Tuesday, November 18

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

Invite Only Meetings

12:00 – 1:30 pm *Membership Forum Business Meeting*

2:00 – 4:30 pm *Information Sharing & Case Discussion*

2:00 – 4:30 pm *Data Analytics Roundtable*

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**

Wednesday, November 19

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

8:45 am – 9:45 am **Opening Remarks & Keynote Speaker**

9:45 am – 10:30 am **Coffee Break in the Anti-Fraud Expo Hall**

10:30 am – 11:30 am **Concurrent Sessions**

Pharmaceutical Fraud Update

This annual session provides attendees with an opportunity to learn about the latest evolutions in the state of the pharmaceutical industry with respect to new directions from the manufacturers, new drug approvals which may present potential for future fraud, and nuances of fraud schemes being seen by government agents and analysts. Participants will learn about new schemes and nuances in pharmaceutical fraud and gain insight into evolutions in the pharmaceutical industry. Participants will also obtain information to facilitate data exploration once returning to the office.

- Michael Cohen, DHSc, JD, PA-C, Operations Officer, Office of Investigations, U.S. Department of Health and Human Services, Office of Inspector General

The Great Grift: How to Defend your Enterprise against Fraud, Waste and Abuse

Participants in the session will be introduced to a robust toolkit of FWA resources that together are capable of identifying schemes, spike billings and claim dumps, outlier providers, and other niche scenarios. The speakers will take a deeper dive into the methods these tools, including Tableau, employ such as benchmarking, trend analysis and forecasting, and pattern identification. The speakers will take a deeper dive during the session into three

known areas of FWA - Substance Use Disorder, ABA Care, and DME Fraud. Attendees will walk away with a better understanding how to implement these tools in their own work processes.

- Michael Lilly, Senior Data Analyst, Blue Cross and Blue Shield of North Carolina
- Kathy Roberts, Senior Data Scientist, Blue Cross and Blue Shield of North Carolina

Anti-Fraud Efforts Meet Real-World Challenges with ACA Enrollments
ACA fraudulent enrollments involve scammers misrepresenting the facts to ultimately acquire benefit coverage and payments from Health Plans across the nation. Just targeting the suspect providers isn't enough. We all know they will open a new facility and start the cycle all over again. Our goal is to limit the fraudulent manipulation of an already vulnerable population of consumers by targeting fraudulent enrollments at the source. Some of the members are complicit to the fraud, while others are victims as well. The speakers will discuss the patterns and data analytics used to identify some of the suspect members, the case triage approach to limit dollar exposure, some of the tools we use in the investigation process, and ultimately the best practices when submitting to CMS for potential rescission of the member's policy.

- Dawn Thurman, AHFI, Senior Investigator, Special Investigation Unit, Blue Cross Blue Shield North Carolina
- Chris Heimburger, Senior Business Intelligence Analyst, Blue Cross Blue Shield North Carolina

I Ain't Afraid of No Ghosts: DME Phantom Supplier Investigation Skill Building
DME phantom supplier schemes continue to significantly impact government and commercial health plans. These schemes represent a paradigm shift, as they operate without relying on traditional paid claims data, making early detection more difficult. Fraudsters submit large volumes of claims quickly, generating payments before standard payment integrity measures can intervene. Elevance Health's SIU has developed new investigative best practices to address this challenge. This presentation outlines the evolving nature of the fraud, offers strategies for identifying bad actors without paid claims data, and shares communication and collaboration techniques to prevent future losses. Case studies will be used to reinforce these investigative skills and concepts.

- Wayne Fisher, MBA, AHFI, CFE, Investigator Lead, Special Investigations Unit, Elevance Health (formerly Anthem, Inc.)

- Shannon Zabo, MPA, AHFI, CPC, Investigator Lead, Special Investigations Unit, Elevance Health, Inc. (formerly Anthem, Inc.)

The Morrow Institute: Cosmetic Surgery Scheme Goes International
The case study showcases 11 different private insurance companies that were victims of a sophisticated fraud scheme perpetrated by David and Linda Morrow with a loss amount of $14 million. The couple used multiple techniques that exploited loopholes within the insurance companies' preauthorization and auditing systems. The couple then orchestrated a cover-up which included altering medical records, operative reports, and patient testimonials. Investigators at the insurance companies, the California Department of Insurance, the IRS, and the FBI all collaborated to prove the illegal conduct. The couple fled the United States and International law enforcement helped locate, extradite, and deport the couple resulting in restitution of over $6 million paid back to the insurance companies. Attendees will learn about the red flags that were critical in identifying CPT codes and claims from single and multiple TIN numbers. These red flags helped agents and investigators prove the intent to deceive the insurance companies which is critical for prosecution. Attendees will also learn about the collaboration process with state and federal law enforcement. There will be some wavetop perspectives shared of international coordination as it applies to extradition.

- Amy Pfeifer, Special Agent (SA), U.S. Department of Justice, Federal Bureau of Investigation
- Robin McIlroy, MBA, Senior Investigator, SIU West, Anthem Blue Cross
- Christine A. Ensko-Spadea, AHFI, HCAFA, Senior Manager, Fraud Investigation and Prevention Unit, Blue Cross Blue Shield of MA

Home Health Schemes: Why You Should Take It Personally
Presented by Cotiviti, an NHCAA Platinum Supporting Member
FWA in home health and personal care services for Medicaid, Medicare, and dual eligible beneficiaries is costing health plans and governments billions of dollars each year. Whether it involves upcoding, licensing deviations, impossible hours or days, inappropriate modifier use, or other suspect practices, staying one step ahead of the constantly evolving schemes of bad actors is an ongoing challenge for SIU teams. Sharing knowledge gleaned from a broad team of credentialed FWA experts, prepay claims, and other data points, Cotiviti investigators will dissect the nuances of the various types of home health services — from companion and personal care to private duty nursing. We'll include details on care levels and licensing requirements for appropriate billing and tips for detecting common schemes. We'll also recommend short- and long-term action plans, best practices, and resources your SIU programs can implement to improve findings and recoveries and

change provider behaviors to stop these schemes in their tracks, all while lowering your administrative burden to focus on providing the best possible care for these vital member populations.

Uncovering Waste and Abuse within Hospital Billing: Itemized Bill Review
Presented by Claritev, an NHCAA Platinum Supporting Member
Due to the nature of hospital billing and its lack of transparency, there is considerable opportunity for waste and abuse to occur on hospital claims. However, because of the time and resources necessary to review itemized bills, some payors don't prioritize itemized bill review (IBR). This is a substantial missed opportunity that often results in significant overpayments. IBR brings transparency and accuracy to the billing process by detecting inadvertent billing errors, promotes accountability and drives considerable savings. Claritev identifies errors on 98% of facility claims we review. In our presentation, we'll present examples that showcase the discrepancies and inappropriate billing that IBR can uncover and demonstrate why it should be prioritized in your cost containment strategy.

- Marla D. Ludacka, Vice President, Payment & Revenue Integrity, Claritev
- Brianne Santoli, Assistant Vice President, Payment & Revenue Integrity, Claritev

11:30 am – 1:00 pm **Lunch in the Expo Hall**

1:00 pm – 2:00 pm **Concurrent Sessions**

Gap in Communication: How Medicare Supplemental Insurers (MEDIGAP) are Funding Fraud
When CMS suspends or denies payment due to a credible allegation of fraud, most assume the financial faucet has been turned off. Yet in many cases, Medicare Supplemental (MEDIGAP) insurers continue to pay their portion of the claim despite CMS's non-payment to the provider, creating a downstream vulnerability ripe for exploitation. This session will explore how bad actors practice flags are raised at the Medicare level. This session will draw on case studies from DME and wound care. We'll dissect how and why the Medigap payment persist in these situations, how these dollars quietly fuel fraudulent enterprises even when CMS stops the dollars and how supplemental payors can close it. More importantly, this presentation will offer actionable solutions for MEDIGAP plan, including system edits, enhanced collaboration with law enforcement, and policy reforms to align with CMS payment decisions in near

real time. Attendees will leave with increased understanding of the Medicare Supplemental space and ways to overcome challenges.

- Patrick Neubert, CDR, U.S. Public Health Service, Director of Special Projects and Initiatives, U.S. Department of Health and Human Services, Office of Inspector General
- Isaac Bledsoe, Director of Special Projects and Initiatives, U.S. Department of Health and Human Services, Office of Inspector General
- Janna Hart, Founding Partner and Chief Product Officer, Previsant Insights

Pharmacy Case Study: Compound Fraud Scheme Migrates to Wound Management

Prime Therapeutics' (Prime) Special Investigations Unit (SIU) has seen a rise in wound management FWA schemes; however, within the pharmacy benefit. Our pharmacy case study is going to dive deep within the scheme, and participants will learn different methods to identify pharmacy wound management FWA through the use of data analytics incorporating both medical and pharmacy claims. Faculty will share different investigative techniques utilized to combat this scheme, in addition to incorporating evidence-based research to support clinical findings. In addition, participants will acquire knowledge and skills to effectively remediate and mitigate pharmacy wound management FWA

- Jared Mendoza Duenas, RN, PHN, AHFI, CPhT, Director, Special Investigations Unit, Prime Therapeutics
- Casey Jenness, PharmD, MBA, Director, FWA Clinical Support Services, Prime Therapeutics

Payment Integrity: Drive with Medical and Payment Policies

This session will offer solutions to the health plan challenges including how to develop a framework that sets the infrastructure to execute short term needs and in parallel to assess the current state and inform the design of a long-term model to drive policies across the product lines. Participants will gain insights on how to leverage benchmarking data to assess cost and utilization against competitors in the market to understand the areas where the organization is lacking performance at the product, market, and network level to prioritize focus. Finally, the speakers will discuss the important role that medical and payment policies play as part of a mature payment integrity function and the various levers to consider when prioritizing policy opportunities and implementation considerations.

- Novelette Wallace, MPH, PMP, CSSBB, Head of Payment Integrity, Johns Hopkins Health Plans
- John Waugh, CFE, Director of SIU, John Hopkins Health Plans

Beyond Face Value: Navigating the Fraud Frontier in DME and Pharmacy Billing
This presentation highlights case studies involving DME suppliers and pharmacy providers engaged in duplicate or crossover DME billing schemes. These cases will illustrate the evolving nature of fraud and underscore the need for early detection and proactive measures. Participants will have the opportunity to walk through case studies containing real medical record & interview examples, fostering an interactive discussion around the strategies used to identify red flags as well as best practices for obtaining the necessary evidence to confirm suspicions beyond what is presented at "face value." The case studies will also guide participants in developing effective documentation methods for investigative actions, supporting the use of findings by legal and governmental agencies in civil and criminal proceedings.

- Kerry Spencer, HCAFA, Fraud and Waste Senior Investigator, Humana
- Whitney Organ, Investigator, Humana

Scholar-Shipped: Patient Brokering and Fraudulent Applications
The presentation will cover both a case study (Commonwealth v. Michael Hislop) as well as the initial and ongoing collaboration between Point32Health, the Insurance Fraud Bureau of Massachusetts, and state and federal law enforcement. Topics of focus will include initial indications of the scheme, evidence building and challenges faced in the criminal investigation, as well as how the scheme has shifted over time. Participants will learn the basic concepts that allow patient brokering and fraudulent applications schemes to occur and gain insights on recent trends involving fraudulent application and patient brokering schemes, including examples from an ongoing investigation. Through a case study, participants will gain insights into the foundation and framework of a multi-agency law enforcement effort to investigate and eventually prosecute individuals involved in these types of schemes.

- Brian Robinson, AHFI, CFE, Senior Investigator, Provider Fraud Unit, Point32Health
- Kevin Richard, CIFI, Senior Investigator, Provider Fraud Unit, Massachusetts Insurance Fraud Bureau

Unmasking Phantom Providers: Leveraging Link Analysis, Analytics and External Data
Presented by Healthcare Fraud Shield, an NHCAA Platinum Supporting Member
This presentation delves into the intricate world of healthcare fraud, waste, and abuse (FWA), specifically focusing on the elusive threat posed by "phantom providers." We will explore how these non-existent or illicit entities exploit vulnerabilities within the healthcare system, leading to significant financial losses and compromised patient care. The session will highlight the critical role of advanced analytics in detecting and preventing phantom provider schemes. We will discuss innovative methodologies for identifying suspicious billing patterns, uncovering hidden networks, and flagging fraudulent activities across various healthcare sectors. Attendees will gain insights into proactive strategies for safeguarding healthcare resources, enhancing compliance, and ultimately, protecting the integrity of the healthcare ecosystem.

- Kristin Griego, CFE, AHFI, CPC, Director, Molina Healthcare, Inc.
- Karen Weintraub, AHFI, CPC-P, CPMA, CDC, Executive Vice President, Healthcare Fraud Shield

2:00 pm – 2:15 pm *Transition break between sessions*

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

Small to Mighty: Part Deux – Diving into Enforcement Culture
At last year's ATC, these speakers participated in a session that discussed strategies for small teams to improve their effectiveness. The presentations addressed methods for increasing return on investment and ways to develop effective teams. This year, the speakers will focus on helping you identify and define your organization's unique enforcement culture and offer practical information for improving Special Investigations programs. The session will start with a summary of key points from last year and then address the role of risk assessments in identifying gaps and developing plans to address them. The discussion will include challenges that SIUs encounter when establishing a culture that supports savings and overpayment recovery programs. Additionally, the session will outline approaches for defining escalation paths to ensure consistent processes for communicating high-risk items within organizations.

- Rocco Cordato IV, AHFI, Sr. Director SIU & Payment Integrity, MVP Health Care
- Cambria Day, MBA, AHFI, CPC, Program Integrity Unit Manager, Health Plan of San Joaquin

Fraud & Order: SIU - From Hashtags to Handcuffs
In the healthcare fraud world, there are two equally important groups: the investigators who build the case, and the analysts who uncover the hidden truths. This is their story. Evernorth's SIU Advanced Analytics Tactical Team presents a case of fraud and digital deception, walking attendees through a realistic request for tactical analytic support. Attendees will learn how social media, public records, and other sources of Open-Source Intelligence (OSINT) are used to uncover connections and elevate investigative findings. The session covers how to blend internal data with online intelligence, build stronger case narratives, and overcome common OSINT roadblocks like private profiles and limited digital footprints. Whether they're chasing red flags or writing reports, you'll leave with practical tools to enhance your next investigation.

- Donna Jallits, AHFI, CPMA, Business Analytics Senior Advisor, Evernorth, a subsidiary of The Cigna Group
- Shawn Lipsey, Business Analytics Advisor, Evernorth, a subsidiary of The Cigna Group

Back to the Future: Care Management Schemes
This session will go back to the future to provide a new look at an old service. Transitional Care Management services were implemented over ten years ago to facilitate a smooth healthcare transition for patients, usually from an inpatient to an outpatient setting. The program evolved to include Principal and Chronic Care Management – and has now grown to include the new Advanced Primary Care Management introduced in the 2025 Medicare Physician Fee Schedule Final Rule. A representative from the Senior Medicare Patrol will discuss rising complaints in this service type – including codes and sanitized complaint examples. Unique care management services including Chronic Pain Management, Principal Illness Navigation, and Community Health Integration will be presented – along with an overview of duplication of service concerns. The emerging trend of remote patient monitoring, the use of AI, and combination services to justify a broad scope of care management billing will also be discussed.

- Jennifer Trussell, Fraud Prevention Consultant, SMP Resource Center
- Dan Wullschleger, Senior Program Analyst, U.S. Department of Health and Human Services, Office of Inspector General

Dental SIU Investigative Techniques and Strategies
In this session, participants will hear from an investigative team about the tools and techniques that were used to uncover dental fraud cases including one

with international connections. The speakers will guide participants through cases from the initial investigative stages to final outcomes, emphasizing how a combination of data sources, including SIRIS and Open Source Data, directed member and provider outreach and gathered relevant evidence. Participants will gain insights on how collaborating with internal colleagues and law enforcement assist in overcoming challenges in an investigation and how a collaborative effort led to the successful resolution to these cases. Additionally, participants will understand the pivotal role that clinical data played in determining case outcomes, and how specific methodologies were employed to analyze and interpret this data. The session will provide a comprehensive overview of the investigative process, highlighting the importance of multidisciplinary collaboration and the utilization of advanced analytical tools to achieve successful case resolutions.

- Krista Thrasher, Senior Investigator, Humana
- Scott Zimmerebner, DDS, Fraud and Waste Lead, Dental Consultant, Humana

Anatomy of Deception: Body Brokers and Sober Living Homes
This session examines a landmark insurance fraud scheme involving body brokers who trafficked patients from sober living homes to undergo medically unnecessary procedures for profit. Attendees will learn how investigators uncovered the $600 million conspiracy through patient interviews, surveillance, and strategic search warrants. The session will detail how tactics used by the Orange County District Attorney's Office (OCDA) froze assets, built airtight prosecutions, and secured record-breaking convictions, including a 10-year prison sentence for a Beverly Hills surgeon. Attendees will gain insight into effective investigative tactics, inter-agency collaboration, and how to identify red flags in insurance fraud tied to addiction recovery centers.

- Nicole Nicholson, ADA, Assistant Head of Court-Senior Deputy District Attorney, Orange County District Attorney's Office
- Vincent Marinaccio, AHC, Assistant Head of Court-Senior Deputy District Attorney, Orange County District Attorney's Office

Inside the Collaborative Efforts in the Federal Health Programs
Presented by Deloitte, an NHCAA Platinum Supporting Member
Maturing Program Integrity in Federal Health Programs – patients and programs from fraud, waste, and abuse (FWA) requires a dedicated, systematic, and continuously evolving approach to program integrity (PI). Health care FWA not only diverts billions of dollars in program resources to inappropriate, unauthorized, or illegal purposes but may also impact the health and safety of Veterans. Fraud schemes often target vulnerable Veterans for schemes like

identity theft, upcoding and medically unnecessary services, resulting in poor quality of care and even patient harm. Effectively fighting FWA and protecting Veterans requires vigilance and a sustained focus on preventing fraud from occurring in the first place, detecting fraud promptly when it occurs, and rapidly remediating detected schemes through investigations, enforcement, and corrective actions. Representatives from VA will discuss their efforts to continuously mature and evolve program integrity efforts and address FWA in veteran health programs.

Uncovering Nonobvious Relationships to Enhance Program Integrity
Presented by LexisNexis, an NHCAA Platinum Supporting Member
This session will showcase how third-party data can identify hidden relationships by analyzing connections between people, places, and businesses. Through real-world examples, attendees will learn the importance of identifying nonobvious networks of businesses that are connected to suspended providers and how these suspended individuals and businesses can continue to operate under different names and/or entities, posing a risk to the system, often across state lines.

- Deepika Sud, Manager, Market Planning, LexisNexis Risk Solutions
- Thomas Figurski, CFE, CPC, Senior Fraud Analyst, LexisNexis Risk Solutions

3:15 pm – 3:30 pm *Transition break between sessions*

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

All the Way to the Top: Complex Fraud Scheme Leads to Conviction of Insurance Commissioner
Anthem Special Investigations Unit (SIU) began an investigation into a multi-provider Ear Nose and Throat medical practice located in Georgia for various issues including improperly claiming immunotherapy preparation and performing unnecessary diagnostic endoscopy procedures. The investigation was worked in conjunction with the Atlanta Division of the FBI and the United States Attorney's Office for the Northern District of Georgia in Atlanta, Georgia. The investigation led to the identification of a multi-state lab scheme involving kickbacks related to genetic testing and toxicology services. Attendees in this session will learn how investigators conducted a large amount of detailed data analytics, interviewed members, reviewed financial records, and completed an exhaustive filter review to prosecute an attorney. The speakers will share key insights about how a whistle blower's complaint led to a parallel investigation (including civil and criminal charges), resulting in federal convictions of the

practice owner and former Georgia Insurance Commissioner on health care fraud related charges and recovery of funds related to these schemes.

- Amanda Wallace, Investigator Senior, Special Investigator Unit, Anthem
- John Stofer, SSA, U.S. Department of Justice, Federal Bureau of Investigation
- James M. Williams, Jr., SA, U.S. Department of Justice, Federal Bureau of Investigation (Retired)

Unmasking 340b: Fraud, Abuse, and Risks from Pharma and Health Plan Perspectives

The 340B Drug Pricing Program has grown into the second-largest federal drug initiative, significantly impacting health plans and pharmaceutical manufacturers. While designed to support healthcare providers, its rapid expansion has introduced compliance challenges, fraud risks, and financial vulnerabilities. This presentation will explore the program's mechanics, its implications for health plans and manufacturers, and fraud detection strategies. The goal of this session is not only to highlight existing vulnerabilities but also to empower SIU professionals with the knowledge necessary to enhance oversight, refine auditing techniques, and contribute to a more transparent and compliant healthcare landscape while preserving the intended integrity of 340B.

- Caroline Jacques, PhD, RPh, CFE, Director, Anti-Counterfeiting/Global Product Security, Gilead Sciences, Inc.
- Harpreet Dhanota, Director, Anti-Counterfeiting/Global Product Security, Gilead Sciences, Inc.

Operation Nightingale

In January 2023, a multi-agency nationwide takedown led to the simultaneous arrests of 26 subjects and execution of twelve additional search warrants across five U.S. States. Dubbed as "Operation Nightingale", this case has attracted public attention and highlighted cause for concern regarding the shortcuts taken by individuals to obtain a nursing degree. This case study presentation will unpack the details of the investigation by looking closely at the expertise and cooperation needed by the team, which included FBI and HHS Agents, an FBI Forensic Accountant, an FBI Intel Analyst, and an FBI Forfeiture Paralegal. Presenters will address the complexity of this case and provide best practices in how individuals within a team can work together in a cohesive manner to navigate the challenges and celebrate the successes. The key takeaways of this presentation will include how to incorporate financial

analytics into an investigation and how out-of-the box thinking can help move an investigation forward.

- Tom Clark, Special Agent, U.S. Department of Justice, Federal Bureau of Investigation - Miami Division
- Mary Wielenga-Cline, DBA, MAcc, MSJA, CFE, CPC-A, CPB, Forensic Accountant, U.S. Department of Justice, Federal Bureau of Investigation - Miami Division
- Eddie Calienes, Special Agent, Department of Health and Human Services, Office of Inspector General - Miami Regional Office

You're So Vain: The treatment and Abuse of Swollen, Twisted Leg Veins
Cosmetic procedures are expanding into vascular surgical intervention, especially varicosities in women. Leg vein procedures are usually not medically necessary, especially in women between 20 and 50. The co-morbidities of these patients are often not addressed, such as obesity, sedentary life-styles, heart disease and the lack of conservative management, especially after having children. Publications have documented that decreased concentrations of anesthetic agents can provide adequate relief. Treatment of singular portions of a vein, accessory and tributary veins allow for continued, unnecessary procedures to be performed over consecutive years and this only increases the revenue for aberrant providers. This presentation will provide correct coding on vein procedures, how to identify cosmetic procedures, and enhance medical and reimbursement policies.

- Rae McIntee, DDS, MD, MBA, FACS, CPE, Medical Director, Clinical Solutions, Louisiana Blue
- Subashis Paul, MD, MBA, Medical Director Clinical Solutions, Louisiana Blue

Fraudulent ePAs Reap Millions for Unscrupulous Pharmacy Owners
The session is a case-study-driven presentation of how to identify fraudulent ePA accounts and ePAs as well as steps that can be taken to mitigate fraud. Independence Blue Cross' (IBX) Corporate Financial Investigations Department (CFID) identified a fraudulent electronic prior authorization (ePA) scheme relative to pharmacy claims. Through a case study, the team will walk through a pharmacy scheme with high utilization of high-cost drugs and a high volume of prior authorizations (PAs). The faculty will discuss the importance of tracking high-cost medications and examine strategies for identifying outliers and red flags including quarterly spikes in pharmacy claims, related ownership between standalone pharmacies/prescription transfers, and relationships between members. Participants will also hear about the importance of communication/relationship with PBM and interdepartmental collaboration.

- Dana Mertz, AHFI, CPhT, Manager Payment Integrity, Corporate and Financial Investigations Department, Independence Blue Cross
- Cindy McCutcheon, Senior Financial Investigator, Independence Blue Cross

How Provider Intelligence Transforms SIU Performance
Presented by 4LData, an NHCAA Platinum Supporting Member
Independent studies suggest that SIU investigators spend as much as 30% of their time searching for provider data and doing administrative tasks that reduce productivity. This panel will address some common efficiency and performance questions facing all SIU teams: 1) How well do you really know your providers? 2) Do you have easy access to accurate and current information on provider integrity such as sanctions/exclusions, relationships, behaviors, ownership interests and patterns that are key FWA indicators? 3) Do your SIU leads include a comprehensive, continuously updated provider profile? The panel of SIU and technology experts will explore how Integr8 AI™ powered, real-time provider intelligence data and automated investigation tools are foundational to improving SIU investigative performance.

- Rick Munson, Senior Fraud Prevention Advisor, 4L Data Intelligence, Former Program Integrity Chief Compliance Officer & Sr. Vice President, Investigations, UnitedHealthcare
- Deb Hamer, Vice President, Product Management, 4L Data Intelligence
- Greg Lyon, Senior Fraud Prevention Advisor, 4L Data Intelligence; Former United Healthcare Director of Fraud Prevention (moderator)

AI That Works Because You Do: Expertise at the Core of Smarter Payment Integrity
Presented by Shift Technology, an NHCAA Platinum Supporting Member
AI is transforming payment integrity, but the most effective uses of AI doesn't replace people, it elevates them. In this session, Shift will showcase real-world examples of how AI is accelerating traditionally manual, expert-driven processes like DRG review and policy analysis and demonstrate the crucial role human expertise plays at the core of AI decision making. You'll learn how expertise and a human-in-the-loop strategy is essential to building and refining AI that delivers real, trusted impact. Shift experts will show how generative AI can navigate complex, nuanced policies or complex medical records when collaboratively trained by payment integrity or SIU leaders, analysts, investigators, medical coders and other team members.

- Jesse Montgomery, Head of Customer Success & Value Engineering, Shift Technology
- Mark Starinsky, Senior Product Manager, Shift Technology

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

Thursday, November 20

8:00 am – 4:30 pm **Information Desk Open**

8:30 am – 9:45 am **General Session**
One Mission, Collective Strength: Collaboration to Combat Health Care Fraud

9:45 am – 10:00 am **Coffee break in hallway**

10:00 am – 11:15 am **General Session**
A Battle Between Good and Evil: Gen AI in FWA

- Timothy Dineen, CFE, MPA, Sr. Director, Special Investigations, Horizon Blue Cross Blue Shield of New Jersey
- Kurt Spear, Vice President, Financial Investigations and Provider Review, Highmark
- Jessie Roy, AHFI, CPC, CEMC, CFE, SIU Director, Mass General Brigham Health Plan
- Matthew Berls, MA, AHFI, Vice President, UnitedHealthcare Investigations
- Michael Cohen, DHSc, JD, PA-C, Operations Officer, U.S. Department of Health and Human Services, Office of Inspector General, Office of Investigations

11:15 am – 11:30 am *Transition break between sessions*

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

Harnessing Generative AI and Advanced Data Analytics to Enhance Fraud Detection
This session focuses on identifying emerging fraud, waste, and abuse (FWA) schemes among Durable Medical Equipment (DME) providers by examining their billing practices. The analysis incorporates data such as procedure groups, allegations, CPT codes, financial exposure, and case discovery notes as supplementary information. Participants will explore methods to detect

schemes like services not rendered, non-existent providers, patient solicitation, unbundling, and issues of medical necessity by utilizing investigative strategies such as identifying aberrant billing, compromised member details, and member-sharing kickback schemes. The presentation will showcase how machine learning and Generative AI can automatically categorize claims based on procedure codes and billing patterns, revealing previously unmonitored billing behaviors that exploit policy gaps. Attendees will gain valuable insights into developing targeted business rules and reducing false negatives through comprehensive provider billing analysis, ultimately enhancing fraud prevention capabilities across healthcare organizations.

- Pavithra Narayanan, Senior Data Scientist, Aetna/CVS Health
- Angelica Branon, Decision Scientist, Aetna/CVS Health
- Ashleigh Ward-Stoner, Senior Manager of Data Science, Aetna/CVS Health
- Ekta Patil, Data Scientist, Aetna/CVS Health

DME - Old Dog New Tricks
Durable medical equipment fraud is one of the most detrimental frauds in the healthcare industry, costing federal and private insurance carriers billions of dollars. On the heels of Operation Brace Yourself in 2019, DME claims nationwide dramatically decreased but with new tricks, they are back on the rise. This presentation addresses enhanced methods utilized by fraudsters including new techniques utilized by telemedicine companies to overcome the lack of patient/physician relationships, the use of straw owners by foreign entities, and the much-anticipated use of artificial intelligence, which has dramatically increased the capabilities of fraudulent telemedicine companies and call centers making their schemes exponentially more complex. Attendees will learn the various new techniques currently utilized to execute this nationwide fraud scheme, the continued importance of claim data analysis, and the benefits of collaboration between law enforcement and SIUs to achieve investigative success.

- Albert Tenuta, CPA, Special Agent, U.S. Department of Justice, Federal Bureau of Investigation
- Anna Ferreira-Pandolfi, JD, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General

A 360 Degree Look at the Diversion of HIV Drugs
There is an increasing and concerning fraud trend in the illegal distribution of prescription medication, which introduces potentially unsafe drugs in the U.S. market. This panel presentation will cover all aspects involved in the diversion of HIV drugs, which are non-controlled and highly reimbursable medications,

based on emerging data, financial trends, and case studies from the New York region. The presentation will look at drug distribution channels, patient and community harm potential, claims and financial data analysis, collaborations with health care plans as well as law enforcement partners, and prosecutorial decisions. Case studies will explore local pharmacy level schemes that are perpetrated by beneficiary kickbacks, buy back arrangements, and money laundering, as well as the aggregation of drugs for national sale through pharmaceutical web marketplaces. The presentation will include multifaceted visual aids.

- Christopher Marsh, Assistant Special Agent in Charge, U.S. Department of Health and Human Services, Office of Inspector General
- Derek Stevens, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General
- Naomi Gruchacz, Special Agent in Charge, U.S. Department of Health and Human Services, Office of Inspector General
- Zach Toner, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General, New York Regional Office

Scaling the Deception: Investigating a Dentist's Fraudulent Activities
This presentation examines the case of a dentist whose unethical choices jeopardized patient welfare and violated trust. The case involves a dentist who, deviating from professional standards, accepted illegal drugs as payment for services, highlighting addiction and its impact on professional conduct and decision-making. The speakers will reveal how the dentist falsely billed Medicaid, exploiting a system meant to support vulnerable populations. This case underscores the importance of ethics, safety protocols, and the legal responsibilities in healthcare, as well as safeguarding patient trust. The speakers will discuss strategies for detecting and addressing substance abuse and fraud within the profession, aiming to inspire a commitment to the highest standards of patient care and professional integrity.

- Toni L. Slocum, AHFI, CPC, CPC-P, Manager, Special Investigator Unit, Moda Health
- Jonnie Massey, CPC, CPC-P, CPC-I, CPMA, AHFI, Director, Special Investigations Unit, Blue Shield of California

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 into the recent results and trends across multiple years.

The Fraud Hunter's toolkit: Finding the cases others miss
Presented by EXL Health, an NHCAA Platinum Supporting Member
Uncovering fraud and abuse in healthcare data requires a multi-faceted strategy—no single tool can expose all risks. Just as a fisherman relies on a variety of lures, fraud investigators need a full toolkit to detect the outliers worth pursuing. A truly effective fraud detection program integrates multiple techniques to reveal hidden risks, target serious offenders, and improve investigative efficiency —ultimately increasing recoveries and referrals. Attendees will learn how to combine these approaches to detect more fraud, strengthen case quality, and better illustrate findings for action. By broadening your detection methods, you can deliver measurable improvements in your fraud investigation outcomes. Join us to review a variety of tools and solutions that can be used in identifying outliers in your data and further illustrating and highlighting them. These solutions can ultimately drive better outcomes in your fraud detection program.

- Joel Bartow, CFE, CPP, MA, Vice President and Service Delivery Leader of Fraud Detection and Investigation, EXL Health
- Cindi Ruiz AHFI, CFE, CPhT, MBA, Senior Assistant Vice President of Fraud Services Operations, EXL Health

Exposing Hidden Schemes: How AI Transformed Oversight and Recoveries in Physical Therapy
Presented by Codoxo, an NHCAA Platinum Supporting Member
Independent Health Association (IHA) leveraged AI assisted analytics to uncover a physical therapy provider with volumes far above peers. Learn how IHA detected the scheme, conducted targeted medical record reviews, secured financial recoveries, implemented prepayment controls, and coordinated with state agencies. This case study shows how AI moves fraud detection beyond post-pay reviews to deliver earlier intervention, stronger recoveries, and more effective fraud prevention.

- Shiela Caulfield, MBA, CHC, Director, Corporate Recoveries, Independent Health Association

12:30 pm – 1:45 pm **Lunch in Expo Hall**

1:45 pm – 2:30 pm **Awards Ceremony**

2:30 pm – 2:45 pm *Transition break between sessions*

2:45 pm – 3:45 pm **Concurrent Sessions**

Prescription Fraud Scheme: It's A Family Affair in New Jersey
This session involves a healthcare fraud investigation regarding the falsification of expensive, brand-name prescriptions in a scheme orchestrated by a family in New Jersey. In this case study, the pharmacy owners submitted fraudulent claims to Medicare, Medicaid and private insurance companies for expensive, brand-name drugs on behalf of themselves, family members, friends and customers of the pharmacy. Participants in the session will learn how to identify this type of pharmaceutical fraud scheme and which investigative techniques can be leveraged in an investigation. Participants will also see how close collaboration between private insurance liaison partners and federal agencies throughout the investigation can lead to a successful prosecution.

- Jamie McMahon, JD, Special Agent, U.S. Department of Justice, Federal Bureau of Investigation
- Paul McGrory, Senior Special Agent, U.S. Department of Health and Human Services, Office of Inspector General
- Cindy McCutcheon, Senior Financial Investigator, Independence Blue Cross

Patient Marketers: Can you hear me now?
Upon receiving seemingly unrelated complaints of patient recruitment at a few dental and hearing providers within the state of Connecticut, data analytics of claims identified an alarming volume of shared patients. Analysis identified 24 providers throughout the state sharing patients causing an estimated $31 million in fraudulent claims to Medicaid. This case study will follow the investigation into one of the providers who participated in this fraud scheme, General Hearing, who became the largest biller of hearing aids to Medicaid recipients in CT as a result of his involvement with the marketing company. The investigators developed an approach to gathering evidence that not only obtained proof of a traditional "services not rendered" fraud, but also involvement in a state-wide patient marketing kickback scheme which ensured a steady stream of new patients to bill. This presentation will illustrate the use of data mining to generate leads and an investigative approach to assessing fraudulent activities and unusual trends. Attendees will also hear about how multiple search warrants and seizure warrants were conducted throughout the investigation of the dental, physician and hearing aid providers resulting in both criminal and civil prosecutions.

- Janet Ambrisco, Special Agent, U.S. Department of Justice, Federal Bureau of Investigation
- Holly Richard, Intelligence Analyst, U.S. Department of Justice, Federal Bureau of Investigation
- Ryan Driscoll, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General

Partnered Paths: A Dental Scheme Uncovered
Join us for a compelling panel discussion that delves into the power of collaboration within the insurance industry in combating health care fraud. After the 2024 ATC, two private insurance companies—Delta Dental of Virginia and Anthem—uncovered something significant they had in common: a similar scheme and trend involving the same provider. This session will explore how both companies independently identified a similar concerning trend and, through indirect cooperation and parallel efforts, sought a mutual resolution. Attendees will gain insight into how shared information on common schemes allowed these organizations to independently file complementary complaints with the dental board and federal authorities. Learn from their experience as they highlight the importance of networking and partnerships in addressing industry challenges, establishing consistent referral documentation, and effectively tackling improper provider behavior. Don't miss this opportunity to understand how collaborative efforts can lead to significant advancements in misconduct detection and prevention.

- Trish Shifflett, RDH, AHFI, Clinical Fraud Analyst, Delta Dental of Virginia
- Carmen Hardin, RDH, Clinical Fraud Analyst at Delta Dental of Virginia

Innovation in Prior Authorization: Introducing the WISeR Model
The Centers for Medicare & Medicaid Services Center for Medicare & Medicaid Innovation (CMS Innovation Center) operates under a vision to make Americans healthy again through prevention, empowerment, choice and competition while responsibly stewarding the taxpayers' dollars. The new Wasteful and Inappropriate Service Reduction (WISeR) Model will help reduce clinically unsupported care in Medicare by working with companies experienced in using enhanced technologies such as Artificial Intelligence (AI) and Machine Learning (ML), to expedite and improve the review process for a pre-selected set of services that are vulnerable to fraud, waste and abuse. The WISeR Model will launch on January 1, 2026, and is planned to run for six years in six states. This presentation will describe the goals, design elements, timeline, and participant information of this new model, as well as address several popular myths about prior authorization in Medicare fee-for-service.

- Amy Turner, Deputy Center Director, Innovation Center, Center for Medicare and Medicaid Services

AI and the Human in the Loop
Presented by MedReview, an NHCAA Platinum Supporting Member
The human-in-the-loop approach to AI is a collaborative approach whereby humans actively participate in the training and development of AI models, provide operational oversight, interject contextual understanding, and mitigate bias. In Healthcare fraud, waste, and abuse, AI assists with diagnostics and identification with human clinicians validating and refining the results. Combining the strengths of AI with human intelligence will lead to more robust, ethical, and adaptable AI solutions.

- Spencer Young, Chief Executive Officer, MedReview

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.

- Speakers will be announced during the conference

3:45 pm – 4:00 pm *Transition break between sessions*

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

Enhanced Data Analytics to Support SIU Case Development
This presentation will review four health care fraud schemes associated with Diagnostic Labs, Home Health, Skilled Nursing Facilities and Acupuncture that were identified through successful advanced data-analytics. Participants will learn the value of productive data analytics in the development of quality health care fraud cases. The speakers will share best practices in enhanced data mining and demonstrate hands-on investigative measures through multiple case studies. Participants will gain insights on how the collaborative

efforts between the Data Analysts and SIU Investigators in the cases presented yielded recoveries and change of behavior in the millions of dollars.

- Michael Devine, PhD, Director, Special Investigations Unit, LA Care
- Adrian Corral, JD, SIU Senior Investigator, LA Care
- Kenneth M. Cole, III, AHFI, CFE, CPC, Director of Special Investigations, SIU Services, Healthcare Fraud Shield

OB-GYN Fraud Scheme Results in Patient Harm
The case presentation involves Dr. Mona Ghosh, OB-GYN. Dr. Ghosh had multiple fraud schemes such as unnecessary labs, telemedicine fraud, and billed for services while she was out of the country. Dr. Ghosh lied to many of her patients by telling them they could have cancer, and she pressured her patients to have medically unnecessary procedures. One procedure that Dr. Ghosh had pressured her patients to cause her patients to no longer have children. The speakers will share how data analytics and interviews assisted in identifying a fraud scheme that resulted in patient harm.

- Karl D. Kraywinkle, Special Agent, U.S. Department of Justice, Federal Bureau of Investigation
- Renee A. Reyes, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General

Investigative Foundations: Strategies and Resources for Team Success
Resources and references that are universally applicable are essential for conducting effective investigations. In this presentation, we will cover topics such as structuring your investigative team for success, creating robust investigative plans, and cultivating the skills necessary to effectively plan and execute complex investigations from start to finish. Key challenges addressed in this session will include hiring the right investigators, guiding them in developing strong cases from the outset, crafting investigative summaries, and managing a heavy caseload.

- Haley Everson, AHFI, SIU Manager, Elevance Health (formerly Anthem, Inc.)
- Carrie Godby, MS, AHFI, CFE, SIU Manager, Elevance Health (formerly Anthem, Inc.)

Unlocking Workflow Efficiencies: Creating capacity for proactive fraud detection
Presented by HMS, an NHCAA Platinum Supporting Member
Healthcare fraud investigation teams can become accustomed to running primarily, if not sometimes entirely, in a reactive mode. The ability to detect

fraud gives way to your teams relying solely on a triggering event, such as someone else finding it. This habitual reactive approach restricts investigators from fully using their investigative skills, knowledge, and the technological advancements available to them. By contrast, proactive data analytics enables the team to uncover emerging fraud schemes and intercept systemic vulnerabilities before losses escalate. In this session, we will share concepts to help you shift from a reactive posture to a balanced model to free capacity for data-driven insights, allowing your team to detect fraud earlier, reduce losses, and stay ahead of evolving schemes. Topics of focus will include workflow optimization, resource alignment, and methods of leveraging business partners to provide you with the tools you need to create additional capacity.

- Chris Larsen, Director, FraudCapture, HMS
- Brian Welter, Sr. Manager, Product Development, HMS

Specialty Benefits Investigation of the Year
This 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.

- Speakers will be announced during the conference

Friday, November 21

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

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

Investigation of the Year Case Study
The recipients of NHCAA's 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.

- Speakers will be announced during the conference

Annual Ethics Seminar
Each year, NHCAA hosts this annual seminar on professional and investigative ethics for health care fraud investigators. The program will combine lecture with group discussion and will focus on practical ethical challenges faced by investigators in the areas of evidence, interviewing, professional and business activities, privacy, as well as review legal and regulatory requirements. This seminar is designed to meet the American Certified Fraud Examiner CFE ethics training requirement.

- Tamara Neiman, Vice President, Investigations, Ethics and Compliance, Kaiser Permanente
- Francine Gross, JD, CFE, CHC, Executive Director, National Special Investigations Unit, Kaiser Permanente

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 exist within both the Commercial and Public sectors, plus those which may be associated to recently added and the 2026 CDT code updates. Key discussion points will be presented, focusing on potential schemes specifically in pediatric dentistry and Medically Necessary Orthodontics, alongside tele-dentistry advancements. Associated Medical cross coding will be identified in the case examples presented.

- Stewart Balikov, DDS, AHFI, State Dental Director, Elevance Health (formerly Anthem, Inc.)
- Vinod Miriyala, BDS, MPH, CAGS, DDS, State Dental Director, Elevance Health (formerly Anthem, Inc.)

Insane in the Membrane: Keeping Ahead of Skin Substitute Schemes
Skin substitute fraud has rapidly become one of the most aggressive and costly trends in Medicare. What appears on the surface as routine wound care often masks complex fraud schemes involving newly enrolled providers, no legitimate business history, and the use of stolen identities. These actors are

exploiting policy gaps and pricing structures to generate sky-high per-beneficiary spending while avoiding early detection. This three-part seminar will provide a background on how to identify issues within claims data regarding skin substitutes, identify fraud schemes, and learn how to prevent future improper payments. Speakers from will also provide insights into current regulatory framework for how these products gain FDA approval and current vulnerabilities in Medicare Part B.

- Jennifer DePaul, MHA, Director, Special Investigations Unit, Elevance Health (formerly Anthem, Inc.)
- Jessica Lahaye, Investigator Senior, Elevance Health (formerly Anthem, Inc.)
- Sandra Nadler, AHFI, Director, Elevance Health (formerly Anthem, Inc.)
- Patrick Neubert, CDR, U.S. Public Health Service, Regional Inspector General, U.S. Department of Health and Human Services, Office of Inspector General
- Dave Tawes, Regional Inspector General, U.S. Department of Health and Human Services, Office of Inspector General

12:00 pm **Conference Adjourns**