JRSSEM 2024, Vol. 04, No. 8, 2025
E-ISSN: 2807 - 6311, P-ISSN: 2807 - 6494

The Legal Reconstruction of The Audit of Health Claims In BPJS Health Claim Refund Based On Justice Principles

Heri Budiono
Universitas Semarang (UNISSULA), Indonesia
Email: heribudi581@gmail.com

ABSTRACT: This research explores the need for legal reconstruction in the audit system of BPJS Health claim refunds, focusing on the principles of justice. The study identifies the inequities in the current claims audit process, especially in remote regions where rigid procedural requirements and technological reliance create significant challenges for healthcare facilities. Using a normative research methodology, the study analyzes existing regulations and proposes a reconstruction based on fairness, efficiency, and equity. Findings suggest that the current system often results in financial instability for hospitals and inefficiencies in service provision due to procedural inconsistencies. The proposed legal reconstruction aims to address these issues by creating a more responsive and just audit system, ensuring that all stakeholders, including hospitals in underserved areas, are treated equitably. This study emphasizes the importance of balancing administrative compliance with the needs of healthcare providers, ultimately fostering a more sustainable and effective healthcare system. By incorporating progressive legal theory, the research highlights how legal reforms can improve the claims audit process, benefiting both healthcare providers and BPJS participants.

Keywords: legal reconstruction, BPJS Health, claim refund

INTRODUCTION

The State organizes a public health social security program to coordinate health activities in order to realize an optimal degree of public health (Agustina, 2015). The 1945 Constitution of the Republic of Indonesia, Article 34, paragraph (2), mandates the government to provide a social security system for all citizens, aimed at improving the welfare of vulnerable populations both socially and economically. The government's commitment to social justice is reflected in the BPJS Health program, which ensures that every citizen has access to adequate healthcare services. This initiative emphasizes the importance of providing fair public services, regardless of individuals' status or background.

BPJS Health covers medical expenses for all citizens with a BPJS Health card, ensuring effective healthcare delivery through collaboration between the public and healthcare providers, especially hospitals. Hospitals play a crucial role as referral facilities in the BPJS Health system, aiming to provide quality and cost-effective services supported by scientific knowledge and healthcare technology. Patient satisfaction is a key aspect of hospital services and contributes to achieving optimal healthcare outcomes.

An essential component of the healthcare system is the health financing sub-system, which is often misunderstood in practice. This misunderstanding leads to discrepancies

between the services provided and the claims submitted by hospitals, especially when procedures and agreed-upon tariffs are not followed. BPJS claims involve hospitals submitting the medical costs for patients registered in BPJS Health to be reimbursed by the system. This claim process is vital in the National Health Insurance (JKN) program, managed by BPJS Health, which reimburses hospitals for the costs incurred while treating participants (Ardhitya & Perry, 2015).

The procedure for the BPJS payment claims process and audit can be explained by the procedure of the hospital providing services to BPJS (Social Security Organizing Agency) participants who come to the health facility. In the process of providing services, hospitals are prohibited from collecting additional payments from BPJS participants, which means that all services must be free of charge. After a period of one month, the hospital then submits a claim to BPJS to get payment. In the implementation of the National Health Insurance in Indonesia, BPJS Health as the manager bears the payment of patient health services to Advanced Health Facilities (FKTL) through *Indonesia Case Base Groups* (INACBG's) (Putri, Karjono, & Uktutias, 2019). The claim tariff is calculated using the INA CBG (Indonesia Case Base Groups) system, which categorises treatment costs based on diagnoses and medical procedures. The INA CBG tariff is typically lower than the standard rates applied by hospitals. Once a claim is submitted, BPJS verifiers will assess the accuracy and completeness of the data. If the claim passes verification, the hospital will then await payment from BPJS.

In order to receive reimbursement, hospitals are required to provide the necessary supporting documentation for the claim. This documentation must be complete and in accordance with the relevant regulations to ensure the smooth processing of the claim. According to BPJS Health Regulation No. 3 of 2017, claims may be submitted in either hardcopy or softcopy formats, which should include the hospital's claim application, proof of service, detailed billing, supporting examination results, and action reports. For inpatient cases, additional requirements include the Eligibility Letter (SEP), inpatient order, a medical summary signed by the responsible doctor, and other signed documents such as operation reports, therapy protocols, detailed hospital bills, and any other required supporting documents.

The determination of health service fee rates has been adjusted to the Minister of Health Regulation Number 3 of 2023 concerning Health Service Tariff Standards in the Implementation of Health Insurance. The determination of the cost of health service results that must be claimed depends on the accuracy of the diagnosis coding results contained in the medical records and INACBG's (Kurniawan & Harjoko, 2021).

The efficiency of the reimbursement process highly depends on the completeness and accuracy of the submitted documentation. Therefore, hospitals must ensure that all required documentation, including proof of care, medical records, and other supporting documents, comply with the established procedures. Incomplete or delayed documentation can lead to payment delays or claim rejections, which can negatively affect the hospital's cash flow and operational capacity (Santiasih, Simanjorang, & Satria, 2022).

BPJS Health plays a crucial role as Indonesia's health insurance body, ensuring that the public has adequate access to healthcare services without high costs. To maintain accountability and compliance with regulations, BPJS Health regularly audits claims submitted by hospitals. The purpose of these audits is to verify if claims align with established procedures. While essential for system integrity, these audits often pose significant challenges for hospitals, particularly regarding claim reimbursements, which can impact their operations.

The cooperation agreements between BPJS Health and hospitals are vital in determining the audit process and how audit results are handled. These agreements typically outline the

rights and obligations of each party, as well as mechanisms for dispute resolution. However, in practice, there are often discrepancies between the terms of the agreements and the actual audit procedures, with unclear schedules, implementation methods, and evaluation criteria causing discomfort and uncertainty for hospitals.

In disputes between BPJS Health and hospitals regarding claim audits, hospitals are often accused of fraudulent practices such as:

1. Phantom Billing: Claiming for services not provided.
2. Upcoding: Altering diagnosis or procedure codes to obtain higher reimbursement rates.
3. Manipulation Diagnosis: Recording incorrect diagnoses to increase claim amounts.
4. Self-Referrals: Receiving payment for referrals to specific hospitals or doctors without facility limitations.
5. Repeat Billing: Submitting duplicate claims for similar cases.
6. Fragmentation: Splitting treatment packages within the same episode to increase claim values.

These disputes highlight the urgent need for a review and reform of existing regulations. Many hospitals face challenges with audit outcomes, leading to conflicts over claim payments, which often impact their financial stability and operations. Issues include regulatory uncertainty, inconsistent policy interpretation, and excessive administrative burdens.

Based on this background, the formulation of the problem to be studied is how the current BPJS Health claim return audit regulations and how to reconstruct the BPJS Health claim return audit law based on the value of justice. The research method used in this study is normative research with a statutory approach and an analytical approach (Marzuki, 2018).

Research by Putri et al. (2019) analyzed the causes of delays in BPJS Health claim submissions for inpatient patients, finding that procedural inefficiencies and communication gaps often led to delays. Similarly, Kurniawan and Harjoko (2021) studied the integration of the Bridging System with P-Care in BPJS Health, demonstrating that technological solutions improve the efficiency of claim processing but still face challenges in remote areas. Both studies highlight the need for improvements in the BPJS claim audit system to address systemic issues that affect healthcare facilities, particularly those in underdeveloped regions.

The urgency of this research stems from the growing concerns regarding the fairness and efficiency of the BPJS Health claim audit process. Health facilities, especially those in remote areas, are increasingly burdened by rigid procedures and technological barriers that lead to delays, financial instability, and inequities in service provision. With BPJS Health playing a critical role in ensuring affordable healthcare for all Indonesians, a more responsive and equitable claims audit system is necessary to ensure that hospitals can continue to provide high-quality care without financial strain. This study aims to address these issues by reconstructing the audit system in alignment with justice principles, focusing on fairness, equity, and efficiency.

While existing studies have examined various aspects of the BPJS Health claim process, there remains a lack of research focused on the legal reconstruction of the BPJS Health audit system from a justice perspective. Most studies focus on procedural or technological improvements but overlook the broader legal and ethical implications of the current system, particularly in addressing the disparities between urban and rural healthcare facilities. This research aims to fill this gap by offering a comprehensive legal reconstruction of the audit process that prioritizes fairness and equality for all stakeholders.

This study is novel in its approach to reconstructing the BPJS Health claim audit system based on the principles of justice. It goes beyond administrative reforms by proposing a legal

framework that ensures a more equitable process for health facilities, especially those in disadvantaged areas. By integrating progressive legal theory and utilitarian principles, this research provides new insights into how legal reforms can improve the BPJS Health claims audit process, ensuring that it serves both the healthcare providers and the beneficiaries more effectively.

The primary objective of this research is to provide a legal reconstruction of the BPJS Health claim audit system that is more equitable and responsive to the needs of healthcare facilities and participants. By focusing on justice principles, the study aims to create a fairer and more efficient audit process that reduces procedural burdens, ensures timely reimbursements, and addresses inequalities faced by hospitals in remote areas. The benefits of this research include improved financial stability for healthcare providers, enhanced service quality, and greater public trust in the BPJS Health system.

RESEARCH METHODOLOGY

The research method used in this study is normative research with a statutory approach and an analytical approach. Normative research is conducted by analyzing various regulations related to the BPJS Health claim audit, including laws, government regulations, and other applicable policies. The statutory approach is used to examine the legal basis governing the claim audit process and the principles of justice upheld in the system. Meanwhile, the analytical approach is applied to assess policy implementation and its impact on hospitals and BPJS Health participants. This study also considers progressive legal theory to reconstruct the BPJS claim audit system to be fairer and more responsive to the needs of hospitals and the well-being of participants.

RESULT AND DISCUSSION

The Present Regulations Pertaining to the Audit of Health Claims Submitted Under the Auspices of BPJS

BPJS Health, as a public legal entity tasked with administering the National Health Insurance (JKN), is one of the main pillars in the Indonesian health system. Its presence is intended to ensure that all people, regardless of economic status, have access to adequate and affordable health services. As the implementer of health insurance, BPJS Health has a great responsibility, not only in providing services but also in ensuring that the funds used come from the community and are distributed properly. One of the mechanisms carried out to ensure this accountability is through audits of claim returns from health facilities such as hospitals, clinics, and other healthcare providers (Samodra & Wirantari, 2024).

Claim return audit is a process carried out to verify cost claims submitted by health facilities to BPJS Health, ensuring that the expenditure is completely in accordance with the procedures, services, and medical conditions provided to BPJS participating patients. These audit policies aim to prevent irregularities and encourage budget efficiency, but they are often faced with implementation challenges that lead to debates regarding the principles of fairness. This, in the end, touches on the principle of distributive and procedural justice that is fundamental in the fulfillment of public health rights (Septian, 2022). Audits conducted by BPJS Health are often considered burdensome for health facilities, both in terms of administration and financial burden, and create the perception that BPJS is more focused on cost control than partnerships with health facilities to provide the best service.

BPJS Health's audit mechanism involves two main stages: administrative verification and medical verification. Administrative verification checks the completeness and compliance of

documents, such as claim forms and medical records, with BPJS standards. Medical verification ensures that the medical services provided match the patient's condition, needs, and treatment procedures. The goal is to prevent excessive or unnecessary claims. However, the strict audit process is often burdensome for healthcare facilities, especially those in remote areas or with limited resources. Meeting the administrative requirements demands significant time, labor, and additional costs, and the lengthy audit process can delay claims, affecting the financial stability of healthcare providers (Ummah & Lestari, 2024). In many cases, healthcare facilities have to wait several months for claims to be approved and funds returned, which impacts their ability to purchase medical equipment, medications, and pay employees on time.

Uncertainty in the audit process is also a significant problem for many healthcare facilities. BPJS Health often implements inconsistent standards, which makes the audit process unpredictable. For example, in one particular region, an auditor may give approval to a claim filed with a certain standard, while in another, a similar claim may be rejected for completely different reasons. These inconsistencies cause confusion and uncertainty for healthcare facilities, so they feel that the results of the audit rely more on the subjective judgment of the auditor than on objective standards. In addition, BPJS Health rarely provides a detailed explanation of the reasons for the rejection or reduction of claims, so health facilities do not have a clear basis for correcting mistakes or improving their administrative processes in the future (Hery, 2016).

Audits of BPJS Health claim returns often create tension between BPJS and healthcare facilities, as facilities feel that strict audit policies hinder their ability to provide quality care. Minor administrative errors, such as unclear signatures, can lead to claim rejections, which is seen as unfair when medical services were provided according to patient needs. BPJS argues that strict verification is essential to prevent fraud and protect funds, but an overly controlling approach can negatively impact service quality. The legal basis for these audits is found in Law No. 24 of 2011, which mandates transparency, accountability, and strict verification to prevent misuse of funds.

Law No. 17 of 2023 concerning Health is the main legal basis that regulates all aspects related to health in Indonesia. In this law, there are several important articles that are the basis for the implementation of health insurance, including the role of BPJS Health. Article 303 concerning Quality Control and Cost Control in Health Services regulates the obligation for medical personnel and health facilities to carry out quality control and cost control in health services, with an emphasis on patient safety. Healthcare audits, including claims verification, are conducted to ensure these quality and cost controls, so that all services comply with applicable medical standards. This obligation emphasizes that health facilities must be able to maintain the accuracy, relevance, and fairness of the costs listed in the claims submitted to BPJS Health. The implementation of quality and cost control is determined as the responsibility of health facilities, while guidance and supervision are carried out by the central and regional governments.

Although Article 303 of this law stipulates that audits of BPJS claim returns are carried out in order to maintain quality and cost control, this regulation is still very administrative and procedural, which prioritizes the completeness of documents and the accuracy of costs submitted by health facilities. This rule ignores the humanitarian aspects contained in Pancasila justice, especially the principle of "Social Justice for All Indonesian People." Ideally, claims audits should not only focus on procedural compliance aspects, but also consider the condition of health facilities in disadvantaged areas that may face obstacles in meeting complicated administrative requirements. Facilities in underdeveloped areas often have

limited access to technology, the number of medical personnel, and adequate infrastructure, which ultimately makes it difficult for them to meet the claim verification standards as stipulated in this Law. From the perspective of Pancasila justice, this system reflects injustice, because the provisions that apply uniformly in all health facilities do not take into account the differences in capacity and field conditions actually experienced by health facilities in various regions.

Article 348 explains the Health Information System and also requires the operator of the Health Information System to provide quality health data and information that can be accessed by the public and patients in accordance with the provisions of the law. In the context of BPJS claim audit, this article emphasizes the importance of the reliability of the data used for the claim verification process. The National Health Information System, which integrates data from all health facilities, is expected to be able to support accurate and efficient verification and auditing of claims, ensuring that only eligible claims are approved and paid by BPJS Health.

A nationally integrated information system is indeed a solution to speed up claim verification and prevent duplicate or invalid claims. However, this regulation does not provide a solution for areas that experience limitations in accessing or utilizing information technology, especially hospitals and health facilities located in remote areas. In the context of Pancasila justice, every citizen, regardless of geographical location, has the right to equal access to health services. When the infrastructure and access to technology in these areas do not support the implementation of Health Information Systems, they experience structural injustices caused by inequalities in technology and information facilities. The audit claims that BPJS is too dependent on this technology indirectly creates discrimination against hospitals in areas that have not been reached by the same infrastructure.

Article 349 which regulates the processing of health data and information in BPJS Health claims audits focuses on the management and security of data that can be used in claim verification. This article emphasizes the importance of managing health data accurately and securely in the BPJS claims audit process. It covers data planning, collection, storage, examination, transfer, use, and destruction to ensure reliable and fraud-free claims. While these regulations promote transparency and internal control, they can be burdensome for health facilities, particularly those in resource-constrained areas. Complex administrative requirements can delay or deny claims, limiting access to proper services for BPJS participants. From a Pancasila justice perspective, this creates inequality, as some health providers struggle to meet these standards, affecting their ability to deliver quality care.

Article 406 which regulates hospital funding emphasizes the importance of BPJS funds to be distributed based on claims that meet administrative and verification requirements. Hospital funding can come from various parties, including budgets from the central government, regions, and other legitimate sources. BPJS Health functions as a social security organizing body that also plays a role in distributing funds to hospitals for services provided to participants. In the claims audit process, this article emphasizes the need for funds to be submitted in claims in accordance with the actual costs incurred by the hospital and in accordance with applicable regulations. Funding from these claims must be accounted for in detail in the claim audit to maintain the sustainability of quality health service financing for the community.

This arrangement regarding verification and audit aims to maintain the sustainability of BPJS funding and ensure that every rupiah paid is really in accordance with the services provided. However, in the concept of Pancasila justice, this aspect is not completely fair to hospitals or health facilities that have limited capacity and access, especially in remote areas

that do not have access to the same resources. Health facilities in these areas experience different barriers in meeting the verification requirements, but they are treated the same as more advanced and technologically and administratively capable facilities. Thus, the provisions in this article do not reflect social justice, because they do not take into account the differences in the needs and capabilities of health facilities in various regions in carrying out claims' audits.

Presidential Regulation No. 82 of 2018 focuses on ensuring justice and propriety in health insurance governance, prioritizing the alignment between services provided and the available budget. It mandates that health insurance funds can only cover medical procedures backed by clear diagnoses to avoid waste and ensure sufficient funding for participants' needs. The Regulation of the Minister of Health No. 28 of 2014 outlines the technical procedure for submitting claims, emphasizing the need for complete documentation, including diagnoses and treatments. Verification by BPJS ensures claims align with medical standards and government-set rates. Additionally, Regulation No. 71 of 2013 further specifies that claims must be based on standard medical procedures and the patient's diagnosis, with non-compliant claims subject to rejection or further audits.

BPJS Health has internal guidelines for its audit team to ensure that claims are verified according to the rules. The team, made up of medical professionals, checks if claims meet administrative requirements and align with patient diagnoses. If discrepancies are found, BPJS can delay or reject payment until corrections are made. Government Regulation No. 87 of 2013 requires BPJS to prepare periodic financial statements that are verified by an independent auditor to ensure accuracy. Law No. 17 of 2003 emphasizes accountability and transparency in managing BPJS funds. BPJS must use health funds effectively and ensure all claims are legitimate. Regulation No. 214 of 2013 outlines the financial procedures BPJS must follow, including regular audits to prevent discrepancies in claim funds.

BPJS is required to verify claims submitted by health facilities in order to ensure funds are not misused and that claims meet both administrative and medical standards (Ministry of Health, 2018). Verification is essential for managing health funds effectively (Ministry of Health, 2018). In accordance with Presidential Regulation No. 12 of 2013, claims must undergo strict verification to ensure compliance with medical and service standards (Ministry of Health, 2018). Invalid or non-compliant claims can be rejected or returned for correction (Ministry of Health, 2018). Minister of Health Regulation No. 99 of 2015 stipulates the criteria for health facilities partnering with BPJS, emphasizing adherence to BPJS administrative procedures to avoid sanctions. The Financial Services Authority Regulation (POJK) No. 55/POJK.05/2017 underscores the principles of good governance, transparency, accountability, and risk management, mandating BPJS to conduct internal audits to prevent claim fraud or errors. This regulation is intended to strengthen the oversight and proper management of health insurance funds.

However, BPJS Health regulations related to claims audits have various weaknesses, including the lack of clear evaluation standards, thus creating uncertainty for health facilities. An overly administrative and rigid audit process, without taking into account special situations such as emergencies, leads to often unfair denials of claims. Additionally, the absence of transparency in audit results and the constraints imposed by technology in facilitating the audit process can impede the verification of claims and elevate the probability of errors. The absence of integration of audit systems with technology engenders delays, errors, and imbalances in claims assessment, exerting a detrimental effect on healthcare facilities. The complexity and rigidity of administrative barriers also impose a substantial burden on healthcare facilities, particularly those with constrained resources, thereby hindering the

expeditious processing of claims and compromising the quality of services rendered (Nurhani & Rahmadani, 2020).

The present study investigates the psychological impact of uncertainty in the BPJS Health claims audit process on management and health workers. It is posited that this uncertainty causes burnout, reduces motivation, and impacts the quality of care. In addition, delays or rejection of claims lead to restrictions on services in hospitals, harming BPJS participants who need treatment. The study further posits that distrust of BPJS is increasing, which can affect public participation in the program and social stability. This systemic weakness has the potential to adversely impact the quality of national health services, given the detrimental effect of delayed claim payments on service standards.

In order to mitigate these adverse consequences, there is a necessity for a reform of audit mechanisms. Such a reform should encompass measures such as digitization and audit automation to enhance efficiency and transparency. Additionally, there is a requirement for training and educational initiatives to be implemented for medical and administrative personnel. The objective of these initiatives is to reduce procedural errors and to enhance the comprehension of claims amongst personnel. It is anticipated that such a reform will result in an enhancement of the quality of service and in the restoration of trust in the BPJS Health system.

The Legal Reconstruction of the Audit of Health Claims in BPJS Health Claim Refund Based on Justice Principles

In a substance of the Indonesian legal system, there are components that are interconnected in the sense of complementing and influencing each other, namely written laws or laws and regulations, laws formed through court decisions or jurisprudence, or customary laws that occur in society (Bakri, 2011). Laws and regulations formed by authorized institutions sometimes cannot regulate all events that occur in society, including the development of science and technology that occurs so quickly in people's lives, so that the gap between law and society causes legal conflicts can be in the form of legal vacuums. This legal vacuum is complemented by jurisprudence or court rulings.

Law and justice are two sides of the same currency that cannot be separated, law aims to realize justice and justice without law becoming paralyzed. However, in order to get justice, justice seekers must go through unfair procedures. So that the law becomes a problem for the community, the law is no longer to make the community happy but instead to make the community miserable. The law cannot provide justice in society. Law enforcement that has been fought for is only a sign without meaning. Legal texts are only a language *of game* that only gives disappointment to the public (Faizal, 2017).

In the view of progressive law, legal actors must have sensitivity to crucial issues in human relations, including human shackles in oppressive structures; both political, economic, and socio-cultural (Mahfud, 2011). In this context, progressive law must appear as an emancipatory institution. Progressive law, which seeks liberation from the tradition of bondage, bears a resemblance to Roscoe Pound's thinking about law as a tool of *social engineering*. The social *engineering* business is considered an obligation to find the best ways to advance or direct society (Sufriadi, 2010).

Financial losses experienced by hospitals due to the inefficient BPJS claim process can disrupt the overall health ecosystem. The financial instability of hospitals can lead to a reduction in facilities, human resources, and preventive health programs. In this case, progressive legal theory invites us to see that law is not only related to formal regulations, but must also be able to create an environment that supports sustainable and quality health

services. The progressive legal approach encourages us to redesign the BPJS Health claims system as a step towards better social justice, by ensuring that hospitals do not suffer losses due to discrepancies in claims, as well as supporting equitable access to health services for the entire community (Rahardjo, 2013).

The legal reconstruction of BPJS Health claims audit is based on the value of justice in line with progressive legal principles that emphasize sensitivity to crucial issues in human relations. In this context, audit law must be able to become an emancipatory institution, freeing individuals from oppressive structures, both in political, economic, and socio-cultural aspects. This approach is also in line with the utilitarianism theory put forward by Jeremy Bentham, which emphasizes the greatest achievement of well-being for the largest number of people (Ali, 2010). Therefore, the BPJS claim process must be designed efficiently, so that hospitals can continue to provide quality health services without being hampered by administrative problems, as well as creating social justice and broader welfare for the community.

Bentham argues that man is placed by nature in a state of power, distress, and pleasure. These pleasures and hardships shape our views, opinions, and the terms of our lives. Anyone who wants to be free from this power may not fully understand the consequences. The main goal is to seek pleasure and avoid distress, with an effort to increase happiness and reduce suffering. In his view, there is no separation between the two variables; Good is defined as happiness, while evil is defined as distress. The two are interrelated. Therefore, the task of law is to maintain goodness and prevent evil, with a focus on usefulness.

Progressive legal theory emphasizes the importance of fairness and responsiveness in every aspect of the law (Haris & Jihad, 2013), including in the audit of BPJS Health claim returns. Legal reconstruction must take into account the social context and needs of hospitals, especially those operating in disadvantaged areas. A fair audit policy will protect the hospital's rights from losses caused by discrepancies in claims, while still ensuring accountability and transparency. The integration of progressive law and utilitarianism, with a focus on efficiency and positive outcomes, will create a more holistic system and build trust between BPJS Health and health facilities, thereby increasing the effectiveness of health services.

The concept of claim return audit in the context of the implementation of health services by BPJS Health is an essential component in ensuring that the claim submission and return process can run efficiently, transparently, and fairly. However, the problem that often arises is that the audit mechanism often focuses too much on the administrative interests of BPJS Health itself, without giving sufficient consideration to other parties involved, namely hospitals as health service providers and BPJS participants as service users. Therefore, the preparation of a draft audit concept based on justice is an urgent need to create a balance between the interests of hospitals, BPJS participants, and BPJS Health.

There needs to be a comprehensive and comprehensive approach, which involves an in-depth understanding of the various needs and limitations of each party involved in order to achieve fairness in claims return audits. Hospitals, as health service providers, have a great responsibility in providing fast, precise, and quality services to patients. They have the financial need to support efficient operations, including treatment costs, medical personnel, and support facilities. On the other hand, BPJS participants are individuals who have the right to access adequate health services without having to experience significant cost constraints. Meanwhile, BPJS Health, as the health insurance agency, is responsible for maintaining the financial sustainability of the program and ensuring that the claims system is not abused.

It is the responsibility of the state to provide welfare to every citizen. There are three main steps that can be taken by the state in creating welfare, namely social protection,

education, and health services. First, social protection can be provided through the implementation of social assistance programs for vulnerable groups, the establishment of social security, and the provision of benefits for parents or individuals who are unable to support themselves. In addition, social protection can be achieved by creating an environment conducive to obtaining jobs, protecting workers' rights, and reducing economic and social disparities. Second, in the field of education, the state can facilitate well-being by ensuring that all individuals have equal access to quality education, including scholarship and job training programs that can enhance their skills and knowledge, thus promoting sustainable economic growth. Third, in the health sector, the state can facilitate the provision of welfare through the implementation of strategies that increase accessibility to health services. This can include the construction of health facilities, the provision of affordable medicines, and the development of effective health programs.

The three steps mentioned above, in fact, can be the main basis for the country to establish policies aimed at improving the welfare of its citizens. It is hoped that through these efforts, the country can guarantee that all citizens have equitable access to the opportunities and services they need. This will allow the state to focus its efforts on providing welfare, as the level of achievement and effectiveness of access provided to the community can be more easily evaluated. The commitment of the Indonesian state to improve the welfare of its citizens, especially in the health sector, is evidenced by a series of progressive initiatives. Greater allocation of financial resources and priority for health infrastructure development are two of the main strategies used by the state to increase access to quality health services for all Indonesians. In addition, the government's efforts in formulating supportive policies and regulations, such as comprehensive laws, are an important aspect of the country's efforts to establish a strong legal framework for the maintenance and improvement of healthcare standards in Indonesia.

The draft concept of fairness-based claim return audit must start from the understanding that each party has legitimate needs and is important to pay attention to. Therefore, the first principle that must be used as a basis in compiling the concept of fair audit is the principle of equality and balance. Equality here means that the audit process should not be biased or prioritize the interests of BPJS Health alone, but also consider the position of hospitals and BPJS participants equally. With this fairer approach, it is hoped that a situation will be created where hospitals feel motivated to continue participating in the BPJS program and BPJS participants feel that they get optimal services.

In order to regulate, organize, and improve health services for the Indonesian people, the Indonesian government has started the process of restructuring health regulations through the establishment of Law No. 17 of 2023 concerning Health. This legal framework is expected to be the basis for affirming the right of every Indonesian citizen to get proper access to quality health services. In addition, Law No. 17 of 2023 concerning Health also regulates the national health system, the establishment of health policies, the implementation and management of health services, the regulation of health resources, the control of infectious and non-communicable diseases, and a number of other aspects related to health promotion, disease prevention, and overall public health protection.

The concept of justice-based audits must consider the need for flexibility for hospitals, particularly those in areas with limited access or resources, so they are not hindered by complex administrative requirements. Exemptions or leniency in some administrative provisions can ensure that hospitals can still submit claims without being obstructed by excessive bureaucracy. Furthermore, transparency in the audit process is essential, providing

clear guidelines, training for hospital administrative staff, and constructive feedback to minimise claim errors.

Information technology also plays a crucial role in speeding up and simplifying the claim verification process. With a digital system, BPJS can automatically verify claims, reducing delays and enhancing the efficiency of the audit process. This system can also assist in analysing claim patterns to improve policies. Additionally, an appeals mechanism should be in place to allow hospitals to present arguments or supporting evidence if claims are rejected without clear reasons, reinforcing BPJS's commitment to fairness and transparency.

It is also important for BPJS to involve hospitals and BPJS participants' representatives in the formulation of audit policies, ensuring that the policies developed reflect the real needs and conditions on the ground. Discussions between all parties will help BPJS understand the challenges hospitals face in claim submissions and find solutions that support quality care and participant satisfaction.

CONCLUSION

The current regulations governing claims audits implemented by BPJS Health have been found to lack fairness, due to their rigid procedural nature, high reliance on technological solutions, and an absence of flexibility for health facilities located in remote areas. This system has been found to impede equitable access to healthcare, particularly in areas facing resource constraints, and to engender uncertainty due to an absence of policy oversight and socialization. Consequently, health facilities are unable to meet the required standards, with a consequent impact on efficiency, service quality, and the timely submission of claims.

The Legal Reconstruction of BPJS Health Claims Return Audit is an endeavor that seeks to establish a fairer and more responsive audit system. In accordance with the principles of substantive justice, this reconstruction ensures the right of BPJS participants to receive optimal health services and provides certainty for health facilities in obtaining appropriate reimbursement. The application of this reconstruction theory is intended to guarantee that audit policies do not solely priorities administrative procedures; rather, they should also be attentive to the various conditions of health facilities, thereby reducing inequality and balancing the interests of all relevant parties. The ultimate aim of this approach is to enhance the efficiency of access to services and utilization of BPJS funds.

REFERENCES

Agustina, Bunga. (2015). Kewenangan Pemerintah Dalam Perlindungan Hukum Pelayanan Kesehatan Tradisional Ditinjau Dari Undang-Undang Republik Indonesia Nomor 36 Tahun 2009 Tentang Kesehatan. *Jurnal Wawasan Yuridika*, *32*(1), 82–98.

Ali, Achmad. (2010). Menguak Teori Hukum (Legal Theory) & Teori Peradilan (Judicialprudence) Termasuk Undang-Undang (Legisprudence) Volume I Pemahaman Awal. *Kencana Prenada Media Group, Jakarta*.

Ardhitya, Tyas, & Perry, Agus. (2015). Faktor-Faktor Yang Melatar Belakangi Penolakan Klaim Bpjs Oleh Verifikator Bpjs Di Rsjd Dr. Amino Gondohutomo Provinsi Jawa Tengah Tahun 2015. *J. Univ. Dian Nuswantoro*, *2*(2), 1–10.

Bakri, Muhammad. (2011). *Pengantar Hukum Indonesia Jilid I: Sistem Hukum Indonesia Pada Era Reformasi*. Universitas Brawijaya Press.

Faizal, Liky. (2017). Produk Hukum Di Indonesia Perspektif Politik Hukum. *Asas: Jurnal Hukum Ekonomi Syariah*, *9*(1).

Haris, Abdul, & Jihad, Asep. (2013). Evaluasi Pembelajaran: Yogyakarta: Multi Pressindo. *Achmad Rifa'i Dan Chatarina Tri Anni. 2009, Psikol*.

Hery. (2016). *Auditing Dan Asuransi (Pemerisaan Akuntansi Berbasis Standar Audit International) (Jakarta: Grasindo)*.

Kurniawan, Mochammad, & Harjoko, Agus. (2021). Implementasi Bridging System Aplikasi Sikda Generik Dengan P-Care Bpjs Kesehatan Di Kabupaten Lamongan. *Journal Of Information Systems For Public Health*, *5*(2), 53–62.

Mahfud, M. D. (2011). Satjipto Rahardjo Dan Hukum Progresif. *Epistema Institute*.

Marzuki, Peter Mahmud. (2018). Pengantar Ilmu Hukum Edisi Revisi. *Kencana Prenada Media Group, Jakarta*.

Nurhani, Nurhani, & Rahmadani, Suci. (2020). Analisis Pelaksanaan Sistem Rujukan Pasien Bpjs Kesehatan Di Puskesmas Mamasa, Puskesmas Malabo Dan Puskesmas Balla Kabupaten Mamasa. *Jurnal Publikasi Kesehatan Masyarakat Indonesia*, *7*(2), 15–22.

Putri, Nevy Kusumaning Ayu, Karjono, Karjono, & Uktutias, Sendy Ayu. (2019). Analisis Faktor-Faktor Penyebab Keterlambatan Pengajuan Klaim Bpjs Kesehatan Pasien Rawat Inap Di Rsud Dr. R. Sosodoro Djatikoesoemo Bojonegoro. *Jurnal Manajemen Kesehatan Yayasan Rs. Dr. Soetomo*, *5*(2), 134–143.

Rahardjo, Satjipto. (2013). Other Sides Of Law In Indonesia. *Jakarta: Compass*.

Samodra, Nadyannisa, & Wirantari, I. Dewa Ayu Putri. (2024). Analisis Kebijakan Publik Dalam Penerapan Program Pelayanan Publik Bpjs Kesehatan. *Socio-Political Communication And Policy Review*, *1*(4), 147–151.

Santiasih, Wayan Ary, Simanjorang, Asyiah, & Satria, Beni. (2022). Analisis Penyebab Pending Klaim Bpjs Kesehatan Rawat Inap Di Rsud Dr. Rm Djoelham Binjai. *Journal Of Healthcare Technology And Medicine*, *7*(2), 1381–1394.

Septian, Erfandi Dwi. (2022). Kewajiban Bpjs Kesehatan Dalam Pemberian Pelayanan Telekonsultasi Klinis Yang Dilakukan Antara Dokter Dan Pasien Bpjs. *Verdict: Journal Of Law Science*, *1*(1), 37–49.

Sufriadi, Yanto. (2010). Penerapan Hukum Progresif Dalam Penegakan Hukum Di Tengah Krisis Demokrasi. *Jurnal Hukum Ius Quia Iustum*, *17*(2), 233–248.

Ummah, Siti Izzatul, & Lestari, Puji. (2024). Audit Komunikasi Tentang Program Pelayanan Pasien Bpjs. *Jurnal Heritage*, *12*(1), 14–32.