NHCAA 2026
ANNUAL TRAINING CONFERENCE

NOVEMBER 3-6
SAN DIEGO, CA

Draft Agenda Subject to Change

Tuesday, November 3

10:00 am – 5:30 pm **Registration and Information Desk Open**

Invitation Only Meetings

12:00 pm – 1:30 pm *Membership Forum Business Meeting*
2:00 pm – 4:30 pm *Information Sharing & Case Discussion*
2:00 pm – 4:30 pm *Data Analytics Roundtable*

4:30 pm – 6:30 pm **Welcome Reception in the Anti-Fraud Expo Hall**

Wednesday, November 4

6:30 am – 4:30 pm **Registration and Information Desk Open**

8:30 am - 8:45 am **Opening Remarks**

Louis Saccoccio, JD, Chief Executive Officer, National Health Care Anti-Fraud Association

8:45 am – 10:00 am **Keynote Speaker**

Inspiring Others to Achieve their Highest Potential
Steve Wiley, Founder and President, The Lincoln Leadership Institute at Gettysburg

10:00 am – 11:00 am **Coffee Break in the Anti-Fraud Expo Hall**

11:00 am – 12:00 pm **Concurrent Sessions**

Federal Law Enforcement Update: Trends, Enforcement, and Future Initiatives
Leaders from key law enforcement agencies focused on health care fraud will share timely insights into their agencies' current priorities, emerging trends, and future enforcement initiatives. The speakers will highlight recent successful takedowns and the investigative strategies that helped disrupt criminal activity in the health care system. Attendees will gain a better understanding of how federal agencies leverage data, intelligence, and interagency partnerships to strengthen enforcement efforts. Panelists will also discuss the importance of collaboration among law enforcement, government partners, and the private sector in advancing complex investigations and protecting health care programs, payers, and patients. This session will provide a valuable look at the collective efforts making an impact in the fight against health care fraud.

NHCAA will apply for AAPC credit, but it is unknown how many will be awarded.
At this time, we estimate 13 CPEs provided for ATC.

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Inside SafeChain Solutions: The Multimillion-Dollar HIV Drug Fraud
This presentation examines the federal prosecution of Patrick and Charles Boyd, owners of Maryland-based SafeChain Solutions, who orchestrated a massive network of counterfeit and diverted drugs between 2020 and 2021. The scheme involved purchasing diverted HIV medications from "black-market" suppliers who obtained the drugs through patient "buyback" programs—often from vulnerable individuals on the street. Through this presentation, attendees will learn to analyze the mechanics of HIV drug diversion, identify indicators of pharmaceutical wire fraud, evaluate money laundering schemes in health care, and assess supply chain risks and compliance failures. In addition, attendees will learn to apply a pharmacy SIU audit lens to counterfeit and diversion schemes, including how to assess pharmacy inventory, sourcing practices, invoicing, and wholesaler relationships beyond claims data. They will also be able to distinguish between state licensure and manufacturer trading partners and identify audit red flags tied to non-authorized wholesalers, including pricing irregularities, documentation gaps, and inventory-to-claims mismatches.

- Carlos Baixauli, CFE, Special Agent, Department of Health and Human Services, Office of Inspector General
- Caroline Jacques, PhD, RPh, CFE, Director, Pharmaceutical Crime/ Healthcare Fraud Investigator, Gilead Sciences
- Cesar Zayas, Special Agent, Department of Health and Human Services, Office of Inspector General

The Trusty Sidekick: Using AI to Support OSINT Investigations
Open-source intelligence (OSINT) is essential to modern fraud investigations, but many teams lack dedicated analytic support, time, or resources. This session offers a practical framework for using AI to strengthen OSINT workflows so investigators can move faster, improve work product, and reach meaningful insights more efficiently. Attendees will learn how to use effective prompts to turn social media research, corporate records, and other open-source findings into structured datasets that support deeper analysis rather than static notes. The session will also show how stronger prompting leads to cleaner outputs, fewer iterations, and more useful analytic products. Finally, the speakers will demonstrate how AI can streamline investigative workflows, surface hypotheses more quickly, and help investigators organize and analyze information in ways that accelerate case development and decision-making.

- Donna Jallits, AHFI, CPMA, Business Analytics Senior Advisor, Evernorth Health Services, a division of The Cigna Group
- Shawn Lipsey, Business Analytics Advisor, Evernorth Health Services, a division of The Cigna Group

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Tackling Hospice Fraud in Medicare Advantage and Traditional Medicare
Hospice fraud continues to evolve as bad actors exploit differences between Medicare Part A (fee-for-service) and Medicare Advantage (Part C) payment structures. This session offers a comparative, data-driven analysis of how schemes converge, diverge, and migrate across both programs. Attendees will learn to distinguish fraud typologies shaped by program design and financial incentives, including Part A vulnerabilities such as improper hospice eligibility certifications, extended lengths of stay inconsistent with terminal prognosis, and provider collusion, as well as Part C risks such as inappropriate enrollment steering, network exploitation, and cost-shifting behaviors. The presentation will also demonstrate how peer benchmarking, outlier detection, and longitudinal member analysis can uncover hospice-related fraud patterns across claims, encounter, and enrollment data. Participants will leave with practical strategies for applying cross-program insights to strengthen investigations, improve prevention efforts, and better detect, validate, and mitigate hospice fraud within SIU and payment integrity operations.

- Wayne Fisher, MBA, AHFI, CFE, Manager, Special Investigations Unit, Elevance Health, Inc.
- Shannon Zabo, MPA, AHFI, CPC, Investigator Lead, Elevance Health, Inc.

Drill Down: A Case-by-Case Look at Dental Fraud, Waste, and Abuse
This session uses two notable dental fraud, waste, and abuse cases to show how similar allegations can lead to different investigative paths and outcomes. A dentist and a SIU Investigator will walk attendees through each case from intake to resolution, demonstrating how to identify and analyze relevant data, apply investigative tools and techniques, and interpret clinical findings that shape the direction of a case. Speakers will highlight the practical use of data mining, clinical review, internal resources, external databases such as SIRIS, and outreach to members and providers to gather evidence and validate concerns. The session will also examine how collaboration with internal partners, law enforcement, and other external agencies strengthens investigations and supports appropriate referrals and reporting. Attendees will leave with a practical framework for evaluating dental FWA cases, using the right tools at the right time, and advancing findings through effective collaboration.

- Julia Goma, Investigator, Humana

Stop Chasing Fraud: Move Prevention Upstream with AI Strategies
Presented by NHCAA Platinum Supporting Member, Optum
Learn how AI, data and investigative expertise are helping payment integrity teams detect fraud earlier and stop losses before they occur. In this session,

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Optum experts will discuss the factors driving fraud and how these trends affect health plans and actionable steps health plans can take to help protect themselves from the ever-evolving threat of fraud. Attendees will gain insight into AI technology that improves provider verification, fraud and abuse detection, interventions and investigations.

- Ryan Breisach, MBA, Senior Product Director, Payment Integrity, Optum
- James Guy, MHA, CFE, AHFI, Director, Fraud and Abuse, Growth and Ideation, Optum

Combating FWA in Substance Use Disorder Services
Presented by NHCAA Platinum Supporting Member, Cotiviti
FWA in substance use disorder treatment costs billions annually. Whether it's medical-assisted treatment, telemedicine, or urine screening, staying ahead of constantly evolving schemes is an ongoing challenge for SIU teams. In this session, the presenters will share knowledge gleaned from a broad team of credentialed FWA experts, claims, and other data. We'll reveal market trends, dissect the nuances of the latest FWA in addiction medicine, and share cases uncovered by Cotiviti's SIU, including one with Medicaid exposure of more than $1M that's currently under investigation. We'll share code sets and detail "tele-testing" and other FWA-vulnerable practices. We'll recommend short- and long-term action plans, best practices, and resources your SIU programs can implement to improve findings and recoveries and change provider behaviors to stop schemes, all while lowering your administrative burden so you can focus on providing excellent member care.

- Brenda Gross, BSN, RN, AHFI, Director of the Special Investigations Unit (SIU), Priority Health
- Heather Rickards, MS, AHFI, CFE, Principal Investigator, Fraud, Waste, and Abuse, Cotiviti
- Andrew Winebrenner, Senior Investigator, Fraud, Waste, and Abuse, Cotiviti

12:00 pm – 2:00 pm **Lunch in the Expo Hall**

1:15 pm – 2:00 pm **Interactive Learning Forums** *(run while the Expo Hall is open)*
These **Interactive Learning Forums** are a new feature at ATC, designed to move beyond traditional presentations and put participants at the center of the conversation. These engaging sessions are designed to foster meaningful discussions, encourage collaborative learning, and build professional connections. Through peer-to-peer exchange participants will exchange ideas and share practical strategies with colleagues from across the health care anti-fraud community. Come ready to engage, contribute, and learn from the experiences of others. These will be held while the Expo Hall is open.

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- Workshop: Developing a Leadership Mindset
- Panel: Transitioning from Public to Private Sector
- Demonstration: Diving into AI

2:15 pm – 3:15 pm **Concurrent Sessions**

NHCAA Annual Emerging Pharmaceutical Threats and Industry News
This annual session provides a timely overview of emerging pharmaceutical fraud schemes, industry developments, and external trends shaping the fraud landscape. Our speaker will highlight new drugs of concern, including products increasingly associated with abuse, diversion, or financial fraud, and examine how evolving scheme patterns appear in claims data. Attendees will learn practical approaches for identifying red flags, spotting emerging risks, and strengthening fraud detection efforts through more informed claims review. The session will also explore broader shifts in the pharmaceutical industry and policy environment, including political and regulatory developments that may influence fraud trends, enforcement priorities, and investigative strategy. Presented in various forms since 2013, this session offers an updated look at the issues investigators and analysts should be watching most closely in the year ahead.

- Michael Cohen, DHSc, JD, PA-C, Operations Officer, Department of Health and Human Services, Office of Inspector General, Office of Investigations

Unmasking Fraud in Rural America
Dr. Eric Haeger operated multiple medical offices across a large rural area in Washington State. In March 2026, he was sentenced to a year in prison for adulterating hundreds of recalled BiPAP and CPAP devices, distributing them to patients, and billing Medicaid as if the devices were new. In February 2024, Eldon Leinweber, a PA-C under Dr. Haeger's supervision, was charged with rape. Data analysis showed Leinweber dispensed an unusually high volume of opioids. Investigations revealed that Leinweber was coercing female patients into performing sex acts in exchange for prescriptions, all while under Dr. Haeger's supervision. Leinweber subsequently pled guilty to both state and federal charges. These cases were developed through a collaborative effort between state and federal agencies, leveraging their combined resources to investigate health care fraud in rural areas of Washington State. The investigative team will demonstrate how they used data mining to identify subjects, locate witnesses, and generate investigative leads. They will also share their strategies and experiences in pursuing health care fraud in rural communities, using the Dr. Haeger case as an example of how small teams can achieve significant results. Finally, these cases also show the effectiveness of parallel civil-criminal proceedings because, while Dr. Haeger resolved the

adulteration counts criminally additional self-referral allegations were resolved civilly, leading to better recoupment of funds for federal programs.

- David DiBartolo, Special Agent, US Department of Justice, Federal Bureau of Investigations
- Jeremy Kelley, JD, Assistant United States Attorney, United States Attorneys Office for the Eastern District of Washington
- Michael Darren, Special Agent, U.S. Department of Health and Human Services Office of Inspector General

Cutting Through the Noise: Leveraging LLMs in Healthcare Fraud Detection
Recent advances in Artificial Intelligence (AI), particularly Large Language Models (LLMs), are creating new opportunities to improve healthcare fraud detection, but due to this newness practical implementation guidance remains limited. This presentation is intended to inform both data scientists/analysts and SIU leadership on how AI can be leveraged. The talk examines where AI can add measurable value across the investigation pipeline, from data collection and analytic detection to investigator review and flag placement. Speakers will highlight where AI can help identify suspicious entities and accelerate review of richer datasets to support faster, more accurate go/no-go decisions. Attendees will leave with concrete examples of where AI and LLMs can strengthen investigative workflows, a clearer understanding of where human judgment remains essential, and a practical methodology for measuring the value and productivity gains of AI-enabled models within SIU operations.

- Mark Kanner, PhD, Senior Director of Data Science, United Healthcare
- Xinqing (Jasmine) Huang, MS, Senior Data Scientist, United Healthcare

The Recovery Pipeline: From Crisis to Commission
This session examines a two-year investigation into a large, coordinated patient-brokering scheme in the addiction treatment industry that identified more than 117 affiliated providers and over $100 million in payments in a single year. Attendees will learn how seemingly separate brokers, treatment centers, labs, and related entities can function as a single fraud ecosystem built on illegal kickbacks, member recruitment, and excessive or unnecessary care. The presentation will show why following the patient—not just the provider—is essential to uncovering these networks, using member-level analysis to detect patterns such as repeated facility transfers, benefit exhaustion cycles, and coordinated billing activity. Speakers will also demonstrate how integrating claims, enrollment, medical record, and premium payment data exposed the full scope of the scheme and strengthened investigative findings. Participants will leave with practical strategies for identifying organized addiction-treatment fraud and building stronger, data-driven cases.

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- Kristine Polasky, Senior Investigator, Elevance Health
- Amanda Wallace, Senior Investigator, Elevance Health

One Analysis, Three Stories: Translating Analytics Across Audiences
Analytics leaders rarely play just one role. Over the course of a project, they may need to think and communicate like an analyst, a strategist, and a product owner—sometimes within the same meeting. Using a real SIU case study, this session explores how analytics managers adapt the same story for technical teams, senior leaders, and end users by shifting language, detail, and emphasis to match the audience and objective. Attendees will learn how to identify which "hat" a conversation requires, apply a practical framework for presenting the same analysis to technical peers and executives without losing rigor or credibility, and design dashboards and other outputs that reduce cognitive load and help investigators move from insight to action. Participants will leave with practical strategies for intentionally shifting between analytical, leadership, and enablement roles to maximize clarity, adoption, and overall analytic impact.

- Kelly McDonough, Senior Manager, Special Investigations Unit, Evernorth Health Services, a division of The Cigna Group

The Hidden Connections Driving Medicaid Fraud
Presented by NHCAA Platinum Supporting Member, Lexis Nexis
Fraud investigations often focus on individual actors, yet many high-impact Medicaid and Medicare fraud schemes involve interconnected networks of providers, members, businesses, and facilitators. Through real-world examples and LexisNexis® Risk Solutions SIU investigations, this session explores how investigators can move beyond traditional claim-by-claim analysis to uncover hidden relationships across individuals and organizations. Attendees will learn how linked data, identity resolution, and relationship analytics can expose coordinated schemes, reveal emerging risks, and support more efficient investigations. Participants will gain practical insights into applying network-based investigative techniques to strengthen provider fraud detection, eligibility integrity, and overall program integrity outcomes.

- Amanda D'Amico, Senior Director of Market Planning, LexisNexis Risk Solutions
- Thomas M. Figurski, CFE, CPC, Senior Fraud Analyst, Federal/State & Local Government LexisNexis Risk Solutions

Fraud Thrives in the Gaps: Close the Divide with Unified Intelligence
Presented by NHCAA Platinum Supporting Member, MedReview
Fraud, waste, and abuse rarely originate within a single claim or a single system. More often, the earliest indicators are scattered across clinical, operational, and financial data that have historically been managed in

isolation. Consider a member who repeatedly transitions into and out of hospice care. Is it a complex clinical situation, a documentation issue, or a pattern that warrants further investigation? Or a member identified as high risk for heart failure with no corresponding evidence of treatment. Is this fragmented care, a coding discrepancy, or a potential indicator of fraud? Individually, these events may not raise concern. Connected through a unified intelligence layer, they begin to tell a much more complete story. Attendees will leave with a practical framework for leveraging unified intelligence to improve visibility across the payer enterprise, strengthen investigative effectiveness, and build a more connected, proactive payment integrity strategy.

3:30 pm – 4:30 pm **Concurrent Sessions**

The Integration of SIU and Payment Integrity
This moderator-led discussion brings together health plan leaders to explore how SIU and Payment Integrity functions are evolving amid rising regulatory demands, advanced analytics, and increasingly complex fraud, waste, and abuse risks. The session will examine how these teams collaborate, where responsibilities intersect, and how organizations can strengthen coordination to improve prevention and early detection. Panelists will share practical examples of breaking down silos, aligning incentives, and balancing pre- and post-payment strategies, while integrating new technologies without increasing provider abrasion or compliance risk. Attendees will gain actionable insights, emerging best practices, and proven strategies to build more proactive, collaborative, and integrated operating models across health plan operations.

- David Popik, CFE, AHFI, Director, SIU, Humana
- Timothy Dineen, CFE, MPA, Senior Director, Special Investigations, Horizon Blue Cross Blue Shield
- Christopher Deery, CFE, AHFI, Director, Corporate and Financial Investigations, Independence Blue Cross
- Rocco Cordato, AHFI, Senior Director, SIU & Payment Integrity, MVP Health Care

Rheumatologist's Revenue Racket
This case presentation involves a $12.5 million health care fraud scheme and $4.2 million tax fraud scheme conducted by Dr. Claribel Tan and her husband, Daniel Tan. For more than a decade the Tans fraudulently enriched themselves at the expense of their patients – who they deceived, underdosed, and injected with expired and/or improper medications. The Tans operated a rheumatology medical clinic in Anchorage, Alaska where they injected patients with high reimbursement medications to treat autoimmune and musculoskeletal diseases. From 2013 to 2021, when the Tans filed tax returns, they materially overstated medication expenses for the clinic. The material overstatements in

addition to the years in that same timeframe when the Tans did not file tax returns at all resulted in a tax loss of approximately $4.2 million to the IRS. This presentation covers how the case was initiated and the investigative steps the agents took to uncover the scheme. Attendees will learn about best practices for investigating rheumatology cases, gain insight into overcoming challenges dealing with patient harm and reinforce the benefits of partnering with public and private sectors.

- Seth Beausang, Investigative Team Member, Assistant United States Attorney
  United States Attorney's Office, District of Alaska
- Harrison Jenkins, Investigative Team Member, Special Agent, Internal Revenue Service -Criminal Investigation (IRS-CI)
- Jim Knauss, CPA, Investigative Team Member, Investigative Auditor, Department of Defense (DOD), Defense Contract Audit Agency (DCAA)
- Katie Yarborough, Special Agent, US Department of Justice, Federal Bureau of Investigations

Detecting Fraud from Day One: A Blueprint for Building an Automated Monitoring Pipeline
Health care fraud schemes now move at a pace that traditional audits often cannot match. As highlighted in FinCEN's March 2026 Healthcare Fraud Advisory, criminal networks increasingly use telemarketing lead generation and complicit ordering providers to drive large-scale durable medical equipment (DME) bulk billing, causing major losses in days rather than months. This session presents a practical blueprint for shifting from reactive review to continuous, proactive monitoring. Attendees will learn how to use SQL to detect billing velocity, same-day bulk billing, behavioral shifts, and provider network connections; apply Python to automate those analytics into a daily end-to-end detection pipeline; and translate the results into a Tableau-based triage hub that helps analysts and investigators visualize risk, prioritize leads, and respond faster. The session will show how early detection can improve resource allocation and significantly reduce financial exposure from fast-moving DME fraud schemes.

- Jared Williams, MS, CFE, HCAFA, Data Science Fraud Manager, Blue Cross Blue Shield of Massachusetts

No Surprises Act (NSA) Fraud Schemes and Legal Updates
The No Surprises Act (NSA) is creating significant fraud exposure for major carriers as some providers and billing companies exploit the law and the Independent Dispute Resolution (IDR) process to pursue abusive reimbursement. Recent reporting and industry attention have highlighted the scale of these tactics and the outsized payments they can generate. This session will provide a plain-language overview of the NSA, key legal

developments, and the current state of the law, then examine case studies of some of the most egregious fraud schemes emerging under the statute. Attendees will learn how medical providers and billing entities manipulate NSA claims, how the IDR process can be abused, and practical tactics for identifying, preventing, and investigating these schemes. Participants will also leave with strategies for recovering funds paid through fraudulent NSA submissions and strengthening internal controls to reduce future exposure.

- Daniel Lyons, Managing Senior Counsel, Aetna

Unlicensed Dentistry and Prescriptions: The Case of Fritz Gabriel
This session examines the 2026 prosecution of Fritz Gabriel, office manager of the Boston dental practice Forest Hills Dental, who was convicted after an eight-day jury trial of unlicensed practice of dentistry, prescription fraud, larceny, and billing Medicaid for services never provided, resulting in a five-year jail sentence. Using this case study, speakers will show how data and comparative analysis can surface potential fraud, how creative investigative tactics—including obtaining x-rays from subsequent dental providers and engaging expert review—can strengthen evidence, and how coordination with the U.S. Department of Health and Human Services Office of Inspector General supported the prosecution strategy. Attendees will leave with practical insight into building a dental fraud case from initial indicators through trial, combining analytic methods, investigative creativity, and interagency collaboration to achieve successful outcomes.

- Sean Hildenbrandt, Assistant Attorney General, Office of the Massachusetts Attorney General
- Kathleen Tansey, Senior Healthcare Fraud Investigator, Office of the Massachusetts Attorney General

A Dynamic Duo: Accelerating Medicare Provider Investigations with AI Agents
Presented by NHCAA Platinum Supporting Member, Shift Technology
Medicare investigations demand speed, but manual open sourced data (OSINT) gathering, provider screening, and policy analysis can consume days of analyst time before a single decision is made.
In this session, experts share how the combination of AI agents and human expertise are transforming two critical stages of the SIU and payment integrity workflow. The first stage is analyzing policy and claims data to surface new detection logic, and the second is creating investigation packages so investigators can focus on judgment and action. Experts will walk through real-world cases illustrating how human-agent collaboration finds net new value, accelerates investigations, standardizes documentation, and improves referral quality. Attendees will leave with a concrete understanding of how payers are

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deploying AI agents today, where human expertise remains irreplaceable, and what measurable impact looks like in an active PI or SIU environment.

4:30 pm – 6:30 pm **Reception in the Anti-Fraud Expo Hall**

Thursday, November 5

6:30 am – 5:00 pm **Information Desk Open**

8:15 am – 9:45 am **General Session**
Navigating the AI Transformation in Fraud, Waste, and Abuse

- Timothy Dineen, CFE, MPA, Sr. Director, Special Investigations, Horizon Blue Cross Blue Shield of New Jersey (moderator)
- Matthew Berls, MA, AHFI, Vice President, UnitedHealthcare Investigations
- Michael Cohen, DHSc, JD, PA-C, Operations Officer, Investigations Unit, U.S. Department of Health and Human Services, Office of Inspector General
- Joshua Orr, Vice President, Privacy and Special Investigations Unit, Senior Associate General Counsel, Point32Health
- Kurt Spear, Vice President, Financial Investigations and Provider Review, Highmark

10:00 am – 11:00 am **Concurrent Sessions**

CRUSHing Fraud: An update from CPI Leadership
This session will provide an update on CMS's current program integrity priorities and the agency's ongoing efforts to prevent, detect, and address fraud, waste, and abuse (FWA) across Medicare and Medicaid. Participants will learn about CMS's evolving approach to program integrity, including advanced analytics and artificial intelligence, enhanced provider enrollment oversight, targeted Medicare and Medicaid initiatives, and strengthened collaboration with stakeholders. The session will also highlight recent operational achievements, transparency initiatives, and regulatory efforts designed to protect beneficiaries, safeguard taxpayer dollars, and strengthen the integrity of CMS programs.

- Jeneen Iwugo, Acting Director, Center for Medicare and Medicaid Services, Center for Program Integrity (CPI)
- Jennifer Dupee, Deputy Director, Center for Medicare and Medicaid Services, Center for Program Integrity (CPI)

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The Price of Excess: Waste Identification, Mitigation and Prevention
Waste accounts for a significant share of health care spending, with unnecessary expenditures estimated at 20–30% of total costs—up to $1.6 trillion annually. In pharmacy benefits, waste can create financial, clinical, and environmental risks, particularly when excess medications are improperly disposed of or patients under- or over-utilize therapy. Yet waste is often difficult to identify and control, especially when utilization management is limited, network pharmacies do not consistently apply drug utilization review, or members seek medications outside clinically appropriate use. This session will explore how fraud, waste, and abuse leaders can use data analytics, cross-functional collaboration, and operational oversight to identify inappropriate pharmacy expenditures and implement front-end controls that prevent future waste. Attendees will learn practical, integrated strategies for detecting, mitigating, and preventing waste in pharmacy claims through a coordinated PBM approach involving pharmacy audit, special investigations, analytics, clinical pharmacy, utilization management, and client collaboration.

- Casey Jenness, PharmD, MBA, Director, FWA Clinical Support Services, Prime Therapeutics
- Rachel Espinosa, PharmD, CSP, Director of Pharmacy Audit Operations, Prime Therapeutics

Provider Overbilling Detection System: An AI Tool for Healthcare Fraud Agents
The USPS OIG developed the Provider Overbilling Detection System (PODS), an AI/ML model trained on more than 20 years of Department of Labor Office of Workers' Compensation claims data for U.S. Postal Service employees, to detect overbilling in physical therapy, chiropractic, and evaluation and management services. DS has identified millions in physical therapy and evaluation and management overbilling. This session will explain how PODS was built, how investigative and analytics teams partnered to operationalize it, and how agents use its 95th-percentile anomaly detection to identify suspicious billing, develop leads, and generate cases. Attendees will also learn how to apply similar methods to their own claims data to detect provider overbilling and strengthen fraud investigations.

- Harjot Sodhi, Data Scientist, United States Postal Service, Office of Inspector General
- Vanessa Molina, Lead Provider Fraud Subject Matter Expert (Special Agent), United States Postal Service, Office of Inspector General

ABA Therapy Medicaid's Next Biggest Pain Point
Applied Behavior Analysis (ABA) is one of the fastest-growing healthcare expenditures, driven by rising autism diagnoses and expanded insurance coverage. Medicaid spending on autism-related therapies increased from

approximately $660 million in 2019 to $2.2 billion in 2023, prompting increased scrutiny from CMS, state Medicaid agencies, and law enforcement. Because ABA relies on individualized treatment plans, time-based billing, and extensive documentation, traditional fraud detection methods often fall short. This session provides SIU investigators and program integrity professionals with practical strategies to identify fraud, waste, and abuse through utilization analytics, peer comparisons, supervision reviews, documentation assessments, and provider network analysis. Participants will learn to recognize emerging fraud schemes, including billing companies and provider enrollment tactics used to evade oversight, while integrating claims, clinical, and operational data to conduct stronger, more defensible investigations.

- Liam C Burke, Lead Investigator, Elevance Health
- Sandra Nadler, AHFI, Program Director, Elevance Health
- Lindsey Taylor, CPC, CPMA, CASCC, Senior Investigator, Elevance Health

Biting Back Against Fraud and Misuse of Dental Plan Benefits
This session examines how employer-sponsored dental plans are exploited through both common and less familiar fraud, waste, and abuse schemes affecting large and small groups alike. Using real case examples, speakers will show how these schemes were identified, the investigative and operational responses used to address them, and the lessons learned when outcomes did not go as planned. Attendees will learn how to recognize red flags in dental claims, analyze CDT code patterns for unusual activity, validate providers and practice locations, assess foreign claims, and use prepayment audits as an effective prevention and detection tool. The presentation will also highlight how collaboration with internal teams helped reduce risk and how partnerships with external agencies strengthened investigations and supported more effective resolution. Participants will leave with practical strategies for detecting employer dental benefit misuse early and responding in a more consistent, informed, and defensible way.

- Suzanne (Sue) Williams, CFE, Lead Program Integrity Auditor, Principal Financial Group
- Jamie Welch, CFE, Lead Program Integrity Auditor, Principal Financial Group

AI-Assisted Record Review for Specialty-Driven Fraud Schemes
Presented by NHCAA Platinum Supporting Member, Health Care Fraud Shield
This session explores how AI-assisted medical record review can help investigators identify specialty-driven fraud, waste, and abuse patterns more efficiently and consistently. Using real-world examples, attendees will see how AI can surface cloned or templated documentation, unsupported high-level E/M services such as CPT 99214 and 99215, and discrepancies between

documented medical decision-making, diagnoses, and billed services. The session will also examine recurring laboratory billing patterns involving the 8XXXX series; procedure-to-documentation mismatches, without a clearly documented specimen or interpretation. Additional examples will include missing orders, inconsistent dates, absent test results, and repeated language across patients or encounters. Attendees will learn how AI-generated insights can strengthen record review, guide investigative prioritization, and support more focused provider outreach and case development.

- Karen Weintraub, AHFI, CPC-P, CPMA, CDC, Executive Vice President, Healthcare Fraud Shield
- Kristin Griego, AHFI, CFE, CPC, Program Director, Special Investigations Unit, Molina

Shift Hard Left: Preventing FWA from network and pre-service through SIU
Presented by NHCAA Platinum Supporting Member, 4L Data
The 2026 4L Fraud Advisory Council collaboration of health plan SIU, network, and payment integrity leaders emphasized that FWA prevention must 'shift left' into a more aggressive prevention posture to meet the economic and operational challenges impacting every health plan. This session will take recommendations from the 4L Fraud Advisory Council's collaboration to focus on breaking down operational silos and moving fraud and abuse prevention as far left as the network and pre-service phases—before claims are ever generated. The session will also highlight the importance of shifting much of what is now adjudication-based edits and provider integrity analysis into the clearinghouse to prevent abuse, suspicious relationships and behaviors, and reduce operating costs. Finally, we will focus on 'shifting left' in the SIU with an emphasis on automating first-line investigations to empower FWA lead management decisions in minutes instead of hours or days.

11:00 am – 12:15 pm **Lunch in Expo Hall**

12:15 pm – 1:15 pm **Awards Ceremony**

1:30 pm – 2:30 pm **Concurrent Sessions**

Phantom Providers: Early Detection, Faster Intervention
Early, proactive detection of fraudulent providers is essential to reducing financial losses and limiting downstream risk across the healthcare ecosystem. As advanced technologies and artificial intelligence reshape the fraud landscape, bad actors are able to submit false claims faster, in greater volume, and for increasingly higher dollar amounts. This growing threat is especially evident in the rise of phantom provider schemes, where fraudulent entities can exploit vulnerabilities before traditional detection methods identify suspicious activity. This panel will examine how organizations are

strengthening their front-end detection strategies to identify high-risk providers earlier in the billing process. Panelists will share practical approaches for using analytics, enhanced review processes, and cross-functional collaboration to generate actionable leads and disrupt fraud more quickly. Attendees will gain insight into the operational challenges, lessons learned, and measurable impact of proactive intervention, including how early detection can reduce financial exposure, protect members, and limit broader system compromise.

- Tom Hixson, MS, Managing Director, Special Investigations Unit, Evernorth Health Services a division of The Cigna Group
- Lynn O'Dea, Executive Director, Special Investigations Department, Health Care Service Corporation
- Latrisha "LT" Oswald, MSFS, AHFI, CFE, Director, Financial Investigation & Provider Review, Highmark
- MaryBeth Hughes, Lead Director, Data Science, CVS Health

Digital Prescriptions, Real Crimes: Unmasking Fraud in Modern Prescribing
Electronic prescribing (e-prescribing), a national mandated requirement, replaced paper prescriptions with a faster, secure way to prescribe medications. E-prescribing was viewed as an effective safeguard against prescription fraud, and its nationwide mandated adoption (CMS and Regulatory Agencies) reflected confidence to reduce those risks. In 2020, Kaiser Permanente's National Special Investigations Unit (NSIU) identified a sophisticated scheme involving fraudulent electronic prescriptions. We will examine how the scheme was detected and the criminal referral triggered a multi-agency investigation involving the Federal Bureau of Investigation (FBI), the Drug Enforcement Administration (DEA), the Los Angeles County Sheriff's Department HALT Team, and other agencies. The presentation will explain how the FBI and DEA uncovered a complex criminal operation working in concert to create fraudulent Electronic Medical Records accounts, authorize large quantities of controlled substances, and ultimately how those prescriptions were dispensed. The presenters will highlight the importance of partnership between law enforcement and health plans.

- Mark Horowitz, RPh, Senior Manager, Kaiser Permanente
- Desiree Johnson, Diversion Investigator, US Department of Justice, Drug Enforcement Administration
- William Stachnik, Special Agent, US Department of Justice, Federal Bureau of Investigations

Leading SIU Teams in the Age of AI
Leading a Special Investigations Unit in the age of AI requires balancing innovation with the human judgment that still drives high-quality investigations. This session explores how AI and advanced analytics can strengthen fraud

detection, pattern recognition, and workload prioritization without replacing the ethical reasoning, empathy, and investigative intuition essential to effective SIU work. Attendees will learn practical strategies for embracing new technologies while continuing to support, grow, and manage investigative staff, including leadership approaches that keep people—not tools—at the center of team performance. The session will also address relationship-building, team development, and practical methods for tracking progress and sustaining a strong investigative culture. Participants will leave with examples of where AI can improve outcomes, a clearer understanding of its limitations and challenges, and actionable guidance for hiring, developing, and leading resilient investigative teams in a rapidly evolving environment.

- Jennifer Kovaly, MBA, CPC, AHFI, Manager, Special Investigations, Horizon Blue Cross Blue Shield of New Jersey
- Danielle Han, Supervisor, Special Investigations, Horizon Blue Cross Blue Shield of New Jersey

Stopping Fraud - One Check at a Time
This presentation examines the development, validation, and organizational impact of the Stop Check initiative, a program internal to Blue Shield of California designed to prevent improper payments for suspected fraud, waste, and abuse (FWA) by stopping checks before they are cashed. Using structured workflows, data-driven analysis, and cross-department collaboration, the initiative strengthens payment integrity and reduces avoidable financial loss. Attendees will learn how a proactive stop check/void approach uses fraud indicators, claims data, scheme patterns, and investigative tools such as SIRIS to identify high-risk payments early and intervene before significant loss occurs. The session will also show how performance results can be translated into a compelling business case that builds leadership support, secures resources, and supports scalable program growth. Participants will leave with practical strategies for shifting from retrospective recovery to proactive payment prevention and strengthening organizational response to emerging FWA risks.

- Julie Steinhorst, Payment Integrity Investigator, Special Investigations Unit, Blue Shield of California
- Michael Tombor, Senior Manager, Special Investigations Unit, Blue Shield of California

Data-Driven Techniques for Uncovering Virtual Behavioral Health Fraud
This presentation introduces data-driven methods for assessing allegations of behavioral telehealth fraud using visit notes and call detail records. By leveraging Python and Excel-based workflows, these techniques aid the early detection of billing and documentation irregularities. Attendees will gain insight into advanced approaches such as cloned note detection, call detail

comparison, and 'call collision analysis', a method for identifying instances where providers were engaged in unrelated calls during claimed patient sessions. The session emphasizes practical application, delineating the concrete steps for collecting and executing this form of analysis.

- Tyler Evans, Data Analyst, DC Office of the Inspector General, Medicaid Fraud Control Unit
- Sarah Cruz, Data Analyst, DC Office of the Inspector General, Medicaid Fraud Control Unit

Finding Hidden Opportunities: A $60M Success Story
Presented by NHCAA Platinum Supporting Member, Codoxo
Most health plans have invested heavily in payment integrity—building experienced teams, implementing sophisticated edits, and partnering with multiple vendors to identify and recover overpayments. But how do you know your program is finding everything it should? This session presents a behind-the-scenes walkthrough of a real-world customer engagement. An AI-driven assessment of 37 million historical claims, 108 million claim lines, and more than $20 billion in paid claims uncovered significant payment integrity opportunities that existing processes had not identified. In just 60 days, the assessment identified more than $60 million in payment integrity exposure, validated more than $30 million for additional review and potential recovery, revealed previously unidentified payment integrity concepts and billing patterns, and identified operational and reimbursement policy improvements through root cause analysis. Attendees will learn the assessment methodology, the types of opportunities uncovered, and practical strategies for evaluating whether similar hidden opportunities exist within their own payment integrity programs.

- Jim Brady, Vice President of Growth, Codoxo

Ecosystem Integrity – An Enterprise Approach to Fraud, Waste, and Abuse
Presented by NHCAA Platinum Supporting Member, HMS
The HMS and Gainwell team will present a unified approach to combating fraud, waste, and abuse across the full Medicaid ecosystem, not simply at the point of claim payment. The session will demonstrate how expertise from Human Services and Public Health, Verification Services, Coordination of Benefits, Payment Integrity, and Medicaid Enterprise Systems can connect eligibility, member, provider, claims, encounter, and other-payer information to identify risks earlier and provide states with a more complete view of program integrity. Attendees will learn how an integrated FWA control layer can combine data mining and investigations, claims editing, clinical review and audit, verification, COB, and subrogation with AI-enabled analytics and workflow orchestration. By coordinating proactive, pre-payment, and post-payment interventions, and applying education, edits, audits, recovery, or

investigative escalation proportionally, the HMS/Gainwell model helps programs move beyond fragmented "pay-and-chase" activities toward prevention, accountable action, and lasting reduction in improper payments.

2:45 pm – 3:45 pm **Concurrent Sessions**

Specialty Benefits Investigation of the Year
This NHCAA Award recognizes the substantial health care antifraud contributions by NHCAA Member Organization specialty benefit plans' investigation units. While not all investigations lead to criminal or civil prosecution, they can result in significant policy or procedural changes that should be recognized. These changes may positively impact the effectiveness and efficiency of specialty benefit plans operations which, in turn, may improve the delivery of benefits to their clients. In this session, the awardees of the new Specialty Benefits Investigation of the Year will break down the investigative steps and results of their case.

- Speakers will be announced during the conference

CDPAP and SADC: Health Care Fraud within New York State
The Consumer Directed Personal Assistance Program (CDPAP) is a Medicaid-funded New York program that allows chronically ill or physically disabled beneficiaries to choose their own caregivers, who are paid through a home health agency or fiduciary. As CDPAP has grown into the largest workforce category in New York State, it has also created significant opportunities for fraud. This session will examine fraud risks within CDPAP and Social Adult Day Care (SADC) programs and show how data analysis can be used to detect suspicious billing patterns, enrollment anomalies, and other red flags. Attendees will also learn how to collaborate with key stakeholders, including Medicaid long-term care organizations, to identify trends and gather critical data, enrollment packages, and complaints. In addition, the speakers will discuss practical controls that organizations can implement to prevent fraud, strengthen oversight, and improve program integrity.

- Kate Teliska, CFE, Special Agent, Department of Health and Human Services, Office of the Inspector General
- Samy Hegazy, Special Agent, Department of Health and Human Services, Office of the Inspector General

Stop Getting Ghosted: The Referral Formula That Gets OIG's Attention
This joint presentation by HHS-OIG and MEDIC gives health care fraud investigators and plan sponsors a practical roadmap for submitting referrals that are more likely to be investigated rather than deemed non-actionable. With OIG receiving roughly 180,000 contacts each year but pursuing only a small share, referrals must compete for limited investigative and prosecutorial

resources. This session will explain what happens after a referral is submitted and show attendees how to distinguish actionable cases from complaints that lack the documentation, financial significance, or evidentiary support needed for prosecution. Participants will also learn how resource constraints and case-prioritization criteria shape referral decisions, and how to package referrals with clear scheme descriptions, complete supporting records, and strong articulation of impact. Attendees will leave with practical strategies for improving referral quality and increasing the likelihood that high-value cases receive law enforcement attention.

- Patrick Neubert, LICSW, Operations Officer, Department of Health and Human Services, Office of the Inspector General
- Matthew Farabaugh, FWA Analytics Strategy Advisor, Aridell, LLC, Qlarant Subcontractor

Licensed to Deceive: Inside Broker Fraud Schemes
This session examines healthcare broker fraud in the Individual and Family Affordable Care Act (ACA) market and its impact on members, health plans, and regulatory compliance. Attendees will learn how brokers exploit enrollment processes, misuse consumer information, and operate through organized schemes to generate improper commissions or create fictitious policies. The presentation will outline common broker fraud typologies, key red flags and risk indicators, and practical techniques for investigating suspicious activity. Speakers will also demonstrate how broker portal activity and interaction data can be analyzed to identify additional scheme participants, validate documentation, and support case development. In addition, the session will cover direct outreach and verification strategies, along with the investigative and reporting steps organizations can use to escalate suspected broker fraud effectively. Participants will leave with a clearer framework for recognizing schemes early, documenting findings, and strengthening oversight in the ACA broker environment.

- Kaitlynn Smith, CFE, Fraud Lead Analyst, Evernorth Health Services, a division of The Cigna Group
- Chelsea Janes, CPC, Fraud Lead Analyst, Evernorth Health Services, a division of The Cigna Group

The Gray Zone: An AI Expedition into the Land of Unlisted and Unspecified Codes
Unlisted and unspecified codes present some of the most complex challenges in health care reimbursement, driving administrative costs, claim denials, payment inaccuracies, and fraud risk. This session will explore how artificial intelligence and advanced analytics can strengthen oversight by shifting payment integrity efforts from reactive reviews to proactive, data-driven investigations. Attendees will learn how AI can identify anomalous billing

patterns, provider outliers, reimbursement disparities, comparator-code behaviors, site-of-care variation, and documentation issues associated with elevated financial risk. Through real-world case studies from specialties such as ENT, orthopedics, neurosurgery, and plastic surgery, participants will see how AI-driven analysis can uncover hidden reimbursement patterns, prioritize investigative resources, and support more effective audit strategies. The session will also provide practical approaches for integrating AI into payment integrity programs, improving oversight of unlisted and unspecified code utilization, and developing policies that balance provider flexibility with responsible financial stewardship.

Pre-Pay Done Differently: Arizona's Program Integrity Journey
Presented by NHCAA Platinum Supporting Member, Alivia Analytics
Arizona's Medicaid agency (AHCCCS) is strengthening program integrity by advancing beyond traditional post-pay investigations to a prevention-first approach that identifies potential fraud, waste, and abuse before payment. Join Arizona's Inspector General and Assistant Deputy Director, alongside Alivia Analytics, as they share how the program advanced from concept to production, including the role of pre-adjudication fraud detection and the integration of pre-pay and post-pay workflows. Attendees will gain insight into the reviewer experience, learning how AI-driven prioritization, real-time fraud edits, and connected case management tools support efficient decision-making while preserving human oversight and accountability. Beyond the technology, this session explores implementation lessons, cross-functional collaboration, operational outcomes, and the performance measures that demonstrate impact, including results, ROI, and KPIs. Attendees will gain practical guidance and transferable strategies for health plans and government programs evaluating more proactive, technology-enabled approaches to program integrity.

- Vanessa Templeman, Inspector General, Arizona Health Care Cost Containment System
- Lynne Emmons, Assistant Deputy Director, Arizona Health Care Cost Containment System
- Matt Perryman, Chief Technology Officer, Alivia Analytics

4:00 pm – 5:00 pm **Concurrent Sessions**

SIRIS Investigation of the Year
The SIRIS Investigation of the Year award honors an outstanding and effective health care fraud investigation and its impact on fraud deterrence and prevention as a result of a SIRIS entry. The winning nomination is a result of or greatly enhanced by receiving additional intelligence from other SIRIS users after having entered a provider case or scheme, researching cases or schemes in the SIRIS database, or submitting a Request for Investigation Assistance

(RIA) through SIRIS. In the session, members of the investigative team from the public and private sectors will discuss how a SIRIS lead led to the investigation and the outcome of the case. Hear how collaboration led to the successful prosecution of this award-winning case.

- Speakers will be announced during the conference

IDeal World: Collaborating to Stop Identity Theft from Driving Healthcare Fraud
Compromised member identifiers are a major driver of health care fraud, enabling billions in improper Medicare Fee-for-Service billing and contributing to similar schemes in private plans. Stolen through social engineering, misuse of lookup tools, and breaches at health care entities, member IDs have become so widely exposed that organizations should treat them as effectively compromised. This session examines identity theft as a root cause behind many major fraud schemes and explores why current health care payment safeguards have not kept pace. Attendees will learn how the payment card industry reduced fraud tied to stolen account numbers and how those lessons can be adapted to the health care payment ecosystem. The presentation will also outline practical strategies the insurance industry can use to reduce exposure, strengthen controls, and better address the systemic vulnerabilities that allow member ID fraud to persist.

- Dennis Sendros, Senior Advisor, Center for Medicare and Medicaid Services, Department of Health and Human Services

Understanding Vulnerability: Aging, Trust, and Fraud Investigations
Older adults are frequent targets of health care fraud, financial exploitation, and impersonation scams, yet investigations often overlook how normal aging affects vulnerability, reporting, and cooperation. Presented from a gerontologist's perspective and incorporating payer/SIU viewpoints, this session explores how age-related changes in risk perception, trust, emotional regulation, information processing, and social isolation can increase fraud risk. Attendees will learn to distinguish normal aging from cognitive impairment, better understand why older adults may delay reporting, minimize losses, or resist help, and recognize how fear, shame, and mistrust shape interactions with investigators. The session will also provide practical strategies for communicating with older adults in ways that improve recall, reduce resistance, and build trust during interviews, intakes, and program integrity reviews. Finally, attendees will examine how aging-related factors influence credibility assessments, evidence development, investigative timelines, and fraud prevention efforts.

- Lisbeth Briones-Roberts, MS Gerontology, Senior Investigator, Providence Health Plan

Draft Agenda Subject to Change

- Sing Tam Lee, CPC, CPCO, CDEO, CPMA, Senior Investigator, Providence Health Plan
- Stefanie Caswell, APRN, Vice President, Clinical Integration, Longevity Health

Detecting Dental FWA Unbundling, Upcoding, Altered Records, and NPI Misuse
This session examines common Medicaid dental fraud, waste, and abuse schemes through concise case examples that highlight recurring red flags in claims, documentation, and billing patterns. Speakers will cover unbundling, upcoding, altered clinical records, and misuse of National Provider Identifier (NPI) numbers, while showing how these issues appear in real-world investigations. Attendees will learn how to apply prepayment review techniques, including claims and utilization analysis, clinical record review, and policy-based validation, to identify questionable billing and documentation patterns. The presentation will also outline typical investigative outcomes and next steps, including recoupment actions, external referrals such as Medicaid Fraud Control Units and licensing boards, and prevention strategies informed by case experience. Participants will leave with a practical framework for detecting common dental FWA schemes, validating concerns, and escalating findings in a consistent, defensible way.

- Charlotte Smith, DMD, CPC, CRC, CPMA, CDEO, CPCO, Clinical Investigator, Horizon Blue Cross Blue Shield of New Jersey
- Jennifer Barton, CFE, CPC, Supervisor, Horizon Blue Cross Blue Shield of New Jersey

Friday, November 6

7:30 am – 10:00 am **Information Desk Open**

8:30 am – 10:30 am **Breakfast Seminars**

Approaches to Building and Optimizing your SIU Team
This presentation explores how intentional leadership, structured processes, and strategic team development can help transform SIUs into high-performing, resilient teams prepared to address the growing complexity of healthcare fraud, waste, and abuse. Designed for current leaders, aspiring leaders, and investigators seeking to broaden their impact, this session offers practical approaches for building, strengthening, and sustaining effective investigative operations. Presenters will examine strategies for identifying talent gaps, developing team members, creating tactical teams, and implementing consistent investigative plans that support clearer documentation and stronger case outcomes. The discussion will also address common operational challenges, including large caseloads, regulatory constraints, remote team engagement, and maintaining morale in demanding investigative

environments. Through presentation, discussion, and shared best practices, participants will gain actionable insights they can adapt to SIU teams of all sizes.

- Lorraine Buckman, AHFI, Lead Investigator, Horizon Blue Cross Blue Shield of New Jersey
- Carrie Godby, AHFI, CFE, MFF, Manager, Special Investigations Unit, Elevance Health
- Haley Everson, AHFI, MSCM, Manager, Special Investigations Unit, Elevance Health
- Alex Kaufmann, Investigator II, Horizon Blue Cross Blue Shield of New Jersey

The Dental Investigator's Toolkit: New Codes, Emerging Risks, and Strategies

This two-hour session presents two connected perspectives on dental investigations. The first examines fraud risks associated with new and evolving CDT codes and the challenges investigators face in distinguishing emerging fraud schemes from questionable billing patterns, documentation deficiencies, and legitimate clinical practices. The second follows the investigative process beyond the data, demonstrating how similar audit findings can lead to very different outcomes. Through comparative case studies, attendees will explore how provider engagement, documentation review, clinical context, and professional judgment influence case direction and resolution. By combining emerging fraud detection techniques with practical investigative strategies, this session equips attendees with the analytical and interpersonal skills needed to evaluate risk, engage providers effectively, and achieve appropriate investigative outcomes in an increasingly complex dental environment.

- Stewart Balikov, DDS, AHFI, Director Dental Special Investigations, Elevance Health
- Louann Goodnough, MPNA, LDA, Clinical Fraud Investigator, Elevance Health

Investigation of the Year

The recipients of NHCAA's Investigation of the Year Award will provide in-depth insights on the investigation and prosecution of this award-winning case. Listen to the investigative strategies, multi-organization cooperation and case-building excellence that led to a successful resolution of this case, as well as to the coveted NHCAA honor. This two-part session provides insight into the investigation process, tactics for building the case, and collaborative efforts necessary for a positive result. Hear from the team that identified the case and the partnership that lead to a successful prosecution.

Draft Agenda Subject to Change

- Speakers will be announced during the conference

Annual Ethics Seminar
Each year, NHCAA hosts its Annual Ethics Seminar to help health care fraud investigators navigate the ethical and professional challenges encountered throughout the investigative process. Through interactive discussions and real-world scenarios, participants will explore practical approaches to ethical decision-making in areas including evidence collection, interviewing, professional conduct, and the ethical implications of emerging technologies, including artificial intelligence. The seminar also examines relevant legal and regulatory requirements and provides practical frameworks for addressing complex ethical issues while maintaining investigative integrity. Designed for professionals across the health care anti-fraud community, this program equips attendees with tools they can immediately apply in their daily work. The seminar is approved to satisfy the Association of Certified Fraud Examiners (ACFE) annual ethics training requirement for Certified Fraud Examiners (CFEs).

10:00 am **Conference Adjourns**

NHCAA will apply for AAPC credit, but it is unknown how many will be awarded.
At this time, we estimate 13 CPEs provided for ATC.