The NHCAA Institute for
Health Care Fraud Prevention
Presents:

Schemes for Health Care Fraud Investigators & Analysts
A Virtual Training Program
June 3 - 14

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 to earn credit.

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 the available content by close of business on June 14.

Videos and corresponding materials will be posted on our program website on June 3 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 June 3 – June 14.
- 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:
        - Watch each session. The video tab must be the active tab and not covered or minimized to count toward the minimum watch time.
        - After watching each session, the quiz for that session will unlock. Quiz participation is required to earn credit.
- Planned live sessions are listed below. For on demand sessions, please set aside 2 – 3 hours each day to participate.

Agenda was last updated: 5/15/2024

Monday, June 3

11:00 am – 11:20 am ET – Program Introduction - LIVE

Understand how the program will work, how to earn credit, and ask questions.

Katie Baker
Director, Education & Training | National Health Care Anti-Fraud Association

11:30 am – 12:30 pm ET – Exploring AI in Health Care Anti-Fraud Investigations – LIVE

Healthcare fraud investigators can leverage AI (Artificial Intelligence) and ML (Machine Learning) in several ways to enhance their efforts against fraudsters who are quickly adopting these new technologies. These technologies can analyze vast amounts of data to identify patterns indicative of fraud and ML algorithms can continuously learn from new data, staying ahead of evolving fraud schemes. AI-powered tools can automate routine tasks like data entry and document processing, freeing investigators to focus on more complex analysis and decision-making.

Discuss how the health care anti-fraud industry is implementing these new tools and ways investigators and analysts can utilize available tools to make investigations efficient. Specifically, presenters will discuss utilizing AI and text analysis for medical record review and how individuals can use AI in their work. Describe best practices for writing prompts and examine ways to become more proficient at work with public tools such as LLMs (ChatGPT, Gemini, etc).

Jason DiNovi, CPMA, AHFI
Health Care Industry Consultant, Global Fraud and Security Intelligence Practice | SAS

Stacey Wang
Solutions Engineer | SAS

Wednesday, June 5

1:00 pm – 2:15 pm ET

The Latest Health Care Fraud Trend: Remote Patient Monitoring & Networking Break – LIVE

The rapid rise of Remote Patient Monitoring (RPM) is driving service and fraud trends across the health care industry. In January 2023, the NHCAA formed a work group of members with data, clinical, coding, and investigative expertise to study the issue. The group conducted a range of data analysis across the private and public spectrum. In this in-depth session, attendees will learn about RPM and Remote Therapeutic Monitoring (RTM), coding details, and the current marketing push to providers and health systems to maximize revenue through RPM/RTM related services. The results of summary and focused data analysis will be presented. Current and potential fraud trends will be discussed across a broad scope of related service types.

Jennifer Trussell
Fraud Prevention Consultant, Senior Medicare Patrol Resource Center

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Monday, June 10

11:30 am – 12:45 pm ET – Program Check-in & Case Study: Weaving Data into an Investigation – LIVE

Through case study examples, examine how data can be utilized at each step of an investigation and how good data enhances investigators work. Discuss when data may need to be reexamined mid-investigation and how to incorporate data into interviews. Finally, learn how to use data to bring the fraud being committed against your members to life.

Raul Portillo, Jr.
Criminal Investigator | U.S. Department of Health & Human Services, OIG-OI

Wednesday, June 12

1:00 pm – 2:15 pm ET

DME Fraud Schemes (Invited) & Networking Break – LIVE

Insurance companies have continued to see an increase in fraud surrounding durable medical equipment (DME). This presentation will explore how these schemes operate and the violations as they relate to Medicare rules and federal law, detail red flags in your claim data and medical records and discuss strategies for investigation. The speakers will also walk participants through case study examples. A review of the investigation process will provide information on these schemes and how they have led to uncovering multiple entities engaging in such behavior. The faculty will also discuss the specific measures taken to further perpetrate Fraud, Waste, and/or Abuse. The goal of this presentation is for the audience to walk away with additional knowledge on how to limit financial loss, reduce future risk, and quickly identify new fraud trends related to the issue(s).

Emily Foss, MBA, MAcc, CFE
Senior Investigator, Special Investigations Unit | Humana, Inc.

On Demand Sessions

Misfeeding Information: Exploring Nutritional Kinesiology & Counseling Fraud and Abuse

This presentation will explore two nutrition schemes. First hear how physicians, chiropractors, and therapists employ nutritional kinesiology to diagnose supposed deficiencies and utilize improper billing practices to secure coverage for their services. Next, dissect a typical nutritional therapy scheme through a case study walkthrough. This quick hit presentation will provide insights into how to identify red flags in your claim data and employ successful investigative strategies. Learn the deceptive practices being utilized and how to start your investigation.

Brian K. Casilli, CFE
Managing Director, SIU & Security | Blue Cross & Blue Shield of Rhode Island

Agenda was last updated: 5/15/2024

Maternity & Delivery Services

Explore the complex realm of coding and billing practices within maternity care and delivery services. This presentation will expose how seemingly harmless medical codes can drive up expenses, resulting in payers bearing extra financial burdens and possibly leaving families with added financial responsibility. Throughout the session, we'll review appropriate coding for delivery services, discuss proper billing practices for antepartum and postpartum care, and identify patterns indicative of improper claim submissions.

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

The Life Cycle of an MCO/SIU Investigation

The life cycle of an MCO SIU Investigation presentation is intended to educate the State, Federal, Law Enforcement, and all others on how an MCO/SIU conducts an investigation on Fraud Waste and Abuse. The presenters have approximately over 30 years of combined investigative experience. To provide the audience with a foundation of an MCO/SIU Case Investigation. This presentation will touch on detecting and pursuing actions against Fraudulent activities and obtaining recoveries. Explaining the use of analyze data, evidence, and technology to help the MCO detect fraud identity liable parties and mitigate their risk.

Sheree Thompson
Senior Business Analyst | AmeriHealth Caritas

Malcolm Fletcher, AHFI
SIU Manager | Amerihealth Caritas

EVV: The Good, the Bad, and the Complex

Electronic Visit Verification (EVV) is mandated by the 21st Century Cures Act and is an emergent area for healthcare fraud schemes and improper billing practices. This session will delve into the significance of EVV systems in ensuring accurate tracking of caregiver visits, optimizing service delivery, and maintaining compliance with regulations. It will explore key metrics and insights derived from EVV data, including visit durations and service outcomes. This session will also focus on the complexity of EVV documentation and contract language surrounding EVV compliance.

Through a comprehensive analysis of EVV data, this session aims to underscore its pivotal role in promoting transparency, accountability, and quality in caregiving services.

Alexis McComas, CPC, CPIP
Consultant | IBM

Kristine Knutson, AHFI
Senior Consultant | IBM

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Healthcare Consultants, Friend or Foe

In the context of a very broad, behavioral health project, Florida Medicaid identified a number of healthcare consultants who, at first blush appear to be traditional consultants, helping new businesses establish themselves. However, some unscrupulous consultants, are more involved in efforts to maximize their profit margins through conspiracies to commit fraud. This presentation will describe the structure of the scheme, ways to identify suspicious consultants participating in your program, efforts to pursue criminal charges, and if all else fails, administrative actions.

Kelly Bennett, AHFI, CFE, JD
MPI Bureau Chief | Florida AHCA, Bureau of Medicaid Program Integrity

Darlene Simmons, JD
Legal consultant | Florida AHCA, Bureau of Medicaid Program Integrity

Ophthalmology and Optometry Coding Clinic

This session will include medical review strategies for in-office procedures used to identify areas of concern and convey valuable audit findings. Review vision vs. medical coverage, general and special ophthalmological services, and documentation requirements for the services. Participants will be able to identify anomalies in claims data and examine common schemes found in ophthalmological and optometric services. The speaker will discuss the best practices for performing a thorough medical review to generate a findings report.

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

Decoding Billing Practices: A Case Study on Cardiovascular Procedures

Explore real-world billing practices in healthcare with a focus on cardiovascular procedures. Learn how analytics identified billing outliers, leading to audits and substantial refunds. Discover the financial impacts, challenges, and key milestones in addressing aggressive billing. Ideal for healthcare professionals and investigators keen on understanding billing complexities and ensuring compliance with medical standards.

David Dunn, AHFI
Senior Investigator – Corporate & Financial Investigations | Blue Cross Blue Shield of Michigan

Ted Wink
Senior Investigator – Corporate & Financial Investigations | Blue Cross Blue Shield of Michigan

Early Detection of Provider Collusion Schemes

This session aims to educate investigators on how collusion schemes work and the importance of identifying provider business ownership relationships for early fraud detection. By understanding how technology can facilitate the uncovering of unusual ownership and business arrangements, investigators can efficiently detect potential fraud that might otherwise remain unnoticed or necessitate extensive manual effort. Participants will learn to recognize provider collusion schemes through various case studies presented through data and visual aids, equipping participants with the skills needed to detect and address collusion effectively.

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Greg Lyon
Sr. Advisor, Fraud | 4L Data Intelligence

Theja Birur
Chief Technology Officer | 4L Data Intelligence

Fraud Focus: Esketamine & Spravato

Spravato (esketamine) treatment is considered for adult patients with treatment-resistant disorder and/or major depressive disorder. Esketamine is a Schedule III controlled substance and may be subject to abuse and diversion. This presentation will discuss fraud, waste, and abuse schemes associated with esketamine therapy and Spravato. Learn how to recognize these issues in your data and explore investigative best practices.

Vincent DiFilippo
Investigations Manager | UnitedHealthcare Investigations

David White
Senior Investigator | UnitedHealthcare Investigations

Understanding the Foundation of Pharmacy Schemes & Scams

This presentation will lay the foundation of pharmacy fraud for participants. The presenter, a former DEA Diversion Investigator and current HHS-OIG Special Agent, will present a basic overview of Medicare Part D, review basic pharmacy operations, and discuss basic legal requirements investigators should be aware of during pharmacy investigations. Next, the presentation will examine common pharmacy schemes and how they operate, as well as drug cocktails to be aware of. The presenter will then discuss basic data analytic patterns and prescription red flags. Lastly, the presenter will describe crucial steps for both controlled and non-controlled drug pharmacy investigations.

Randy D'Antoni
Special Agent | U.S. Department of Health & Human Services, OIG-OI

Decoding Behavioral Health

In this session, participants will explore a variety of behavioral health concerns. The speakers will start by discussing a few of the problematic modifiers and add-on codes seen on behavioral health claims. Examine the code criteria and understand how codes are being misused and how to recognize the schemes in your data. Next, explore instances of ABA certification discrepancies and what actions some providers will take to get the claims paid. The speakers will differentiate between psychotherapy and progress notes, explaining documentation practices and why this is important to fraud investigations. Participants will also discuss some of the pertinent laws surrounding Substance Use Disorders and when to exclude SUD data according to state/federal law. Lastly, walk-through the codes and data associated with Spravato schemes.

Tanya Pennington, CFE, AHFI
Manager, SIU Investigations | Magellan Health

Shameeka Jones, CFE
Manager, SIU Investigations | Magellan Health

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Investigating Agent and Broker Fraud

In this presentation attendees will learn about fraud perpetrated by agents and brokers. Explore common schemes and trends, as well as various tools used to investigate agent/broker fraud. Speakers will focus on various Medicare and ACA enrollment schemes, including those involving providers and kickback schemes. Gain insights into identifying these schemes in claims data, understand how the schemes work, and best investigative practices.

David Webb, HFI, HCAFA
Associate Director of Investigations | UnitedHealthcare Investigations

Keytelynne Radde
Investigations Manger | UnitedHealthcare Investigations

Leveraging Public Records in Investigations

Uncover how to harness public records for effective health care fraud investigations. Explore how to navigate public databases, including state licensing boards, court records, and government registries. Learn how to leverage these invaluable resources to identify fraudulent activities, detect patterns, and build compelling cases against perpetrators. Gain insights into best practices for interpreting and cross-referencing data to ensure accuracy and maximize investigative outcomes.

Melissa Presley
Supervisory Forensic Accountant | U.S. Department of Justice, Federal Bureau of Investigation

Ana Virella Cruz
Forensic Accountant | U.S. Department of Justice, Federal Bureau of Investigation

What the Fraud is This?

Everywhere our society looks, and listens are statistics and accounts of the destruction of the fentanyl crisis that is facing every layer of our nation. In 2015, Naloxone (Narcan) was approved by the FDA and is now utilized in society much like AED systems. Narcan is approved and covered by the 340B Drug Pricing Program which was originally enacted in 1992 with the objective to serve large numbers of low-income, Medicaid, uninsured and under-insured populations with care, regardless of their ability to pay. This presentation will explore and identify the holes of the 340B Program and where payors can troubleshoot to identify prospective players who have their pocketbooks taking priority over the health and wellbeing of an addicted nation.

Jami Little, MPA, MJ, CFE
Health Care Fraud Specialist | Defense Health Agency - Office of the Inspector General

Visualizing Networks to Identify Fraud – *Invited*

This session will provide an overview of investigative techniques and network analysis used to visualize fraud indicators obscured in data. Investigative entities may face challenges in purchasing third party data visualization software to aid in their investigative efforts due to cost. This presentation will highlight how augmenting and diversifying investigative resources can detect hidden connections without fee-based subscriptions.

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The components of using network analytics and OSINT research will be explored and a panel discussion will highlight how these tools can enhance fraud detection while maximizing return on investment (ROI). A use case will be presented including identification methodologies, line of business targets (i.e., telemedicine/DME), and how network analysis assisted in the early identification of emerging fraud schemes. The discussion will also include how the audience can incorporate the methodology into existing fraud programs.

Gary Cantrell
Specialist Leader, Program Integrity Solutions | Deloitte

Althea Matthews
Statistician | U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Program Integrity

Audits Across the Claims Universe – *Invited*

This session will present key areas of opportunities for identifying FWA with audit review programs and specific code sets. Focus will include audit types, payment methodologies, selection criteria, and provider avoidance activities within the inpatient and outpatient claims.

Maria Rivera, MD
Lead Medical Director |Humana Inc.

Becky Kundert
Director, Code Edit and Coding Audit | Humana Inc.

A Federal Worker's Compensation - Provider Fraud - Case Study – *Invited*

The presentation will focus on a Federal Worker's Compensation Provider Fraud investigation involving the US Postal Service Office of Inspector General (OIG), Department of Labor (OIG), and Department of Justice (DOJ) Health Care Fraud Strike Force. Data Analytics identified a chiropractor among the top five paid providers in their state, with certain billing anomalies, and use of codes that were potentially outside the scope of chiropractic practice. The presentation will highlight the medical codes used by the provider, the investigative strategies utilized by the team, discuss intricacies of the Federal Worker's Compensation Program, and highlight the pitfalls, successes, and outcome of the case.

Bryan Glinkin
Special Agent | US Postal Service, Office of Inspector General

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