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Analysis of Fraud Prevention Efforts in JKN Claims Against Potential Unsuitable Claims at Al Ihsan Regional General Hospital

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Abstract: Ineligible claims in the National Health Insurance (JKN) system are a problem and challenge for the sustainability of health financing, especially if they contain elements of fraud that can reduce state finances and the reputation of service providers. This study aims to prevent fraud related to potential invalid claims at Al Ihsan General Hospital by focusing on preventive, detective, and corrective actions. The methods applied include reviewing claim documents, interviewing verification staff, and analyzing the hospital's internal policies. The findings indicate that implementing a multi-tiered verification system before claim submission, using data analytics-based claim review technology, conducting regular training for healthcare and administrative staff, and strengthening internal audits are important strategies to reduce ineligible claims. Additionally, implementing a whistleblowing system and providing training for service providers play a crucial role in reducing fraud risks. These findings emphasize that invalid claims are not always caused by fraudulent intent but can constitute fraud if there is evidence of intentional misconduct. Therefore, a combination of stringent policies, technological support, and a culture of integrity within hospitals is a critical factor in maintaining the accuracy of JKN claims while safeguarding the integrity of the national health financing system.

Keyword: JKN, Ineligible claims, Health claim fraud, Fraud prevention

INTRODUCTION

Hospitals are one of the institutions that provide comprehensive health services and play a strategic role in maintaining and improving the health of the community. According to Law Number 44 of 2009 of the Republic of Indonesia on hospitals, hospitals or Advanced Referral Health Facilities (FKTRL) provide comprehensive individual healthcare services, including inpatient care, outpatient care, and emergency services. Hospitals also have interconnected service aspects, namely promotive services focused on improving health, preventive services aimed at disease prevention, curative services for healing, and

rehabilitative services for recovery. These four elements form the pillars of healthcare service delivery.

In the provision of health services, medical records play an important role as official documents that contain information about patient identity, examination results, treatment, medical procedures, and other services received by patients. With the advancement of digital technology, medical records have transformed into electronic form, making Electronic Medical Records (EMR) the digital format of medical records created through a specialized digital system designed for the implementation of integrated digital medical record management, as regulated by the Ministry of Health of the Republic of Indonesia Regulation No. 24 of 2022. The implementation of EMR is carried out from the patient's arrival at the hospital until the patient is discharged, whether discharged in good health or deceased, with digital recording and management of data. This system is expected to improve efficiency, accuracy, and integration of information, ultimately supporting the quality of hospital services.

Health insurance is an important component of the national health system. BPJS Health Regulation No. 6 of 2020 explains health insurance as a form of protection in the health sector, ensuring that participants receive healthcare benefits and protection in meeting their health needs, which are provided for all individuals. The establishment of the Social Security Agency (BPJS) and Presidential Regulation No. 12 of 2013 on National Health Insurance, which came into effect on January 1, 2014, represent the Indonesian government's efforts to provide equitable and quality access to healthcare services for all Indonesian citizens.

However, there are various obstacles in the process that threaten the continuity of this program, one of which is fraud in health services, which can harm the state and reduce the quality of health services themselves. Fraud in the context of National Health Insurance (JKN) is an act committed intentionally to obtain financial gain through fraudulent actions that violate applicable laws. Fraud related to JKN occurs in the form of false claims, data manipulation, altering the primary diagnosis or adding additional diagnoses to obtain higher rates, and various other forms of misconduct by healthcare providers and participants. These actions not only harm the economy but also reduce the quality of services.

The potential for healthcare fraud increases significantly when there are weaknesses in oversight, pressure from newly implemented financing systems, and perpetrators feel justified in their actions (Mariska, 2020). Hospitals, as FKTRL, have an important role in the JKN claim submission process. Therefore, it is crucial to ensure that every claim submitted undergoes proper, transparent verification and validation in accordance with existing procedures. The possibility of invalid claims may also arise, either due to administrative negligence or intentional misconduct.

Al Ihsan Regional General Hospital, as a health facility owned by the West Java regional government, is committed to supporting the implementation of the JKN program. However, similar to other hospitals, there is a possibility of invalid claims. Therefore, an in-depth analysis of the fraud prevention measures that have been implemented at Al Ihsan Regional General Hospital is needed, including identifying the obstacles faced.

In addition to internal hospital factors, fraud prevention in JKN claims is influenced by external oversight policies and mechanisms implemented by the Health Social Security Agency (BPJS Kesehatan) and the Ministry of Health. Clear regulations, transparent verification processes, and the use of integrated information technology can identify signs of fraud from the outset. Several Indonesian hospitals have utilized digital verification systems to speed up claim checks and reduce administrative errors. However, the successful implementation of this system requires support from trained human resources and adequate technological infrastructure to achieve optimal results and reduce the risk of fraud (Gunadi et al., 2024).

On the other hand, an organizational culture that prioritizes integrity is an important aspect in preventing unjustified claims. Hospitals that are highly committed to transparency and accountability will be more effective in creating a system that is strong enough to prevent fraud. The application of strict sanctions for violations, along with rewards for staff who excel in maintaining verification quality, can increase staff motivation to comply with existing procedures. This step not only protects state finances but also maintains public trust in the healthcare services provided through the JKN Program (Safitri et al., 2024).

Therefore, a thorough analysis of the fraud prevention measures implemented at Al Ihsan General Hospital is needed. This study aims to evaluate the prevention strategies that have been implemented and identify the challenges faced in preventing the occurrence of unwarranted claims. The findings of this study are expected to provide positive recommendations for improving the claim management system and strengthening the integrity of healthcare services at the hospital. Based on the above description, this study is titled "Analysis of Fraud Prevention Efforts in JKN Claims Against Potential Unsuitable Claims at Al Ihsan Regional General Hospital."

METHOD

This study uses a descriptive qualitative research method. This type of research uses a scientific approach to identify a phenomenon by describing information and facts in detail through comprehensive words about the object being studied. The primary objective of applying the qualitative approach is to gain a deep understanding of fraud prevention efforts in national health insurance (JKN) claims against potential invalid claims at Al Ihsan Regional General Hospital. The study examines the relationship between fraud prevention efforts and the reduction of invalid claims in JKN claims.

This research was conducted at Al Ihsan Regional General Hospital, a provincial general hospital in West Java that has collaborated with the Indonesian Health Insurance Agency (BPJS Kesehatan). Purposive sampling was used to include claim documents with indications of ineligible claims and to ensure that the collected data had high relevance and accuracy. A combination of data was used to support the validity of the research results, namely primary and secondary data. Primary data was obtained from the primary source through an interview with one of the verifiers. The in-depth interview provided the researcher with the opportunity to gain a comprehensive perspective and research insights from the information source. Secondary data was obtained from internal hospital policy documents and claim documents from October to December.

RESULT AND DISCUSSION

Based on the interview results, fraud occurs due to the potential for cheating, and there are various types of fraud. The verification results from BPJS show that one of the issues is ineligible claims, and in several cases at Al Ihsan Regional General Hospital, there has been an increase in ineligible claims every month. To collect data, the observation method was used to observe phenomena in the field, conduct in-depth interviews with verification staff, and document relevant data and information. It is hoped that the results of this study will assist staff and improve the claim management system and strengthen the integrity of health services at the hospital, thereby reducing the number of ineligible claims.

The following table presents the results of the recapitulation of data on invalid JKN outpatient claims at Al Ihsan Regional General Hospital during the last quarter of the current year, showing variations in the number of invalid claims.

Table 1. Number of Invalid JKN Outpatient Claims at Al Ihsan Regional General Hospital

No	Month	Number of invalid claims
1	October	731
2	November	729
3	December	672
	Total	2132

Source: Data analysis results, 2024

Ineligible claims and indications of potential fraud

According to the final quarterly data for 2024, Al Ihsan Regional General Hospital reported a total of 2,123 ineligible JKN out patient claims, with 731 claims in October, 729 claims in November, and 672 claims in December. Although there was a decrease in December, the numbers still indicate a significant amount and suggest that potential fraud remains a serious challenge. The decrease in the final month suggests improvements in verification procedures or increased awareness among staff, but it is not sufficient to resolve the issue comprehensively. The types of irregularities that frequently occur are readmissions (patients readmitted within a short period of time with the same diagnosis) and fragmentation (the splitting of a single episode of care into multiple episodes). These claims often indicate patterns of duplicate claims that should not occur if internal control procedures are functioning properly. These cases underscore the need for strict oversight of the initial verification process to prevent potentially fraudulent claims from reaching the billing stage with BPJS Kesehatan.

Effectiveness of the verifier's role and implementation constraints

At Al Ihsan Regional General Hospital, the role of verifiers is divided into two main categories, namely medical and non-medical verifiers. Medical verifiers consist of doctors who are responsible for checking the completeness and suitability of inpatient claims from a medical perspective, including diagnoses, medical indications, and medical procedures performed. Meanwhile, non-medical verifiers or coders are tasked with checking administrative completeness while coding diagnoses and procedures according to the ICD. This division of roles is designed to create an effective multi-layered control system to prevent ineligible claims (Safitri et al., 2024). Although the division of tasks appears ideal, in practice there are significant operational challenges, one of the main challenges being the high workload on non-medical verifiers as they also serve as coders and conduct administrative reviews. This situation results in administrative verification processes not always being conducted thoroughly due to time constraints and pressure to complete claims. As a result, there is a possibility that ineligible claims may pass through to the submission stage at BPJS Kesehatan (Hana & Prabowo, 2022). In addition to workload, another challenge that arises is the lack of consistency in understanding the definitions and indicators of fraud among all field staff. Some of them still believe that fraud only involves intentional actions for financial gain. However, in the context of the National Health Insurance (JKN), the potential for fraud includes administrative or procedural errors that can harm the system (Tito & Siregar, 2024). The lack of socialization and technical training on fraud prevention increases the likelihood of staff engaging in risky actions without realizing it. This indicates that strengthening human resource (HR) capacity is a critical factor in the effectiveness of verifiers' roles. Regular training is needed that covers aspects of JKN regulations, types of fraud, and methods for detecting potential claim irregularities so that perceptions can be aligned and verification accuracy improved. In addition, regular evaluation of verifiers' performance is also important to ensure that verification procedures are carried out in accordance with established standards.

Optimization of Governance and SOP Compliance in Preventing Fraud in JKN Claims

Al Ihsan Regional General Hospital has implemented the principles of Good Corporate Governance and Good Clinical Governance as part of its strategy to prevent fraud. These principles clearly define the division of tasks and responsibilities and ensure accountability at every stage of service and claim submission. In theory, this division of tasks should prevent the emergence of loopholes that could be exploited for fraudulent or procedural errors. However, implementation in the field is still not fully effective, particularly in terms of supervision and consistent application of existing rules. One weakness identified is the overlap in tasks that reduces staff concentration, such as when non-medical verifiers also serve as coders. This situation risks causing the verification process to be rushed or not follow the specified procedures. Meanwhile, the principle of good governance requires a clear separation of functions to prevent conflicts of interest and maintain objectivity in claim examinations.

Compliance with Standard Operating Procedures (SOP) in clinical services also serves as a vital tool to prevent fraud. The SOP at Al Ihsan General Hospital have been developed based on the National Guidelines for Medical Services (PNPK) and fraud prevention mechanisms. However, implementation on the ground shows a gap between the SOP documents and daily practices. Several stages of verification, both administrative and medical, are not carried out thoroughly, which can result in ineligible claims continuing through the payment process (Safitri et al., 2024).

Strengthening Staff Competence and Understanding in Preventing Unjustified JKN Claims

Improving staff skills and knowledge is an important step in efforts to avoid unjustified JKN claims. Many staff members, both medical and non-medical, are unaware that they are making procedural errors due to a lack of understanding of JKN rules and fraud indicators. These errors often do not stem from malicious intent but rather from a lack of information or misunderstanding of existing regulations (Tito & Siregan, 2024). Therefore, clear and easily understandable training is essential to address this gap. An effective training program should not only present theory about JKN regulations and policies but also include real-life case examples. By discussing actual fraud cases, staff will better understand the types of violations that should be avoided. In addition, training should also cover techniques for early detection, such as how to recognize claims that show signs of abnormality or inconsistent data. This approach will help staff to be more sensitive to potential fraud from the beginning of the claims process (Hana & Prabowo, 2022). In addition to training, a continuous monitoring and evaluation system is also very important. Regular monitoring will ensure that all staff are actually applying the knowledge gained from training. Routine evaluations can be carried out through internal audits, performance assessments by verifiers, and random checks of submitted claim documents. These steps aim to identify weaknesses in the process and make improvements immediately before the issue develops into costly fraud. The combination of continuous training and strict supervision will strengthen the overall fraud prevention system. When staff are aware of their respective roles and have the ability to detect anomalies, the likelihood of invalid claims can be significantly reduced. Ultimately, this enhancement of human resource capacity will help create a more transparent, accountable, and regulation-compliant claims process, thereby maintaining the quality of service and trust of JKN participants (Safitri et al., 2024).

Based on the results of interviews, the National Health Insurance (JKN) claim process at Al Ihsan Regional General Hospital follows the standards set by BPJS Kesehatan. This process begins with filling out a medical resume, internal verification, and submitting a claim to BPJS Kesehatan. This process is carried out to ensure the authenticity of the services

claimed. Based on in-depth interviews, fraud is not only cheating but also the potential for cheating. When there is potential for cheating, cheating occurs.

CONCLUSION

The results of this study conclude that invalid claims in the JKN system at Al Ihsan Regional General Hospital still require serious attention, despite a decrease in the number of invalid claims at the end of the quarter. The occurrence of potential invalid claims is largely due to weaknesses in the initial verification stage, the workload faced, and a lack of in-depth understanding among staff regarding the definition, forms, and risks of fraud. This finding indicates that fraud does not only arise from intentional fraudulent intent but can also result from negligence and a lack of understanding of proper procedures.

Preventive measures that have been implemented, such as layered verification before claims are submitted, the application of SOPs based on national guidelines, and the use of the SIMRS application to support oversight, including the presence of medical and non-medical verifiers, have helped reduce the number of ineligible claims. However, effectiveness is still hindered by limitations in human resources, lack of knowledge updates, and suboptimal implementation of procedures.

Therefore, to reduce ineligible claims and prevent fraud, it is recommended to enhance the knowledge or understanding of internal hospital verifiers regarding the proper procedures for claims, fraud prevention approaches, and potential actions that may inadvertently lead to fraud. This applies not only to verifiers but to all units. Additionally, improving the knowledge of coders is necessary, as knowledge evolves annually. Lastly, facilitating measures, such as through the SIMRS application with features to prevent actions or activities that could lead to fraud, is essential.

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