The NHCAA Institute for
Health Care Fraud Prevention
Presents:

Schemes for Health Care Fraud Investigators & Analysts
A Virtual Training Program
June 4 - 18

Program Set Up

This is a hybrid training, which mostly involves watching pre-recorded presentations. In addition to approximately 8 pre-recorded sessions, there are 6 live sessions, and 1 live networking event scheduled. Participants must participate in at least ten of the sessions to earn credit. The networking event is not required and does not count toward earning 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 the end of the day on June 18.

Videos and corresponding materials will be posted on our program website on June 4. 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 14 CPEs.
- Presentations must be watched, and quizzes submitted between June 4 – June 18.
- Participants should watch at least 80% of the presentations, approximately 10 sessions.
    - Live sessions require participation in poll questions/credit checks.
    - Live sessions will be recorded and available on-demand.
    - 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.
- Set aside 2 hours each day to participate.

Wednesday, June 4

1:00 pm – 1:20 pm ET – Program Introduction - LIVE
Understand how the program will work, how to earn credit, and ask questions.

1:25 pm – 2:30 pm ET – Case Study – LIVE

Tuesday, June 10

1:00 pm – 2:00 pm ET – Program Check-In and Case Study - LIVE

2:05 pm – 3:15 pm ET – Networking Break - LIVE
Join participants and speakers at this informal networking event.

Agenda was last updated: 5/15/2025

Wednesday, June 11

1:00 pm – 2:15 pm ET – Program Check-in and Case Study - LIVE

Thursday, June 12

1:00 pm – 2:15 pm ET – Program Check-in and Case Study - LIVE

Monday, June 16

1:00 pm – 2:30 pm ET – Program Wrap Up and Case Study – LIVE

Wednesday, June 18

1:00 pm – 2:30 pm ET – Program Wrap Up and Case Study – LIVE

On Demand Sessions

Make Six Figures Your First Year!
Explore how Wisconsin's Medicaid Child Care Coordination benefit became the unwitting stage for a complex, multi-million-dollar fraud scheme involving enrollment incentives, kickbacks, identity theft, and provider "training academies." The Office of Inspector General at the Wisconsin Department of Health Services used data analytics, post-payment audit tools, and investigative work to uncover systemic abuse. This session walks through red flags, investigative strategies, and policy reforms—like an enrollment moratorium and prepayment review—to prevent future fraud. A must-attend for those examining how operational gaps can escalate into large-scale fraud.

Tabitha Ramminger
Deputy Inspector General
Wisconsin Department of Health Services, Office of Inspector General

Illegal Self-Referrals and Discovery Diagnostic Laboratory
In this case study, the Massachusetts Attorney General's Office presents its landmark prosecution under the state's Self-Referral Law. Discovery Diagnostic Laboratory (DDL) accepted referrals from substance abuse clinics operated by the owner's son, who held a financial interest in the lab. Investigators conducted over 60 interviews, issued grand jury subpoenas, and conducted deep financial and claims data analysis to prove the tainted claims theory. The session shows how these methods led to a successful prosecution and how these legal strategies can be replicated to pursue self-referral and anti-kickback violations.

Agenda was last updated: 5/15/2025

Katie Davis
Assistant Attorney General
Massachusetts Office of the Attorney General

The Ins and Outs of Transcranial Magnetic Stimulation (TMS)
This presentation details an ongoing fraud case involving falsified PHQ-9 scores to meet requirements for TMS treatment. Attendees will gain a foundational understanding of TMS, how to evaluate medical policies, and what documentation is necessary to support its use. The speaker will walk through the entire investigative process—from hotline referral to record review—comparing real records against best practices for TMS documentation. This session highlights how clinical understanding and fraud detection intersect.

Rebecca Bowman, CPC
Investigator
Blue Shield of California

The Mask of Zorro
Providers may use unlisted CPT/HCPCS codes to obscure inappropriate billing—and this session reveals how. Through specific case examples, attendees will learn how codes like 97139, 97799, J7999, and others are inappropriately used for services such as infusion therapy, group therapy, and anesthesia. This presentation will break down coding guidelines, show how to detect abuse patterns, and explain what correct documentation looks like. It's a targeted guide to uncovering fraud masked in "miscellaneous" codes.

Roderica Morris, DHA, MSHM, CPC
Associate Director
Optum

Matthew Garis
SIU Analytic Program Manager
Optum

Cultivating Effective Program Integrity and Law Enforcement Partnerships
Learn how a successful tripartite collaboration in West Virginia—between managed care organizations, the Bureau for Medical Services Office of Program Integrity, and the Medicaid Fraud Control Unit—led to enhanced fraud detection and prevention. This session showcases how private and public sector entities can overcome obstacles and establish shared goals. Attendees will gain practical strategies to build or improve their own partnerships for greater investigative and enforcement effectiveness.

Michael Taylor, AHFI
SME-Senior Fraud Analyst
West Virginia Attorney General's Office - Medicaid Fraud Control Unit

Andrew Pack
Director
West Virginia Bureau for Medical Services Office of Program Integrity

Richard Howell AHFI, CMC, CMCA-E/M
Director SIU
The Health Plan

Agenda was last updated: 5/15/2025

Best Practices for DMR Schemes
Direct Member Reimbursement (DMR) claims pose a growing fraud risk. This session explores common DMR schemes—including fake documents and misrepresented services—and shares successful case examples. Attendees will leave with a toolkit of red flags, data analysis tips, and investigative strategies, including how to incorporate social media and public records into background checks. Whether you're new to DMR investigations or looking to refine your skills, this session offers concrete takeaways.

Hilary Williams, CPC
Fraud Advisor
Evernorth Health Services

Unpacking Medicare "Self-Enrollment" Schemes: Tactics, Red Flags, and Investigative Strategies
This insightful session explores a growing and often overlooked Medicare Advantage scheme in which agents fraudulently "self-enroll" beneficiaries into new plans—sometimes with different carriers—and then re-enroll them back into their original plans to secure commissions as the new agent of record.

Using real-world case examples, the session will break down how and why these schemes succeed, including how agents manipulate personal information, exploit special enrollment periods (SEPs), and bypass oversight using consumer-facing platforms. Attendees will learn how enrollment data, device and browser metadata, and beneficiary/agent interviews can be used to identify patterns of fraud.

The speaker will also share prevention strategies, investigative tips, and lessons learned, providing practical takeaways for Medicare plan administrators, compliance staff, and SIU teams working to safeguard enrollment integrity.

Kurt Rasmusson
Sr. Fraud & Waste Investigator
Humana

Sober Homes: Uncovering Fraudulent Recruitment Tactics
This session delves into the intricate schemes employed by fraudulent sober living homes, focusing on deceptive recruitment practices and the exploitation of vulnerable populations. Attendees will gain insights into common red flags, such as excessive and unnecessary drug testing, billing for unprovided services, and the use of "body brokers" to recruit patients. The presentation will also highlight data analysis techniques to detect anomalies, including unusual billing patterns and patient overlaps. By examining real-world cases and enforcement actions, participants will learn effective strategies for identifying, investigating, and preventing such fraudulent activities within the behavioral health sector.

Magellan Health

Case Study: Skilled Nursing Facility

Description coming soon.

Anna Zendzhiryan
Special Agent
US Dept. of Health & Human Services – Office of the Inspector General

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Multi-Provider Investigations Involving Pain Management
This session delves into a complex pain management fraud scheme involving multiple providers. Attendees will explore how data analysis uncovered same-day billing patterns and how investigative efforts traced connections among related Tax Identification Numbers (TINs). The presentation will highlight best practices for organizing information across multiple TINs, identify key indicators within medical records that signal fraudulent activity, and discuss how certain TINs attempted to bypass Special Investigations Unit (SIU) detection mechanisms. Additionally, the session will cover the process of making external referrals to appropriate agencies.

Stephanie DeRoia, MS, CPC
Fraud Advisor, Special Investigations Unit
Evernorth Health Services