

Fraud Issues in the National Health Insurance (Causes, Legal Impacts, Dispute Settlement and Preventive Measures)

Yohanes Firmansyah^{1*}, Imam Haryanto², Ernawati Ernawati³

^{1,2}Health Law, Faculty Of Law, Pembangunan Nasional Veteran University,
Jakarta

³Department of Public Health, Faculty of Medicine, Tarumanagara University,
Jakarta

ABSTRACT: National Health Insurance which covers all financing of health services in terms of national insurance. This causes the National Health Insurance to manage a very large amount of money and has an impact on many challenges regarding overcoming fraud committed by various parties. This research is a literature search that analyzes the concept of fraud, legal impact, dispute resolution, and preventive actions in dealing with and preventing fraud. The legal basis used is very diverse, starting from the regulations governing national health insurance, as stated in Presidential Regulation no. 12 of 2013 concerning Health Insurance and the Law of the Republic of Indonesia Number 24 of 2011 concerning the Social Security Administering Body; The legal implications contained in the criminal code of law; and prevention of fraud as regulated in PERMENKES RI 269/MENKES/PER/III/2008 concerning Medical Records and Regulation of the Minister of Health of the Republic of Indonesia Number 36 of 2015 concerning Prevention of Fraud in the Health Insurance Program in the National Social Security System

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Corresponding Author: yohanesfirmansyah28@gmail.com

INTRODUCTION

Awareness of the importance of social protection insurance continues to grow. This is in accordance with the mandate of Pancasila and the 1945 Constitution which states that the State shall develop a Social Security System for all Indonesian people. Furthermore, the issuance of Law Number 40 of 2004 concerning the National Social Security System (In Indonesia, it is called the Sistem Jaminan Sosial Nasional or SJSN) is a strong evidence that the government and related stakeholders have a great commitment to realizing social welfare for all its people. Through SJSN as a form of social protection, the government intends to ensure that all people can fulfill their basic needs for a decent life. (Mukti & Moertjahjo, 2008; Nurman & Martini, 2008)

Law Number 40 of 2004 concerning the National Social Security System also mandates that the social security program is mandatory for all Indonesians. The program also includes a health insurance program that is implemented and managed through a social security administering agency. The social security administration agency appointed by the government has been regulated by Law Number 24 of 2011 concerning Social Security Administering Institutions (In Indonesia, it is called the Badan Penyelenggaraan Jaminan Sosial or BPJS), which consists of BPJS Health and BPJS Employment. The health insurance program organized by BPJS Health has been started since January 1, 2014. (UNDANG-UNDANG REPUBLIK INDONESIA NOMOR 24 TAHUN 2011 TENTANG BADAN PENYELENGGARA JAMINAN SOSIAL, 2011)

The Indonesian government implements the National Health Insurance (In Indonesia, it is called the Jaminan Kesehatan Nasional or JKN) for all its people in stages until January 1, 2019. This is a form of government performance in an effort to achieve the highest public health status as stated in the health development goals. Therefore, the JKN program is implemented following a mandatory financing pattern. This means that all Indonesians (without exception) must become program participants by January 1, 2019. Through the implementation of JKN, the government hopes that there will be no more Indonesians, especially the underprivileged, who do not seek treatment at health facilities because they have no money. Many parties welcome the government's initiative, considering that the implementation of JKN is an effort by the government in implementing the 1945 Constitution, particularly related to the fulfillment of the right to health for its citizens. But on the other hand, there are also parties who are worried about the "collapse" of the healthy paradigm concept that has been built so far due to the application of this financing pattern. For that, we need to understand the concept of health insurance comprehensively in order to support government programs and maintain the concept of a healthy paradigm. (Mukti & Moertjahjo, 2008; Nurman & Martini, 2008)

According to the Presidential Regulation of the Republic of Indonesia No. 12 of 2013 concerning Health Insurance, health insurance is a guarantee in the form of health protection so that participants receive health care benefits and protection in meeting basic health needs that are given to everyone who has paid contributions or whose contributions are paid by the government. This guarantee is called the National Health Insurance (JKN) because all Indonesian residents

are required to become participants in the health insurance managed by BPJS, including foreigners who have worked for at least six months in Indonesia and have paid dues..(Presiden Republik Indonesia, 2013)

The National Health Insurance (JKN) is applied based on a pre-effort financing pattern, meaning that health financing is issued before or not in a sick condition. This financing pattern refers to the "large amount" and "risk summary" rules. This means that in order for risk to be spread widely and effectively reduced, this financing pattern requires a large number of participants. Therefore, in its implementation, the government requires all Indonesians to become JKN participants so that the "large number" rule can be fulfilled. Risk summarization occurs when a number of individuals who are at risk agree to collect the risk of loss with the aim of reducing the burden (including the cost of loss/claims) that must be borne by each individual when one of the individuals experiences a loss/disaster (Azwar, 1996; Murti, 2000)

The National Health Insurance Program (JKN) developed in Indonesia is part of the mandatory National Social Security System (SJSN). This program is implemented through a social insurance mechanism that aims to ensure that all Indonesians are protected in the insurance system so that they can meet their basic health needs. This provision is based on Law Number 40 of 2004 concerning the National Social Security System (Mukti & Moertjahjo, 2008; Nurman & Martini, 2008)

The problem of National Health Insurance in the field is very complicated because of the very large amount of money that is managed centrally by the National Health Insurance. On the other hand, all the limitations of data sources and systems create gaps for fraud or fraudulent acts committed by various individuals. This paper discusses the ins and outs of fraud, as well as the legal impact, dispute resolution, and fraud prevention efforts in terms of health law

METHOD AND MATERIAL

BeriThe research that will be used uses a normative juridical review, namely research by examining various sources such as sources of library materials such as journals, literature, books, written documents, as well as various laws such as legal theories, legislation, doctrines, opinions of legal experts. The approach used in this research is a statutory approach and a conceptual approach. (Ibrahim, 2006)

RESULTS AND DISCUSSION

A. BASIC UNDERSTANDING AND CONCEPTS OF FRAUD

Currently, Indonesia has entered the era of the National Health Insurance (JKN). This has an impact on changes in the method of payment for health services. Initially, payments for health services were mostly made using the retrospective payment method, which means that payments were made by the patient after the service was rendered. Such payments are often made by patients who do not have insurance membership or other health financing guarantee institutions. Furthermore, with the implementation of JKN by the government which is managed by the Health Insurance Administration (BPJS) Health, the public is

gradually starting to recognize the prospective payment method, which means that health payments are made in advance before the service is provided. Because payments are received and managed in advance before health services are provided, this creates opportunities for fraud and misuse of existing health resources.(Hatta, 2011)

Since operating from January 1, 2014 until now, BPJS Health has experienced many challenges in implementing the national health insurance program (JKN). One of them is the occurrence of fraud. Fraud prevention is an important part of implementing the National Health Insurance/Healthy Indonesia Card (JKN/KIS) program organized by BPJS Health. One of the effects of the fraud is the disruption of the BPJS Health financial management system because the funds paid to provide benefits to participants are very large. If this continues, the management of the Health Social Security Fund will be disrupted. In fact, the sustainability of the ongoing JKN/KIS program is being threatened.(Azwar, 1996; Hatta, 2011; Murti, 2000)

Actually, the term fraud in general has long been known as a form of fraud. However, the specific meaning is still not very clear. Therefore, some experts try to define the meaning of fraud

The Institute of Internal Auditor (2005) defines fraud as an unlawful act committed by individuals, both inside and outside the organization, with intentional intent, which aims to benefit certain individuals or organizations and result in losses to other parties. Furthermore, The Institute of Internal Auditors together with The American Institute of Certified Public Accountants and the Association of Certified Fraud Examiners (2008), define fraud in the form of any intentional act or wrongful act designed to deceive others so that the victim suffers losses and damages. perpetrators make a profit. Fraud can also mean fraud committed by one party to another party who deliberately hides the true situation and causes the other party to suffer losses.(The Institute of Internal Auditor, The American Institute of Certified Public Accountants, And Examiners, 2008; The Institute of Internal Auditor, 2005)

From these definitions, fraudulent acts that can be categorized as fraud have several elements, including:

1. the existence of statements or data, both written and unwritten, indicating deviations;
2. deception or fraud by taking advantage of the victim's ignorance and/or negligence so that the victim acts according to the will of the perpetrator;
3. there is a deliberate intention to commit fraudulent acts to achieve the perpetrator's goals;
4. there is an element of concealment of actual facts and violations of applicable laws or regulations; and
5. There is an advantage for the perpetrator and a loss for the victim.

B. THEORY ABOUT FRAUD - FROM AGE TO AGE

Theories about fraud continue to be developed by experts to define what factors encourage fraud to occur. The following describes several theories of fraud. (Hall, 2011; Hatta, 2011; Nurman & Martini, 2008; The Institute of Internal Auditor, The

American Institute of Certified Public Accountants, And Examiners, 2008; The Institute of Internal Auditor, 2005)

1. Fraud Triangle Theory

This theory was first put forward by Donald Cressey in 1953. This theory explains the reason someone commits fraud or cheating. According to him, someone who commits fraud is influenced by three things, including:

a) Pressure

Someone commits fraud because of pressure. Pressure is divided into financial pressure, stress on bad habits, and pressure related to work. Financial stress arises because of greed, an excessively high standard of living, low salaries, many bills and debts, and unexpected necessities of life. The pressure of bad habits is an urge to do bad habits such as gambling, drinking alcohol, and drugs. Work-related pressures can occur due to unfairness in the company, lack of leadership attention, and an unfavorable work atmosphere.

b) Opportunity

Fraud occurs because someone has the opportunity to do it. This occurs due to weak internal control at the company, lack of supervision, and/or abuse of authority.

c) Rationalization (Rationalization)

The rationalization in question is that someone seeks justification for their fraudulent actions. In general, someone who commits fraud assumes that he feels that his actions are not cheating but that it is his right. In addition, someone usually commits fraud because he follows similar actions carried out by those around him. James Hall defines the fraud triangle as a combination of three factors including:

- 1) situational pressure, which includes personal stress and/or work-related stress that can force a person to act dishonestly;
- 2) opportunity, which is mainly directly related to resources/information related to organizational assets; and
- 3) ethics, which relates to a person's level of morality to act dishonestly. If a person's ethics and morality are high while pressure and opportunity are low, this situation tends to minimize or even eliminate the incidence of fraud, and vice versa.

2. Fraud Scale Theory

Fraud Scale Theory is a theoretical development of the Fraud Triangle Theory. This theory was developed by W. Steve Albrecht in 1983. This theory explains the possibility of fraud by observing pressure, opportunity (opportunities to commit), and personal integrity (personal integrity) of someone who will commit fraud. If someone has high pressure, the opportunity to commit major fraud, and low personal integrity, the possibility of fraud will be high, and vice versa. Pressure usually occurs because of financial problems. The opportunity to commit fraud is usually due to weak organizational control and supervision. Meanwhile, low personal integrity is caused by bad individual habits

3. GONE theory

The GONE theory (greed, opportunity, need, and exposure) is a theory proposed by Jack Bologne in 1999. In this theory there are four factors that encourage fraud, namely:

- a) greed, related to the greed that has the potential to exist in everyone, greed can occur in power or financial matters;
- b) opportunity, related to circumstances in certain organizations so that it opens a person's opportunity to commit fraud, lack of supervision and control will increase the opportunity to commit fraud;
- c) need, is a demand for individual needs that must be met, both primary needs for food, clothing, and housing as well as secondary and tertiary needs related to lifestyle; and
- d) exposure (disclosure), which relates to the possibility of disclosing the fraud that has been committed as well as the legal sanctions that ensnare, the lower the incidence of disclosure and light legal sanctions will increase the chances of fraud.

4. Diamond Fraud Theory

This theory is a development of the Fraud Triangle Theory. This theory explains the relationship between the four elements that cause fraud, namely incentive, opportunity, rationalization, and capability.

a) Incentive

Incentive is an encouragement that arises because of the demands or pressures faced by someone. Incentives can trigger fraud such as greed which results in pressure to meet these needs.

b) Opportunity

Opportunity is an opportunity that arises because there are weaknesses in the organization's internal control in preventing and detecting fraud. Opportunity can occur because of the power over the organization and also because someone who commits fraud knows the weaknesses of the existing system.

c) Rationalization

Rationalization is the condition of a fraud perpetrator looking for a justification for his actions. This is done to gain profit and wealth quickly regardless of the applicable rules.

d) Capability

Capability is an ability and skill of detailed understanding so that a fraud perpetrator can find out weaknesses and can take advantage of them to commit fraud. Capability can result in a serious threat to the organization because the perpetrator is usually a person who has a high position/power within the organization and has intelligence and understanding of the system within the organization.

5. The Pentagon Fraud Theory

Recent research conducted by Crowe in 2011 resulted in a new fraud theory. This theory is an extension of the Fraud Triangle Theory with the addition of two other factors. According to Crowe, fraud arises because there are five factors, namely pressure, opportunity, rationalization, competence, and arrogance.

- a) pressure, is the pressure experienced by a person related to his daily life as well as his financial and work conditions so as to encourage him to commit fraud;
- b) opportunity, is a person's opportunity to commit fraud due to weak organizational supervision and control;
- c) rationalization, is the condition of a person seeking justification for the fraudulent act he has committed;
- d) competence, similar to ability or capability, is a person's ability to ignore internal control, develop concealment strategies and commit dishonest acts, and control social situations for his personal gain; and
- e) arrogance, namely an attitude of superiority over the rights and authorities he has so that he feels that internal control or organizational policies do not apply to him.
- f) These five factors are usually better known as Crowe's Fraud Pentagon Theory. This theory is considered more complete to find out the factors causing fraud compared to other theories

C. FRAUD IN THE TIME OF NATIONAL HEALTH INSURANCE

In Indonesia, the Government – through the Ministry of Health of the Republic of Indonesia – has issued Regulation of the Minister of Health of the Republic of Indonesia Number 36 of 2015 concerning the Prevention of Fraud in the Implementation of the Health Insurance Program in the National Social Security System (SJSN). In it, fraud is defined as an act carried out intentionally by participants, BPJS Health officers, health service providers, both primary level health facilities and advanced referral health facilities, as well as providers of drugs and medical devices to obtain financial benefits from health insurance program in SJSN through fraudulent acts that are not in accordance with the provisions. The fraudulent acts committed by each party are described as follows. (Kementrian Kesehatan RI, 2015)

1. Cheating committed by participants:
 - a. make a statement that is not true in terms of eligibility (falsifying membership status) to obtain health services;
 - b. take advantage of their rights to unnecessary services by falsifying health conditions;
 - c. provide gratification to service providers so that they are willing to provide services that are not appropriate/not covered;
 - d. manipulating income so as not to have to pay excessive contributions;
 - e. cooperate with service providers to submit false claims;
 - f. obtain medicines and/or medical devices that are prescribed for resale, and others.
2. Fraud committed by BPJS Health officers:
 - a. cooperate with participants and/or health facilities to submit false claims;
 - b. manipulating benefits that should not be guaranteed in order to be guaranteed;

- c. withhold payments to health facilities/partners with the aim of obtaining personal gain;
 - d. pay capitation funds not in accordance with the provisions; and others.
3. Fraud committed by health service providers Fraud acts are grouped into two, namely fraud committed by first-level health facilities (FKTP) and advanced referral health facilities (FKRTL).
- a. a. Fraud committed by first-level health facilities:
 - i. i. utilizing capitation funds not in accordance with the provisions of the legislation;
 - ii. ii. manipulating claims on services paid for on a non-capitation basis;
 - iii. iii. receive commissions for referrals to advanced referral health facilities;
 - iv. iv. collect fees from participants that should have been guaranteed in capitation and/or non-capitation fees in accordance with the stipulated tariff standards;
 - v. v. make patient referrals that are not in accordance with the purpose of obtaining certain benefits; and others.
 - b. Fraud committed by advanced referral health facilities:
 - i. excessive writing of diagnostic codes by changing the diagnostic codes and/or procedures into codes that have higher rates than they should be (upcoding);
 - ii. plagiarism of claims from other patients by copying a patient's claim from another patient's existing claim and usually the copied claim has a higher value (cloning);
 - iii. false claims made by filing a claim for services that were never provided (phantom billing);
 - iv. inflated bills for drugs and medical devices carried out by submitting claims for higher costs of drugs and/or medical devices (inflated bills);
 - v. solving service episodes carried out by submitting claims for two or more diagnoses and/or procedures that should be a service package at the same treatment episode or billing several procedures separately when they should be billed together in the form of a service package to get the claim value greater in one episode of patient care (services unbundling or fragmentation);
 - vi. pseudo referrals which are claims for service costs due to referrals to the same doctor at other health facilities except for reasons of facilities (self referrals);
 - vii. recurring billing made by submitting repeated claims for the same case intentionally (repeat billing);
 - viii. extending the length of treatment carried out by submitting a claim for higher health care costs due to changes in the length of treatment days, especially in cases of extended length of stay;

- ix. manipulating the treatment class by changing the treatment class to a higher class so that the bill for health care claims is getting bigger (type of room charges);
 - x. cancel the actions that must be taken which are carried out by continuing to file health service claims even though the diagnosis and/or medical procedures are not carried out (cancelled services);
 - xi. take unnecessary actions by submitting claims for actions that are not based on medical needs or indications (no medical value);
 - xii. deviations from service standards carried out by submitting claims for diagnoses and/or procedures that are not in accordance with proper service standards (standard of care);
 - xiii. take unnecessary medical treatment by filing a claim for unnecessary treatment;
 - xiv. increase the length of time the ventilator is used so that the claims submitted are getting bigger;
 - xv. not conducting a proper visitation which is a claim for a fake patient visit (phantom visit);
 - xvi. not carrying out the proper procedures that should have been done by filing a claim for actions that have never been done (phantom procedures);
 - xvii. repeated admissions carried out by filing a claim for a diagnosis and/or procedure from one episode of patient care that is billed many times so that it appears as if the patient was treated for more than one episode of treatment (readmission);
 - xviii. make patient referrals that are not up to standard with the aim of obtaining certain benefits;
 - xix. requesting cost-sharing with other parties (BPJS Health, providers of drugs and medical devices) not in accordance with the provisions of the applicable laws and regulations; and others.
4. Fraud committed by providers of drugs and medical devices:
- a. does not meet the need for drugs and/or medical devices in accordance with the provisions of the legislation;
 - b. cooperate with other parties to change drugs and/or medical devices listed in the e-catalog at prices that are not in accordance with the e-catalog; and others.

D. FRAUD IN REGULATION

In the Criminal Code, fraudulent acts are regulated in chapter XXV Articles 378 to 395, the criminal sanctions of which Article 379a is described as follows: Article 379a: "Whoever makes as a livelihood or habit to buy goods, with the intention that without full payment ensures control of against such items for oneself or for another person, shall be punished by a maximum imprisonment of four years:(Nurbaningsih, 2015)

Punishment is an action aimed at a person or legal entity who commits a criminal offense. The punishments or sanctions adopted by criminal law aimed at

maintaining security and regular life have become debated by experts on the basis for the implementation of these penalties which eventually led to three theories, namely: (Marpaung, 2005)

- a. Reward Theory (absolute / vergeldingstheorie);
- b. Theory of Purpose or Objectives (relatieve / doeltheorie);
- c. Combined Theory (verenigingstheorie).

The theory of rewards (absolute / vergeldingstheorie) explains that the legal basis must be sought from the crime itself because the crime has caused suffering to others. In return (vergeliding) the perpetrator must also be given suffering. The scholars of this adherent are Immanuel Kant, Hegel, Jean Jacques Rousseau, and Stahl.

Theory of Purpose or Purpose (relatieve/doeltheorie). Based on this theory, punishment is imposed based on the intent and purpose of this punishment, namely to improve public dissatisfaction as a result of the crime. The purpose of punishment must be viewed as ideal. In addition, the purpose of punishment is to prevent (prevention) crime, but there are differences in terms of prevention, namely: first, there are those who argue that prevention is aimed at the public, which is called general prevention (algemene preventie) this can be done with the threat of sentencing and execution (execution) punishment, secondly there are those who argue that prevention is aimed at the person who committed the crime (speciale preventie).

Combined theory (verenigingstheorie), basically this theory is a combination of reward theory and goal theory. Teaching that punishment is for risking the rule of law in society and improving the personality of the criminal, by examining the theories above, it can be concluded that the purpose of punishment is: a) trapping criminals; b) Destroy or render helpless the criminal; c) Fix criminals.

In essence, these three things are the basis for holding criminal sanctions, but destroying criminals is still a matter of debate among experts. Some countries have abolished the death penalty, but some still accept it.

Punishment or crime consists of various types of forms. However, in accordance with Chapter II Article 10 of the Criminal Code, it consists of: (Nurbaningsih, 2015)

1. Principal Crime.
 - a. Death Penalty;
 - b. Imprisonment;
 - c. Criminal Cage: V; and
 - d. Penalty.
2. Additional Criminal.
 - a. Revocation of certain rights;
 - b. confiscation of certain goods;
 - c. Announcement of judge's decision.

E. SETTLEMENT OF CASE AGAINST THE CRIMINAL ACTS OF FRAUD AND THEIR CHALLENGES (MECHANISM FOR RESOLVING CRIMINAL CASES)

Referring to the process and mechanism for resolving criminal cases according to the Criminal Procedure Code, the settlement of cases against perpetrators of

fraudulent crimes in business activities is carried out in 3 (three) stages, as follows: (Nurbaningsih, 2015)

1. Examination stage at the investigation level;
2. Prosecution stage (Case Settlement at the Prosecutor's Office);
3. The stage of examination in court.

Law enforcers carry out their respective functions in accordance with their authority, by ensuring that the alleged article fulfills the criminal elements. Application of criminal sanctions against perpetrators who commit fraudulent acts in business, in particular Article 379a of the Criminal Code. (Nurbaningsih, 2015)

1. Objective Elements.
 - a. Purchase Act. Buying and selling, according to Article 1457 of the Civil Code is an agreement in which one party (called the seller) binds himself to deliver an object and the other party (called the buyer) pays the promised price.
 - b. The object. objects or goods.
 - i. movable and fixed objects;
 - ii. More than one different object.
 - c. As a livelihood (beroep) or a habit (gewoonte).
 - i. Livelihood, it is enough only once but from the other things that he does it can be concluded that he will do it again;
 - ii. Habits, done more than once.
2. Subjective Elements. The intention is to ensure power over things for himself and others without paying in full.
 - a. The intent is an element of error;
 - b. Intent is aimed at:
 - i. Ensuring mastery of things both for himself and for others.
 1. The controlling element is the same as the controlling element in embezzlement;
 2. Other people/auxiliary actors who facilitate buying and selling.
 - ii. Without paying in full

If the concept of law enforcement is reviewed above, its application is studied in the process of resolving cases of criminal acts of fraud committed by business actors related to feed supply. Thus, even though the act of the business actor has fulfilled the elements of a criminal act as regulated in Article 379a of the Criminal Code, that the act is carried out as a livelihood or habit, because the act is repeated not only to one business actor but to other business actors, so that it has indication of intent not to pay in full. However, law enforcement agencies did not follow up further because the case was a civil case not a criminal case, so that the purpose of implementing the provisions of Article 379a of the Criminal Code against business actors who committed fraudulent acts was not achieved, in: (Nurbaningsih, 2015)

1. providing legal certainty;
2. provide legal comparability; and
3. provide legal protection for the parties involved, cannot be expected.

F. FRAUD PREVENTION

After getting to know the definition and types of fraud, you must also understand the efforts that can be made to prevent and overcome fraud. This is important in order to minimize or even eliminate the possibility of fraud. In the Regulation of the Minister of Health of the Republic of Indonesia Number 36 of 2015 concerning Fraud Prevention in the Implementation of the Health Insurance Program in the National Social Security System (SJSN), fraud prevention efforts can be carried out using a fraud prevention scheme which includes preventive efforts, detection efforts, and handling efforts. (Kementrian Kesehatan RI, 2015)

1. Preventive measures

To prevent fraud, BPJS Health, district/city health offices and advanced referral health facilities (FKRTL) must build a fraud prevention system. The system built includes the formulation of policies and guidelines for fraud prevention, the development of an anti-fraud culture as part of good organizational and clinical governance, the development of health services oriented to quality control and cost control, and the formation of a fraud prevention team. (Kementrian Kesehatan RI, 2015)

Fraud prevention policies and guidelines that are prepared must be able to regulate and encourage all human resources to work in accordance with ethics, professional standards, and service standards. The substance of the policies and guidelines that are prepared must include the arrangements to be applied and the procedures for their implementation. In addition, policies and guidelines must also include standards of behavior and discipline, monitoring and evaluation schemes aimed at ensuring compliance with the implementation of policies, and the application of sanctions for violators. (Kementrian Kesehatan RI, 2015)

The development of an anti-fraud culture as part of good organizational governance must be based on the principles of transparency, accountability, responsibility, independence, and fairness. The principle of transparency can be achieved by the disclosure of information, both in the decision-making process and in disclosing information as needed in an effort to prevent fraud. The principle of accountability is defined as the clarity of the system structure and service accountability so that service management becomes more effective. The principle of responsibility refers to conformity or compliance in the management of services to good organizational principles in the context of preventing fraud. The principle of independence is an organizational condition that is managed professionally without any conflict of interest or pressure from any party that is not in accordance with the principles of a healthy organization. The principle of fairness leads to fair and equal treatment in fulfilling the rights of stakeholders that arise based on agreements or cooperation in terms of preventing fraud. (Kementrian Kesehatan RI, 2015)

Apart from being part of good organizational governance, the development of an anti-fraud culture is also part of good clinical governance. To be able to fulfill this, health facilities can take actions in the form of regulating the accuracy of the competence and authority of each health worker, implementing service standards, implementing clinical service guidelines, implementing clinical pathways,

implementing clinical audits, and establishing correct and appropriate claim procedures. (Kementrian Kesehatan RI, 2015)

The development of health services that are oriented towards quality control and cost control can be done by using effective and efficient management concepts and the use of evidence-based information technology. The management concept can be implemented effectively and efficiently if it is supported by good synergy and cooperation between the leadership and staff. Evidence-based technology is considered capable of supporting the implementation of a quality control system if the system is able to monitor and evaluate all service activities carried out in health facilities in a measurable and efficient manner.

The fraud prevention team at FKRTL involves the internal examination unit (SPI), medical committee, medical recorders and health information, coders, and other related elements. The fraud prevention team can work together and coordinate with BPJS Health. This team is tasked with: (Kementrian Kesehatan RI, 2015)

- a. conduct early detection of JKN fraud based on data on health service claims conducted by FKRTL;
- b. promote new policies, regulations, and culture oriented towards quality control and cost control;
- c. encourage the implementation of good organizational and clinical governance;
- d. improve the ability of coders, doctors, and other officers related to claims by conducting training and education on knowledge related to fraud, training and education on the correct coding system, increasing interaction between related health workers, increasing compliance with applicable standard operating procedures, and encouraging documentation clear, complete, and timely;
- e. make efforts to prevent, detect, and take action against JKN fraud;
- f. monitoring and evaluation; and g. make reports on the results of fraud prevention efforts.

2. Detection attempt

Efforts to detect fraud cases can be carried out by health facilities through a claim data surveillance scheme or claim data audit. This activity can be carried out by the fraud prevention team. Audits should be carried out regularly. Audits can also be included as part of investigative activities in an effort to detect JKN fraud early. Investigations can be carried out by a team consisting of medical/coding experts, hospital associations/health facilities associations, and professional organizations. The investigation aims to ensure that there is a suspected fraud, an explanation regarding the occurrence of the fraud incident, and the reasons/cause of the fraud case. (Kementrian Kesehatan RI, 2015)

The results of the audit of claim data are then analyzed with the following approaches: looking for data anomalies, predictive modeling, or case finding. Searching for data anomalies is intended to find out whether there is deviant/suspected claim data that is an incident that leads to fraud. Predictive modeling usually uses certain statistical methods (usually with regression techniques) to predict the incidence of fraud. Case finding refers to examining or

auditing medical record documents in an effort to find cases of claims that are considered part of a fraud case. (Kementrian Kesehatan RI, 2015)

3. Handling efforts

If the results of the clinical data audit and/or investigation lead to a fraud incident, the fraud prevention team must report it to the head of the health facility. The report submitted contains information regarding the presence or absence of fraud incidents, recommendations for preventing the recurrence of similar incidents in the future, and recommendations for administrative sanctions for perpetrators. (Kementrian Kesehatan RI, 2015)

According to the Regulation of the Minister of Health of the Republic of Indonesia Number 36 of 2015 concerning Prevention of Fraud in the Implementation of the Health Insurance Program in the National Social Security System (SJSN), administrative sanctions that can be given include: (Kementrian Kesehatan RI, 2015)

- a. verbal warning;
- b. written warning;
- c. an order to refund the loss to the aggrieved party;
- d. penalty for refund of losses (maximum 50% of the total loss);
- e. revocation of practice license;
- f. dismissal from office; and/or
- g. dismissal.

In addition to through the Ministry of Health, the Social Security Administering Body (BPJS) for Health has also issued BPJS Health Regulation No. 7 of 2016 concerning the Fraud Prevention System in the Implementation of the Health Insurance Program. The regulation contains the management of JKN fraud prevention by social security participants, BPJS officers, and health service providers which is carried out with the stages of prevention, detection, and handling of fraud cases. In terms of managing fraud prevention by social security participants, BPJS Health takes preventive action by making commitments with health facilities not to accept gratuities from participants, educating participants and related parties, and requiring health facilities to check the suitability between the identity cards of JKN participants and another identity card before valid participants receive health services. The act of detecting fraud by participants is carried out by checking the authenticity of the JKN participant card, checking the authenticity and validity of the referral letter, ensuring that health facilities have and comply with standard operating procedures and applicable medical service standards, providing applications that are able to detect acquisitions. excessive benefits for participants, compliance checks on participants, requests for explanations from health facilities regarding requests for self-referrals by participants, and explanations regarding falsification of identity/participation data. Handling is done by stopping the provision of health insurance programs, imposing sanctions on participants, reporting incidents of fraud to the health office/health facility association/hospital committee, and/or reporting it to the authorities accompanied by evidence to be processed according to applicable law. (Kementrian Kesehatan RI, 2015)

In terms of managing fraud prevention by BPJS Health officers, BPJS Health takes preventive actions by building a good organizational culture, regulating and ensuring that the job descriptions of officers are carried out correctly, ensuring standardized business processes, increasing the knowledge and competence of officers on the latest policies and regulations, improve coordination between officers, and conduct periodic monitoring and evaluation. The act of detecting fraud by BPJS Health officers is carried out by conducting audits and evaluating the performance of officers. Handling is carried out by reviewing fraud cases and continuing with the preparation of reports addressed to the Technical Director of BPJS Health. The end result is the determination of sanctions for officers who are proven to have committed fraud in accordance with the BPJS Health Employment Regulations. (Kementrian Kesehatan RI, 2015)

In terms of managing fraud prevention by health service providers, BPJS Health takes preventive action by including clauses on fraud prevention measures contained in cooperation agreements and integrity pacts, socializing fraud prevention, installing good information media, improving good governance by health facilities, monitoring and evaluating, and/or coordinating with the leadership of health facilities regarding indications of fraud. Fraud detection actions by health service providers are carried out by implementing early detection of fraud cases based on claim data, tracing information on indications of fraud, and submitting indications of fraud cases to the leadership of health facilities. Handling is done by tracing and further investigation of indications of fraud cases, reporting the results of investigations to the head of the health department and the minister of health, giving sanctions in the form of not paying claims that are the result of fraud, and/or calculating the overpayment of claims as bills for the following month, returned directly, or legally processed. (Kementrian Kesehatan RI, 2015)

G. MEDICAL RECORD IN THE CONTEXT OF FRAUD RESPONSE

According to Law no. 29 of 2004 concerning Medical Practice, Article 46 paragraph 1 describes medical records as files containing records and documents regarding patient identity, examination, treatment, actions and other services that have been provided to patients. This understanding is clarified by the Regulation of the Minister of Health of the Republic of Indonesia No. 269/MENKES/PER/III/2008 concerning Medical Records which explains that medical records are files containing records and documents including patient identity, examination results, treatment that has been given, as well as other actions and services that have been provided to patients. (Kementrian Kesehatan RI, 2008)

As a document containing patient health care records, medical records have important useful aspects that are often abbreviated as ALFRED, namely:

1. Aspects of Administration (Administration)

Medical records have administrative value because their contents involve actions based on the authority and responsibility as medical and paramedical personnel in achieving health service goals.

2. Legal Aspects (Legal)

Medical records have legal value because their contents involve guarantees of legal certainty on the basis of justice, in the context of enforcing the law and providing evidence to uphold justice.

3. Financial Aspects (Financial)

Medical records have financial value because they contain data and information that can be used in calculating health care costs.

4. Research Aspects (Research)

Medical records have research value because their contents involve data/information that can be used in research and development of science in the health sector.

5. Aspects of Education (Education)

Medical records have educational value because their contents involve data/information about the development/chronology and activities of medical services provided to patients which can then be used as educational and teaching reference materials/references.

6. Aspect of Documentation (Documentation)

Medical records have documentation value because their contents involve memory sources that must be documented and used as material for accountability.

To be able to meet these aspects, medical records must be managed and documented properly. The data in the medical record file must be filled in completely. However, until now, there have been occasional problems related to this. Constraints that often arise are usually the data is not recorded on time, fails to document the doctor's orders and signatures, the data input on the medical record form is too detailed, and the data recorded is inaccurate. These constraints have an impact on the incomplete data entry in the medical record file. If this is allowed then the opportunity for fraud will be wide open.

Poor (incomplete) medical record documentation will lead to potential fraud. For example, incomplete and accurate documentation of diagnosis and medical treatment will give rise to the opportunity to determine the diagnosis code and inappropriate action. Inaccuracies in determining the code will encourage certain people to manipulate the code so that the claims submitted are of higher value. This, of course, is a form of fraud.

Efforts that can be made to overcome incomplete documentation is to conduct qualitative analysis and quantitative analysis of medical records. Hatta (2011) describes qualitative analysis as a review process aimed at medical record documents to identify incomplete filling of medical record documents. The analysis is focused on checking the certainty of a complete and consistent diagnosis, consistent input from all health care providers, determining the certainty of reasons for patient care and the course of treatment, proper documentation related to informed consent, implementation of good and adequate documentation, and conditions that are potentially subject to prosecution. . The implementation of qualitative analysis must be supported by knowledge of medical terminology, anatomy and physiology, the basics of disease science, as well as the contents of medical records. (Hatta, 2011)

Furthermore, Hatta (2011) describes quantitative analysis as a study/review of certain parts of the contents of medical records in order to find deficiencies, specifically those related to recording medical records. Quantitative analysis is also called incompleteness analysis, both the form that must exist and the completeness of filling out the data items contained in the form in accordance with the services provided to the patient. This analysis consists of four components, namely identification review, authentication review, reporting review, and record review. An identification review is carried out to check the patient's identity component on each sheet of the medical record form which at least contains the medical record number and patient's name. Authentication reviews are intended to ensure that medical record documentation is accompanied by the date and time of service, as well as the signature and full name of the health service provider. Reporting reviews are carried out to ensure the accuracy of the data listed in medical records because medical records are a source of statistical data reporting at health facilities. Recording reviews are carried out to check incomplete or illegible notes, use of abbreviations and symbols in accordance with mutual standards/agreements, and rules for correcting errors in data writing. (Hatta, 2011)

The implementation of the analysis when the service is running or after the medical record document has been in the medical record work unit needs to be evaluated because it involves "cost & benefit." The analysis should be carried out routinely. Therefore, analytical activities require adequate personnel, materials, and workplaces. By doing this qualitative analysis and quantitative analysis, the percentage of completeness of medical record documentation is expected to increase. Thus, the quality of the information submitted to the cost bearers, especially BPJS Health, will also increase. This can be used to reduce the potential for fraud. (Hatta, 2011)

CONCLUSION AND RECOMMENDATION

Fraud is an action that often occurs in the administration of health, whether it is financed privately, private insurance, to national insurance. Fraud has an impact on various aspects of the law. The legal basis for fraud in the national health insurance is stated in Presidential Regulation no. 12 of 2013 concerning Health Insurance and the Law of the Republic of Indonesia Number 24 of 2011 concerning the Social Security Administering Body; The legal implications contained in the criminal code of law; and prevention of fraud as regulated in PERMENKES RI 269/MENKES/PER/III/2008 concerning Medical Records and Regulation of the Minister of Health of the Republic of Indonesia Number 36 of 2015 concerning Prevention of Fraud in the Health Insurance Program in the National Social Security System

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