
Advanced Certificate in Healthcare Fraud Case Studies

Legal Aspects of Fraud

Advanced Certificate in Healthcare Fraud Case Studies: A certificate program that provides in-depth study of real-world healthcare fraud cases, enabling students to understand the legal aspects of fraud in the healthcare industry.

Anti-kickback Statute (AKS): A federal law that prohibits the exchange of anything of value in return for referrals for services paid by federal healthcare programs, such as Medicare and Medicaid. It is designed to prevent fraud, waste, and abuse in these programs.

Billing Fraud: A type of healthcare fraud that involves submitting false or exaggerated claims to insurance companies or government programs for reimbursement. Examples include upcoding, unbundling, and phantom billing.

Claim: A request for payment submitted by a healthcare provider to an insurance company or government program for services provided to a patient.

Compliance Program: A set of internal policies, procedures, and controls designed to ensure that an organization follows all applicable laws, regulations, and standards. Compliance programs are mandatory for healthcare organizations that participate in federal healthcare programs.

False Claims Act (FCA): A federal law that imposes penalties on individuals and organizations that submit false or fraudulent claims to the government. It includes whistleblower provisions that allow individuals to report fraud and receive a portion of any recovery.

Fraud: The intentional deception or misrepresentation of facts for the purpose of financial gain. In healthcare, fraud can involve providers, suppliers, or patients.

Healthcare Fraud: The use of false or misleading information to obtain payment or reimbursement for healthcare services or products. It can involve providers, suppliers, or patients.

Medicaid: A joint federal-state program that provides healthcare coverage to low-income individuals and families.

Medicare: A federal program that provides healthcare coverage to individuals aged 65 and older, as well as some younger individuals with disabilities.

Phantom Billing: A type of billing fraud that involves submitting claims for services or items that were not provided or were not medically necessary.

Qui Tam: A provision of the False Claims Act that allows individuals to file lawsuits on behalf of the government and receive a portion of any recovery. Qui tam whistleblowers are also known as relators.

Stark Law: A federal law that prohibits physician self-referral for certain healthcare services paid by federal healthcare programs. It is designed to prevent conflicts of interest and ensure that medical decisions are based on patients' needs rather than financial incentives.

Upcoding: A type of billing fraud that involves submitting claims for more expensive services or procedures than were actually provided.

Unbundling: A type of billing fraud that involves submitting claims for individual components of a procedure or service, rather than the bundled rate that is typically used. This results in higher payments for the same services.

Whistleblower: An individual who reports fraud or misconduct, often as a protected activity under federal or state law. Whistleblowers may be eligible for rewards or protections under certain laws, such as the False Claims Act.

ZPIC: Zone Program Integrity Contractors are private companies hired by the Centers for Medicare and Medicaid Services (CMS) to investigate fraud, waste, and abuse in the Medicare program. They have the authority to conduct audits, issue subpoenas, and refer cases for criminal investigation.