

Healthcare Fraud and Abuse

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1. Introduction

- Healthcare fraud is intentional deception to gain unauthorized benefits or payment.
- Abuse involves practices that are improper or wasteful but may lack intent to deceive.

2. Common Forms

- **Billing fraud:** charging for services not provided or upcoding to higher-paying codes.
- **Kickbacks:** payments for patient referrals or product use.
- **Phantom claims:** billing for non-existent patients or treatments.

3. Distinguishing Fraud from Abuse

- Fraud requires knowing intent and deliberate misrepresentation.
- Abuse includes overuse of services and substandard care that raises costs.
- Both drain resources and undermine trust in the system.

4. Legal and Regulatory Controls

- Anti-kickback statutes and false-claims laws impose penalties.
- Audits, claim reviews, and whistleblower protections aid detection.
- Penalties include fines, exclusion from programs, and imprisonment.

5. Prevention

- Accurate documentation and coding practices.
- Compliance programs and staff training.
- A culture of integrity and prompt reporting of suspected misconduct.