Agenda*

All of the ATC will be hosted on the Convention Level of the Hyatt Orlando.

Tuesday, November 15

10:00 am - 5:30 pm — ***Registration and Information Desk Open***

4:00 pm – 5:15 pm — ***Opening Remarks*** *(Plaza Ballroom FG)*
Louis Saccoccio
Chief Executive Officer
National Health Care Anti-Fraud Association

Keynote Address
Making an Impact
Rick Rigsby, PhD
Internationally Acclaimed Speaker and Professor

5:15 pm - 6:45 pm — ***Welcome Back Reception*** *(Regency Foyer)*

Anti-Fraud Expo Hall Opens on Wednesday, Nov 16 @ 9:30 am and closes on Thursday, Nov 17 @ 2:00 pm

Wednesday, November 16

7:00 am - 5:00 pm — ***Registration and Information Desk Open***

8:00 am - 9:30 am — ***General Session*** *(Plaza Ballroom FG)*

Federal Agencies Fighting Health Care Fraud: Effective Collaboration and Proven Success

- Bradley K. Hart, Deputy Director, Center for Program Integrity, Centers for Medicare and Medicaid Services
- Greg Heeb, Unit Chief, Health Care Fraud Unit, Federal Bureau of Investigation, U.S. Department of Justice
- Allan Medina, Acting Senior Deputy Chief, Fraud Section, Criminal Division, U.S. Department of Justice
- Christian Schrank, Deputy Inspector General for Investigations, Office of Inspector General, U.S. Department of Health and Human Services

9:30 am - 10:15 am — ***Coffee Break in the Expo Hall*** *(Regency Ballroom R)*
Opening of the Expo Hall

10:15 am - 11:15 am — ***Concurrent Sessions***

Investigative Quality: How to Ensure Your Team Produces High Caliber Work *(Regency Ballroom Q)*
When was the last time you took a hard look at the quality of work produced by your team? With the events over the last few years, teams have had to do more

Agenda as of November 10, 2022. **This agenda is not final. Updates continue to be made to this agenda.*

work with less resources often sacrificing quality in order to handle higher volumes of work. Join us for this session where attendees will learn key questions to ask in evaluating investigative case quality, who should set those standards and why you need to raise the bar. We will discuss ways in which SIU leaders have successfully set metrics that accurately measure the caliber of investigative output from the receipt of a referral to the moment a case is closed.

- Harry Guglielmo, AHFI, Senior Director, Centene (Formerly Fideliscare)
- Jala Attia, AHFI, CFE, CHC, President, Integrity Advantage

Prepayment Review: Impact and Prevention While Adapting to Change *(Plaza Ballroom I-K)*
Understanding the SIU Prepayment Review (PPR) process and building a high performing SIU PPR Program are only some of the goals for the faculty in this session. The faculty will provide details to allow attendees to understand how data analysis is used to lead to optimal results and identify the best cases for the greatest impact. They will share real results that can be immediately implemented. The discussion will include a review of proactive vs reactive techniques, and the impact and difference between the two. There will be details on the operation and inner workings of the PPR process including addressing InterPlan issues/concerns. In addition, the faculty will provide key components of datamining, examples on identification and prevention, and "fast tracking" PPR investigations.

- John Houston, CPC, Director Special Investigations Unit, Elevance Health, Inc.
- Joan Cooper, RN, CCM, CPC, Director, Clinical Fraud Investigator, Special Investigations Unit, Elevance Health, Inc.

Annual Update on Pharmaceutical Fraud Schemes *(Plaza Ballroom H)*
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, opioids, and related drug-treatment schemes, along with other areas of impact. He'll offer insights of COVID-19 on prescribing controlled and non-controlled drugs and enable participants to recognize new pharmaceuticals and associated schemes on the rise in their community.

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

60 Minutes That Never Happened: A Psychotherapy Fraud Case Study *(Orlando Ballroom LM)*
This case study will focus on a scheme to defraud the Connecticut Medicaid Program by submitting claims for psychotherapy services that were not rendered or were rendered by an unlicensed individual of more than $1.3 million from August 2018 to October 2020. Faculty will demonstrate how data analysis lead investigators to identify the significant increase in the fraudulent billings quickly, identified targeted patients to interview, and assisted in bringing to light the identity theft component of the fraud. Participants will gain insight into techniques used to maximize recovery of assets through coordinated and timely partnerships, and how impactful Victim Assistance can be to support and transition the victims in this case.

- Janet Ambrisco, Special Agent, Federal Bureau of Investigation, U.S. Department of Justice (New Haven Division)
- David Sheldon, Assistant U.S. Attorney, United States Attorney's Office (Connecticut)

The Perpetration of Member Data and Emergence of New Schemes *(Regency Ballroom P)*
The current methods for obtaining beneficiary information, and generating claims, have evolved past cold calls by marketing companies to members. Instead, providers are believed to be obtaining this member info from marketing agencies, clearing houses, provider portals, and/or payer eligibility vendor databases. Recent DME and lab investigations have confirmed, through interviews, record reviews, and website research, that services are being billed without any services rendered to members or action by their providers, and instead, appear to be generated solely from access to the member data. A review of the investigation process, will provide information on these schemes and how they have led to uncovering multiple entities engaging in such behavior. The faculty will also discuss the specific measures taken to further perpetrate Fraud, Waste, and/or Abuse. The goal of this presentation is for the audience to walk away with additional knowledge on how to limit financial loss, reduce future risk, and quickly identify new fraud trends related to the issue(s).

- Nicole Granato, CFE, Senior Investigator, Special Investigations Unit, Humana, Inc.
- Justin Cain, CFE, Manager, Humana, Inc.

A Shared Advantage: Building Robust Anti-FWA Analytics with Multi-payer Data *(Regency Ballroom O)*
Presented by Healthcare Fraud Shield
One company's data alone can certainly provide enough intelligence to detect Fraud, Waste, Abuse and Error. However, imagine each time your data is

analyzed in a post-payment environment it is automatically compared against other plan's data? What if then you could also turn that into prepayment review and savings? This session will explore the power of Healthcare Fraud Shield's near real-time Shared Analytics initiative including the types of data that can be aggregated across plans, the schemes that are applied across shared data and how Artificial Intelligence captures emerging schemes across shared data analytics.

- Karen Weintraub, AHFI, CPC-P, CPMA, Executive Vice President, Healthcare Fraud Shield
- Bill Van Fleit, AHFI, Vice President of Data Science, Healthcare Fraud Shield

Protecting Payers Against the Risks of Digital Transformation *(Orlando Ballroom N)*
Presented by Mastercard
Annual healthcare expenditures in the U.S. totaled $4.1 trillion in 2020 – almost 20 percent of the GDP – with projections of $6.2 trillion in 2028. This massive system is vulnerable to fraud, data breaches and other illegal activities. Novel applications of machine learning and artificial intelligence are turning the tables on nefarious actors within the healthcare industry. The panel in this session will discuss how the latest technological innovations are helping uncover patterns and identifying FWA before claims are paid. Gain insight from the pandemic to prepare for the next big shift or change in the industry.

- Tim McBride, AHFI, Director of Healthcare Product Development and Innovation, Mastercard
- Jessica Gay, CPC, CFE, AHFI, Vice President, Integrity Advantage
- Adam Faurot, Chief Commercial Officer, SPEAR Human Performance

11:30 am – 12:30 pm ***Concurrent Sessions***

Managed Care Organizations - SIU 101: What State Agencies & Law Enforcement Need to Know *(Orlando Ballroom LM)*
Designed to provide state and federal agency staff with insights on the Special Investigations Unit (SIU) within a health plan to provide a greater understanding of the unique business operations and practices of a Managed Care Organization (MCO) and fill the gaps to augment and streamline collaborative investigations. The presenters will briefly describe MCO functions but take a deeper dive into how the SIU operates within the overall managed care plan construct and what is/has to be done to meet contract requirements. Specifically, it's staffing, tools, methodology, and purpose as it aligns with their goals in the spirit of "Program Integrity" at a higher level. The vast experience of the presenters provides insight into not-for profit and commercial MCOs and Medicare contractors.

- David Collins, CFE, Manager of Investigations, Elevance Health, Inc.
- Malcolm Fletcher, AHFI, Special Investigations Unit, Manager, AmeriHealth Caritas
- Lori Peters, AHFI, Special Investigations Unit, Senior Director, Centene Corporation

Tackling the Large, Multi-Specialty Provider Group Investigation *(Regency Ballroom O)*
SIUs may avoid investigating large multi-specialty provider groups for various reasons. These types of investigations can be difficult to analyze and highly complex to sample. With large provider groups, there is also an elevated risk of provider abrasion, and the larger the group the more likely it is they serve a significant portion of the member population. This presentation shares why investigating these groups is important. The presentation will also include a step-by-step investigation of a large, multi-specialty provide group investigation from detection using data mining through sampling and record review.

- Michelle Rua, Investigations & Analytics Consultant, Integrity Advantage
- Jessica Gay, CPC, CFE, AHFI, Vice President, Integrity Advantage

A Little Something for the Pain: Prescriber-Focused Investigations to Safeguard Members *(Plaza Ballroom I-K)*
Prescriber investigations primarily focus on one of two prescription concerns: high-cost and potentially unnecessary medications, and low-cost and potentially abused controlled substances. Both types of prescribing concerns are harmful to health plan members and simultaneously drive up the cost of health care. This presentation will demonstrate best practices in pharmacy and professional data analysis methods, which support the identification and investigation of outlier prescribers suspected of fraud, waste and abuse. The data analysis demonstration occurs at the prescriber level as well as the dispensing pharmacy and health plan member levels to ensure investigations comprehensively address all possible concerns. Participants will also learn the essential components of constructing prescriber education letters, which logically present the identified patterns of concern to the health care provider to promote a change in prescribing behavior. Though demonstrating these methods, SIUs will be better equipped to safeguard members' health and actualize cost of health care savings.

- Shannon Zabo, MPA, AHFI, CPC, Investigator Lead, Elevance Health, Inc.
- Wayne Fisher, MBA, AHFI, CFE, Manager, Elevance Health, Inc.

COVID-19: Be Ready for the Unexpected *(Regency Ballroom P)*
This presentation will look back over the last two and half years' worth of COVID-19 investigative findings, to review where we are, what we've learned, and what we expect going forward. The Public Health Emergency, associated with COVID-19, came with many challenges as well as opportunities for entities to engage in several schemes, such as price gouging, abusive and fraudulent billing of infectious agent testing services, inappropriate testing sites, member solicitation, and so much more. In this presentation we will discuss impediments that have affected many payers, and review what data mining strategies/investigative techniques have proven successful. We'll also review strategies for identifying recovery opportunities, and how law enforcement has responded to investigative findings. The audience can expect to walk away with a robust understanding of the current landscape of COVID-19 investigative trends, strategies used to identify aberrant behavior, and ways of investigating new COVID-19 claims.

- Justin Cain, CFE, Manager, Humana, Inc.
- Nicole Granato, CFE, Senior Investigator, Special Investigations Unit, Humana, Inc

U.S. vs. Marshall Plotka: An Atypical Investigation and Prosecution of a Pain Management and Addiction Doctor *(Plaza Ballroom H)*
Dr. Marshall Plotka owned and operated an urgent care clinic that specialized in pain management and addiction services in Huntsville, Alabama. Claims data analysis identified him as an outlier in several classifications, including opioid-cocktail prescribing. Agents learned from local law enforcement that there had been over thirty calls to his residence for drug related activity, including three street-drug overdoses. In the doctor's own words, it was "Dr. Plotka's fun house," where he allowed others to abuse drugs. The case team took an aggressive and novel approach to quickly charge Dr. Plotka and neutralize the danger he posed to the community. This presentation will focus on the value and challenges of using non-traditional charges, the benefits of cell phone data, and the importance of coordinated efforts between law enforcement (federal and local), the pharmacy board, and commercial insurer when public safety is a factor.

- Susan Shimpeno, Special Agent, Federal Bureau of Investigation, U.S. Department of Justice (Birmingham Division)
- Ben Bridges, Special Agent, Federal Bureau of Investigation, U.S. Department of Justice (Birmingham Division)

Remaining in Fraud Compliance While Preventing More Waste and Abuse *(Regency Ballroom Q)*
Presented by Cotiviti
By definition, health care fraud is the intentional deception to secure unfair or unlawful gain. As such, alleging fraud requires that payers spend months if not years of work to prove intent, which cannot be addressed within Prompt Pay deadlines of 45 days or less. So, what exactly is FWA *prevention* the industry talks about so much? In this session our experts will use examples of FWA trends to explain how a combination of claims-based and provider-centric reviews both post-payment and prepayment can help prevent waste and abuse while minding strict fraud compliance guidelines. Faculty will discuss best practices for administering an effective FWA program, inclusive of retrospective and prospective reviews to manage compliance requirements and optimize savings results. And the faculty will demonstrate how to execute a collaborative approach to claims review, resulting in incremental savings and catching bad actors before significant losses are incurred.

- Jennifer Putt, CFE, Manager, Special Investigations Unit, Highmark Wholecare
- Ryan Cleverly, AHFI, MSC, CSPO, Product Director, FWA, Cotiviti
- Ed McCormick, AHFI, CFE, CPC, Client Services Manager, FWA, Cotiviti

Leveraging Analytics in Missouri: Prioritizing Targets, Reducing Time, Recovering More Money *(Orlando Ballroom N)*
Presented by Alivia Analytics
The Missouri Medicaid Audit and Compliance Unit (MMAC) within the Missouri Department of Social Services (DSS) recently implemented a new solution to help investigators and auditors identify, recover, and prevent inappropriate payments in a more efficient and robust manner. By putting advanced analytics in the hands of the MMAC team, investigators can now identify emerging fraud trends to build more accurate, confident, and efficient investigative and audit plans. More specifically, investigators can proactively create a priority target list, determine a review plan for the primary allegation(s), conduct reviews in a more efficient manner, and improve the target list and fraud detection scenarios over time. The improved analytics ultimately assist to create a more efficient triage process for incoming referrals from various sources.

- Darla Weekley, Provider Review Manager, Missouri Medicaid Audit and Compliance/ DSS
- Matt Perryman, Lead Data Scientist, Alivia Analytics

12:30 pm - 1:45 pm ***Lunch in the Anti-Fraud Expo Hall*** *(Regency Ballroom R)*

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

Services Not Rendered: Pharmacy and Prescriber Fraud Scheme Case Study *(Plaza Ballroom H)*
In recent years the telemedicine fraud scheme evolved, which has only been exacerbated by the COVID 19 pandemic. In this case study, the faculty will explore how they identified FWA related to the Pharmacy and Prescriber in question utilizing data mining capabilities. They not only explored high spikes in utilization but took a deeper dive into the claims to utilize reversed and rejected claims, manufacture information, pricing information, submission times, and more to detect and escalate instances of FWA regarding the pharmacy/prescriber services not rendered scheme. Participants will learn how to navigate, review, and expand upon their investigative techniques to assist in obtaining evidence to support instances of pharmacy and prescriber services not rendered schemes. They will also gain new knowledge regarding documentation, and how to effectively utilize the documentation to combat instances of FWA pharmacy and prescriber services not rendered schemes.

- Jared Mendoza Duenas, Director, Special Investigations Unit, Prime Therapeutics, LLC
- Casey Jenness, Senior Clinical Pharmacist, Special Investigations Unit, Prime Therapeutics, LLC

Total Mishandling of Disease (TMD): Temporomandibular Disorders *(Orlando Ballroom N)*
Temporomandibular joint disorders are a diagnosis of exclusion. TMJ can be a medical problem, a dental problem, or a combination of both. It is essential to understand what is causing the patient's disorder before creating a treatment plan. Many states have mandates requiring the temporomandibular joint to be covered as any other joint. This allows for submission of the diagnostic and therapies to medical insurance. This presentation will assist in navigating the dental and medical insurance overlap, identify the CPT and CDT codes with details of appropriate utilization. Documentation requirements and examples of egregious record submission will be reviewed in detail. Outlier data analytics will be discussed with new trends and financial impact to the plans. Ancillary services including pain management, DME, physical therapy, trigger point injections and surgical intervention will be discussed.

- Rae McIntee, DDS, MD, MBA, FACS, CPE, Medical Director, Payment Integrity and Special Investigation Unit, Blue Cross and Blue Shield of Minnesota
- Lawrence Simon, MD, MBA, FACS, Medical Director, Blue Cross and Blue Shield of Louisiana

DME Fraud Schemes *(Plaza Ballroom I-K)*
Insurance companies have continued to see increase in fraud surrounding durable medical equipment (DME). This presentation will explore how these schemes operate and the violations as they relate to Medicare rules and federal law, detail red flags in your claim data and medical records and discuss strategies for investigation. The speakers will also walk participants through case study examples. A review of the investigation process will provide information on these schemes and how they have led to uncovering multiple entities engaging in such behavior. The faculty will also discuss the specific measures taken to further perpetrate Fraud, Waste, and/or Abuse. The goal of this presentation is for the audience to walk away with additional knowledge on how to limit financial loss, reduce future risk, and quickly identify new fraud trends related to the issue(s).

- Emily Foss, MBA, MAcc, CFE, Senior Investigator, Special Investigations Unit, Humana, Inc.
- David Popik, AHFI, CFE, Director, Special Investigations Unit, Humana, Inc.

Rural Hospital Investigation: Unraveling a Large Pass-through Billing Scheme *(Orlando Ballroom LM)*
The presentation will be a case study involving Palo Pinto General Hospital (PPGH), a rural hospital in Mineral Wells, Texas targeted for its lucrative in-networks contracts for lab tests. The faculty will explain how a conspiracy was orchestrated between the PPGH CEO and four executives from two marketing companies to defraud private insurance carriers in a $52 million-dollar HCF scheme. The scheme involved paying kickbacks to doctors for the ordering of allergy and genetic tests. The faculty will discuss physical and digital evidence acquired, to include the use of a key cooperator in the case. In addition to case details, the presentation will address best practices when working with our private insurance partners, differences in reimbursement rates of rural versus non-rural hospitals, the challenges of conducting the investigation, and the prosecutorial process.

- Diana Hernandez, Special Agent, Federal Bureau of Investigation, U.S. Department of Justice (Dallas Division)
- Matthew Weybrecht, Assistant U.S. Attorney, United States Attorney's Office (Northern District of Texas)

HFPP: Leveraging Data Analytics to Identify Fraud Leads *(Regency Ballroom O)*
The presentation will focus on current HFPP data analytics, with a particular focus on leveraging analytic results to develop investigative leads. Data analytics is often the catalyst for successful healthcare fraud investigations. The HFPP conducts data analytics based on known fraud indicators against their cross-payer healthcare claims database. This unique database is comprised of

healthcare claims data from both public and private health insurers allowing HFPP Partners a global perspective of potential fraud, waste, and abuse activity. HFPP Partner members, including State Medicaid Program Integrity Units, Private Payer Special Investigation Units (SIU), and Law Enforcement are leveraging HFPP study results to identify actionable leads and program savings. Attendees will learn how HFPP studies are developed and observe a live demonstration of specific study outcomes.

- Eric Roberts, Data Scientist, Healthcare Fraud Prevention Partnership, Trusted Third Party (HFPP TTP), General Dynamics Information Technology
- Jill Carraher, Partner Liaison Lead, Healthcare Fraud Prevention Partnership, Trusted Third Party, General Dynamics Information Technology

DRGs: Historical Review, Current Upcoding, and Future Technology Advancements *(Regency Ballroom Q)*
Presented by MedReview Inc.
This presentation explores the history of the DRG system, the refinements made over time, and how those refinements are being abused to game the system. The speakers will also breakdown how the latest technology is changing modern payment integrity to combat this type of fraud, waste, and abuse. The speakers will explore news stories with egregious examples of upcoding and review individual cases within their own book of business to highlight cases physician reviewers have found. Building upon workflow automation, MedReview's technology includes AI, natural language processing (NLP) and machine-learning (ML). MedReview uses NLP to ingest medical records and scan these records for keywords that will, tell the machine-learning piece of the algorithm what data to look for and the supporting clinical values. While many payment integrity firms have moved away from clinical validation using a physician, the speakers will illustrate why they believe it's time to double down on clinical validation.

- Michael Menen, MD, Chief Medical Officer, MedReview Inc.
- Spencer Young, Chief Executive Officer, MedReview Inc.

3:00 pm– 4:30 pm ***Workshops***

SIU Leadership Workshop *(Regency Ballroom Q)*
We've all been through some turbulent times over the past few years. There have been professional challenges, industry changes, and personal hurdles each of us has had to conquer. Now that we are back together in person, we have an opportunity to hear from the leadership within the Special Investigations Unit about issues and trends for the SIU. What are the current challenges and stressors for the SIU? How has the SIU changed over the past few years and what's on the horizon? Engage with this panel to find out what the leaders of SIUs are wrestling with.

- Robert Mays, AHFI, Staff Vice President, Elevance Health, Inc. (moderator)
- David Popik, AHFI, CFE, Director, Special Investigations Unit, Humana, Inc.
- Richard Munson, Program Integrity Chief Compliance Officer & Vice President, Investigations, UnitedHealthcare Investigations
- Sabrina Vera, Senior Director, Special Investigations Unit, Florida Blue
- Patricia Hoofnagle, Vice President, Special Investigations Unit, Magellan Health, Inc.

Dental Fraud Quick Hits: Leading Trends and Schemes *(Orlando Ballroom N)*
Dental fraud, waste and abuse schemes tend to present themselves in somewhat habitual forms, however over the past few years, some new schemes have emerged. The progression of technology and yearly updates to the CDT code set may create more opportunities for future fraud waste and abuse schemes. A review of the present schemes is helpful to keep in mind as investigators begin to consider emerging and possible future schemes along with examples of dental abuse as seen by both commercial and public investigators. The panel will dissect the schemes that might be within your claims data and how best to investigate them.

- Nicholas J. Messuri, Vice President, Fraud Prevention & Recovery, DentaQuest (moderator)
- Linda Altenhoff, DDS, Vice President, Program Integrity, MCNA Dental
- Brian J. Klozik, AHFI, CFE, Manager, Special Investigation Unit, Compliance, UnitedHealthcare Investigations
- Linda Vidone, DMD, Chief Clinical Officer, Delta Dental of Massachusetts

HHS-OIG Update: The Priorities and Opportunities for Law Enforcement *(Plaza Ballroom I-K)*
This panel from the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) will describe some of the most successful initiatives of the past year and examine priorities for the coming year. The panel will address key topics including Medicare Part C investigations, Health Resources and Services Administration/Pandemic Related fraud, Opioid/Prescription Drug cases, and Public/Private Partnership. This is a unique opportunity for an in-depth discussion on HHS-OIG's investigative efforts, effective techniques, outstanding achievements and to better understand public sector goals and the intersection with private sector insurers and other law enforcement partners.

- Isaac Bledsoe, Operations Officer, Office of Inspector General-OI, U.S. Department of Health & Human Services
- John Croes, Operations Officer, Office of Inspector General-OI, U.S. Department of Health & Human Services

- Stephanie Cheek, Operations Officer, Office of Inspector General-OI, U.S. Department of Health & Human Services
- Michael Fairbanks, Operations Officer, Office of Inspector General-OI, U.S. Department of Health & Human Services

Pharmacy Data and Documentation Workshop *(Orlando Ballroom LM)*
The workshop is designed to examine pharmacy data, the challenges in investigations, and effective partnerships between health plans and the pharmacy benefit managers (PBM). With panelists from both the insurer perspective and the PBM, participants will gain insights on steps for creating successful partnerships. The discussion will focus on fraud waste and abuse issues including how PBM's and health plans investigate FWA and partner to mitigate the identified issue.

- Mark Horowitz, Senior Manager, Investigations, Kaiser Permanente (moderator)
- Susan Collare, AHFI, CFE, CPhT, Investigations Consultant, Highmark
- Connie Gautreaux, Senior Investigator II, BlueCross BlueShield of Tennessee
- Blake Stockwell, CPhT, AHFI, Fraud Senior Manager, Express Scripts
- Robert Page, MS, CPhT, AHFI, Investigator, CVS/Caremark

4:30 pm - 6:00 pm ***Reception in the Anti-Fraud Expo Hall*** *(Regency Ballroom R)*

Thursday, November 17

8:00 am - 5:00 pm ***Registration and Information Desk Open***

8:30 am - 9:15 am ***General Session*** *(Plaza Ballroom FG)*

Lisa H. Miller, Deputy Assistant Attorney General, Criminal Division, U.S. Department of Justice

9:15 am - 10:00 am ***Coffee Break in the Anti-Fraud Expo Hall*** *(Regency Ballroom R)*

10:00 am - 11:00 am ***Concurrent Sessions***

Auditing with a Firm Foundation, Ensuring the Infrastructure is in Place *(Plaza Ballroom H)*
We don't know what we don't know. Conducting audits on your Managed Care Entities (MCE) and other applicable agencies allows an insight into all things

program integrity related. The audits are geared toward ensuring Program Integrity departments have appropriate language in their policies and procedures, and their requirements are clearly outlined, understood, and implemented prior to auditing. The audits also provide an opportunity for the State or contract holder to access case documentation to ensure appropriate actions, steps, and decisions were made. When you are ready to audit, draw from the instructions given to build an audit tool. Define your audit, give notification, and then see how the requirements seemed so clear to you, but not the MCE! This presentation aims to provide information as to how to build a foundation to build from if and when an agency wants to conduct audits on their contractors.

- Cindi Furlough, Compliance Manager, Office of Program Integrity, Division of TennCare, State of Tennessee
- Yvette Casey, Compliance Officer, Office of Program Integrity, Division of TennCare, State of Tennessee

Leveraging Advanced Analytics and Artificial Intelligence in the FWA Space: Guidelines and Best Practices *(Regency Ballroom O)*
Advanced Analytics and Artificial Intelligence are powerful FWA detection tools that can both greatly increase the number of actionable leads and reduce the time it takes to discover them. Successful application of AI in the FWA space requires both appropriate use of AI techniques as well as solid integration into the investigative workflow. In this session, participants will gain insight on the appropriate use of AI techniques as well as solid integration into the investigative workflow. They will gain an understanding on how to work with data scientists a checklist will be proposed to ensure alignment on requirements for actionable generated leads. And finally, participants will gain a real life application by a case study that highlights the application of both the analytic and integration techniques previously described where collaborative tweaks to actionable insights.

- Krystine Mahmood, Vice President, Data Science, UnitedHealthcare
- Mark Kanner, Principal Data Scientist, UnitedHealthcare

Noninvasive Ventilators: The Use and Abuse of Bi-level Positive Airway Pressure Devices *(Regency Ballroom P)*
Noninvasive ventilators are a form of bi-level positive airway pressure devices used in the treatment of a variety of lung diseases. These devices have been the subject of increased abuse since 2013. In 2020, a national DME provider entered a $40 million dollar settlement with DOJ regarding the fraudulent misuse of these devices in the treatment of chronic obstructive lung disease patients. The above-mentioned settlement notwithstanding, the improper use of these devices is still a problematic area for physicians, DME providers, and health

insurance plans. The purpose of this presentation is to share an introduction into the beneficial use of positive airway pressure devices, discuss the idiosyncrasies in regulatory law that created an opportunity for DME providers to engage in abuse, describe schemes used in the fraudulent provision of positive airway pressure therapies, and discuss how health plans can ensure the proper delivery of non-invasive ventilatory therapies based on current regulations.

- Robert "Steven" Slack, MD, Medical Director, Payment Integrity, UnitedHealthcare

Combating Emergency Room Visits and Hospice Fraud in a Billion Dollar Industry *(Orlando Ballroom LM)*
The presentation will cover trends in emergency room upcoding visits. Identify data to show unique patient examples of over billing with a less severe diagnosis. We will show year to year utilization trends for level 1 to level 5 of evaluation and management codes. We will show how we found exposure and finding to each higher levels of codes. Second part of the presentation will be on hospice trends and exposure which is hot topic today in all areas for fraud, waste and abuse. The faculty will show how to identify hospice patient with a non-terminal diagnosis and the number of days enrolled in hospice necessary based on the diagnosis. There will trends to show patient sharing and marketers who sign up patient for hospice. The faculty will have many visuals to show examples of each topic and have the audience walk away with knowledge to find any trends within their employment.

- RoseAnna Alcala, Special Investigation Unit Investigator III, LA Care Health Plan
- Joe Christensen, AHFI, Special Investigation Unit Manager, LA Care Health Plan

Fraud, Waste and Abuse Updates from the FBI *(Plaza Ballroom I-K)*
The presentation will discuss the FBI's Health Care Fraud Unit, and their FY22 initiatives and priorities for all 56 field offices. The presentation will cover emerging HCF schemes and threats, which are continually evolving and occur throughout the country, targeting both public, government-sponsored health care programs, including Medicare and Medicaid, and private health insurance plans of all sizes. The faculty will use actual case examples involving these emerging schemes to explain how the FBI and their partners conducted these investigations.

- Joseph Parker, Supervisory Special Agent, Criminal Investigative Division, Health Care Fraud Unit, Federal Bureau of Investigation, U.S. Department of Justice

Coordination is King: Use Case of Impossible Days for a Dietary Specialty *(Orlando Ballroom N)*
Presented by Codoxo
This session will demonstrate how MVP used an AI-based fraud detection platform to help their analysts to quickly identify suspicious activities that surfaced from their FWA platform. Attendees will hear how the AI platform flagged a suspicious Dietary specialty provider for billing impossible days by exposing a significant spike in the baseline of claims per month, primarily for their Medicaid population. MVP will share their best practices for managing a major case of this kind, including the steps their SIU team took to quickly move into action, procure recovery and have cost avoidance. This provider alone generated nearly $1.5 million in exposure for the health plan, emphasizing the criticality of early detection and rapid intervention, as well as seamlessly managing all pre-pay, post-pay, and investigation measures across internal stakeholders and the Northern District of New York Health Care Task Force.

- Sandra Caffarella, RN, CPC, CMPA, AHFI, Leader of Investigations, Special Investigations Unit, MVP Health Care
- Derik Ciccarelli, Healthcare Fraud Analyst, Codoxo

The Marriage of AI and HI in Pursuing Payment Integrity *(Regency Ballroom Q)*
Presented by MultiPlan
This presentation explores some of the benefits and potential pitfalls of a combined approach to using both artificial and human intelligence in fraud, waste and abuse investigations. Experts will explore how to avoid common pitfalls that arise when implementing AI/machine learning payment integrity efforts and identify best practices for the integration of machine learning and AI techniques with human intelligence. The session will also showcase specific examples of uncovering fraudulent activities and how the use of both human and artificial intelligence helped recover costs. Lastly, the session will dive into a specific case study example where AI and HI drove successful payment integrity outcomes.

- Ben Perryman, PhD, Operations Research, Vice President, Data Science Operations, MultiPlan
- Evan Pollack, MD, Chief Medical Officer, Medical Audit and Review Solutions

11:15 am – 12:15 pm ***Concurrent Sessions***

Planning and Implementing Program Integrity Risk Assessments *(Plaza Ballroom H)*
CMS conducts 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, as well as structures and environmental factors that influence or help managers achieve their objective to mitigate fraud risks. CMS will discuss its process for planning and implementing these risk assessments and how attendees can use them to focus their program integrity efforts on their most serious risks. CMS will also discuss how the Framework was used to evaluate potential fraud risks in both the Medicare and Medicaid programs.

- Dennis Sendros, Director, Division of Vulnerabilities, Innovation, and Strategy, Centers for Medicare and Medicaid Services
- Laura Minassian-Kiefel, Deputy Director, Division of Vulnerabilities, Innovation, and Strategy, Centers for Medicare and Medicaid Services

The Power of Pivot Tables *(Regency Ballroom O)*
The faculty will demonstrate and share best practices from an investigator perspective on how to exploit the power of Pivot Tables and explore the limitless range of use-function that these valuable analytic tools offer. The faculty will discuss innovative approaches on how Microsoft Excel's Pivot Tables can be leveraged to isolate, expose, and extract meaningful investigative details from a large data set. Participants will take part in an interactive demonstration of creative applications for using Pivot Tables to investigate healthcare fraud, waste, and abuse. Participants will also walk away with an understanding of advanced skills and techniques for manipulating healthcare claims data with Pivot Tables.

- Joseph Lamb, Lead Fraud Investigator, Health Care Service Corporation / Blue Cross Blue Shield of Illinois
- Tom Kusior, Lead Fraud Investigator, Health Care Service Corporation / Blue Cross Blue Shield of Illinois

Operation Double Helix: Cancer Genetic Screening Fraud Scheme *(Plaza Ballroom I-K)*
This presentation examines a scheme to defraud Medicare Part B, as well as Medicare Part C plans maintained by private insurance providers, through the submission of Cancer Genetic Screening (CGx) tests that were mass marketed to elderly individuals throughout the United States. With the help of co-conspirators, Ravitej Reddy was able to bill and receive payment from Medicare for over $127 million dollars for CGx tests that his laboratories, Personalized Genetics and Med Health, were not equipped to conduct. The faculty will discuss the importance of analyzing financial data, along with the value of private and public insurance data in federal health care fraud investigations. They will also discuss the importance of communication, and the use of internal

databases to deconflict on a larger scale with larger investigations involving multiple jurisdictions

- William Ray, Special Agent, Health Care Fraud Unit, Federal Bureau of Investigation, U.S. Department of Justice
- Al Vogt, Forensic Accountant, Health Care Fraud Unit, Federal Bureau of Investigation, U.S. Department of Justice

Prescribers and Co-Conspirators: A Partnership in TeleFraud *(Orlando Ballroom LM)*
In this presentation, faculty will discuss current fraud schemes, known as "telefraud", involving prescription drugs. The specific focus will be on the role of the prescriber (victim or accomplice?) and other co-conspirators which have led to a multi-million dollar fraud scheme affecting health insurance carriers today. In addition to an overview of the current schemes, participants will learn to use data analytics, interview skills, and other investigation techniques to fully illustrate the overall scheme. Lastly, participants will learn how to properly link the prescribers, co-conspirators, and all involved parties to share with law enforcement, medical boards, and other appropriate entities to combat the fraud risk and move towards prosecution.

- Stephanie Benson, CFE, AHFI, Senior Manager, Express Scripts
- Rick Battelle, Senior Director, Enhanced Fraud, Waste and Abuse, Special Investigation Unit, Express Scripts

CDT Update: Tracking the Changes, Additions and Revisions *(Orlando Ballroom N)*
Dentistry is dynamic and the CDT (Current Dental Terminology) code set is updated annually. Without a thorough understanding of CDT, today's compliance auditors are at a disadvantage. This session will help you plan for the latest version of dental coding changes and learn more about how the CDT is updated and maintained. Our faculty will provide you with an overview of CDT (Current Dental Terminology) and the changes for CDT 2023 which will go into effect January 1, 2023. Participants will have the opportunity to take notes, ask questions, and discuss potential schemes related to the changes. The process of how the CDT is updated and maintained will also be addressed. Included in the session the faculty will take a deep dive into dental implant coding.

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

Breaking the Rules of Behavioral Health Fraud Detection *(Regency Ballroom P)*
Presented by Shift Technology

In March 2022, the OIG reported that behavioral health services made up about 16% of telemedicine used by Medicare beneficiaries during the first year of the COVID pandemic. Access to virtual behavioral health and the rise of other behavioral health equity initiatives makes this an ever evolving, moving target for fraud. It is becoming increasingly challenging for SIUs to stay ahead of these schemes with static, rules-based methods. Learn from Shift healthcare fraud experts on what happens when investigators break out of the confines of rules-based detection methods, and how to take your SIU to the next level. In this session, attendees will learn about the rise and impact of behavioral health fraud and emerging behavioral health schemes.

- Mandy Fogle, U.S. Healthcare Value Engineering Lead, Shift Technology
- Mark Starinsky, Product Lead, Healthcare Improper Payment Detection Solution, Shift Technology

Tell the Whole Story with Composite Artificial Intelligence
(Regency Ballroom Q)
Presented by SAS
Despite often repeated mantras to allow data to tell a story, it turns out algorithms and logic do a poor job of constructing full, coherent narratives surrounding fraud. In reality, the savvy analyst or investigator must parse through disjointed data sets and algorithmic outputs to create a salient accounting of complex behaviors that accurately portray an identified scheme. In the domain of healthcare fraud, a major challenge is to determine how to allocate limited resources to stop the worst offenders. These decisions are not fully automated, but require human oversight coupled with the ability to communicate a complex narrative about multiple observations. Utilizing Composite Artificial Intelligence can help to combine different analytical methods to obtain the best possible outcome. Composite AI captures a multitude of billing patterns, relationships, and other behavioral signatures and ultimately brings the analyst or investigator one step closer to telling the story that data alone cannot.

- Jason DiNovi, CPMA, AHFI, Senior Industry Consultant, Fraud and Security Intelligence, SAS
- Tyanne Ryan, Lead Director, Performance Management and New Programs, Payment Optimization Analytics, CVS/ Health

12:15 pm - 1:30 pm ***Lunch in the Anti-Fraud Expo Hall*** *(Regency Ballroom R)*

1:30 pm - 2:30 pm ***Concurrent Sessions***

Some Call It Prepping: Some Call It Risk Management *(Plaza Ballroom I-K)*

Wanting to understand and be prepared for the risks life may throw at us is a concept that is gaining in popularity throughout society today. So too is the idea of proactively identifying and managing risks in a company or organization before events occur. While you are likely already engaging in some form of risk management to prioritize your work, conducting formal risk assessments can help drive an organization to support initiatives to prevent fraud. This session will focus on the core concepts of fraud risk management and the various ways they can be implemented in your organization. Concepts such as enterprise risk management's three lines of defense, assessing the maturity of your anti-fraud program, policy and standard development, risk assessments, risk metrics and reporting to leadership will be covered.

- Christa Jewsbury, JD, AHFI, CFE, Director, Enterprise Risk Management, Humana, Inc.
- Sally Walker, JD, AHFI, Vice President of Enterprise Risk Management, Blue Cross and Blue Shield of Massachusetts, Inc.

The Thing About Behavioral Health: How to Not Botch Your Investigation *(Orlando Ballroom LM)*

Are your behavioral health cases turning out to be something other than what you thought it would? Do you get distracted by a seemingly obvious component of your case and forget to look at the big picture? Well, you're not alone. As licensed behavioral health clinicians in an SIU, one of the common themes we hear from other investigators is that nothing about behavioral health investigations is easy! We will provide you with tools to help create a solid case theory by identifying key components of strong allegations and how to avoid potential pitfalls that could botch your investigation. While this presentation will focus on building solid behavioral health investigations, it can also provide a framework to use in other types of investigations. During this presentation, the faculty will talk about utilizing and understanding data, developing your allegations, utilizing clinical reviews to gather evidence, and how to identify patterns to make a strong case.

- Courtney Rhodes, MA, LPC, AHFI, Supervisor, Clinical Investigations, Special Investigations Unit, Centene Corporation
- Jessi Clark, LMHC, AHFI, CHC, Director, Clinical Investigations, Special Investigations Unit, Centene Corporation

Relational Data: The Saga of Operation Abandoned Harbor *(Plaza Ballroom H)*

In the ever-increasing age of data and the collection of claims and financial data, investigators are overloaded by the sheer volume. In this presentation, the faculty will show how data can be used to find large cases, focus the targets of this investigations, and show the scheme in numbers. Participants will learn how Operation Abandoned Harbor was discovered through purely proactive

analysis. The investigative team created a custom database to form the data together and actually show the fraud scheme. Financial data was measured against claims data, NPI data, and various other sources of data. It was used at all point of the case. Find your next big case, focus it with relational data, save time waiting for financial analysis, and blow the mind of your targets during interviews with awesome reports.

- Aaron Cohen, MBA, Special Agent, Health Care Fraud Unit, Federal Bureau of Investigation, U.S. Department of Justice
- Denise Scott, Special Agent Office of Inspector General (OIG), U.S. Department of Health and Human Services

The Reemergence of Foreign Claims Fraud - with a Side of COVID *(Regency Ballroom O)*

After two years of declining fraud associated with foreign travel, insureds, providers, billing agencies and other parties (such as hotels and resorts) have now started to submit fraudulent claims that leverage emergency rules put in place by the U.S. government to address the COVID pandemic to maximize profits. After a review of longstanding schemes used by foreign providers to defraud U.S. healthcare insurers, attendees will be provided with tools that will help them identify how foreign fraud schemes are evolving to take advantage of unproven treatment and medications to inflate claims. The presentation will include two case studies that that will provide insight into how different schemes were perpetrated and how the new pandemic landscape affected the investigations.

- Joaquin Basauri, Lead Investigator, Kaiser Permanente
- Kurt Vogan, Lead Investigator, Kaiser Permanente

Case Study: The Value of Collaboration in Fighting Dental Fraud *(Orlando Ballroom N)*

This case study will demonstrate how the collaborative efforts between TennCare and DentaQuest, TennCare's dental benefits program administrator, as well as Delta Dental and Cigna, led to the successful prosecution of a Tennessee dentist committing health care fraud. In this presentation, the faculty will explain how the dentist submitted fraudulent claims for dental work including: falsified dates of service, services not completed or performed at all, and upcoded dental services, among other false statements. Participants will learn how records and data can be reviewed and a case can be coordinated when initial complaints are received from several sources. Information will also be shared on research, data analysis and peer comparison. The roles of various federal and state investigative agencies, will be examined, along with the importance of collaboration, perseverance and teamwork. Finally, this case is a

clear demonstration of the deterrent effect a successful prosecution can have on the dental community and other dental clinics in the area.

- Christine Thompson, Field Investigator, Office of Program Integrity, Managed Care Operations, Division of TennCare, State of Tennessee
- Floyd Price, Director, Office of Program Integrity, Managed Care Operations, Division of TennCare, State of Tennessee
- Richard M. Baer, Acting/Assistant Special Agent in Charge, Federal Bureau of Investigation, U.S. Department of Justice (Nashville)

The Value of Adding Provider-Centric Analytics to Your Pre-Pay Program *(Regency Ballroom Q)*
Presented by Optum
Most pre-pay programs are designed to identify individual fraudulent claims, giving little regard to the overall billing behaviors of the provider. In this session, the faculty will share how provider-centric analytics can be applied to pre-pay claims to proactively identify potentially fraudulent providers. The faculty will also share how these analytics can increase the early identification of fraud and drive additional savings for *your health plan's pre-pay program.* The presenters will share how we use historical data, payer-specific data, and our vast library of fraud schemes to power provider-centric analytic models. These models identify provider billing behaviors that correlate to a higher likelihood of fraud. Participants will learn best practices for utilizing their existing pre-pay payment integrity solutions to prevent fraud or aid in fraud investigations.

- Jeremy Hill, Vice President, Payer Solutions, Optum
- James Guy, Director Payment Integrity SIU Consulting and Lead Development, Optum

Rebuilding Payment Integrity Programs in a Post-Pandemic World *(Regency Ballroom P)*
Presented by EXL Health
The COVID-19 pandemic changed the healthcare industry. During this transitional and critical time, we have the opportunity to redefine the payment integrity space to not only address the new challenges brought on by the pandemic but to rebuild the right way to correct errors and fraud further up the claim continuum and take the time to get it right. Moving toward the future, payers need to lean on innovative Payment Integrity programs to mitigate these risks. The faculty in this session will examine how to challenge the administrative burdens around PI programs and how digital solutions can deliver efficiency and cost savings. The faculty will also demonstrate best practices on how to integrate prepayment and advanced digital tools to optimize performance, minimize FWA, while creating a positive provider and member experience.

- Tina Azar, Vice President, Market Leader, EXL Health

2:45 pm – 3:45 pm Concurrent Sessions

SIRIS Investigation of the Year *(Plaza Ballroom H)*
The SIRIS Investigation of the Year award honors an outstanding and effective health care fraud investigation and its impact on fraud deterrence and prevention as a result of a SIRIS entry. The winning nomination is a result of or greatly enhanced by receiving additional intelligence from other SIRIS users after having entered a provider case or scheme, researching cases or schemes in the SIRIS database, or submitting a Request for Investigation Assistance (RIA) through SIRIS. In the session, members of the investigative team from the public and private sectors will discuss how a SIRIS lead led to the investigation and the outcome of the case. Hear how collaboration led to the successful prosecution of this award-winning case.

Three Pillars of a Strong Fraud Prevention Program: Investigators, In House Counsel, and Law Enforcement *(Plaza Ballroom I-K)*
Any fraud prevention program needs three strong pillars to include maximizing government restitution, preparing for criminal referrals and understanding how to prepare for civil litigation. Faculty in this session will draw from their vast experience and from recent cases in urgent care facilities, substance abuse clinical owners and kickback schemes. They will share their perspective on how best to work with DOJ and federal law enforcement to ensure that carriers recover the most money through restitution and criminal forfeiture. They will provide tips on how the SIU can work closely with legal in the flag placement process to maximize fraud savings and defense of flags in subsequent litigation. And finally, the faculty will offer guidance on how the SIU and in house attorneys can work together to identify and prepare cases that are most appropriate for criminal prosecution.

- Daniel Lyons, Attorney, Senior Counsel, Aetna Inc.
- Richard Statchen, Special Investigation Unit Lead, Executive Director, Special Investigations, Aetna Inc.

Enhancements and Upgrades: Dental Schemes to Increase Revenue *(Orlando Ballroom N)*
Dentist do not always agree with the approved fee for a service and can find inventive ways to make up the difference between the approved fee and what they want to receive in payment for the procedure. These schemes involve charging an upgrade fee for the materials used or for what is presented to the patient as an upgraded better product such as a superior denture or the top of the line crown. Another way to increase revenue is to charge the patient for

the instrument or equipment used to perform the procedure. These charges are often not submitted on a claim as the practice knows they are going to be disallowed. This presentation will explain some of the procedures that are charged to the patients incorrectly or as unbundling to increase revenue. The faculty will also show how these overcharges were discovered and how to try and prevent the patient from being overcharged.

- Patricia Shifflett, RDH, AHFI, Clinical Fraud Analyst, Delta Dental of Virginia
- Kim Brown, RDH, AHFI, Clinical Fraud Analyst, Delta Dental of Virginia

Methods of Detection: A Case Study Using a Clinical and Data Analytical Approach *(Regency Ballroom Q)*
This presentation will utilize asthma and allergy codes in a case study demonstrating how to leverage clinical and data analytics to detect fraud, waste and abuse schemes. Further, a review of medical record documentation with be utilized to elaborate on the crucial implications present in various documentation submitted that can raise red flags, warranting further review. The faculty will demonstrate how to analyze claims data to effectively identify patterns and schemes, and how to recognize red flags when conducting cursory examinations of medical documentation.

- Sharron Cannella, Senior Investigator, Elevance Health, Inc.

Assessing a Lead: Does it Warrant Further Investigation? Useful Methods for Analyzing Data *(Orlando Ballroom LM)*
Presented by Change Healthcare
When a payer sees a trend in the news or in case experience, how should the data analyst assess whether to create an edit in the system or put individual providers on review? This presentation will show the analyst how to approach a large set of historical data to conduct a Proof of Concept to see whether the trend is affecting payments, which providers are contributing to that trend, and how to take action in the system by creating an edit or a flag to follow up on those claims that are contributing to the trend. Participants will learn the steps involved to approach a large dataset for conducting a Proof of Concept, and the steps to assess whether an individual provider's billing experience warrants a focused review such as a flag. Finally, the faculty will illustrate how to create a system edit that target aberrant billing behavior.

- Debra Riekkoff, AHFI, HCAFA, Director of Business Systems Strategy Management, Change Healthcare
- Lori Larson, RHIT, Senior Manager, PrePay Business Rules Analyst, Change Healthcare

Just a Little Poke: Lifecycle of a Recovery for Vaccine Administrations *(Regency Ballroom P)*
Presented by IBM Consulting
The path to a payment recovery begins long before the financial transaction is completed. Recoveries typically start years before and require the right resources, data, staff, and technology all to align at the precise time you need them. This presentation will walk through the lifecycle of a recovery using a real-life example that starts with a lead generated in an analytic and ends in a payment recovery. Specifically, a COVID Vaccine Administration analysis will be used to highlight data anomalies and risky provider behavior. Use some of the tips and tricks provided to help acquire the resources and move through the process to meet your final goal of maximizing recoveries.

- Kristine Knutson, AHFI, MPH, Senior Consultant, IBM Consulting
- Lindsay Marsh, MPA, Senior Consultant, IBM Consulting

4:00 pm – 5:00 pm ***Concurrent Sessions***

Specialty Benefits Investigation of the Year *(Orlando Ballroom LM)*
This new NHCAA Award recognizes the substantial health care antifraud contributions by NHCAA Member Organization specialty benefit plans' investigation units. While not all investigations lead to criminal or civil prosecution, they can result in significant policy or procedural changes that should be recognized. These changes may positively impact the effectiveness and efficiency of specialty benefit plans operations which, in turn, may improve the delivery of benefits to their clients. In this session, the awardees of the new Specialty Benefits Investigation of the Year will break down the investigative steps and results of their case.

Profile of a Fraudster *(Regency Ballroom O)*
The purpose of this presentation is to provide an overview of the characteristics of a fraudster, points of compromise that may lead to fraudulent behavior (e.g., financial duress), and payor system vulnerabilities that may be exploited. The Association of Certified Fraud Examiners (ACFE) reports in its 2020 Annual Report to the Nations that 42 percent of fraudsters were living beyond their means and 26 percent of fraudsters were experiencing financial difficulties. Participants will learn about common characteristics of fraudulent behavior, common rationalizations given by a fraudster, and patterns to identify fraudulent behaviors. Through case studies, the faculty will examine the three components of the fraud triangle (i.e., pressure, opportunity, and rationalization), discuss each point of the triangle, and offer insight on how provider behaviors can be detected to identify potential points of compromise.

- Dan Olson, Vice President, Product Management, Deloitte (moderator)

- Gary Cantrell, Specialist Leader, Program Integrity Solutions, Deloitte
- Dermot O'Reilly, Specialist Leader, Risk and Financial Advisory, Deloitte
- Jessica Vesey, Senior Manager, Deloitte

Developing and Managing Collaborative Clinical and Coding Reviews *(Orlando Ballroom N)*
This presentation will focus on how to develop broad based clinical and coding programs to meet the needs of SIU investigators, including potential groupings/teams and required skill sets. There will be discussion around how to collaborate to develop associated pre-payment rules, post-payment recoupments and code edits. Additional time will be spent discussing how to handle the impact of outside factors such as the pandemic and onshore only contracts on resources and programs. Participants will gain greater understanding what data sets bring value to cases, and support in developing the skills to request and review this data.

- Becky Kundert, CPC, Director, Code Edit and Coding Audit, Humana, Inc.
- Maria Rivera, MD, Lead Medical Director, Humana, Inc.

DME Scheme: USA vs. JCPB et al *(Regency Ballroom Q)*
In this case study, faculty will illustrate how the perpetrators in this scheme used shell companies to bill Medicare Part C for medically unnecessary durable medical equipment. The faculty will examine how law enforcement utilized data from multiple managed care plans leading to the standardization of data requests from plans. They will offer some helpful tips on information that assists law enforcement in the case and explain some of the challenges presented to law enforcement during an investigation. Participants will leave with a better understanding of how to collaborate with federal law enforcement partners.

- Kyle King, Special Agent, Federal Bureau of Investigation, U.S. Department of Justice (Birmingham Division)
- Scott Gisetto, Special Agent, Office of the Inspector General (OIG), U.S. Department of Health & Human Services (Boston Regional Office)
- Berivan Demir-Neubert, Deputy Branch Chief, Office of the Chief Data Officer, Office of the Inspector General (OIG), U.S. Department of Health & Human Services
- Zachary Davies, Postal Inspector, United States Postal Inspection Service

Behavioral Health Case Analysis *(Regency Ballroom P)*
From administrative activities to criminal prosecutions, behavioral health cases continue to monopolize the time and efforts of many fraud fighting organizations. In this session, the presenters will highlight case investigations, describe what worked and what didn't, and pinpoint some of the more successful efforts to get cases to the finish line. Participants will benefit from

the lessons learned from the efforts of the data team to develop background reports which summarized billing and identified excessive and even impossible billing. The faculty will also describe how the team worked closely with the HHS OIG investigator and the AUSA to achieve a fast indictment and subsequent plea deal, ultimately resulting in the judge awarding restitution and jail time for both a clinic owner and patient recruiter.

- Kelly Bennett, JD, AHFI, CFE, MPI, Chief, Florida Agency for Health Care Administration
- Ann Kaperak, AHFI, Detection Manager, Florida Agency for Health Care Administration

Friday, November 18

8:00 am - 10:30 am ***Information Desk Open***

8:30 am - 10:30 am ***Seminars***

Investigation of the Year Case Study *(Orlando Ballroom LM)*
Welcome the recipients of NHCAA's 2022 Investigation of the Year Award and listen to the investigative strategies, multi-organization cooperation and case-building excellence that led to a successful resolution, as well as to the coveted NHCAA honor. This two-part session provides insight into the investigation process, tactics for building the case, and collaborative efforts necessary for a positive result. Hear from the team that identified the case and the partnership that lead to a successful prosecution.

Knocking Out Genetics Fraud, Waste, and Abuse *(Regency Ballroom P)*
Genetic testing is a common target for fraud, waste, and abuse. Correct CPT coding is complicated by limited code sets to describe a variety of different tests and by methodology-based coding, with diverse reimbursement rates encouraging incorrect coding. Payors often need records to assess coding, with records reviewed by staff with knowledge of genetic testing methodologies. Record reviews can also be utilized to identify indicators of fraud and further drive investigations into possible fraud. This presentation will review several known fraud, waste, and abuse patterns identified in genetic claims, with particular attention paid to cardiac genetic panels as a recent example. This in-depth seminar will address topics including an in-depth examination of common CPT coding patterns, datamining techniques, appropriate vs inappropriate use of such tests, and concerning findings in medical records. The faculty will also review key reminders for data mining that produce higher quality referrals and investigations.

- Becky Kundert, CPC, Director, Code Edit and Coding Audit, Humana, Inc.
- Maria Rivera, MD, Lead Medical Director, Humana, Inc.

Authenticity and Coaching for Empowered Leadership *(Orlando Ballroom N)*
Over the past two years, societal changes, the pandemic, and the evolution of our companies, has resulted in many of us evaluating our personal goals as managers, mentors, and leaders. A recent study published by Gallop found that great leaders build relationships, motivate, and engage their staff and drive decisions based on productivity (vs politics). These are all emotional intelligence skills that ultimately result in lower turnover, more productivity, and an overall happier, more engaged staff. In this session, the faculty will focus on the EQ subscales associated with Authenticity and Coaching. The participants will learn about EQ overall and then dive into 3 specific subscales and learn how to increase their use of these sub-scales to improve their overall leadership style. This leads to increased productivity and a decrease in turnover by creating trust and overall work satisfaction for the staff. We'll also cover Leadership Derailers and how to balance these derailers.

- Aneta Andros, AHFI, Senior Director, Fraud Analytics, Cigna

Coding Corner: Frequent Fliers *(Regency Ballroom Q)*
The first hour of this session will focus on the frequent fliers of the CPT including red flags in several areas including ambulance coding, chiropractic, and E/M modifiers. In the second hour of the session, the faculty will review commonly asked questions specific to Pathology and Laboratory Procedures codes. The faculty will examine some of the ongoing lab issues with COVID-19, addiction treatment, bundling, and explain what CLIA means and how to use FOIA in your cases. This session will provide participants with examples of typical clinical usage of the codes discussed and will showcase the red flags and investigative techniques needed to find issues in your own claims systems.

- Toni L. Slocum, AHFI, CPC, CPC-P, Supervisor, Special Investigations Unit, Moda Health
- Kara McVey, MA, CPC, CPB, CPMA, CPCO, Principal, Ilex Consulting

Annual Ethics Seminar: Utilizing a Framework for Ethical Reasoning *(Regency Ballroom O)*
This year's Annual Ethics Seminar will focus on how to effectively use the Eight (8) Key Questions framework for ethical decision-making. This framework was developed by faculty at James Madison University in an effort to improve the ethical reasoning skills of its students; it has since been adopted by many other universities and organizations. The eight (8) key questions can be used to guide a course of action and support a person's decision-making. Participants will examine how to apply these standards with your organization's team and department. This guidance may help establish what factors you want your team

to use in their decision-making and help set clear expectations. It can have a very positive impact on your teams.

- Laura Parks-Leduc, PhD, Professor, Department of Management, James Madison University

10:30 am ***Conference Adjourns***