BPJS Fraud Prevention Strategy at Royal Prima Hospital

Santy Deasy Siregar*[1], Chrismis Novalinda Ginting[1], and Cecilia Arnas Bertha Harefa[1]

Department of Public Health, Universitas Prima Indonesia, 20118, (Medan) Indonesia
santysiregar@unprimdn.ac.id

Abstract. Fraud or fraud is an act that is against the law and is carried out intentionally for certain purposes that harm other parties. This research aims to find out some of the efforts made by RSU Royal Prima Medan in detecting and preventing fraud in BPJS claims. The method used in this research is a qualitative approach with a phenomenological design. The number of samples in this study were 5 people. The results obtained by Royal Prima Medan General Hospital, in preventing fraud, first validate new patients. Second, providing therapy in accordance with the Clinical Pathway. The third, conduct supervision (Monet) per day. The fourth is Double Cross-check. And finally, empowering human resources.

Keywords: uric acid, urea, creatinine, and kidney histopathology

1 Introduction

Current conditions show that government spending on health is increasing in absolute terms and also increasing as a share of total government spending. This suggests that health has become a greater government priority over time. Many countries channelled budgets to health care purchasing agents such as social health insurance funds. Out of pocket health expenditure is increasing in absolute terms, but decreasing relatively as a share of total health expenditure today. As a guarantee for all Indonesians to meet the basic needs of a decent life, a social security system is realised as a form of social protection for the people. In the health insurance programme, there are efforts to control quality and financing by minimising the potential for fraud. This is done so that health services are implemented rationally, in accordance with the needs of health insurance participants, cost-effective and to ensure the continuation of the Health Insurance program.

Fraud is an act that is against the law and is carried out deliberately for a specific purpose (manipulation or providing false reports to other parties) carried out by people from inside or outside a system or organisation to obtain personal or group benefits either directly or indirectly harming other parties. Until the end of 2023, it is detected that the potential for fraud and gratuity is getting smaller, because the BPJS (Health Insurance) has made an effort

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by dividing several teams as controllers so that phantom billing does not occur. Potential fraud that occurs usually comes from groups of health service providers, such as BPJS Health staff, patients, and suppliers of medical devices and drugs.Without prevention, the occurrence of fraud can be damaging, especially with the assumption of small payments given in the INA-CBG scheme. In some places, information has been provided about the systematic increase in Up-Coding. The existence of fraud will worsen the absorption of BPJS funds by areas with many health facilities and those in difficult areas.

Royal Prima University Hospital Medan is one of the private hospitals in Medan City that implements the use of BPJS Health for patients other than insurance. This of course cannot be separated from the efforts they make in preventing fraud so that at this time there is no fraud in Health Insurance claims. This is a good example of insurance management, where it is known that the Hospital works and makes claims in accordance with ethics and does not take advantage either personally or in groups against insurance in this case BPJS.

2 Literature Review

In the Health Insurance system, there is a very controversial issue related to financing, namely, fraud. Fraud is a criminal act using dishonest methods to take advantage of others. Fraud that often occurs is a serious problem that can damage the morale of health human resources and threaten the efficiency of the health system. Fraud in the health sector includes corruption, misuse of assets, and falsification of statements. The potential for healthcare fraud arises and can become more widespread due to the pressure of the new financing system in Indonesia, the opportunity due to the lack of supervision, and the justification for committing this act.

According to the National Health Care Anti-Fraud Association (NHCAA), common forms of fraud are false statements, misrepresentation, or deliberate omission of facts. This is critical for determining the payment of insurance benefits. The act of fraud is a criminal offence that hardly varies, although there may be variations in the specific nature or extent of the criminal offence between states. Healthcare fraud is more comprehensively defined as the intentional representation of a fact that a person knows to be false or does not believe to be true and knows that the representation may result in some unauthorized benefit to self or others.

Types of fraud are categorized based on the perpetrator, which includes:

1. Participants
2. BPJS Health
3. Health facility or health care provider
4. Providers of drugs and medical instruments
5. Other stakeholders

Some of the factors that cause fraud are:

1. Incentive or pressure to commit fraud (pressure)
2. Opportunity or chance to commit fraud (opportunity). In addition, an inadequate external monitoring system makes fraud detection not optimal.
3. Justification to rationalize fraud (rationalization). Low income and profit-oriented backgrounds contribute to rationalization.
4. Capabilities

The types of fraud in healthcare, according to the American Health Insurance Association (AAKA) in its survey, classify the main types of fraud perpetrators as follows:

1. Health service provider (PPK)
2. Consumer
3. Agent / others

Based on No.16 of 2019, fraud in the implementation of the Health Insurance program can be committed by:

1. Participants
2. BPJS Health
3. Health Facilities or health service providers
4. Providers of drugs and medical devices
5. Other stakeholders

Stakeholders are all parties who commit and/or contribute to fraud. According to Permenkes No.16 of 2019, in general, the objectives of effective fraud prevention are:

1. **Prevention:** Preventing the occurrence of fraud in all lines of the organization.
2. **Deterrence:** Warding off parties who will try to commit fraud to create a deterrent effect.
3. **Disruption:** Complicating the steps of fraud perpetrators as far as possible.
4. **Identification:** Identifying high-risk activities and control weaknesses.
5. **Civil action prosecution:** Prosecuting and imposing appropriate sanctions for fraudulent acts on the perpetrators.

3 Methods

The method used in this research is a qualitative approach. Where a qualitative approach is a research method that uses descriptive data in the form of written or spoken language to understand the phenomena experienced by the subject. With a phenomenological design where this design is a qualitative research approach that aims to understand and explore the meaning of the subject's experience in depth. This approach assumes that each individual experiences a phenomenon with his awareness, and focuses on personal experiences and the structure of thoughts about an object. In this study, the researcher wants to know more

deeply how the experience and self-awareness of the research subjects about the ways and strategies they use for early detection, prevention and even solutions to prevent fraud in BPJS claims/use in hospitals. In this way, researchers also want to see an evaluation of the strategies that have been implemented whether they have a big impact and how the development is progressing

4 Results

This research uses the interview method to collect data. The first step researchers take is to compile interview questions that are appropriate and in line with the research conducted in this case the questions asked are related to BPJS Fraud at Royal Prima Medan Hospital. Furthermore, conducting questions and answers to sources (samples). After the researcher conducts an interview and gets answers to the questions asked, then the researcher analyses the data and draws conclusions about the BPJS Fraud Prevention Strategy carried out by RSU Royal Prima Medan.

5 Discussion

Based on the latest regulation of the Ministry of Health, it is stated that in the implementation of the health insurance program under the national social security system, various problems arise, including the potential for fraud. Fraud can cause significant losses to the national social health insurance fund. This situation prompted the issuance of the law on fraud prevention in the National Health Insurance (JKN), which is continuously being developed to achieve optimal results and ensure fraud prevention strategies are realized in all healthcare facilities, from the first level to higher levels, whether private or government-owned.

The findings from research at Royal Prima General Hospital Medan highlight that the hospital has established a specialized Anti-Fraud Team. This team is responsible for quality control and BPJS Health services and consists of a Chairperson, Secretary, and nine members. Researchers conducted interviews with five team members responsible for service units, following the provisions of the 2019 Permenkes regulation regarding fraud prevention.

According to Informant 1:

> *"I am clear about what fraud is. One example that we often hear and may occur in several hospitals is the falsification of patient status. The hospital conducts an examination or makes a false status when, in fact, the patient does not exist or did not receive treatment at the hospital. Alhamdulilah, at RSU Royal Prima, there has never been such a case because many patients come directly without falsifications. However, we are aware of cases involving claim inflation and misuse of diagnosis codes."*

The misuse of diagnosis codes, as described by Informant 1, involves practices such as diagnosing a patient with a higher-cost condition. For instance, a patient presenting with common fever might be falsely coded as having typhoid fever, resulting in a higher claim. Previous research by Ida, Imas, and Fery (2022) supports this finding, stating that upcoding can sometimes reflect intent for financial gain.

To prevent such fraud, RSU Royal Prima implements several strategies in accordance with the 2019 Permenkes regulation for fraud prevention:

1. **Validation of New Patients**
   Identity validation is performed for every new patient entering the emergency room or outpatient unit. The BPJS card is matched against the patient's KTP. Any minor discrepancies, such as a difference in punctuation or a single letter (e.g., "Dedy" vs. "Dedi"), are addressed by verifying additional documents like family cards or certificates. Fingerprinting and face documentation are also carried out to ensure accurate patient identification. This aligns with research by Tatik (2022), which emphasizes using original identity cards and conducting direct interviews to verify patient conditions.
2. **Therapy According to Clinical Pathway**
   Drug administration and medical device usage strictly adhere to clinical pathways. For instance, a patient diagnosed with typhoid is prescribed only appropriate medications. If multiple drugs with similar effects are considered, the attending physician (DPJP) selects the most necessary option. Any inappropriate drugs are stopped, returned to the pharmacy, and logged into the Electronic Medical Record (EMR) system to maintain traceability. Ayu Mitriza (2019) highlighted that adherence to SOPs and clinical pathways is a key strategy in fraud prevention.
3. **Monet Every Day**
   Daily routine checks are conducted by the account manager and BPJS units. These checks ensure consistency between diagnosis, treatment duration, and administrative processes. Complete patient files are reviewed within 24 hours after discharge to prevent delays or errors.
4. **Double Cross-Check**
   Before claims are submitted, multiple layers of verification are performed. Relevant units ensure that all drug and medical device entries align with treatment needs. Case managers monitor actions requiring prior approval and verify BPJS coverage limits based on regulations.
5. **HR Empowerment**
   Human resources (HR) at RSU Royal Prima, particularly the Anti-Fraud Team, undergo regular training and mentoring. Training covers BPJS updates, medical record systems, and quality control practices. Continuous training ensures compliance with the latest JKN regulations and enhances the team's ability to implement fraud prevention measures effectively.

6 Conclusion

Royal Prima Medan General Hospital, in preventing fraud, applies the latest Minister of Health Regulation No.16 of 2019, with the strategy of developing a reporting system and quality control, namely first, validating new patients. Second, providing therapy in accordance with the Clinical Pathway. The third, conduct supervision (Monet) per day. The fourth is Double Cross-check. And finally, to increase awareness and improve service quality, it is necessary to empower human resources, by means of training and seminars related to service delivery and flow in BPJS Health.

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