DIJEMSS:
Dinasti International Journal of Education Management and Social Science
E-ISSN: 2686-6331
P-ISSN: 2686-6358
https://dinastipub.org/DIJEMSS dinasti.info@gmail.com +62 811 7404 455
DINASTI PUBLISHER
DOI: https://doi.org/10.38035/dijemss.v7i5

Insurance Claim Dispute Resolution at General Hospital in Pacitan

Agung Suhirman[1], Muh Endriyo Susila[2]
[1]University of Muhammadiyah Yogyakarta, spogagung@gmail.com
[2]University of Muhammadiyah Yogyakarta, endriosusilo@umy.ac.id

Corresponding Author: spogagung@gmail.com[1]

Abstract: The discrepancy between the medical standards applied by health workers and the policy provisions of insurance companies often creates uncertainty for policyholders. This condition has led to the emergence of various legal disputes that have an impact on the fulfillment of patients' rights and the sustainability of health institution operations. This study aims to analyze the mechanism for handling and resolving health insurance claims disputes that occur at the institutional level. A descriptive qualitative approach is used to provide an in-depth overview of the settlement procedures, handling measures, and obstacles that arise at the Pacitan Regional General Hospital. The claim dispute resolution mechanism is implemented through cross-unit coordination that prioritizes a win-win solution approach through file reconciliation and synchronization of clinical actions with national practice guidelines. The main obstacles found include incompleteness of administrative documents, differences in diagnosis interpretation between hospitals and guarantors, and incompatibility of medical services with the set cost ceiling. The effectiveness of resolving this problem relies heavily on the use of quality and cost control instruments, such as the Clinical Pathway, to ensure that patients' medical rights are fulfilled according to scientific evidence. Transparent collaboration between professions in adjusting patient care to insurance policies has proven to be able to maintain the financial stability of hospital operations.

Keywords: Medical Services, Insurance Claim, and Dispute Resolution Mechanisms

INTRODUCTION

Legal issues related to health insurance claims are becoming increasingly complex alongside the rapid development of medical standards and regulatory provisions in the insurance sector. Differences between clinical standards applied by healthcare professionals and administrative provisions set by insurance companies often create uncertainty for policyholders (Putri & Yusuf, 2024). When claims are deemed inconsistent with policy terms, legal disputes may arise, affecting the rights and obligations of patients, hospitals, and insurers (Putri et al., 2025).

From the perspective of conflict management theory, disputes in health insurance claims can be understood as a form of organizational conflict arising from differences in interests, interpretations, and information asymmetry among stakeholders. Healthcare providers

prioritize clinical judgment based on evolving medical science, while insurance companies rely on standardized and often rigid policy clauses (Rahayu et al., 2024). This misalignment creates structural tension that may escalate into formal disputes when not managed through effective communication and negotiation mechanisms (Sihite et al., 2023).

In the context of health service management, hospitals function not only as clinical service providers but also as administrative entities responsible for ensuring accurate documentation, coding, and claim submission (Rambe & Sekarayu, 2022). Discrepancies in medical records, differences in diagnosis interpretation, and emergency interventions not explicitly covered in insurance policies often become critical points of contention. These issues highlight the need for integrated clinical and administrative systems to support efficient and transparent claim processes.

Furthermore, from a legal compliance and institutional theory perspective, dispute dynamics are shaped by regulatory frameworks and institutional pressures that require both hospitals and insurance companies to adhere to established legal norms. In Indonesia, health insurance claims are governed by several regulations, including Law Number 40 of 2014 on Insurance, Law Number 8 of 1999 on Consumer Protection, and Financial Services Authority Regulation Number 69/POJK.05/2016. These regulations aim to balance the interests of consumers and insurers; however, gaps in interpretation and implementation often lead to disputes (Shaubilhaq & Siska, 2023) (Zahra et al., 2024). Empirical data from the Financial Services Authority (OJK) in April 2025 indicates that the health insurance claim ratio reached 51.29% in the life insurance sector and 49.97% in general insurance (Rahmana, 2025). This significant claim burden increases the potential for disputes, particularly between insurance companies and hospital management during claim verification processes. As a result, patients may experience claim rejections, delays, or unclear communication, which further complicates service delivery and trust in the healthcare system.

Previous studies have examined related issues, such as legal protection for medical professionals in insurance schemes (Amalina et al., 2024), and legal responsibility of healthcare personnel in relation to competency standards (Afrita & Triana, 2025). However, these studies have not specifically addressed how disputes over insurance claims are resolved at the institutional level, particularly in the interaction between hospitals and insurance providers.

Therefore, this study offers a novel contribution by proposing and analyzing an institutional mechanism of dispute resolution that integrates clinical and administrative systems within hospital settings. This research aims to examine how insurance claim disputes are managed and resolved in practice, and to identify an ideal mechanism that ensures legal certainty, operational efficiency, and fairness for all parties involved.

METHOD

This study employs a qualitative approach aimed at developing an in-depth understanding of insurance claim dispute practices and providing a descriptive analysis of dispute resolution mechanisms at the General Hospital in Pacitan. The research focuses on procedures, stages of settlement, and obstacles arising from differences between hospital medical standards and insurance policy provisions (Sugiyono, 2021).

The study involved 10 informants selected using purposive sampling based on their direct involvement in the insurance claim process. The selection criteria included: (1) individuals directly engaged in claim administration or verification, (2) healthcare professionals involved in clinical decision-making affecting claims, and (3) representatives from insurance parties collaborating with the hospital. The informants consisted of registration officers (medical records unit), the head of healthcare services, *Professional Pemberi Asuhan* (PPA) including nurses, midwives, doctors, pharmacists, nutritionists, and physiotherapists, insurance claim officers, and insurance representatives.

Data were collected through semi-structured interviews, observations, and documentation. The semi-structured interviews were guided by key questions related to claim procedures, causes of disputes, communication between hospital and insurance parties, and strategies for dispute resolution, while still allowing flexibility to explore informants' experiences in depth. Observations were conducted to examine activities and interactions in the claim process, particularly during verification and dispute handling stages. Documentation included hospital records, claim files, standard operating procedures (SOPs), and other administrative archives that support the understanding of dispute resolution mechanisms (Sugiyono, 2021).

To ensure data validity, this study applied source triangulation by comparing and confirming data obtained from interviews, observations, and documentation. Information from registration officers, healthcare service managers, medical personnel, and claim officers was validated through direct observation of claim submission processes, hospital–insurance interactions, and dispute resolution flows, supported by relevant documents.

Data analysis followed an interactive model adapted from Miles and Huberman (2018), incorporating coding, categorization, and thematic analysis (Miles & Huberman, 2018). The process began with data reduction through open coding to identify key concepts from interview transcripts, observation notes, and documents. The codes were then organized into categories such as administrative procedures, clinical considerations, communication barriers, and dispute resolution practices. Subsequently, thematic analysis was conducted to identify broader patterns and relationships across categories, leading to the formulation of key themes that explain the institutional mechanism of insurance claim dispute resolution. The results were presented in narrative and visual forms to clearly illustrate the mechanism applied at the General Hospital in Pacitan.

RESULTS AND DISCUSSION

Mechanism of Health Insurance Claim Dispute Resolution

The findings of this study indicate that the mechanism for resolving health insurance claim disputes at the General Hospital in Pacitan is not positioned as a separate or reactive legal procedure. Instead, it is embedded within the overall healthcare delivery system as a continuous and integrated process. Dispute resolution unfolds along the service pathway, beginning from patient registration, continuing through clinical care, and culminating in claim verification by the insurance provider. This indicates that the potential for dispute is already managed from the earliest interaction between patients and the hospital.

At the initial stage, registration officers play a particularly strategic role in shaping the trajectory of the claim process. Their responsibility goes beyond administrative formality; they function as the first layer of risk control. Through careful verification of patient identity, insurance status, and referral requirements, they ensure that patients are properly aligned with the applicable financing scheme. The issuance of the Participant Eligibility Letter (SEP) serves not only as administrative validation but also as a form of legal assurance that the services provided will be covered. This early-stage precision reflects the broader institutional responsibility of hospitals to deliver services in accordance with established standards while simultaneously safeguarding financial accountability

As the service process progresses, the role of healthcare professionals becomes increasingly central. Clinical documentation is not merely a record of patient care, but a critical bridge between medical practice and administrative accountability. Doctors, nurses, midwives, pharmacists, and other professionals contribute to the completion of Integrated Patient Progress Records (CPPT) and medical resumes, which collectively form the backbone of claim justification. In this context, the consistency between diagnosis, treatment, and documentation becomes essential. Even small discrepancies can create significant consequences at the claim verification stage. The quality of documentation thus reflects not only professional discipline

but also the effectiveness of the hospital's management system in integrating clinical and administrative functions (Sabran & Deharja, 2021).

Before claims are submitted externally, the hospital implements an internal verification process through the claims administration unit. This stage acts as a crucial control point where potential discrepancies are identified and addressed. Verification is conducted based on Standard Operating Procedures (SOPs), clinical pathways, and insurer requirements. When inconsistencies are detected, the process does not immediately escalate into conflict; instead, it is managed through internal coordination, document revision, and clarification across units. This reflects an important characteristic of the system: dispute resolution begins internally, long before any formal disagreement with the insurer arises (Rohmatika, 2023).

When claims reach the insurance provider, an additional layer of verification is applied. At this stage, differences in interpretation may surface, particularly regarding diagnosis coding, treatment eligibility, and cost coverage. Rather than approaching these differences in an adversarial manner, the hospital tends to prioritize communication and negotiation. Clarification, resubmission, and adjustment of documents are commonly used strategies to resolve disagreements. This indicates that dispute resolution is not treated as a rigid legal confrontation, but as a flexible and iterative process of alignment between two institutional systems.

Taken as a whole, the mechanism demonstrates that dispute resolution is inherently embedded within a continuous workflow of coordination. It reflects an integrative system in which administrative and clinical processes are closely intertwined, allowing potential conflicts to be identified, managed, and resolved progressively.

Table 1. Institutional Mechanism of Insurance Claim Dispute Resolution

Stage	Actors	Main Activities	Purpose
Preventive	Registration officers	Eligibility verification, SEP issuance	Prevent early claim rejection
Clinical	Healthcare professionals (PPA)	Documentation (CPPT, medical resume, coding)	Ensure clinical validity
Internal Control	Claims unit & management	SOP verification, internal audit	Detect and correct discrepancies
Resolution	Hospital & insurer	Reconciliation, negotiation, document revision	Achieve mutual agreement

Obstacles in Dispute Resolution

Although the mechanism appears structured and systematic, the findings reveal that its implementation is frequently challenged by various obstacles that arise from the intersection of clinical realities and administrative requirements. These challenges are not isolated incidents but recurring patterns that reflect deeper systemic tensions.

One of the most prominent issues is the inconsistency of medical documentation. Differences between recorded diagnoses, procedures, and clinical pathway standards often become the primary trigger for claim disputes. In practice, healthcare professionals must document patient conditions accurately while also ensuring that the documentation aligns with insurance requirements. This dual expectation creates a complex situation, particularly in high-pressure clinical environments where time constraints and patient needs take priority.

Another significant challenge lies in differences in interpretation between healthcare providers and insurance companies. Medical decision-making is inherently dynamic, adapting to patient conditions and clinical judgment. In contrast, insurance systems operate based on predefined policy clauses that tend to be rigid and standardized. This mismatch creates a structural gap that frequently leads to disputes. As highlighted by Rahayu et al. (2024), insurance policy limitations often fail to keep pace with the rapid development of medical

science, resulting in differences in interpretation that are difficult to reconcile (Rahayu et al., 2024).

Administrative barriers also contribute substantially to the emergence of disputes. Patients who do not meet referral requirements or whose insurance status is inactive often face complications from the outset. These issues not only delay claim processing but can also affect patients' access to healthcare services, indicating that administrative inefficiencies have broader implications beyond financial matters.

In addition, financial constraints imposed by insurance coverage ceilings create dilemmas for healthcare professionals. Doctors and pharmacists, in particular, are often required to balance optimal clinical decisions with cost limitations set by insurers. This situation forces them to make adjustments that may not fully reflect the ideal standard of care, highlighting the tension between medical ethics and financial regulations.

Communication challenges further complicate the process. Differences in terminology, coding systems, and procedural expectations between hospital units and insurance providers often lead to misunderstandings. These require repeated clarification, which slows down the resolution process and increases the administrative burden.

Taken together, these obstacles demonstrate that disputes are not merely legal conflicts, but rather manifestations of broader institutional misalignments. The interaction between clinical, administrative, and financial systems creates a complex environment where differences are almost inevitable.

Effectiveness of the Dispute Resolution Mechanism

Despite the various obstacles encountered, the findings indicate that the dispute resolution mechanism at the General Hospital in Pacitan operates with a considerable degree of effectiveness. This effectiveness is not measured solely by the absence of disputes, but by the hospital's ability to manage them in a way that maintains both patient rights and institutional sustainability.

One important factor contributing to this effectiveness is the emphasis on preventive measures at the registration stage. By ensuring that administrative requirements are fulfilled early, the hospital significantly reduces the likelihood of claim rejection. This proactive approach demonstrates an understanding that effective dispute management begins long before a dispute actually occurs.

The integration between clinical documentation and administrative verification also plays a crucial role. Healthcare professionals demonstrate a strong awareness of the importance of accurate documentation, and this awareness translates into more reliable claim submissions. As a result, the number of discrepancies that lead to rejection is minimized.

When disputes do arise, the hospital adopts a collaborative approach in resolving them. Communication and negotiation are prioritized, allowing both parties to reach mutually acceptable solutions without escalating the issue into formal legal proceedings. This approach reflects a collaborative conflict management style, in which stakeholders actively seek solutions that accommodate shared interests (Thomas & Kilmann). At the same time, the emphasis on dialogue and clarification aligns with the problem-solving approach described by Pruitt and Rubin, which highlights the importance of open communication in achieving integrative outcomes.

Through these practices, the hospital is able to maintain trust and cooperation with insurance providers, while ensuring that patients continue to receive the services they need. This balance between operational sustainability and patient protection is a key indicator of the mechanism's effectiveness.

Theoretical Interpretation: Dispute Resolution as an Integrative Coordination Mechanism

The findings of this study provide a deeper understanding of dispute resolution by framing it as an integrative coordination mechanism. Rather than viewing disputes as isolated legal events, this perspective emphasizes the continuous interaction between clinical and administrative systems.

From a health service management perspective, effective dispute resolution depends on the ability of hospitals to integrate documentation, service standards, and financial controls into a coherent system. This integration ensures that clinical decisions are supported by administrative processes that meet regulatory and insurance requirements (Sabran & Deharja, 2021).

From an institutional perspective, the findings highlight the coexistence of different logics within the healthcare system. Hospitals operate based on a clinical logic that prioritizes patient care and flexibility, while insurance companies operate under a financial-administrative logic that emphasizes standardization and control. Disputes arise when these logics intersect without sufficient alignment. In this context, the dispute resolution mechanism functions as a bridge that connects these differing perspectives, allowing them to coexist within a shared framework.

Comparison with International Contexts

The patterns identified in this study are broadly consistent with international findings, which also highlight documentation gaps, coding discrepancies, and policy interpretation differences as major sources of dispute. However, the way these disputes are managed differs significantly.

In many developed healthcare systems, dispute resolution tends to rely on formal mechanisms such as audits, appeals, and legal proceedings. These systems emphasize procedural clarity and legal accountability. In contrast, the approach observed in Pacitan hospitals relies more heavily on informal coordination, communication, and document reconciliation.

This difference suggests that the Pacitan model represents a more relational approach, where maintaining institutional cooperation is prioritized over formal dispute escalation. Such an approach may be particularly relevant in contexts where flexibility and collaboration are needed to sustain healthcare services.

Contribution of the Study

This study contributes to the literature by offering a more nuanced understanding of dispute resolution in health insurance claims. It demonstrates that dispute resolution is not merely a reactive process that occurs after conflict arises, but rather a continuous and integrated mechanism embedded within healthcare service delivery.

By conceptualizing dispute resolution as an integrative coordination mechanism between clinical and administrative systems, this research provides a practical framework that can be applied in similar institutional contexts. It highlights the importance of coordination, communication, and documentation in managing disputes, offering insights that go beyond purely legal perspectives.

CONCLUSION

This study concludes that the mechanism for resolving health insurance claim disputes at hospitals in Pacitan is carried out through an integrated and coordinated process across administrative and clinical units. The process begins with patient eligibility verification at the registration stage and continues through clinical documentation and internal verification, culminating in claim reconciliation with the insurance provider. Rather than relying on formal legal procedures, dispute resolution is primarily approached through collaborative strategies

that emphasize communication, document revision, alignment of diagnoses, and synchronization of medical services with national clinical guidelines and insurer provisions. This approach reflects a practical effort to achieve mutually beneficial outcomes while maintaining continuity of healthcare services.

However, the implementation of this mechanism is not without challenges. The study identifies several recurring obstacles, including incomplete administrative documents, differences in diagnosis interpretation between healthcare providers and insurers, and mismatches between clinical services and insurance cost ceilings. In addition, technical issues such as inactive insurance membership status and the absence of referral documents often delay claim processing and trigger repeated clarification. These obstacles highlight the persistent gap between clinical realities and administrative requirements, which continues to shape the dynamics of dispute resolution in hospital settings.

Despite these challenges, the mechanism demonstrates a considerable level of effectiveness. The use of quality and cost control instruments, such as clinical pathways and standardized documentation, supports the alignment between medical services and insurance requirements. At the same time, the emphasis on interprofessional collaboration and transparent communication enables hospitals to protect patients' rights to appropriate care while maintaining financial sustainability. This balance indicates that dispute resolution is not merely about resolving claims, but also about sustaining trust and cooperation between healthcare providers and insurers.

From a theoretical perspective, this study contributes to the development of health service management and institutional theory by conceptualizing dispute resolution as an integrative coordination mechanism that bridges clinical and administrative systems. This perspective shifts the understanding of disputes from isolated legal events to ongoing organizational processes that require continuous alignment between different institutional logics, namely clinical professionalism and financial-administrative regulation.

Nevertheless, this study has several limitations. It is based on a qualitative approach conducted in a single hospital setting, which may limit the generalizability of the findings to other regions or healthcare systems. In addition, the study relies on perspectives from hospital actors and insurers, without directly incorporating patient experiences as primary data, which could provide a more comprehensive understanding of the impact of claim disputes.

Future research is therefore recommended to expand the scope of analysis by including multiple hospitals or comparative settings across different regions. Quantitative approaches may also be employed to measure the effectiveness of dispute resolution mechanisms more objectively. Furthermore, incorporating patient perspectives and examining the role of digital health information systems in improving claim accuracy and reducing disputes would provide valuable insights for strengthening healthcare governance and insurance collaboration in the future.

REFERENCES

Afrita, I., & Triana, Y. (2025). Tanggung Jawab Hukum Tenaga Medis Terhadap Standar Kompetensi Atas Tindakan Medis. *Jurnal Kesehatan Tambusai*, *6*(1).

Amalina, D. N., Mau, H. A., & Edwin. (2024). Aspek Perlindungan Hukum Bagi Dokter Peserta Asuransi Profesi Berdasarkan Undang-Undang Nomor 17 Tahun 2023. *Jurnal Cahaya Mandalika ISSN 2721-4796 (online)*, *3*(1).

Andika, R. (2025). *Buku Ajar Manajemen Konflik*. Serasi Media Teknologi.

Matippanna, A. (2019). *Tanggung Jawab Hukum Pelayanan Medis Dalam Praktek Kedokteran*. uwais inspirasi indonesia.

Miles, & Huberman. (2018). *Qualitative Data Analysis*. SAGE Publication.

Putri, A. A., & Yusuf, H. (2024). *Analisis Hukum terhadap Aspek Sengketa Medis: Perspektif Penyelesaian dan Pencegahan*. *1*(2).

Putri, S. H., Windraji, P., & Purnomo, B. (2025). Tinjauan Hukum Perjanjian Kerjasama Antara Rumah Sakit dan Perusahaan Asuransi Kesehatan. *JIIP (Jurnal Ilmiah Ilmu Pendidikan)*, *8*(10).

Rahayu, A., Rokhmat, R., Silitonga, V. D., & Suswantoro, T. A. (2024). Payung Hukum Terhadap Profesi Dokter Dalam Menghadapi Perselisihan Medis. *Jurnal Cahaya Mandalika ISSN 2721-4796 (Online)*, *3*(1).

Rahmana, A. I. (2025). *OJK Ungkap Kondisi Rasio Klaim Kesehatan Asuransi Jiwa dan Umum per April 2025*. https://keuangan.kontan.co.id/news/ojk-ungkap-kondisi-rasio-klaim-kesehatan-asuransi-jiwa-dan-umum-per-april-2025

Rambe, S. H., & Sekarayu, P. (2022). Perlindungan Hukum Nasabah Atas Gagal Klaim Asuransi Akibat Ketidaktransparanan Informasi Polis Asuransi. *JURNAL USM LAW REVIEW*, *5*(1).

Rohmatika, F. (2024). Perlindungan Hukum Klaim Asuransi Pemegang Polis Asuransi. *JREA : JURNAL RISET EKONOMI DAN AKUNTANSI*, *2*(1).

Sabran, & Deharja, A., a. (2021). *Buku Ajar Praktik Klinis Rekam Medis (Pengantar Awal Turun Lapang)*. Pelita Medika.

Shaubilhaq, F. A.-R., & Siska, F. (2023). Pelaksanaan Klaim Asuransi Kesehatan di Masa Pandemi Covid-19 dan Tanggungjawab Perusahaan Asuransi terhadap Pemenuhan Klaim Dikaji Menurut Undang–Undang Nomor 40 Tahun 2014 Tentang Perasuransian Dihubungkan dengan Peraturan Otoritas Jasa Keuangan Nom. *Bandung Conference Series: Law Studies*, *3*(1).

Sihite, G. A., Dachi, R. A., & Silitonga, E. M. (2023). Analysis of the Causes of Disputes in Medical Record Files for Inpatient BPJS Patients at the Imelda General Hospital for Indonesian Workers in 2022. *Jurnal Info Sains : Informatika Dan Sains*, *13*(02).

Sugiyono. (2021). *Metode Penelitian Kuantitatif, Kualitatif dan R&D*. Alfabeta.

Utami, D. T., Muskitta, F. M., Fardiyani, F., Widjaja, Y. R., & Sanjaya, U. A. R. (2024). Analisis Hukum Manajemen Strategik Keselamatan Pasien di Rumah Sakit / Analysis of Legal Strategies for Patient Safety Management in Hospitals. *Jurnal Kesehatan Indra Husada*, *12*(2).

Zahra, R. A., Abdurrahman, L., & Husnoh, A. U. (2024). Perlindungan Hukum Bagi Nasabah Bank Selaku Konsumen Ditinjau dari Undang-Undang Nomor 8 Tahun 1999 Tentang Perlindungan Konsumen. *Indonesian Journal of Law and Justice*, *1*(4).