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Advanced Certificate in Healthcare Fraud Investigation Best Practices

## **Unit 9: Collaboration and Communication with Law Enforcement and Regulatory Agencies**

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Advanced Certificate in Healthcare Fraud Investigation Best Practices: A certification program that provides professionals with the knowledge and skills necessary to detect, investigate, and prevent healthcare fraud. Unit 9 focuses on collaboration and communication with law enforcement and regulatory agencies.

Anti-kickback Statute (AKS): A federal law that prohibits the exchange of anything of value in return for referrals for services paid for by federal healthcare programs.

Collaboration: The process of working together with other individuals or organizations to achieve a common goal. In the context of healthcare fraud investigation, collaboration often involves working with law enforcement and regulatory agencies to investigate and prosecute fraud.

Communication: The act of exchanging information, ideas, or messages. Effective communication is essential in healthcare fraud investigation, as it helps to ensure that all parties are on the same page and working towards the same goal.

Compliance program: A set of internal policies, procedures, and controls designed to ensure that an organization is operating in accordance with applicable laws and regulations. A compliance program can help an organization prevent, detect, and respond to healthcare fraud.

Confidentiality: The practice of keeping certain information private and only disclosing it to individuals who have a need to know. In the context of healthcare fraud investigation, confidentiality is essential to protect the integrity of the investigation and to ensure that sensitive information is not disclosed to unauthorized individuals.

Data mining: The process of analyzing large datasets to identify patterns, trends, or anomalies. Data mining can be a useful tool in healthcare fraud investigation, as it can help to identify potential fraudulent activity.

Federal Bureau of Investigation (FBI): The primary federal law enforcement agency responsible for investigating healthcare fraud. The FBI works closely with other law enforcement and regulatory agencies to investigate and prosecute healthcare fraud.

Healthcare Fraud Prevention and Enforcement Action Team (HEAT): A joint initiative between the Department of Justice and the Department of Health and Human Services to combat healthcare fraud. HEAT brings together federal, state, and local law enforcement agencies to investigate and prosecute healthcare fraud.

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

The IRS can be involved in healthcare fraud investigations when there is evidence of tax evasion or other financial crimes.

**Medicaid Fraud Control Unit (MFCU):** A state agency responsible for investigating and prosecuting Medicaid fraud. MFCUs are funded through a federal grant and are required to meet certain performance standards.

**Medicare Fraud Strike Force:** A team of federal, state, and local law enforcement agencies that investigates and prosecutes healthcare fraud, particularly in high-fraud areas. The Medicare Fraud Strike Force uses data analytics and other tools to identify and investigate potential healthcare fraud.

**Office of Inspector General (OIG):** The federal agency responsible for overseeing and investigating fraud, waste, and abuse in federal healthcare programs. The OIG has the authority to exclude individuals and entities from participating in federal healthcare programs.

**Qui tam:** A legal provision that allows private citizens to bring a lawsuit on behalf of the government against individuals or entities that have defrauded the government. Qui tam lawsuits are often used in healthcare fraud investigations.

**Regulatory agencies:** Government agencies responsible for enforcing regulations and laws related to healthcare. Examples of regulatory agencies include the Centers for Medicare & Medicaid Services (CMS), the Food and Drug Administration (FDA), and the Drug Enforcement Administration (DEA).

**Risk assessment:** The process of identifying, analyzing, and prioritizing risks in order to develop strategies to mitigate or manage those risks. In the context of healthcare fraud investigation, a risk assessment can help an organization identify potential vulnerabilities and take steps to prevent fraud.

**Subpoena:** A legal document issued by a court or government agency that orders an individual or entity to produce documents or appear in court. Subpoenas are often used in healthcare fraud investigations to obtain evidence.

**Whistleblower:** An individual who reports suspected illegal or unethical activity within an organization. Whistleblowers play an important role in detecting and preventing healthcare fraud.

**Witness:** An individual who provides testimony in a legal proceeding. In the context of healthcare fraud investigation, witnesses may include victims, suspects, or experts who can provide information related to the investigation.