Tuesday, October 15
All Educational Sessions held at the Music City Center

7:30 am – 5:30 pm Registration and Information Desk Open (2nd floor)
8:30 am – 4:30 pm Preconference Program (additional registration required)

AHFI® Prep Course (2nd floor – Room 204)
The AHFI® Prep Course is a one-day intensive program designed to highlight key content areas of the AHFI® Exam. Experienced faculty provide instruction on the key areas addressed in the AHFI® Exam enabling candidates to feel better prepared. This course should serve as a “refresher” on information that a seasoned investigator should already know.

9:00 am – 3:00 pm Preconference Program (additional registration required)

Coding- It’s a Numbers’ Game (2nd floor – Room 202)
The annual coding pre-conference program focuses on the CPT series of codes by the numbers. This year faculty will walk through CPT codes and address current schemes. Participants will be able to ask questions and dive into case examples in this always entertaining and engaging educational program. Participants will once again walk away with information necessary to investigate providers.

- Barbara Scott, BSN, RN, CPC, CFE, AHFI, Senior Consultant, Blue Cross Blue Shield Association
- Jonnie Massey, CPC, CPC-P, CPC-I, CPMA, AHFI, Director, Special Investigations Unit, Blue Shield of California
- Kathleen A. Shaker, RN, BSN, CPC, CPC-H, AHFI, Investigative Consultant, Healthcare Fraud Shield
- Karen Weintraub, MA, CPC-P, CPMA, AHFI, Executive Vice President, SIU, Healthcare Fraud Shield

12:30 pm – 4:30 pm Preconference program (additional registration required)

Honing Investigator Skills and a New Twist on Managerial Oversight with Data (2nd floor – Room 201)
Four rapid fire modules focused on building and honing various investigative skills, as well as improving managerial oversight capabilities through the application of “data.” At a micro-level topics will include skills and techniques for interviews and onsite inspections/field work; ‘how-to’ handle complex investigations; and ‘how-to’ fuse data intelligence with SIU management.

Module I – Interview Skills and Techniques
Lucy Russo, CPC, AHFI, Director, SIU, UnitedHealthcare Investigations

Module II – Onsite Skills and Techniques
- Danielle Wilson, CPhT, Manager, SIU, UnitedHealthcare Investigations

Module III – Large Case Handling
- Andrea Johnson, MHA, AHFI, Manager, UnitedHealthcare Investigations

Module IV – A Fusion of Data and SIU Management
- Matthew Berls, Director, SIU, UnitedHealthcare Investigations

4:30 pm – 5:00 pm  Anti-Fraud Expo Hall Preview (3rd floor – Hall A1)

5:00 pm – 7:00 pm  Welcome Reception in the Anti-Fraud Expo Hall (3rd floor – Hall A1)

Wednesday, October 16
All Educational Sessions held at the Music City Center

7:00 am – 5:00 pm  Registration and Information Desk Open (2nd floor)

8:00 am – 9:15 am  Opening General Session (4th floor)
- Powerhouse: 13 Teamwork Tactics that Build Excellence and Unrivaled Success
  - Kristine Lilly, Two-time World Cup Champion Soccer Player, and Two-time Olympic Gold Medal Winner in Soccer

9:15 am – 10:00 am  Coffee Break in the Anti-Fraud Expo Hall (3rd floor – Hall A1)

10:15 am – 11:15 am  Concurrent Sessions (2nd floor)
- Sharpening the Spike Report (Room 201)
The spike report, which identifies large increases in activity, is a staple of fraud analytics. When working well, spike reports can provide valuable leads on emerging schemes, as well as intelligence on overall trends in medical expense. However, cultivating an effective spike report means getting the details right. The faculty will discuss how to choose metrics and time periods, and situations where a spike report is appropriate and where one is not appropriate, including a comparison of a spike report to a trend analysis or exposure analysis. Faculty in this session will also examine problems and solutions in spike reports, from design to implementation, and evaluation of the output.

- David Angevine, MPH, Team Lead, Data Analytics, Blue Cross Blue Shield of North Carolina
- Erik Jensen, Data Scientist, Blue Cross Blue Shield of North Carolina
Legal Issues for 2020 (Room 202)
Two practicing attorneys, former federal prosecutors, and good friends will explore
the most important emerging anti-fraud legal and regulatory developments
including recent state and federal court decisions, federal regulatory actions and
interesting legislative initiatives. Attendees will be able to determine how
regulatory and legislative changes will impact their investigations and discuss state
and federal decisions and the repercussions for fraud schemes and cases.

- Jeremy Sternberg, Partner, Holland & Knight LLP

A Love Letter to the SIUs (Room 204)
A variety case of briefings will be discussed during the presentation to further
explain how some investigations have been started by Special Investigation Units
(SIU) or NHCAA SIRIS reports, how those cases progressed through the
investigation stages with help from SIUs, and conclude with successful, and
sometimes unsuccessful, results. These case briefings will include a Dental Fraud
whodunit with a twist, cases where the FBI collaborated with State agencies to
move the investigations forward at the State level, an explanation of cases which
were closed without prosecution, the winding road of a serial fraudster which
ultimately ended at Federal prison, and the most recent successful outcome of our
collaboration with at least ten different SIU's to secure the 2019 conviction of a
California dentist. We applaud health care benefit programs which continue to fund
and support their robust SIU's and we hope to continue our successful relationships
in the future.

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

The Opioid Strike Force Model (Room 205)
The nation’s opioid epidemic represents the single greatest threat to public health
and safety in decades. This presentation discusses the blending of white-collar
health care fraud investigations with traditional drug diversion investigations as
part of the new Appalachian Regional Prescription Opioid Strike Force. Topics will
include using data to identify problem prescribers and drug seeking patients;
investigative techniques for pill mills; and successful prosecution strategies for
opioid over-prescribers. Attendees will develop a better understanding of the
opioid crisis and the challenges involved when investigating prescribers acting
outside the legitimate practice of medicine.
• Chris Covington, Assistant Special Agent in Charge, U.S. Department of Health and Human Services, Office of Inspector General
• Amy Markopoulos, U.S. Department of Justice, Counsel to the Chief, Health Care Fraud Unit
• Kilby MacFadden, Assistant Chief, ARPO Strike Force, Northern Hub
• Katherine Payerle, Assistant Chief, ARPO Strike Force, Southern Hub

Telling A Better FWA Story: How to Bring Data Analysis Results and Investigative Findings to Life for Vital SIU Audiences (Room 207AB)
Presented by HMS, A NHCAA Platinum Supporting Member
In an ever more data-centric and -dependent environment, how can SIU analysts and investigators avoid “data-overload” syndrome in presenting often-complex FWA data analysis findings and investigation results to their SIU’s vital internal and external audiences, from SIU Leadership, Legal and Senior Management to customers, outside counsel, law enforcement investigators, prosecutors and insurance anti-fraud regulators. The presenters will discuss and illustrate a variety of tools and approaches ranging from standardized formats and visuals for detection-model output and investigation reports to creative use of case-specific graphics and images—all designed to convey that information in ways that most effectively engage and inform those key constituents and reinforce their support of the SIU’s cases and overall mission.

• Julia Twaddle, Program Integrity Solutions Director, HMS
• William J. Mahon, President, The MAHON Consulting Group LLC

Consumer Privacy Laws and What They Mean for Your FWA Investigation Room 208)
Presented by LexisNexis, A NHCAA Platinum Supporting Member
Over the past 12 months the industry has seen a sudden rise in state legislation focused on protecting consumer privacy. While privacy legislation is important to give consumers greater control of their personal data, unfortunately, these laws may impact FWA investigative success. Limitations may potentially include loss of member/provider insights, loss of public data assets, and loss of industry research tools. Ultimately these limitations may result in gaps such as critical leads going unknown, which impacts the breadth of your investigation and your potential for recovery and the potential for increased risk that fraudsters may leverage their consumer anonymity in order to conduct their illicit business. This session will explore how these new consumer privacy laws may impact FWA investigations.

• Rick Grape, Director, Market Planning, LexisNexis Risk Solutions
• Danielle Nelms, Senior Product Manager II, LexisNexis Risk Solutions
2019 Emerging Issues in Medicare (Room 209)
Participate in this annual 'Health Care Fraud Trends' presentation with one of the leading experts from the Office of the Inspector General, U.S. Department of Health and Human Services on common fraud schemes and emerging trends affecting Medicare and Medicaid. Participants will hear about areas of focus and concern in the government programs. In addition, the participants will take away specific data points to leverage in their fraud fighting efforts.


11:30 am – 12:30 pm Concurrent Sessions (2nd Floor)
Are you ready? Spanning the Horizon for Fraud Risk (Room 201)
Over the past few years phantom cases have emerged nationwide, which unfortunately may have caught many health insurers off guard. This session will showcase how one health insurer’s reflection on a provider phantom case changed their data philosophy, analytics, and management oversight to quickly counteract fast-moving schemes. Additionally, the faculty will overview insights gained on best practices when working with data to ensure integrity, effectiveness, and continuous improvement.

- Jennifer Olmeda, Manager, SIU Analytics, Horizon Blue Cross Blue Shield of New Jersey
- Jian Tong, Supervisor, SIU Analytics, Horizon Blue Cross Blue Shield of New Jersey

Navigating Laboratory Investigations: What You Need to Know and Then Some (Room 202)
Investigators from UnitedHealthcare Special Investigations Unit (UHC SIU) will present on the basics of a laboratory investigation from identification of suspect laboratories to case closure and referrals. Attendees will walk away with a comprehensive understanding of how to conduct a laboratory investigation, what information to seek in the investigation and patterns and red flags to be mindful of during the investigation. Building upon the basics of laboratory investigations, we will dive deeper into laboratory onsite inspections including preparation, documentation and collection of materials, and post-inspection activities. The presentation will compare and contrast operating and non-operational laboratories with real-world case examples.

- David Webb, AHFI, HCAFA, Principal Investigator, UnitedHealthcare
- Kelly Tobin, AHFI, CFE, Director, Special Investigations Unit, UnitedHealthcare
Dental Director Panel (Room 204)
Dental directors from across the country will offer insights for investigators on how to develop competent investigations. Faculty will share their perspectives on best practices for working with the investigation teams, common schemes and red flags, along with other lessons learned. Participants should be prepared to ask questions and participate in the session making this session an active learning experience.

- James Thommes, DDS, Vice President, Clinical Management, DentaQuest
- Linda M Altenhoff, DDS, Vice President, Program Integrity, MCNA Dental
- Brent Martin, MD, State Dental Director, DentaQuest
- Nicholas J. Messuri, Vice President, Fraud Prevention & Recovery, DentaQuest

The Gift that Keeps on Giving: A Nationwide Kickback Scheme and the Largest Medical Device Settlement Ever (Room 205)
This presentation will showcase how the parallel criminal and civil investigations into a nationwide kickback scheme perpetrated by Advanced BioHealing (later Shire Pharmaceuticals) affected Medicare, Medicaid, TriCare, FEHB and the Veterans Administration. The investigation resulted in six Federal criminal felony convictions of physicians and company executives, as well as a $350 million-dollar settlement (the largest medical device settlement ever). The faculty will outline the investigation from beginning to end, highlighting special tools and techniques utilized by the investigative team of agents and prosecutors, towards its successful resolution. Investigators and data analysts attending this session will take away key points on the use of data throughout this investigation, both in identifying the fraud and later use alongside other evidence to target the fraud.

- Isaac Bledsoe, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General
- Jason Bell, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General
- Sean Keefe, Assistant United States Attorney, Civil Division, U.S. Department of Justice (Middle District of Florida)

Beyond the Bell Curve: 2019 Sampling Updates and Strategies (Room 207AB)
Presented by Cotiviti, Inc., A NHCAA Platinum Supporting Member
For years, investigators have struggled with statistical terminology and methodologies, and 2019 also brought significant updates that special investigative units (SIUs) must address. Cotiviti will be joined by Health Partners Plans to present examples of how advanced statistical sampling methods can drive successful recoveries. The faculty will address the basic principles, including how and when to conduct statistical sampling and when to seek outside help. Presenters will also
focus on how to address recent sampling requirements that impact on SIU operations.

- Jason Pino, Investigator, Health Partners Plans
- Mark Starinsky, AHFI, CFE, CHC, Product Director, FWA Solutions, Cotiviti, Inc.

**Telemedicine and Telemarketing: What you need to know for successful investigations (Room 207CD)**

Detecting schemes in a world where new technology is widely used, and is ever changing, can be challenging even to a seasoned investigator! This session will focus on a review of the all-important basics related to the billing of telemedicine services so the investigator will understand the norm and more readily identify aberrant billing patterns. Service codes and modifiers required for the billing of telemedicine services will be reviewed along with the variety of health settings in which telemedicine fraud and abuse occur, including virtual offices. Attendees will learn how to detect telemedicine schemes and how successful investigations require creative use of the investigator's complete toolbox, understanding the role technology plays in the billing of telemedicine services, including the analysis of data, as well as how a team approach will provide the best foundation for success.

- Barbara Scott, Senior Consultant, FEP SIU, Blue Cross Blue Shield Association

**Healthcare Fraud Shield: We’re the Whole Package (Room 208)**

*Presented by Healthcare Fraud Shield, A NHCAA Platinum Supporting Member*

An effective Fraud, Waste and Abuse (FWA) solution should consist of multiple services and solutions dedicated to your needs, a one stop shop. Learn how Healthcare Fraud Shield can offer a fully integrated and comprehensive FWA platform built by FWA Subject Matter Experts. Faculty will explain how Healthcare Fraud Shield leverages the latest advanced technology to provide your organization with a comprehensive FWA solution. Participants will learn why FWA Subject Matter Experts are integral to your vendor partnership from implementation, customer service, and account management.

- Jim McCall, AHFI, Vice President of Data Science, Healthcare Fraud Shield
- Karen Weintraub, MA, AHFI, CPC-P, Executive Vice President, Healthcare Fraud Shield

**Prescription Drug Fraud Schemes (Room 209)**

Expert faculty will examine trends and schemes in the dynamic world of pharmaceuticals. Faculty will explore newly approved pharmaceuticals of concern, new schemes by criminals, legislative impacts, opioid plots, drug-treatment related ruses, and other areas of impact. Attendees will be able to recognize new pharmaceuticals and associated schemes on the rise in their community and
discuss the substance abuse treatment schemes and types of activity to be aware of.


12:30 pm – 1:45 pm   Awards Luncheon (4th floor)

1:45 pm – 2:30 pm   Dessert with Exhibitors in the Anti-Fraud Expo Hall (4th floor)

2:45 pm – 3:45 pm   Concurrent Sessions (2nd Floor)

**Developing a Rapid Response Mechanism to Identify and Combat Laboratory FWA (Room 201)**
This presentation is geared towards expanding investigative skills using both data analysis and clinical issues for healthcare fraud investigators, focused on laboratory FWA. This presentation will include a discussion of the problems posed by laboratory abuse, review emerging and evolving schemes, while also discussing the process and benefits of developing a rapid response mechanism to combat new schemes and billing patterns. Framed through the discussion of common laboratory schemes including UDT billing, we include a brief case study analysis exhibiting the rapid response mechanism and how it can be used to address the evolving fraud. We will also allow for a brainstorming session to expand on emerging lab schemes seen in the industry. Attendees with varying levels of investigative experience will leave with tools that will allow them to identify large schemes plaguing their companies and a method to develop rapid response mechanism to assist in the identification of varying types of Fraud, Waste and Abuse.

- Zachary Zabo, CPC, Investigator II, Anthem Inc.
- John Kearney, Senior Investigator, Anthem Inc.

**Ambulatory Surgical Centers: Mitigating Risk from New Facilities (Room 202)**
Throughout the country there are several companies that partner with surgeons to help develop ambulatory surgical centers (ASC). In early 2019, Harvard Pilgrim’s SIU encountered a situation where a large number of contracted physicians began referring services to a newly developed out-of-network ASC for orthopedic surgeries. As could be expected, the claims from the out-of-network ASC were incredibly expensive; often exceeding the cost of a multiple-day inpatient stay. This presentation will discuss data-mining efforts used to identify the case, the investigative activity performed by the SIU, as well as the risk-mitigating policies put in place to protect the plan from similar exposures in the future.

- Brian Robinson, Managing Investigator, Special Investigations Unit, Harvard Pilgrim Healthcare
Data Analytics and Dental Investigations: Not All Doughnuts Have a Hole (Room 204)

Analytics can drive and provide continuous support during dental investigations. Specific case examples will be presented to illustrate how analytical methods and insights are used to identify abusive patterns as well as contradictory informatics. Patterns, trends and correlations utilizing data visualization as a tool to educate providers, negotiate settlements and change aberrant billing behaviors will also be presented. Case studies will further show how clinical findings can be interwoven with influencing data, and how a variety of challenges were overcome during the investigative process, since not all doughnuts have a hole.

As the Fraud Turns: How Yesterday’s Schemes Become Today’s Cash Cows (Room 205)

Are you seeing new schemes that are reminiscent of old concepts? Let’s look at how new treatment strategies and technologies are driving change in how providers are maximizing reimbursement. From DME to unqualified providers in various specialties (Home Health, PT/OT) to telemedicine and more, the faculty will walk participants through how to examine billing patterns and emerging codes for data mining at the health plan. Faculty will demonstrate how to apply internal policy, coding definitions and regulations to review claims for coding accuracy. The faculty will also examine the specifics steps to prepare for reviewing the record once patterns are identified.

Proactively Dealing with EPSDT Fraud through Medicaid Prepayment Review (Room 207AB)

Faculty in this session will walk attendees through fraud schemes concerning billing of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services by pediatricians and how Special Investigations proactively confronted this scheme through Medicaid Prepayment Review (PPR). Participants will be educated on how to identify inappropriate patterns of billing through data mining, impossible day review, red flags in CPT coding for EPSDT services and how to prevent payment for suspected fraud in order to eliminate the standard "pay and chase" investigation. Participants will also gain significant insight on the value of analytics and peer
comparisons in order to identify outliers and inappropriate coding patterns surrounding EPSDT services.

- Megan Brennan, CPC, CPMA, CFE, Supervisor, Horizon Blue Cross Blue Shield of New Jersey
- Jennifer Kovaly, CPC, AHFI, Senior Investigation, Senior Investigation, Horizon Blue Cross Blue Shield of New Jersey

Case Study: Integrating Clinical and Pharmacy Audits to Solve Complex Fraud (Room 207CD)

Presented by Conduent, A NHCAA Platinum Supporting Member

Join a pharmacy practice subject matter expert from Conduent for a case study discussion of how a pharmacy audit lead to a wider discovery of diversion and suspected fraud, waste, and abuse. Walk through the case as pharmacy practice, clinical assessment, and FWA analysis ultimately uncovered a greater issue than one misfill. Learn from this case how a seed can grow into something unexpected and that expectations can lead to incorrect conclusions.

- Joshua Peters, PharmD, RPH; Client Manager and FWA Lead Auditor, Conduent Commercial Healthcare
- Kristine Kurschner, Senior Director, Business Product Management, Conduent Commercial Healthcare

Fighting Fraud with Analytics: The New World of Value Based Payments (Room 208)

Presented by SAS, A NHCAA Platinum Supporting Member

Provider fraud hits the bottom line directly while adversely affecting quality of care and health outcomes. Fraud, waste, and abuse (FWA) takes on added meaning in our newly emerging world of performance/value models. The growing complexity of risk-based payments is expanding the focus of PI/SIU/SUR departments. New analytic strategies are needed to spot FWA in this new paradigm. Techniques, algorithms, and data investigations will be discussed as the cutting-edge tools needed for today’s fraud investigator.

- Tom Wriggins, Principal Solutions Architect, Global Fraud, Risk and Security Intelligence Practice, SAS

SIRIS Investigation of the Year (Room 209)

Each year NHCAA awards an investigation the SIRIS Investigation of the Year. This session offers participants the opportunity to hear how a SIRIS lead led to an award-winning investigation. Attendees will follow the investigative twists and turns and best practices for building a successful case.
4:00 pm – 5:00 pm  Concurrent Sessions (2nd floor)

Innovative Techniques for Building Peer Groups *(Room 201)*
Anomaly detection in medical billing patterns is challenging due to the inherent variation in common provider behaviors across the industry. Everyone has experienced the pitfalls of relying on specialty to categorize groups of providers and practices (e.g. self-reporting, multiple specialties, inconsistent specificity etc.). In this session, participants will learn how to leverage machine learning techniques for designing useful peer groups that are agnostic of reported specialty and purely data driven. We will demonstrate this technique to a sample FWA scheme. Reduce false outliers in your FWA scheme analysis by applying a novel provider outlier detection methodology.

- **Thomas Snyder**, Senior Informatics Analyst, Payment Integrity, Query Analytics, Aetna
- **Karen Spratley**, Senior Director, Data Science, Aetna

Pharmacy Fax Scheme: From Investigation to Law Enforcement Engagement *(Room 202)*
Currently there is a pharmacy fax scheme epidemic facing the healthcare industry. The audience will learn how Kaiser Permanente investigated a recent pharmacy fax scheme that impacted health plans across the nation. We will walk the audience through the investigation from allegation to law enforcement engagement, including a referral to the NBI MEDIC. We will discuss how Kaiser Permanente mitigated the risk through partnering within the organization and also with the contracted pharmacy benefit manager (PBM). The partnership with our PBM led to the subject pharmacy being terminated from the PBM’s pharmacy network.

- **Mark Horowitz**, Senior Manager, National Fraud Control Unit, Kaiser Permanente
- **Tamara Neiman**, Director, National Special Investigations Unit, Kaiser Permanente

Operation MediRaid *(Room 205)*
Government employees from the Puerto Rico Department of Health (PRDOH), Office of the Medicaid Program, also known as the Medicaid Office, along with others involved in the scheme were convicted in a conspiracy to commit Health Care Fraud. This investigation involved Medicaid Office employees who solicited cash bribes and monetary payments, with or without the assistance of runners (facilitators), in return for the fraudulent enrollment of individuals into the Medicaid program. Participants in this session will hear how the investigative team used Confidential Informants, physical surveillance, telephone search warrants, and
office search warrants in this investigation. Faculty will also share how data, including financial records, beneficiary files, interviews, and Medicaid data helped in the investigation.

- Alfredo Trejo, Special Agent, U.S. Department of Justice, Federal Bureau of Investigation
- Jose Luis Soto, Assistant Special Agent in Charge, U.S. Department of Health & Human Services, Office of Inspector General

Stopping Fraud at the Front Door: New Non-Par Provider Validation (Room 207AB)

How to stop new non-par fraudulent providers before you let them in your systems and pay any claims. The learned concepts from implementing this program can be applied to organizations of any size and we will show how you can scale down our program to fit your current environment. We’ve created a holistic end-to-end process from start to finish which identifies high-risk new non-par providers and investigates them before we pay any claims and allow them in our systems. We will go over the 5 Design Elements of our program (Registration Form, Analytic Model, Authentication Team, SIU and Fraud Flag Committee) as well as focus on how we were able to demonstrate savings to our organization that allowed the addition of resources as well how we worked with our financial partners to build in an agreeable cost avoidance savings methodology.

- Melissa Nevala, AHFI, CFE, Associate Director, Fraud Prevention, UnitedHealthcare
- Greg Lyon, Director, Fraud Prevention, UnitedHealthcare

SIU Prepayment Review: A Proven Strategy in Your FWA Playbook (Room 208)

Learn how the SIU Prepayment Review Program can be the most effective offensive strategy in your FWA playbook. Whether you are a healthcare professional, investigator, law enforcement, regulatory/compliance officer, or local/state/federal official, this session will share real, tactical plays to increase your potential to win against FWA schemes. Hear from our Head Coach (Director, Special Investigations) and Offensive Coordinator (Director, Special Investigations Prepayment Review) to understand how to analyze the data, develop your prepayment review approach, call the plays, and realize tangible results that win the game. Participants will be armed with the tools to communicate with public and private partners after hearing examples of information sharing as well as the prepayment review findings and results related to specific facilities, practices and providers and potential schemes.

- John Houston, Director, Special Investigations Unit (SIU), Anthem, Inc.
- Beth Franke, Director, SIU Provider Prepayment Review, Anthem, Inc.
Investigation of the Year *(Room 209)*
Welcome the recipients of NHCAA’s 2019 Investigation of the Year Award and listen to the investigative strategies, multi-organization cooperation and case-building excellence that led to a successful resolution, as well as to the coveted NHCAA honor.

5:00 pm – 7:00 pm   Reception in the Anti-Fraud Expo Hall

Thursday, October 17
All Educational Sessions held at the Music City Center

7:00 am – 4:00 pm   Information Desk Open *(2nd floor)*
7:30 am – 8:30 am   Breakfast in the Anti-Fraud Expo Hall *(3rd floor – Hall A1)*
8:30 am – 9:45 am   General Session *(4th floor)*
  Federal Agencies: Effective Collaboration, Proven Success *(4th floor)*
  - **Alec Alexander**, Deputy Administrator and Director, Center for Program Integrity, Centers for Medicare & Medicaid Services
  - **Gary Cantrell**, Deputy Inspector General, Investigations Office of Inspector General at the Department of Health and Human Services
  - **Allan Medina**, Acting Chief, Health Care Fraud Unit, Criminal Division, U.S. Department of Justice

10:00 am – 11:00 am   Concurrent Sessions *(2nd floor)*
  Medicare Case Collaboration: Best Practices in Fighting Health Care Fraud *(Room 201)*
Learn about the major case coordination (MCC) used by agencies in an effort to fight health care fraud. Faculty from the leading agencies will discuss an overview of priority health care fraud work and best practices used to strengthen collaboration of health care fraud investigations. The faculty will discuss best practices for collaboration of both Medicare & Medicaid health care fraud investigations. Participants will learn about the necessary activities and steps required for effective collaboration and accountability among the stakeholders.

  - **Christian Schrank**, Assistant Inspector General Health and Human Services, Office of the Inspector General
  - **Kathleen McGinty**, Acting Director Investigations & Audits Group, CMS/CPI
Preparing for and Executing a Successful Settlement Negotiation *(Room 202)*
Participants will learn tips and tools that will assist them in preparing for and executing a successful settlement negotiation. Advice will be given from two perspectives: investigator and lawyer. The presentation will cover all phases of the settlement process, from drafting the initial audit findings letter to the final settlement agreement. Case examples will be discussed to illustrate the key learning concepts and demonstrate the usefulness and successful outcomes of settlements. At the end of the presentation, the participant should feel more confident and prepared to handle a settlement negotiation.

- Michael Goldfarb, Esq, AHFI, Director, Cigna
- Kayla Maciejewski, AHFI, CPC-A, Fraud Advisor, Cigna

Medicaid Fraud Involving Phantom Dental Clinics *(Room 204)*
This presentation will analyze notable variances involved in investigating fraud within Government Programs versus Commercial lines of business. The faculty will address how schemes can present differently to individual insurers. Through a recent case study, the faculty will illustrate how fraudsters avoided detection for over five years by utilizing member and provider medical identity theft to establish multiple phantom dental clinics and create false dental claims. Participants will learn the significance of having the requisite internal department workflows in place to generate potential FWA leads to the Special Investigations Unit (SIU) and how strong investigative collaboration between independent insurers/MCOs and their vendors for specific services (i.e. Dental, Pharmacy, Transportation, etc.) can lead to identifying the true nature and extent of a fraud scheme.

- Angela Niemiec, Clinical Investigator, DentaQuest
- Joe Lamb, Senior Fraud Investigator, BlueCross BlueShield of Illinois / HCSC

Gordin Medical Center: A Multi-generational Russian Family Fraud Scheme *(Room 205)*
The Gordin Medical Center case was a clear demonstration of pure articulated greed masquerading itself as healthcare. The three (3) Gordin’s were of Russian decent, as was as a large portion of their patient base. The Gordin’s, fluent in Russian, initially ingratiated themselves by meeting their patient’s deductibles by billing for non-rendered services. Patient-specific global data mining showed that many Gordin patients, mostly Russian, were also having procedures billed from Ultrasound Mobile Services (UMS) for the same date-of-service. Participants in this session will gain insights on how to detect and identify unexpected anomalies within investigations, exploit identified inconsistent and outlying aspects and behaviors, and utilize the strengths of both the authority and capability of federal law enforcement, compounded and enhanced by working with private insurance fraud investigative efforts and resources.
Tips and Tools to Identify Leads and Build FWA Cases *(Room 207AB)*

*Presented by ChangeHealthcare, A NHCAA Platinum Supporting Member*

Whether it's fraud, waste or abuse, having the right tools at the right time is necessary to develop leads, validate provider identities and identify patterns in the data. Discovery of leads can start anywhere, from an NHCAA article to a patient call. You can also take an active role in developing leads by leveraging paid claims data to discover outliers. From using pivot tables to analytic tools, the faculty will demonstrate how to delve into provider claim data to turn a lead into a case. This faculty will also provide ideas and resources to illustrate a multi-pronged approach to identify aberrant providers and build a solid, well-rounded case. Finally, the faculty will show how public data, social media and both public and private data sources can provide relevant information on leads.

*Louise Dobbe, Esq., Director, Insight Operations*

*Debra Riekkoff, AHFI, Product Manager, Change Healthcare*

Overcoming Challenges Facing Today’s SIU Analyst *(Room 207CD)*

SIU analysts, data scientists and their leaders face several challenges to detect FWA in both a changing healthcare environment and a rapidly evolving data science field. This presentation will identify some of these challenges, and offer guidance to navigate this complex area. Topics to be discussed include considerations in the application of machine learning, the prioritization of analytic methodologies, the future of feature engineering, as well as the interpretation and communication of the output of advanced analysis. Participants will gain insight on solutions for applying the right advanced analytic techniques in their SIU.

*Douglas Rahden, MPH, CPMA, Advanced Analytics Senior Manager, Cigna*

Payment Integrity: How to effectively stand up and run a commercial health plan pre-pay program. *(Room 208)*

*Presented by Optum, A NHCAA Platinum Supporting Member*

Presenters will review and discuss in detail the value levers that can lead to incremental savings above and beyond what current vendors are generating. Discussion will include details related to how the right pre-pay program improves provider relationships by reducing provider abrasion via clear and transparent billing guidance. The participants will learn about a well-established, successful pre-pay program from analytic build through invoice reconciliation. Additionally,
participants will learn how pre-pay processes can and should co-exist with a post pay program and benefit in both the short and long term.

- **Jeremy Hill, Product Director, Payment Integrity, Optum**

**U.S. v. Robert Maughon: The Investigation and Prosecution of an Allergy Scam (Room 209)**

Dr. Robert Maughon of Gatlinburg, TN, owned a chain of primary and urgent care clinics in East Tennessee. He was indicted, and later pled guilty, to a healthcare fraud scheme where he billed Medicare, TennCare, and commercial plans for non-covered and non-FDA approved mobile allergy therapy and E&M services that were not provided. The investigation and prosecution team will discuss this unique fraud scheme, which originated at a small-town East Tennessee festival, and the steps that ultimately led to a guilty plea and lengthy prison sentence for Dr. Maughon. Participant will gain insights into investigative strategies including how to work collaboratively with public and governmental agencies impacted with a specific fraud scheme.

- **Laura A Bell, CPhT, AHFI, Senior Investigator, Special Investigations Unit, BlueCross BlueShield of Tennessee**
- **Margaret Chuinard, Special Agent, Criminal Investigator, Tennessee Bureau of Investigations, Medicaid Fraud Control Division, Knoxville**
- **Tony Maffei, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General**
- **Donna Lamb, AHFI, Fraud Lead Analyst, Special Investigations, CIGNA**
- **Wahtawah T.J. Battle, MSH, AEMT, CFE, Special Investigation Unit, Investigator II, BlueCare, BlueCross BlueShield of Tennessee**
- **Cindy Davidson, Assistant United States Attorney, U.S. Department of Justice**

**11:15 am – 12:15 pm  Concurrent Sessions (2nd floor)**

**Modeling Collaborative Efforts in an MCC Environment: A Tennessee Case Study (Room 201)**

In this presentation, Tennessee's Office of Program Integrity (OPI) will highlight some of the most effective tools and resources utilized to detect, report and reduce suspected Fraud, Waste and Abuse (FWA) within the TennCare program. Additionally, OPI, along with their Dental Benefit Manager DentaQuest, will highlight a recent case study where collaboration and attention to detail lead to a successful outcome. Faculty will demonstrate how standardized reporting and deliverable reports aids the oversight and detection of Fraud and maximizes resources with minimal personnel. Participants will see how TennCare leverages FWA concerns into policy reform and cost avoidance measures, and how collaboration can help to meet the program integrity requirements of the contract.
The faculty will also review NHCAA best practice recommendations for coordination among MCO SIUs, Program Integrity Units, and Law Enforcement Agencies.

- Nicholas J. Messuri, Vice President, Fraud Prevention & Recovery, DentaQuest
- Jarrod Webb, CFE, CPIP, OPI Compliance Manager, Office of Program Integrity, TennCare

Sleep Study Fraud: Leveraging Data to Unlock a $200M Scheme (Room 202)
This presentation examines the investigation of a $200 million sleep study scheme. The case was prosecuted in the Eastern District of Virginia and is the largest health care fraud scheme ever prosecuted in that district. The presentation will highlight how the prosecution team detected this unique and sophisticated fraud scheme by analyzing trends in health insurance claims data and evaluating financial records. To that end, the presentation will consider the perspective of each member of the prosecution team: the prosecutor, case agent, and forensic accountant. The faculty will also outline various red flags associated with sleep study fraud specifically (as well as health care fraud and kickback schemes more generally), as well as synthesize several key takeaways for health insurance industry professionals and government investigators.

- Laura Walker, Special Agent, U.S. Department of Justice, Federal Bureau of Investigation
- Stephanie Anderson, Forensic Accountant, U.S. Department of Justice, Federal Bureau of Investigation
- Jessica Marrone, Special Agent, U.S. Department of Justice, Federal Bureau of Investigation

Dental Clinic Owners Convicted for Medicaid Fraud (Room 204)
This Medicaid dental fraud scheme involving a husband and wife team in Southern Missouri offers participants with insights into techniques and strategies for investigating and prosecuting complex dental schemes including pediatric speech aid prosthetics, dentures and other dental services for adults. This case study provides perspective on how the collaboration between federal and state agencies resulted in a coordinated investigation and ultimate prosecution. The faculty will demonstrate how to use data analytics and dashboard reports to identify potential dental fraud targets. Participants will learn how to develop a trial strategy and the types and amount of evidence needed to convict the defendant dental clinic owners and operators of Medicaid fraud and other charges at trial.

- Cindi Woolery, Assistant United States Attorney, United States Attorney's Office for the Western District of Missouri
• Shannon Kempf, Assistant Attorney General, State of Missouri, and Special Assistant United States Attorney, Western District of Missouri

Telemedicine and DME Fraud: National Takedown (Room 205)
This presentation will examine how to use data analytics and other tools to identify, investigate, and prosecute nationwide telemedicine fraud schemes. Legitimate telemedicine companies generate revenue by billing insurance for telemedicine consultations and/or by billing patients for these consultations. In contrast, the fraudulent telemedicine companies are paid by providers (either directly or indirectly through call centers). This presentation examines the investigative and prosecutorial tools that can be brought to bear to combat this cutting-edge area of fraud and abuse.

• Jacob Foster, Acting Assistant Chief, Fraud Section, U.S. Department of Justice
• Kate Wagner, Trial Attorney, Criminal Division, U.S. Department of Justice
• Albert Tenuta, Special Agent, U.S. Department of Justice, Federal Bureau of Investigation
• Anna Ferreira-Pandolfi, U.S. Department of Health and Human Services, Office of Inspector General

Logical Analysis of Emergency Services Supported through a Holistic Approach (Room 207AB)
Presented by CGI, A NHCAA Premier Supporting Member
As the health care industry continues to make significant investments in innovations to combat fraud, waste, and abuse, a health plan’s ability to identify and address outliers in their claim’s data is essential to the health plan’s success. Legitimate emergency services are presenting a variety of billing practices and thus, opportunities for waste and abuse in the system. Coding for these services can be complex, involving ICD-10-CM, HCPCS, AMA-CPT, and Revenue Codes that in "the right" combination can substantively overstate a situation resulting in inappropriate, significantly inflated reimbursement per episode of care. This presentation will show how each element in the episode is subject to abusive billing and how to discover the variances. Join this session to learn more about conducting a logical analysis of emergency services as a necessary safeguard through a more holistic approach to combat waste and abuse.

• J. David Ott, Senior Director, Consulting Services, CGI
• Robert S. Haskey, M.D., Senior Medical Director, CGI
Good at Fraud or Bad at Business: How can investigators tell? (*Room 207CD*)

Agents will discuss factors and tools that they used during a joint HHS/FBI investigation into Stark compounding pharmacy in Kansas City, Missouri, to help determine if the pharmacy was good at committing fraud, or bad at conducting business. The pharmacy made over $23 million from Missouri Medicaid between June 2013 and September 2015; during calendar year 2014, the pharmacy was paid $7.8 million for compounded pain creams. A whistleblower complaint filed in late 2015 accused Stark of a number of violations, including auto-filling prescriptions for certain pain creams without patients' consent, changing prescriptions without a doctor's authorization, and waiving or reducing co-pays. The investigators will discuss the data and documents used to determine which of the many allegations set forth in the complaint could be explained by sloppy business practices, and which were a concerted attempt to circumvent rules and regulations in order to bill Medicaid for creams that netted a profit of approximately $2,000 per compound.

- Teresa Dailey, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General (Kansas City)
- Lindsay Schloemer, Special Agent, U.S. Department of Justice, Federal Bureau of Investigation
- Matt Sparks, Assistant United States Attorney, U.S. Department of Justice

Leveraging Data, Analytics and Technology Innovation to Enhance the Provider Experience (*Room 208*)

Presented by EXL Healthcare

In this session, thought leaders will share an innovative program integrity approach to creating a positive provider experience. Topics discussed will include 360° provider profiles and an analytics framework enabled by technology innovations (e.g. financial impact, provider experience and data quality scores) coupled with proactive engagement interventions to mitigate abrasion. In addition, best practices and outcomes exemplars including the impact of deploying a tiered prescriptive approach to provider engagement and the ability to gold card providers based on actionable data and insights will be included.

- Lalithya Yerramilli, Vice President Solutions, EXL Healthcare
- Drew Morgan, Vice President Payment Services, EXL Healthcare

The Music Behind Medical Necessity and Cardiac Care Cases (*Room 209*)

Medical necessity cases are often closed before they are opened. In this case, the diverse faculty will explore the music behind making a medical necessity case including what is needed to prove medical necessity, what data and red flags articulate probable cause, and how to manage and review voluminous records. Only once you have all the notes lined up, does the case come together. In the end, the presenters will show the harmonious melody of putting together a criminal
prosecution based on medical necessity. Hear the unique perspectives of a federal agent, an MFCU agent, and an AUSA who collectively worked together to investigate and prosecute a medical necessity case.

- Michael Fairbanks, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General
- Jacob Mulinix, Ohio Attorney General’s Office - Medicaid Fraud Control Unit
- Justin Cain, Manager, Commercial Team, Special Investigations Unit, Humana
- Ken Affeldt, Assistant United States Attorney, United States Attorney’s Office

**12:15 am – 1:30 pm**
**General Session Lunch (4th floor)**
**Prescription Opioids, Heroin and Fentanyl: What could possibly be next?**
- Joseph Rannazzisi, Deputy Assistant Administrator/Deputy Chief of Operations, Drug Enforcement Administration (Retired)

**1:45 pm – 2:45 pm**
**Concurrent Sessions (2nd floor)**
**Using Risk Based Detection Models to Drive Investigations (Room 201)**
Using risk modeling in the detection of suspected fraudulent behavior among providers can drive robust, thorough, and efficient investigations. In this session, faculty will use ABA case examples to demonstrate how the risk model was used to identify providers for investigation. The case example will also show how the continual integration of additional quantitative data elements, as well as the qualitative data obtained as part of earlier investigations, facilitated ongoing refinements that were critical for improving investigative outcomes. Finally, this presentation will demonstrate that when combined with appropriate data visualizations that adequately capture risk elements identified from both quantitative and qualitative data sources, suspicious behavior can be relatively easy to identify and explain to personnel at every level of an investigation and can be used to drive robust and thorough investigations with the desired outcomes.

- Tim Helms, MHSc, LDO, AHFI, AHCA Administrator, MPI Detection, Medicaid Program Integrity, Florida Agency for Health Care Administration
- Courtney LeBlanc, MHL, CPIP, AHFI, AHCA Administrator, MPI Prevention Strategies, Medicaid Program Integrity, Florida Agency for Health Care Administration

**Interviewing Skills for Health Care Fraud Investigators (Room 202)**
This interactive session will focus on basic investigative interviewing skills as well as interviewing skills specific to health care fraud and abuse investigations. The session will help enhance interview skills through the discussion of: the basic 5-step interview process; interview research/preparation; rapport building; considerations (in-person interviews vs. phone interviews, and scheduled vs. unscheduled); interview pitfalls; use and presentation of props, evidence and data during an
interview, question development and phrasing, detecting and overcoming deception/denials; non-verbal communication; and active listening. The session is geared for anyone who conducts interviews related to healthcare fraud and abuse investigations. The topics will assist newer investigators (one to five years) improve their interviewing skills and a refresher for more seasoned investigators.

- Thomas Floersch, Assistant Special Agent in Charge, U.S. Department of Health and Human Services, Office of Inspector General
- John Croes, Assistant Special Agent in Charge, U.S. Department of Health and Human Services, Office of Inspector General

Program Integrity in a Cross-Payer Environment *(Room 204)*
Program Integrity is challenging work when considering one’s data, policies, priorities and resources. Using data provided by commercial health plans, state and local payers, and federal agencies, the Trusted Third Party (TTP) for the Healthcare Fraud Prevention Partnership has built the largest multi-payer healthcare claims database and uses it to perform Fraud, Waste, and Abuse analytics on behalf of our Partners. To meet the challenges presented by such a large cross-payer dataset, the TTP must consider a variety of needs from implementing data layouts to conceptualizing studies to designing methodologies useful to multiple payers, and delivering outcomes actionable by all. In this session, the TTP will discuss outcomes from its own efforts and answer questions that may be leveraged in your own initiatives.

- Dan Kreitman, Program Director, Trusted Third Party (TTP)
- Jacob Gray, Studies Manager, Trusted Third Party (TTP)
- Uduak Udoeyo, Data Scientist, Trusted Third Party (TTP)

The Evolution of Telemarketing Health Care Fraud Schemes *(Room 205)*
The faculty in this session will examine how telephone call centers and telemarketing schemes are evolving, with a particular focus on genetic testing. The presentation will follow how a patient lead is generated, and then follow that lead as it is sold to fraudulent providers including pharmacies, labs and DME providers. Participants will gain insights into how telemarketing companies are structured and relationship between this emerging trends and overseas entities. Data related to cancer genetic testing codes will be incorporated into the presentation so that participants can return to their office and identify fraudulent providers who are using telemarketers.

- Stephen Mahmood, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General (Miami Regional Office)
- Stephen Lutz, Special Agent, U.S. Department of Justice, Federal Bureau of Investigation
Cyber Stalking in Pharmacy Fraud *(Room 207AB)*

Technological advancements have enabled unprecedented capabilities. However, they have also facilitated illegal activities such as pharmacy fraud. All stakeholders, including pharmacy benefit managers, health plan, law enforcement and regulators need to work differently, in concert, to stay in front of fraudulent technology advancements. The need for rapid response and collaboration will be highlighted through several case studies e.g., pharmacies leverage technology to try to avoid detection. The faculty will review how loopholes are exploited and what is needed to close them, as well explore ways investigators can use technology to better detect these emerging schemes.

- *Anne Mack, Senior Director, Pharmacy Audit & FWA, Prime Therapeutics*

Parallel Criminal and Civil Opioid Physician Investigation: Overt v. Covert Methods *(Room 207CD)*

Faculty will dissect the successful parallel investigation of Dr. Jayam Iyer in Florida, identified by both Department of Justice and Health and Human Services and Office of Inspector General as one of the highest prescribing Medicare/ Medicaid physicians. Dr. Iyer was investigated by multiple state/federal agencies since 1999 for prescribing a high amount of opioid drugs such as Oxycodeone, Hydromorphone, subsys, etc. By 2009, Dr. Iyer was federal indicted twice but was acquitted after a week long trial in 2011. A new case was opened in the summer of 2017 under the new national opioid initiative. In this session, faculty will discuss the initial challenges of re-opening a case that has failed multiple times in the past and the benefit of opening a parallel criminal/civil investigation to obtain records from a target of an opioid investigation. The faculty will also compare the overt investigative to the traditional covert investigative methods.

- *Ian Ives, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General*
- *Shannon Muldrow, Special Agent, U.S. Department of Justice, Federal Bureau of Investigation*

Leveraging Payment Fraud Mitigation Expertise with AI in Healthcare *(Room 208)*

Presented by MasterCard

For almost 20 years, Mastercard has leveraged Artificial Intelligence to mitigate payment fraud in its payment network globally, saving its financial institution clients billions of dollars. They detect this fraud on a real-time basis while processing billions of transactions a year. Think of the positive impact this expertise can bring to healthcare to mitigate FWA, complimenting established claims fraud solutions. Join industry experts from Mastercard on how they are
leveraging Brighterion, a Mastercard company and leader in AI, to detect and prevent fraud, waste, and abuse (FWA) in healthcare.

- Tim McBride, AHFI, Director, Product Development and Innovation, Mastercard
- Beth Griffin, Vice President, Healthcare, Acquisitions & Innovation, Mastercard
- Jala Attia, President, Integrity Advantage

3:00 pm – 4:00 pm  
**Concurrent Sessions (2nd floor)**

**Collaborative Efforts to Fight Health Care Fraud in Medicaid (Room 201)**

Through a collaborative process spanning several months, NHCAA brought together anti-fraud partners under Medicaid to act as a Work Group with the goal of developing and adopting best practices for addressing fraud and abuse in Medicaid. The partners in this effort included state MFCUs, Medicaid Program Integrity Units, Medicaid MCOs, HHS-OIG, the CMS Center for Program Integrity, NAMFCU, NAMPI and NHCAA. There was consensus among the participating organizations that many of the fraud challenges in Medicaid can be met, or at least mitigated, by the building of collaborative relationships and a commitment to consistent, routine communication among the partners. Participate in this session to learn more about the 12 best practices resulting from this important effort and consider how they can be applied to your anti-fraud program.

- Rick Munson, AHFI, Program Integrity Chief Compliance Officer & Vice President, Investigations, UnitedHealthcare
- Kelly Bennett, JD, CFE, AHFI, Chief, Medicaid Program Integrity, Florida Agency for Health Care Administration
- Keesha R. Mitchell, Section Chief, Health Care Fraud Section, Office of Ohio Attorney General

**Internal Drug Diversion: A Case Study from Detection to Prosecution (Room 202)**

The presentation will detail the life cycle of an investigation involving the detection of controlled substances diversion at a pharmacy. The identification of the suspect (Pharmacist in Charge) and how the matter was investigated from detection (by datamining) to on-site auditing of records, review of video and other electronic evidence as well as interviews, referral to law enforcement and prosecution. The presenter will highlight the importance of maintaining a robust datamining program and how to validate data by conducting audits and reviewing other available evidence, such as video and electronic access data. The presenter will also emphasize the significance of maintaining detailed records of all evidence to facilitate the preparation of the investigative report and the subsequent referral to law enforcement. Additionally, the presenter will stress the importance of fostering relationships with law enforcement and prosecutors.
Gumshoe Analytics: Leveraging Widely Available Data Mining to Link Multi-customer, Multi-claim, Multi-Carrier Fraud Scheme (Room 204)
The faculty will discuss the widely available & common data-mining techniques used to link multi-customer, multi-claim, multi-carrier fraud through internal data-mining. Geared toward newer investigators, participants will gain insights into how an insurance agent wrote fraudulent supplemental policies for multiple carriers. Through this case discussion, the faculty will discuss the importance of working with carrier partners and regulators to build a case that leads up to successful criminal prosecution. The panel discussion includes three carrier perspectives as it relates to their investigations as well as how it was handled at the state level that lead to prosecution and a guilty plea.

Operation True Bill: Multi-state Physical Therapy Scheme (Room 205)
Operation True Bill was a year-long investigation targeting the owners of multiple medical billing companies in the Miami area which billed private insurance companies on behalf of fraudulent physical therapy clinics located across the United States. The two billing companies, Billing USA Corp. and American Fast Services, Corp., submitted approximately $200M in false and fraudulent claims to multiple private insurance companies on behalf of fraudulent clinics across the country. Participants will learn about the plethora of investigative techniques used in this investigation including consensual monitoring by multiple confidential human sources, a pen register, search warrants, and the analysis of many bank accounts and insurance records. The faculty will offer insights into the reasoning for the extensive techniques, including the complexity of the fraud scheme and the billing company owner’s ability to distance themselves from the actual fraud clinics by assuming the role of a third-party contractor or consultant.
Neuro Stimulators: A Medical Device Scam of Painful Proportions (Room 207AB)
Centers for Medicare and Medicaid Services (CMS), Center for Program Integrity (CPI) learned of a scam to bill electronic acupuncture devices as implantable nerve stimulators. CPI learned that the manufacturers of the device were marketing to select audiences of Medicare providers. The faculty will describe the process of determining what was being billed, and how it was that mainly non-physician practitioners (NPPs) were billing including the successful results. Participants hear how data analytic techniques identified the scheme, how interview subjects were selected and interviewed, how the overpayment process was identified, and key information about the FDA approval process that enable these devices were approved and marketed.

- Lawrence Ball AHFI, CFE, Director, Field Operations West, Centers for Medicare & Medicaid Services (CMS), Investigation and Audit Group
- Brent Person, Senior Investigator, Division of Field Operations West, Centers for Medicare & Medicaid Services (CMS), Investigation and Audit Group

Fraud Risk Identification and Management (Room 208)
Proactive fraud risk management is one of CMS' strategic efforts to enhance program integrity within its programs. Participants in this session will gain insight on the fraud risk assessment process used to assess CMS programs. The faculty will provide a high-level overview of the Government Accountability Office (GAO) Fraud Risk Management Framework and how the Center for Program Integrity Risk Management Support contract follows that framework to conduct CMS' fraud risk assessments, including providing an overview of the process. Lastly, the faculty will provide an opportunity for the audience to provide insight into any risks they perceive or have identified through their investigations.

- Jen Dupee, Acting Director for the Governance Management Group, Center for Program Integrity (CPI), Centers for Medicare & Medicaid Services (CMS)
- Steven Ferraina, Deputy Director, Governance Management Group, Center for Program Integrity (CPI), Centers for Medicare & Medicaid Services (CMS)
- Afee Roberts, CFE, AHFI, Health Care Associate, Booz Allen Hamilton
- Kia Tollett McLain, RMP, PMP, Senior Associate, Booz Allen Hamilton
Friday, October 18

All Educational Sessions held at the Music City Center

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

9:00 am – 11:00 am  Seminars (Coffee provided) (2nd Floor)

Analytical Models and Strategies for the Modern SIU (Room 201)
This two-hour seminar is dedicated to examining data analytical models and platforms so that data analysts take full advantage of all that the data can reveal when fighting health care fraud. The session will walk through the evolution SIU data analytics, provide an extensive review of different platforms such as R, Hadoop, Jupyter/Python, SAS and SQL as well as a session that will break down modeling concepts and strategies for trend and scheme analysis. For newer and mid-level analysts, this seminar will sharpen your skills and provide practical lessons for your caseload.

- Aneta C.D. Andros, AHFI, Director, SIU Analytics, Special Investigations Unit, Cigna
- Kelly McDonough, Analytics Advisor, Data Scientist, Cigna
- James Bowers, Analytics Advisor, Data Scientist, Cigna
- Jason DiNovi, Senior Data Scientist, Aetna

Health Care Fraud Investigation Ethics Seminar (Room 202)
Each year, NHCAA hosts this two-hour seminar on professional and investigative ethics for the health care fraud investigator. 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.

- Nicholas J. Messuri, Esq., Vice President and Deputy General Counsel, Fraud Prevention & Recovery, DentaQuest
- Ralph Carpenter, Retired Senior Director, SIU, Aetna, Inc.
- Sara “Sally” A. Walker, Esq. Vice President, Enterprise Risk Management, Blue Cross Blue Shield of Massachusetts

Examining CDT Code Updates and Emerging Trends Dental Fraud (Room 204)
Yearly updates to the CDT Code can provide new opportunities for fraud, waste and abuse--- in addition to the emerging trends and habitually common dental fraud
schemes. To augment the investigator’s skill set, this session will provide examples of schemes related to the 2018 and 2019 CDT code updates for the reporting of teledentistry, occlusal guards and the application of an interim caries arresting medicament. Case examples of emerging trends across a variety of clinical service areas will be presented along with examples of historically common schemes which continue to exist within both the Commercial and Public sectors. Associated Medical cross coding will be identified in the case examples presented.

- Stewart Balikov, DDS, AHFI, Director of Dental Special Investigations, Anthem
- Jason Coomer, Senior SIU Dental Fraud Investigator, Humana

U.S. v. Esformes: Breaking Down the Largest Medicare Fraud Scheme (Room 205)
In 2016, the DOJ charged Philip Esformes and 2 others with engaging in a complex Medicare fraud scheme that resulted in $1 billion to Medicare. Esformes ran a complex system of nursing homes, skilled nursing facilities and hospitals in South Florida. He moved patients throughout each of his facilities to maximize Medicare reimbursement and paid kickbacks and bribes to receive referrals to include patients into this cycle and get advanced notices of state inspections of his facilities. In February 2019, prosecutors took the case to trial. This two-part seminar will focus on the investigative tactics and the prosecutorial strategy of this case. In part one, the agents who worked the case will highlight the investigative techniques used to uncover the scheme and the fraudulent billing practices. The second part of the seminar will offer insights into the prosecution’s method and review the types of evidence used at trial.

- Ricardo Carcas, CFE, Special Agent, Miami Regional Office, U.S. Department of Health & Human Services, Office of the Inspector General
- Terence Reilly, Special Agent, U.S. Department of Justice, Federal Bureau of Investigation
- Allan Medina, Assistant Chief, Fraud Section, Criminals Division, U.S. Department of Justice
- Elizabeth Young, Trial Attorney, Fraud Section, Criminals Division, U.S. Department of Justice
- Jim Hayes, Trial Attorney, Fraud Section, Criminals Division, U.S. Department of Justice

11:00 am Conference Adjourns