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Implementation of Clinical Pathways as A Strategy To Address Pending BPJS Claims

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ABSTRACT

Pending BPJS Health claims are a recurring problem that affects hospital cash flow, cost efficiency, and service quality. At Rama Hadi Hospital Purwakarta, the average pending claim rate in 2025 reached 12.5% for outpatient services and 20% for inpatient services, with monthly fluctuations that did not indicate sustained improvement. This study analyzes the causes of pending claims, strategies for enhancing medical documentation quality, clinical pathway integration, and the casemix team's role, alongside their combined impact on hospital cost efficiency and service quality. Using a descriptive qualitative design, data were gathered through in-depth interviews, observations, and document reviews involving seven key personnel: a hospital director, specialist physician, general practitioner, internal verifier, case manager, claims officer, and coder. The findings reveal that incomplete discharge summaries, operative reports, and diagnostic results are the primary drivers of pending claims. Although clinical pathways effectively reduce care variations and claim delays, their implementation is often hindered by patient comorbidities and differing viewpoints among specialists. Additionally, while the casemix team is crucial for ensuring accurate ICD-10 and INA-CBG coding, they frequently encounter obstacles regarding documentation compliance and conflicting interpretations with BPJS verifiers. Unresolved claim delays ultimately strain hospital cash flow, threatening overall service continuity. To resolve these challenges, the study concludes that hospitals must adopt an integrated management strategy. Key recommendations include strengthening electronic medical record (EMR) documentation, improving adherence to clinical pathways, optimizing casemix operations, enforcing continuous monitoring, and leveraging modern digital technologies.

Keywords: BPJS Health, Casemix Team, Clinical Pathway, Hospital Management Pending Claims

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INTRODUCTION

Hospitals are increasingly viewed as strategically important for balancing business objectives with public trust (Murtini, 2026). However, hospital business goals are often hindered by delays in BPJS claim processing. Delayed claims result in non-payment for healthcare services by BPJS Kesehatan, leading to reduced hospital revenue and impacting operational activities (Pratama et al., 2023). Such delays reduce claim reimbursements and disrupt hospital cash flow, a critical issue given that nearly 90% of patients are covered by BPJS Kesehatan (Astuti & Hidayah, 2022). When claims are pending, cash flow disruptions can impede the settlement of obligations to vendors and suppliers, delay employee salary payments, and force cuts to hospital maintenance costs (Nabila et al., 2020). An organization's financial health comes under pressure when profitability declines while costs rise, potentially leading to financial distress (Sulviani & Sutisna, 2025)

Data from RS QIM (Qolbu Insan Mulia) Batang indicates that between October and December 2022, there were pending BPJS inpatient claims; the leading causes were coding errors (60%), re-selection issues (21.66%), and duplicate codes (15.83%) (Widaningtyas et al., 2024). Similar instances of pending claims were observed in a study at RSUD Pongtiku. Using the POAC (Planning, Organizing, Actuating, Controlling) framework, the identified causes included incomplete documentation (45.8%), coding errors (29.5%), insufficient examinations (21%), lack of evidence regarding therapy (6.8%), and disagreements with BPJS verifiers (3.5%) (Michael et al., 2025). Persistent claim delays also result in delayed reimbursement for hospital expenses incurred for BPJS Kesehatan patients (Syahira et al., 2024) (Syahira, 2024). Effective financial management is a crucial component in achieving organizational goals (Magribi et al., 2025).

Preliminary study results indicate that the phenomenon of pending claims also occurs at Rama Hadi General Hospital in Purwakarta. This facility is a Class C private hospital located in the Purwakarta Regency, West Java Province. Data regarding pending BPJS claims at Rama Hadi General Hospital shows an upward trend over the past three years. The percentage of pending claims was recorded at 5.5% in 2023, rising to 8.5% in 2024, and further increasing to 16.3% in 2025. Regarding the overall pending claim figures for the observation period of January through December 2025, the average pending claim rate for the outpatient unit was 12.5%. The highest rate occurred in June (20%), while the lowest was in April (5%).

The researcher hypothesizes that the issue of pending BPJS claims at Rama Hadi General Hospital is influenced by clinical pathways was standards for clinical care that encompass detailed medical procedures, administration, and coding (Artanto, 2018). This is because clinical pathways help ensure that every clinical action is scientifically grounded, comprehensively documented, and accountable during audits and the verification of healthcare financing claims (Rotter et al., 2019). Implementing clinical pathways not only supports improved service quality but also strengthens administrative and financial accountability within the hospital (Permenkes No. 24, 2022).

Based on this background, this study aims to examine the status of pending patient claims at Rama Hadi General Hospital in 2025 and to assess the effectiveness of clinical pathway implementation in reducing the rate of pending BPJS claims. The novelty of this study lies in an approach that positions clinical pathways not merely as instruments for clinical service quality control, but also as a management strategy to reduce the number of pending BPJS claims. This research is significant as it enables hospitals to understand how clinical pathways can facilitate a reduction in pending claims, thereby alleviating operational burdens and allowing for the successful implementation of planned work programs by overcoming associated obstacles.

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LITERATURE REVIEW, FRAMEWORK AND HYPOTHESIS

Pending BPJS Kesehatan claims lead to reduced claim payments, thereby disrupting hospital cash flow, particularly given that nearly 90% of the hospital's patients are covered by BPJS Kesehatan (Artanto, 2018). Persistent pending status results in delays in the reimbursement of costs already incurred by the hospital for BPJS Kesehatan patients (Syahira et al., 2024). Pending BPJS Kesehatan claims can also affect the quality of hospital services by impacting financial management and operational patient care (Purwanti & Dhamanti, 2026). Incomplete administrative files remain a primary cause of pending claims for inpatient services; these administrative factors include incomplete membership documentation such as the failure to attach a birth certificate, which is a requirement for issuing the Eligibility Guarantee Letter (SEP) (Widaningtyas et al., 2024). Minister of Health Regulation No. 76 of 2016 defines coding as the process of assigning codes for primary and secondary diagnoses based on the ICD-10 classification, as well as codes for medical actions or procedures using ICD-9-CM. This process plays a crucial role in the prospective payment system, as the coding results serve as the basis for determining the claim payment amount issued by BPJS Kesehatan to Advanced-Level Referral Health Facilities (FKRTL) (Fahreza & Sukawan, 2024). Under Minister of Health Regulation No. 76 of 2016, the assignment of diagnosis and procedure codes is based on information contained in the medical record files. Incomplete files can result in claims being marked as pending and returned to the hospital for correction. Medical factors within claim files relate to the content of the patient's medical record, such as the Integrated Patient Progress Note (CPPT) sheet, surgical reports, medication administration forms, and reports from other supporting examinations (Salima & Zein, 2023).

METHODS

This study employs a qualitative research design with a descriptive approach to formulate a clinical pathway management strategy aimed at reducing delayed BPJS inpatient claims at RSUD Rama Hadi, Purwakarta. The research was conducted at RSUD Rama Hadi using data collection methods consisting of interviews, observations, and document analysis. The tools instrument data collection included interview guides, observation sheets, and document review protocols. The study involved seven participants selected based on their direct involvement in the management of BPJS claims within the hospital. A purposive sampling technique was used to select participants based on their position, experience, and direct involvement in the planning, implementation, task execution, and evaluation processes within the hospital, criteria deemed appropriate for generating rich and in-depth data. Data analysis was carried out in three stages: data reduction, data display, and conclusion drawing and verification.

RESULTS AND DISCUSSION

Through a thematic analysis of the implementation of clinical pathways, the researchers identified five key themes and their associated indicators. The thematic data display is presented in Table 1 below.

Tabel 1. Display of Thematic Data on Clinical Pathway Implementation

Theme	Indicator
Implementation of Clinical Pathways in BPJS Services	1. Availability of clinical pathways for the 10 most common diseases 2. Patient management guidelines based on disease type 3. Flowcharts for examination, treatment, medical procedures, and estimated Length of Stay (LOS) 4. Developed by the Medical Staff Committee's quality team and

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	communicated to the Attending Physicians (DPJP)
Purpose of Using Clinical Pathways	1. Provide services in accordance with clinical practice guidelines 2. Manage cost control for procedures and medical support services
Challenges in Implementing Clinical Pathways	1. Variation in patients' underlying conditions (comorbidities) 2. Differences of opinion among medical specialists 3. Suboptimal physician adherence
Monitoring of Clinical Pathway Compliance	1. The case manager is responsible for monitoring adherence to specialist physicians' clinical pathways. 2. Monitoring the alignment of claim reimbursement. 3. Adherence to clinical pathways impacts quality and cost control.

Source : Primary Interview Data, Rama Hadi General Hospital Purwakarta, 2026

Research results indicate that 20% of Thoracic and Cardiovascular Surgery (BTKV) cases failed to meet established clinical pathway standards. This finding reveals significant variation in BTKV cases, meaning that the majority of care provided did not adhere to the clinical pathways mandated by the hospital. Such conditions suggest that clinical pathways for BTKV cases are not yet functioning optimally as instruments for standardizing care. However, low adherence does not necessarily imply that the care provided was clinically inappropriate. BTKV cases are highly complex, often involving comorbidities and critical conditions, and requiring individualized clinical decisions by specialists. Clinical pathways serve as vital tools for standardizing and improving the quality of medical services—a fundamental aspect of modern healthcare systems (Rotter et al., 2012), including Indonesia's National Health Insurance (JKN) system. The JKN system, which utilizes INA-CBG package rates, requires management to prioritize cost efficiency and quality control (Nurfarida et al., 2014). Clinical pathways are essential for ensuring quality and cost control, particularly in cases that have the potential to consume significant resources (Fitria et al., 2021).

CONCLUSION

The implementation of clinical pathways contributes to reducing the number of pending claims by helping to control variations in care and costs that could otherwise lead to non-compliance with BPJS regulations. However, the effectiveness of this implementation still faces obstacles, such as variations in patient conditions involving comorbidities, differences of opinion among medical specialists, and suboptimal monitoring of physician adherence to the clinical pathways. Given the limitations of this study, future research should employ a mixed methods approach to more objectively assess the impact of clinical pathway implementation on reducing pending BPJS claims.

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