



Healthcare Fraud, Waste and Abuse (FWA) Detection Training for Payers and Providers

23 – 27 November 2026

London - Central London four-star



Healthcare Fraud, Waste and Abuse (FWA) Detection Training for Payers and Providers

Ref: 2060_30138 **Date:** 23 – 27 November 2026 **Location:** London - Central London four-star **Fees:** 23000 SAR

Introduction:

Healthcare fraud, waste and abuse FWA detection for payers and providers is a 1-week course for insurer, third-party administrator and provider units handling claims integrity, special investigations and provider audit, ending with an FWA Detection and SIU Operating Plan for a case organisation. Health schemes leak money through phantom services, inflated codes, split procedure bills and referral kickbacks that pass routine claim checks and surface late. Nominees already review claims, audit providers or handle suspicious-claim referrals, and learn through case studies built on claim lines, provider profiles and investigation files. CoreConcept Training Center delivers this healthcare FWA detection course.

Course Objectives:

- Classify suspected healthcare schemes as fraud, waste or abuse and route each to the correct response based on intent, pattern and value
- Build red-flag rules, provider peer comparisons and member utilisation screens that surface suspicious claim lines from payer data
- Run a special investigative unit case from referral and triage through evidence gathering, interviews and a defensible case report
- Plan and conduct provider billing audits using claim sampling, medical record comparison and overpayment extrapolation
- Recover overpayments and apply provider sanctions, prepayment review and network actions in proportion to the findings
- Design prevention controls on both the payer and provider side that stop recurring FWA schemes before payment

Target Audience:

- Claims integrity units that screen medical, pharmacy and dental claims for irregular billing before and after payment
 - Special investigative units that receive suspicious-claim referrals, gather evidence and prepare case files
 - Provider audit and network units responsible for billing reviews, contract enforcement and overpayment recovery
 - Provider-side compliance and revenue integrity units that monitor their own coding, billing and referral practices
 - Data and reporting units that maintain claims analytics, dashboards and FWA performance indicators
 - Member services and enrolment units that detect eligibility misuse and medical identity theft
-

Course Outline:

Day 1: FWA Definitions, Scheme Landscape and Exposure Baseline

- Fraud, Waste and Abuse Definitions Separated by Intent and Pattern
- Provider Scheme Catalogue Covering Phantom Services and Inflated Codes
- Member Scheme Catalogue Covering Ineligible Dependents and Card Sharing
- Organised Ring and Medical Identity Theft Case Patterns
- FWA Exposure Baseline Scorecard for Claims Lines and Networks

Day 2: Detection Models, Red-Flag Logic and Investigation Frameworks

- Special Investigative Unit Two-Stage Case Model Before and After Contact
- Red-Flag Rule Library for Medical, Pharmacy and Dental Claims
- Statistical Outlier Detection Using Provider Peer Group Benchmarks
- Supervised and Unsupervised Scoring Logic for Referral Prioritisation
- Tip Line, Whistleblower and Adjuster Referral Intake Channels

Day 3: Claims Analytics, SIU Casework and Provider Billing Audits

- Procedure Code Pair Edits Revealing Split and Duplicate Billing
- Member Utilisation Screens for Doctor Shopping and Pharmacy Abuse
- SIU Triage Matrix Weighing Value, Evidence and Recurrence
- Provider Billing Audit Sampling and Medical Record Comparison
- Investigative Interview Plan for Providers, Members and Staff

Day 4: Recovery, Sanctions, Prevention Controls and Problem Cases

- Overpayment Calculation and Extrapolation From Audited Claim Samples
- Recovery Letters, Repayment Schedules and Offset Against Future Payments
- Provider Sanctions Ladder From Education to Network Termination
- Prepayment Review Flags and Payment Hold Controls for High-Risk Providers
- Provider-Side Self-Audit and Voluntary Overpayment Disclosure Routine

Day 5: Case Study Clinic and FWA Detection and SIU Operating Plan

- Case Study on a Phantom Physiotherapy Billing Network
 - Case Study on Pharmacy Kickbacks and Prescription Diversion
 - FWA Key Performance Indicators for Savings, Recoveries and Cycle Time
 - SIU Staffing, Referral Workflow and Escalation Matrix Drafting
 - FWA Detection and SIU Operating Plan Completion and Defence
-

Skills You Will Gain:

- FWA Scheme Classification
- Red-Flag Rule Design
- Provider Peer Benchmarking
- Suspicious Claim Triage
- Investigative Case Building
- Billing Audit Sampling
- Overpayment Extrapolation
- Payment Integrity Controls

Why Attend This Course:

- Deliver an FWA Detection and SIU Operating Plan for a case organisation to the head of claims and the compliance committee
- Decide which suspicious claims merit full investigation, which call for provider education and which justify payment holds or recovery
- Avoid paying repeat phantom, inflated and split bills, and avoid losing recoveries through weak evidence or poorly sampled audits
- Pass on the red-flag rule library, triage matrix and audit sampling worksheets to claims reviewers and investigators

Conclusion:

Back at work, the participant hands the head of claims, the special investigative unit lead and the compliance committee an FWA Detection and SIU Operating Plan that sets red-flag rules, referral routes, audit priorities, recovery steps and prevention controls. The committee uses it to approve detection rules, investigator staffing and which providers enter prepayment review. After the first quarter of use, the unit should compare referral volumes, confirmed case rates, recovered amounts and false-positive rates against the baseline and retune the rules.

Frequently Asked Questions FAQ:

What should participants know before a healthcare fraud, waste and abuse FWA detection course?

Participants should already review claims, audit provider billing, handle suspicious-claim referrals or manage provider compliance. Familiarity with procedure and diagnosis codes and with claims data fields helps. Bringing anonymised claim extracts or a past case summary makes the case work closer to their own setting.

How does healthcare FWA detection differ from a general fraud risk or medical insurance operations course?

This course concentrates fully on health claim schemes, SIU casework, provider audits and recovery. A general fraud risk course covers cross-sector frameworks and corporate investigations, while a medical insurance operations course covers benefit design, pre-authorisation and routine adjudication with only a short look at fraud screening.

Why do healthcare FWA red flags need investigation rather than automatic claim denial?

A red flag only shows that a claim differs from expected patterns; it does not prove fraud. Investigation separates honest coding errors and waste from deliberate schemes, protects legitimate providers and builds the evidence needed for recovery, sanctions or referral to the authorities.

What do participants take back from healthcare fraud, waste and abuse FWA detection training?

Participants return with an FWA Detection and SIU Operating Plan for a case organisation, covering red-flag rules, triage criteria, audit sampling, recovery steps and prevention controls, together with worksheets that claims reviewers and investigators can adopt.
