

SIMRS Fraud Against INA-CBGs/INA-DRG in the Implementation of KRIS in Hospitals

Andi Yaumil Bay R Thaifur^{1*}, Reski Dewi Pratiwi¹, Afriyana Amelia Nuryadin¹, Mangindara¹

¹Institut Ilmu Kesehatan Pelamonia Kesdam XIV Hasanuddin, Makassar, Indonesia

*Corresponding author: andiyaumilbay.t@gmail.com

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ABSTRACT

Hospital Management Information Systems (SIMRS) serve as a critical foundation for ensuring the accuracy of National Health Insurance (JKN) claims under the Indonesian Case Based Groups (INA-CBGs/INA-DRG) payment system. However, limited SIMRS integration quality combined with the policy shift toward Standard Inpatient Class (KRIS) implementation pursuant to Presidential Regulation No. 59 of 2024 potentially increases the risk of data conflicts and claim fraud in hospitals. This systematic literature review aimed to examine the role of SIMRS in potential fraud within INA-CBGs/INA-DRG claims during KRIS implementation. A systematic literature review using descriptive qualitative analysis was conducted across PubMed/Medline, ScienceDirect, Wiley Online Library, Cochrane Library, and Google Scholar. From 205 initially identified articles, five primary studies were included. Significant weaknesses were found in SIMRS integration, data quality, and claim verification that increased fraud risk. BPJS Kesehatan data indicated potential fraud amounting to IDR 866.8 billion was successfully prevented in 2023. A negative tariff disparity averaging IDR 3,036,855.37 (36.66%) was identified for Caesarean section cases. Fingerprint-based verification technology reduced fraud to 0.01% in one facility. An integrated and reliable SIMRS supported by verification technology plays a strategic role in preventing INA-CBGs/INA-DRG claim fraud and supporting effective KRIS implementation.

INTRODUCTION

The digital revolution in the healthcare sector has positioned the Hospital Management Information System (SIMRS) as a critical component in enhancing the effectiveness, efficiency, and accountability of hospital services. SIMRS serves as the foundation for managing clinical, administrative, and financial data, while simultaneously functioning as an essential instrument for ensuring the quality and integrity of health data. The complexity of national policies, particularly within the National Health Insurance (JKN) financing system, demands an adaptive and reliable SIMRS capable of responding to changes accurately and consistently.¹

The JKN program managed by BPJS Kesehatan has covered more than 252 million participants, approximately 92.31% of the total Indonesian population, as of March 2023.² In 2023, total healthcare expenditure under JKN reached IDR 158 trillion. The magnitude of this budget underscores the urgency of a claim management system that is accurate, transparent, and free from fraud.

Healthcare fraud is not merely a national issue but an international challenge. It is estimated that fraud consumes up to 10% of total healthcare expenditure worldwide.³ In Indonesia, fraud has contributed to BPJS Kesehatan budget deficits, reaching IDR 3.3 trillion in 2014, rising to IDR 5.7 trillion in 2015, and IDR 9.7 trillion in 2016.²

The JKN payment system employs the Indonesian Case Based Groups (INA-CBGs/INA-DRG) method, which is highly dependent on the accuracy of clinical and administrative data. Fraud, as defined under Ministry of Health Regulation No. 16 of 2019, constitutes intentional acts committed to obtain financial benefits from the JKN program through deceptive acts inconsistent with applicable regulations.⁴ Various experts define fraud as acts involving deception, falsification, and record manipulation to obtain unjust or illegal advantages.⁵

Based on Cressey's Fraud Triangle Theory (1953), fraudulent acts are driven by three main factors: pressure, opportunity, and rationalization.⁶ Further developments produced the Fraud Diamond Theory adding capability, and the Fraud Pentagon Theory adding arrogance and collusion as additional predictors.⁶ In the JKN context, financial pressure from tariff disparities between actual hospital costs and INA-CBGs rates, combined with weak SIMRS verification as opportunity, and justification of fraudulent acts as rationalization, form a conducive ecosystem for fraud.

The Deputy Chairman of the Corruption Eradication Commission (KPK), Alexander Marwata, disclosed that healthcare fraud losses reach 10 percent of public health expenditure, approximately IDR 20 trillion.⁷ KPK investigations in 2024 identified phantom billing of physiotherapy services at three private hospitals, where of 4,341 claimed cases, only 1,072 cases (24.7%) had valid medical record documentation.⁸

Implementation of the Standard Inpatient Class (KRIS) policy under Presidential Regulation No. 59 of 2024, replacing the existing inpatient class system with uniform facility standards, adds further complexity to the challenges facing hospitals. This policy requires fulfillment of 12 standard inpatient facility criteria by June 30, 2025, directly impacting INA-CBGs tariff calculations. Without adequate SIMRS support, the KRIS transition potentially increases claim data inconsistencies and fraud risk.^{9,44}

An in-depth study of SIMRS's role in preventing INA-CBGs/INA-DRG claim fraud during KRIS implementation is therefore critically important as a basis for improving information systems, internal controls, and long-term sustainable healthcare financing governance.

MATERIALS AND METHODS

Study Design

This study employed a systematic literature review approach using descriptive qualitative analysis to identify, evaluate, and synthesize scientific evidence regarding the relationship between SIMRS, INA-CBGs/INA-DRG claim fraud, and KRIS implementation in Indonesian hospitals.

Literature Search Strategy

Literature searches were conducted in both international and national scientific databases, including PubMed/Medline, ScienceDirect, Wiley Online Library, Cochrane Library, and Google Scholar. Search keywords included: "Hospital Management Information System (SIMRS)", "INA-CBG/INA-DRG", "JKN claim fraud", "BPJS Kesehatan claim fraud", "health information system integration", "Standard Inpatient Class (KRIS)", "claim verification", and "JKN pending claim".

Inclusion and Exclusion Criteria

Inclusion criteria comprised: (1) scientific publications on the use, integration, or evaluation of SIMRS in hospital services; (2) articles on INA-CBGs/INA-DRG claim systems including administrative, financial, and internal control aspects; (3) articles on JKN claim fraud or potential anomalies in healthcare financing systems; (4) articles relevant to KRIS policy and its implementation readiness in hospitals; and (5) publications in Indonesian or English that had undergone peer review.

Exclusion criteria included: (1) articles unrelated to health information systems, JKN claims, or hospital governance; (2) articles addressing only technical aspects of information technology without relevance to claim processes or healthcare management; and (3) non-scientific materials including popular opinions, non-academic reports, or papers that had not undergone peer review.

Data Extraction and Analysis

Data extraction was performed systematically, identifying key information from each article meeting the inclusion criteria, including author names, year of publication, study objectives, research methods, population or setting, and major findings related to SIMRS implementation, INA-CBGs/INA-DRG claim processes, fraud potential, and KRIS readiness. Data were then thematically analyzed to identify patterns, similarities, and differences in findings across studies, building a comprehensive synthesis of SIMRS's role in preventing claim fraud.

RESULTS

Literature Search Results

Based on the applied search strategy, a total of 205 articles were obtained from various databases within the last five years. Following title and abstract screening and application of inclusion and exclusion criteria, five primary articles were selected as primary literature sources meeting all research criteria. These five articles were analyzed in depth and are presented in the following table:

Table 1. Summary of Selected Literature

No	Article Title	Author (Year)	Method	Key Findings
1	Analysis of SIMRS User Satisfaction on JKN Claims at RSUD Khidmat Sehat Afiat, Depok City, 2023	Adawiyah & Sutiawan (2025)	Quantitative cross-sectional	SIMRS integration with INA-CBGs E-Claim and V-Claim is essential for JKN claim success. System changes hindered the claim process; however, user satisfaction positively affected system quality, information quality, service quality, and net benefits.
2	Evaluation of Fingerprint Use as a Fraud Prevention Measure for BPJS Outpatient Participants at RSIA X Kupang	Amabi et al. (2025)	Qualitative in-depth interview	Fingerprint-based biometric verification significantly reduced fraud potential, with only 2 of 14,817 patients (0.01%) identified as fraudulent in 2024, demonstrating the need for proper evaluation to optimize service quality.
3	Cost Difference Analysis Between Hospital Actual Rates and INA-CBGs Rates in Caesarean Section Cases at Panti Nugroho Hospital	Pradnyantara (2023)	Qualitative descriptive	A negative disparity was identified between hospital actual rates and INA-CBGs tariffs for Caesarean section cases, with a mean difference of IDR 3,036,855.37 (36.66%), indicating that hospital rates exceed INA-CBGs tariffs.
4	Descriptive Analysis of BPJS Inpatient Document Completeness Against Claims at RSUD Bandung City, August 2024	Latifah et al. (2025)	Qualitative descriptive	Incomplete BPJS inpatient documents were the primary cause of pending and rejected claims. Outdated SIMRS and poor medical record completion contributed directly to claim data inconsistencies and potential administrative fraud.
5	Implementation of Fraud Prevention Policy in the National Health Insurance Program at Diponegoro National Hospital, Central Java	Sari et al. (2022)	Qualitative descriptive	Fraud prevention policy implementation was suboptimal due to weak internal PK-JKN team coordination, insufficient regulatory socialization to clinical staff, and lack of SIMRS-based audit system integration with BPJS Kesehatan control mechanisms.

Literature Review

SIMRS is a comprehensive system designed to manage all clinical, administrative, and financial data in a hospital setting. SIMRS constitutes the backbone of JKN claim processing under the INA-CBGs/INA-DRG system, a payment mechanism grouping diagnoses and medical procedures using ICD-10 and ICD-9-CM.¹⁰ The INA-CBGs tariff system encompasses 1,077 tariff groups consisting of 789 inpatient codes and 288 outpatient codes, grouped using the UNU-Grouper developed by the United Nations University.¹⁰

Fraud in the JKN context can involve various parties including participants, health facilities, healthcare workers, and insurance administrators. Various experts define fraud as acts encompassing cunning schemes, dishonesty, and improper means to deceive others for personal gain, causing harm to other parties.⁵ The Association of Certified Fraud Examiners (ACFE) defines fraud as deceptive acts resulting in unauthorized benefits for the perpetrator or certain parties.⁵

The Fraud Triangle Theory explains that fraud occurs through the interaction of three elements: financial pressure, opportunity, and rationalization of fraudulent actions.⁶ The Fraud Diamond Theory adds the perpetrator's capability factor, while the Fraud Pentagon Theory incorporates arrogance and collusion as additional predictors.⁶ These theories are directly relevant in the JKN fraud context, where financial pressure from tariff disparities, weak SIMRS verification as opportunity, and act justification as rationalization form an ecosystem conducive to fraud.

The Theory of Planned Behavior (Ajzen, 1991) is also relevant as a foundation for understanding fraudulent behavior, stating that an individual's intention to behave is determined by attitude, subjective norms, and perceived behavioral control.¹¹ Research demonstrates a significant positive relationship between perceived behavioral control and the intention to commit fraud, particularly when oversight systems are weak.¹¹

KRIS implementation under Presidential Regulation No. 59 of 2024 requires fulfillment of 12 standard inpatient facility criteria by June 30, 2025. Of 3,176 national hospitals, 3,060 will implement KRIS. These changes in service standards directly impact INA-CBGs tariff calculation mechanisms and demand higher SIMRS readiness.⁹

DISCUSSION

Role of SIMRS in INA-CBGs/INA-DRG Claim Accuracy

The literature review confirms that SIMRS quality and integration directly correlate with INA-CBGs/INA-DRG claim accuracy. Adawiyah and Sutiawan's study¹² at RSUD Khidmat Sehat Afiat demonstrated that SIMRS user satisfaction, reflecting system quality, information quality, and service quality, positively influences the success of JKN claim processing. This aligns with the DeLone and McLean Information Systems Success Model, which identifies system quality, information quality, and service quality as key determinants of information system effectiveness.¹³

The study by Nazla Nur Latifah et al.¹ revealed that incomplete BPJS inpatient documentation was the primary cause of pending and rejected claims at RSUD Bandung City. This illustrates that imperfect SIMRS integration with claim systems creates opportunities for data inconsistencies. A study at RS UNS also reported that 11.3% of inpatient claim files for the August–October 2023 period had pending status due to coding confirmation issues, with diagnosis inaccuracy as the primary cause.¹⁴

BPJS Kesehatan implements a multilayer claim verification system comprising initial verification, post-claim verification (VPK), and claim administrative audit (AAK). In 2023, average payment time was 11.5 working days for FKTP and 13.7 calendar days for FKRTL, reflecting system efficiency supported by adequate information infrastructure.¹⁵

Claim Fraud and Contributing Factors

Various studies identify the most common fraud patterns in JKN claims: (1) phantom billing, where services are claimed but never provided; (2) upcoding or diagnostic manipulation to obtain higher INA-CBGs tariffs; (3) undercoding occurring when hospital actual rates exceed INA-CBGs tariffs; and (4) duplicate or repeated claims due to weak patient identity verification systems.^{16,17}

Pradnyantara's study¹⁸ revealed an average negative disparity of IDR 3,036,855.37 (36.66%) between actual hospital rates and INA-CBGs tariffs for Caesarean section cases. This creates financial pressure (pressure) consistent with the Fraud Triangle Theory,⁶ potentially driving fraudulent behavior. Tariff disparity is a structural triggering factor compounded by INA-CBGs tariffs that increased only 9.5% through Ministry of Health Regulation No. 3 of 2023 after nearly six years without adjustment.¹⁹

The study by Pratila Sari et al.²⁰ at Diponegoro National Hospital found that fraud prevention policy implementation was suboptimal due to weak internal PK-JKN team coordination, insufficient regulation socialization, and the absence of SIMRS-based audit system integration. This reinforces that opportunity, the second element of the Fraud Triangle, remains open due to deficiencies in the oversight system.⁶

KPK and PK-JKN team investigations in 2024 identified phantom billing of physiotherapy at three private hospitals, where only 1,072 of 4,341 claimed cases (24.7%) had medical record documentation.⁸ This condition was previously detected as early as mid-2015, when fraud was identified in up to 175,774 FKRTL claims worth IDR 440 billion, though observations were then limited to the provider group.²

Verification Technology as Fraud Prevention Solution

Sumiati Amabi et al.²¹ provided empirical evidence that biometric-based identity verification technology (fingerprint) can significantly reduce fraud potential. At RSIA X Kupang, fingerprint system implementation reduced fraud rates to only 0.01% (2 of 14,817 patients) in 2024. This finding affirms that technological innovation in SIMRS, particularly regarding patient identity verification, represents an effective investment in fraud prevention.

BPJS Kesehatan has also developed a Whistle Blower System (WBS) as a fraud reporting mechanism and conducts periodic post-claim clinical audits (AAK).¹⁶ The JKN Fraud Prevention and Handling Team (PK-JKN) formed under Ministry of Health Regulation No. 16 of 2019 encompasses elements from Kemenkes, BPKP, KPK, and BPJS Kesehatan.⁴

Research by Bauder et al.²² on machine learning-based fraud detection in healthcare insurance systems demonstrated that data mining techniques applied to integrated electronic medical record systems can detect anomalous claim patterns with over 85% accuracy. This reinforces the urgency of transitioning from manual to automated, SIMRS-integrated verification.

Implications of KRIS for SIMRS and Fraud Risk

KRIS implementation introduces fundamental changes in hospital inpatient data management. The elimination of class differentiation (classes 1, 2, and 3) replaced by 12 uniform facility criteria directly impacts INA-CBGs tariff calculation mechanisms. Research from CHEPS UI (2024) indicated that hospitals were concerned about negative impacts on cash flow during the KRIS transition period, concurrent with plans to revise the payment system from INA-CBGs to INA-DRG.²³

Munadi et al.'s study²⁴ at RS Muhammadiyah Lamongan found that several KRIS criteria remained incompletely fulfilled, with space limitations and renovation costs as primary constraints. This situation can create inconsistencies between facility data recorded in SIMRS and actual conditions, potentially exploited for claim fraud.⁴⁴

The literature review by Syntax Literate^{25,44,45} on hospital readiness for KRIS implementation confirmed that technological infrastructure including SIMRS is the most critical determinant of implementation success. Hospitals with well-integrated SIMRS demonstrated significantly better readiness in adapting to new policy requirements compared to those with fragmented information systems.

Strategic Recommendations

Based on the synthesis of findings, several strategic recommendations can be implemented: (1) hospitals should design and periodically update SIMRS to reflect changes in INA-CBGs/INA-DRG claim systems and KRIS policies, including coding system updates per Ministry of Health Regulation No. 26 of 2021; (2) system integration should be strengthened, particularly between SIMRS, INA-CBGs E-Claim v5, and V-Claim BPJS Kesehatan, to minimize manual input; (3) implementation of biometric-based control technology or SIMRS-based internal audit systems is recommended as an early fraud prevention measure; (4) continuous capacity building for human resources, particularly coders and SIMRS staff; and (5) strengthening periodic SIMRS-based internal audit mechanisms to detect claim anomalies before submission to BPJS Kesehatan.^{26,27,28}

CONCLUSION AND RECOMMENDATIONS

SIMRS plays a critical and strategic role in ensuring the accuracy of INA-CBGs/INA-DRG claims and supporting effective, transparent, and accountable KRIS implementation in hospitals. Limitations in system quality, integration, and SIMRS data verification increase fraud probability, particularly in the context of financial pressure from the disparity between hospital actual rates and INA-CBGs tariffs.

Empirical evidence demonstrates that biometric-based identity verification technology and enhanced information system integration can significantly reduce fraud risk and improve JKN claim accountability. KRIS implementation demands a more adaptive and policy-responsive SIMRS. Continuous SIMRS improvement through strengthened technical integration, verification technology utilization, human resource capacity building, and comprehensive regulatory mechanisms constitutes an essential component of transparent and sustainable healthcare financing governance.

Future research is recommended to empirically investigate the relationship between hospital and INA-CBGs tariff disparities with fraud risk levels, and to analyze SIMRS effectiveness in supporting national KRIS implementation using multi-site study approaches.

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