The NHCAA Institute for
Health Care Fraud Prevention

Schemes for Health Care Fraud Investigators & Analysts
A Virtual Training Program
June 4 - 22

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 1.5 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 22.

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 from NHCAA and 6 CEUs from AAPC.
- Presentations must be watched, and quizzes submitted between June 4 – June 22.
- Participants should watch at least 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 1.5 hours each day to participate.

Wednesday, June 4 – Eastern Time

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

1:25 pm – 2:30 pm ET – Reading Chart Notes for Investigations – Live & On Demand

Understanding clinical documentation is key to identifying red flags in health care fraud. This session explores the concept of “note bloat”—excessive, redundant, or irrelevant information in medical records—and how it can obscure the facts investigators need. Participants will learn how to identify documentation that may inflate coding or hide inconsistencies, making it harder to assess medical necessity and support billing claims.

Agenda was last updated: 6/16/2025

Real-world examples will highlight how to spot patterns that trigger audits, denials, or deeper investigation. Investigators will gain tools to navigate bloated records and extract the elements essential for case development. The session will also cover how poor documentation practices can be linked to compliance risks and potential fraud schemes.

Yvonne Ellison, MSN, RN, CPC
Nurse Investigator, Audit Team
Utah Office of Inspector General

Tuesday, June 10 – Eastern Time

1:00 pm – 2:00 pm ET – Program Check-In and Unpacking Medicare "Self-Enrollment" Schemes: Tactics, Red Flags, and Investigative Strategies - Live & On Demand

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

2:05 pm – 3:15 pm ET – Networking Break – LIVE ONLY
Join participants and speakers at this informal networking event. This does not count toward earning credit and is optional.

Wednesday, June 11 – Eastern Time

1:00 pm – 2:00 pm ET – Program Check-in and Exposing Fraud & Hidden Profits: A Prosthesis Providers Deception - Live & On Demand

This presentation delves into the investigation of fraudulent activities and hidden profits of a prosthesis provider. Speakers will cover the background of the business involved, the investigative process, and the impact on members. The session will highlight the methods used to uncover the fraud, including data analysis, member and provider interviews, and claims reviews.

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Attendees will gain insights into the emotional toll on affected members and the financial impact on the plan and the steps taken to address the overpayments identified.

Rosemary Dejesus, CFE, CPCO
Senior Investigator
Blue Cross Blue Shield of North Carolina

Ariel Vazquez, CPC, CPCO, AHFI
Senior Investigator
Blue Cross Blue Shield of North Carolina

Thursday, June 12 – Eastern Time

1:00 pm – 2:15 pm ET – Program Check-in and Identification and Prevention of Substance Use Disorder "Treatment" Schemes – Live & On Demand

This session examines the tactics and red flags associated with fraudulent substance use disorder (SUD) treatment operations, using real-world investigative strategies. Hear how the speakers team identified suspect providers through legal proceedings, public data sources, and link analysis. The session outlines a proactive, multi-pronged response—prepayment reviews, collaboration with legal and clinical partners, and continual claims monitoring—to disrupt deceptive practices. Attendees will learn how to trace fraud networks, engage internal and external partners, and apply preventative controls to protect members and payers.

Patricia Hoofnagle, MSc, AHFI
Vice President, SIU Investigations
Magellan Health, Inc.

Monday, June 16 – Eastern Time

1:00 pm – 2:30 pm ET – Program Check-in and Billing Without Illness: A COVID-19 Waiver Case Study – Live Only

During the COVID-19 pandemic, the Centers for Medicare and Medicaid Services ("CMS") waived the requirement that a person must have a hospital stay of at least three days (signaling an acute illness or injury) before starting a Medicare Part A covered stay in a nursing home, in order to conserve hospital beds. ReNew Health Group LLC, and their affiliates submitted Medicare Part A (acute care) claims for nursing home residents who did not have COVID-19, or any symptoms of COVID-19, or any other acute illnesses or injuries, but merely had been near other people who had COVID-19. Participants will hear red flags, scheme details, and investigative strategies.

Anna Zendzhiryan
Special Agent
U.S. Department of Health and Human Services, Office of Inspector General – Office of Investigations

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2:30 pm – 3:30 pm ET – Networking Break – Live Only
Join participants and speakers at this informal networking event. This does not count toward earning credit and is optional.

Wednesday, June 18 – Eastern Time

1:00 pm – 2:00 pm ET – Program Wrap Up and Services Not Rendered, Pharmacy Case Study – Live Only

For multiple years, we have continued to see services not rendered cases and have become familiar with unique drug trends within this scheme. This case study is going to explore new drug trends we have seen in recent months. In addition, we will be sharing investigative techniques utilized throughout the course of this investigation to substantiate fraud, waste, and abuse. We will also be discussing key partnerships utilized to assist with taking quick action against the pharmacy in question, with a final outcome of the Pharmacy repaying back over $1M.

Dani Wright
Pharmacy Investigator, Special Investigations Unit
Prime Therapeutics

On Demand Sessions

Best Practices for Direct Member Reimbursement 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

Uncovering Illegal Self-Referrals: Laboratory Prosecution Case Study
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.

Katie Davis
Assistant Attorney General
Massachusetts Office of the Attorney General

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The Ins and Outs of Transcranial Magnetic Stimulation
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

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

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

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Hospice Fraud – Investigating the Wrongful Billing of Revenue Code 0650

This presentation will examine a Home Hospice Fraud scheme involving the wrongful billing of Revenue Code 0650. The L.A. Care SIU leveraged critical contributions from other Departments such as the Advanced Analytics Lab (AAL), Utilization Management (UM), Configuration and Claims Integrity to enhance the investigative capabilities and create the Hospice Fraud Initiative. The goal of the Hospice Fraud Initiative is to identify, investigate and recover funds that were wrongfully paid due to fraudulent billing practices by various hospice providers. Together, the staff identified the issue, reviewed the billing regulations, developed an investigative plan, recovered the overpayments, processed the claims adjustment and established a protocol to prevent future fraudulent overpayments regarding revenue code 0650. Participants will gain insight into the hospice scheme as well as collaborative successes to apply to their own investigations.

Michael J. Devine, PhD
Director, Special Investigations Unit
LA Care

Frank Arteaga, MPA, AHFI
Lead Investigator, Special Investigations Unit
LA Care

Unlocking Vitality: An Enteral Nutrition and PKU Case Study

This case study reveals how an investigation uncovered fraudulent billing practices in which a provider billed for enteral formula but delivered solid food to patients with Phenylketonuria (PKU). Attendees will gain insight into the strategic, multidisciplinary approach used to expose and address this scheme. Key investigative steps include disease-specific research, provider interviews, patient statements, data analysis, product verification, and a thorough review of state mandates and insurance coverage policies. The session will guide participants through the process of evaluating financial impact, forming actionable conclusions, and leveraging collaboration across departments. Attendees will also learn how relationship building and cross-enterprise cooperation contribute to successful outcomes and significant cost savings.

Christine Hagg, CI, CMBI, CPC
Fraud Advisor, SIU
Evernorth Health Services

Uncovering Nonobvious Relationships to Enhance Program Integrity

This session will showcase how third-party data can help identify hidden relationships by analyzing hidden connections between people, places, and businesses. Through real-world examples, attendees will learn the importance of identifying nonobvious networks of businesses that are connected to suspended providers and how these suspended individuals and businesses can continue to operate under different names and/or entities, posing a risk to the system, often across state lines.

Thomas Figurski, CFE, CPC
Senior Fraud Analyst, Federal/State & Local Government
LexisNexis Risk Solutions

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