The NHCAA Institute for
Health Care Fraud Prevention
Presents:

Schemes for Health Care Fraud Investigators & Analysts
A Virtual Training Program
May 1 – 12

Register for Schemes Program

Program Set Up

This is a hybrid training, which mostly involves watching pre-recorded presentations. There are two live sessions and one live networking event scheduled. Participants must participate in at least 15 of the sessions (including live and on demand content) to earn credit. The networking event is not required.

Set aside about 2 hours per day to complete the program. 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 available content by 11:59 pm ET on May 12.

Videos and corresponding materials will be posted on our program website on May 1 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 1 – May 12.
- Participants should watch at least 15 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 1

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 – 12:45 pm ET – Case Study – LIVE

Part 1 - Overview of the Lead Junkies Investigation

TBA

Stephen Mahmood
Assistant Special Agent in Charge | U.S. Department of Health & Human Services, OIG-OI
Part 2 - Commonly Abused Codes

Agenda was last updated: 4/3/2023

This presentation will focus on three commonly abused coding scenarios: manipulation of modifiers, unbundling, and medically unlikely edits. Discuss typical clinical usage of these codes and examine the schemes that occur in each area. Explore possible red flags and hear case examples that highlight fraud schemes in these areas.

Philip A. David, BS, AHFI, CFE, RHIT, CPMA, CCS, CCS-P, MBA
Supervisor, Special Investigations Unit | AvMed

Wednesday, May 3

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 8

11:30 am – 1:00 pm ET – Program Check-in and Case Study – LIVE

Case Study: U.S. vs. Insys Therapeutics, Inc. et al

Break down the decision making, scheme mechanics, and investigative strategies behind this 2020 NHCAA Investigation of the Year Award case. This five-year multistate investigation resulted in the first successful prosecution of top pharmaceutical executives from crimes related to prescribing opioids. Four former Insys executives were convicted of RICO conspiracy for their role in leading a nationwide conspiracy to bribe medical practitioners to prescribe Subsys and of defrauding Medicare and private insurance carriers.

Paul Baumrind
Supervisory Special Agent | U.S. Department of Justice, Federal Bureau of Investigation

On Demand Sessions

(Un)Check the Box on Pharmacy Schemes

Follow along as one plan applies a back of the envelope theory on pharmacy billing to identify a complex scheme. Utilizing data along with low touch and high impact outreach efforts, see how the Plan gathered evidence, mapped out the scheme and brought the case to resolution. Learn how similar tactics can be implemented across RX, medical and other complex investigations.

Nicole Matty
Associate Director, Special Investigations Unit | Oscar Health

Eleni Thibodeau, CPC, CPMA, CEMA
Investigator, Special Investigations Unit | Oscar Health

Identifying Emerging and Evolving Schemes in Medicare through Data

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This presentation will focus on various Medicare fraud schemes and the process used by OIG data analysts to identify them. Attendees will gain insight into general trends for each scheme, data analysis techniques used to advance OIG work in each area and strategies employed to work with internal and external partners to communicate analytic results and insights. Schemes covered will include billing for continuous glucose monitors and other DME, urine drug tests, Ozempic, and chronic care management.

Nora Witek
Team Leader | Department of Health & Human Services, OIG

Robin Sheehan
Senior Program Analyst | Department of Health & Human Services, OIG

Remote Patient Monitoring – Quick Hit

In this quick hit, learn the basics of this emerging scheme and what do look for to detect this issue in your own claims data.

Michael Cohen, DHSc, JD, PA-C
Operations Officer, Investigations Unit | U.S. Department of Health & Human Services, OIG-OI

Jennifer Trussell
Fraud Prevention Consultant | Senior Medicare Patrol

Unzipping Genetic Testing Fraud Waste & Abuse

As scientists continue to make advancements in genetic testing, the landscape is everchanging. This presentation will dive into de-identified data to show participants how to analyze their own data, using Microsoft Access and Excel, to uncover red flags. Explore scheme mechanics and associated red flags, including lack of referring provider visit, repeated testing, and unqualified providers. Discuss applicable rules and regulations surrounding genetic testing and how to incorporate into your investigation and medical record review.

Carlyn Hoffman, AHFI
Senior Investigator | Integrity Advantage

Jessica Gay, AHFI, CPC, CFE
Vice President & Co-Founder | Integrity Advantage

Unraveling Agent/Broker Investigations

In this session participants will hear various Medicare and ACA enrollment schemes. Speakers will examine ways to spot common schemes in your claims data and showcase strategies to effectively investigate cases. Some of the schemes addressed include enrollment kickback, enrolling without permission, misuse of special election period does, and application forgery. Learn various methods and tools employed in these unique investigations.

David Webb, AHFI, HCAFA
Associate Director | UnitedHealthcare

Keytelynne Radde, MSoc. Sc., CFE
Manager | UnitedHealthcare

Exploring EEG Schemes

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This presentation will represent two separate provider cases involving an emerging EEG Scheme trend. In this scheme medical clinics routinely misrepresent their services by billing for a covered EEG code and other related neurological services to obtain payment for non-covered experimental, investigational, or unproven (EIU) neurofeedback / biofeedback services. Explore data analytics strategies to identify this scheme along with investigative techniques such as, medical record reviews, medical coverage policy reviews, internet research, customer outreaches, and provider interviews. Hear insights into current investigations and steps to proactively identify new providers engaging in this scheme.

Greg Przybylski, MD
Medical Director | Cigna

Christopher Oblinger
Fraud Advisor, Sr. Investigative Coach | Cigna

Katherine Giuliani, AHFI
Fraud Lead Analyst | Cigna

The Thing About Behavioral Health: How to Not Botch Your Investigation – Reprised from 2022 ATC

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

Courtney Rhodes, MA, LPC, AHFI
Supervisor, Clinical Investigations, Special Investigations Unit | Centene Corporation

Jessi Clark, LMHC, AHFI, CHC
Director, Clinical Investigations, Special Investigations Unit | Centene Corporation

Behavioral Health: An Overview and Case Studies of ABA & Psychotherapy

This presentation has been designed to share investigative findings of fraud waste and abuse in the behavioral health arena. Through real life case studies that were completed by utilizing both prepay and/or post-pay investigations, participants will leave the presentation with a better understanding of how to analyze their data, and how to utilize investigative tools to identify the presented emerging trends and schemes.

The speakers will demonstrate investigative techniques including identifying coding concerns, conducting records reviews, analyzing data trends, and researching required certifications of the providers.

Whitney Organ
Senior Investigator | Cotiviti

Brittny Eberhart
Senior Investigator | Cotiviti

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What's in a Policy? Translating Policy into Analytics

Applied Behavior Analysis (ABA) Therapy has gained traction as an emergent area for healthcare fraud schemes and improper billing practices. The rules on billing for ABA Therapy tend to vary between guidelines set by health plans, state Medicaid programs, and Managed Care Organizations (MCOs).

This session will demonstrate how to translate excerpts from policy documentation into queries for data analysis using ABA Therapy as a case study. Speakers will focus on analytic strategies around utilization limitations, prior diagnoses, timed billing, and provider credentials. By leveraging these methodologies to find anomalies in data, analysts and investigators can work with their healthcare programs to seek recoupments for improper billing and to identify providers for further investigation.

Kristine Knutson, AHFI
Senior Analytic Consultant | IBM

Socheatha Chan
Analytic Consultant | IBM

Proactive FWA Detection: A Strategic Approach to a Urine Drug Testing (UDT) Scheme

During this session, HMSA will take the audience through the identification and investigation of a pro-active urine drug testing (UDT) scheme using fraud detection software, data analysis and investigative activities that led to over $2M in identified overpayments. The presenters will provide practical insights into the data, codes, and analytics that helped to detect this outlier provider and the investigation process that followed. Hear strategies for tackling the record reviews and the process for determining overpayments for thousands of claims.

Virginya Aronson,
Director, Special Investigations Unit | Hawaii Medical Service Association (HMSA)

Reef Weaver
Investigator | Hawaii Medical Service Association (HMSA)

Are You Allergic to Fraud?

This session will walk through various schemes around improper billing of allergy serums and units related to allergy injections. Providers may be attempting to manipulate claim systems by submitting for services not performed by the provider or manipulating units billed by submitting separate claims or consecutive days. The presenters will discuss specific cases as well as dig into the various analytics that can be used to effectively detect and prevent these schemes.

Kristin Griego, AHFI, CFE, CPC
SIU Manager | Molina Healthcare

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

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Methods of Detection: A Case Study Using a Clinical & Data Analytical Approach – Reprised from 2022 ATC

This presentation will utilize asthma and allergy codes in a case study demonstrating how to leverage clinical and data analytics to detect fraud, waste, and abuse schemes. Further, a review of medical record documentation with be utilized to elaborate on the crucial implications present in various documentation submitted that can raise red flags, warranting further review. The faculty will demonstrate how to analyze claims data to effectively identify patterns and schemes, and how to recognize red flags when conducting cursory examinations of medical documentation.

Sharron Cannella
Senior Investigator | Elevance Health, Inc.

Fraud in the Wake of Natural Disasters

Stock up on food and water, board up the windows, make sure the pipes don't freeze - we all have our personal plans for natural disaster prep; but what can health plans do to stay protected from fraud, waste, and abuse during the chaos of these uncontrollable events?

During this session, briefly review the impact of natural disasters on the US Healthcare system and dive into a variety of schemes that can emerge across the industry – from ambulance services and in patient treatment centers to family practices. Examine detection strategies and discuss the best tools to leverage for investigations. Learn how to incorporate the news into your analytics and effectively assess for concerning patterns.

Cambria Day
Program Integrity Unit Manager
Health Plan of San Joaquin

Mandy Fogle
Solution Lead
Shift Technology

Ricky Sluder, CFE
Head of Healthcare Value Engineering, Americas
Shift Technology

What's New in Electrodiagnostic (EDX) Schemes?

This session will examine the proper usage of EDX (EMG and Nerve Conduction Studies), the equipment needed, and what patients would experience during their examination. This information can be utilized to find aberrant billings in your claims data and then incorporated into your investigations. Some of the topics covered include pain fiber NCS testing, the newest permutations of mobile EDX schemes, hand-held EDX devices, and surface EMG/Spinal ROM devices. Inappropriate use of CPT codes 97937 (repetitive nerve stimulation) and the NCS codes 95912 and 95913 will also be discussed.

Peter Grant, MD
Chairman | American Board of Electrodiagnostic Medicine

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The NHCAA Institute for Health Care Fraud Prevention Presents:

Cosmetic Schemes

Explore cosmetic procedures that are masked utilizing legitimate codes. Understand which procedures are commonly exploited and what codes to analyze in your own claims data. Discuss what to look for in the medical record and how to incorporate clinical knowledge of these procedures into your investigation and interviews. Through case examples, understand how these schemes operate and best practices for starting your investigation.

Rae McIntee, DDS, MD, MBA, FACS, CPE
Medical Director | Blue Cross and Blue Shield of Minnesota

Lawrence Simon, MD, MBA
Medical Director, Clinical Solutions | Blue Cross and Blue Shield of Louisiana

The Basic Building Blocks of Dental Fraud Schemes – Deep Dive

Dental fraud, waste and abuse schemes have remained relatively the same over the past years. Although they have traditionally presented themselves in various forms, some new schemes have emerged. The progression of technology and yearly updates to the CDT Code set may create more opportunities for future fraud waste and abuse schemes. Keeping the past, current and emerging schemes in mind, along with concern for future schemes can be a challenge for investigators when identifying/investigating dental fraud, waste and abuse. During this presentation, participants will learn the fundamentals of dental fraud including common schemes, ways to identify, and correct CDT coding to assist in identifying areas of misreporting.

Stewart Balikov, DDS, AHFI
Chief Clinical Officer, Director of Dental Special Investigations | Elevance Health

Enhancements and Upgrades: Dental Schemes to Increase Revenue – Reprised from 2022 ATC

Dentists do not always agree with the approved fee for a service and can find inventive ways to make up the difference between the approved fee and what they want to receive in payment for the procedure. These schemes involve charging an upgrade fee for the materials used or for what is presented to the patient as an upgraded better product such as a superior denture or the top-of-the-line crown. Another way to increase revenue is to charge the patient for the instrument or equipment used to perform the procedure. These charges are often not submitted on a claim as the practice knows they are going to be disallowed. This presentation will explain some of the procedures that are charged to the patients incorrectly or as unbundling to increase revenue. The faculty will also show how these overcharges were discovered and how to try and prevent the patient from being overcharged.

Patricia Shifflett, RDH, AHFI
Clinical Fraud Analyst | Delta Dental of Virginia

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

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