
Advanced Certificate in Healthcare Fraud Investigation Best Practices

Unit 1: Introduction to Healthcare Fraud Investigation

Advanced Certificate in Healthcare Fraud Investigation Best Practices: A certificate program that provides students with advanced knowledge and skills in healthcare fraud investigation, with a focus on best practices for detecting, preventing, and prosecuting fraud.

Anti-kickback Statute (AKS): A federal law that prohibits the exchange of anything of value in return for referrals of federal healthcare program business, such as Medicare or Medicaid.

Billing fraud: A type of healthcare fraud that involves falsely billing for services or procedures that were not provided, were unnecessary, or were upcoded (billed at a higher level than actually provided).

Clinical Laboratory Improvement Amendments (CLIA): Federal regulations that establish quality standards for all laboratory testing performed on humans in the US, except research laboratories.

Compliance program: A set of internal policies, procedures, and controls designed to prevent and detect violations of laws and regulations applicable to an organization.

Confidentiality: The practice of protecting sensitive or private information from unauthorized access or disclosure.

Conviction: A judgment of guilt against a criminal defendant.

Data mining: The process of analyzing large datasets to discover patterns, trends, and anomalies that may indicate fraudulent activity.

Deep web: The portion of the internet that is not indexed by search engines and requires special software or authorization to access.

Delivery system: The network of providers, hospitals, clinics, and other entities that deliver healthcare services to patients.

Digital forensics: The process of collecting, analyzing, and preserving electronic evidence for use in investigations or legal proceedings.

Electronic Health Record (EHR): A digital version of a patient's medical history that is stored and shared electronically among authorized providers.

False Claims Act (FCA): A federal law that imposes civil and criminal penalties on individuals or entities that submit false or fraudulent claims to the government.

Federal Bureau of Investigation (FBI): The primary federal law enforcement agency responsible for investigating healthcare fraud and other crimes.

Fraud: The intentional deception or misrepresentation of facts for the purpose of financial gain.

Health Insurance Portability and Accountability Act (HIPAA): Federal regulations that protect the privacy and security of patients' medical information.

Identity theft: The unauthorized use of another person's personal information, such as their name, social security number, or credit card information, for fraudulent purposes.

Internal Revenue Service (IRS): The federal agency responsible for collecting taxes and enforcing tax laws.

Kickback: An illegal payment made in exchange for referrals of healthcare program business.

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 over the age of 65 and certain disabled individuals.

Mental health parity: The principle that mental health benefits should be equivalent to medical and surgical benefits in terms of coverage and access.

Money laundering: The process of making illegally-gained proceeds appear legitimate through a series of transactions.

Office of Inspector General (OIG): The agency within the US Department of Health and Human Services responsible for detecting and preventing fraud, waste, and abuse in the healthcare system.

Pharmacy benefit manager (PBM): A third-party administrator of prescription drug programs for health insurers, self-insured employers, and other payers.

Physician self-referral: The practice of referring patients to healthcare services in which the referring physician has a financial interest.

Qui tam: A legal provision that allows private citizens to file lawsuits on behalf of the government and receive a portion of the recovered funds.

Stark Law: Federal laws that prohibit physician self-referral for certain designated health services paid for by Medicare.

Telehealth: The use of telecommunication and information technologies to provide healthcare services remotely.

Upcoding: The practice of billing for a more expensive service or procedure than was actually provided.

Whistleblower: An individual who reports suspected illegal activity within an organization.

Wire fraud: A federal crime involving the use of interstate wire communications to further a fraudulent scheme.