LAMPIRAN

Lampiran 1 Tabel Data *Literature*

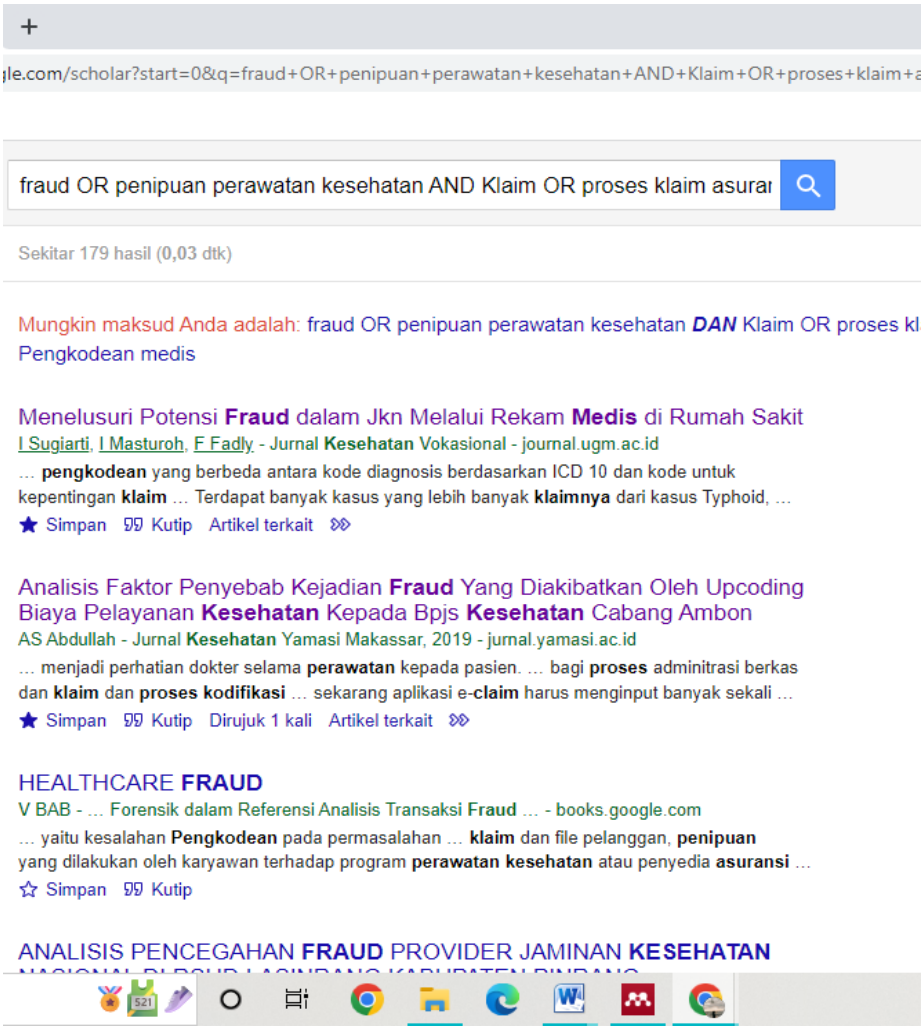
NO.	JUDUL	NAMA JURNAL	KETERANGAN
1.	Analisis Kebijakan Operasional Tentang *Fraud Clinical Pathway* Pasien JKN Rawat Inap RSUD Buru Maluku	Jurnal Ilmu Kesehatan Masyarakat, p-ISSN: 2252-4134, e-ISSN 2354-8185, 2022	**Metode :** kualitatif **Sampel :** 6 informan (Direktur RSUD, dokter, kepala ruang rawat inap, kepala tim BPJS RSUD, kepala instalasi farmasi, dan bendahara) **Pengumpulan data :** observasi, wawancara mendalam, dan telaah dokumen **Tempat penelitian :** Maluku **Topik penelitian :** potensi *fraud* pada *clinical pathway* pasien JKN di unit pelayanan rawat inap RSUD Kabupaten Buru Provinsi Maluku **Kekurangan :** tidak dijelaskan secara rinci hasil implementasi kebijakan pengendalian *fraud* **Kelebihan :** menggunakan QSPM untuk menentukan prioritas strategi pencegahan *fraud* pada *clinical pathway*
2.	Analisis Pengendalian Potensi *Fraud* di Rumah Sakit Umum Daerah Achmad Moechtar Bukittinggi	Jurnal Kesehatan Andalas, p-ISSN: 2301-7406, e-ISSN 2615-1138, 2019	**Metode :** kualitatif **Sampel :** Petugas RSUD dr Achmad Moechtar Bukittinggi yang mengetahui tentang pengendalian *fraud* **Pengumpulan data :** wawancara **Tempat penelitian :** Bukittinggi **Topik penelitian :** [1] komponen input, [2] komponen proses, [3] upaya dari RSUD dr Achmad Moechtar Bukittinggi dan BPJS Kesehatan dalam pencegahan potensi *fraud* **Kekurangan :** tidak dijelaskan jenis *fraud* yang terjadi di RSUD dr Achmad Moechtar Bukittinggi **Kelebihan :** pada komponen proses terbagi menjadi faktor pendorong dan penghambat *fraud*
3.	*Detection of Healthcare Fraud in The National Health Insurance Program Based on Cost Control*	*Advances in Economics, Business and Management Research*, e-ISSN: 1559-4122, PIMD: 35440932, 2020	**Metode :** kualitatif **Sampel :** Petugas RSUD bagian pelayanan medis dan penjaminan **Pengumpulan data :** dokumentasi dan wawancara **Tempat penelitian :** Jawa Timur **Topik penelitian :** sistem deteksi *fraud* berdasarkan pengendalian biaya **Kekurangan :** pembahasan

NO.	JUDUL	NAMA JURNAL	KETERANGAN
			algoritma deteksi kurang mendalam, **Kelebihan :** fokus pada kecurangan klaim INA CBGs
4.	*Fourteen years of manifestations and factors of health insurance fraud, 2006-2020: a scoping review*	*Health & justice*, p-ISSN: 2194-7899, PIMD: 34591187, 2021	**Metode :** *scoping review* **Sampel :** 67 artikel kualitatif dan kuantitatif **Pengumpulan data :** *ACM, EconPapers, PubMed, Science Direct, Scopus, Springer,* dan *Web of Science* **Tempat penelitian :** AS **Topik penelitian :** [1] manifestasi penipuan, [2] faktor penipuan **Kekurangan :** pencarian jurnal terbatas pada rentang 1 Januari 2006-31 Juli 2020 **Kelebihan :** menyertakan bukti relevan dari jurnal terindeks
5.	*Fraud and Abuse in the Saudi Healthcare System: A Triangulation Analysis.*	*Inquiry : a journal of medical care organization, provision and financing*, e-ISSN: 1945-7243, PIMD: 32975465, 2020	**Metode :** kualitatif **Sampel :** 5 pemimpin dari lima perusahaan asuransi kesehatan **Pengumpulan data :** wawancara **Tempat penelitian :** Arab Saudi **Topik penelitian :** [1] dokumen terkait *moral hazard, [2] peraturan terkait moral hazard, [3] implikasi terkait moral hazard* **Kekurangan :** pembahasan mengenai hubungan *fraud* dan *moral hazard* kurang mendalam **Kelebihan :** menyajikan data prevalensi *moral hazard* tahun 2014-2019
6.	*Healthcare Fraud Data Mining Methods: A Look Back and Look Ahead.*	*Perspectives in health information management*, e-ISSN: 1559-4122, PIMD: 35440932, 2020	**Metode :** kualitatif **Sampel :** Artikel penipuan perawatan kesehatan di Amerika Serikat **Pengumpulan data :** - **Tempat penelitian :** AS **Topik penelitian :** [1] deteksi penipuan berbasis aturan, [2 deteksi penipuan berbasis data, **Kekurangan :** tidak membahas tindakan atau proses yang terjadi di luar deteksi penipuan **Kelebihan :** mengulas sistem dan metode deteksi penipuan perawatan kesehatan dari literatur akademik
7.	*How to detect healthcare fraud? "A systematic review"*	*Gaceta sanitaria*, e-ISSN: 1578-1283, PIMD: 34929872,	**Metode :** *Systematic review* **Sampel :** 9 artikel metode dekteksi *fraud*

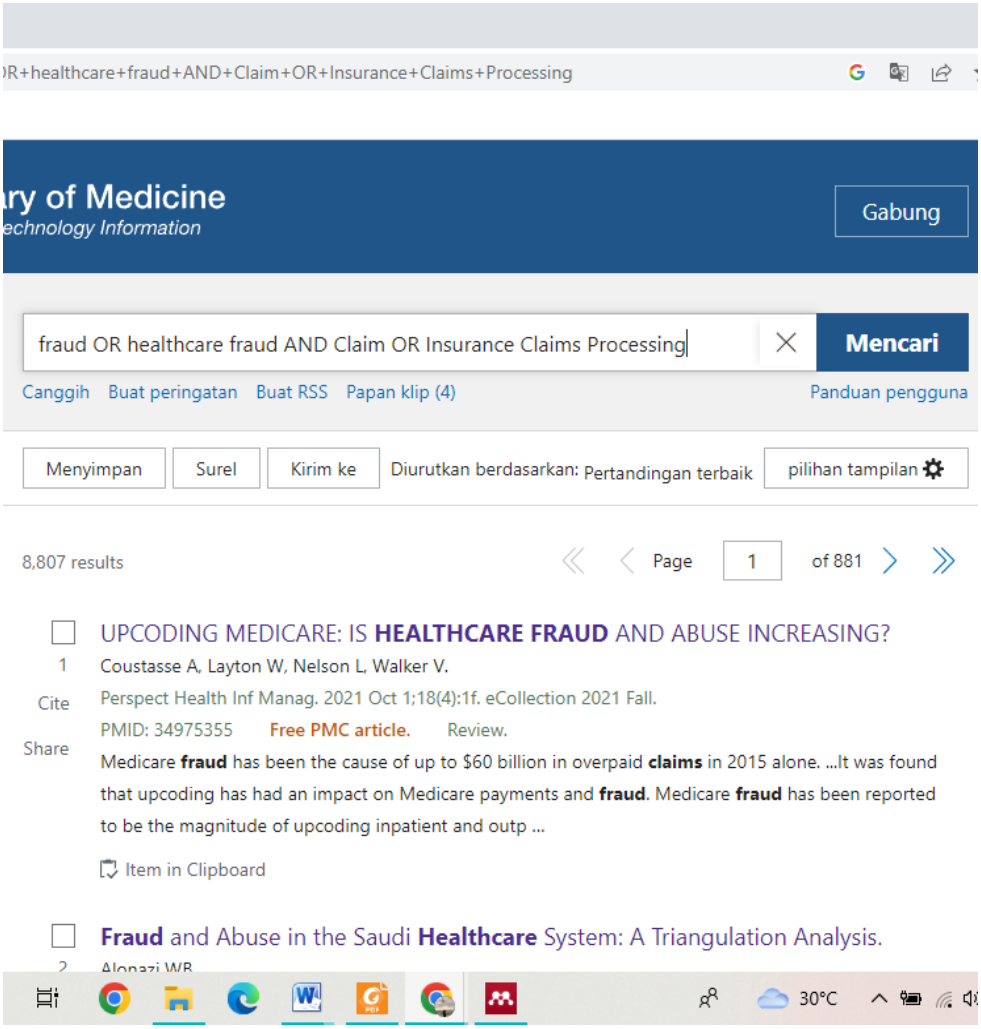
NO.	JUDUL	NAMA JURNAL	KETERANGAN
		2021	**Pengumpulan data :** *PubMed/Medline, Cochrane, Wiley, ScienceDirect, Google Scholar* **Tempat penelitian :** Indonesia **Topik penelitian :** identifikasi jenis dan pelaku *fraud* **Kekurangan :**peneliti tidak memebahas kelemahan metode deteksi *fraud* melalui data, jenis dan aturan yang berlaku bagi pelaku *fraud* **Kelebihan :** peneliti tidak hanya membahas jenis dan *fraud*, namun juga membahas mengenai metode deteksi
8.	Menelusuri Potensi *Fraud* dalam Jaminan Kesehatan Nasional melalui Rekam Medis di Rumah Sakit	*Jurnal Kesehatan Vokasional*, e-ISSN: 2599-3275, 2022	**Metode :** kuantitatif – kualitatif **Sampel :** 87 dokumen rekam medis kaus *Typhoid* di RSU S **Pengumpulan data :** observasi dan wawancara mendalam **Tempat penelitian :** Priangan Timur **Topik penelitian :** [1] akurasi koding diagnosis, [2] telusur biaya klaim sesuai koding diagnosis, [3] pelaksanaan *clinical pathway* kasus *typhoid* **Kekurangan :** peneliti hanya berfokus pada kecurangan dalam penggunaan *clinical pathway* **Kelebihan :** peneliti melakukan analisis langsung dari dokumen rakam medis
9.	*Potential for fraud of health service claims to BPJS Health at Tenriawaru Public Hospital, Bone Regency, Indonesia*	*International Journal of Innovation, Creativity and Change*, ISSN: 22011323, 2019	**Metode :** kualitatif **Sampel :** 15 informan, terdiri dari: – Petugas verifikator BPJS 2 orang – Manajemen rumah sakit 1 orang – Koder rumah sakit 1 orang – Petugas RS di ruang BPJS Center 3 orang – Perawat poli 1 orang – Pasien dilipih secara purposive 7 orang **Pengumpulan data :**wawancara,

NO.	JUDUL	NAMA JURNAL	KETERANGAN
			observasi, dan dokumentasi **Tempat penelitian :** Bone **Topik penelitian :** potensi penipuan **Kekurangan :** hanya mengalisis potensi *fraud* **Kelebihan :** lebih akurat karena didapatkan dari wawancara langsung dengan petugas
10.	*Potential Fraud in The Primary Healthcare*	*Jurnal* Medicoeticolegal dan Manajemen Rumah Sakit, ISSN: 20882831, 2018	**Metode :** kualitatif **Sampel :** 5 kepala puskesmas **Pengumpulan data :** wawancara mendalam dan observasi **Tempat penelitian :** Puskesmas Kabupaten X **Topik penelitian :** potensi *fraud* di puskesmas **Kekurangan :** pembahasan masih terlalu umum **Kelebihan :** peneliti membahas mengenai oengelolaan dana yang ada di pelayanan kesehatan primer
11.	Urgensi Pencegahan Tindak Pidana Curang *(Fraud)* Dalam Klaim Asuransi	Halu Oleo Law Review, P-ISSN: 2548-1762, E-ISSN: 2548-1754, 2020	**Metode :** kualitatif (hukum doktrinal) **Sampel :** Sumber informasi menggunakan bahan hukum primer (peraturan dan dokumen relevan) **Pengumpulan data : -** **Tempat penelitian :** Indonesia **Topik penelitian :** [1] pengaturan hukum mnegenai penyelenggaraan asuransi di Indonesia, [2] tinjauan tentang asuransi dan klaim asuransi, [3] modus operandi tindak pidana kecurangan *(fraud)* dalam klaim asuransi, [4] kebijakan dan strategi pencegahan praktik *fraud* dalam kliam asuransi **Kekurangan :** tidak menjelaskan proses klaim ausransi **Kelebihan :** peneliti membahas dengan lengkap dan mendalam

Lampiran 2 *Screenshoot* Hasil Pencarian
Google Scholar



PubMed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fraud OR healthcare fraud AND Claim OR Insurance Claims Processing
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Diurutkan berdasarkan: Pertandingan terbaik
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8,807 results
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1
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UPCODING MEDICARE: IS HEALTHCARE FRAUD AND ABUSE INCREASING?
1
Coustasse A, Layton W, Nelson L, Walker V.
Cite
Perspect Health Inf Manag. 2021 Oct 1;18(4):1f. eCollection 2021 Fall.
PMID: 34975355
Free PMC article.
Review.
Share
Medicare fraud has been the cause of up to $60 billion in overpaid claims in 2015 alone. ...It was found that upcoding has had an impact on Medicare payments and fraud. Medicare fraud has been reported to be the magnitude of upcoding inpatient and outp ...
Item in Clipboard
Fraud and Abuse in the Saudi Healthcare System: A Triangulation Analysis.
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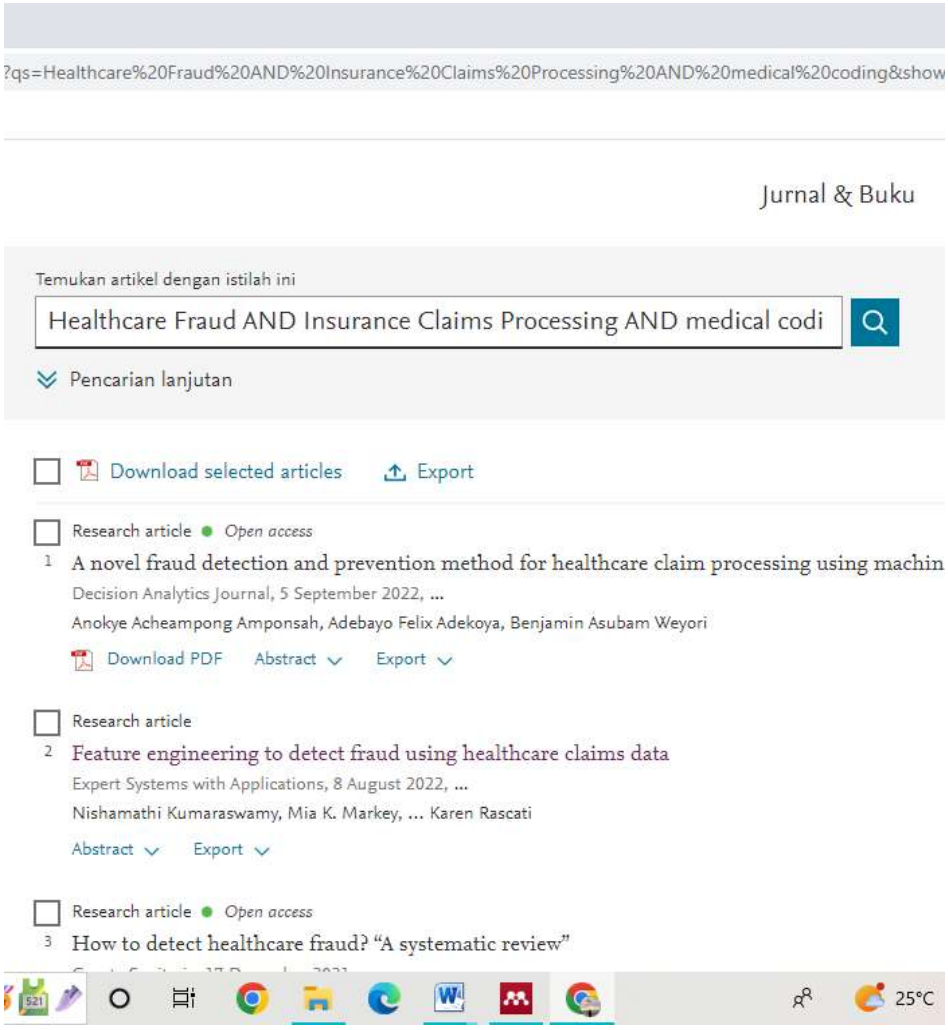
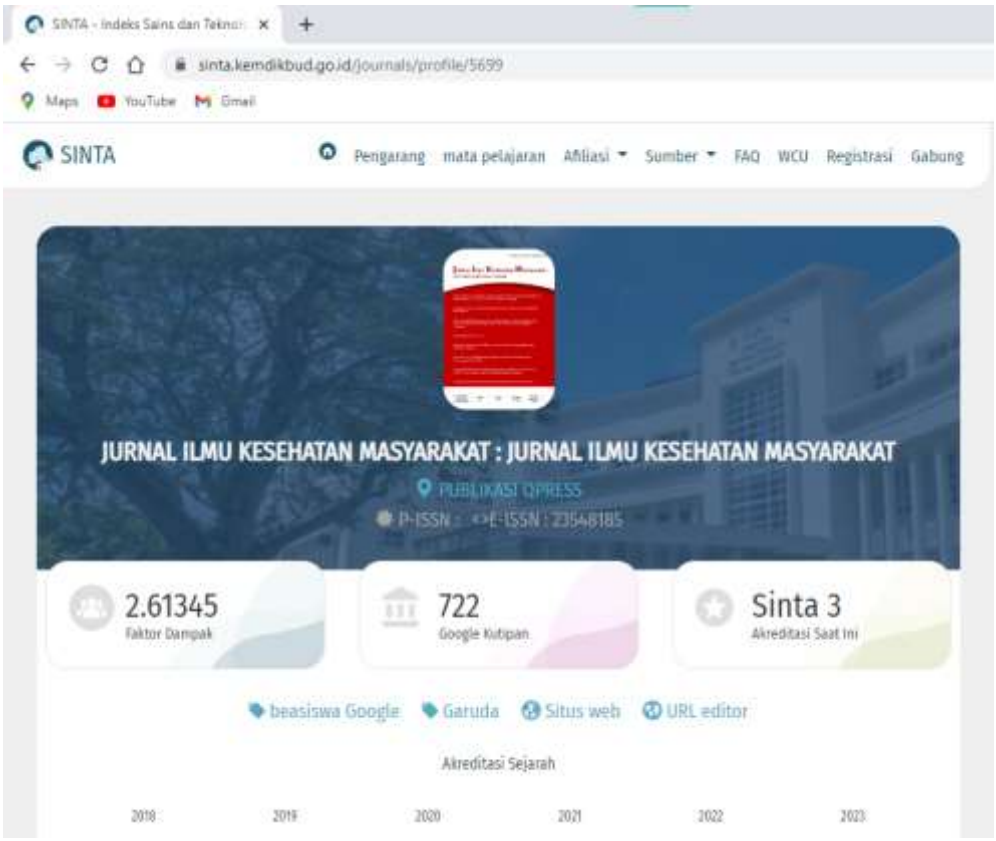
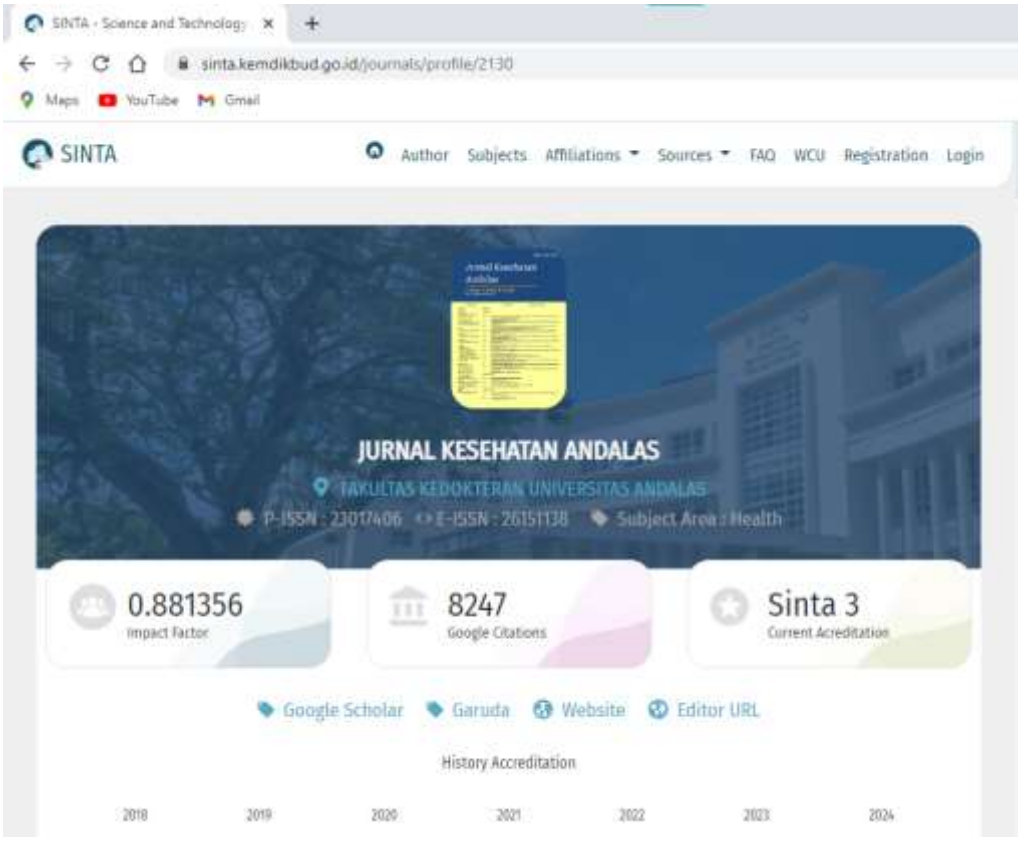


Lampiran 3 *Screenshoot* Akreditasi SINTA

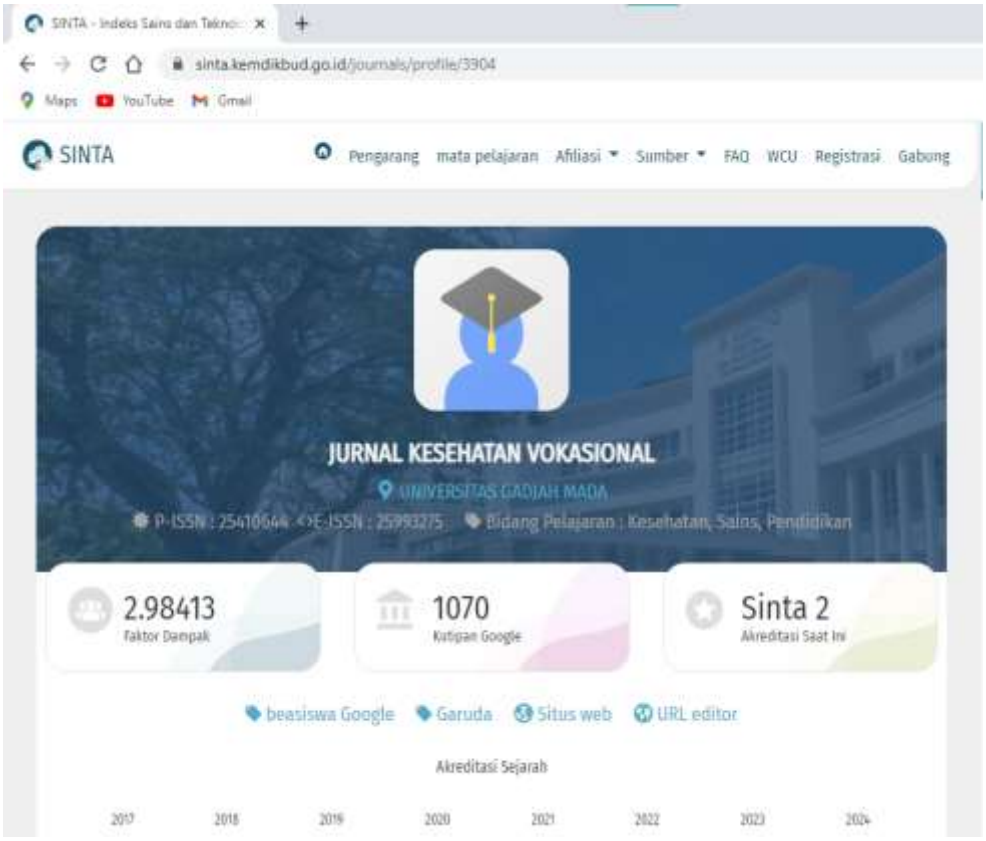
Analisis Kebijakan Operasional Tentang *Fraud Clinical Pathway* Pasien JKN Rawat Inap RSUD Buru Maluku



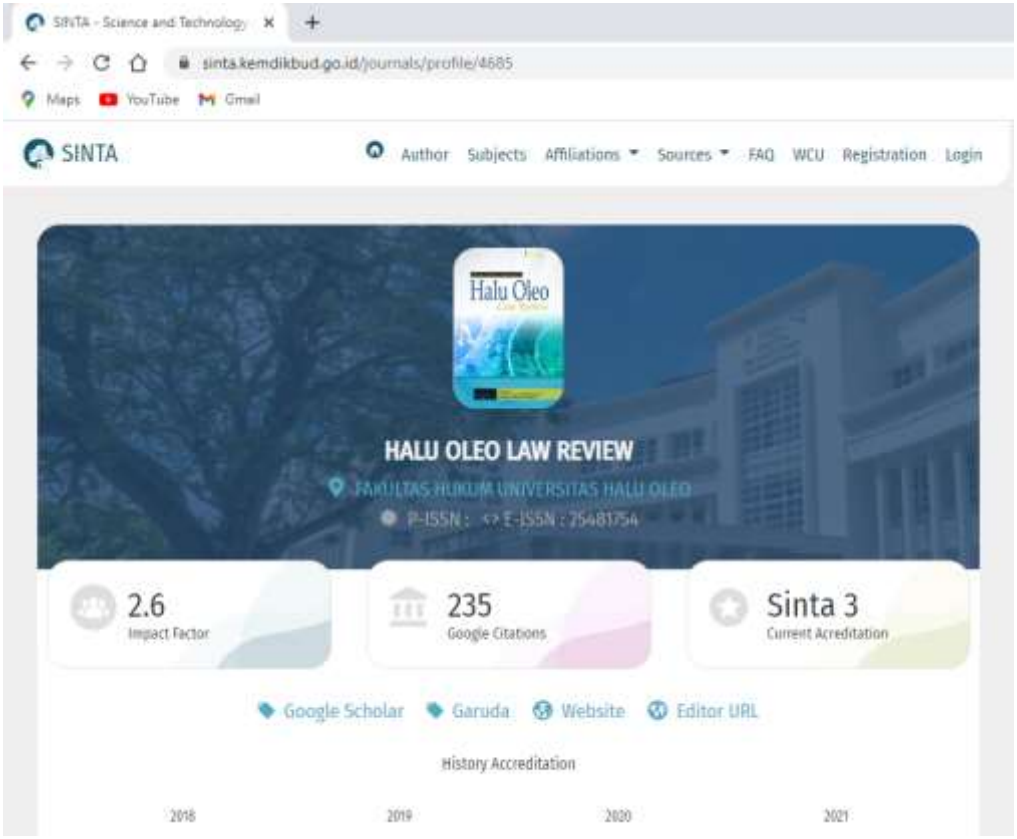
Analisis Pengendalian Potensi *Fraud* di Rumah Sakit Umum Daerah Achmad Moechtar Bukittinggi



Menelusuri Potensi *Fraud* dalam Jaminan Kesehatan Nasional melalui Rekam Medis di Rumah Sakit



Urgensi Pencegahan Tindak Pidana Curang *(Fraud)* Dalam Klaim Asuransi)



Lampiran 4 Jurnal 1. Analisis Kebijakan Operasional Tentang *Fraud Clinical Pathway* Pasien JKN Rawat Inap RSUD Buru Maluku

Jurnal Ilmu Kesehatan Masyarakat. 2022; 11 (1): 42-56

Jurnal Ilmu Kesehatan Masyarakat
(The Public Health Science Journal)

Journal Homepage: http://journals.stikim.ac.id/index.php/jikm

Analisis Kebijakan Operasional Tentang *Fraud Clinical Pathway* Pasien JKN Rawat Inap RSUD Buru Maluku

Chatmah Bin Thahir[1]*, Sobar Darmadja[2]
[1,2]Program Studi Magister Kesehatan Masyarakat
Sekolah Tinggi Ilmu Kesehatan Indonesia Maju (STIKIM)

Abstrak
RSUD Kabupaten Buru merupakan Fasilitas Kesehatan Rujukan Tingkat Lanjut (FKRTL) yang bekerjasama dengan BPJS Kesehatan. Dalam pelaksanaannya sering terjadi kendala dalam pelaksanaan program JKN tersebut. Penelitian ini bertujuan menganalisis kebijakan operasional tentang *fraud* pada *Clinical Pathway* pasien Jaminan Kesehatan Nasional. Penelitian ini merupakan penelitian kualitatif dengan pendekatan studi kasus. Teknik pengumpulan data dengan cara observasi, wawancara mendalam dan telaah dokumen. Pengambilan data dengan menggunakan teknik *Purposive Sampling*. Informan penelitian ini adalah Direktur RSUD, dokter, kepala ruang bedah, kepala tim BPJS RSUD, kepala instalasi farmasi, dan bendahara. Hasil yang diperoleh dalam penelitian ini adalah potensi *fraud* pada *clinical pathway* pasien JKN yang terjadi disebabkan belum optimalnya pelaksanaan sejumlah kegiatan yaitu; ketidakpatuhan tenaga kesehatan terhadap *clinical pathway* di Unit Pelayanan Rawat Inap,ketidakterbukaan mengenai hasil laporan klaim, keterbatasan SDM BPJS dalam memverifikasi selisih tarif, dan tidak adanya saling koordinasi antara tim BPJS dan dokter penulis resep. Alternatif yang sebaiknya digunakan adalah strategi membuat format *clinical pathway* sesuai pedoman penyusunan panduan praktik klinis dan *clinical pathway* dalam asuhan terintegrasi sesuai standar akreditasi rumah sakit.
Kata Kunci: Clinical Pathway, Fraud, JKN, BPJS, Rumah sakit.

Abstract
Buru District Hospital is an Advanced Referral Health Facility (FKRTL) in collaboration with BPJS Kesehatan. In the implementation there are often obstacle in the implementation of the JKN program. The purpose of this study was to analyze operational policies on fraud in clinical pathways of National Health Insurance patients. This research was qualitative research with a case study approach. Data collection techniques using observation methods, in-depth interviews,document studies. Sampling using Purposive Sampling technique. Informant this research is director of rsud, doctor, head of surgery room, head of BPJS RSUD team, head of pharmaceutical installation, and treasurer. The results obtained in this study were potency fraud in JKN patient clinical pathway that have occurred due to several activities whose implementation has not been ioptimal,namely ; non compliance of health workers with clinical pathways in inpatient service units; openness regarding the results of the claim report; BPJS HR limitations in verifying tariff differences; and the lack of mutual coordination between the BPJS team and the prescribing doctor. An alternative that should be used is the strategy to create a clinical pathway format in accordance with guidelines for developing clinical practice guidelines and clinical pathways in integrated care according to hospital accreditation standards.
Keywords *: Clinical Pathway, Fraud, JKN, BPJS, Hospital.*

Korespondensi*: Chatmah Bin Thahir, Program Studi Magister Kesehatan Masyarakat, Sekolah Tinggi Ilmu Kesehatan Indonesia Maju, Gedung HZ Jl. Harapan No. 50, Lenteng Agung – Jakarta Selatan 12610, E-mail: chatmah1979@gmail.com, No.Telp: +6285231221235*

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Lampiran 5 Jurnal 2. Analisis Pengendalian Potensi *Fraud* di Rumah Sakit Umum Daerah Achmad Moechtar Bukittinggi

Artikel Penelitian

Analisis Pengendalian Potensi *Fraud* di Rumah Sakit Umum Daerah Achmad Moechtar Bukittinggi

Ayu Mitriza[1], Ali Akbar[2]

Abstrak

Sejak berlakunya Jaminan Kesehatan Nasional (JKN) di Indonesia, potensi *fraud* dalam pelayanan kesehatan semakin meningkat karena adanya tekanan dari sistem pembiayaan yang baru berlaku, adanya kesempatan karena minim pengawasan, serta ada pembenaran saat melakukan tindakan *fraud*. **Tujuan:** Mengeksplorasi upaya pengendalian potensi *fraud* d Rumah Sakit Dr. Achmad Moechtar Bukittinggi. **Metode:** Penelitian ini menggunakan desain metode kualitatif. Penelitian ini dilihat dari komponen input dan komponen proses. **Hasil:** Komponen input mencakup kebijakan, tenaga dan sarana. Komponen proses mencakup faktor pendorong dan faktor penghambat potensi *fraud*. Faktor pendorong potensi *fraud* yaitu perbedaan pemahaman antara verifikator dan dokter penanggung jawab pasien tentang diagnosis. Kesenjangan tarif riil rumah sakit dengan tarif INA CBGs. Faktor penghambat potensi *fraud* yaitu Penerapan Standar Operasional dan *Clinical Pathway*. **Simpulan:** Upaya dari Rumah Sakit Dr. Achmad Moechtar dalam pencegahan potensi *fraud* dengan melakukan tindakan sesuai Standar Prosedur Operasional. BPJS Kesehatan dalam pencegahan potensi *fraud* dengan meningkatkan aplikasi penyaringan potensi *fraud*.

Kata kunci: JKN, sistem pembiayaan, pencegahan potensi *fraud*

Abstract

Since the enactment of the National Health Insurance (JKN) in Indonesia, the potential for fraud in health services has increased due to pressure from the new system of financing, the opportunity due to minimal supervision and there is justification when doing fraud. ***Objectives:*** *To explored efforts to control the potential of fraud at Achmad Moechtar Hospital Bukittinggi.* ***Methods:*** *This research used qualitative method design. This research was seen from input components and process components. Input components were included policies, personnel and facilities.* ***Results:*** *The process components were included the driving factors and potential inhibiting factors of fraud, the efforts of Achmad Moechtar Hospital and Social Health Insurance Provider (BPJS Kesehatan) in the prevention of potential fraud. The potential driving force of fraud was difference in understanding between the verifier and the physician in charge of the patient regarding the diagnosis, the real hospital tariff gap with the tariff of INA CBGs. Fraud potential inhibiting factors were the Application of Operational Standard and Clinical Pathway.* ***Conclusions:*** *Efforts from Achmad Moechtar Hospital in preventing potential fraud by taking action in accordance with Standard Operating Procedures. Social Health Insurance Provider (BPJS Kesehatan) in the prevention of fraud potential by increasing fraud potential filtration applications.*

Keywords: *JKN, financing system, prevention of fraud potential*

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PENDAHULUAN

Undang-Undang Nomor 36 Tahun 2009 tentang kesehatan, di tegaskan bahwa setiap warga Negara memiliki hak yang sama untuk mendapatkan pelayanan kesehatan.[1] Kesadaran

Lampiran 6 Jurnal 3. *Detection of Healthcare Fraud in The National Health Insurance Program Based on Cost Control*

ATLANTIS PRESS
Advances in Economics, Business and Management Research, volume 103
International Conference on Tourism, Economics, Accounting, Management, and Social Science (TEAMS 19)

Detection of Healthcare Fraud in The National Health Insurance Program Based on Cost Control

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***Abstract*— Fraud in healthcare services has the potential to reduce the quality of health services, harming patients, and state finances. However, the implementation of fraud prevention in healthcare services has not been fully carried out. The purpose of this study is to determine the cost control-based fraud detection algorithm and detect potential healthcare services fraud in hospitals. The study was conducted at 4 hospitals in East Java - Indonesia. Data retrieval is done by the method of documentation and interviews. With interactive analysis generated, 10 cost control-based algorithms that can be used to detect fraud potential in the hospitals. Based on the time series linear regression analysis, the results show that the data groups that can show the fraud potential in the sample hospitals are (i) outpatient cases with special procedures; (ii) inpatient cases with special drugs; (iii) outpatient cases with special drugs; and (iv) inpatient cases with special prosthesis. Data groups that have not been proven to have the fraud potential are (i) a comparison of the number of JKN inpatients with the number of bills of INA-CBGs inpatients; (ii) comparison of the number of JKN outpatients with the number of bills of outpatient INA-CBGs; (iii) disease severity level; (iv) Inpatient cases bills to BPJS Health; (v) Outpatient case bills to BPJS Health; and (vi) inpatient cases with special procedures.**

Keywords*— *Fraud; Healthcare; Hospital, Cost Control

I. INTRODUCTION

With the increase in the number of participants enrolled in the health insurance program, it will have an impact on increasing the volume of money that is very large in the healthcare industry and will lead to an increased risk of fraud activities [1]. In the United States, the Federal Bureau of Investigation (FBI) estimates that fraud in healthcare services reaches 3–10% of all bills [2]. In Indonesia, The Corruption Eradication Commission (KPK) notes that based on the BPJS Health report, up to June 2015, with only minimal supervision, 175,774 Advanced Referral Health Facility (FKRTL) have been detected with a value of Rp. 440 billion suspected fraud [3].

Fraud in healthcare services aims to obtain unauthorized benefits from deliberate fraud. Unlike mistakes and harassment, fraudulent behavior is usually defined as a crime in law. However, there is no global consensus on the definition of fraud and abuse in healthcare services or health insurance arrangements [4].

Fraud in healthcare services can be grouped into 3 (three), namely fraud by healthcare service providers (provider fraud), patients (consumer fraud) and insurance (insurer fraud). While the party that most commits fraud is the health service provider. Based on a literature study on fraud-themed papers in healthcare, it was found that there were 69% of papers that concluded that the healthcare service provider was the party that did a lot of fraud, while 31% of the paper stated that insurance customers committed fraud [5].

To anticipate the spread of fraud in the health sector, the Government of Indonesia through the Ministry of Health issued Minister of Health Regulation No. 36 of 2015 concerning Prevention of Fraud in the Implementation of the Health Insurance Program in the National Social Security System. The development of service-oriented quality control and cost control is done through the use of evidence-based information technology and the establishment of a fraud prevention team of National Health Insurance (JKN) at the Advanced Referral Health Facility (FKRTL). The Fraud Prevention Team is tasked with detecting potential fraud through analysis of claim data. However, according to research [6] currently, the detection of potential fraud is done manually by comparing a suspected fraud with the regulations of the Ministry of Health and the Head of Health BPJS.

Payment for health services in Indonesia in the JKN program uses the INA-CBGs (Indonesia Case Base Groups) system, which is the average cost spent by a diagnosis group.

Lampiran 7 Jurnal 4. *Fourteen years of manifestations and factors of health insurance fraud, 2006-2020: a scoping review.*

Villegas-Ortega et al. Health and Justice (2021) 9:26
https://doi.org/10.1186/s40352-021-00149-3

Health and Justice

RESEARCH ARTICLE Open Access

Fourteen years of manifestations and factors of health insurance fraud, 2006–2020: a scoping review

José Villegas-Ortega[1,2*], Luciana Bellido-Boza[3] and David Mauricio[1*]

Abstract

Background: Healthcare fraud entails great financial and human losses; however, there is no consensus regarding its definition, nor is there an inventory of its manifestations and factors. The objective is to identify the definition, manifestations and factors that influence health insurance fraud (HIF).

Methods: A scoping review on health insurance fraud published between 2006 and 2020 was conducted in ACM, EconPapers, PubMed, ScienceDirect, Scopus, Springer and WoS.

Results: Sixty-seven studies were included, from which we identified 6 definitions, 22 manifestations (13 by the medical provider, 7 by the beneficiary and, 2 by the insurance company) and 47 factors (6 macroenvironmental, 15 mesoenvironmental, 20 microenvironmental, and 6 combined) associated with health insurance fraud. We recognized the elements of fraud and its dependence on the legal framework and health coverage. From this analysis, we propose the following definition: "Health insurance fraud is an act of deception or intentional misrepresentation to obtain illegal benefits concerning the coverage provided by a health insurance company". Among the most relevant manifestations perpetuated by the provider are phantom billing, falsification of documents, and overutilization of services; the subscribers are identity fraud, misrepresentation of coverage and alteration of documents; and those perpetrated by the insurance company are false declarations of benefits and falsification of reimbursements. Of the 47 factors, 25 showed an experimental influence, including three in the macroenvironment: culture, regulations, and geography; five in the mesoenvironment: characteristics of provider, management policy, reputation, professional role and auditing; 12 in the microenvironment: sex, race, condition of insurance, language, treatments, chronic disease, future risk of disease, medications, morale, inequity, coinsurance, and the decisions of the claims-adjusters; and five combined factors: the relationships between beneficiary-provider, provider-insurance company, beneficiary-insurance company, managers and guilnil.

Conclusions: The multifactorial nature of HIF and the characteristics of its manifestations depend on its definition. Identifying the influence of the factors will support subsequent attempts to combat HIF.

Keywords: Healthcare, Fraud, Insurance, Behaviour, Factor, Manifestation

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Lampiran 8 Jurnal 5. *Fraud and Abuse in the Saudi Healthcare System: A Triangulation Analysis.*

Original Research

Fraud and Abuse in the Saudi Healthcare System: A Triangulation Analysis

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Abstract

In the insurance industry, the majority of fraud and abuse cases fall into a limited number of patterns, yet false claims normally lead to negative national, local, and organizational effects. Through monitoring the exploitative and abusive behavior commonly found in healthcare services, this paper aims to analyze initiatives implemented by governmental and related healthcare insurance agencies in Saudi Arabia to reduce moral offenses. To accomplish this objective, major governmental health insurance policy documents were analyzed at the macro-level. At the meso-level, semi-structured interviews were conducted with five health insurance professionals on measures undertaken to prevent such incidents. At the micro-level, the critical factors of fraudulent behaviors were analyzed using a retrospective analysis. Data were retrieved from anti-fraud records of ten leading health insurance companies and the focus was mainly on individuals involved in unethical practices between 2014 and 2019. After a full audit was completed, the results concluded that the Saudi healthcare system is composed of twenty-six cooperative health insurance agencies and over 5,202 health services providers. The official documents contain the details of various moral hazard measures. On annual average, more than 196 fraudulent cases were reported with a claim rejection rate of approximately 15%. The majority of fraud cases were reported in dental services with invalid card usage, followed by obstetrics-gynecology services (47 and 113 cases, respectively). Females tended to make up most deceit cases in obstetrics-gynecology with a high level of abuse (95% confidence interval: −83.398 to −24.202; $P < .003$ and −28 > 638 to −7.362; $P < .005$, respectively). This study ultimately identifies basic measures employed at the macro-level to reduce moral hazards. However, such measures are not intended to be coherently implemented at the micro-level, especially by health insurance companies and healthcare providers.

Keywords

Measures, health insurance, fraud, abuse, Saudi Arabia

What do we already know about this topic?
Fraud and abuse are secretly practiced within the health insurance industry. Governments and other agencies are collaborating to reduce such risks.

How does your research contribute to the field?
Based on existing practices and data analyses on fraud and abuse, this study proposes a triangulation technique to enhance scrutiny and increase the effectiveness of the healthcare system.

What are your research's implications toward theory, practice, or policy?
Various approaches have concluded to date that public agencies, private insurance companies as well as major health providers are exercising their respective general guidelines to prevent fraud and abuse within the Saudi healthcare context. Applying a more integrated approach on diverse levels should ensure more effective policy in fighting falsifications.

Introduction

In healthcare management, health status is typically measured by some basic health indicators related mainly to healthcare access, effective of treatment, and quality of life.[1] Health insurance is a worldwide resource for financing healthcare systems, and any violations or misinterpretations of the processes may induce defragmentation in the population's health.[2,3] While health policies intend to increase overall health and well-being, moral hazards (such as certain

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Lampiran 9 Jurnal 6. *Healthcare Fraud Data Mining Methods: A Look Back and Look Ahead.*

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Healthcare Fraud Data Mining Methods: A Look Back and Look Ahead

By Nishamathi Kumaraswamy, MS; Mia K. Markey, PhD; Tahir Ekin, PhD; Jamie C. Barner, PhD, FAACP, FAPhA; and Karen Rascati, PhD

Abstract

Healthcare fraud is an expensive, white-collar crime in the United States, and it is not a victimless crime. Costs associated with fraud are passed on to the population in the form of increased premiums or serious harm to beneficiaries. There is an intense need for digital healthcare fraud detection systems to evolve in combating this societal threat. Due to the complex, heterogenic data systems and varied health models across the US, implementing digital advancements in healthcare is difficult. The end goal of healthcare fraud detection is to provide leads to the investigators that can then be inspected more closely with the possibility of recoupments, recoveries, or referrals to the appropriate authorities or agencies. In this article, healthcare fraud detection systems and methods found in the literature are described and summarized. A tabulated list of peer-reviewed articles in this research domain listing the main objectives, conclusions, and data characteristics is provided. The potential gaps identified in the implementation of such systems to real-world healthcare data will be discussed. The authors propose several research topics to fill these gaps for future researchers in this domain.

Keywords: Medicaid, fraud detection, class imbalance, machine learning, health insurance claims

Healthcare Fraud Introduction

Background and Significance

Caring for health has become more expensive, making both private and public administrators more cost conscious in recent years. Therefore, health decision-makers are actively looking for ways to reduce costs. One such avenue of saving potentially billions of dollars is to avoid and detect healthcare fraud. The National Health Care Anti-Fraud Association' conservatively estimates that about 3 percent of our healthcare spending is lost to fraud ($300 billion approximately) yearly. Fraud is a complex and difficult problem. It is important to acknowledge that fraud schemes constantly evolve, and fraudsters adapt their methods accordingly. The earliest account' of "fraud" in the healthcare literature is from the 1860s when railway collisions were a frequent occurrence, leading to a controversial condition called "railway spine," which later became a leading cause of personal injury compensation in rail accidents. These accidental events were made profitable by means of insurance settlements in-court or out-of-court by opportunistic claimants, and these events laid the groundwork for fraud definitions and fraud management in the insurance industry.

Healthcare fraud has evolved in the 21st century and has a varied set of profiles ranging from simple fraud schemes to complex networks. The twin objectives of fraud management have always been

Lampiran 10 Jurnal 7. *How to detect healthcare fraud? "A systematic review"*

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How to detect healthcare fraud? "A systematic review"

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ABSTRACT

Objective: To identify the method used in detecting fraud cases.
Methods: Articles searching by using topic-appropriate keywords and incorporated into search engines (data-based) journals Pubmed/Medline, Cochrane, Wiley, ScienceDirect, and secondary data-based Google scholar. Then data extraction is done based on inclusion criteria. The selected articles have the aim of investigating/detecting cases of fraud that have occurred in the health sector or other related sectors that support the study.
Results: The findings of the nine reviewed articles have suggested that most of the fraud perpetrators are performed by medical personnel (doctors) and providers. Many types of fraud occur such as insurance claims or medical actions that are completely unadministered nor following the procedure and duplicating claims. The methods that appropriate to be used in detecting fraud are secondary data tracking, information, and technology specialist provision.
Conclusion: Secondary data tracking is the most widely used method in fraud detection. Fraud perpetrators are ones who dominated by medical circles with fictitious claim cases. Perpetrators tend not to act themselves but in organizations with network.

Introduction

Fraud on health care has been classified as an international challenge as well as illegal actions, where perpetrators create a zero-sum game for maintenance costs that contribute to the cumulative effect on the quality of service.[1,2] Estimated Fraud costs up to 10% of total health care expenditure worldwide.[3] In the United States from 3.6 trillion dollars incurred for health care costs, billions of dollars are claims for fraud.[4] Viewing RGA data (2017) the state of Asia Pacific that responds to fraud event data including Australia, Singapore, Malaysia, Thailand, the Philippines, Vietnam, Japan, Hong Kong, Korea, Taiwan, and Indonesia.[5] The Data indicates there are opportunities of various stakeholders in the act of fraud, not limited to state conditions both developed and developed.

Fraud is building a serious threat that disrupts the global economy with the extravagance of unnecessary or counterfeit maintenance costs and adverse health consequences, as it takes solving appropriate problems in their finishing.[6,7] Fraud in the field of health occurs and continues to increase in South Africa.[8] The European continent has at least €56 billion losses annually over fraud practices. However, the data is only reported from some countries in Europe, some of which deny the problems related to fraud with privacy assumptions.[9] Fraud issues also occur in Korea and continue to increase, reportedly at least 798.2 billion won claimed in 2018 or up 9.3% from the previous year.[10]

These conditions and situations have an impact on policymakers, anti-fraud, and practitioner difficulties to find reliable evidence and keep abreast of the literature review that has been published in a variety of different formats and references. Therefore, comprehensive synthesis and evaluation are critical to providing useful information and reliable evidence to decision-makers who can be gained through systematic review reviews as an efficient solution to address these issues.

Literature review

The fraud case impacts the increase in its main cost to everyone involved in the healthcare system and damages the long-term solvency of programs such as insurance services/health care plans in the underprivileged community (Medicare/Medicaid) on millions of people in the American (Baranek, Action, & Services, 2018).[11] Anti-fraud agencies have tried to detect those frauds and it is strongly suspected that they do not act on their own but have a network like an organization.[1,2,12]

The review of the literature aims to review the results of published studies/reviews and gather the best evidence, then summarizes the evidence and current knowledge regarding the effects of intervention or policy from various sources.[13] Our review aims to collect, evaluate, and synthesize evidence from a variety of published literature reviews on fraud detection that occur in the areas of service and health insurance, to provide reliable evidence and enable researchers, policymakers, and practitioners to make

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Lampiran 11 Jurnal 8. Menelusuri Potensi *Fraud* dalam Jaminan Kesehatan Nasional melalui Rekam Medis di Rumah Sakit

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Menelusuri Potensi *Fraud* dalam Jaminan Kesehatan Nasional melalui Rekam Medis di Rumah Sakit

Tracing Potential Fraud in National Health Insurance Through Medical Records in Hospitals

Ida Sugiarti[1][2], Imas Masturoh[2], Fery Fadly[3]

[1,2,3]Prodi D3 RMIK Poltekkes Kemenkes Tasikmalaya

ABSTRAK

Latar Belakang: Akibat *fraud*, BPJS (Badan Penyelenggara Jaminan Sosial Kesehatan) harus membayar klaim lebih besar, sehingga terjadi kerugian negara. Salah satu bentuk *fraud* yang ditemukan di kelompok *provider* adalah *upcoding*. Data koding dan rekaman pelayanan kesehatan dalam rekam medis dapat digunakan sebagai deteksi *fraud*.
Tujuan: Menelusuri potensi *fraud* dalam rekam medis melalui telusur keakuratan kode diagnosis dan *clinical pathway*.
Metode: Pendekatan kuantitatif kualitatif. Jenis penelitian *case study*, kasus thypoid. Subjek penelitian ditentukan dengan *purposive sampling*. Sampel penelitian kuantitatif menggunakan berkas rekam medis. Metode pengumpulan data menggunakan lembar observasi dan *indept interview*. Analisis data kuantitatif dengan analisis deskriptif dan Analisa data kualitatif dengan analisis konten.
Hasil: Dari 87 dokumen, ketidaktepatan kode diagnosis 31,03%, dengan presentase ketidaksesuaian tarif klaim 26,44%. Terdapat berbagai penyebab *upcoding* diantaranya karena aturan pengkodean yang berbeda antara kode diagnosis berdasarkan ICD 10 dan kode untuk kepentingan klaim yang mengacu pada peraturan dari BPJS yang dituangkan dalam Berita Acara. 91,30% ketidaksesuaian merupakan tarif klaim naik. Ketidaksesuaian *clinical pathway* paling banyak pada item tes widal dengan presentase 21,84%.
Kesimpulan: *Upcoding* tidak selalu disebut *fraud*, harus ada unsur kesengajaan untuk mendatangkan keuntungan finansial. *Upcoding* dapat merubah klaim menjadi lebih tinggi. Keberadaan *clinical pathway* penting sebagai acuan tindakan pelayanan kesehatan.

Kata Kunci: *upcoding; clinical pathway; fraud*; BPJS; ICD

ABSTRACT

Background: *The Health Social Security Administering Body has to pay more extensive claims due to fraud, resulting in state losses.One form of fraud found in the provider group is upcoding. Coding data and health records in medical records can be used as fraud detection.*
Objective: *Tracing potential fraud by tracing the accuracy of diagnostic codes and clinical paths in medical records.*
Methods: *A qualitative-quantitative approach with a case study, a typhoid case. The research subjects were selected by purposive sampling. Quantitative research samples are medical records. The instrument used an observation sheet and interview guidelines. Data collection with; observation and in-depth interviews. Quantitative data analysis is descriptive analysis and qualitative data is content analysis.*
Results: *From 87 documents, the diagnosis code was 31.03% inaccurate, with a claim rate mismatch percentage of 26.44%. There are various causes of upcoding including the different coding rules between the diagnosis code based on ICD 10 and the code for claims purposes that refer to the regulations of the BPJS as outlined in the Minutes. 91.30% non-conformity represents an increased claim rate. The most clinical pathway discrepancies were in the widal test items with a percentage of 21.84%.*
Conclusion: *Upcoding is not always called fraud, there must be an element of intent to bring financial gain. Upcoding can change the claim to be higher. Clinical pathways are essential as a reference for health service actions.*

Keywords: *upcoding; clinical pathway; fraud; BPJS; ICD*

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Lampiran 12 Jurnal 9. *Potential for fraud of health service claims to BPJS Health at Tenriawaru Public Hospital, Bone Regency, Indonesia*

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Potential for Fraud of Health Service Claims to BPJS Health at Tenriawaru Public Hospital, Bone Regency, Indonesia

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Background: National Health Insurance (NHI) to meet the demand for Universal Health Coverage in Indonesia is still relatively new. The potential for fraud that can harm patients and others is possible.
Objective: The aim of this study was to obtain in-depth information about the potential fraud of health care claims to the Social Security Agency of Health (BPJS) in Tenriawaru Public Hospital of Bone regency, Indonesia.
Methods: This type of research is qualitative with descriptive analysis. The technique for informant choice was purposive sampling. Data collection techniques included an interview, observation, and documentation. Data analysis was descriptive and validity of data used was achieved through a triangulation of data source.
Results: The results showed that there is a potential fraud that occurs at Tenriawaru Regional General Hospital. The fraud is caused by health care providers such as health workers and coders. There is potential fraud of 8 types: up-coding, readmissions, type of room charge, unnecessary treatment, phantom billing, keystroke mistake, service unbundling of fragmentation and cancelled service. This regulation has included elements of fraud and the types of potential fraud that occurs in primary health care and referral health.
Recommendation: The findings of this research recommend rule development to deter potential fraud perpetrators.

Key words: *Fraud, Health Service Claim, BPJS Health, Bone, Indonesia.*

Lampiran 13 Jurnal 10. *Potential Fraud in The Primary Healthcare*

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Potential Fraud in The Primary Healthcare

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INDEXING

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Kata kunci:
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Sumber Daya Manusia;
Kapitasi;

ABSTRACT

This study discusses of potential fraud at the primary healthcare. Fraud is more often associated with secondary healthcare, namely hospitals, so that fraud in primary healthcare rarely supervises. Payers of JKN around 38.5 trillion and estimating the potential fraud of around 5% will disappear 1.8 trillion per year. This research used qualitative methods with phenomenological design, so the data are collected using in-depth interview and observation techniques. The number of respondents in this research were 3 public healthcare and 2 private healthcare in X regency. The results showed potential fraud in primary healthcare related to human resources (HR), management of health service, leadership policies, management of capitation funds and operational audits.

Penelitian ini membahas potensi fraud pada fasilitas kesehatan tingkat pertama (FKTP). Fraud lebih sering di kaitkan dengan fasilitas kesehatan tingkat lanjut (FKTL) yaitu rumah sakit, sehingga fraud di FKTP jarang ada yang mengawasi. Premi BPJS kesehatan sekitar 38,5 triliun dan diperkirakan potensi terjadinya fraud sekitar 5% maka akan hilang sebesar 1,8 triliun per tahun. Penelitian ini menggunakan metode kualitatif dengan desain fenomenologi, pengumpulan data menggunakan wawancara mendalam. Responden penelitian adalah 3 kepala puskesmas dan 2 kepala klinik swasta di kabupaten X. Hasil penelitian menunjukan potensi fraud pada FKTP berkaitan dengan sumber daya manusia (SDM), manajemen pelayanan kesehatan, kebijakan kepemimpinan, pengelolaan dana kapitasi dan audit operasional.

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INTRODUCTION

The implementation of national health insurance in Indonesia began on January 1, 2014. National health insurance was organized by Badan Penyelenggara Jaminan Sosial (BPJS). This health insurance aims to facilitate access to health services needed and the ease of access is also supported by the quality and quality of good service. Gradually until 2019 the entire community will be covered by a Universal Health Coverage.[1]

Universal Health Coverage (UHC) is a concept dealing with health service reform covering all communities in terms of accessibility and equity of health services, quality and comprehensive health services that cover preventive, promotive, curative to rehabilitative services and reduce financial limitations to obtain health services for every resident.[1]

One strategy for achieving UHC is by the existence of the National Social Security System (SJSN), in which there is a National Health Insurance (JKN) held using a mandatory social health insurance mechanism. National Health Insurance (JKN) is a guarantee that is used to ensure participants get the benefits of health care and protection for the fulfillment of basic health needs, which are given to everyone who has paid contributions or fees paid by the Government. In an effort to realize the UHC organized by the BPJS, there must be a number of problems, including advocacy and JKN socialization, institutional policies, program transformation, participation, referral systems, health facility infrastructure, HR, capacity building, financing, the risk of JKN Fraud, the impact of JKN on utilization, provider satisfaction and participants.[2]

Health care is an important factor in improving the health and well-being of every person in the world. Everyone has the right to obtain health services and the government is responsible for the availability of all forms of quality, safe, efficient and affordable health efforts by all levels of society.[3]

One such effort is to increase the availability and equity of basic health care facilities such as health centers in each region increasing public awareness of health, will lead to demands for improved health services. One effort to anticipate this situation is to maintain the quality of service, so that continuous efforts need to be made to find out the weaknesses and shortcomings of health services. The increasing demand of the community for the quality of health services, the function of health services needs to be improved to provide patient satisfaction. Quality of service

Lampiran 14 Jurnal 11. Urgensi Pencegahan Tindak Pidana Curang *(Fraud)* Dalam Klaim Asuransi

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Urgensi Pencegahan Tindak Pidana Curang (*Fraud*) Dalam Klaim Asuransi

Urgency of Fraud Prevention in Insurance Claims

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ABSTRACT

Insurance is a special agreement and can not be separated from the legal field, because in an insurance claim submission by the insured can lead to an insurance, namely fraud (fraud), in the insurance arena known as Insurance Fraud. This article discusses matters relating to the pattern or modus operandi of fraud in insurance claims and formulates a fraud strategy policy on insurance claims. This research uses doctrinal law research. Legal information sources use primary legal materials (relevant regulations and documents) for subsequent qualitative licensing analysis. The recommendations used are institutional, conceptual analysis and participation in helping to solve the problem formulation. Fraud consideration policy in insurance claims needed for a conducive work environment. The parties, both the guarantor and the insured person must have the same commitment and good faith so that the insurance claim process can be carried out properly. Basically, the commitment and good faith are insurance company policies which are the main key in the coverage related to insurance fraud. Fraudulent practices in insurance claims can be found because there is malicious intent or mens rea to obtain material benefits in a way against the law, whether done by individuals or together. This act can only be done by people who really understand the operational procedures of insurance both data and information, namely from the beginning of the guarantee process to the completion of the policy and the form of the agreed and unapproved policy (wide guarantee).

INFO ARTIKEL

Kata kunci:
Pencegahan;
Curang;
Klaim Asuransi

ABSTRAK

Asuransi merupakan suatu perjanjian khusus dan tidak terlepas dari aspek hukum, karena dalam suatu pengajuan klaim asuransi oleh tertanggung bisa menimbulkan terjadinya suatu tindak pidana yaitu kecurangan (Fraud), dalam bentuk asuransi dikenal dengan istilah Insurance Fraud. Artikel ini bertujuan untuk menggali hal-hal yang berkaitan dengan pola atau modus operandi fraud pada klaim asuransidan merumuskan kebijakan strategi pencegahan fraud pada klaim asuransi. Penelitian ini menggunakan penelitian hukum doktrinal. Sumber informasi hukum menggunakan bahan hukum primer (peraturan dan dokumen relevan) untuk selanjutnya