Tuesday, November 16

11:00 am – 11:15 am **Welcome Remarks**

11:15 am – 12:15 pm **Opening Keynote Speaker**

The Age of Distraction
Curt Steinhorst, Founder, Focuswise; and Author

12:15 pm – 12:30 pm **Break with Exhibitors**

12:30 pm – 1:30 pm **Concurrent Sessions**

ABA Therapy: Putting The Pieces Together
Treatment of Autism Spectrum Disorder (ASD) is an area of growing financial risk that is frequently not well understood by payers and their FWA investigators. Presented by SIU Clinical Investigators with personal experience in ASD, this session takes a deep dive into the topic. Detailed discussion will include risk factors and how ASD is diagnosed, Applied Behavior Analysis (ABA) treatment, and the types of providers, certifications and oversight expectations. The presentation will address diagnosis and procedure coding, data mining and potential schemes. Investigators and analysts will be equipped with an understanding of challenges related to auditing ABA services, approaches for data analysis and steps for moving forward with investigation.

- Maria Seedorff, DC, AHFI, CPC, Senior Clinical Investigator, Healthcare Fraud Shield

COVID Drive Through - E/M and ER services billed with COVID testing and vaccinations
Since passage of FFCRA and Cares Act, Covid Schemes have come out of the woodwork. The E/M and ER codes billed in these schemes are among the most commonly billed codes, so how do we perform an audit on them? This presentation will demonstrate how to organize a query to capture claims that are related to COVID E/M and ER schemes while avoiding false positives. Participants will hear how the investigators and analysts used claim code "groups" and "matches" to identify applicable claim lines and avoid false positives, and "imaging" codes to exclude providers who were symptomatic. The presenters will also explain how COVID Drive Throughs utilize apps to create medical records which mimic a true doctor/patient interaction.

- Angelica Branon, SIU Senior Data Mining Consultant, Aetna
- Donna Paulsson, Senior Informatics Analysts, Aetna

Improving Analytical Techniques: The Spreadsheet and Beyond
This session will demonstrate on how data analytical strategies enabled the investigation team to identify one fraudulent DME supplier which led to one of

the largest health care fraud cases in the country. With a focus on data analytics, participants will learn about the datamining and data analytics techniques and the steps necessary to develop a complex investigation. Participants will also learn how to leverage social media and public use sites to advance an investigation. This session dives in the details of a large complex case and offers insights that can be leveraged in your own cases.

- Sharron Cannella, AHFI, Senior Investigator, Special Investigations Unit (SIU), Anthem, Inc.

Planning and Implementing Fraud Risk Assessments on Emerging Areas of Concern

CMS has undertaken a project to conduct comprehensive program integrity risk assessments on federal programs based on the principles of the Government Accountability Office (GAO) Fraud Risk Framework (the Framework). The Framework encompasses control activities to prevent, detect, and respond to fraud, with an emphasis on prevention and helps managers mitigate fraud risks. CMS will discuss its process for planning and implementing these risk assessments and its initial findings. Additionally, an example of how CMS applied the Fraud Risk Framework to evaluate fraud risks associated with the COVID-19 waivers in the Medicare and Medicaid programs will be shared. Attendees of this session will learn about the varied facets of the Framework, how the Framework can be applied to their organizations to address the most serious fraud risks and how CMS has adapted the Framework to their program integrity work.

- Dennis Sendros, Division of Vulnerability, Innovation and Strategy (DVIS), Center for Program Integrity (CPI), Centers for Medicare and Medicaid (CMS)
- Laura Minassian-Kiefel, MPH, Deputy Director, Division of Vulnerability, Innovation and Strategy (DVIS), Center for Program Integrity (CPI), Centers for Medicare and Medicaid (CMS)

Non-Emergency Medical Transportation Fraud

This presentation focuses on a case worked in the District of Arizona in which the owner of a non-emergency medical transportation company was indicted and convicted of Health Care Fraud. The company submitted claims to Arizona Medicaid for “ghost” rides to medical appointments or Alcoholics Anonymous meetings which never took place. The presentation will examine the specifics of the investigation, including investigative actions and techniques, challenges faced, data analytics, and best practices.

- Jennifer Schlinz, Supervisory Special Agent, Department of Justice, Federal Bureau of Investigations (FBI)
- Dominick Margarella, Forensic Accountant, Department of Justice, Federal Bureau of Investigations (FBI)

Predicting the Future: Preparing your PI programs for 2022 and Beyond
Presented by Cotiviti
COVID-19 is currently creating an urgency around FWA detection and prevention among payers and vendors. Whether it's setting more edits to stop wasteful or abusive telehealth claims or rooting out testing and vaccination fraud. But that trend will pass, and the industry will move on. How do we leverage what we learned from the past 1.5 years to create successful prevention plans for 2022 and beyond in other non-COVID areas? What levers do we need to pull to ensure that we're more accurately predicting other types of FWA? In this session, FWA subject matter experts and former investigators will discuss 2020 billing trends and how to use consistent, agile analysis techniques to stay ahead of future schemes. Participants will learn how to conduct effective retrospective analysis for identifying potential gaps that arose during the COVID-19 pandemic and how to apply the lessons learned to more real time prevention of FWA.

- Erin Rutzler, AHFI, CFE, CPC, Vice President, Fraud, Waste and Abuse, Cotiviti, Inc.
- Ryan Cleverly, AHFI, CSPO, MCS, Product Director, Fraud, Waste and Abuse, Cotiviti, Inc.

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1:30 pm – 1:45 pm **Attendee Activities**

- Taste of San Antonio
- Health and Wellness

1:45 pm – 2:45 pm **Concurrent Sessions**

Generic Cost Manipulation
CMS' Plan Program Integrity (PPI) MEDIC will present on Medicare Part D generic cost manipulation schemes that have been recently identified using Part D data and other drug information databases. In this scheme, new National Drug Codes (NDC) are being developed for older generic medication at extremely elevated costs. In addition, the Investigations MEDIC (I-MEDIC) will present on the investigation of these cases and associated challenges. Individuals will learn how to identify new drugs/manufacturers in this emerging and evolving fraud, waste and abuse scheme.

- Jonathan Haag, PharmD, Program Director, Plan Program Integrity MEDIC, Qlarant
- Jodi Sullivan, PharmD, CPh, Clinical Director of Operations for the Investigations Medicare Drug Integrity Contractor (I-MEDIC), Qlarant

Preventative/Orthomolecular COVID-19 Infusions
Internal data mining revealed high billed charges related to intravenous (IV) infusions billed with COVID-related diagnosis codes from a provider's website

advertised as "super-immune boosting IV infusions" to help "protect against Coronavirus". A review of claims data suggested that the provider billed for infusions of this nature with diagnosis codes related to various mental health conditions like depression and Attention Deficit Hyperactivity Disorder (ADHD). Issues identified throughout the evidence included pass through billing, unbundling, services not rendered as billed, experimental/investigational/unproven services, and misrepresentation of services. The hospital was most notably billing for parenteral nutrition which is a form of nutrition administered intravenously to supplement some or all food intake for patients with moderate to severe gastrointestinal dysfunction. Participants in this session will learn how to distinguish orthomolecular medicine from evidence-based medicine based on data and medical records and different methods for analyzing data to review the accuracy of providers' explanations after they have been notified of audit findings.

- Brenna Andersen, Fraud Lead Analyst, Cigna

Data Analytics Applied to CMS Memos leading to an I-MEDIC Referral and Resulting in a Recovery from Contracted Pharmacy Benefit Manager
Each quarter CMS releases memos (e.g. Pharmacy Risk Assessment, Quarterly Drug Trend Analysis, Outlier Prescribers of Schedule II Controlled Substances) to Medicare Part D Plan Sponsors to support their efforts to combat fraud, waste, and abuse in the Medicare Part D program. The presenters in this session will demonstrate how data visualization identified an issue which led to a clinical review confirming the incident of Fraud Waste and Abuse. The presenters will walk through the next steps taken including referrals made to the I-MEDIC, SIRIS, HFPP, HPMS and contracted Pharmacy Benefit Managers. Ultimately the investigation led to a successful 100% recovery of Kaiser Permanente's financial loss.

- Mark Horowitz, RPh, Senior Manager, Kaiser Permanente
- Derek Ho, Manager, Kaiser Permanente

The Many Hats of an Identity Thief
The presentation focuses on BCBSIL's investigation into The Champion Center of Autism that led to the indictment and recent guilty plea of the Executive Director, Latrice Harrell. This was a multi-million-dollar investigation into a provider that stole licensed professionals' identities and billed for fraudulent ABA and OT services. The presentation will examine the following key components: (1) data analysis that predicated the case; (2) data analysis and social media analysis that substantiated the belief that services were not rendered; (3) in-person interview techniques where provider involvement remained unclear; and (4) medical record analysis conducted where the probability of member complicity was high. The presentation will also highlight the actions taken by a private insurer to mitigate loss, while simultaneously collaborating with the FBI.

- Tom Kusior, Lead Investigator, Health Care Service Corporation
- Erin Mutter-McKeon, Senior Investigator, Health Care Service Corporation

Case Study of the Tri-County Physician Group's Injections for Opioids
This session will highlight a $150 Million healthcare fraud investigation that was predicated on confidential human source information and data analysis that identified multiple physicians working at one medical practice in the Detroit in addition to their own private practices or employment at local hospitals. The practice was owned and operated by an individual that masked his ownership of a physician clinic and laboratory under the guise of being a "venture capitalist". The scheme involves multiple defendants that participated in a web of fraud that included money laundering, kickbacks, healthcare fraud, and a significant community impact that included medically unnecessary services that were billed to Medicare in exchange for pain medications that included 6.6 million doses of opioids. Participants in this session will learn how to establish an investigation by identifying outliers in a region by analyzing data, identify potential witnesses to be interviewed through data analysis, and how to develop trends using a large data set that can be used to make the data more granular.

- Brian Tolan, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General
- Stephen Osterling, Special Agent, Department of Justice, Federal Bureau of Investigations (FBI)

Digital Transformation and the SIU
Presented by SAS
Health care payers are experiencing digital transformation like other industries. What can SIUs expect? Learn about advancing technologies, including advanced analytics, and what SIUs can expect now and for the near future. Fraud, waste, and abuse solutions must align to these broader strategic goals and how analytics solutions are managed across the business by augmenting human efforts with tools like computer vision, document vision, robotic process automation (RPA), text analytics, and intelligent decisioning that promote efficiency. During this session, the presenters will explore examples of how payers and providers can operationalize and automate data and analytics to be proactive in the fight against fraud, waste, and abuse. Some of the issues to be discussed include data security, cloud deployment, streaming data analytics, augmenting human efforts with AI and intelligent decision making.

- Tom Wriggins, Principal Solutions Architect, Global Fraud and Security Intelligence Practice, SAS
- John Maynard, Fraud and Risk Solutions Specialist, SAS
- Ben Wright, Senior Payment Integrity Solutions Architect, SAS

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2:45 pm – 3:00 pm **Break with Exhibitors**

3:00 pm – 4:00 pm **Concurrent Sessions**

Attacking COVID-19 Fraud with Analytics
COVID-19 introduced volatile changes in the healthcare data landscape. With a rapid introduction of new CPT codes, new diagnostic codes, policy and coverage changes, the risk of potential fraud intensified and demanded an immediate response from SIUs. Learn how Cigna's Advanced Analytics team jumped into action to develop and execute successful COVID-19 fraud models across the globe. Collaboration with other business units and teams within and outside the SIU and the lessons learned from the experience will be explored. While many of the fraud models developed by analysts and data scientists were COVID-19 specific, attendees will also take away a number of skills and methods that can be used to manage fraud models and methodologies beyond COVID-19. Methods to track successful referrals, models and the use of multiple analytical coding environments (including R, Python, SQL, SAS and ESRI) will be discussed as well as the use of datasets beyond traditional healthcare claims databases.

- Douglas Rahden, MPH, CPMA, Advanced Analytics Sr Manager, Cigna

The Power of Leveraging Data Analytics to Identify Fraud Leads
Data analytics is often the catalyst for successful healthcare fraud investigations. This presentation will focus on current Healthcare Fraud Prevention Partnership (HFPP) data analytics, with a particular focus on leveraging analytic results to develop investigative leads. The HFPP can uncover trends and patterns conducting analytics against their unique cross payer healthcare claim data base leading to potential investigations. HFPP Partner members from Special Investigative Units (SIUs) and law enforcement are leveraging HFPP study results to identify actionable leads. One example to be discussed will include how the U. S. Department of Health and Human Services, Office of Inspector General (HHS, OIG) has harnessed the law enforcement reports built from the HFPP data analytics to identify healthcare providers submitting questionable billings to commercial and government health care programs. HHS, OIG will discuss a specific case where a report originating from an HFPP study resulted in federal action.

- Christopher Sterling, Data Scientist, Healthcare Fraud Prevention Partnership (HFPP), Trusted Third Party (TTP), General Dynamics Information Technology (GDIT)
- Christian Schrank-Assistant Inspector General for Investigations, U.S. Department of Health and Human Services, Office of Inspector General, Office of Investigations

Laboratory Investigations - Reading the fine print
The presenters in this session will provide a step by step review of laboratory requisition forms, results, custom panel agreements, and CMS-116 application forms to demonstrate how these pieces of documentation contain frequently overlooked fraud/abuse indicators. The investigators will use data sets during the review to demonstrate the effectiveness of leveraging data during a documentation review. More specifically, the presenters will demonstrate how to leverage claims data when reviewing laboratory orders to identify add on tests, unbundling, and other discrepancies between the claim and laboratory order. For the purposes of this presentation, CPT codes related to drug testing and COVID-19 will be used in examples. Lastly, the presenters will provide best practices for documentation requests such as medical records, audit, and overpayment demands.

- David Webb, AHFI, HCAFA, Principal Investigator, UnitedHealthcare
- Brianne McCort, CFE, CPC, AHFI, Principal Investigator, UnitedHealthcare

Operation Compound Fracture: Exploitation of the pharmacy claim environment
This presentation will explore fraud trends with the pharmacy industry, provide examples of these fraud trends within the context of a case example, and discuss strategies that can be employed by insurers to counteract these trends. Participants will learn about trends in the areas of pharmacy ownership, relationship of pharmacies to entities within the drug manufacturing and packaging process, manipulation of Average Wholesale Price (AWP), and abuse of contractual relationships. The presenters will discuss strategies for addressing these trends by (1) identifying exposure areas pertaining to pharmaceutical product information relied upon in the claims processing system and (2) identifying how contractual language may inadvertently impact the ability to prevent and detect fraud. Throughout the presentation, the speakers will highlight the opportunities for collaboration between insurers and criminal investigators.

- Dianne Shaffer, Special Agent, Federal Bureau of Investigation
- Susan Collare, CFE, Fraud Consultant, Financial Investigation and Provider Review, Highmark

A Comprehensive, Prospective and Retrospective Approach to FWA Identification
Presented by Change Healthcare
In order to address the massive threat of fraud, waste and abuse, organizations must create a comprehensive, prospective and retrospective approach to identifying, combating, and mitigating fraud – both before claims are paid and after payments have been issued. In this session, a diverse panel of experts will describe the critical steps to identify aberrant behavior indicating potential FWA through pre-payment claims analysis. The presenters will also describe specific

steps to prevent security gaps, identify security breaches and take action when post payment breaches do occur. Participants will walk away with both strategic and actionable insights about emerging concepts in FWA, and key elements is preparing, identifying and addressing critical threats.

- Louise Dobbe, JD, Director, Insight Operations, Change Healthcare
- Vanessa Templeman, Deputy Inspector General, Office of the Inspector General
- Jennifer Cant, CFE, CCEP, FCLS, Enterprise Payments Fraud Prevention Specialist, Change Healthcare

Knowledge Network

4:00 pm **Happy Hour**
Sponsored by ClarisHealth

Wednesday, November 17

11:00 am – 11:15 am **Daily Welcome and Awards Presentation**

11:15 am – 12:30 pm **General Session**

Federal Agencies: Effective Collaboration, Proven Success

- Allan Medina, Chief, Healthcare Fraud Unit, U.S. Dept. of Justice, Criminal Division, Fraud Section
- Greg Heeb, Unit Chief, Health Care Fraud Unit, U.S. Dept. of Justice, Federal Bureau of Investigation
- Gary Cantrell, Deputy Inspector General, Investigations Office of Inspector General at the Department of Health and Human Services

12:30 pm – 12:45 pm **Break with Exhibitors**

12:45 pm – 1:45 pm **Concurrent Sessions**

Annual Pharmaceutical Fraud Update
Each year, expert faculty from HHS-OIG share with us the latest trends and schemes in the dynamic world of pharmaceuticals. Dr. Cohen explores newly approved pharmaceuticals of concern, new schemes by criminals, legislative impacts, opioid plots, drug-treatment related ruses, and other areas of impact. Participants will be able to recognize new pharmaceuticals and associated schemes on the rise in their community and discuss the substance abuse treatment schemes and types of activity to be aware of.

- Michael Cohen, DHSc, JD, PA-C, Operations Officer, Investigations Unit, U.S. Department of Health & Human Services, Office of the Inspector General (HHS-OIG)

COVID-19 Data Trends and Their Fraud Implications
The U.S. Department of Health and Human Services (HHS) and its Operational Divisions, and the Centers for Medicare & Medicaid Services (CMS) were uniquely positioned to respond to the pandemic over the past two years. In their roles to support healthcare providers, CMS took aggressive action and exercised regulatory flexibilities. This flexibility inadvertently appealed to fraudsters willing to take advantage of relaxed policies. From COVID-19 laboratory testing to vaccine administration, fraudsters took advantage of the system. In this session, participants will learn how CMS worked with their partners to trend data and identify vulnerabilities during the pandemic. The speakers will discuss the trends, examine the vulnerabilities, address the actions taken, and offer perspectives on the lessons learned.

- Mark Starinsky, AHFI, CFE, CHC, Data Analyst and Senior Advisor, General Dynamics Information Technology
- Althea Matthews, Statistician, Centers for Medicare & Medicaid Services (CMS)

A 360 Degree View Of Using Specialized Monitors to Resolve Fraud, Waste and Abuse Matters
Too often, investigators, SIU directors and managers, government attorneys, and regulators, are challenged to consider the appropriate remedy, resolution or corrective action plan of matters involving healthcare providers subject to criminal, civil, or administrative discipline. They are often also asked to review cases for violations of regulations, statutes, practice standards, record keeping, billing and coding, behavioral or other issues. This presentation suggests ways in which enforcement on both the private and public side can include case ending solutions other than just fines, penalties, suspension, revocation or other forms of sanctions, in remedial ways. One such solution, independent monitoring is being used with ever greater frequency to resolve disciplinary or practice issues, to ensure that health care providers behavior modify in accordance with the investigation findings and conclusions. This presentation offers the different perspectives in the use of independent monitors from: the

head of an SIU unit, an attorney who represents practitioners, and an independent monitor.

- Vincent DiCianni, Compliance, President, Affiliated Monitors, Inc.
- Nicholas Messuri, Vice President, Deputy General Counsel for Fraud Prevention and Recovery, DentaQuest
- Paul Cirel, Attorney, Todd and Weld

Exploiting the Most Vulnerable: Hospice Fraud
In this session, representatives from the Senior Medicare Patrol (SMP) and State Health Insurance Assistance Program (SHIP) will provide detailed information regarding hospice fraud complaints and assistance requests received by the 54 state-based SHIP and SMP programs. The scope of hospice fraud complaints will be discussed - including patient harm and hospice enrollment schemes. The session will provide an analysis of billing codes noted by the SMP, with a focus on the Q5 series. Program concerns will be presented with a focus on the fraud risks to patients during the hospice agency selection process. Participants will learn about best practices and collaborative efforts to create educational resources to protect Medicare beneficiaries from fraud, errors, and abuse.

- Rebecca Kinney, Director, ACL - Office of Healthcare Information and Counseling, US Dept of Health and Human Services - Administration for Community Living
- Michael Klug, JD, Consultant, State Health Insurance Assistance Program Technical Assistance Center

R2B2 - The Investigation of Indivior, its executives, and former parent, Reckitt Benckiser Group
A case study on the national investigation of Reckitt Benckiser Group and Indivior, the makers of the opioid treatment drug, Suboxone. The seven-year investigation resulted in a 2019-2020 global settlement of over $2 billion in restitution, fines and forfeiture, and the criminal convictions of Indivior Solutions, Inc. and Indivior' s CEO and Medical Director. A lead federal prosecutor and case agent will recount the complex and vast investigation and prosecution of Indivior's scheme to defraud healthcare benefit programs by falsely marketing and misbranding Suboxone through false superiority and pediatric safety claims to health care professionals and state program managers. The presentation will walk participants through the investigation from beginning to end - Indivior's criminal fraud scheme; the methods and manner of investigation, including a momentous search warrant execution at Indivior's corporate headquarters in Richmond, Virginia; the key evidence that was developed; successes and failures throughout the case and lessons learned by the government's team.

- Jeffrey Overbeck, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General

- Randy Ramseyer, Assistant U.S. Attorney, U.S. Attorney's Office - Western District of Virginia

Buckle Up and Hold On As We Tour How to Navigate FWA Changes
Presented by Healthcare Fraud Shield
The healthcare industry may feel like driving along a windy road constantly under construction. How do you stay focused when it feels like the road never ends? This session will walk through new and changing information from trends, schemes, regulations to procedure codes and drugs. What are the best approaches to stay up-to-date and how does this ever-changing landscape translate to data mining and capturing fraud, waste, and abuse (FWA)? Participants in this session will learn about the best resources for keeping up to date on the changes impacting FWA, strategies for modifying your processes to account for changes and updates. Finally, learn how to stay ahead of emerging schemes and still monitor known FWA behaviors.

- Jennifer Hendrix, CFE, CPC, CPMA, Fraud Scheme Analyst
- Karen Weintraub, AHFI, CPC-P, CPMA, Executive Vice President

Knowledge Network

1:45 pm – 2:00 pm **Break with Exhibitors**

2:00 pm – 3:00 pm **Concurrent Sessions**

Investigation of the Year
Learn about the case that won NHCAA's 2021 Investigation of the Year Award. Attendee can listen to the investigative strategies, multi-organization cooperation and case building excellence that led to a successful resolution in this case. Congratulate the winners of this coveted NHCAA honor.

Cloning, signatures and the use of extenders, it's not fraud it's abuse.
Investigations are getting increasingly complex as guidelines change and providers documentation continue to be grey. This often is complicated when payers do not have clear policies surrounding some of the major issues that are being identified in provider documentation. Cloning, signature guidelines, and the use of extenders are making the ability to render findings and overpayments more time consuming and difficult. What happens when your health plan doesn't have a solid policy in place around these issues- how can your health plan save the investigation and render findings? This presentation will discuss different ways that you may be able to save these investigations including how to triage multiple findings and render education. Case studies with redacted PHI will be presented to show examples of real case documentation.

- Elizabeth Deak, CPC, CPMA, CEMA, Lead Investigator, Evolent Health

- Mary Beach, AHFI, CFE, HIA, HCAFA, MHP, Sr. Director Program Integrity, Evolent Health

A Case Study of a Dentist Who Preyed upon the Elderly and Vulnerable
Although most dentists are caring and professional, unfortunately, there are a troubling number of dentists who are dishonest and engage in a number of fraud schemes. The presentation will begin with an overview of common fraud schemes (billing for services not rendered, misrepresenting services, upcoding, and unbundling services) and an explanation of CDT (Current Dental Technology) codes, procedural codes developed by the American Dental Association (ADA) and used nationwide for dental billing. The presentation will then focus on one dental fraud case that took the DC MFCU several years to resolve. The presentation will use examples from other dental fraud cases to highlight key investigative and data analytic points.

- Benjamin Kellam, Senior Special Agent, Medicaid Fraud Control Unit, Inspector General of District of Columbia
- Jane Drummey, Deputy Director, Medicaid Fraud Control Unit, Inspector General of District of Columbia
- Jordi Clop, Medicaid Fraud Control Unit, Inspector General of District of Columbia

Impossible Days: How to create your own query
"Impossible days" is a well-known scheme which utilizes hundreds or thousands of procedure codes. In this session, the presenters will explain the elements required to create an impossible days rule and show how they gathered 'known durations' for 'known codes' to create a reference chart of times and integrated this into the organization's existing data. They will cover the resources needed, creation of a physician time chart, decreasing false leads, learning from QC, identifying the best leads and setting your threshold. Finally, the presenters will show how they ran queries to identify providers who performed services which took more than 16 hours per day.

- Jared Williams, CFE, SIU Senior Data Mining Consultant, Aetna
- Donna Paulsson, Senior Informatics Analyst, Aetna

Million Dollar Referral
On a daily basis an SIU receives referrals from departments within the Insurance Company, Members and even providers. Many of these referrals are billing issues and can be referred to the appropriate departments. However, some referrals require SIU intervention. How do we discern the difference? In this case study, participants will learn how one member referral led to an SIU investigation recovering over one million dollars. In this case, it was uncovered that the hospital's third-party vendor site had incorrectly use a Medicaid member's name with a private insurer's account. Participants will hear about

the steps of this in-depth investigation and recognize the value of following a claims submission, and how incorrect claims can affect members.

- Brian Lally, CPC, Manager SIU, Anthem
- Raymond August, Investigator II, Anthem

No Surprises Billing Act: Are Payers Ready for January 1, 2022?
Presented by EXL Health
The deployment of the No Surprise Bill Act on January 1st, 2022, is likely to bring extreme opportunities and challenges to Providers and Payers alike. The new legislation that offers consumer protections for the member on balance bill events will also force a new relationship among payers and providers that have historically relied on out-of-network billing. Providers will need to adopt new billing practices to meet federal laws, including guidelines for denials and arbitration. Payers will need to prepare for price transparency and counter-arbitration events. Awareness and sound implementation strategies will be critical, as well as preventive measures around violations. Payers will need to consider their operational readiness for the law, consumer outreach efforts, and negotiation strategies. Learn how to create a road map to ensure compliance with the bill's regulations, and ways to prevent against potential disputes with provides, arbitration submissions, and potential non-compliance fines.

- Tina Azar, Vice President, EXL Health
- Cheryl Duva, Vice President, EXL Health

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3:00 pm – 3:15 pm **Break with Exhibitors**

3:15 pm – 4:15 pm **Concurrent Sessions**

SIRIS Investigation of the Year
Each year NHCAA awards an investigation of the year that leverages the data available in the SIRIS database. This session offers participants the opportunity to hear how a SIRIS lead led to an award-winning investigation. Attendees will follow the investigative twists and turns and lessons learned for building a successful case.

Implanting Integrity with Breast Reconstruction
The Women's Care Act provides for reconstructive procedures associated with breast cancer. Cosmetic and specialty practices are leveraging the subtle differences between the reconstructive procedures to expose payor organization to cosmetic surgery that is not covered under this act. In addition to breast procedures, many other associated procedures will be identified to

alert investigators and clinical staff to be aware of these practices. With the expansion of cosmetic services in offices and provider owned surgical centers, the opportunities for recovery will be explained. Correct coding initiatives, guidance and sourcing will be defined with clinical examples to identify unbundling, abuse of modifiers and misrepresentation of non-covered services. Multiple surgical specialties, wellness clinics and spas are often involved in these schemes.

- Rae McIntee, DDS, MD, MBA, FACS, CPE, Medical Director SIU, Blue Cross and Blue Shield of Minnesota
- Lisa Hornick, CPC, CPMA, CEDC, CPC-I, CPhT, Ideation and Coding Specialist, Blue Cross and Blue Shield of Minnesota

The Nitty Gritty – the Sequence of Dental Procedures
The presentation will discuss the pattern of multiple dental codes in sequence. There are patterns of codes that should be together and other patterns that SHOULD NOT be together and there is also a factor of the time frames of sequences that are important. During this session, the presenters will discuss the patterns that are red flags to potential abuse or fraud. Some examples of patterns that should be together are core buildups followed by a crown or scaling and root planning followed by periodontal maintenance. There are also cases where multiple codes should not be together or in sequence and here again reveals a pattern of potential abuse or fraud. Some examples of this would be multiple surface restorations followed by extractions, prophy followed by scaling and root planing and single surfaces on the same tooth done in a short period of time. Case examples for each scheme will be given which will include how the pattern was discovered, how the investigation was conducted and the outcome of the case.

- Patricia Schifflett, RDH, AHFI, Clinical Dental Analysts, Delta Dental of Virginia
- Kim Brown, RDH, AHFI, Clinical Fraud Analysts, Delta Dental of Virginia

Optimizing Opportunities with Credentialing Partners
Blue Cross NC SIU has designed and implemented a highly effective partnership with our credentialing partners to prevent problem providers from gaining entry into our networks. This session will show how this strong relationship has been mutually beneficial in that we assure high quality providers for the members as well as take an active step in prevention of FWA. Presenters will demonstrate how shared goals and ideals can serve as a foundation for these relationships and bridge the gaps in the system. Attendees should leave with an understanding of the significance of this partnership as well as steps they can take to maximize their own partnerships within their organization.

- Kelley Anglin, SIU Investigator Blue Cross NC

- Anne Marie Oberheu, SIU Medical Director, Blue Cross Blue Shield of North Carolina

Medicaid Managed Care Compliance Oversight and Program Integrity
Presented by IBM Watson Health
State Program Integrity units often lack dedicated resources, training, or expertise to fully oversee Medicaid Managed Care Organizations (MCOs). So, what can be done in the midst of a pandemic to comply with federal MCO oversight regulations? Join IBM Watson Health policy experts for a fast-paced, focused discussion on developing a consistent, effective compliance plan that incorporates best practices and exceeds federal requirements. Managed Care oversight consists of reviewing fraud, waste, and abuse prevention efforts as well as encounter data validation, payment suspension, overpayment recovery, terminated provider and adverse action reporting. The presenters will review areas of oversight weakness found in federal state audits to promote compliance with relevant rules and requirements. This presentation focuses on policy requirements that guide proper and necessary data requirements and collection to promote Medicaid MCO Program Integrity. The actual codes and techniques will vary by MCO and by state.

- Dennis Garvey, JD, Director of Managed Care Program Integrity Oversight, IBM Watson Health
- Thomas Schenck, MBA, Senior Manager, IBM Watson Health

Knowledge Network

4:15 pm **Adjourn for the day**

Thursday, November 18

11:00 am – 11:45 am **Daily Welcome & General Session**

11:45 am – 12:00 pm **Break with Exhibitors**

12:00 pm – 1:00 pm **Concurrent Sessions**

Genomics: A FWA Model
This project was a result of the DME Telemarketing Brace Scheme, which began with a list of DME providers suspected of fraudulent activity. This presentation will describe how three areas of the company came together to analyze another possible scheme and identify providers with a high potential for fraud within that scheme. The SIU Data Mining team, and Aetna's Clinical Insights Analysis team brought together their unique skills and collaboratively identified features

and fraud characteristics which are used in a machine learning model built by the Fraud Analytics team. This model of collaboration leveraged machine learning and genomics billing data to identify labs with high probability of FWA billing patterns and assigns a fraud probability score to labs billing for genetic testing. That score is then used by the Data Mining team to focus in on providers with a high fraud probability score, research and pass on the investigative teams as appropriate. Participants will learn about cross organization collaboration, interpreting predictive analysis models, and strategies for leveraging analytics in investigations.

- Rima Malla, SIU Project Lead, Aetna
- Ed Wang, Lead Data Scientist, Aetna
- Joanne Armstrong, MD, CMO Women's Health and Genomics, CVS Health

Graph Analytics: We're on a Node to Nowhere
Graph analytics are underutilized in FWA data analysis. The composition of graph data is fundamentally different than that of a traditional relational database. Use of entities and the links which connect them illustrate a picture not otherwise captured using table-composition data extracted from claim forms. Separately, community detection algorithms can be deployed to identify new leads leveraging previously unseen connections including patient referrals. Graph analysis is derived by the nature of relationships between entities. The concept of homophily implies that bad actors are not randomly distributed among a population of entities; rather, they tend to cluster together. These clusters can be identified by exploring existing relationship patterns whether through member referral, utilization of mutual providers like DME or laboratories or same company officers/authorized officials. This presentation will describe fundamental components and nomenclature of graphing data including nodes and edges which can be used to expand existing investigations.

- Jason DiNovi, Senior Analytics Consultant, CVS Aetna
- Ying Xue, Senior Analytics Consultant, CVS Aetna

Data Analytics and Dental Investigations
This presentation will provide an understanding of how data analytics can be utilized to compare dentists to their peers and profiles dentists relative to submitted CDT codes to identify FWA. It will demonstrate how data analytics can used throughout the investigation, not just initial date mining and the lessons learned by presenting related case examples. The presentation will show how date can be visualized to present investigative findings, educate providers, negotiate settlements, change aberrant billing behaviors and aid in illustrating findings to law enforcement, the court, and other non-clinical personnel

- Stewart Balikov, DDS, Director of Dental Special Investigations, Anthem, Inc
- Debra Sahulka, RDH, MBA, Clinical Investigator, Anthem, Inc.

The Value of Technology in Claims Investigations
Presented by Skopenow
Technology is changing how insurers manage the claims process. This presentation will explore how manual SIU investigations can be augmented by utilizing technology to save 80% of staff hours currently spent on each investigation. We'll discuss how computer vision and AI can increase efficiency by automatically finding and verifying a claimant's digital profiles across social media and the web. The presenters will demonstrate how automation can help an investigator sift through thousands of images and pieces of content instantly and automatically trigger alerts by matching photos, videos, and keywords to specified behavior types. Participants will learn to automate the identity verification process and how to easily create legally compliant reports.

- Mike Pekala, Director of Sales, Skopenow
- Rob Douglas, Chief Executive Officer, Skopenow

Innovations in Payment Integrity: How AI Identified Over $235M in FWA for One Healthcare Payer
Presented by MasterCard
In this session participants will learn how Artificial Intelligence identified over $235M of previously unknown fraudulent claims, 2,700 high risk providers and improved claim-level detection by 3X for one regional healthcare insurance company. Presenters will explain how AI technology identifies healthcare fraud before payments are made, preventing the "pay and chase" cycle for healthcare payers. By drawing from an actual case study, attendees of this session will learn how AI can be deployed successfully in the field and why AI is the next generation in innovations being applied to healthcare FWA mitigation. The session will also explore FWA problems and challenges; how AI drives operational efficiencies; actual examples of how AI identified fraudulent providers; and how AI models produce scores of suspiciousness per provider that allow SIUs to take actions to save their organizations hundreds of millions of dollars.

- Tim McBride, AHFI, Director, Healthcare Product Development and Innovation, Mastercard
- Jessica Gay, CPC, AHFI, CFE, Vice President and Co-Founder, Integrity Advantage
- Beth Griffin, Vice President, Healthcare Vertical, Cyber and Intelligence, Mastercard

Knowledge Network

1:00 pm – 1:15 pm **Attendee Activities**

- Taste of San Antonio
- Health and Wellness

1:15 pm – 2:15 pm **Concurrent Sessions**

"Gimme Some Skin": Current Skin Substitute Schemes
In this session, participants will walk through a case study which will illustrate how the skin substitute scheme was identified, what our data revealed, and codes and red flags on "Q code claims". Participants will also hear how LCDs and policies used, the nuances in FDA language, and how companies abuse public's lack of understanding the differences in the various types of approvals to employ deceptive marketing tactics. The presenter will illustrate an organization's avoidance savings generated from the setting of custom edits and provide information about CR 10901. Participants will gain insight on how the revamped the LCD process allows stakeholders to directly communicate and collaborate with the MACs in the LCD process. During the presentation, the presenter will also discuss some backlash and provider complaints that was encountered, as well as offer perspective on other emerging trends in skin substitute schemes.

- Tameika Lewis, MD, Medical Director Payment Integrity, WellMed/Optum

How Accurate Coding, the FDA, and other Sources Can be Used to Address Schemes, including COVID, Impacting Your Organization
The COVID-19 pandemic resulted in very quick legislation through the Families First and CARES Act that appeared to bind health insurance organizations into paying claims without the due diligence, including medical management, normally available. This presentation will break down some of the nuances throughout those acts as well as information available through the FDA that your organization can consider examining to determine whether certain claims should be paid and/or what they should be paid at. The presenter will discuss how to pull that information together in a format that can be presented to your leadership. The presenter will also cover other ways that the FDA site information combined with other resources including the AMA, CDC/CLIA, manufacturer sites, and CPT(R) can be used to determine appropriate coding for various lab tests to ensure your organization is not paying for incorrect billed or lab tests not performed.

- Shauna Vistad, AHFI, CPC, CPC, CFI, Director, SIU, Oscar Health

On the Front Lines of COVID-19 Fraud with the SMP
In this session, representatives from the Senior Medicare Patrol (SMP) program will provide a unique perspective on COVID-19 fraud complaints received over the course of the pandemic. The SMP tracked COVID-19 fraud complaints for over a year in order to develop "real time" fraud prevention materials for the public and provide case referrals and fraud intelligence to law enforcement. Detailed information will be provided regarding the fraud type and method of contact trends that developed during tracking. Specific trends noted in the 54

state-based SMP programs will be provided including geographical analysis about the shift from 2019's genetic testing schemes to 2020's pandemic fraud. Information will be provided regarding social engineering techniques used by the scam artists, especially in their efforts to commit medical and financial identity theft. The presentation will include new products and processes created by the SMP to assist law enforcement and educate Medicare beneficiaries on fraud prevention and reporting.

- Marissa Whitehouse, ACL Program Manager, Senior Medicare Patrol, US Dept of Health and Human Services - Administration for Community Living
- Jennifer Trussell, Consultant, Senior Medicare Patrol National Resource Center

In the Trenches with Missouri: Best Practices for Building a Top-Tier Payment Integrity Unit
Presented by Alivia Analytics
When you're responsible for Medicaid payment integrity and protecting billions in taxpayer dollars, building a top-tier payment integrity unit is critical. With the landscape changing so fast, how do you stay ahead? Join us for an impactful session where you'll hear directly from Missouri's Director of Medicaid Audit and Compliance, as he shares his real-world experience and learnings. Participants will gain actionable, tangible best practices to put into practice right away, along with a transparent view into Missouri's health care payment integrity unit and the real-world challenges and learnings.

- Dale Carr, Director of Medicaid Audit and Compliance, State of Missouri
- Alex Kormushoff, President & COO, Alivia Analytics

Using Pre-pay Tools and Insights to Fight Fraud
Presented by Optum
Healthcare fraud detection is an ever-evolving process in today's payer markets. As a result, special investigation units (SIUs) spend a lot of time and effort working internal and external tip lines, researching published schemes, and utilizing various tools and platforms built internally and purchased through third-party partners. In parallel, Payment Integrity offices are increasingly investing in sophisticated pre-payment detection and review processes. With this shift to pre-payment avoidance of improper payments, a clear opportunity has emerged for SIUs to detect fraud faster and to scale their review operations. The presenters will teach how to use pre-payment claim reviews as a source of data for identifying new case leads and how to better target provider flags with pre-payment solutions. They will also demonstrate the ability to run data analytics against claim-level review outcomes to incrementally identify bad providers and schemes.

- Jeremy Hill, Vice President, Payer Solutions, Optum
- Matt Choffin, Vice President, Payer Market Solutions, Optum

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2:15 pm – 2:30 pm **Break with Exhibitors**

2:30 pm – 3:30 pm **Concurrent Sessions**

The Triple Threat: Brace Yourself, Don't Get Soaked, & It's Genetics
The telemarketing scheme has expanded from the old 'cold calling' scheme into new territory to include not only the 'free' DME, but high dollar inappropriately prescribed antibiotics and antifungal pharmacy medications, and 'free' genetics testing. Telemarketers enlist practitioners, or those masquerading as physicians, to 'prescribe' unnecessary high dollar antibiotics (aka the CMS 'foot bath scheme'), and to order thousands of dollars in unnecessary genetic testing; such services which may actually cause harm to Plan individuals. During this presentation, participants will learn to identify providers who engage in all three of these schemes simultaneously. Such providers may also add to this scheme by billing for 'telemedicine' visits not actually provided. Participants will learn to spot the suspicious CPT and HCPCS codes, as well as the pharmacy drug names, which will then allow you to open your own SIU investigations and prevent fraud.

- Roberta Hooyman, AFHI, HIAA, Lead Developer SIU, Optum Payment Integrity
- Kristine Whittaker, Senior Fraud Investigator, United Health Care - Optum

Skills for Effective Fraud Examination Report Writing
This session will examine the fraud laws, auditing principles, and investigating procedures that are needed for effective fraud examination reporting. The session will discuss the how non-government agencies and insurance companies can develop reports for different audiences including law enforcement investigations and criminal and civil court cases. Finally, the session will review ethical and professionals standards that should be considered for healthcare investigations and fraud examination reports. The elements that will be discussed in this session will include; requirements, ethics, and professional standards of fraud examination and reporting; fraud laws to audit and investigate fraud including the importance of referencing this information in fraud reports; elements of the fraud examination or investigative reports; and different types of audit and investigative reports including supplemental correspondences that will assist with fraud examinations. Finally, the presenter will discuss the importance of including law enforcement.

- Melissa Berdell, DHCE, CFE, AHFI, CHC, Director, Fraud, Waste, and Abuse, Compliance Department, Gateway Health

Teledentistry: A Response to a Pandemic Causes Concerns to Dental Benefit Plans

As the COVID-19 pandemic sent dental offices into lockdown, teledentistry appeared as a means of providing access to care. Though not a new medium in itself, teledentistry has historically been slow to take hold; that is, until a pandemic forced a rapid advancement of technology and policy to support its use. Naturally, this has created an environment loaded with uncertainty — and ripe for fraud, waste and abuse. This presentation will give an overview of the development and current applications of teledentistry with the focus on proper coding and claim submission as well as the areas of concern for dental fraud investigator.

- Linda Vidone DMD, Chief Clinical Officer, Vice President Clinical Management Delta Dental of Massachusetts

Detect the Undetected: Using AI & Data Analytics to Identify Previously Unknown FWA Schemes

Presented by Codoxo

During this session, HMSA will take the audience through their journey of using fraud detection software to identify and investigate a previously unknown testosterone replacement therapy (TRT) FWA scheme that significantly impacted patient safety and created a projected risk exposure of over $2.2M in an 18-month period. The presenters will provide practical insights into the data, codes, and analytics that helped to detect this outlier provider behavior and the investigation process followed for rapid intervention. Detecting previously unknown schemes is a critical strategy HMSA is using to help improve patient safety and mitigate their overall risk exposure.

- Virginya Aronson, Sr. Manager, Special Investigations Unit, Hawaii Medical Service Association (HMSA)
- Derik Ciccarelli, Healthcare Fraud Analyst, Codoxo

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3:30 pm – 4:30 pm **Concurrent Sessions**

The Winnebago Scheme

The Winnebago Scheme in the classic sense is when a “provider” fills an RV with diagnostic/testing devices and drives around the country and sets up in church parking lots, health fairs, shopping malls or any place that testing or screening of Medicare patients can be done with patients run through quickly. High dollar testing in ultra-sounds—total body, bone density, nerve conductions, autonomic testing, balance testing, and now even cognitive testing via laptop. CMS has several LCDs (Local Coverage Determinations) on this testing and this will be a springboard for how we look at what is billable to Medicare (and others). In this presentation, participants will learn about the scheme, the

pattern of the 'packaged' non-invasive testing, including what is normal versus abuse or fraud, and the red flags to watch for.

- Cheryl Ray, DO, MBA, FACN, Senior Medical Director- Payment Integrity, WellMed/Optum

SIU Prepayment Review, History, Lessons Learned and The Future
The presentation will address the basic development and operation of the Prepayment Review (PPR) process including development of cases for submission, coding review, professional and facility review, claims platform issues, and the role of staff in the process. The role of data will be discussed as it pertains to development of the investigation for PPR and use of data analytics throughout the entire process. Participants will learn what parts of the process are important to communicate with public and private partners including the PPR findings and results related to specific facilities, practices and providers and potential schemes. The presentation will also address strategies for maintaining provider portfolios and methodologies to avoid loss of savings through having to dump claims. And finally, participants will learn about the current status of PPR application and future issues and concerns.

- John Houston, CPC, Director, Anthem, Inc.
- Beth Franke, PMP, CPC, MBB, Director, Anthem, Inc.

Leveraging AI for Success
Presented by Shift Technology
This presentation will focus on how an AI solution can be leveraged so that discovery and knowledge is distributed to key stakeholders of major areas of an organization. The goal of the presenters is to provide insight by exposing best practices. They will highlight the ways in which an AI solution can lay the foundation for improved knowledge, workflow, and the operationalization of the decisions that the system creates. The presenters will show how different areas of the same organization can use new knowledge to make decisions on the potential fraud by an individual provider or a group practice and how imperative that the same data and findings need to be distributed to the special investigations, audits, network, credentialing, legal teams and medical review staff.

- Peter Kapasakis, MHA, Customer Success Manager, Shift Technology
- Sherri Horowitz, Senior Healthcare Executive, Shift Technology

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4:30 pm **Adjourn for the day**

Friday, November 19

11:00 am – 2:00 pm **Workshops**

Enhancing your Management and Leadership Skills

Part I - Different Recipes for Creating an SIU

There is no such thing as a cookie cutter SIU. However, in order to build an SIU there may be different ingredients and varying ways to cook it up. This session will discuss all the fixings including, but not limited to structure, staffing, regulatory requirements, obstacles, and resources and how they all mix together in one bowl. The presenters will demonstrate considerations impacting different plan sizes, states and the various lines of business for a well-rounded SIU meal.

- Kristin Griego, AHFI, CFE, CPMA, Payment Integrity Unit Supervisor, Prominence Health Plan
- Karen Weintraub, AHFI, CPC-P, CPMA, Executive Vice President, Healthcare Fraud Shield

Part II - Setting Goals for FWA Program Success

Healthcare fraud, waste and abuse (FWA) teams provide tremendous value across health payer organizations. However, many organizations find it challenging to create SMART goals to measure the value of their FWA team and as a result, are unable to clearly articulate that value to their leadership. Instead, many use cascaded goals or create goals that are difficult to measure. In order to effectively gauge the success of your program and describe the impact it has on the health payer, you must tie the goals to the work that your team performs each day. This session will cover five (5) types of goals that that every FWA team should have in place and provide specific examples of metrics that can be measured. We will also discuss ways to track each type of goal, explore the benefits of instituting a team goal and options for integrating these goals into other organizational cascaded goals.

- Jala Attia, AHFI, CFE, CHC, President, Integrity Advantage
- Jessica Gay, CPC, AHFI, CFE, Vice President, Integrity Advantage

Data Analytics Workshop

Part I - Navigating a Sea of Technology and Analytical Jargon

Using architectural assessment as a navigation chart to traverse through sea of technology jargon and name Are you drowning in a sea of technical jargon? Do analytical terms or acronyms such as NLP, machine learning, AI, or augmented reality confuse you? If yes, the presenter in this session will discuss, debunk and define what these terms really mean. Additionally, the presenters will provide attendees with an architectural assessment tool, a navigation chart that may be utilized to traverse the sea of "tech" jargon and aid in the investigative process. The presentation will examine a generic definition of regression as mental

model to understand these algorithims and enable participants to make better technology choices as investigations grow increasingly complex.

- Hadi Halim, Compliance Consultant, UHC
- Matthew Berls, Senior Director of Investigations for UHCSIU, United HealthCare
- Matthew Haberman, Associate Director UHC SIU, United HealthCare

Part II - AI Driven Healthcare Fraud Detection and Prevention Platform

Part two of this session with enable an investigator to get more comfortable with Artificial Intelligence. Are you curious about how Augmented Intelligence (AI) is used to enhance investigation? In this panel, the presenters will share their experience with collaborating across investigation-technical team to implement AI. The panel will provide a roadmap for upgrading your organization's technology footprint. They will discuss examples of how to engineer claims data, case tracking systems, and enhanced credentialing. Through this strategy, the collaborative team was able to use some AI tools to augment investigations by pointing out lead faster than manual search through several databases. This session will conclude with Q&A with architects that collaborate to create this AI system.

- Krystine Mahmood, MHA, Vice President, United HealthCare
- Hadi Halim, Compliance Consultant, United HealthCare
- Mayank Kumar, Associate Director Data Science, United HealthCare

2:00 pm **Conference Adjourn**