim payments.

The study used primary and secondary data. Primary data were obtained through semi-structured in-depth interviews using a pre-developed interview guide. The interviews explored the BPJS Kesehatan claim management process, factors contributing to claim disputes, dispute resolution procedures, and the informants' perspectives on the implications of disputed claims for hospital cash flow. Secondary data were obtained through document review of the BPJS Kesehatan claim dispute recapitulation records for the fourth quarter of 2025 and the verification results reports (BAHV). The documentary data were used to identify the number and monetary value of disputed claims and to support the interpretation of information obtained from the interviews. In addition, relevant scientific articles, previous studies, and

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applicable regulations concerning BPJS Kesehatan claim disputes and hospital cash flow were reviewed to provide the theoretical and contextual basis for the study.

Data were analyzed qualitatively using the Miles and Huberman interactive model, consisting of data reduction, data display, and conclusion drawing and verification. During data reduction, interview transcripts and documentary information were selected, categorized, focused, and summarized according to the study objectives. Particular attention was given to information concerning the causes of claim disputes, the number and value of disputed claims, delays in reimbursement, and their implications for hospital cash flow. In the data display stage, relevant findings were organized into narrative descriptions and tables to facilitate systematic interpretation. The final stage involved drawing and verifying conclusions by identifying patterns and relationships among claim disputes, delayed reimbursement, cash inflows, liquidity, and operational financing. Documentary findings were compared with information obtained from the interviews to ensure consistency of interpretation.

The credibility of the findings was strengthened through source and method triangulation. Information obtained from the interviews was compared with evidence from the BPJS Kesehatan claim dispute recapitulation records and BAHV documents. Statements concerning the causes and financial implications of claim disputes were cross-checked against the available documentary evidence. This process was undertaken to reduce reliance on individual informant perceptions and to strengthen the consistency and credibility of the findings. This study received ethical approval from the Research Ethics Committee of Politeknik Piksi Ganesha, Bandung, under approval number 095/LPPM-PIKSI/III/26.

RESEARCH RESULTS

Table 1. Recapitulation of BPJS Kesehatan Claim Dispute Cases

Month	Number of Disputed Claims	Disputed Claim Value (IDR)	Total Claims Submitted	Dispute Rate (%)
October	155	1,257,554,100	6,871	2.26%
November	207	1,853,678,800	6,514	3.21%
December	509	2,363,221,500	5,991	8.46%
Total	871	5,474,454,400	19,376	4.50%

Source: Recapitulation Data of BPJS Kesehatan Claim Dispute Cases, Fourth Quarter of 2025.

Based on Table 1. the documentary review showed that a total of 19,376 claims were submitted to BPJS Kesehatan during the fourth quarter of 2025. Of these, 871 claims were classified as disputed claims, with a total disputed claim value of IDR 5,474,454,400. Based on BPJS Kesehatan claim submission data for the fourth quarter of 2025, a total of 19,376 claims were submitted. Of these, 871 claims (4.50%) were classified as disputed. In October 2025, 155 (2.26%) of the 6,871 submitted claims were classified as disputed. In November, the number of disputed claims increased to 207 cases (3.21%), while the number of submitted claims decreased to 6,514. In December, 509 of 5,991 submitted claims were classified as disputed (8.46%). Thus, December recorded the highest number of disputed claims and the highest reported dispute rate during the study period.

The number of disputed claims increased by 33.55% from October to November and by 145.89% from November to December. The monetary value of disputed claims also increased each month, from IDR 1,257,554,100 in October to IDR 1,853,678,800 in November and IDR 2,363,221,500 in December. Overall, 871 disputed claims with a total value of IDR 5,474,454,400 were recorded during the fourth quarter of 2025. These documentary findings indicate that the number and monetary value of claims requiring further verification or dispute resolution increased during the study period, with the highest number recorded in December 2025.

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The review of BAHV documents identified several types of cases associated with claim disputes, including malnutrition, chemotherapy, prophylaxis, and pediatric pneumonia, as well as discrepancies in diagnosis and procedure coding. Several cases required further review by the quality and cost control team (TKMKB) before a final decision was reached. Interviews with the BPJS Kesehatan claim verification officer and hospital finance officer provided information on the claim submission and verification process. According to the informants, the process begins after patient discharge with retrieval and review of the medical record, followed by diagnosis and procedure coding, INA-CBGs grouping, internal verification by the hospital claim team, and submission through the e-Klaim system for BPJS Kesehatan verification. The informants also reported several issues encountered during the process, including incomplete medical resumes, missing surgical reports, suspected diagnoses, undocumented medical procedures, supporting examination results not yet entered into the electronic medical record (EMR), and discrepancies between service billing and medical documentation.

DISCUSSION

The findings indicate that BPJS Kesehatan claim disputes remained a significant challenge during the fourth quarter of 2025, involving 871 disputed claims with a total value of IDR 5,474,454,400. Based on the BAHV, the number of disputed claims increased throughout the study period, with the highest number and proportion recorded in December 2025. This pattern indicates that claim disputes remained an important issue in hospital claim management, particularly because unresolved claims may prolong the verification and settlement processes and consequently delay reimbursement to the hospital.

The monetary value of the disputed claims further indicates that this issue extends beyond administrative claim processing and may have broader financial implications for hospital operations. Delayed settlement may prevent the hospital from receiving expected cash inflows according to the anticipated reimbursement schedule, potentially affecting the availability of funds for operational needs and creating a timing mismatch between cash inflows and operational expenditures. Therefore, the increasing number and value of disputed claims highlight the importance of strengthening internal claim management through improving the completeness of clinical documentation, ensuring the accuracy of diagnosis and procedure coding, conducting comprehensive internal verification before claim submission, and enhancing coordination among healthcare professionals, coders, claim officers, and finance personnel. These measures may help minimize claim disputes, facilitate timely reimbursement, and support stable hospital cash flow management.

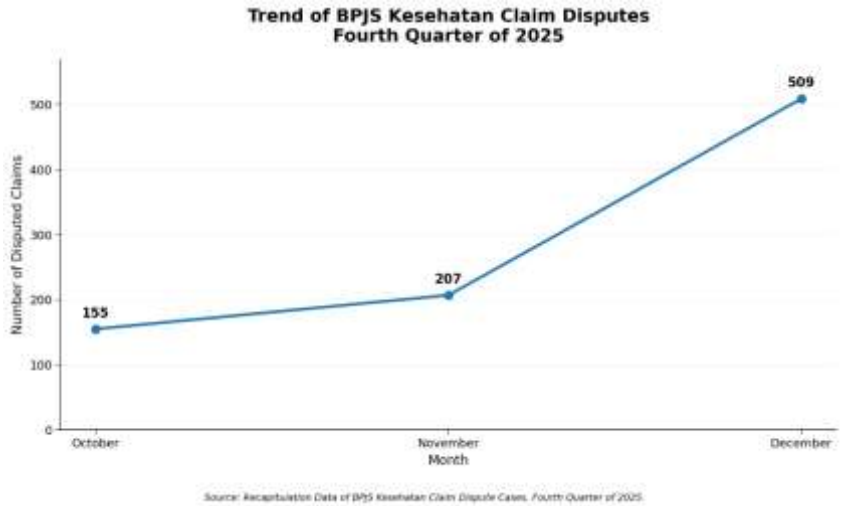


Figure 1. Number of BPJS Kesehatan Claim Dispute Cases in the Fourth Quarter of 2025

Source: Verification Results Report (BAHV) Data for the Fourth Quarter of 2025 (processed by the researchers, 2026)

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Based on the graph, the number of BPJS Kesehatan claim disputes showed an increasing trend during the fourth quarter of 2025. The number of disputed claims increased from 155 cases in October to 207 cases in November, representing a 33.55% increase. From November to December, the number increased substantially from 207 to 509 cases, equivalent to a 145.89% increase. This upward trend indicates that an increasing number of claims required additional verification and follow-up before settlement, potentially resulting in delays in claim reimbursement.

The increase in disputed claims during the fourth quarter of 2025 indicates that the BPJS Kesehatan claim settlement process continued to require further verification for specific cases. Based on document reviews and interviews, disputes were identified in cases requiring additional clinical assessment, including malnutrition, chemotherapy, prophylaxis, and pediatric pneumonia, as well as cases involving differences in the interpretation of healthcare service evidence and BPJS Kesehatan claim requirements. These conditions may present challenges during the claim verification process. However, the present study did not quantitatively assess the frequency of each contributing factor; therefore, it cannot establish which factor was the predominant contributor to claim disputes. This finding is consistent with a previous study, which reported that medical factors were among the predominant causes of pending claims, followed by coding and administrative factors (Aisy, 2025). This suggests that consistency between patients' clinical conditions and documented evidence of healthcare services is an important component of the claim verification process.

The role of medical factors was reflected in cases involving the determination of medical indications, the appropriateness of healthcare services, and cases requiring further discussion by the TKMKB before a final decision could be reached. This finding is consistent with a previous study that identified coding, administrative, and medical factors as major causes of BPJS Kesehatan claim disputes (Maharani et al., 2025). Therefore, the increasing number of disputed claims was not solely related to the volume of claims submitted but may also have been influenced by the complexity of the verification procedures and the conformity of supporting documentation with applicable claim requirements. The findings also demonstrate that discrepancies in diagnosis and procedure coding contributed to BPJS Kesehatan claim disputes. Coding discrepancies may result in inconsistencies between the patient's clinical condition, the procedures performed, and the resulting INA-CBG classification. This finding is consistent with previous research reporting that coding-related problems and incomplete documentation contribute to pending inpatient claims (Maulida & Djunawan, 2022). These findings are further supported by evidence that discrepancies between diagnosis and procedure codes and their supporting clinical evidence are recurring causes of claim reconfirmation, while the quality of medical record documentation directly affects the accuracy of diagnosis codes used in INA-CBG claims (Puspitasari et al., 2024; Yuliani et al., 2024).

Based on the document review, several disputed cases required further discussion with the TKMKB to ensure consistency among healthcare documentation, coding practices, and BPJS Kesehatan claim requirements. Differences in interpretation or inconsistencies in medical documentation may require additional clarification during the verification process, thereby prolonging claim settlement and increasing the likelihood of disputes. In addition to medical and coding factors, the interviews identified administrative factors, particularly incomplete supporting documentation, as another contributor to BPJS Kesehatan claim disputes. Informant 1 stated:

"Incomplete medical resumes or supporting examination results that have not yet been entered frequently contribute to claim disputes."

This finding demonstrates that the completeness of medical documentation plays an important role in the verification of BPJS Kesehatan claims. The document review identified recurring issues, including incomplete medical summaries, missing surgical reports, and supporting examination results that had not yet been entered into the EMR system. These deficiencies require additional clarification and completion of the relevant documentation, which may subsequently delay the claim settlement process. Previous research reported that document completeness, medical aspects, and coding were associated with pending claims (Dinnillah et al., 2024). These findings reinforce the importance of

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complete and accurate supporting documentation in facilitating efficient BPJS Kesehatan claim verification and settlement. Incomplete medical record files were associated with delays in BPJS claim submission, while inadequate verification of supporting documents was identified as a leading cause of returned BPJS Kesehatan inpatient claims (Regina & Fauzi, 2024; Yunawati et al., 2025). In this study, the impact of claim disputes on hospital cash flow was analyzed primarily based on information provided by the hospital finance informant and supported by documentary evidence. The informant reported that delays in resolving disputed claims resulted in delayed BPJS Kesehatan reimbursements, thereby reducing the availability of funds that could otherwise be used to finance hospital operations. This finding is further illustrated by the total disputed claim value of IDR 5,474,454,400 during the fourth quarter of 2025, representing a substantial amount of expected reimbursement that was not received according to the anticipated payment schedule.

Overall, the study identified medical factors, discrepancies in diagnosis and procedure coding, and administrative factors related to incomplete supporting documentation as contributing factors to BPJS Kesehatan claim disputes. Based on the document review and interviews, medical factors were frequently identified in the disputed cases observed in this study. However, because the present study did not quantitatively assess the frequency or proportion of each contributing factor, it cannot establish which factor was the most predominant contributor to claim disputes. These findings differ from those of a previous study, which reported a higher proportion of administrative factors than other causes (Damayanti, 2025). This difference may be attributed to variations in case characteristics, documentation practices, internal claim management, and verification procedures across hospitals. Nevertheless, the present findings are consistent with the identification of medical, coding, and administrative factors as important contributors to BPJS Kesehatan claim disputes (Maharani et al., 2025). Similarly, incomplete medical documentation and coding inaccuracies have been identified as factors contributing to pending claims and challenges in the BPJS Kesehatan claim verification process (Mursyid et al., 2023).

From a financial perspective, unresolved BPJS Kesehatan claim disputes may delay hospital cash inflows because claims requiring further verification may not be reimbursed until the disputes are resolved. According to the informants, such delays reduce the hospital's ability to utilize funds that would otherwise be available for operational needs and short-term financial management. Delays in claim payments may also reduce the cash reserves available to the hospital to support routine operational activities. This finding is consistent with previous research indicating that pending claims can constrain hospital cash flow and affect operational stability (Yastori & Khumaira, 2025). Thus, delays in claim resolution may limit the availability of financial resources required to maintain hospital operations. The finance informant further explained that delays in claim payments may affect the hospital's ability to fulfill its payment obligations to vendors by the established due dates. Informant 2 stated:

"When claim payments are delayed because of disputes, the hospital's cash receipts are also postponed, so we have to rearrange our payment priorities."

These findings indicate that delays in the settlement of disputed claims affect not only the timing of hospital cash inflows but also the management of operational liabilities. When dispute resolution is prolonged, the resulting reduction in available cash may increase pressure on the hospital's short-term financial obligations, including payments to medical and non-medical vendors. Consequently, hospital financial management may need to reprioritize expenditures to maintain the continuity of essential healthcare operations. From a cash flow perspective, these findings demonstrate that the timing of BPJS Kesehatan claim reimbursement is closely associated with the availability of cash for hospital operations. Delayed reimbursement may create a timing mismatch between cash inflows and cash outflows, particularly when operational expenditures and vendor obligations remain due while expected claim revenues have not yet been received. If such delays accumulate, the hospital may experience reduced short-term liquidity and increased pressure on working capital, even when the disputed claims are eventually reimbursed following completion of the verification process.

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Therefore, the impact of BPJS Kesehatan claim disputes extends beyond administrative and verification issues. Disputed claims may have direct implications for the timing of cash inflows, the availability of cash reserves, the management of vendor payments, and overall short-term liquidity. Given the disputed claim value of approximately IDR 5.47 billion during the fourth quarter of 2025, timely resolution of claim disputes is particularly important for maintaining stable hospital cash flow. Strengthening the completeness of medical documentation, improving coding accuracy, conducting rigorous internal claim verification, and enhancing coordination among physicians, coders, claim officers, and finance personnel may help reduce claim disputes and support the financial and operational sustainability of hospital services.

CONCLUSION

Based on the findings, 871 disputed BPJS Kesehatan claims with a total value of IDR 5,474,454,400 were identified during the fourth quarter of 2025. The disputed claims involved several contributing factors, including incomplete supporting documentation, medical factors requiring further verification, and discrepancies in diagnosis and procedure coding that did not comply with applicable BPJS Kesehatan claim requirements. The findings indicate that claim disputes affected hospital cash flow primarily through delays in reimbursement from unresolved claims. These delays reduced the availability of funds for hospital operations and may have increased pressure on short-term financial obligations, including payments to medical and non-medical vendors. Therefore, strengthening medical documentation, coding accuracy, internal claim verification, and coordination among relevant personnel may help reduce claim disputes and support timely reimbursement, adequate liquidity, and stable hospital cash flow.

SUGGESTION

Future research should consider using quantitative or mixed-methods approaches to statistically examine the relationship between BPJS Kesehatan claim disputes and hospital cash flow indicators, such as the current ratio, cash ratio, and accounts receivable turnover, to provide a more precise assessment of their financial impact. Subsequent studies could also involve a larger and more diverse group of informants, including coders, physicians, and BPJS Kesehatan verification staff, as well as multiple hospitals, to enhance the generalizability of the findings. In addition, extending the observation period beyond a single quarter, such as to a full fiscal year or several consecutive years, could enable researchers to identify seasonal patterns and longer-term trends in claim disputes and their potential cumulative effects on hospital liquidity.

For Hospital X, the hospital is encouraged to strengthen internal claim verification prior to claim submission, improve the accuracy and consistency of diagnosis and procedure coding through regular training and coordination between coders and clinicians, and ensure the completeness of medical summaries, surgical reports, and supporting examination results before claim submission.

REFERENCES

Aisy, M. R. (2025). *Analisis pending klaim rawat inap BPJS Kesehatan di Rumah Sakit Sumber Hurip Kabupaten Cirebon tahun 2025*. (Doctoral dissertation, Politeknik Kesehatan Tasikmalaya).

Ambarwati, W. (2021). Pembiayaan pasien COVID-19 dan dampak keuangan terhadap rumah sakit yang melayani pasien COVID-19 di Indonesia analisis periode Maret–Desember 2020. *Jurnal Ekonomi Kesehatan Indonesia*, *6*(1), 3.

Amin, M., Arifin, Z., & Indrawati, Y. (2026). Analisis kasus pending klaim pelayanan asuransi BPJS Kesehatan Rumah Sakit PKU Muhammadiyah Temanggung. *Jurnal Ners*, 10(1), 340–349.

Damayanti, N. (2025). Analisis penyebab pending klaim berkas pasien rawat inap BPJS Kesehatan Di RS Daan Mogot. *Jurnal Kesehatan Tambusai*, *6*, 14249–14256..

Dinnillah, A. H., Hardiana, H., & Susanti, F. A. (2024). Gambaran penyebab pending klaim BPJS Kesehatan pasien rawat inap Rumah Sakit X di Kota Bogor. *Jurnal Ilmiah Kesehatan*, *23*(1), 9–18.

Siti Aulia Lestari*, Sali Setiatin

Rekam Medis dan Informasi Kesehatan, Politeknik Piksi Ganesha
Corresponding author: *E-mail: saullstrii@gmail.com

DOI: https://doi.org/10.33024/minh.v9i8.4368

Errisya, M. K. (2024). Analisis penyebab pending klaim BPJS Kesehatan rawat inap di Rumah Sakit X Kota Tebing Tinggi. *Jurnal Kesehatan Ilmiah Indonesia (Indonesian Health Scientific Journal)*, *9*(1), 321-327.

Fulla, R., Basinda, N., Tupa, T., Chilipweli, P., Kapesa, A., Konje, E. T., Morona, D., & Mshana, S. E. (2025). Patterns and mitigation strategies for rejected claims among health facilities providing services for the National Health Insurance Fund in Mwanza, Tanzania. *In Healthcare, 13*(3), 320.

Government of the Republic of Indonesia. (2023). *Law of the Republic of Indonesia Number 17 of 2023 concerning Health*. https://peraturan.bpk.go.id/Details/258028/uu-no-17-tahun-2023

Government of the Republic of Indonesia. (2024). *Presidential regulation of the republic of indonesia number 59 of 2024 concerning the third amendment to presidential regulation number 82 of 2018 concerning health insurance.* https://peraturan.bpk.go.id/Details/285181/perpres-no-59-tahun-2024

Maharani, S. D., Aryani, B., Rahmawati, F. D., & Haryanto, Y. (2025). Tinjauan pending klaim BPJS rawat inap di RS X Cirebon tahun 2024. *Jurnal Manajemen Informasi Kesehatan (Health Information Management)*, *10*(2), 209-218.

Maulida, E. S., & Djunawan, A. (2022). Analisis penyebab pending claim berkas BPJS Kesehatan pelayanan rawat inap Rumah Sakit Universitas Airlangga. *Media kesehatan masyarakat Indonesia*, *21*(6), 374-379.

Mursyid, H., Rahayu, S., & Koloi, V. S. (2023). A scoping review: faktor penyebab pending klaim BPJS Kesehatan rawat inap di rumah sakit. *Jurnal Rekam Medis dan Informasi Kesehatan, 6*(1), 22–35.

Pramesti, A., Legowo, P. S., & Tambunan, M. E. (2022). Analisis risiko dispute klaim covid terhadap operasional cashflow di RS. JT. *Jurnal Manajemen Resiko*, *3*(1), 1–28.

Puspitasari, S., Hidayat, A. D., & Pangestuti, A. (2024). Analysis of the accuracy of diagnosis and action codification with reconfirmation of BPJS inpatient patient claims for the January-April period of 2024 at SLG Kediri Hospital. *Procedia of Engineering and Life Science*, 7(1), 29–37.

Regina, P. S., & Fauzi, H. (2024). Completeness of medical record files and the timeliness of BPJS claims on inpatients with bronchitis cases at Purwokerto Islamic Hospital. *Procedia of Engineering and Life Science*, *6*, 241-245.

Septina, B. D., Sastrawan, S., & Setiawan, S. (2026). The Impact of BPJS Health Post-Claim Refunds on Hospital Administrative Services. *Jurnal Penelitian Pendidikan IPA*, *12*(5), 975-981.

Valentina, V., Simanjuntak, E., Lubis, S. P. S., & Hulu, L. I. Z. (2023). Overview of pending and dispute events in the health BPJS claiming process for inpatients at Imelda Hospital, Medan, Indonesia in 2022. *Jurnal Kesehatan Komunitas (Journal of Community Health), 9*(2), 240–248.

Wirdah, W., Soewondo, P., & Dewi, E. K. (2025). Analisis klaim pending BPJS Kesehatan di RSUD Pasar Minggu Tahun 2024. *COMSERVA: Jurnal Penelitian dan Pengabdian Masyarakat,* 5(2), 251–262.

Yastori, Y., & Khumaira, N. F. (2025). Analysis of Pending Claims As a Basis for Designing an Internal Coding Audit Application in a Hospital. *Journal of Hospital Administration and Management*, 6(1), 91–102.

Yuliani, N., Noor, H. L., & Maryati, W. (2024). Quality of medical record documentation affects accuracy of diagnosis codes in InaCBGs claims in hospitals. *Indonesian Journal of Global Health Research*, *6*(5), 3237-3242.

Yunawati, N. P. L., Aridayana, I. P. M., Faidah, N., & Murcittowati, P. A. S. (2025). Analisis aspek-aspek verifikasi yang berhubungan dengan pengembalian klaim BPJS Kesehatan pasien rawat inap di RSU Surya Husadha Denpasar. *Procedia of Engineering and Life Science*, *7*, 16-22.

Zalukhu, L. A., & Permanasari, V. Y. (2025). Scoping review: factors causing claim pending in indonesian hospitals. *Jurnal Health Sains*, *6*(9), 252-262.

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