Certificate in Healthcare Compliance

Healthcare Fraud and Abuse

A

ABN (Advance Beneficiary Notice) – A written notice given to Medicare beneficiaries when a provider believes that Medicare will not pay for a service. Related terms: Medicare, beneficiary responsibility. The ABN informs the patient that they may be billed directly if the claim is denied, helping to avoid surprise billing and ensuring transparency.

ACA (Affordable Care Act) – Federal legislation enacted in 2010 to expand health coverage, control health care costs, and improve the health care system. Related terms: Marketplace, individual mandate. The ACA includes provisions that affect fraud and abuse monitoring, such as enhanced data sharing among agencies.

ACO (Accountable Care Organization) – A group of health care providers who voluntarily come together to coordinate high-quality care for Medicare patients. Related terms: shared savings, risk adjustment. ACOs are subject to compliance oversight to prevent fraudulent billing for services not rendered.

ACS (American Cancer Society) – Not a fraud term but often appears in billing contexts for cancer-related services. Related terms: diagnostic coding. Misuse of ACS codes can lead to fraudulent claims for unnecessary tests.

Adverse Claim – A claim that is denied, returned, or flagged for potential fraud. Related terms: audit, reversal. Identifying adverse claims is a key step in fraud detection.

Affidavit of Truthfulness – A sworn statement by a provider affirming that all submitted information is accurate. Related terms: attestation. Used in investigations to establish intent.

Agency for Healthcare Research and Quality (AHRQ) – Federal agency that provides data and tools for improving health care quality. Related terms: HCUP. AHRQ data can be leveraged to spot outlier billing patterns.

Algorithmic Screening – Use of computer-based rules to flag suspicious claims. Related terms: predictive analytics. Algorithms examine variables such as frequency, dollar amount, and provider specialty.

Anti-Kickback Statute (AKS) – Criminal law prohibiting the exchange of remuneration to induce referrals or generate business. Related terms: safe harbor, FCPA. Violations can result in fines, imprisonment, and exclusion from federal programs.

Appeal – The process of requesting reconsideration of a denied claim. Related terms: CMS 2008, reversal.

Improper or repeated appeals may indicate fraudulent activity.

Audit Trail – A chronological record of who accessed or modified claim data. Related terms: log file, integrity. Maintaining a robust audit trail helps prove compliance and detect tampering.

Billing Cycle – The regular interval (monthly, quarterly) during which providers submit claims. Related terms: submission deadline. Shortened cycles can be used to conceal fraudulent activity.

Billing Error – An unintentional mistake in coding, pricing, or documentation. Related terms: unbundling, upcoding. Distinguishing errors from intentional fraud is a critical compliance task.

Billing Provider – The entity (individual or organization) that submits claims to payers. Related terms: NPI, assignor. The billing provider is legally responsible for the accuracy of submitted claims.

Bundling – The practice of grouping multiple services into a single payment. Related terms: global fee. Improper bundling may hide separate billable services, constituting fraud.

CAP (Corrective Action Plan) – A documented strategy to remediate identified compliance failures. Related terms: FCPA, OIG. CAPs often include training, monitoring, and reporting enhancements.

CMS (Centers for Medicare & Medicaid Services) – Federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program. Related terms: HCFA, MAC. CMS issues regulations and guidance on fraud prevention.

COBRA (Consolidated Omnibus Budget Reconciliation Act) – Provides continuation of health coverage after certain qualifying events. Related terms: beneficiary notice. Fraud may involve falsifying qualifying events to claim continuation benefits.

COI (Conflict of Interest) – A situation where personal interests could compromise professional judgment. Related terms: disclosure. Undisclosed COIs can lead to kickbacks or biased referrals.

COQ (Cost of Quality) – The total cost of ensuring and failing to ensure quality, including fraud detection expenses. Related terms: risk management.

CPR (Clinical Practice Review) – Evaluation of clinical documentation for appropriateness. Related terms: utilization review. CPR findings can uncover over-utilization fraud.

CRNA (Certified Registered Nurse Anesthetist) – Advanced practice nurse providing anesthesia services. Related terms: scope of practice. Incorrect billing for CRNA services can be fraudulent if services are not actually rendered.

CMS-1500 – Standard claim form for non-institutional providers. Related terms: UB-04. Errors or intentional manipulation on the CMS-1500 can lead to fraud investigations.

Data Mining – Extraction of patterns from large datasets to identify anomalies. Related terms: machine learning. Used by insurers to detect fraudulent claim clusters.

Denial Management – Process of handling denied claims, including appeals and corrective actions. Related terms: reversal. Persistent denial patterns may signal fraudulent activity.

Disallowed Charge – A claim line that a payer will not reimburse. Related terms: non-covered service. Providers may attempt to re-bill disallowed charges, constituting fraud.

DRG (Diagnosis-Related Group) – Classification system for inpatient stays used to determine reimbursement. Related terms: case-mix index. Manipulating DRG assignments (upcoding) is a common fraud scheme.

Duplicate Claim – Submission of the same claim more than once. Related terms: reimbursement error. Intentional duplicates are fraudulent; accidental duplicates are billing errors.

E-Verify – System to confirm employee eligibility for work. Related terms: employment fraud. Using ineligible staff for billing can lead to fraudulent claims.

EBM (Evidence-Based Medicine) – Clinical decision-making based on current best evidence. Related terms: clinical guidelines. Billing for services not supported by EBM may be fraudulent.

Electronic Health Record (EHR) – Digital version of a patient's chart. Related terms: HIPAA. EHR data can be audited to verify services billed.

Electronic Data Interchange (EDI) – Standardized electronic transmission of claim information. Related terms: ANSI X12. Improper EDI formatting can be exploited for fraudulent submissions.

Emergency Medical Treatment and Labor Act (EMTALA) – Requires emergency departments to provide stabilizing treatment regardless of ability to pay. Related terms: patient dump. Billing for non-emergency services after EMTALA stabilization can be fraudulent.

Enforcement Action – Legal steps taken by regulators to address non-compliance. Related terms: civil monetary penalty. Actions may include fines, exclusion, or criminal prosecution.

Exclusion – Bar from participating in federal health programs. Related terms: OIG List. Providers found guilty of fraud may be excluded, ending their ability to bill Medicare/Medicaid.

FCPA (Foreign Corrupt Practices Act) – U.S. Law prohibiting bribery of foreign officials. Related terms: anti-bribery. International health organizations must ensure compliance to avoid fraud allegations.

Fee-for-Service – Payment model where each service is billed separately. Related terms: volume incentive. This model can encourage upcoding and unnecessary services.

FQHC (Federally Qualified Health Center) – Community-based health care provider receiving federal funding. Related terms: sliding fee scale. Fraud may involve inflating patient counts to receive higher reimbursements.

Fraud Triangle – Framework describing three elements that lead to fraud: Pressure, opportunity, rationalization. Related terms: risk assessment. Understanding the triangle helps design effective controls.

Fraudulent Claim – A claim that includes false information, misrepresentation, or omitted facts to obtain payment. Related terms: intent. Examples include billing for services not provided or using false diagnoses.

FWA (Fraud, Waste, and Abuse) – Collective term for improper activities that increase health care costs. Related terms: program integrity. Programs target FWA through detection, prevention, and enforcement.

G

GPCI (Geographic Practice Cost Index) – Adjustment factor applied to Medicare payments based on local costs. Related terms: RVU. Manipulating GPCI data can affect reimbursement amounts.

HCFA (Health Care Financing Administration) – Former name of CMS. Related terms: CMS. Historical documents may still reference HCFA.

HCPCS (Healthcare Common Procedure Coding System) – Set of codes for billing services, supplies, and equipment. Related terms: CPT, HCPCS Level II. Incorrect HCPCS coding is a frequent fraud mechanism.

HIPAA (Health Insurance Portability and Accountability Act) – Federal law protecting patient privacy and establishing security standards. Related terms: PHI, security rule. HIPAA violations can accompany fraudulent billing when data is misused.

HMO (Health Maintenance Organization) – Managed care plan that provides health services through a network of providers. Related terms: capitation. HMOs may be subject to fraud investigations for inflated enrollment numbers.

ICD (International Classification of Diseases) – Diagnostic coding system used for billing and statistical purposes. Related terms: ICD-10-CM. Upcoding involves selecting a higher-severity ICD code to increase reimbursement.

IDN (Integrated Delivery Network) – A system of health care providers and facilities under a single corporate umbrella. Related terms: vertical integration. IDNs must monitor internal billing to prevent systemic fraud.

Impairment Billing – Submitting claims for services rendered to a patient with a documented impairment. Related terms: disability. Fraud occurs when impairment is fabricated or exaggerated.

Indemnity Plan – Insurance plan that reimburses a set portion of charges. Related terms: fee-schedule.

Providers may inflate charges to increase indemnity reimbursements.

Inflated Charge – Billing for a service at a rate higher than the allowable amount. Related terms: upcoding. Inflated charges are a classic form of fraud.

Inpatient Prospective Payment System (IPPS) – Medicare payment method for hospital inpatient stays based on DRGs. Related terms: DRG. Manipulating clinical documentation to achieve a higher-paid DRG is fraudulent.

Inpatient Rehabilitation Facility (IRF) – Facility that provides intensive rehabilitation services. Related terms: IRF-PPS. Billing for IRF services without meeting intensity criteria is fraudulent.

Intent – The purposeful decision to commit fraud. Related terms: mens rea. Proving intent differentiates fraud from inadvertent errors.

Internal Controls – Policies and procedures designed to safeguard assets and ensure accurate reporting. Related terms: segregation of duties. Weak internal controls increase fraud risk.

J

J-Code – HCPCS Level II code used for drugs administered by a health care professional. Related terms: medication billing. Using a J-code for a drug not administered is fraudulent.

Kickback – Payment or remuneration given in return for referrals or services. Related terms: AKS, safe harbor. Kickbacks are illegal under federal statutes.

Koch v. United States – Landmark case clarifying the definition of “kickback.” Related terms: legal precedent. The decision helps interpret anti-kickback regulations.

L

Lawsuit Settlement – Financial resolution of a legal claim without admission of guilt. Settlements may include compliance remediation.

Liability Insurance – Coverage for legal claims arising from professional services. Related terms: errors and omissions. Insurers may investigate alleged fraud before providing coverage.

Limitation of Liability – Contractual clause capping damages. Related terms: indemnity. Does not protect against criminal fraud penalties.

Medicaid – Joint federal-state program providing health coverage to low-income individuals. Related terms: State Medicaid Agency, MMIS. Medicaid fraud often involves false enrollment or billing for non-covered services.

Medicare – Federal health program for individuals 65+, certain younger people with disabilities, and end-stage renal disease. Related terms: Part A, Part B, Part C, Part D. Medicare fraud is a major focus of OIG investigations.

Medicare Advantage (Part C) – Private-managed plan offering Medicare benefits. Related terms: risk adjustment. Fraud may involve inflating risk scores to receive higher payments.

Medicare Part D – Prescription drug benefit. Related terms: formulary. Fraud includes billing for drugs not dispensed.

Medicare Part B – Covers outpatient services. Related terms: physician fees. Upcoding and unbundling of Part B services are common fraud schemes.

Medicare Part A – Covers inpatient hospital care. Related terms: IPPS. Fraud includes billing for hospital stays that never occurred.

Medical Necessity – Requirement that services be appropriate for diagnosis or treatment. Billing for services lacking medical necessity is fraudulent.

Medicare Secondary Payer (MSP) – Situation where Medicare pays after another insurer. Related terms: primary payer. Failure to coordinate MSP can lead to overpayment fraud.

MedPAC (Medicare Payment Advisory Commission) – Independent agency advising Congress on Medicare issues. Related terms: payment policy. Recommendations influence fraud-prevention incentives.

Misrepresentation – Providing false information to obtain payment. Related terms: material fact. Intentional misrepresentation is a core element of fraud.

Mitigation Strategy – Plan to reduce identified fraud risks. Includes training, monitoring, and corrective actions.

MRA (Medical Review Audit) – Detailed examination of clinical documentation versus billed services. Related terms: clinical validation. MRAs uncover both errors and intentional fraud.

MS-DRG (Medicare Severity-DRG) – Refined DRG system incorporating severity of illness. Related terms: case-mix. Upcoding to a higher MS-DRG is a fraudulent practice.

N

National Provider Identifier (NPI) – Unique 10-digit identifier for health care providers. Related terms: enrollment. Using a false NPI on claims is fraudulent.

National Practitioner Data Bank (NPDB) – Repository of information on health care practitioners. Related

terms: disciplinary actions. Fraud convictions are reported to NPDB.

National Health Care Anti-Fraud Association (NHCAA) – Professional organization focused on combating health care fraud. Related terms: industry standards. Provides best-practice guidance.

Non-covered Service – Service not reimbursable under a specific payer's policy. Related terms: benefit limitation. Billing for non-covered services can be fraudulent if claimed as covered.

Obligation to Report – Legal duty to inform authorities of known fraud. Related terms: whistleblower. Failure to report can result in liability.

OIG (Office of Inspector General) – Agency within HHS that conducts audits, investigations, and enforcement. OIG issues advisory opinions on compliance matters.

On-Site Review – Physical inspection of a provider's records and operations. Related terms: audit. Used to verify the authenticity of billed services.

Open-Claims Database – Publicly accessible repository of settled health care fraud cases. Related terms: case law. Useful for compliance training.

Outlier Payment – Additional reimbursement for unusually costly cases. Related terms: cost-based. Manipulating data to create artificial outliers is fraudulent.

Overbilling – Charging for more services or higher rates than provided. Related terms: inflated charge. Overbilling is a primary fraud mechanism.

Overutilization – Providing services in excess of what is medically necessary. Related terms: unnecessary procedures. Overutilization can be driven by fee-for-service incentives.

P

Patient Protection and Affordable Care Act (PPACA) – Formal name for the ACA. Related terms: exchange. Includes provisions for fraud prevention financing.

Peer Review – Evaluation of clinical performance by colleagues. Related terms: utilization management. Peer review can identify patterns of suspicious billing.

Per-Diem Rate – Fixed daily payment for services such as skilled nursing. Billing per-diem for days not actually serviced is fraudulent.

Phantom Provider – Non-existent entity used to submit claims. Related terms: shell company. Phantom providers generate false claims for illicit gain.

Phantom Billing – Submitting claims for services never rendered. Related terms: ghost patient. A classic

fraud example.

Physician Self-Referral (Stark Law) – Prohibits physicians from referring patients to entities in which they have a financial interest. Related terms: safe harbor. Violations can lead to civil penalties.

Plan Sponsor – Entity that establishes and funds a health plan. Related terms: ERISA. Sponsors must ensure compliance to avoid plan-level fraud exposure.

Point-of-Service (POS) Billing – Billing at the time services are rendered. Related terms: real-time claim. POS systems can incorporate validation checks to reduce fraud.

Pre-Authorization – Prior approval required for certain services. Bypassing pre-authorization and billing anyway may be fraudulent.

Pre-Existing Condition – Health condition that existed before coverage start date. Related terms: exclusion. Misrepresenting a condition's onset can affect eligibility and payment.

Prevention Program – Proactive initiatives to stop fraud before it occurs. Related terms: education, monitoring. Includes staff training, policy development, and risk assessments.

Primary Care Provider (PCP) – Health professional who delivers first-line care. Related terms: medical home. PCPs may be targeted for kickback schemes.

Prior Authorization Denial – Refusal to approve a service before it is performed. Related terms: appeal. Billing after denial without justification can be fraudulent.

Prioritization Matrix – Tool for ranking fraud risks based on impact and likelihood. Helps allocate monitoring resources.

Prohibited Transaction – Any action that violates federal health-care fraud statutes. Related terms: AKS, Stark Law. Includes kickbacks, false claims, and illegal referrals.

Provider Enrollment – Process of registering with Medicare/Medicaid to submit claims. Related terms: NPI. Fraudulent enrollment (e.G., Using false addresses) leads to false claims.

Provider Number – Identifier assigned by a payer (e.G., Medicare provider number). Related terms: tax identification number. Misuse of another provider's number is fraudulent.

Public Law 101-508 – The Medicare Fraud and Abuse Control Program statute. Related terms: FFS. Established OIG's authority to combat fraud.

Q

Qualifying Event – Circumstance that triggers eligibility for certain benefits (e.G., COBRA). Related terms:

coverage continuation. Falsifying qualifying events is a fraud method.

Quality Assurance (QA) – Systematic monitoring of performance to ensure standards. Related terms: continuous improvement. QA data can also reveal anomalies indicative of fraud.

R

RAC (Recovery Audit Contractor) – Contractor hired by CMS to identify and recover improper Medicare payments. Related terms: overpayment. RAC findings often lead to recoupments.

RBRVS (Resource-Based Relative Value Scale) – System assigning relative values to physician services. Manipulating RBRVS codes (upcoding) creates higher payments.

Recoupment – Recovery of overpaid amounts by the payer. Failure to repay recoupments can result in additional penalties.

Referral – Directing a patient to another provider for services. Related terms: kickback. Illegal referrals in exchange for remuneration constitute fraud.

Reimbursement – Payment made to providers for services rendered. Related terms: allowed amount. Claiming reimbursement for unprovided services is fraudulent.

Remediation – Actions taken to correct compliance failures. Related terms: CAP. Effective remediation can mitigate enforcement actions.

Reportable Event – Incident that must be reported to regulators (e.G., Fraud, abuse). Related terms: OIG Hotline. Timely reporting is a compliance requirement.

Rescission – Cancellation of a contract or agreement. Related terms: settlement. Fraudulent contracts may be rescinded by courts.

Risk Adjustment – Process of modifying payments based on patient health status. Related terms: CMS-RAC. Inflating risk scores to receive higher payments is fraudulent.

Risk Assessment – Systematic evaluation of potential fraud exposures. Related terms: risk matrix. Guides the design of monitoring controls.

Rural Health Clinic (RHC) – Facility in underserved areas receiving specific reimbursement. Related terms: RHC PPS. Fraud can involve billing for services not delivered in RHCs.

S

Safeguard – Control designed to protect against fraud. Related terms: internal control. Examples include segregation of duties and automated claim validation.

Safe Harbor – Statutory provision that protects certain arrangements from anti-kickback liability if specific criteria are met. Related terms: AKS. Properly structured contracts can utilize safe harbors.

Scope of Practice – Legal boundaries of services a provider may deliver. Related terms: licensure. Billing for services outside scope is fraudulent.

Self-Referral – Provider refers a patient to a service in which they have a financial interest. Related terms: Stark Law. Illegal self-referral leads to false claims.

Servicing Entity – Organization that processes claims on behalf of a provider. Related terms: billing service. Misuse of a servicing entity to hide fraudulent activity is a risk.

Share-of-Savings – Compensation model where providers receive a portion of cost savings. Related terms: value-based. Improper documentation to achieve savings can be fraudulent.

Shell Company – Entity created to conceal ownership and facilitate fraud. Related terms: phantom provider. Used to submit false claims without traceable accountability.

Short-Term Disability (STD) – Benefit providing income during temporary disability. Related terms: FMLA. Fraud includes falsifying disability status to obtain payments.

Skilled Nursing Facility (SNF) – Facility providing 24-hour nursing care. Related terms: Per-Diem. Billing for SNF days not actually provided is fraudulent.

SNA (Special Needs Account) – Not a standard term; sometimes used in Medicaid contexts for managed care. Related terms: MMIS. Misallocation can be a fraud risk.

Statute of Limitations – Time period within which legal action must be commenced. Related terms: civil action. Fraud may be barred if discovered after the limit expires.

Stark Law – Federal prohibition on physician self-referral for certain designated health services. Violations result in civil penalties and potential exclusion.

State Medicaid Agency (SMA) – State entity administering Medicaid. SMAs conduct their own fraud investigations.

Statewide Data Warehouse – Central repository of health-care utilization data. Related terms: analytics. Enables cross-payer fraud detection.

Statistical Sampling – Technique for selecting a subset of claims for detailed review. Increases efficiency while identifying fraud patterns.

Subrogation – Right of a payer to recover costs from a third party responsible for injury. Related terms:

reimbursement. Failure to subrogate can lead to overpayment.

Supplemental Insurance – Additional coverage that pays after primary insurance. Related terms: secondary payer. Fraud may involve double-billing both primary and supplemental insurers.

T

Telehealth – Delivery of health services via electronic communication. Related terms: remote consult. Fraud includes billing for telehealth when in-person services were provided.

Therapeutic Misuse – Prescribing or billing for treatments not medically indicated. Related terms: off-label. Can constitute fraud if billed to insurers.

Third-Party Administrator (TPA) – Entity that processes claims on behalf of an insurer. Related terms: claims processing. TPAs must ensure claims integrity to avoid becoming conduits for fraud.

Tip-off – Information provided to regulators about suspected fraud. Tip-offs can trigger investigations.

Trafficking in Stolen Health Information – Illegal sale or distribution of PHI. Related terms: HIPAA breach. Enables identity theft and fraudulent billing.

True-Up – Adjustment made after the fact to reconcile projected versus actual payments. Related terms: reconciliation. Manipulating true-up calculations can hide fraud.

U

UCR (Usual, Customary, and Reasonable) – Standard for determining allowable charges. Related terms: charge master. Overcharging beyond UCR may be fraudulent.

UCC (Uniform Commercial Code) – Governs commercial transactions. Related terms: contract law. May be cited in fraud settlements involving equipment purchases.

Unbundling – Billing separately for services that should be combined under a single code. Unbundling inflates reimbursement and is a fraud violation.

Upcoding – Submitting a claim with a code that reflects a higher level of service than performed. Upcoding is a common fraudulent practice.

Utilization Review (UR) – Assessment of the appropriateness of health-care services. Related terms: medical necessity. UR findings can uncover overutilization fraud.

V

Value-Based Purchasing (VBP) – Payment model linking reimbursement to quality metrics. Related terms:

pay-for-performance. Manipulating quality data to receive higher VBP payments is fraudulent.

Verification Process – Steps taken to confirm the authenticity of claims or provider credentials. Related terms: credentialing. Robust verification reduces fraud risk.

W

Whistleblower – Individual who reports suspected fraud to authorities. Related terms: qui tam. Whistleblowers may receive a portion of recovered funds under the FCA.

Qui Tam – Legal action allowing private parties to sue on behalf of the government for fraud. Related terms: False Claims Act. Successful qui tam actions can result in substantial penalties.

False Claims Act (FCA) – Federal law imposing liability for knowingly submitting false claims. The FCA is a primary tool for prosecuting health-care fraud.

Fraudulent Inducement – Offering false promises to obtain a contract or enrollment. Related terms: misrepresentation. Can be grounds for rescission and damages.

Fraudulent Enrollment – Registering a non-existent patient or provider to receive payments. Related terms: phantom billing. Often discovered through data analytics.

Fraud Hotline – Dedicated channel for reporting suspected fraud. Related terms: OIG. Organizations are encouraged to maintain an accessible hotline.

Front-Running – Submitting claims for services before verification is complete, anticipating approval. Related terms: premature billing. Increases risk of false claims.

G

Gross Negligence – Severe lack of care that may rise to the level of fraud if it results in false claims. Related terms: recklessness. Courts may treat gross negligence as intentional.

H

HCFA Form 1500 – Earlier version of the CMS-1500 claim form. Related terms: paper claim. Still used in some legacy systems.

HIPAA Privacy Rule – Component of HIPAA protecting PHI. Related terms: security rule. Violations can accompany fraudulent activities.

Hospital Acquired Condition (HAC) – Condition that develops during a hospital stay. Related terms: quality metric. Billing for HAC-related services when none exist can be fraudulent.

Hospital Compare – CMS website displaying hospital performance data. Related terms: public reporting. Data can be used to detect outlier billing patterns.

Hospital Outpatient Prospective Payment System (OPPS) – Medicare payment system for outpatient services. Related terms: HCPCS. Upcoding OPPS services is a fraud risk.

I

Identity Theft – Unauthorized use of another's personal information. Related terms: PHI. Enables fraudulent enrollment and billing.

Impersonation Fraud – Pretending to be a provider or patient to submit claims. Related terms: credential theft. Often uncovered through verification failures.

Inducement – Something offered to persuade a party to act, potentially illegal in health-care contexts. Illicit inducements violate AKS.

Inpatient Hospital Services – Services provided during an admitted stay. Billing for inpatient services without admission is fraudulent.

Insurance Fraud – Deception to obtain unauthorized benefits. Related terms: FCA. Health-care fraud is a subset focusing on medical claims.

Internal Audit – Independent review within an organization to assess compliance. Findings often trigger corrective actions.

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) – U.S. Adaptation of ICD for diagnosis coding. Related terms: ICD. Accurate coding is essential to avoid false claims.

JCAHO (Joint Commission) – Accrediting body for health-care organizations. Related terms: accreditation. Accreditation findings may reveal compliance gaps.

K

Kickback Safe Harbor – Specific statutory criteria that, if met, shield a remuneration arrangement from AKS liability. Must involve fair market value and not be tied to volume.

L

Legal Settlement – Agreement to resolve a dispute without admission of wrongdoing. May include compliance requirements.

Legitimate Claim – Claim that accurately reflects services rendered and complies with payer rules. Serves as a benchmark for identifying false claims.

Liability Exposure – Potential for legal responsibility due to non-compliance. Reducing exposure involves strengthening controls.

Loss Prevention – Strategies to prevent financial loss, including fraud. In health care, loss prevention overlaps with compliance.

M

Medicare Fraud Prevention Law (MFPL) – Legislation enhancing penalties for Medicare fraud. Encourages stricter enforcement.

Medical Billing Fraud – Deliberate deception in the billing process to obtain payment. Related terms: false claims. Encompasses upcoding, unbundling, phantom billing, and more.

Medical Record Review (MRR) – Examination of documentation to verify services. Related terms: clinical audit. Essential for substantiating claims.

Medicare Advantage Risk Adjustment Data Validation (RADV) – Audit of risk-score data submitted by MA plans. Inaccurate data can trigger fraud penalties.

Misuse of Codes – Applying incorrect CPT/HCPCS/ICD codes. Can be intentional (fraud) or accidental (error).

Monetary Penalty – Financial sanction imposed for violations. Penalties may be per claim or per incident.

Motor Vehicle Accident (MVA) Fraud – Submitting false injury claims after an accident. Related terms: workers' comp. Often involves fabricated medical records.

N

National Health Care Anti-Fraud Association (NHCAA) Guidelines – Best-practice standards for fraud detection. Used to benchmark compliance programs.

Non-Compliance – Failure to adhere to laws, regulations, or internal policies. Related terms: risk. May lead to investigations and penalties.

Non-Provider – Entity that does not meet provider definition but may submit claims illicitly.