RINGKASAN

Fraud adalah tindakan yang dilakukan dengan sengaja untuk mendapatkan keuntungan finansial dalam Program Jaminan Kesehatan dalam sistem jaminan sosial nasional melalui perbuatan curang tidak sesuai denganketentuan peraturan perundang- undangan. Fraud di Era JKN seolah-olah ditujukan kepada dokter, padahal dokter dalam bekerja mendapat pengawasan dari berbagai pihak. Bagaimana sosialisasi tentang poin-poin tindakan fraud (Permenkes No 36, 2015 diperbarui Permenkes No 16, 2019) kepada dokter dari pihak manajemen rumah sakit. Bagaimana peran para manajer di rumah sakit dalam mengawasi tindakan fraud. Apakah RSUD Banyumas memiliki tim fraud yang bertugas mengawasi, mencegah dan memberikan sanksi apabila terjadi fraud? Belum ada satupun penelitian tentang peran dokter dalam fraud di era JKN di rumah sakit, tetapi pada penelitian lain ditemukan adanya fraud di rumah sakit dan ada potensi fraud di RS. Bahkan KPK mendeteksi adanya potensi fraud oleh dokter. Tujuan penelitian ini adalah untuk menggambarkan bagaimana peran dokter dalam fraud di era JKN di RSUD Banyumas. Penelitian ini adalah penelitian analisis deskriptif dengan pendekatan kuantitatif dan kualitatif (mixed methods). Teknis analisis untuk data primer menggunakan analisis deskriptif kuantitatif, dan untuk data sekunder dilakukan perhitungan sendiri (manual) lalu dianalisis secara deskriptif kualitatif. Sampel penelitian diambil dengan cara pengambilan "Purposive Sampling". Data primer dari hasil kuisioner dan wawancara. Data sekunder berasal dari RSUD Banyumas, tim fraud dan manajemen RSUD Banyumas. Teknik analisis data menggunakan metode studi kasus. Validitas data diperiksa dengan metode triangulasi. Penelitian dilakukan di RSUD Banyumas yang merupakan RSUD kelas B Pendidikan dan melibatkan 38 informan dokter spesialis yang melayani pasien BPJS rawat inap, 5 informan manajer dan 9 informan tim fraud. Hasil penelitian menunjukkan bahwa sebagian informan dokter spesialis RSUD Banyumas tidak tahu tentang poin-poin fraud. Ada tiga tindakan fraud yang pernah dilakukan oleh dua informan dokter spesialis di RSUD Banyumas, yaitu *Self referals, Standard of care dan Phantom visit.* Semua manajer tahu tentang poin fraud. Telah ada pengawasan dari pihak manajemen RSUD Banyumas agar tidak terjadi fraud dengan dibentuknya tim pencegahan atauanti fraud, tetapi sosialisasi belum maksimal. Ada sosialisasi dari manajemen pada rapat rutin dan ada tim Kendali Mutu dan Kendali Biaya (KMKB). Adanya audit mutu klinis serta rapat koordinasi dengan tim fraud. Sudah ada tim fraud di RSUD Banyumas berdasarkan SK Direktur RSUD Banyumas nomor 17 tahun 2020. Timfraud sudah berfungsi mengawasi tetapi belum maksimal, sudah berfungsi mencegah tetapi belum seratus persen, dengan sosialisasi dan adanya notulensi rapat serta rapat koordinasi dengan manajer. Tim fraud belum berfungsi memberikan sanksi, karena menurut tim fraud tidak ada tindakan fraud.

SUMMARY

Fraud is an act that is carried out intentionally to obtain financial benefits in the Health Insurance Program in the national social security system through fraudulent acts that are not in accordance with the provisions of the legislation. Fraud in the JKN Era seemed to be directed at doctors, even though doctors in their work received supervision from various parties. How to socialize the points of fraud (Permenkes No 36, 2015 updated Permenkes No 16, 2019) to doctors from hospital management. What is the role of managers in hospitals in supervising fraud. Does RSUD Banyumas have a fraud team tasked with supervising, preventing and imposing sanctions in case of fraud? There has been no research on the role of doctors in fraud in the JKN era in hospitals, but other studies have found fraud in hospitals and potential for fraud in hospitals. Even the Corruption Eradication Commission has detected potential fraud by doctors. The purpose of this study is to describe the role of doctors in fraud in the JKN era at Banyumas Hospital. This research is a descriptive analysis research with quantitative and qualitative approaches (mixed methods). Technical analysis for primary data using quantitative descriptive analysis, and for secondary data self-calculation (manual) and then analyzed descriptively qualitatively. The research sample was taken by taking "Purposive Sampling". Primary data from the results of questionnaires and interviews. Secondary data came from the Banyumas Hospital, the fraud team and the management of the Banyumas Hospital. The data analysis technique used the case study method. The validity of the data was checked by triangulation method. The study was conducted at the Banyumas Hospital, which is a Class B Education Hospital and involved 38 specialist doctor informants who serve inpatient BPJS patients, 5 manager informants and 9 fraud team informants. The results showed that some of the informants who were specialist doctors at the Banyumas Hospital did not know about the points of fraud. There were three acts of fraud that had been carried out by two specialist doctor informants at the Banyumas Hospital, namely Self referrals, Standard of care and Phantom visits. All managers know about fraud points. There has been supervision from the management of the Banyumas Hospital to prevent fraud by forming a prevention or anti-fraud team, but socialization has not been maximized. There is socialization from management at regular meetings and there is a Quality Control and Cost Control team (KMKB). There is a clinical quality audit and coordination meeting with the fraud team. There is already a fraud team at the Banyumas Hospital based on the Decree of the Director of the Banyumas Hospital number 17 of 2020. The Fraud team has the function of supervising but not optimally, it has functioned to prevent but not one hundred percent, with socialization and the existence of meeting minutes and coordination meetings with managers. The fraud team has not functioned to provide sanctions, because according to the fraud team there is no fraud.