Agenda Subject to Change
As of September 27, 2023

Monday, November 6

9:00 am – 5:30 pm **Registration and Information Desk Open**

4:30 pm – 5:00 pm **Anti-Fraud Expo Hall Preview**

5:00 pm – 6:30 pm **Welcome Reception in the Anti-Fraud Expo Hall**

Tuesday, November 7

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

8:00 am – 9:00 am **Opening Remarks & Keynote Speaker**

How to Go from Grit to Great

Based on her best-selling book, "Grit to Great," Ms. Thaler will reveal how some of the world's most extraordinarily successful people were completely ordinary growing up. In fact, their meteoric rise had little to do with an "it" factor- a brilliant IQ or virtuoso talents- and everything to do with having the "grit" factor- guts, resilience, initiative, and tenacity. Through a myriad of interviews and cutting-edge research, Ms. Thaler will illustrate why grit is the most important determinant of future success and offers tips on how anyone can improve their concentration, perseverance, and determination.

- Linda Kaplan Thaler, Advertiser and Author

9:00 am – 9:30 am **Coffee Break in the Anti-Fraud Expo Hall**

9:40 am – 10:40 am **Concurrent Sessions**

Development and Enhancement of Proactive Fraud Waste and Abuse Investigations

The presentation will be directed towards attendees interested in the development and enhancement of FWA investigations through the successful use of initiative-taking datamining process, prepayment review process, and related techniques. The demonstrated model will lean heavily on addressing FWA though the employment of various proactive techniques. The session will include numerous real case examples of successful FWA investigations developed and enhanced through the use of these techniques. The examples will cover a broad spectrum of investigations that led to significant loss prevention as well as successful prosecution. The overall investigative process will be discussed and demonstrated through identification, investigative action taken and ultimate results. Throughout the session the attendees will be provided with the actual codes or series of codes impacted as a result of the investigation (CPT, HCPCS, ICD10, REV, etc.).

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

Diving into the NHCAA "Private-Public Partnership"
The NHCAA is the leading national organization focused exclusively on the fight against health care fraud focusing on the partnership between the private and public sectors. This presentation will focus on how that partnership has evolved over the years. SIUs are under extreme pressure to produce "business" results and asked to streamline their processes to address and reduce the impact of fraud on health care claims more quickly. Law enforcement agencies have been asked to work larger and larger cases that have become more and more complex. This presentation offers insight into how data and sound management practices can be used to guide the SIU's resources to have optimal impact. The discussion also examines components of a high-quality investigation supported by strong indicia of health care fraud. In closing, the faculty will discuss the synergies between high quality carrier investigations and successful law enforcement and regulatory agency criminal and civil cases.

- Tim Dineen, CFE, MPA, Senior Director Special Investigations, Discovery and Recovery & Payment Integrity, Horizon Blue Cross Blue Shield of New Jersey
- Eric Rubenstein, MS, CFE, Senior Director, Litigation, Fraud Waste and Abuse Support, Advize Health LLC

Private Equity Liability for Healthcare Fraud
Private equity companies continue to expand their footprint in the healthcare system. Not only are they investing in institutional providers along with smaller companies, like behavioral health clinics, which may not have well-established compliance and billing processes. As these acquisitions continue, MFCUs and federal partners will increasingly face the question of whether to target private equity companies as part of their investigations and enforcement. The faculty in this session will describe how they successfully navigated private equity liability under the FCA and how this case has established precedent for holding private equity companies accountable for fraud at portfolio companies. The faculty will explain that the litigation strategy involved a fairly novel theory of "causation" under the FCA, required a string of admissions in depositions with former employees at South Bay and H.I.G. employees, and succeeded in part because the private equity company was very involved in the portfolio company's operations, a key detail for future investigations. The faculty will also describe the successful

litigation partnership between the Massachusetts MFCU and Relator's counsel, which represented the federal FCA claims.

- Kevin Lownds, Deputy Chief, Medicaid Fraud Division, Office of the Massachusetts Attorney General
- Caitlyn Silhan JD, Partner, Waters, Kraus, & Paul
- Christopher Hamilton JD, Partner, Hamilton Wingo, LLP

Alexander Istomin: An Inter-Agency Collaboration Takes Down International Fraudster
In this presentation, the faculty will discuss the origins of the allegations against Alexander Istomin and why previous attempts by past agencies and insurers to investigate Istomin failed. The faculty will examine steps taken by HHS-OIG and FBI in Rhode Island to investigate Istomin, including a large-scale data analysis of claims submitted to Medicare and many private insurers, and how field work was the key to the criminal case. As the faculty review the case, they will discuss the evidence found during the investigation, including surprises found during a search warrant and how they were handled. Attendees will learn new ways to investigate fraud committed by individuals who operate across several states, plus how traditional investigative techniques can be applied to emerging fraud schemes today. They will gain an understanding of how collaboration was KEY in bringing down a multi-million dollar fraud scheme. Attendees will see how data gathered across multiple payors and from multiple (non-claims) sources can be combined to see a larger fraud picture.

- Lindsay Walford, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General
- James Crowley, Special Agent, Federal Bureau of Investigation

That Hurt! The Chronic "Bankbreaking" Pain of Spine and Pain Management Fraud
Minimally invasive pain management techniques are rapidly hitting the market and expanding in utilization, leading to confusion in terms of appropriate utilization, correct coding, and best practices. Add to that the already complex medical terminology, anatomy, and coding structure of spine surgery and the intense scrutiny of medical pain management, and you have the perfect recipe for fraud, waste, and abuse. This presentation will break down the particular schemes by providing a detailed overview of spine anatomy and physiology, together with the various techniques used to treat spine pathology and chronic pain. The presenters will discuss injections, fusions, implants, stabilizers, ablations, stimulators, and the myriad new minimally invasive techniques for addressing sacroiliac joint pathology.

Attendees will gain an in depth understanding of the relevant CPT, HCPCS, ICD-10, and REV codes; the schemes related to these codes; guidelines and appropriate use criteria for pain management; and how to assess and analyze utilization data.

- Lawrence Simon, Managing Medical Director for Medical Policy and Medical Appeals, Blue Cross and Blue Shield of Louisiana
- Rae A. McIntee, Medical Director, Payment Integrity and Special Investigations, Blue Cross and Blue Shield of Louisiana

Time is Money: Automating Your Case Prioritization Process
Presented by Healthcare Fraud Shield, a NHCAA Platinum Member
How much time do you and your teams spend triaging cases? Do you ever ask yourselves, there has to be a faster way? In today's fast-paced business environment, time is money. That's why it's so important to have an efficient and effective case prioritization process in place. Manual case prioritization can be time-consuming, may be error prone, and may incorporate inconsistent practices if performed by different individuals. However, by automating your case prioritization process, you can save time, improve accuracy, ensure consistency, add efficiencies, and make certain that your cases are streamlined to be handled in the most effective manner possible. In this session, we will discuss not only the benefits, but the best methods to apply when automating your case prioritization process. We will cover the key attributes to consider regarding various allegations including, but not limited to regulatory considerations, financial considerations, patient harm, prior history and more. All these data points can be configured into a simple to use case prioritization tool built directly into your case management solution.

- Karen Weintraub, AHFI, CPC-P, CPMA, CDC, Executive Vice President, Healthcare Fraud Shield

Artificial Intelligence: Practical Applications for Healthcare and Program Integrity
Presented by SAS, a NHCAA Platinum Member
Generative Artificial Intelligence (GAI) technologies like ChatGPT are exploding in use across the health care space. Providers, payers, pharmacy benefit managers, and government organizations are rushing to determine how to implement GAI to substantially reduce human time spent on tasks such as document generation, claim system billing, and beneficiary communications. While GAI holds great promise to be transformative for healthcare, the downside is this new technology is

also being wielded by fraudsters: from generating fake medical records and diagnostic images in mere seconds to enhanced schemes to steal or fabricate patient identities. Those responsible for payment integrity and stopping fraud, waste, and abuse will need to quickly evolve strategies to keep up. Join us as we discuss these threats and practical methods to detect potential AI generated content.

- Jason DiNovi, CPMA, AHFI, Health Care Industry Consultant, Global Fraud and Security Intelligence Practice, SAS
- Elisabeth Dill, Sr. Associate Solutions Advisor, Global Fraud and Security Intelligence Practice, SAS
- Sean Petree, AHFI, Fraud Senior Manager, Special Investigations Unit, Evernorth

10:50 am – 11:50 am **Concurrent Sessions**

Fraud Lead Prioritization
The presentation will be directed towards attendees interested in the development and enhancement of FWA investigations through the successful use of initiative-taking datamining process, prepayment review process, and related techniques. The demonstrated model will lean heavily on addressing FWA though the employment of various proactive techniques. The session will include numerous real case examples of successful FWA investigations developed and enhanced through the use of these techniques. The examples will cover a broad spectrum of investigations that led to significant loss prevention as well as successful prosecution. The overall investigative process will be discussed and demonstrated through identification, investigative action taken and ultimate results. Throughout the session the attendees will be provided with the actual codes or series of codes impacted as a result of the investigation (CPT, HCPCS, ICD10, REV, etc.).

- Ed Wang, Lead Director, Data Science, CVS Health
- Fenny Fan, Senior Data Scientist, CVS Health
- Richard Statchen, Executive Director, Special Investigations Unit, Aetna

Promoting Your SIU: The Right Message to the Right Audience
Promoting the work of an SIU can be tricky. Raising awareness is one of the most efficient and effective ways to increase the number of quality tips that units receive, and those tips are the lifeblood of any highly functioning SIU. But today's SIU are not operating in a bubble. Increasingly organizations are looking to balance

rising customer and consultant expectations, along with potential provider and member abrasion against the good will achieved through promoting the protection of its' groups and members against potential fraud, waste, abuse. Routinely SIU communication strategies, and the desired outcomes of these efforts, aren't aligned with the objectives of other internal departments. Delivering the right message to the right audience at the right time can be challenging. The panel will primarily focus on three communication lanes: (1) tips on how to communicate with members and providers to increase awareness and incoming tips; (2) strategies to raise awareness and coordination efforts within their organizations; and (3) techniques to improve relationships with external stakeholders, to include law enforcement and regulators. Attendees should expect to receive real communication strategies that they could mimic and implement to increase awareness and activities.

- Christopher Deery, AHFI, CFE, Director, Corporate and Financial Investigations, Independence Blue Cross
- Bob Mays, Staff Vice President, Special Investigations Unit, Anthem
- Junius Nottingham Jr., Executive Director, National Anti-Fraud Department, Blue Cross Blue Shield Association
- Sabrina Vera, Special Investigations Unit, Senior Director, Florida Blue
- Earl Bock AHFI, CIFI, HCAFA, Senior Investigations Consultant, Financial Investigations and Provider Review, Highmark

The Annual Review of Emerging Pharmaceutical Threats
For the past decade, this presentation updated the audience on emerging concerns in the pharmaceutical industry. That includes newly derived schemes, relevant new statutes and regulations, news from the industry, and emerging drugs of concern from a financial or abuse standpoint. OIG will present the latest information from field intelligence, looking at the year in review, plus where problems will arise in the coming year. OIG will make suggestions to the audience as to what to look for in their own data to search for the discussed vulnerabilities.

- Mike Cohen, Operations Officer, U.S Department of Health & Human Services, Office of Inspector General
- Patrick Neubert, Opioid Rapid Response Coordinator, U.S. Department of Health & Human Services, Office of Inspector General

Chronicles of a Silicon Valley Pandemic Fraud
Mark Schena, self-proclaimed "father of microarray technology," president of Arrayit Corporation, a Silicon Valley-based medical technology company, engaged in a scheme to defraud Arrayit's investors by claiming that he had invented

revolutionary technology to test for allergens and COVID-19 using only a few drops of blood. Schena also falsely represented to investors that Arrayit could be valued at $4.5 billion based on purported revenues of $80 million per year. After a four-week trial, Schena was convicted by a federal jury and is pending sentencing. This presentation will highlight nation-wide interagency collaboration during an unprecedented pandemic that resulted in the successful investigation and prosecution of this case. The investigative team received the US Department of Justice 2022 Criminal Division Assistant Attorney General Award for their work on this case.

- Morning Johnson, Special Agent, U.S. Department of Health and Human Services
- Elaine Farrell, Special Agent, U.S. Department of Defense, Defense Criminal Investigative Services
- James Gawrych, Special Agent, U.S. Department of Justice, Federal Bureau of Investigations

The DME Empire: Because One Entity Isn't Enough
The presentation will review how the identification of an owner of a DME company located in upstate New York led to the uncovering of a multi-provider DME scheme. The provider was initially identified through customer complaints of services not rendered. Through the review of medical records, patient communications, and internal information sharing, the investigation uncovered a web of related entities engaging in the DME fraud. The investigation leveraged both basic and advanced investigative steps. Focus was placed on the fine print in the medical records, asking specific questions when interviewing patients, searching the NPPES NPI registry, and utilizing internal provider tools (CignaforHCP.com). The faculty will review the key discoveries in the case which ultimately, the case led to a default motion in Cigna's favor in the amount of $18 million. Additionally, the owner was identified as the subject of two separate criminal indictments, one of which was specifically related to DME fraud. This is not your typical DME case common to the industry such as telemarketing or Medicare patient targeting.

- Alyssa Cangemi, Senior Investigator, Evernorth

Changing the Prepayment FWA Game With Effective Use of Machine Learning
Presented by Cotiviti, a NHCAA Platinum Member
Advancements in prepay solutions paired with machine learning technology for identifying FWA proactively rather than reactively is becoming the go-to approach for more and more SIUs. In this session, our experts will use examples of how effective prospective data analytics and machine learning play a critical role that is

missing in many Program Integrity Units today in identifying potential FWA and the importance of end-to-end service, to not only combat FWA, but also stay in compliance with regulations/guidelines. Attendees will learn the critical role a prepay solution coupled with machine learning has on early detection of FWA and how these can work in tandem with post pay investigation to create better collaboration with Payment Integrity counterparts. Faculty will offer insight into the effectiveness of incorporating FWA end to end services within their programs and the important role machine learning can have in identifying bad actors prospectively to potentially identify fraud before the money is out the door. Attendees will gain a better understanding of how to execute effective prospective investigations and the financial impact they can have on both a Payment Integrity Unit and SIU's retrospective investigations in terms of savings and overall FWA compliance.

- Angela Mitchell, AHFI, CFE, Client Services Manager, FWA, Cotiviti, Inc.
- Ed McCormick, AHFI, CFE, CPC, Manager, FWA, Cotiviti, Inc.

The Real AI: Demystifying AI for Investigators
Presented by Shift Technology, a NHCAA Platinum Member
Whether we're in our industry bubble or consuming content in everyday life, it's safe to say we're now bombarded with artificial intelligence buzzwords, terminology and seemingly magic capabilities. When it comes to AI for investigators, how are you telling the buzzwords from the true AI-powered capabilities apart? In this session, investigative and AI experts will provide clear definitions and real-world use cases of AI, including concepts such as predictive models and Generative-AI. The faculty will discuss strategies for ethical, accurate AI-powered decisions and outline the benefits of AI-powered techniques for investigators. Attendees will be able to unlock the benefits that AI-powered techniques bring to investigators and amplify your investigative teams.

- Mandy Fogle, Solution Lead, Shift Technology
- Mark Starinsky. AHFI, CFE, CHC Product Lead, Healthcare Improper Payment Detection Solution, Shift Technology

11:50 am – 1:15 pm **Lunch in the Expo Hall**

1:15 pm – 2:00 pm **Awards Ceremony**

2:15 pm – 3:15 pm **Concurrent Sessions**

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Fraud-Fighting Foresight: A Proactive Approach to Reducing Healthcare Fraud
The team at UnitedHealthcare takes a proactive approach to fraud & abuse. Learn how the team is tackling their investigations by implementing a program to authenticate and validate new providers which increases the accuracy of provider data as well as aid in the identification of bad actors. During the session, the team will highlight the value of a left shifted and provider focused mentality to assess risk and how it enhances an end-to-end solution in tackling fraud & abuse. Attendees will gain a better understanding of capabilities necessary, potential roadblocks, and lessons learned in developing a comprehensive program, including defining success.

- David Beachler, AHFI, Director, Payment Integrity, UnitedHealthcare
- J. Brent Cooley, Associate Director, Payment Integrity EPV Program Manager, UnitedHealthcare
- Kristen Nolan, Manager, Payment Integrity EPV Product Owner & Program Support, UnitedHealthcare

Legal Issues and Updates for Health Care Fraud Investigators
This presentation will address health fraud care legal topics in a straight-forward manner designed for non-lawyers. The faculty will draw on many years of litigation experience on both the government and carrier side to summarize the key legal statutes and principles that every investigator should know. Recent case examples will be provided to highlight how to best leverage legal resources to maximize recovery. Attendees will learn specific legal principles that can be immediately applied to both new and ongoing investigations to increase chances of success and enhance recoveries. Attendees will receive a summary of 2023 court decisions and statutes affecting health care fraud investigations and learn how to maximize restitution recovery associated with criminal prosecutions.

- Daniel Lyons, Managing Senior Counsel, Aetna

Best Practices in Collaboration: MCOs and Medicaid Stakeholders
Building collaborative relationships between MCO SIUs and government enforcement agencies requires a commitment to consistent, routine communication in the fight against health care fraud, including Medicaid programs. In this discussion, the panel representing insurers and state Medicaid law enforcement will discuss best practices and lessons learned when working health care fraud cases. With examples from dental and medical fraud cases in Texas and Tennessee, the panel will provide insight into how public and private organizations

can effectively get the best from one another, partner and collaborate. Participants will learn effective strategies that can be applied to their anti-fraud programs and efforts to partner.

- Steve Dallas Johnson, JD, Chief of Investigations and Utilization Reviews, Texas HHS Office of Inspector General
- Cindi Furlough, Compliance Manager, Division of TennCare, Office of Program Integrity
- Nicholas Messuri, Vice President, Fraud Recovery, DentaQuest

DME Fraud Scheme: Leveraging Alternative Investigative and Analytical Techniques

The COVID-19 pandemic eased entrance to the Medicare program and allowed hundreds of DME providers to enroll in Medicare using COVID-19 waivers. South Florida alone saw an increase in DME providers entering the program and submitting claims with 80-100% of the claims listing a physician that had no prior relationship with the beneficiaries. The owners of the DMEs were fleeing the US sometime before the DME started billing or as soon as the true owners became aware that a formal investigation was underway by CMS, the Unified Program Integrity Contractors, or Law Enforcement. Attendees will understand how agents implemented unique tools and techniques to stop fraudulent claims from being submitted. The faculty will highlight how evidence was developed and used in very streamlined criminal investigations and in the seizure of millions of dollars in fraud proceeds.

- Stephen Mahmood, Assistant Special Agent in Charge, U.S. Department of Health and Human Services, Office of Inspector General, Miami Region
- Omar Perez, Special Agent in Charge, U.S. Department of Health and Human Services, Office of Inspector General, Miami Region
- Robin Sheehan, Senior Program Analyst, U.S. Department of Health and Human Services, Office of Inspector General

Hospice Investigation: Leveraging Risk Indicators

The prevalence of hospice fraud waste and abuse (FWA) has been increasing in this country. Numerous articles have been published addressing this disturbing trend that affects the most vulnerable population. This session will explore hospice FWA from a CMS investigative perspective focusing on data analysis, investigation, and medical review. Attendees will gain insight into effective ways to minimize this risk. The presenters will discuss using risk indicators derived from claims data to identify

outlier providers, which can lead to further investigation. They will also highlight how the medical review team examines the medical records of these claims to determine whether they warrant overpayment assessment or necessitate further investigation.

- Larry Ball, Director, Field Operations West CPI/FIG, Centers for Medicare and Medicaid Services
- Debra Tubbs, Senior Health Insurance Specialist, Centers for Medicare and Medicaid Services

Audacious Auditory Therapy
Presented by Codoxo, a NHCAA Platinum Member
This session will demonstrate how MVP and their analysts used an AI-based fraud detection platform to quickly identify suspicious activities within their FWA platform. Attendees will hear how the AI platform flagged a suspicious speech therapy provider for billing excessive services per patient with seasonal trends in 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 review medical records, identify documentation and contracting issues, pursue recoveries, mitigate future costs, and liaise with law enforcement. This provider alone generated nearly $1.1 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.

- Sandy Caffarella, RN, CPC, CPMA, AHFI, Leader of Investigations, Special Investigations Unit, MVP Health Care
- Derik Ciccarelli Fraud Analyst, Codoxo

Leveraging Health Equity and Social Determinants of Health Data
Presented by Deloitte, a NHCAA Platinum Member
Health equity is a program integrity issue that includes monitoring agency funds to establish compliance with policy and proper use to serve the organization's mission and regulatory obligations. Individuals whose social determinants of health (SDOH) lead to health disparities are often vulnerable to FWA. These individuals are disproportionately impacted by fraud prevention safeguards and less able to mitigate harm caused by FWA, or broader quality of care issues. Understanding and acting on these issues may have a dramatic impact on overall program performance. This session explores how health equity and SDOH data can be incorporated in Program Integrity initiatives from two perspectives – understanding

how equity relates to FWA and how it relates to providing beneficiaries timely access to high-quality care regardless of their personal characteristics. It outlines how program integrity activities can support achievement of health equity goals, including providing examples from both federal and state programs.

- Nancy Brown, JD, Senior Counsel, Department of Health and Human Services, Office of Inspector General
- Tanya Balsky, MPP, Senior Manager, Deloitte

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

HFPP: Converting Cross-Payer Data Analytics to Fraud Leads and Case Outcomes
The presentation will focus on identifying actionable leads from HFPP data analytics. During the session attendees will learn how HFPP study designs and algorithms are applied to HFPP cross-payer claims data to identify suspect healthcare providers and generate results that HFPP Partners use to open cases that lead to measurable outcomes for their programs. HFPP data analysis provides insights that cannot be obtained from a single payer's data alone by using cross-payer data analysis. Presenters, including HFPP Partner members, will walk attendees from the study design using cross-payer analysis techniques, to the identification of actionable leads, and through an overview of HFPP Partner actions and case outcomes reporting. Partner members will highlight cases opened utilizing HFPP study results and provider leads derived from HFPP data analysis.

- Christopher Sterling, Data Scientist Manager, Healthcare Fraud Prevention Partnership, Trusted Third Party (TTP), General Dynamics Information Technology (GDIT)
- Jessie Silverman, AHFI, CFE, CPC, CEMC, Partner Liaison, Healthcare Fraud Prevention Partnership, Trusted Third Party (TTP), General Dynamics Information Technology (GDIT)
- Bob Mays, Staff Vice President, Special Investigations Unit, Anthem
- Katreece Tate BBA, CPC, CPC-I Senior Manager Fraud, Waste, & Abuse GlobalHealth Holdings, LLC

Investigator Motivation, Autonomy, and Retention Strategies for SIU and Program Integrity Leaders
An unmotivated and dissatisfied investigator is a growing concern in our industry. Dissatisfied investigators are inefficient performers. Their lack of interest also represents significant compliance risks as their mistakes and lack of attention often have significant regulatory consequences. Motivating and retaining existing associates is a better approach than hiring and developing new investigators. This

presentation demonstrates the signs and symptoms of a "checked out" investigator. It explores the potential consequences of an investigator looking for the exit. We will identify several organizational behavior theories which contribute to how our investigators remain motivated and how our managers lead effective teams. We will define autonomy and demonstrate techniques to create a more autonomous work environment built on a culture of work and trust. Finally, we will explore the Quality Assurance and Quality Control (QAQC) role of lead or senior investigator and the impact of this process on investigator performance, including examples of positive outcomes. The key pursuit in our presentation is to provide analysis and detail of what excites, engages, motivates, and most importantly retains our investigators in their role. It is our hope these principles and techniques will greatly benefit the leadership within our industry and beyond.

- Wayne Fisher, MBA, AHFI, CFE, Manager II Special Investigations Unit, Elevance Health
- Shannon Zabo, MPA, AHFI, CPC, Investigator Lead, Elevance Health

Forensic Accounting in Healthcare Fraud Investigations
Healthcare fraud is a form of white-collar crime that is on the rise and costing billions of dollars in the United States. Forensic Accountants are trained to follow money and apply dollars to motive. Typically, there is only one motive in healthcare fraud and that motive is to increase a bank account. The fraud may be perpetrated individually or as a conspiracy with many parties involved. The Forensic Accountant can evaluate healthcare fraud from a different perspective, which attaches the dollars to the schemes being perpetrated. The presenter will discuss investigative strategies that assist with “following the money” and making sense of the dollars associated with various schemes. Schemes to defraud versus policy/plan violations will be discussed. A discussion of what constitutes criminal activity will focus on when a provider “knowingly” and “willingly” performs an act to increase their bank account.

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

The Raheja Playbook: Will Write for Food, Fame, and Fortune
Learn how a Neurologist from Ohio became the country's top prescriber and speaker for Avanir Pharmaceuticals by conspiring with sales representatives to fraudulently promote the drug Nuedexta in exchange for kickbacks. The investigative team, including undercov`er patients, cooperating witnesses, and medical experts, proved that Dr. Deepak Raheja intentionally misdiagnosed his

patients with pseudobulbar affect (PBA), a condition characterized by involuntary, sudden, and frequent episodes of uncontrollable laughing and crying. Dr. Raheja and co-conspirators caused the submission of claims to CMS for Nuedexta prescriptions for patients who did not have PBA by falsifying their records so that insurance programs would pay for the expensive medication. Avanir sales representatives incentivized and enticed Dr. Raheja to write Nuedexta prescriptions through various means. Attendees will gain insight into the Neurology specialty, pharmaceutical industry (non-Opioid) and prescription drug programs. Faculty will share various investigative techniques used to build evidence in support of the case and to prepare for trial. Attendees will have a better understanding of the various criminal statutes involved such as kickbacks, health care fraud, conspiracy, and identity theft/forgery.

- Ashlee Waikem, Special Agent, Department of Health and Human Services, Office of Inspector General, Office of Investigations
- Brad Karns, Special Agent, U.S. Department of Justice, Federal Bureau of Investigation

A Dental Fraud Case Reaches Oversees
Conferences like the ATC enable participants to hear about useful tips and cases, and even share leads between the SIU and law enforcement. At one program, a SIU staff from MetLife connected with the FBI about a potential scheme with the Federal Employees Dental and Vision Plan (FEDVIP). Since 2015, the individual had submitted dental claims to Metlife totaling $525,765.85 in his name and the names of 10 dependents (1 adult (wife) and 9 children). Metlife paid $122,893.13 for these claims for dental services received overseas in Ghana. The presentation will show how the case evolved over the next few years with claims analysis, interviews, and the assistance from the authorities in Ghana. The case involved services not rendered with regards to dental claims and medical claims, which previously unknown. The presentation will cover overseas claims and some best practices in proving fraud with these types of claims.

- Joseph Parker, Supervisory Special Agent, U.S. Department of Justice, Federal Bureau of Investigation

A Historical Perspective of the Most Common DRG
Presented by MedReview, a NHCAA Platinum Member
Evolving, and controversial, definitions and interpretations of sepsis have led to the development of complex coding systems that attempt to capture the severity of sepsis. Sepsis is one of the most frequently coded DRGs, and one of the most expensive. Much effort has gone into promoting the appropriate detection and

treatment of sepsis, yet there is a high rate of overdiagnosis. This has led to a high volume of sepsis diagnosis that do not seem supported by the patient's clinical course, or the resources used to care for the patient. This presentation explores our understanding of sepsis. We explore how our current understanding of sepsis has thus resulted in coding challenges. We will dive into how these challenges can be reconciled using clinical validation and claims review, and will present a variety of case studies that illustrate how we can protect against inappropriate coding and expense.

- Michael Menen, MD, Chief Medical Officer, MedReview

The FWA Prevention Power of Integr8 AI Powered Contextual Claims Analysis
Presented by 4L Data Intelligence, a NHCAA Platinum Member
In our seminar, the speakers will review how technology can expand provider integrity-based pre-payment detection. The benefits of an 'a-claim-and-all-claims' approach to FWA detection and prevention will be outlined and the importance of dynamic provider trend, pattern, and outlier overpayment analysis will be demonstrated. This seminar will provide detailed examples of how Integr8 AI technology enables analyses that once required hundreds of hours of post-payment investigation time to be performed in seconds, pre-payment. And it will demonstrate how rapid, automated Integr8 AI-powered post-payment audit and recovery can accelerate recovery and continuous program and process improvement.

- Clay Wilemon, Chief Executive Officer, 4L Data Intelligence

4:30 pm – 6:00 pm **Reception in the Anti-Fraud Expo Hall**

Wednesday, November 8

7:00 am – 5:00 pm **Information Desk Open**

7:45 am – 8:30 am **Breakfast with Exhibitors in the Anti-Fraud Expo Hall**

8:30 am – 9:45 am **General Session**
Federal Agencies: Effective Collaboration, Proven Success
- Dara A. Corrigan, Deputy Administrator and Director, Center for Program Integrity, Centers for Medicare and Medicaid Services
- Christian Schrank, Deputy Inspector General for Investigations, Office of Inspector General, U.S. Department of Health and Human Services

- Laura Walker, Unit Chief, Health Care Fraud Unit, Federal Bureau of Investigation, U.S. Department of Justice

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

Let's Get Tactical! Putting Your Analytic Models to Work for Case Investigations
This presentation will review ways in which analysts and investigators can work together to use analytic models and processes to support case investigations. The faculty will demonstrate techniques such as peer analysis, link analysis and other models to refine case investigations and generate visualizations to communicate the severity of the behaviors being alleged. They will dive into scenarios encountered in a recent Covid-19 lab scheme investigation, walking through the application of various analytic techniques to the different related cases. The presentation will provide examples of the different considerations for both the investigator and the analyst and how together they can translate what they've learned into an actionable analytic product. Considerations addressed will include using techniques like peer analysis to show unusual behavior in a way that is analytically defensible and communicating requirements on both sides effectively so that the analytic results further the investigation.

- Elizabeth Olson, Senior Informatics Specialist, Evernorth
- Kayla Uba-Oyibo, AHFI, CPC-A, CFE, Fraud Senior Manager, Evernorth

Bridging the Gap: Transitioning to a Successful Healthcare Fraud Career
Hear from panelists in the SIU who have successfully transitioned their careers from the public sector to the private healthcare arena. The panelists will address how they prepared for the transition and the obstacles encountered. They will offer tips and insights into how to successfully integrate into a special investigations unit (SIU). Whether you are early in your career, mid-career or nearing retirement the session will provide a deeper understanding of how an SIU operates, the necessary skills you will need, and how to function within the larger organization, to include the importance of internal and external partnerships.

- Tamara Neiman, Executive Director, National Special Investigations Unit, Kaiser Permanente
- Sabrina Vera, Senior Director, Florida Blue
- Dan Crowell, AHFI, CFE, Senior Director, Blue Cross Blue Shield of Michigan
- Tim Dineen, CFE, MPA, Senior Director Special Investigations, Discovery and Recovery & Payment Integrity, Horizon Blue Cross Blue Shield of New Jersey

Reference / Pass-Through Labs: The Real Driver of Genetic Testing Fraud
Reference laboratory and pass-through lab arrangements have grown exponentially in recent years. This growth is one of the essential indicators of genetic testing fraud trends and schemes within specific geographic areas. Commercial and Medicare Advantage plans generally don't pay for these services but are likely paying for inappropriate services due to deceptive claims submission practices. We will describe these complicated relationships, how they function, why they are concentrated in particular geographic areas, how we can identify this behavior, and why we continue paying for services that violate our payment rules.

- Stephen Mahmood, Assistant Special Agent in Charge, U.S. Department of Health and Human Services, Office of Inspector General, Miami Region
- Isaac Bledsoe, Operations Officer, U.S. Department of Health and Human Services, Office of Inspector General
- Patrick Neubert, Opioid Rapid Response Coordinator, U.S. Department of Health and Human Services, Office of Inspector General

Health Plan and HHS-OIG Partner to Investigate High Dollar Medication Fraud
This presentation will take the attendees on a journey showing how a health plan identified and investigated a contracted pharmacy for perpetrating a telefax/telemedicine scheme. The presentation will detail investigative steps to include data analysis, public source review and outreach to the Pharmacy Benefit Manager. The health plan faculty will present how the pharmacy was referred to CMS through an I-MEDIC referral for billing high dollar topical medications which led to an investigative partnership with HHS-OIG. The HHS-OIG presenter will walk the audience through their investigation which resulted in a successful outcome and the ultimate closure of the pharmacy.

- Mark Horowitz, Senior Manager, Kaiser Permanente
- Jonathan Madore, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General

Combating Significant Multi-Year Fraud Scheme Past, Present Future
The presentation will focus on a multi-year, multi-faceted fraud, waste, and abuse scheme. This multi-million-dollar health care fraud scheme included numerous subjects and several conspiracies. The numerous scheme included billing for services not rendered, billing for unnecessary services, recruitment of patients, kickbacks, and money laundering. The services billed over the course of this scheme primarily aimed at physical therapy codes but also allergy testing, lab testing, and sleep studies in the south Florida area. The faculty in this session will highlight the efforts of the many SIU investigators and federal law enforcement

agents who conducted several hundred investigations from approximately 2015 to the present. The faculty will highlight the investigative work and lessons learned from this complicated case.

- Julie Nixon, Investigator, Elevance Health
- Elizabeth Combs, Senior Investigator, Elevance Health

Best Practices for Optimizing your Pre-pay Fraud Prevention Program
Presented by Optum, a NHCAA Platinum Member
Recovering payments from fraudulent providers is both challenging and expensive for health plans. To maximize savings and improve overall efficiency, plans need to continue shifting fraud investigations away from pay-and-chase and toward pre-pay fraud prevention. In this session, Optum experts will share how health plans can leverage innovative claim review technology and new investigative methods to identify potentially fraudulent providers, including best practices for conducting provider- and claim-level reviews pre-payment, incorporating advanced analytics and machine learning models into pre-pay workflows, and supplementing post-pay fraud investigations with pre-pay reviews.

- Jeremy Hill, MSc, VP, Payer Solutions, Optum
- Kendra Jenkins, Coding Consultant, United Healthcare/Optum

The Ultimate Showdown: PI, Generative AI and Trivia
Presented by IBM, a NHCAA Platinum Member
Generative AI is reshaping the landscape of healthcare and the rest of our digital world. Payment integrity will have to adapt to this new technology and use it to manage the vast amount of data available. Soon, generative AI will be leveraged to identify fraud, waste and abuse, and other data anomalies. This interactive presentation is an exploration and collaboration. In this session, the faculty will discuss opportunities for various program functions to incorporate Generative AI into existing workflows and ways to uncover insights that were not been possible until now. The faculty will also explore a few Generative AI applications including eligibility redeterminations, policy research and development, and payment recoveries.

- Jillian Scalvini, MPA, AHFI, Associate Partner, Program Integrity Analytics, IBM Consulting
- Lindsay Marsh, MPA, Senior Consultant, IBM Consulting

11:00 am – 12:15 pm **Lunch in Expo Hall**

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

The Tactical Toolbox: Leveraging Social Media, Open-Source Intelligence & Data Visualization
The tactical analysts within the Cigna SIU's Advanced Analytics Team provide support to investigators in the healthcare, IFP (Individual & Family Plans), Medicare Advantage and pharmacy divisions. Through the use of social media investigation and other Open-Source Intelligence (OSINT) sources, these analysts seek to clarify and validate connections and potential behaviors. The faculty will review the tactical approach to public records vendor reports, the most efficient way to use Google, effective mining of Social Media, image and video analysis, extrapolating connections within OSINT and benefits to creating supplementary visualization. The faculty will also will address leveraging data sources, both internal and external, to expedite the investigation or analysis. This portion will also include the utilization of open-source software like R and Python to aggregate data and research to clearly identify patterns and connections. The overall focus is to effectively research the individuals/entities, establish connections and alleged behaviors, and then incorporate data utilization to analyze, strengthen and visualize information gleaned from all sources.

- Donna Jallits, Business Analytics Advisor, Evernorth
- Shawn Lipsey, Business Analytics Advisor, Evernorth

Is SIU Department Size Important to Create SIU Program Excellence?
Are you challenged with a small department or a non-existent SIU? Whether you're an SIU of over 100 or conducting FWA investigations out of the Compliance Department, it is important to understand how to mature processes to create a culture that promotes continuity, consistence, and ultimately efficiency. As SIUs mature, they often face challenges in maintaining consistency when determining the balanced response to SIU findings. Establishing methodologies that provide consistency to SIU's actions will establish comfort among stakeholders and expedite investigations. Developing a culture of shared responsibility, organizations can create sustainable, high-performing teams capable of reducing internal abrasion while effectively handling complex investigations and delivering consistent results. Attendees will learn how to implement these changes within their own organization.

- Brian K. Casilli, CFE, Director, Special Investigations Unit, Blue Cross & Blue Shield of Rhode Island

- Rocco Cordato, IV, AHFI, Director, Special Investigations Unit & Payment Integrity, MVP Health Care
- Danielle Nelson, MA, CFE, Fraud Waste and Abuse Program Manager, PacificSource Health Plans

Portable Radiology Services LLC
Portable Radiology Services LLC (PRS) was a mobile x-ray service provider, with the majority of services being provided in skilled nursing facilities. An investigation into PRS was initiated when a Caresource (Ohio Medicaid MCO) case manager noticed x-ray claims did not correlate with the members medical records. After a data analysis of the claims and medical record review, Caresource referred their findings and documentation to the Ohio Medicaid Fraud Control Unit who in-turn reached out to HHS/OIG and FBI to work the case jointly. Agents interviewed the physician and radiology techs and determined the signatures had been forged. After a search warrant was conducted, comparing PRS records to billing it was determined approximately 95% of all of the billing was fraud. In this session, attendees will gain insight on how data analytics and record review aided in the investigation. Finally, attendees will understand best practices for collaboration between insurance companies and law enforcement.

- Jeremy Buening, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General
- Ann-Marie Sclafani, AHFI, CPhT, HCAFA. Program Integrity Investigator Lead, Caresource
- Krista Toole, Special Agent, U.S. Department of Justice, Federal Bureau of Investigation

The "Skinny" on GLP-1 and Type II Diabetes
This presentation will address how the weight loss craze is impacting the health care industry and our members with or without diabetes. The faculty will discuss the issues with the off-label prescribing of GLP-1 drugs, some of the fraud, waste, and abuse schemes, and potential long term affects for members. The discussion will include a closer look at the impact telemedicine and continuous glucose monitors are having on this trend. The faculty will also examine the negative consequences of these trends including medication shortage causes for members with a legitimate diagnosis including Type II Diabetes. Attendees will gain insights on the observed lessons thus far and consider how to plan for this trend today and into tomorrow.

- Justin Cain, Manager, Humana, Inc.

- Dan Girsch, Special Investigations Unit Manager, Pharmacy, Humana, Inc.

SIRIS Investigation of the Year
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.

User-Focused Advanced Analytics to Detect Fraud
Presented by GDIT, an NHCAA Platinum Member
In this presentation, CMS and GDIT will delve into the fascinating world of machine learning in healthcare fraud detection. This includes extensive experience partnering to develop Medicare and Medicaid fraud detection algorithms, which have led to tangible benefits and positive results. The primary focus of this session is to bridge the gap between complex algorithms and user-friendliness, ensuring that individuals from diverse backgrounds can easily comprehend and harness the power of machine learning. The faculty will showcase innovative approaches that prioritize intuitive interfaces, interactive visualizations, and plain language explanations, demystifying complex solutions and making the technology accessible even to non-technical users. Through real-world examples including our framework/approach to AI/ML, specific examples of cutting-edge algorithms developed and the benefits they have provided - with an emphasis on why these solutions are important for the broader fraud detection community and actual results (e.g., improved rates of suspect leads and positive outcomes).

- Aaron Testoff, Statistician (Health), Division of Modeling and Analytics, Data Analytics and Systems Group, Center for Program Integrity , Centers for Medicare & Medicaid Services
- W. Dean Vogt, Jr., Senior Data Science Manager, General Dynamics Information Technology
- Su Kim, Healthcare Fraud Consultant, General Dynamics Information Technology

Trends Impacting Payment Accuracy: Pre-Pay, AI, Security
Presented by Alivia Analytics, an NHCAA Platinum Member
This expert panel for fraud, waste, and abuse (FWA) includes physicians, a health plan executive, a special investigations unit (SIU) lead, a payment integrity technology leader, and an artificial intelligence (AI) strategist. They will discuss the movement of payment integrity from post-payment to pre-payment and the importance of both sides speaking to each other using quality data to avoid the pay-and-chase transaction process; misconceptions and opportunities for AI today vs. tomorrow and what it can and cannot do in the claims process with data that is complex, sensitive, and highly regulated; and data security and privacy challenges and opportunities where the risks and penalties are greater than ever. The panelists have in-depth expertise in commercial, private, and government healthcare focused on best practices and solutions for healthcare payment accuracy.

- Michael Taylor, MD, CEO, Alivia Analytics (moderator)
- Steve Goldberg, MD, MBA, Chief Medical Officer, Alivia Analytics
- Scott Whyte, Partner, Value Creation, Health Enterprise Partners

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

Visual Thinking: Charts, Graphs, Maps, Diagrams, Oh My!
From data exploration to communicating results, data visualizations are an essential part of the data science process. First, this presentation explores how, in a world of enormous datasets, visuals generated through exploratory data analysis are key to understanding our data. Then, this presentation dives into the details of creating persuasive, evidence-based visuals to support decision making through the many steps of a project. The elements of good visualizations and best practices when using basic charts such as scatterplots, histograms, and maps are discussed along with advanced topics such as optimizing visual perception. Attendees can follow along through portions of this presentation in a Kaggle Notebook, a free online resource that utilizes Python or R.

- Josh Myers, Business Analytics Advisor, Evernorth
- Andrea McLain, Business Analytics Senior Advisor, Evernorth

From Paper to Data: Fighting Fraud in the UK's NHS

If you listen to British people talk to each other for more than five minutes it's highly likely you'll overhear a conversation about the weather and/or the National Health Service. A free at the point of care service is a source of national pride but also great concern as an ageing population, rising demand for services and worsening economic conditions combine to put unprecedented pressure on service delivery. The NHS Counter Fraud Authority was established in 2017 to manage fraud, bribery and corruption in the service. Alex and George will provide a history of the NHS, discuss the modern-day challenges faced by the health sector in tackling fraud and how the response is currently delivered versus the opportunities that exist for the future. This will include the management of bulk intelligence, approaches to data analysis, working with stakeholders and turning strategy into reality.

- Alex Rothwell, Chief Executive Officer, National Health Service
- George Cooke, Head of Data Analytics and Performance, National Health Service

Investigating Pandora's Box: From Social Media to Conviction
In April 2020, Patricia Derges posted on Facebook that she had a cure for COVID in southwest Missouri. This "cure" turned out to be a fake stem cell treatment and led law enforcement down a tangled path of lies. In this session, the faculty will discuss how law enforcement honed in on specific violations of federal law amid a Pandora's Box of issues raised during the case. They will examine how they determined what actions were violations of federal law, what was relevant, and what was not worth pursuing. The faculty will highlight various methods used in the investigation to put together a case quickly and effectively. Attendees will gain an understanding of a fraud case worked from a social media post to conviction at trial and learn about the critical decision points in examining the subject's actions for evidence of intent. The faculty will demonstrate how the investigative team wove seemingly disparate lines of investigation together to tell a story at trial.

- Teresa Dailey, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General, Office of Investigations
- Michael Effland, Special Agent, U.S. Department of Justice, Federal Bureau of Investigation
- Randy Eggert, Supervisory Assistant United States Attorney, Department of Justice
- Shannon Kempf, Assistant United States Attorney, Department of Justice

Egregious Engagement: Fraud Schemes in ABA Therapy

Applied Behavioral Analysis (ABA) therapy is well known as an area ripe for potential fraud. To fully understand the challenges that may arise when developing cases, it is important to understand the treatment methodologies and common terms. This presentation will provide an overview of Autism Spectrum Disorder (ASD), ABA therapy, and the Behavior Analyst Certification Board (BACB) who governs individuals tasked with providing ABA therapy to children with ASD. The session will culminate with a case study addressing data analytics, common schemes and investigative techniques used to protect our most vulnerable population. Participants will gain a better understanding of the terms and techniques unique to ABA cases and discover unique methods of investigation and data application to arrive at successful fraud prosecution.

- Jennifer K Dietz, MSCR, MSL, AHFI, CHC, CFE, Director, Health Care Fraud Division, Acting Deputy Assistance Inspector General, Defense Health Agency, Office of the Inspector General
- Carlos Baixauli Jr, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General

A Case Study: Fraud Schemes Seen in Substance Use Disorder Treatment
Beauty is in the eye of the beholder. In this session, participants will hear how a tip from a local hair stylist turned into a multi-state, multi-million-dollar case. This session will highlight a 10-year federal investigation that began in Abingdon, Virginia, and concluded with successful prosecutions of defendants from Florida, Nevada, Tennessee, and Virginia. It will touch on multiple health care fraud schemes involved in the various aspects of Substance Use Disorder treatment, including Medication Assisted Treatment and urine drug screening. In total, seven defendants pled guilty and were ordered to pay $9.9 million dollars in fines, forfeitures, and restitution. Participants will hear about the strategies used in this investigation that can be applied to their own health care fraud cases.

- Janine Myatt, Senior Assistant Attorney General, Health Care Fraud and Elder Abuse Section, Virginia Medicaid Fraud Control Unit, Office of the Attorney General.
- Erin Thompson, Investigative Supervisor, Health Care Fraud and Elder Abuse Section, Virginia Medicaid Fraud Control Unit, Office of the Attorney General.

Empowering Healthcare with GenAI: A Paradigm Shift in Long-Term Strategic Planning
Presented by EXL Health, an NHCAA Platinum Member

Attendees will gain a comprehensive understanding of the GenAI landscape, including its transformative potential, inherent concerns, and actionable steps for health plans to harness its power effectively. As healthcare moves towards a data-driven and patient-centric future, GenAI offers numerous opportunities for health plans to optimize operational processes, enhance the quality of care, and improve cost containment programs.

- Tina Azar, Vice President, Market Leader, EXL Health
- Will O'Neill, Vice President Payment Services, EXL Health

3:00 pm – 4:15 pm **Workshops**

Uncovering the Truth: The Power of On-Site Investigations
This course is designed to provide investigators with tools and insights to help them define, plan, conduct, and document a thorough on-site investigation from conception through implementation. With the end of the COVID-19, investigators are once again conducting on-site visits to audit and investigate providers. A properly planned on-site audit can yield a wealth of information not available through a desk audit; a poorly planned one can lead to provider abrasion and negatively impact your results. The presentation will also address the different types of interviews that are conducted by auditors and investigators and breakdown what motivates people to cooperate when they are interviewed. The faculty will also offer tips including the advantages of recording interviews and ways to protect the interviewer.

- Sean Rosner, CFE, Special Investigations Unit Senior Investigator, Centene
- Chris Keppel, Special Investigations Unit Senior Investigator, Centene
- Steven Anderson, Medicaid Inspector General, Kansas Office of Medicaid Inspector General

SIU Benchmarking: Leveraging the NHCAA Management Survey
As an SIU leader, do you face issues like determining the right pay scale for staff, appropriate SIU size, scope of SIU responsibility, and what kind of ROI an SIU should generate? The NHCAA Anti-Fraud Management Survey serves as a benchmarking tool for assessing the structure, staffing, funding, operations, and results of the special investigations units that support NHCAA Member Organizations. Members of this year’s Anti-Fraud Management Survey Committee will offer insights on the 2022 results and trends across multiple years. After analyzing the key management areas, the panel will discuss the challenges of developing the survey, key data points relative to the key areas, and ways that SIU managers can leverage the

survey results in their own fiscal and resource planning. Participants will gain insights on management data and industry trends on personnel, organizational structure, return on investment definitions, and average caseload.

- Patricia Hoofnagle, MSc, AHFI, Vice President, Special Investigations Unit Investigations, Special Investigations Unit, Magellan Health, Inc.
- Josh Orr, JD, Director of Special Investigations Unit & Senior Associate General Counsel, Point32Health
- Joseph Popillo, AHFI, CPC, Director, Special Investigations Unit, Blue Cross Blue Shield of North Carolina
- Brian Robinson, CFE, AHFI, Director, Special Investigations Unit, Point32Health

Examining CDT Code Updates, Emerging and Habitual Trends in Dental Fraud
Yearly updates to the CDT Code can provide new opportunities for dental fraud, waste and abuse. The addition of these new opportunities to emerging trends and habitually common dental fraud schemes have forced investigators to modify and adapt their skills to these potential new opportunities in addition to recognizing and investigating the historically common schemes. To augment the investigators skill set, this popular session will provide case example of the historically common and emerging schemes in dental fraud which continue to exit within both the Commercial and Public sectors, plus those which may be associated to recent and 2024 CDT code updates. Discussion points for potential schemes related to teledentistry will be presented. Associated Medical cross coding will be identified in the case examples presented.

- Stewart Balikov, Director of Dental Special Investigations, National Dental Director Utilization Review, Elevance Health
- Jason Coomer, Clinical Investigator, Humana, Inc.

The Latest Health Care Fraud Trend: Remote Patient Monitoring
The rapid rise of Remote Patient Monitoring (RPM) is driving service and fraud trends across the health care industry. In January 2023, the NHCAA formed a work group of members with data, clinical, coding, and investigative expertise to study the issue. The work group coordinated with high-level industry experts, received case briefings from prosecutors and investigators, and researched current and potential fraud trends. The group also conducted a range of data analysis across the private and public spectrum. In this in-depth session, attendees will learn about RPM and Remote Therapeutic Monitoring (RTM), coding details, and the current marketing push to providers and health systems to maximize revenue through RPM/RTM related services. The results of summary and focused data

analysis will be presented. Current and potential fraud trends will be discussed across a broad scope of related service types. The presentation will include educational products developed by the work group to assist members with future program integrity efforts in this area.

- Jennifer Trussell, Fraud Prevention Consultant, Senior Medicare Patrol Resource Center
- Michael Cohen, Operations Officer, U.S Department of Health & Human Services, Office of Inspector General
- Aimee Smith, Medical/Financial Risk Evaluation Professional, Humana Inc.

Thursday, November 9

8:30 am – 11:00 am **Information Desk Open**

9:00 am – 11:00 am **Breakfast Seminars**

Investigation of the Year Case Study
The recipients of NHCAA's 2023 Investigation of the Year Award will provide in-depth insights on the investigation and prosecution of this award-winning case. Listen to the investigative strategies, multi-organization cooperation and case-building excellence that led to a successful resolution of this case, 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.

Annual Ethics Seminar: *Ethical and Compliance Challenges in an Evolving World*
This session is still under development.

Annual Coding Clinic
This session is still under development.

The Use and Potential Misuse of Artificial Intelligence in Health Care
This session is still under development.

11:00 am **Conference Adjourns**