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Medical Audit of Hemophilia Services for National Health Insurance Participants in Bogor: A Case Report

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Abstract: BPJS Kesehatan is a legal entity established to implement social security programs, provide health service benefits through regulations, and manage (purchasing and investing) carefully, prudently, transparently, efficiently, and effectively. One of the health service benefits provided by BPJS Kesehatan is for hemophilia. Hemophilia is a hereditary blood clotting disorder that is currently the most prevalent globally and is based on X-linked recessive genetic inheritance. Since the Regulation of the Minister of Health of the Republic of Indonesia Number 3 Year 2023, claims for hemophilia services, including the top-up of anti-hemophilia factor drugs in 2023, have increased. The method used to write this article is quantitative descriptive with a case report approach in the form of a report from BPJS Kesehatan, which conducted an administrative claim audit on the potential fraud committed in an attempt to inflate costs, which is then followed by a medical audit. The result of the medical audit indicated that there were inaccuracies in the financing of hemophilia services based on medical service standards that were not yet met, leading to sanctions that the hospital must undergo, namely the recovery of financing losses.

***Keywords*:** Social security program; medical audit; hemophilia; fraud; health service

INTRODUCTION

The National Health Insurance Program (JKN) is a government initiative that provides comprehensive health insurance coverage for every Indonesian citizen, enabling the population to live healthily, productively, and prosperously. The benefits of this program are offered in the form of comprehensive individual health services. The JKN program is organized according to social insurance and equity principles, meaning everyone receives services for their medical needs unrelated to the amount of contributions paid. The aim is to provide health protection and meet the basic health needs of every person who has paid contributions or whose contributions are covered by the government (Regulation of the Minister of Health Number 28, 2014).

The Social Security Agency for Health (BPJS Kesehatan) is a legal entity that administers the social security program. BPJS Kesehatan has the role of providing benefits and financing health services according to provisions of the social security program, as well as conducting governance (purchasing and investing) with care, caution, transparency, efficiency, and effectiveness to meet

the health protection needs of JKN participants. (Constitution of Republic of Indonesia Number 24, 2011). BPJS Kesehatan guarantees all medical expenses. This is carried out in stages, starting from the First Level Health Facility (FKTP) to the Referral Health Facility (FKRTL), based on medical indications by the referral system regulated by statutory provisions (Regulation of the Minister of Health Number 28, 2014).

One of the diseases covered by BPJS Kesehatan is hemophilia. Hemophilia is today's most common hereditary blood clotting disorder, resulting from x-linked recessive genetic inheritance. Hemophilia can be diagnosed based on medical history, physical examination results, and supporting tests. The diagnosis of hemophilia can be confirmed with several supporting examinations. The management of hemophilia currently follows the gold standard of administering blood clotting factors, which can be provided *on demand* (when bleeding occurs) or prophylactically. In bleeding, the blood clotting factor is determined by the clinical manifestations and the severity of hemophilia the patient experiences. Prophylactic therapy helps prevent bleeding and joint destruction to maintain normal musculoskeletal function. Prophylactic therapy includes primary, secondary, tertiary, and intermittent prophylaxis (Minister of Health Decree, 2021).

Replacement therapy in Indonesia utilizes factor VIII concentrate, which still follows the on-demand pattern; this is due to the high cost of clotting factor concentrate, the uneven distribution of clotting factors across regions, and the limited financial support from the government (Darman et al., 2023). Episodes of joint bleeding in children with severe hemophilia can occur 3-4 times per month, resulting in substantial monthly costs. Currently, the cost of factor VIII concentrates on the on-demand treatment of one episode of joint bleeding in a child weighing 25 kg, ranging from Rp4,500,000 to Rp9,000,000. This amount does not include other expenses such as laboratory tests, radiology, additional medications, and multidisciplinary consultations (Pratiwi et al., 2024).

Ease of access to services and administration is provided to JKN participants, particularly those with hemophilia who receive routine blood transfusion therapy, antihemophilia drugs, and iron chelation drugs at the hospital (Hiru, 2021). Hemophilia services in Bogor City are organized at PMI Hospital, a class B private FKRTL that collaborates with BPJS Kesehatan. BPJS Kesehatan processes claims through a payment mechanism that adheres to applicable regulations, one of which is Minister of Health Decree number HK.01.07/MENKES/243/2021 concerning National Guidelines for Medical Services in Hemophilia Management and the Regulation of the Minister of Health Number 3 Year 2023.

BPJS Kesehatan finances services provided by advanced health facilities based on *Indonesian Case-Based Groups* (INA-CBG). The cost components covered in INA-CBG include doctors and medical personnel services, inpatient accommodation, consumable medical materials, medical devices, procedures/actions, and administration. The INA-CBG tariff includes a *top-up payment* for

Special Casemix Main Groups (CMG). In CMG, additional payments (top-up payments) *are* designated for certain services based on service criteria and FKRTL competence. According to Minister of Health Regulation number 3 of 2023, there were changes in INA CBG rates, one of which pertains to hemophilia services (Regulation of the Minister of Health number 3, 2023).

Table 1. Comparison of Hemophilia Drug Top-up Rates Years 2016 and 2023

Regional Tariff 1	Hospital Class	Regulation of the Minister of Health number 64 Year 2016	Regulation of the Minister of Health number 3 Year 2023
	A	10.219.818	12.637.400
	B	5.593.518	12.637.400
	C	5.593.463	12.637.400
	D	5.550.000	12.637.400

Funding for consultation rates at Private Type B Hospitals for hemophilia services without a top-up is IDR 205,900. If topped up, the provision of hemophilia drugs will be IDR 12,637,400 (Regulation of the Minister of Health Number 3, 2023).

Since its operation on January 1, 2014, BPJS Kesehatan has faced many challenges in implementing the national health insurance program (JKN), including preventing fraud. According to Cristian et al. (2019), as the diversity of fraud forms increases, the number of fraud theories proposed by experts or organizations can serve as references to identify the causes of *fraud*. Four theories are commonly used to examine the existence of fraud: *the fraud triangle, fraud diamond, fraud pentagon, and fraud hexagon theories.* As stipulated in the regulation, the mechanism for handling fraud in BPJS Kesehatan is carried out by forming an anti-fraud team (Board of Directors of BPJS Kesehatan Decree Number 13, 2023).

Fraud is an act committed intentionally to obtain financial benefits from the National Social Security System Health Insurance program through fraudulent acts that do not comply with the provisions of laws and regulations. Regulation of the Minister of Health Number 16 (2019) stipulates sanctions for *fraud* perpetrators. Administrative sanctions that can be imposed on the perpetrator include verbal reprimands, written reprimands, and orders to return losses to the injured party. A fraud prevention and handling team was formed at the central and provincial levels to enhance efforts to prevent and address fraud in implementing the Health Insurance Program (Ismawardani, 2015).

Fraud can be prevented by conducting a claim audit, which entails periodic re-examining of claims paid. An internal audit consists of a series of independent and objective examinations and

consulting activities to improve the value and operations of the organization through a systematic approach by evaluating and enhancing the effectiveness of risk management, internal control, and organizational governance. BPJS Kesehatan no. 8 (2016) on the Implementation of Quality Control and Cost Control in the Implementation of the National Health Insurance Program states that according to Article 11, paragraph 3, one of the authorities of TKMKB is to conduct utilization reviews and medical audits.

A medical audit is a systematic examination or review of medical procedures that aim to improve the quality and outcomes of patient care through a structured review to examine and compare medical practices, medical procedures, and their results with agreed standards of standardized medical procedures (Abubakar, 2019). The results of the medical audit review are utilized to modify medical procedures in specific sections or to replace them with new standards if necessary. After the recommendations and minutes of agreement regarding the medical audit results are submitted to the stakeholders, dissemination or socialization of the medical audit results is conducted to achieve a common understanding among all health facilities based on the medical audit results. The dissemination or socialization of the medical audit results is done for the relevant parties according to the recommendations of the medical audit results, along with the team conducting the medical audit. The most important aspects following the implementation of a medical audit are monitoring, evaluation, and guidance. This is essential because it will be a determining factor in ensuring that medical audits have an impact on improving the quality of services and the efficiency of financing the National Health Insurance (JKN) program.

METHOD

The article's method utilized is descriptive quantitative with a case study approach. According to Priyono (2016), descriptive research is conducted to provide a more detailed description of a symptom or phenomenon obtained based on respondent's answers to questions or derived from the indicators to be studied. Case studies are empirical investigations that explore contemporary phenomena in the context of real life. Types of evidence in the case study method include documents, tools, interviews, observations, and, in some situations, participant observation and informal manipulation may occur.

This research is a secondary data analysis study of post claims in the BPJS Kesehatan *Self-Service Business Intelligence* application. Data was also analyzed to examine PMI Hospital outpatient hemophilia service claims for the January to December 2023 service months. Data and information are collected through documentation, recording, or quotation from documents or archives in regulations, magazines, and the Internet, which are necessary to complete the data.

Implementation was conducted at the Bogor Branch Office from March 25 to May 4, 2024.

RESULT

Medical Audit

Based on the results of the utilization review, it was found that the frequency of top-up financing for hemophilia services in 2023 at PMI Hospital was the highest amount compared to hospitals in the West Java Province region that also provided hemophilia services.

Table 2. Utilisation Review of Hemophilia Top-up Frequency in West Java and DKI Jakarta 2023

	Top up Hemofilia Frequency												
Branch	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**Amount**
West Java													
Bogor	84	99	144	210	240	322	320	252	130	209	144	169	2.323
Bandung	549	476	327	174	137	63	8						1.734
Bekasi	394	139	436	130									1.099
Cikarang	34	281	1.160	675	6								2.156
Cirebon	591	34	44	10									979
Depok	8	3											11
Karawang	4												4
Soreang	18	14											33
Sukabumi	104	41	11	4									160
Sumedang	112	48	2	10	8	7							185
Tasikmalaya	222	20		2									244
Total	**2.120**	**1.455**	**2.124**	**1.215**	**390**	**392**	**328**	**252**	**130**	**209**	**144**	**169**	**2.928**

This finding aligns with the hemophilia billing costs from 2014, which increased after the Regulation of the Minister of Health Number 3 Year 2023 enactment in January 2023. The increase was 24% from the average number of claims in the 2022 service year, with the percentage increase in claim billing costs for 2023 being 190%, or a difference of Rp18,367,912,300 from the 2022 claim service costs.

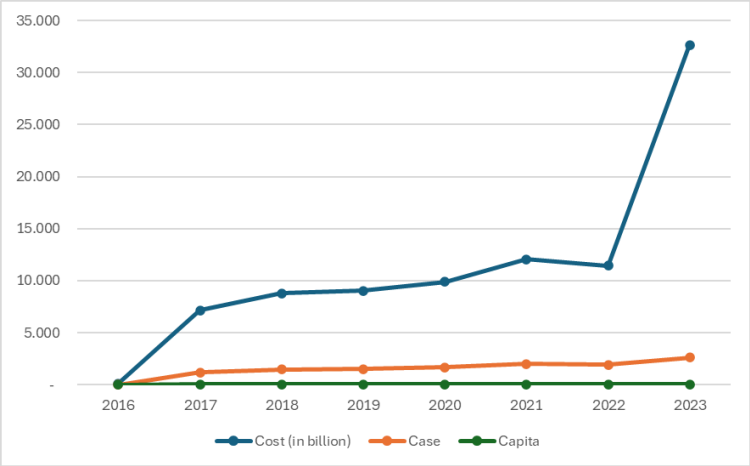

Figure 1. Trend in Hemophilia Care Services

Since the enactment of Regulation Number 54 by the Minister of Health in 2018, which was promulgated on January 19, 2019, BPJS Kesehatan has begun to require the fulfillment of necessary documents for submitting hemophilia drug claims at the collaborating FKRTL, namely PMI Hospital, during the process of verifying the eligibility of payments to FKRTL. After the claim submission documents are completed, one of the obstacles is that PMI Hospital does not have a Doctor in Charge specializing in Hemato-Oncology for consulting patients, so patients must still be referred to Level 3 FKRTL. Other hospital obstacles include medical support results, therapy protocols, and law enforcement documents not being documented in an orderly. During the transition period of implementing these regulations, BPJS Kesehatan Bogor Branch is very concerned. It prioritizes patient safety and ensures it does not require the hospital to fulfill administrative completeness while complying with the protocols established by DPJP pediatricians or internal medicine specialists at PMI Hospital.

Table 4. Average Cost of Top-Up Claims for Anti Hemophilic Factor RS PMI 2022-2023

Year	Cost	Average Cost per Month
2022	11.463.576.800	955.298.067
2023	32.657.015.100	2.721.417.925
Total	**91.185.672.300**	**7.598.806.025**

BPJS Kesehatan raised dispute claims for the service months of May 2019 to July 2019 after discovering that one patient had a visit frequency of visits 18-23 times per month, with all visits billed for top-up drugs to BPJS Kesehatan. One reason for the dispute claims is the lack of regulations governing the limitations of top-up drug guarantees for hemophilia. The dispute discussion was subsequently held with the hospital. After considering the improvement efforts made

by PMI Hospital, specifically the commitment to conduct internal audits, it was determined that all visits were conducted according to the PNPK Hemophilia on January 4, 2022. Consequently, it was agreed that the dispute claim would be resolved through the Dispute Resolution Minutes.

In 2023, the Minister of Health Number 3 Regulation was enacted, regulating the increase in top-up rates for hemophilia drugs. During the claims billing process, the frequency of visits increased compared to 2022. Thus, a utilization review was conducted again on January 19, 2024. Subsequently, a claim administration audit was performed on January 24, and a response was received from PMI Hospital stating that the service and billing of top-up hemophilia drugs were based on the medical indications of the DPJP. This effort then drew the attention of the BPJS Kesehatan Deputy Region V, overseeing the West Java Province area, leading to a recommendation for a follow-up medical audit involving professional organizations.

The findings of the medical audit from the Jakarta Professional Organization of the Indonesian Pediatric Association (IDAI), the West Java Hematology Oncology Medical Association (PERHOMPEDIN), and the Bogor City Quality Control Cost Control Team (TKMKB) indicated that the audit referred to the National Guidelines for Hemophilia Medical Services established on February 12, 2021. Therefore, since March 2021, service claims for hemophilia services that do not meet administrative requirements cannot be paid. The findings reveal that the hospital has not complied with the therapy provisions based on the Hemophilia PNPK in 2021 regarding severity classification, prophylactic or on-demand therapy, calculation of factor requirements, and other supporting examinations, which are not documented in the patient's medical records and the Integrated Hemophilia Team according to the new decree of March 19, 2024. This has led to the highest frequency of hemophilia drug top-up billing in West Java Province.

Completion of Medical Audit

Based on the Regulation of the Minister of Health Number 16 year 2019, which regulates sanctions for fraud perpetrators, administrative sanctions that can be imposed on the perpetrator include verbal reprimands, written reprimands, and orders to return losses to the injured party. A discussion meeting on the follow-up to the completion of the audit and plenary was held between the Bogor Branch Office and PMI Hospital, with the results of the agreement still paying attention to the interests of patients in receiving quality services to their medical needs. More importantly, The considerations for compensation for the return of losses are as follows:

1. Consultation fees, supporting examinations, and/or INA-CBG fees outside of top-up *anti-hemophilic factor* drugs are not included in the calculation of cost recovery.
2. Potential excess costs are calculated based on hemophilia drug top-up billing data in 2023, using the increase in hemophilic drug top-up billing frequency following the tariff increase.

This is in line with the enactment of Minister of Health Regulation Number 3 of 2023 concerning changes in INA CBG rates.

Based on these matters, the basis for refunding the overpayment of claims is as follows:

1. On-demand therapy should be carried out if, after two administrations of the drug, a therapeutic response is not achieved. The patient should be referred to a hematologist, pediatrician, or an internal medicine specialist in the hematology-oncology subspecialty. This is followed by evaluating the patient's medical condition before administering the next drug. In this case, the hospital has not been examined by a sub-specialist doctor and assessed, resulting in continuous financing without monitoring by a pediatric hematologist or internal medicine specialist in the subspecialty of hematology-oncology. Therefore, BPJS Kesehatan overpaid Rp3.073.380.000 for the 2023 service.
2. Prophylactic therapy is carried out one to two times or two to three times a week. After the second visit, there must be a consultation or referral to a pediatric or adult KHOM sub-specialist doctor as a basis for consideration of inhibitor testing. The FKRTL that can be a referral hospital is RSUPN Dr. Cipto Mangunkusumo or RSUP Dr. Hasan Sadikin, the hospital closest to Bogor City. Based on the above recommendations, the maximum top-up drug billing is four times monthly, resulting in a potential overpayment of Rp6.098.327.900 for 2023 services.
3. This amount is obtained by considering the improvement efforts made by PMI Hospital management in the letter from the Director of Medical Services of PMI Hospital Number 001/Diryanmed/X/2023 dated October 1, 2023. An evaluation and renewal of the therapy protocol by a pediatric hematologist have been conducted on pediatric patients. This letter was initiated by a joint discussion before the medical audit in the verification process, which took effect from the month of service, October 1, 2023. Therefore, the refund calculation for the loss of payment is from January 1, 2023, to September 30, 2023. Consequently, the total refund of payment losses is Rp9.171.777.200.

DISCUSSION

Clinical audits are regarded as one of the methods for improving patient service quality by examining deficiencies in the healthcare system to curb ineffective and inefficient practices. Enhancements in governance through clinical audits demonstrate the integration of clinical quality improvement with organizational performance and services at all levels (Àbubakar, 2018). Conducting a clinical audit establishes an extensive database available for corrective action. Clinical audits in the developed world focus on patient outcome measures (Nundy, 2022).

The audit of hemophilia services at PMI Hospital was initiated by a case identified as overutilization or an unusual utilization pattern from the utilization review results. This case exhibits

a different behavioral pattern than other FKRTLs and has the potential for undetected discrepancies in the verification application feature (BPJS Kesehatan, 2023).

BPJS Kesehatan detects the conformity of claim payments with the services provided to participants and the competence according to the facilities and infrastructure in FKRTL. Following this, the conformity of claim documents with applicable service guidelines or standards is examined. Furthermore, the Claim Administration Audit effort is performed as official confirmation to FKRTL through requests for supporting evidence and confirmation responses to FKRTL until the issuance of the Claim Administration Audit Report. Administrative actions have been undertaken by BPJS Kesehatan, which were deemed necessary to conduct a Medical Audit as a systematic evaluation of clinical and administrative practices at FKRTL to enhance service quality and patient safety. The medical audit involves collecting, analyzing, and interpreting data related to health services to assess compliance with applicable standards, guidelines, and regulations. A medical audit can be a means to address an issue when a legal case or deviation occurs when medical personnel or doctors provide health or medical services to patients (Abubakar, 2018).

Type of Fraud

From the results of the medical audit and the recommendations of the Professional Organization mentioned above, there are indications of fraud by FKRTL in the form of upcoding, leading to financial losses for BPJS Kesehatan. Referring to the Regulation of the Minister of Health number 16 (2019), several parties have the potential to commit fraud within the JKN program, namely participants, first-level health facilities (FKTP), advanced referral health facilities (FKRTL), and BPJS Kesehatan officers. Several initial references are used to identify forms of fraud in the JKN, particularly in FKRTL. The National Health Care Anti-Fraud Association (NCHAA) indicates at least 15 models of fraud in billing. Based on the correspondence conducted by Ismawardani (2015), a study was undertaken in 7 hospitals, where multiple forms of fraud were identified. The research concluded that fraudulent activities occurred in several hospitals throughout Indonesia. Fraudulent actions occur at the FKRTL level, such as excessive writing of diagnosis codes (upcoding). Various factors trigger this fraud; for example, the costs listed in the INA-CBGs package are considered low, prompting hospitals to seek ways to generate profit. The payment for BPJS Kesehatan claims to hospitals, according to the INA-CBG tariff package without an upper limit, further encourages fraud.

Fraudulent actions are explained through the development of the fraud triangle theory to identify the causes of fraud occurrences; the type of fraud that arises can be based on the presence of pressure, opportunity, and rationalization, which then evolves into six elements or the fraud hexagon with the addition of components such as competence, arrogance, and collusion (Evana et al., 2019). According to Sadikin and Wiku (2016), the pressure factor in fraud within the Health

Insurance Program is that high unmet needs exert specific pressure on employees and can lead to actions with the potential for fraud. Usually, doctors provide diagnoses, while coders assign codes according to the diagnoses written by the doctors, resulting in a billing value that can be charged to BPJS Kesehatan.

Opportunity refers to the existence or availability of a chance to commit fraud or a situation that allows management or employees to engage in fraudulent activities (Devi et al., 2023). For instance, when an employee responsible for providing disease diagnosis codes, inputting data into the INA-CBG system, and conducting internal verification is the same person, it creates an opportunity for committing fraud in providing diagnosis codes or inputting data that is not justified by rationalization.

Rationalization: This study discusses how employees can justify fraudulent behavior, believing they deserve more because of their tenure or contributions to the organization. This rationalization can foster a mindset where fraud is acceptable, especially if individuals do not receive adequate compensation. For example, the rationalization factor in fraud within the Health Insurance Program is the habit of placing trust in one employee. This can lead to rationalization since the employee may feel superior to others. The trusted employee may also be more inclined to commit fraud because they see themselves as the leader's confidant (Fatimah, 2021).

According to Sadikin and Wiku (2016), various fraud issues in health services consist of at least ten schemes, including claiming services that have never been provided, claiming services that cannot be covered by insurance as services eligible for insurance coverage, falsifying service times, falsifying service locations, falsifying service providers, alleging bills that should be paid by patients, reporting incorrect diagnoses and procedures, excessive services, corruption (bribes), and prescribing unnecessary drugs.

Fraud prevention is carried out by providing feedback to healthcare facilities. Suppose there are elements of unintentionality leading to inaccuracies in claim submissions. In that case, BPJS Kesehatan is obligated to reprimand the hospital to correct it and conduct a review of the potential losses that have occurred. BPJS Kesehatan has performed a utilization review with RS PMI and disputed claims. However, the frequency of hemophilia drug top-up payments has increased again after the implementation of Regulation of the Minister of Health Number 3 of 2023. Therefore, discussions were held again according to the Claim Administration Audit flow mechanism and discussions with the Fraud Prevention Team, responsible for socializing regulations and fostering a culture oriented towards quality control and cost control, enhancing the culture of fraud prevention, encouraging the implementation of good organizational governance and clinical governance, making efforts to detect and resolve fraud, as well as monitoring and evaluation (Yesiariani, 2017)

The classification of fraud occurring at PMI Hospital requires a more profound study, especially at a broader level within a large organization, as the indications of fraud at PMI Hospital only involve small units that do not reach the awareness of top management. There has been a loss of periodic oversight functions by the hospital management and evaluation of services that have been routinely conducted. There is no analysis of Hemophilia PNPK, so all services are considered on-demand, with claims always submitted at high rates. The oversight and control functions have been conducted alongside the verification process carried out by BPJS Kesehatan. However, there are still no regulations governing limits on the frequency of health services, which also need to be examined and proposed to the government to prevent financial losses without compromising the quality of services for BPJS Kesehatan participants. Therefore, the initiation by BPJS Kesehatan to conduct medical audits is necessary so that health services can always prioritize quality control and costs.

Based on PWC's Global Economic Crime and Fraud Survey 2022, the health insurance industry predominantly experiences cybercrime, asset misappropriation, and fraud committed by customers or participants (customer fraud). Data obtained from Indonesian Corruption Watch indicates that in the health sector, the value of state losses caused by corruption reached Rp59.3 billion in 2021. Data released by the KPK in (Djasri et al., 2016) explains that since the implementation of JKN, 175,774 potential frauds have been detected in claims from hospitals classified as Advanced Referral Health Facilities (FKRTL), amounting to Rp440 billion.

CONCLUSION

Implementing hospital audits is important and strategic for providing medical services to patients. It ensures that actions are carried out effectively and according to hospital operational standards.

According to the author, the relationship between medical audit and medical record officers and INA CBG input coders is inseparable, as the assessment becomes correct and accurate in the medical records when measured against professional standards and standard operating procedures. The accuracy of the medical audit, consisting of a group of doctors or medical experts, is a form of evaluation of doctors' actions based on professional standards and standard operating procedures. According to the author, the medical audit results are very reliable. They can be accepted as proof when deviations or issues in the medical field occur that affect the billing of hemophilia services to BPJS Kesehatan, as the medical audit is based on medical records. Its assessment aligns with the provisions of professional standards and standard operating procedures.

The types of fraud that occur require a new classification study within a broader scope, namely the fraud triangle theory, which takes place within the internal departments of the hospital

but remains unknown to higher management. Additionally, the weak regulatory factor that has not yet established an upper limit on service frequency means that the definition of fraud committed by the hospital is not yet tangibly provable. The hospital and BPJS Kesehatan have fulfilled the completeness and administrative inspections per existing regulations. Preventive efforts must be enhanced through policy development, strengthening supervision, fostering a culture of integrity, collaborating with stakeholders, and consistently leveraging technological advancements.

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