Advanced Certificate in Healthcare Fraud Investigation Best Practices

Unit 4: Identifying Red Flags and Indicators of Fraud

Advanced Certificate in Healthcare Fraud Investigation Best Practices: a professional certification program that provides participants with the knowledge and skills necessary to identify, investigate, and prevent healthcare fraud.

Affordable Care Act (ACA): a US federal law that requires most individuals to have health insurance and provides subsidies to help them afford it. The ACA also expanded Medicaid eligibility and created new regulations for the health insurance industry.

Aggregate Expenditures Test: a method used to detect healthcare fraud in which the total amount of healthcare expenditures for a particular group or population is compared to the expected amount based on historical data and trends.

Anti-Kickback Statute (AKS): a US 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 in which providers submit false or inflated claims to healthcare programs or insurance companies for reimbursement.

Churning: a type of healthcare fraud in which providers repeatedly order unnecessary tests or treatments in order to increase their reimbursement.

Cloning: a type of healthcare fraud in which providers use the identifying information of another provider to bill for services not rendered.

Compliance Program: a set of policies, procedures, and practices designed to ensure that an organization is operating in accordance with applicable laws, regulations, and standards.

Data Mining: the process of analyzing large datasets to identify patterns, trends, and anomalies that may indicate fraudulent activity.

False Claims Act (FCA): a US federal law that prohibits the submission of false or fraudulent claims to the government for payment or reimbursement.

Fraud Hotline: a confidential reporting mechanism for individuals to report suspected instances of healthcare fraud.

Healthcare Fraud: the intentional misrepresentation or deceitful conduct resulting in an unauthorized benefit or payment.

Identity Theft: a type of healthcare fraud in which an individual's personal identifying information is used without their knowledge or consent to obtain healthcare services or prescription medications.

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 who are 65 or older, or who have certain disabilities.

Microlevel Analysis: a method used to detect healthcare fraud in which individual claims are examined for accuracy and appropriateness.

Phantom Billing: a type of healthcare fraud in which providers bill for services or equipment that were not provided.

Prevalence Rate: the number of cases of a particular condition or illness in a given population.

Provider Screening: the process of verifying the credentials and qualifications of healthcare providers before they are allowed to participate in healthcare programs.

Upcoding: a type of healthcare fraud in which providers use billing codes that reflect a more severe or complex condition than was actually treated in order to receive a higher reimbursement.

Utilization Review: the process of examining healthcare services and treatments to ensure that they are necessary, appropriate, and in compliance with applicable guidelines and regulations.

Whistleblower: an individual who reports suspected instances of fraud or wrongdoing, often as a protected activity under laws such as the False Claims Act.