The NHCAA Institute for
Health Care Fraud Prevention
Presents:

Schemes for Health Care Fraud Investigators & Analysts
On Demand Training Program
May 2 – 13

Visit the NHCAA Website to Register

Program Set Up

This is a mostly on demand training, which involves watching pre-recorded presentations. There is currently two live sessions and one live networking event scheduled. Participants must watch 70% of the content (includes live and on demand content) to earn credit. The networking event is not required.

You may watch the on-demand presentations in any order, but NHCAA will publish a recommended agenda to help guide you through the program to ensure you have time to watch all the available content by close of business, Pacific Time, on May 13.

Videos and corresponding materials will be posted on our program website on May 2 after the live program introduction and case study session have concluded. Note, these recordings are for the registered participant. This content was not designed to be shared or streamed with others.

Earn Credit

- This program is worth 20 CPEs.
- Presentations must be watched, and quizzes submitted between May 2 – May 13.
- Participants should watch at least 70% of the presentations (on demand and/or live).
    - Live sessions require participation in poll questions/credit checks.
    - On Demand sessions:
        - Each session video has a unique code; write this code down when you see it.
        - Use the code to unlock the quiz for that session. Quiz participation is required.
- Planned live sessions are listed below. For on demand sessions, please set aside 2 – 3 hours each day to participate.

Monday, May 2

11:00 am – 11:20 am ET – Program Introduction - LIVE
Understand how the program will work, how to earn credit, and ask questions.

11:30 am – 12:30 pm ET – Bust-Out DMEs in Southeast and Southwest Florida – LIVE

The presenters will provide the audience with an overview of the current Bust-Out DMEs fraud trend that is occurring in Southwest and Southeast Florida. The presenters will explain the unique characteristics of this fraud scheme and how to identify a Bust-Out DME. The audience will also be provided with a general understanding of investigative strategies used to combat this ongoing trend and how fraudsters have taken advantage of the COVID-19 Public Health Emergency. The presentation will be unique because the subject matter will be delivered by Investigative Analysts who detect health care fraud by combining claims data and criminal intelligence.

Agenda was last updated: 4/18/2022

Stephen Mahmood
Assistant Special Agent in Charge | HHS-OIG Miami Regional Office Strategic Operations Squad

Xuanvi Huynh
Investigative Analyst | HHS-OIG Miami Regional Office Strategic Operations Squad

Pauline Bethel-Roberts
Investigative Analyst | HHS-OIG Miami Regional Office Strategic Operations Squad

Wednesday, May 4

4:00 pm – 5:00 pm ET – Networking Break - LIVE
Join participants and speakers at this informal networking event. WebEx will be utilized for this event.

Monday, May 9

11:30 am – 12:45 pm ET – Program Check-in &
Unlisted Cherries: Picking Up on Fraud with Unlisted Codes – LIVE

Unlisted surgical CPT codes are a versatile tool that can be used to correctly report services that do not have a dedicated listed CPT code. However, due to their lack of a dedicated description of work, they also create a potential mechanism for committing and concealing various types of fraud, waste, and abuse. Therefore, having a proper understanding of unlisted CPT codes is essential to comprehensive payment integrity and fraud detection programs. In this presentation the speakers will discuss various schemes in which providers attempt to use unlisted codes to bypass benefit configurations, medical policy reviews, and/or payment policies, including correct coding and code pair edits. Additionally, the speakers will offer several pearls on how to protect your company through proper handling of unlisted codes in both pre-service and post-service reviews.

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

Larry Simon, MD, MBA, FACS
Medical Director for Utilization Management, Coding, and Reimbursement
Blue Cross and Blue Shield of Louisiana

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On Demand Sessions

The P.I.T. Scheme

For this scheme to work there needs to be a provider, interpreter, and transportation driver, each with a crucial role to execute the scheme. This presentation will explain how the scheme was identified, including key analytics, examine the key components of the scheme, and discuss red flags, potential resolutions, and collaborating with government programs. Frequently seen in primary care, physical therapy, and behavioral health services, this presentation will address a physical therapy case study.

Angie Weidemann
Principal Investigator | UCare

Peter Monson
Special Investigation Unit Manager | UCare

Medicaid Dental Fraud Schemes

This session will showcase several examples of Medicaid dental fraud schemes. The speaker will review how these schemes operate as well as red flags to look for during an investigation. At the end of the presentation, walk through a case study that included federal and state collaboration and resulted in the indictment and conviction of a dentist from West Virginia.

Cathy Landon, CPC
Dental Investigator II | Cotiviti

Anita Ruiz, CDC
Dental Investigator II | Cotiviti

Mass Immunization Scheme

Participants will walk through this scheme starting with data mining techniques that may be used to identify and address this scheme and the rules related to mass immunizer status. Examine how to investigate this type of issue to identify related entities, role of the medical director, and potential for double billing. Lastly, the speakers will then show the application of techniques to prevent this type of scheme from negatively impacting your organization.

Kelly Hensley
Senior Investigator | Anthem, Inc.

How Fraudulent Signatures and Documents Drive Health Care Fraud Schemes

Medical documentation is essential for good clinical care. The use of fraudulent medical documents in the nation's health care system have resulted in losses of millions of dollars every year. To perpetuate fraud schemes, fraudsters knowingly misrepresent or misstate the type, scope, or nature of the medical treatment or services provided, submitting false documents or false signatures that frequently go unnoticed.

This presentation will review the types of false documents or false certifications used to commit health care fraud. Approving treatment plans, signing prescriptions, and validating services are only a few of the activities that require signatures in the health care world. Learn to identify the three types of signature fraud: blind, unskilled, and skilled through examples of each type.

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The second part of the presentation will show participants how to detect document fraud. Discuss strategies to spot false documents and signatures using real examples from the speakers' cases. In addition, review signatory fraud as most organizations, including health care programs, still use signatures as their primary way of authorizing or authenticating transactions. Finally, the presenters will discuss how to prevent document fraud, including putting controls in place to block such fraud.

Benjamin Kellam
Special Agent in Charge, DC Medicaid Fraud Control Unit | DC Office of the Inspector General

Jordi Clop,
Special Agent, DC Medicaid Fraud Control Unit | DC Office of the Inspector General

Excel for Record Reviews: Leveraging Pivot Tables for Summary Reports

Reviewing medical records can be a time-consuming but critical part of an investigation. Summarizing your findings is an essential piece, whether you are working post payment or prepayment claims. Efficiency in pulling together audit findings saves time, but also improves case outcomes and validates results. In this session, attendees will learn how to summarize medical review findings using Excel. We will provide examples and creative ways to use pivot tables to streamline the creation of review summary documentation. Investigators and reviewers, join us to learn this essential skill and summarize your next review in a fraction of the time.

Michelle Rua, PSM
Investigations and Analytics Consultant | Integrity Advantage

Lora Beth Naron, RN
Investigative Nurse Auditor | Integrity Advantage

Critical Components of Critical Care

A cost driver data analysis showed that there was an increase in utilization of critical care services in 2020 and 2021. This increase in billing for critical care services prompted an in-depth review of coding and billing guidelines with a thorough analysis of claims data. This presentation will share findings from our review of health care claims in which general violations of billing guidelines were evaluated; admission and discharge patterns associated with critical care services were analyzed; and impact of COVID-19 on billing for these services was assessed. Data analysts and investigators will learn the 2022 changes adopted by CMS in defining these services, understand the basic coding guidelines to appropriately bill these services, and will leave with the ability to review data for potential FWA schemes related to critical care services.

Jillian Scalvini, MPA, AHFI
Associate Partner, Program Integrity Analytics | IBM Consulting

Lindsey Marsh
Senior Consultant | IBM Consulting

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E/M Add on Codes: Pre and Post Covid How Providers are Preserving Revenue with Telehealth

When providers see members face-to-face there are a variety of add on codes that can be used to increase revenue. During the pandemic and transition to telehealth providers have started to look for other add on codes that they can utilize without needing a face-to-face requirement to preserve their revenue. The utilization of these add on codes may or may not be appropriate. In this session, the speakers will present examples of the pre-and post-pandemic add on codes that providers have been utilizing to enhance revenue and discuss issues with the documentation of these codes in a telehealth setting. Speakers will walk through a case study that was found via data mining and developed into an investigation for a health plan due to add on code revenue enhancement.

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

Mary Beach, AHFI, CFE, HIA, HCAFA, MHP
Senior Director | Evolent Health

A Pain Management Scheme

In this presentation, we will describe a new pain management treatment protocol and its associated billing fraud scheme, including an alleged profit-sharing scheme involving three companies. We will also cover indicators of the treatment in claims and medical records and how to reduce your plan exposure.

Mallory Klum, CPC
Audit Investigator | Cambia-Regence

Physical Therapy FWA: The Road to Recovery Starts Here

Physical therapy schemes have resulted in millions of dollars of improper payments and are a serious area of concern for fraud, waste, and abuse. This session will address and demonstrate data analysis techniques utilized to identify this complex FWA challenge as well as examine medical review strategies used to identify areas of concern and
convey valuable audit findings. Schemes being discussed include: upcoding units, unskilled therapy, referrals, billing application of modality procedures via telephone, and changing diagnoses. Participants will know how to perform a thorough medical review to generate a findings report.

Carlyn Hoffman
Senior Investigator | Cotiviti

Gerry Petrowski, CPC, COC
Manager of Fraud Waste and Abuse Services | Cotiviti

From Playing by the Rules to AI-Powered Decisions: How analytics has evolved to strengthen the fight against increasingly complex fraud patterns

Healthcare fraud has taken new forms, latching onto dynamic trends and areas such as telehealth, medical devices, opioids, and others. As fraud becomes more complex and unpredictable, how have our analytics evolved to better understand, respond, and enhance fraud prevention activities? Are today's healthcare analytics fighting the best fight if simply playing by the rules? Join MITRE's principal scientist and Shift Technology's healthcare fraud experts as they illustrate the evolution of analytics to capture complex fraud schemes - otherwise invisible using traditional techniques. Attendees will gain insights on the power of today's true AI and machine learning methods to strengthen their fraud mitigation strategies.

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Jaya Tripathi
Principal Scientist; Data Analytics and Research | MITRE

Peter Kapasakis
Sr. Healthcare Customer Success Manager | Shift Technology

Mandy Fogle
Healthcare Value Engineering | Shift Technology

Panels, Panels, Panels

Explore ongoing issues with panel testing schemes in the Louisiana Medicaid program. Participants will learn how the various schemes operate and what red flags to look for in their own claims data. Review what codes and panel tests are involved and discuss how agile the laboratories can be with adapting these schemes and staying ahead of insurers.

Brian Signorelli, RN, AHFI
Investigator II | Anthem

Behavioral Health Project

In this dynamic presentation, participants will learn about behavioral health schemes (old and new) and innovative approaches to addressing them from a payer's perspective. Examine the evolution of a behavioral health project to address rampant fraudulent and abusive billing. Participants will hear the teams' early detection efforts to look for the most suspicious providers, not the highest billers, and how that evolved. The presentation will conclude with a discussion of the sometimes-contradictory priorities of maximizing law enforcement referrals and administratively protecting the money.

Kelly Bennett, JD, CFE, AHFI, CIG
Chief, Medicaid Program Integrity | Florida Agency for Health Care Administration

Stephanie Gregie, LCSW, AHFI
Health Care Analyst | Florida Agency for Health Care Administration

Ann Kaperak, AHFI, CFE, CIGA
AHCA Administrator | Florida Agency for Health Care Administration

Penny Taylor, AHFI, CEMA
AHCA Administrator | Florida Agency for Health Care Administration

Snake Oil Cases

The pandemic has created a cottage industry of those looking to sell cures or treatments for COVID-19. Though these schemes are not new, they've been cleverly adapted. This presentation will discuss various snake oil schemes that have emerged over the last couple of years as well as appropriate investigative strategies once identified. Through case examples, understand how these schemes operate and ways to identify issues in your own claims data.

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Eric Panicucci, MSCJ, CFE
Special Agent | U.S. Dept. of Health and Human Services, OIG - OI

Victoria Schwarz
Special Agent | U.S. Dept. of Health and Human Services, OIG - OI

Coding Schemes & Scams, What Were They Thinking…

In this session the speakers will examine problem codes that are hidden in plain sight and will explore red flags to look for in your own data and medical records.

Toni Slocum, AHFI, CPC, CPC-P
Supervisor, SIU | Moda Health

Carrie Townsend, CPC
Investigator I, SIU | Moda Health

The Nitty Gritty – the Sequence of Dental Procedures

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

Patricia Shifflett, RDH, AHFI
Clinical Dental Analysts | Delta Dental of Virginia

Kim Brown, RDH, AHFI
Clinical Fraud Analysts | Delta Dental of Virginia

Generic Cost Manipulation

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

Jonathan Haag, PharmD
Program Director, Plan Program Integrity MEDIC | Qlarant

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

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