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Analysis Of Potential Fraud Control At Metta Medika Hospital Sibolga

Erni Triyani Lubis[1], Juliandi Harahap [2], Nuraini [3]

[1]Faculty Of Public Health, Helvetia Institute of Health, Jl. Sumarsono No.107, Deli Serdang
[2]Faculty Of Medical Science, University of North Sumatra, Jl. Universitas No. 21, Kampus USU, Medan 20115.
[3]Faculty Of Public Health, Helvetia Institute of Health, Jl. Sumarsono No.107, Deli Serdang

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ABSTRACT

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. The problem that often occurs in health services is fraud. Fraud or in Indonesian better known as fraud, is something that is very likely to happen anywhere and in any form. The purpose of the study was to analyze the potential for fraud control at Metta Medika Hospital Sibolga. This study uses a descriptive qualitative method with a phenomenological approach to control potential fraud at Metta Medika Hospital Sibolga. This research was conducted at Metta Medika Hospital Sibolga. This research was conducted in November 2020–July 2021 starting with the submission of titles, preparation of proposals, proposal seminars, research, data processing, research results seminars, trial results and thesis revision. Research informants are 6 employees at Metta Medika Hospital Sibolga. Sources of data are carried out by means of in-depth interviews and field observations to formulate problems found by researchers at the research site. The results of the study show that the phenomenon that occurs is that fraud is a big challenge in companies including Metta Medika Hospital so that to prevent fraud, the anti-fraud section is involved to go directly to the field in terms of supervising, checking every document and evaluating every report given. If fraud is found, it will be resolved immediately by involving the management and director of the Hospital to impose sanctions on the perpetrators of fraud in terms of the size of the fraudulent act committed and immediately evaluate all related parties to complete it. Suggestions for hospitals to be more aware of the potential for fraud that can be carried out by everyone so it is necessary to develop a system to prevent fraud at Metta Medika Sibolga Hospital. The next researcher becomes a reference for further qualitative research regarding the incidence of fraud in companies and hospitals with a larger number of participants and more in-depth interviews.

E-mail: emi.triyani81@gmail.com[1]

1. Introduction

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. The implementation of national health insurance in Indonesia began on January 1, 2014. National health insurance is organized by a special agency, namely the Social Security Organizing Agency (BPJS) for health. This health insurance aims to facilitate access to health services needed by the community and this ease of access is also supported by good quality and service. Gradually until 2019, the entire community will be covered by comprehensive health insurance services (Universal Health Coverage).[1][3]

The public can enjoy first-level health services, namely non-specialist health services carried out at first-level health facilities such as puskesmas or the equivalent, doctor and dentist practices, pratama clinics or equivalent and type D hospitals pratama or equivalent. In addition, the community can enjoy advanced level services that are specialized or sub-specialized and medical emergency health services whose actions must be taken as soon as possible to prevent death, severity and disability.[1][2]

With various access facilities obtained by participants and not accompanied by commensurate compensation provided by the BPJS to health service providers, it creates many opportunities for problems that occur in the health service system for the community. In accordance with the Regulation of the Minister of Health of the Republic of Indonesia Number 69 of 2013 concerning Standard Tariffs for Health Services at First Level Health Facilities and Advanced Health Facilities in the Implementation of the Health Insurance Program, it is stated that for outpatient services at a Primary Hospital, Doctor's Practice or Health Facility, the equivalent is Rp. 8,000.00 to Rp. 10,000.00. Dentist practice outside health facilities A1 and B1 Rp. 2,000.00. With the large tariffs set, many are not sufficient in the allocation of the required costs, so that the opportunity for substandard services to occur can occur and affect the quality of service, the availability of drugs and tools and other supporting facilities, making the service process to the community not optimal. With these problems, the possibility of fraud is very large.[4][5]

Fraud or in Indonesian better known as cheating, is something that is very possible to happen anywhere and in any form. Fraud in many types and modes has become a classic problem in business activities. Fraud can occur in the private sector as well as in the public sector since many years ago until now. Everything has been done to prevent and overcome a series of frauds that occurred. Starting from increasing supervision, strengthening functions in each section, giving severe legal sanctions to the perpetrators, but that still doesn't reduce fraud. [4][6].

Based on a survey conducted by the Association of Certified Fraud Examiner (ACFE) in 2010 that the highest fraud in the world is found in Banking Services at 17.8%, while fraud in Health Care ranks fourth at 7.3%. Indonesia ranks third with

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the highest number of cases out of 30 countries surveyed. [9][10][4].

The results of the Indonesian Transparency research at the end of 2015 released, Indonesia ranks 88 most corrupt countries out of a total of 175 countries. Indonesia's ranking is still far behind that of neighboring countries such as Malaysia, the Philippines, Singapore and even other developing countries such as Sri Lanka. This is how high the level of corruption in our country is, and it is rooted in all levels and levels of society, both in our government and private sector. This can be seen in the evidence of the results of the examination by the Supreme Audit Agency (BPK). [11][12] [13].

Since the enactment of the National Health Insurance (JKN) in Indonesia, the potential for fraud in health services has expanded due to pressure from the new financing system, opportunities due to lack of supervision, and justification for committing fraud. The act of fraud causes state financial losses. Throughout Indonesia, data released by the Corruption Eradication Commission (KPK) shows that as of June 2015 potential fraud was detected from 175,774 claims for Advanced Level Referral Health Facilities (FKRTL) with a value of Rp. 440 M. This value is not total considering the monitoring and detection system used by the KPK in 2015 is still simple. [9][14] [15].

In order to prevent cases of operational irregularities in banking and violations of the provisions of laws and regulations, especially fraud that can cause financial losses, either directly or indirectly, it is necessary to increase the effectiveness of internal control, as an effort to minimize fraud risk by implementing strategies anti fraud.[10][16] [17].

Fraud prevention has been implemented, among others, through the implementation of Risk Management, especially the internal control system, and the implementation of good governance. However, in order for its implementation to be more effective, it is still necessary to increase the risk culture culture so that fraud prevention really becomes the focus of attention and concern for all levels of the hospital organization, both by management and employees, which is manifested among others by the willingness to signing of facts of integrity by hospital management and employees. The effectiveness of fraud control in the business process is the responsibility of the management, so a proper and thorough understanding of fraud is needed by management in order to provide direction and raise awareness for fraud risk control in hospitals. The anti-fraud strategy is a manifestation of the hospital management's commitment in controlling fraud which is implemented in the form of a fraud control system. This strategy requires management to optimize existing resources so that the fraud control system can be implemented effectively and sustainably. The guidelines for implementing the anti-fraud strategy in this provision direct the Hospital in carrying out fraud control through efforts that are not only aimed at prevention but also to detect and investigate and improve the system as part of an integral strategy in controlling fraud. [10][18] [19].

Fraud incidents that often occur in hospitals, for example, patients who use BPJS Health class 1 but the rooms in the Hospital with class 1 are full so the patient wants to be demoted to the patient's approval class, but when calculating the billing to the BPJS section, the patient Fixed care is calculated with class 1. Fraud that often occurs is that the PPE that will be used for patients is limited but the billing for PPE for complete patients is calculated. Then the use of an ambulance at the hospital, the bill given is the use of Pertamax fuel, but the filling is done with Pertalite fuel. The finding of upcoding is that diagnostic codes and services are made more complex than what is actually being done, for example, patients with type 2 DM are coded with type 2 DM with various complications. The discovery of an action in the hospital that makes a bill that is not actually in the service performed. There is a cancellation of a service at the hospital but the canceled service is still included in the bill. It is also often found that hospitals provide health services that are not needed by the patient, for example, the patient must be operated on for appendicitis even though the patient does not need surgery.

The phenomenon found at the location where the research will be conducted through interviews at the Metta Medika Hospital Sibolga is that upcoding is often found in patient status, it is found that the number of patient care in the hospital is reduced from the number of existing treatments, errors in auditing. The data on the number of cases at Metta Medika Sibolga Hospital increased from 2016 to 2019 was around 80%. BPJS Kesehatan shows that upcoding is the highest potential for fraud at 70%. Data on the service utilization of BPJS Health participants at Metta Medika Sibolga Hospital in 2019, showed that the most primary diagnoses were sectio caesarean as many as 405 cases. On average, patients who underwent caesarean section in 1 month were 80 cases, while normal deliveries in 1 month were only 7 cases on average. Based on the above phenomenon, researchers are interested in analyzing the potential for fraud control at Metta Medika Hospital Sibolga

2. Method

This research was conducted at Metta Medika Hospital Sibolga. The research location was chosen by researchers in carrying out research at Metta Medika Hospital Sibolga The source of data in this study is data obtained by researchers from informants who have been determined according to the criteria for the research objectives. To obtain data, it was done by means of in-depth interviews and field observations to formulate problems found by researchers at the research site.

Qualitative data analysis was carried out at the time of data collection and after completion of data collection in the research period. Activities in qualitative data analysis are carried out interactively and take place continuously until they are completed until the researchers get the results from the questions and the researchers feel bored. Data analysis was carried out in the following ways, namely making data transcripts, reducing data, presenting data, inferring and interpreting data.

3. Results and Analysis

3.1 Characteristics of Research Respondents

Participants who were sampled in this study were participants who met the criteria and were willing to be interviewed and signed the consent form to become research participants before the interview was conducted. The following are the results of interviews obtained from all participants based on demographic data filled in through the participant characteristics sheet. 1) Director of Metta Medika Hospital in Sibolga, 2) Head of Finance at Metta Medika Sibolga Hospital, 3) Head of JKN at Metta Medika Sibolga Hospital, 4) Head of Nursing at Metta Medika Sibolga Hospital, 5) Head of Anti-Fraud Hospital Metta Medika Sibolga, 6) Head of Registration/Administration Section of Metta Medika Hospital Sibolga.

3.2 Fraud di Rumah Sakit Metta Medika Sibolga

Based on the results of the study, four themes were found, including prevention of potential fraud, how to detect potential fraud, the investigation process, reporting and sanctioning fraud, monitoring, evaluating and following up on fraud.

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Prevention of Potential Fraud

Fraud prevention is the responsibility of management. The audit team is responsible for testing and assessing the effectiveness of management actions to fulfill obligations and responsibilities in preventing fraud. Fraud prevention is not an easy thing to do because fraud can occur in various forms and ways. Fraud prevention in this study, according to participants' explanations, was grouped with the implementation of claims meetings and administrative reports as well as the implementation of supervision. The following is a fraud prevention scheme.

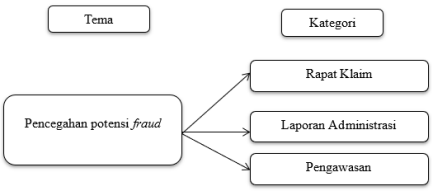

Figure 1 Prevention of Potential Fraud

Claims Meeting

The claims meeting is one of the prevention applications carried out at Metta Medika Hospital Sibolga in accordance with the results of the exposure of the research participants. The claims meeting was held with the aim of evaluating the financing carried out at Metta Medika Sibolga Hospital.

In this category there are several explanations of fraud explained by the participants, the six participants said that the prevention of potential fraud must be done gradually and consistently, as follows:

Participant 1:

"Fraud must be monitored properly and closely, this fraud often occurs due to negligence and must be prevented with strict supervision".

Participant 2:

"There are still often problems in meetings where some members have not been able to explain in detail the documented income and expenses."

Participant 3:

"This meeting is held to follow up on every report that has been given as an accountability"

Participant 4:

"Meetings are held if findings are found in the report for further examination"

Participant 5:

"Several parties were gathered in a meeting to report on what problems were found in the room."

Participant 6:

"The meeting is held as an activity in conducting an examination, both in terms of problems found and the follow-up of each financial activity".

Administration Report

An administrative report is a written report or information objectively and based on financial facts. Based on the results of the study, there were several explanations regarding administrative reports, five participants said that administrative reports were routine reports, as follows:

Participant 1: "Every admin in the room and work unit at the hospital is required to provide financial administration reports and how the income and expenses are made to check their existence".

Participant 2: "This administrative report serves as evidence that must be accounted for what has been used or is still in the finances of each unit".

Participant 3: "Administrative reports are very important because many are misused so that the targets are often inaccurate".

Participant 5: "The administrative report becomes a written evidence report for each unit so that we can carry out inspections related to the administration given to us".

Participant 6: "The number of cases found on existing complaints that it is not in accordance with the use of a tool so that its existence must be re-checked".

Supervision

Supervision is one way to prevent fraud. Supervision will minimize the occurrence of fraud, but the possibility of fraud is also difficult to avoid. Based on the results of the study, several explanations regarding supervision were obtained, the six participants revealed the following:

Participant 1: “Supervision is the most important action taken, especially in a company, it helps to prevent fraud, although we still see that there are certain parties who try to find ways to keep fraud in small matters. This is why we ask the anti-fraud team to play an active role in supervision, assisted by several people who we entrust to supervise.”

Participant 2: “This supervision is still ongoing and until now it has always been monitored, lest there be parties who commit fraud, both in small things. However, this is not a 100% guarantee because there are also parties who cooperate to keep cheating.”

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Participant 3: “Every patient case report that is given to us, we always monitor it closely, for example whether the action is carried out on a patient with a certain indication. Supervision is carried out to help reduce fraud from certain parties.
Participant 4: "In the nursing department, we always brief the head of the room every day, we urge and emphasize to supervise fraudulent actions and not harm others, and the nursing field also often carries out sudden surveillance to the room without notifying in advance to see how it actually is in the field".
Participant 5: "Supervision is one of our biggest duties and responsibilities, we really have to carry out supervision in the field, look at documents and be objective to adjust to the existing reality".
Participant 6: "The administration department is an important point in one company, so we always carry out reporting and field supervision for the evaluation of the documents that have been reported".

3.3 How to Detect the Occurrence of Potential Fraud

Based on the results of the study, it was found that the way to detect the occurrence of potential fraud was the existence of financial statements.

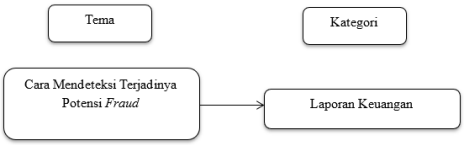

Figure 2 How To Detect The Occurrence Of Potential Fraud

Financial Report

Based on the research results obtained several explanations regarding the financial statements of each work unit, six participants said as follows:
Participant 1: "Revenue is a hospital investment to be re-managed as short-term and long-term assets, so it needs to be clearly evaluated. Expenditures and income are important reports to be accounted for because these are too sensitive to financial problems, so they must be reported regularly".
Participant 2: "Finance that comes in is an important calculation for us to be able to compare with existing expenses, it must be clear what written evidence is the income from the hospital so we can also report it to the Director and General Manager of the Hospital. Income and expenses are our responsibility every month yes, to be reported in accordance with the reports we receive from each unit”.
Participant 3: "The JKN section provides reports on the number of patients as authentic evidence that exists to calculate patient claims for inpatient and outpatient services that are already running. Usually the expenditure is seen from how many medical equipment or needs are used, especially JKN patients to be calculated as patient expenses, so this is what we report on an audit basis"
Participant 4: "In every room, I must report each shift the number of patients so that I can also report the patient's whereabouts according to the status of their medical records as well. Expenditures in the room are usually with evidence of what is used according to the use of each patient's medical needs, and all are reported using a computer system. , so that the input of each item is clear in the computers already in each room”.
Participant 5: "Revenue is a benchmark to be re-managed and this must be monitored to see directly in the field whether it is in accordance with the reports provided. Fraud incidents are not only large-scale but also small-scale, so any expenditures made must be shown with evidence. physical and accountable”.
Participant 6: "Income and expenses are calculated in the administration section so that we can notify you of the financial differences that exist on a regular basis. Income and expenditure reports are the task of the overall administration at this hospital so we have to receive every bill and we re-check it according to the items that are ordered. out, if there are any discrepancies, we will immediately hold a meeting with the related units.”

3.4 Fraud Investigation, Reporting and Sanction Process

Based on the results of the study, it was found that the process of investigating, reporting and sanctioning fraud is in the form of planning, implementing, reporting

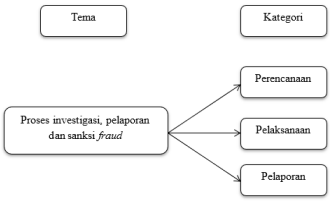

Figure 3 Fraud Investigation, Reporting and Sanction Process

Planning

Based on the results of the study obtained several explanations regarding work planning, six participants said as follows:
Participant 1: "Every activity must be planned so that we can see how the achievements of each plan are obtained, whether each is within 1 point in a predetermined timeframe or has reached the 3rd point, for example from the 5 points we have targeted, so everything must be planned at the beginning, If from the planning carried out it turns out that there are irregularities, it will be followed up immediately, and a fraud incident is found, it will be transferred first to the anti-fraud section to assess what is included in the fraud category from the findings, then we will give strict sanctions even if it is fatally we will remove it."

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Participant 2: "Usually every plan that we have made, we will re-evaluate, especially in this finance, then we will re-check what has been summarized from what has been planned, we will see every incident that has occurred, if there are irregularities, we will follow up and strictly processed".
Participant 3: "The plan is closed for each achievement target and then we report the results, if there are complaints from several parties due to discrepancies, we will correct them again and if it is done intentionally, we will re-evaluate and be given sanctions in accordance with what has been directed".
Participant 4: "In the nursing department, every planning has been explained at the beginning, both when the nurse will carry out her duties in each shift, so that whatever problems are found and there are complaints, we will handle them first until we can solve them ourselves, but if we have to require handling it goes to director, we will meet first to ask for a solution and assess every report that exists and be resolved in a firm way".
Participant 5: "Fraud incidents are sometimes not realized by several work units at this hospital, so we always explain what the fraud category is and what sanctions will be received if it is found that one or more parties are collaborating intentionally to commit fraud. check reporting, ask related members, examine documents and evidence of records, evaluate activities carried out and carry out supervision. If it is included in the category of fraud as described, we will follow up with strict sanctions."
Participant 6: "We will provide the administration department with careful planning, we will evaluate the experience of members regarding financial coding, then we will check every document that has been done and we will examine physical evidence, this is one of the plans to avoid fraud, but if negligence persists we will give sanctions by involving anti-fraud parties at the hospital for direct evaluation".

Reporting
Based on the results of the study, there were several explanations regarding reporting in the work unit, six participants said as follows:
Participant 1: "I evaluate every report that exists and follow it up firmly."
Participant 2: "Reporting of fraud is a big topic to be evaluated and followed up with strict sanctions".
Participant 3: "Intentional frauds are detrimental to various parties, so strict sanctions must be given."
Participant 4: "We are trying to monitor every nursing activity to avoid any existing frauds."
Participant 5: "Hospital anti-fraud acts as a fraud controller in hospitals so we always evaluate existing reports".
Participant 6:
"Administrative reporting always tries to collect every file, so that it becomes physical evidence and documents to assess possible frauds to be reported".

3.5 Fraud Monitoring, Evaluation and Follow-up
Based on the results of the study, it was found that the monitoring, evaluation and follow-up of fraud is the implementation of evaluating.

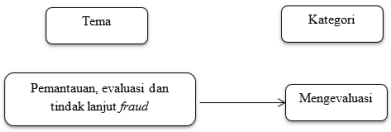

Figure 4 Fraud Monitoring, Evaluation and Follow-up

Evaluating
Based on the results of the study obtained several explanations regarding work planning, six participants said as follows:
Participant 1: "I evaluate every report that exists and follow it up firmly."
Participant 2: "Reporting of fraud is a big topic to be evaluated and followed up with strict sanctions".
Participant 3: "Intentional frauds are detrimental to various parties, so strict sanctions must be given."
Participant 4: "We are trying to monitor every nursing activity to avoid any existing frauds."
Participant 5: "Hospital anti-fraud acts as a fraud controller in hospitals so we always evaluate existing reports".
Participant 6: "Administrative reporting always tries to collect every file, so that it becomes physical evidence and documents to assess possible frauds to be reported".

4. Discussion
Interpretation and Discussion of Results
The following is a discussion of all the themes that have been identified based on the results of the researcher's analysis. here's the explanation:
Prevention of Potential Fraud
Based on the results of research through interviews with participants, it said that prevention for fraud had been carried out based on claims meetings and administrative reports that discussed coding, seeking work agreements, reporting income and expenses as well as approval of every action and periodic monitoring. Fraud prevention is an attempt to eliminate the causes of fraud. According to BPKP, (2008) that effective fraud prevention efforts are beneficial for organizations in particular with the following five objectives:

a. Prevention
   Efforts to prevent fraud in an organization must be carried out thoroughly from the lower level to the top management.
b. Deterrence
   Deterrence efforts must be carried out with strict procedures, so that every room in the organization is protected from opportunities to commit fraud.
c. Termination
   The most effective fraud prevention efforts can be done by breaking the chain of fraud perpetrators who are still in the organization.
d. Identification
   One way to identify activities that have a high chance of fraud is to identify activities that are routine and risky. Identification of the internal control that has been running must still be done to find out what weaknesses exist in the control.

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e. Prosecution

Other prevention efforts that can be done are to impose sanctions that are graded according to the type and magnitude of the fraud committed. The sanctions given will serve as a warning and self reminder for other employees.

How to Detect the Occurrence of Potential Fraud

Based on the results of research through interviews with participants, they said that the way to detect fraud was to look at the financial statements, how the company's income was, how the company spent, how to use assets and what obligations were carried out. Detecting is a process to examine or examine something using certain methods and techniques. According to Karyono, the way to detect fraud is by:

1. Techniques to detect through auditing of accounting records that lead to symptoms or the possibility of fraud (Critical Point Auditing). Critical Point Auditing with the following.
   a) Trend analysis, which is a trend pattern (conjuncture) that occurs from one period to the next.
   b) Special testing, namely testing activities that have a high risk of fraud.
2. Detection technique with job sensitivity analysis by looking at potential actors (Job Sensitivity Analysis). Job Sensitivity Analysis with the following.
   a) Identify all job positions that are prone to fraud (method approach).
   b) Identify the level of control exercised by the manager. Cheating is easy when managers are careless or busy with other responsibilities. And neglecting his responsibility in exercising control.
   c) Identification of symptoms (symptoms) that occur such as unexplained personal wealth, luxurious lifestyle, dissatisfaction, selfishness, neglect of instructions, and wanting to be considered important (personal character).
   d) Detailed testing of whether testing and follow-up improvements have been carried out at the first opportunity for high-risk types of work.

The results of interviews conducted that the detection method is based on participant answers, namely the existence of financial reports so that there is evidence of all activities and the process of entering and leaving each activity or transaction that has been carried out.

Fraud Investigation, Reporting and Sanction Process

Based on the results of research through interviews with participants, it is said that the process of investigating, reporting and sanctioning fraud is carried out by forming planning, implementation and reporting in which there are types of fraud that occur, the causes of fraud, are there elements of cooperation, the parties involved and supervised by observation, interviews, examination of written evidence, physical examination, information and confirmation as well as documents as evidence.

According to Giddens, In conducting an investigative audit, there are several techniques that can be used. Seven of them are:

a) Physical Check

Physical observation of evidence or evidence of fraud helps investigators to find possible corruption that has been committed.

b) Requesting information and confirmation

Requesting information from the auditee in an investigative audit must be accompanied by information from other sources in order to minimize the auditee's opportunity to lie. Asking for confirmation is asking another party (other than the auditee) to confirm the truth or untruth of an information. Requesting confirmation can be applied to a variety of information, both financial and non-financial. It should be noted whether the third party consulted has an interest in the investigative audit. If there is, the confirmation must be confirmed by confirmation to other third parties

c) Checking Documents

There is no investigative audit without document checking. The definition of a document has become wider due to technological advances, including information that is processed, stored, and transferred electronically. Therefore, the technique of examining documents includes computer forensics.

d) Analytical Review

In analytical review, the important thing is: master the big picture first (think analytical first!). Analytical review is a form of reasoning that leads the auditor to a picture of the fairness or appropriateness of an individual data inferred from the picture obtained globally. Reasonable conclusions or not obtained from comparisons to benchmarks. The gap between what is being faced and the benchmark: whether there is an error (error), fraud, or incorrectly formulating the benchmark. Recognize the relationship pattern of one financial data with another or one non- financial data with other non-financial data.

e) Counting Back (Reperform)

Reperform in investigative audits must be supervised by experienced auditors because the calculations encounteredin investigative audits are generally very complex, based on very complex contracts, and the possibility of changes and renegotiations many times.

f) Net Worth Method

Proving the existence of illegal and unlawful income. Auditing can be related to the amount of tax that is reported and paid annually. The official's wealth report is the basis of the investigation. Reversal of the burden of proof to the person concerned.

g) Follow The Money

Means following the trail left by the flow of money until the flow of money ends. The criminal's instincts are always to seal the identity of the perpetrator, trying to give the impression of being invisible or not at the scene when the incident took place. Funds may flow gradually and in stages, but will eventually stop at one or more final stopping places. This place provides strong clues about the perpetrators of fraud.

According to Bona, (2015) that in Indonesia the term fraud has not been specifically known as a crime (criminal act), the public is more familiar with the term corruption, even though corruption is qualified as part of fraud, because the nature of the scope of fraud is wider than corruption. The analysis of the occurrence of a fraud can be viewed from several aspects, namely the intentionality of the perpetrator, the modus operandi, the material loss (money) suffered by the victim, and the profit gained by the perpetrator. Thus, it can be formulated that the definition of fraud is any dishonest act (deviation or abuse of position / power / position) which aims to take money (wealth) of the victim through trickery, deceit, cunning, fraud, forgery or other means that done intentionally by the perpetrator.

Fraud perpetrators are usually the closest people or people in the company / organization and generally are employees

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who work well, are experienced, have influential positions (strategic, trusted, and respected), so that fraud perpetrators usually have the peace, opportunity and time to plan their actions properly. The goal is that the fraud committed cannot be detected (eliminate traces). Fraud perpetrators often think that what they do has a lower risk than the results of the fraud and it is possible that the perpetrator thinks that he will not be punished for his fraud. Opportunities to commit fraud usually arise due to the weakness of the control and supervision system in a company / organization, but there are also caused by low wages, causing dissatisfaction for the perpetrator.

In the Criminal Code (KUHP), fraud that occurs in a company / organization is a crime that violates the provisions of Article 374 of the Criminal Code, and is known as the Crime of Embezzlement in Position (embezzlement with weight) which is punishable by imprisonment for five years. Article 374 of the Criminal Code stipulates that "Embezzlement committed by a person who holds the goods in connection with his work or position or because he gets money wages, is sentenced to a maximum imprisonment of five years". Thus, based on these provisions, the perpetrator must have an employment relationship with the victim based on wages (money), and the perpetrator has been given authority/power/position (beroep) by the victim to store and/or manage the embezzled property of the victim.

Aspects of planning in the crime of fraud can be seen from the modus operandi of the perpetrator, usually carried out by deceit, trickery, cheating, cunning, forgery (some are faked as if they were true) all of which are carried out for the purpose of benefiting themselves (the perpetrator). so that the crime of fraud can also be rewarded with the provisions of Article 378 of the Criminal Code and Article 263 of the Criminal Code. The existence of opportunity and time for the perpetrator in compiling a series of acts against the criminal law gives the conclusion that fraud is a premeditated crime, which does not only focus on the achievement or realization of the fraud, but also the perpetrator's efforts to avoid the reach of the law or be separated from it. legal responsibility or eliminating traces by doing trickery, deceit, fraud, cunning and or falsification of letters / documents that are carried out intentionally (dolus) containing the will and knowledge of the perpetrator.

The legal rules that threaten a criminal act of fraud are not only contained in the Criminal Code, but there are other legal rules that are special (lex specialis), as regulated in the Banking Law (Law No. 7 of 1992 in conjunction with Law No. 10 of 1998).), the Law on the Eradication of Criminal Acts of Corruption (Law No. 31 of 1999 in conjunction with Law No. 20 of 2001), and so on but the implementation is casuistic.

Fraud Monitoring, Evaluation and Follow-up

Based on the results of research through interviews with participants, it said that monitoring, evaluating and following up on fraud was carried out through an evaluation consisting of how the experience was known, asking related members, checking documents, checking records, observing activities carried out and carrying out strict supervision. Monitoring, evaluation and follow-up actions are part of the fraud control system which at least contains steps to monitor or evaluate fraud, as well as follow-up mechanisms.

Evaluation is carried out by identifying the weaknesses and causes of fraud and determining the necessary corrective measures, including strengthening the internal control system. Evaluation is part of the fraud control system. The evaluation is carried out by utilizing fraud incident data which is managed in the incident management module. The fraud incident data shall at least include the type of fraud, the place where the fraud occurred, the work unit where the fraud occurred, the parties involved, the positions of the parties involved, the causes of fraud, losses due to fraud, follow-up to the incidents and causes of fraud. In terms of monitoring is carried out on the implementation of follow-up actions carried out on fraud incidents since they were discovered, the investigation process, the disciplinary process, to the loss recovery process. Monitoring is part of the fraud control system. Follow-up actions are taken to correct weaknesses and strengthen the internal control system in order to prevent the recurrence of fraud due to similar weaknesses. Follow-up is part of the fraud control system.

5. Conclusion

The results of the research conducted obtained four themes regarding fraud at Metta Medika Hospital Sibolga with several sub-themes of each theme for the interviews conducted to each participant. The findings based on the interviews are that: The occurrence of upcoding in the JKN unit is when the coder performs coding that does not match the coding rules or does not match the diagnostic code written by the doctor in charge with the patient's medical resume, The existence of document reporting that is not in accordance with the evidence in the field, There is a difference in the number of bills with the use of medical devices reported by the patient and the patient's family at the time of payment of treatment, D. Inadequate control measures lead to negligence occurring in the field. e. Administrative reports that become accountability through documents have not been completed properly.

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