Research Article

Fraud Prevention Legal Certainty Principle In Health Sector and Implementation of Health Insurance Program in Indonesia

Endah Labati Silapurna
Idaman Hospital in Banjarbaru, South Kalimantan, Indonesia

Correspondence Email: endahlabaty2004@gmail.com

ABSTRACT

The Corruption Eradication Committee (KPK) says that high number of potential irregularities occurs most often in the health sector and in the implementation of the National health insurance program as obtained through efforts to prevent, coordinate, and synergize with relevant government agencies, such as the BPK, the BPKP, etc. It is important for early detection of fraud along with repressive actions and sanctions that need to be followed up if there is such a potential. The issues to be discussed here are How do the laws and regulations regulate fraud prevention in the health sector in Indonesia, What is the relationship between the statutory norms regarding Fraud Prevention and the Principle of Legal Certainty? This research method uses a normative juridical approach, and the specifications of the data used in this study are qualitative secondary data. The data collection method used is literature study. The conclusion, in the form of a provisional answer: if regulations are formed relating to fraud prevention in Indonesia referring to the 1945 Constitution of the Republic of Indonesia, where everyone is entitled and guaranteed by the constitution to maintain life and receive services maximally, then the principle of legal certainty is fulfilled.

Keywords: Fraud prevention, principle of legal certainty, statutory norms

INTRODUCTION

Efforts to improve the quality of human life in the health sector is a very broad and comprehensive effort. These efforts include improving health, both physical and non-physical. In the National Health System (NHS) it is stated that health concerns all aspects of life whose scope and scope is very broad and complex. This is in line with the notion of health given by the social world, well being and not merely the absence of disease or infirmity.[1] Health is a human right and one of the elements of welfare that must be realized in accordance with the ideals of the Indonesian nation as referred to in Pancasila and the Preamble to the 1945 Constitution of the Republic of Indonesia. This can be seen especially in the 5th precepts and in Article 28H and Article 34 the 1945 Constitution (hereinafter abbreviated as UUD 1945). Furthermore, in Article 5 paragraph[2] of Law no. 36 of 2009 concerning Health it is emphasized that everyone has the right to obtain safe, quality and affordable health services. In addition, health development must basically be carried out on the principle of protection. This is as confirmed in Article 2 of Law no. 36 of 2009, that Health development must be carried out based on the principle of protection. This means that health development must be able to provide legal protection and certainty to providers and recipients of health services.

From the above understanding, it can be understood that basically health problems involve all aspects of life and cover all the time of human life, both past life, present life, and future life. Judging from the history of its development, there has been a change in value orientation and thinking about efforts to solve health problems. The process of changing the orientation of values and thoughts in question always develops in line with technological and socio-cultural developments. The main problem now is that the capacity of health management which is the key to the success of health development is currently not fully adequate. Some of the factors that cause it are the inadequacy of the health information system to be disseminated to the public, the integration of health services that has not gone well, the control and supervision and evaluation of the established programs are not yet stable.[2] Through the National Social Security System as a form of social protection, it essentially aims to ensure that all people can fulfill their basic needs for a decent life. To realize the global

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commitment as mandated by the 58th World Health Assembly (WHA) resolution in 2005 in Geneva which wants every country to develop Universal Health Coverage (UHC) for the entire population, the government is responsible for implementing public health insurance through the National Health Insurance (JKN) program . Furthermore, to overcome this problem, Law Number 40 of 2004 was issued in 2004 which mandates that the social security program is mandatory for all residents, including the Health Insurance program through a social security administration agency.

The social security administering body has been regulated by Law Number 24 of 2011 concerning the Social Security Administering Body (BPJS), which consists of BPJS employment. For the Health Insurance program organized by BPJS Health, its implementation has started on January 1 2014. The program is hereinafter referred to as the National Health Insurance (NHI) program. Implementation Guidelines Technical Guidelines Furthermore, Law no. 40 of 2004, specifically that the implementation of a mandatory social security program for all residents, including a health insurance program through a social security administering agency. Therefore, everyone has access to resources in the health sector and obtains proper, safe, quality and affordable health services.

Since the enactment of the National Health Insurance, the potential for fraud in health services is increasingly visible in Indonesia. This potential can become wider due to pressure from the new financing system in Indonesia, minimal supervision and a tone of justification when taking this action. Health service fraud has the potential to harm the state health fund and reduce the quality of health services. The Corruption Eradication Commission of Indonesia (KPK) has begun to actively carry out activities to assess potential fraud in the health sector. Corruption is part of fraud. In the health sector, the term fraud is more commonly used to describe forms of fraud, not only in the form of corruption, but also including misuse of assets and falsification of statements. Fraud in the health sector can be carried out by all parties involved in the National Health Insurance program, BPJS health participants, and providers of drugs and medical devices. The magnitude of the potential loss caused the government to issue Ministry of Health Regulation No. 16 of 2019 concerning the Prevention and Handling of Fraud and the imposition of administrative sanctions against fraud (Fraud) in the implementation of the Health Insurance Program. The basic considerations for making PMK 16/2019 are: 1. The implementation of the Health Insurance Program can run effectively and efficiently. Efforts need to be made to prevent the loss of social security funds due to fraud; 2. The implementation of the Health Insurance Program in the National Social Security System needs to be adjusted to the needs of the implementation of the Health Insurance program.

The definition of fraud is an act that is carried out intentionally to obtain financial benefits from the health insurance program in the national social security system through fraudulent acts that are not in accordance with the provisions of the legislation. Meanwhile, Health Insurance is a guarantee in the form of health protection so that participants receive health care benefits that are given to everyone who has paid the Health Insurance contribution or the health insurance contribution is paid by the Central Government or Local Government.

Fraud in the implementation of the Health Insurance Program can be by: participants, BPJS Health, Health Facilities or health service providers, providers of drugs and medical devices, other stakeholders. Fraud in health services is referred to as a form of effort that is intentionally carried out by creating an advantage that should not be enjoyed by either individuals or institutions and can harm other parties. As stated above, the loss of health social security funds due to fraud requires prevention with a national policy on fraud prevention so that the implementation of the national health insurance program in the national social security system can run effectively and efficiently.

The objectives of this study are two-fold as: Explore and analyze the prevention of fraudandthe causal relationship between the laws and regulations regarding fraud prevention.

Based on the background above, the problems to be discussed are: 1) How do the statutory norms regulate fraud prevention in the health sector in Indonesia; and 2) How is the relationship between the statutory norms regarding fraud prevention and the principle of legal certainty.

METHOD

This study uses a normative juridical approach, which is a way of researching in legal research conducted on library materials or secondary data, using deductive thinking methods and coherent truth criteria. The research specification used is secondary data which is qualitative. The data collection method used is literature study.

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RESULT AND DISCUSSION

How do the statutory norms regulate fraud prevention in the health sector in Indonesia

Fraud is literally defined as fraud, but this understanding has been further developed so that it has a broad scope. Black's Law Dictionary Fraud describes The notion of fraud includes everything that a human being can think of, and which a person seeks, to take advantage of another person by wrong advice or coercion of truth, and includes all ways that are unexpected, full of tactics. Cunning, hidden, and every dishonest way that causes others to be deceived. In short, it can be said that fraud is a fraudulent act (cheating) related to a certain amount of money or property.[3] The fraud triangle theory is an idea that examines the causes of fraud. This idea was first coined by Donald R. Cressey (1953) introduced in the professional literature in Statement on Auditing Standards (SAS) No. 99, which is called the fraud triangle. Cressey was quoted by Abdullahi R. and Mansor N. as saying "The hypothesis about the fraud triangle is to explain the reasons why people commit fraud. Based on research conducted, Cressey found that people commit fraud when they have financial problems that cannot be solved together, know and believe that these problems can be solved secretly with the position/job they have and change the mindset of their concept as a person. who are entrusted with holding assets become their concept as users of the assets entrusted to them.[4]

Cressey also adds that many of these breaches of trust know that what they are doing is illegal, but they are trying to create the idea that what they are doing is normal. The fraud triangle describes three factors that are present in every fraud situation, namely: 1) Pressure, namely the existence of an incentive/pressure/need to commit fraud. Pressure can cover almost anything including lifestyle, economic demands, and others including financial and non-financial matters. According to SAS No. 99, there are four types of conditions that commonly occur in pressure that can lead to fraud. Namely financial stability, external pressure, personal financial need, and financial targets, for example debts or bills that accumulate, a luxurious lifestyle, drug dependence, etc. In general, what drives fraud is financial need or problems. But there are also many who are only driven by greed; 2) Opportunity (opportunity), which is a situation that opens an opportunity to allow a fraud to occur. Usually occurs due to weak company internal controls, lack of supervision and abuse of authority. Among other elements of the fraud diamond, opportunity is the element that is most likely to be minimized. Opportunity is an opportunity that allows fraud to occur. Among the 3 elements of the fraud triangle, opportunity is the most likely element to be minimized through the implementation of processes, procedures, and controls and early detection of fraud. through the implementation of processes, procedures, and early detection of fraud. 3) Rationalization (rationalization) is the existence of an attitude, character, or set of ethical values that allow certain parties to commit fraudulent acts, or people who are in a sufficiently stressful environment that makes them rationalize fraud. The most widely used rationalization or attitude is only borrowing stolen assets and the reason that their actions are to make their loved ones happy. Rationalization is an important element in the occurrence of fraud, where perpetrators seek justification for their actions, for example: a) That his actions are to make his family and loved ones happy; b) The offender's tenure is quite long and he feels he should be entitled to more than he has now (position, salary, promotion); and c) The company has made huge profits and it is okay if the perpetrators take a small share of the profits. On the other hand, the fraud triangle has weaknesses, namely pressure and rationalization factors that cannot be observed and also other limitations in detecting the fraudulent motives of the perpetrators. Limitations in the fraud triangle can be improved with the second fraud triangle model, namely Act, concealment (Concealment), and Conversion.[5]

Based on the Uniform Occupational Fraud Classification System, The ACFE (2012) divides fraud into 3 (three) types or typologies based on actions, including: 1. Misappropriation of assets (Asset Misappropriation). Asset misappropriation includes misuse/theft of assets or assets of the company or other parties. This is the easiest form of fraud to detect because it is tangible or can be measured/calculated (defined value). 2. Fraudulent statements include actions taken by officials or executives of a company or government agency to cover up the actual financial condition by performing financial engineering in the presentation of its financial statements to obtain profits or may be analogous to window dressing terms. 3. Corruption, this type of fraud is the most difficult to detect because it involves cooperation with other parties such as bribery and corruption, where this is the most common type in developing countries where law enforcement is weak and lacks awareness of good governance so that the integrity factor is still questionable. This type of fraud often cannot be detected because the collaborating parties enjoy the

benefits (symbiosis mutualism). In this case, there is an abuse of authority/conflict of interest, bribery, illegal acceptance (illegal gratuities), and economic extortion.

In article 2 paragraph 1 of the Minister of Health Regulation 16/2019 it is stated that BPJS Health, District/City Health Offices, and FKRTL with BPJS Health must build a fraud prevention system (Fraud) through: Formulation of policies and guidelines Fraud prevention, fraud prevention guidelines, Development of culture of fraud prevention (Fraud), Development of health services oriented to quality control and cost control, Formation of a fraud prevention team. The Fraud Prevention Team at the district/city Health Office consists of elements: District/City Health Office, BPJS Health, Association of Health Facilities, Professional organizations, Other related elements.

According to the provisions of Article 2 of the Minister of Health Regulation No. 16/2019, those who can commit fraud are: participants, BPJS Health officers, health service providers; and/or, providers of drugs and medical devices. In principle, JKN participants have the potential to commit fraud as stated on pages 49 and 50. Fraud committed by participants, as specified in Article 3 of the Minister of Health Number 16 of 2019 can be in the form of: a. Making a statement that is not true in terms of eligibility (falsifying membership status) to obtain health services; b. Take advantage of their rights for unnecessary services by falsifying health conditions; c. Giving gratuities to service providers so that they are willing to provide services that are not appropriate/not covered; d. Manipulating income so that you don't have to pay too large contributions; e. Collaborating with service providers to submit false claims; f. Obtain medicines and/or medical devices that are prescribed for resale; and/or g. Performing other JKN fraudulent acts other than letters a to f. Losses are also not only done by JKN participants, but are actually carried out by BPJS Health officers themselves. This is as stated in the provisions of Article 4 of the Minister of Health Number 16 of 2019, that the JKN fraudulent actions carried out by BPJS Health officers include: a. Collaborating with participants and/or health facilities to submit false claims; b. Manipulating benefits that should not be guaranteed to be guaranteed; c. Withholding payments to health facilities/partners with the aim of obtaining personal gain; d. Paying capitation funds is not in accordance with the provisions; and/or e. Perform other JKN fraudulent actions other than letter a to letter d. The most classic form of fraud committed by BPJS officers is cooperation with participants and/or health facilities to submit false claims and manipulate benefits that should not be guaranteed so that they can be guaranteed.

For JKN fraud acts carried out at FKRTL according to Article 5 of the Minister of Health Regulation Number 16 of 2019 include: a. Excessive writing of diagnostic codes/upcoding, namely changing the diagnostic code and/or procedure to a code that has a higher rate than it should be; b. Plagiarism of claims from other patients/cloning, namely claims made by copying from other existing patient claims; c. False claims/phantom billing are claims for services that were never provided; d. Inflated bills for drugs and medical equipment/inflated bills, namely claims for the cost of drugs and/or medical devices that are greater than the actual costs. e. Solving service episodes/services unbundling or fragmentation, namely claims for two or more diagnoses and/or procedures that should be a service package in the same episode or billing several separate procedures that should be billed together in the form of service packages, to get the claim value greater in one episode of patient care; f. Pseudo-referrals/self-referals, are claims for service costs due to referrals to the same doctor at another health facility except for reasons of the facility; g. Repeat billing, is a claim that is repeated in the same case; h. Prolonged length of stay is a claim for higher health care costs due to changes in the length of the day of hospitalization; i. Manipulating the class of care / type of room charge, is a claim for the cost of health services that is greater than the actual cost of treatment class; j. Canceling a mandatory action/cancelled service is a claim for a diagnosis and/or action that has not been implemented; k. Taking unnecessary actions/no medical value, is a claim for actions that are not based on medical needs or indications; l. Deviations from service standards/standard of care, are claims for diagnoses and/or actions that are not in accordance with service standards; m. Taking unnecessary treatment, is a claim for unnecessary action. n. Increasing the length of time you use the ventilator is a bigger claim due to the additional length of time you use a ventilator that doesn't match your needs; o. Not doing the proper visitation/phantom visit, is a claim for a fake patient visit; p. Not performing the procedure as it should be/phantom procedures, are claims for actions that were never performed; q. Repeat admissions/readmissions, are claims for diagnosis and/or treatment of one episode that are treated or claimed more than once as if more than one episode. Furthermore, acts of JKN fraud committed by drug and medical

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device providers according to the provisions of Article 2 of the Minister of Health Number 16 of 2019 include: a. Does not meet the need for drugs and/or medical devices in accordance with the provisions of the legislation; b. Cooperating with other parties to change drugs and/or medical devices listed in the e-catalog at prices that are not in accordance with the e-catalog; and commit other fraudulent acts other than letter a and letter b. As a concrete example, fraud that may occur at the FKRTL level is the writing of excessive diagnostic codes (upcoding). This form of fraud was triggered by several things, for example, because they felt that the costs listed in the INA-CBGs package were considered low, the hospital looked for other ways to make a profit.

Payment of BPJS Health claims to the hospital according to the package rate. Indonesia Case Based Groups (INA-CBGs) with no upper limit also trigger fraud. In addition, the current laws and regulations such as Law No. 40 of 2004 concerning the National Social Security System and Law No. 24 of 2011 concerning BPJS are not strong enough to prevent fraud. Permenkes No. 16 of 2019 instructs each related party to build a fraud prevention system. For BPJS Health, Minister of Health Regulation 16 of 2019 orders the formulation of policies and guidelines for preventing JKN fraud, developing a culture of preventing JKN fraud as part of good organizational governance and forming a JKN fraud prevention team at BPJS Health. FKRTL must establish a similar system as mandated by Permenkes 16 of 2019. The role of the community is also needed to prevent fraud in the JKN program, because anyone who knows of fraud in the JKN program can file a complaint. The way, the complainant submits in writing to the head of the health facility, district/city and/or provincial health office. Complaints must be completed with data on the identity of the complainant, then the name and address of the agency suspected of committing fraud and the reasons for the complaint.

Development of a fraud prevention system according to Permenkes No. 16 of 2019 must go through three things, namely: a. FKRTL prepares internal regulations in the form of good organizational and clinical governance. b. FKRTL is able to develop health services that are oriented towards quality control and cost control through the use of effective and efficient management concepts, evidence-based information technology and forming a JKN Fraud Prevention Team at FKRTL. c. FKRTL is able to develop a culture of preventing JKN fraud as part of organizational governance and clinical governance oriented to quality control and cost control based on TARIK principles (transparency, accountability, responsibility, independence and fairness).

Furthermore, specifically Minister of Health Regulation No. 16 of 2019 requires FKRTL to build a fraud prevention system, but has not yet explained the minimum standards that are clear what kind of prevention system FKRTL needs to build. Standards were submitted to FKRTL, so it was necessary to standardize the prevention system built by FKRTL to minimize the subjectivity of FKRTL owners or officials in building a prevention system. Permenkes No. 16 of 2019 stipulates that guidance and supervision in the context of preventing fraud in JKN is carried out by the Minister, Head of the Provincial Health Service and Head of District/City Health Office in accordance with their respective authorities. The forms of guidance and supervision are in the form of advocacy, socialization and technical guidance, training and capacity building of human resources as well as monitoring and evaluation. Furthermore, Permenkes 16 of 2019 regulates sanctions for fraud perpetrators. Administrative sanctions that can be imposed on perpetrators are verbal warnings, written warnings and/or orders to return losses to the injured party. The administrative sanctions, in principle, do not eliminate the penalties that can be imposed on the perpetrators of fraud or fraud as regulated in Article 378 of the Criminal Code. That is, the application of administrative sanctions must be synergistic with criminal sanctions. Therefore, in the future it is necessary to make special regulations governing fraud, in the form of the Anti-Fraud Law in Health Services. Complaints can be submitted to the head of the health facility, the District/City Health Office and/or the Provincial Health Office (Article 25 paragraph (2) of the Minister of Health Regulation No. 16 of 2019). Complaints to health facilities in this case are hospitals, both first level health facility (FKTP) and next level referral health facility (FKRTL).

Complaints in the FKTP are addressed to the JKN Fraud prevention team at the FKTP which was formed by the District/City Health Office. The JKN Fraud prevention team at FKTP consists of elements from the health office, professional organizations, BPJS Health, and health facility associations. According to the provisions of Article 11 paragraph (4) Minister of Health Regulation No. 16 of 2019 The JKN Fraud prevention team in FKTP as referred to in paragraph (2) is tasked with: a. Disseminate new policies, guidelines, and culture oriented towards quality control and cost control; b. Encouraging the implementation of

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good organizational and clinical governance; c. Carry out prevention, detection and prosecution of JKN fraud in FKTP; d. Resolving JKN fraud disputes; e. Monitoring and evaluation; and f. Reporting.

Good corporate governance in the hospital sector is a system (organization) of relationships within a hospital organization that contains elements of control, direction, accountability, and liability between owners, managers, and directors as well as operational management ranks as a unified movement to achieve the vision and mission of organizational values. Good and healthy governance through the principles of corporate governance will ensure the continuity and development of the hospital. The principles developed in corporate governance are openness, accountability, accountability to the assignor, integrity and fairness.

By referring to the provisions of Article 27 paragraph (2) of the Minister of Health Regulation No. 16 of 2019, fostering and supervising the prevention of JKN fraud in hospitals has involved hospital supervisory bodies, hospital supervisory boards, hospital associations/associations, and professional organizations. One of the components in this supervision is to monitor compliance with the application of hospital ethics, professional ethics, and laws and regulations, including Minister of Health Regulation No. 16 of 2019. Complaints about alleged JKN fraud must include at least the following: the identity of the complainant, the name and address of the agency suspected of committing JKN fraud, and the reasons for the complaint (Article 25 paragraph.[3] of the Minister of Health Regulation No. 16 of 2019). With the complaint of JKN fraud, the head of health facilities, the District/City Health Office and/or the Provincial Health Office must follow up.

How is the relationship between the statutory norms regarding Fraud Prevention and the Principle of Legal Certainty?

This principle is reviewed from a juridical point of view. Normative legal certainty is when a statutory regulation is made and promulgated with certainty, because it regulates clearly and logically, it will not cause doubt because of the existence of multiple interpretations, so it does not clash/cause norm conflicts. Norm conflicts arising from the uncertainty of laws and regulations can take the form of contestation, norms, norm reduction, or norm distortion. The principle of legal certainty is a principle which according to Gustav Radbruch is included in the basic value of law. This principle basically expects and requires that the law be made definitively in written form. The existence of this principle is important because it will ensure the clarity of an existing positive legal product. The important meaning of this principle also has a similarity with the main idea in the construction of legal positivism reasoning, namely clarity (certainty). According to Hans Kelsen, law is a system of norms. Norms are statements that emphasize the should or das sollen aspect by including some rules about what to do. Norms are deliterative products and human actions. Laws that contain general rules and regulations serve as guidelines for individuals to behave in society, both in their relationships with fellow individuals and in their relationships with society. These rules become limitations for society in burdening or taking action against individuals. The existence of these rules and the implementation of the rules do not create legal certainty.[6]

According to Utrecht, legal certainty has two meanings, firstly, the existence of general rules that make individuals know what actions may or may not be done, and secondly, in the form of legal security for individuals.[7] The general nature of the rule of law proves that the law does not aim to achieve justice and benefit, but solely for legal certainty. [8]

CONCLUSION

Legislative norms concerning Fraud Prevention in the Health Sector are regulated in Law No. 36 of 2009, Permenkes no. 16 / Year 2019. The statutory norms emphasize prevention, closing the room for potential fraud as small as possible, both from administrative, civil and criminal matters. Often the potential for fraud occurs not only because of the intention to enrich oneself, but maybe also because of maladministration etc. Courts for fraud should use an ad hoc court system, where one of the judges is a legal expert as well as an expert in health policy and financing and administration. The principle of legal certainty is the main and universal principle in the formation of legislation and is based on realizing the prevention and detection of fraud, supported by the principles of justice and the principle of expediency, always guided by religious norms and Pancasila. Fraud laws should be definite and not change policies too often.

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