2024 ANNUAL TRAINING CONFERENCE

NOVEMBER 19 - 22 / NEW ORLEANS, LOUISIANA

NHCAA

Agenda

(updated September 3, 2024)

Tuesday, November 19

9:00 am – 5:30 pm **Registration and Information Desk Open**

12:30 pm – 4:30 pm ***NHCAA Membership Events (Invitation Only, RSVP required)***

4:30 pm – 5:00 pm **Anti-Fraud Expo Hall Preview**

5:00 pm – 6:30 pm **Welcome Reception in the Anti-Fraud Expo Hall**

Wednesday, Nov 20

7:00 am – 5:00 pm **Registration and Information Desk Open**

8:30 am – 9:30 am **Opening Remarks & Keynote Speaker**

Living Life Intentionally
Michael A. Mason, former Senior Vice President and Chief Security Officer, Verizon Communications, and former Executive Assistant Director, Federal Bureau of Investigations

9:30 am – 10:00 am **Coffee Break in the Anti-Fraud Expo Hall**

10:15 am – 11:15 am **Concurrent Sessions**

Small to Mighty: Maximizing Impact Through Focus on Three Core Elements
Join this informative presentation on building out Special Investigation Units (SIUs) and maximizing their impact. Learn how to build an effective team, analyze data, and conduct risk assessments. Discover the importance of crossing into Payment Integrity and understanding your leadership culture. Explore the benefits of showing value to growth through prevented loss, policy change, and recoupment. Finally, learn how to move from informal to formal risk assessments, create workgroups to break down silos, and choose the right members for your team. Unlock your team's potential and maximize your impact through three core elements.

- Rocco Cordato, IV, AHFI, ACAMS, Director, Special Investigations Unit & Payment Integrity, MVP Health Care
- Cambria Day, Program Integrity Unit Manager, Health Plan of San Joaquin

Prevention Methodologies for Fighting Fraud
The presentation will be directed at attendees interested in the development and enhancement of FWA investigations through the successful use of proactive datamining, prepayment review, and related techniques. The demonstrated model will lean heavily on addressing FWA though the employment of various proactive techniques. The session will include multiple case studies with real case examples of successful FWA investigations developed and enhanced using these techniques. The examples will cover a broad spectrum of investigations that led to significant loss prevention as well as successful prosecution. These examples will include ER/EM, ABA (Autism treatment), Physical Therapy, Lab testing as well as Behavioral Health and

member fraud examples. The overall investigative process will be discussed and demonstrated through identification, investigative action taken and ultimate results. Throughout the session the attendees will be provided with the actual codes or series of codes impacted as a result of the investigation (CPT, HCPCS, ICD10, REV, etc.)

- John Houston, Director, Elevance Health, Inc.
- Joan Cooper, Director, GBD &CSBD Pre-Pay Review, Elevance Health, Inc.

Annual HHS OIG Pharmaceutical Trends Update *AAPC Approved*
This annual presentation will showcase the latest intel trends in pharmaceutical frauds and industry progression. The faculty will analyze the new and evolving schemes, review data, utilization trends, new emerging drugs, as well as the costs of those drugs.

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

Identifying Fraud in Special Stains and Outpatient IV Insulin Infusion Therapy
Through data mining, internal referrals, and vendor leads, the Blue Cross and Blue Shield of Louisiana (BCBSLA) Financial Investigations Department (FID) identified two new potential health care FWA schemes - Inappropriate Billing of Special Stains (CPT codes 88312 and 88313) and Experimental Outpatient IV Insulin Infusion Therapy Investigative Steps. Participants in this session will gain a better understanding of the processes that are to be followed to provide for appropriate billing of 'special stains' so they can idenitfy FWA in their own claims. In addition, participants will gain insight into what outpatient IV infusion is, what is considered nationally 'non-covered' and how billing can be manipulated to allow for payment.

- Kandyce Cowart, AHFI, CFE, Manager, Special Investigations, Blue Cross and Blue Shield of Louisiana
- Latisha Mire, AHFI, CFE, Director, Financial Investigations, Blue Cross and Blue Shield of Louisiana

Sprint Through the Finish!
Hear unique insights and gain expert knowledge from two seasoned FBI agents as they prepare to retire. Brief case presentations will cover a wide range of recent health care fraud schemes such as dental fraud, home health care fraud, and international claims fraud by a college student studying abroad. They'll share some of what they've learned over the years including the simple principal of concentrating on the lie being told. Health care fraud schemes can be complex, and fraudsters can be impressive liars, but fraud is simply a lie for money. Participants will hear about three cases and the unique challenges and successes of working in different jurisdictions with many different valued investigative partners, and the sometimes painful and sometimes hilarious process of trying to bring mature cases to fruition despite unforeseen obstacles.

- Jessica Marrone, Special Agent, Federal Bureau of Investigation
- Joseph S. Parker, Jr., Supervisory Special Agent, Federal Bureau of Investigation

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How Artificial Intelligence (AI) is Impacting Payment Integrity
Presented by MultiPlan, a NHCAA Platinum Supporting Member
As healthcare fraud, waste and abuse (FWA) becomes more sophisticated, there is an increased focus on leveraging AI in partnership with clinical expertise. In this session we will discuss how to create an effective collaboration between data scientists and physicians/medical coders, with step by step touchpoints. Using the new and expanding healthcare practice of concierge medicine as an example, we will explore how to approach a focused area and how to create a dialogue between doctor and data.

- Marla Ludacka, Vice President, Payment Integrity, MultiPlan
- Ben Perryman, Vice President, Data Science Operation, MultiPlan

Combatting Medicaid Fraud: Tech-Driven Strategy to Derisking your FWA Plan
Presented by Alivia Analytics, a NHCAA Platinum Supporting Member
Learn how one health plan is leveraging cutting-edge technology and refined operational processes to derisk their organizations. This session will showcase a collaborative approach between Alivia and CareSource that has enhanced the Special Investigations Unit's (SIU) focus on advanced AI tools, process optimization, and measurable improvements. Examine how this partnership maximizes the SIUs functions to remain in regulatory compliance, generate leads, and manage reporting requirements ultimately leading to significant cost savings and operational efficiency.

- Kelly Anderson, Vice President of Program Integrity, CareSource
- Matthew Perryman, FWA Technology Expert and Senior Data Scientist, Alivia Analytics

11:30 am -12:30 pm **Concurrent Sessions**

Legal and Medical Issues for Health Care Fraud Investigators *AAPC Approved*
This presentation will address the interplay of legal and medical issues related to healthcare fraud investigations in a straight-forward manner designed for investigators and analysts. The faculty will draw on many years of medical and litigation experience to summarize the key topics that every investigator should know. Recent case examples will be provided to highlight how best to leverage internal resources and maximize recovery. Some of the key topics covered in this presentation include a review of key statutes that effect healthcare fraud and a discusion about the most significant legal and medical issues of 2024. Participants will feel better prepared to ensure that all investigations meet the necessary legal and medical standards, and the value of incorporating Medical Directors in their investigative processes.

- Daniel Lyons, Senior Managing Counsel, Aetna
- Saleen Manternach, MD, Medical Director, Aetna

Connecting the Docs: Network Analysis for Fraud Detection
Graph Analytics, or network analysis, is a growing analytical technique used in fraud detection. In this session, the faculty will take the audience through a high-level overview of how this can be used to identify relationships and networks. The faculty will

begin by reviewing graph analytics, including discussing graph components, types of graphs, and the importance of this methodology in fraud detection and prevention. The faculty will also discuss visualization techniques and graph algorithms, as well as demonstrate how networks can develop and look using color-coded building blocks. Using publicly available data, the faculty will show how to calculate centrality statistics that can evaluate the strength of identified connections and how these statistics can be used within a machine learning model to help boost model performance.

- Kelly McDonough, Senior Manager, Fraud Analytics, Evernorth Health Services

Local Fraud Trends Having National Implications: Fighting Outside the Box
This presentation is a strategic overview of new and continuous health care fraud schemes/trends with a national impact. Leadership from the HHS-OIG Miami Region will discuss strategy and tactics for utilizing limited resources to combat fraud schemes, including patient lead brokering, genetic testing, DME, HIV drug counterfeiting, etc. Senior and mid-level leaders will use exceptional case study examples to explain how resources were allocated to investigate and deter fraud nationwide.

- Stephen Mahmood, Special Agent in Charge, U.S Department of Health and Human Services, Office of Inspector General, Miami Regional office
- Ricardo Carcas, Assistant Special Agent in Charge, U.S Department of Health and Human Services, Office of Inspector General, Miami Regional office

Behavioral Health Provider FWA Scheme *AAPC Approved*
Join us on this journey into the forefront of healthcare billing integrity, and discover the latest tools and expertise needed to protect the organization and patients from the ever-evolving threats of fraud, waste, and abuse (FWA). The presentation highlights the pressing need for behavioral health services, citing the significant prevalence of mental health and substance use disorders among the U.S. population. While health plans are working to address this demand, the complex nature of behavioral health treatment creates vulnerabilities to FWA. This session will examine specific cases investigated by the SIU, showcasing how providers are being compared to each other to identify potential FWA schemes including unusual billing patterns, overutilization of services, and questionable treatment protocols. By sharing this presentation, we'll provide valuable insights into the challenges of behavioral health service reimbursement and the importance of vigilant monitoring to prevent FWA.

- Todd Kasdan, MD, Senior Medical Director, Behavioral Health Quality, CVS Health
- Lyn Delaney, Senior Decision Scientist, CVS Health
- Neha Ruhela, Senior Manager, Data Science, CVS Health

Overprescribing and the Impossible Day
This presentation involves a recent criminal case against Dr. Fazal Panezai, a cardiologist with a penchant for freely prescribing controlled drugs without a legitimate medical purpose. After receiving a referral from a local police department stating that

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Dr. Panezai was running a 'pill mill', the investigation took a few twists before ending in federal charges of health care fraud for billing both government and private insurers for offices visits that never took place. The investigative team utilized advanced techniques as well as complex data analysis to show that the solo practitioner was claiming to work extremely long days. Attendees will learn how to work smarter, not harder, when it comes to analyzing billing data from a doctor's office, how to use advanced investigative techniques to gain evidence to corroborate data, and how to utilize a holistic approach to an investigation, incorporating operations, intel and data analysis for a successful result.

- Katie Holden, Supervisory Special Agent, Federal Bureau of Investigation
- Tara Manley, Intelligence Analyst, Federal Bureau of Investigation

Beyond the Hype: Applying GenAI in Payment Integrity
Presented by Shift Technology, an NHCAA Platinum Supporting Member
Generative AI (GenAI) is everywhere we turn. The hype is as big as for any technology in recent memory, and its future uses seem limitless. But it's not all hype and potential. GenAI use cases and value propositions are real, especially within payment integrity. GenAI is impacting critical stages of the payment integrity lifecycle. From enhancing claims editing, to accelerating medical record review, to keeping up with the ever-evolving policy and care delivery landscape - GenAI has the power to drive incredible value for plans. Faculty will share which technologies and Large Language Models (LLM) are the foundation for AI and GenAI adoption; and share use cases and business processes in which adopters are seeing a significant impact from the use of GenAI including claims editing and medical record review. In addition, the faculty will demonstrate how GenAI will change the payment integrity landscape in the short and long term.

- Mark Starinsky, AHFI, CFE, CHC, SE, Product Lead, Shift Technology
- Jesse Montgomery, Head of US Healthcare Customer Success and Value Engineering, Shift Technology

Gaining Dental FWA Insights from Industry Professionals *AAPC Approved*
Presented by Cotiviti, an NHCAA Platinum Supporting Member
Every health payer should be on the alert for fraud, waste, and abuse (FWA), but for payers in dental services, "at risk" dollars are considerably lower than those of medical services. As a result, many dental payers have developed a habit of overlooking incorrect billing. But overlooking even minor overpayments is a slippery slope, which can lead to providers continuing to bill inappropriately—and possibly more often. A major problem for dental payers that often goes unchecked is waste, or billing for medically unnecessary services. Waste in dental services not only affects the dental plans, but it inaccurately deducts from their members' yearly maximum benefit, potentially leaving insufficient funds for other necessary procedures. Hear from an industry panel about effective techniques to identify, prevent and investigate dental fraud, waste, and abuse.

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- Thomas Redd, DDS, Vice President, Professional Relations, Delta Dental of Arkansas
- Steven Canfield, DDS, Senior Dental Director, Cotiviti, Inc.
- Ryan Cleverly, AFHI, CSPO, Product Director, Fraud, Waste, & Abuse, Cotiviti, Inc.
- Meagan Baxley, MBA, RDH, Dental Investigator II, Cotiviti, Inc.

12:30 pm – 1:45 pm **Lunch in the Expo Hall**

1:45 pm – 2:30 pm **Awards Ceremony**

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

Untapped Opportunity for Preventing Fraud *AAPC Approved*
Examine some the under-utilized resources available to those performing Payment Integrity work in the Medicare space and how enforcing "little-known" rules already on the books can derail even the hottest trends in FWA. The faculty in this session will demonstrate how to leverage these resources to prevent improper payments and initiate recoupment of overpayments with the ultimate goal of altering provider behavior and forcing them to move on to the next scheme. As investigators, we all use policies to help guide our clinical decision-making, but there are many policies and guidelines that are unexplored and untapped. The faculty will take a dive deep into the Federal Register as well as the Social Security Act and the NCCI to examine a few interesting areas that have completely revolutionized how to perform medical reviews. The faculty will also share potential edit-setting opportunities.

- Tameika Lewis, Medical Director, Program Integrity, Optum/WellMed
- Cheryl Ray, Senior Medical Director, Payment Integrity, Optum/WellMed
- Maria Ishmael, Data Analyst, Optum/WellMed

Navigating Case Investigation Analytics
This presentation will take the attendee through the process of interpreting an investigative request, planning the approach, and staying on-course in the face of pitfalls, setbacks, and floods of data. The faculty will focus on tips, tricks and techniques, situational examples, and the decision-making processes. They will explore setting appropriate expectations and documenting analytics in support of a case investigation. The faculty will also review how to incorporate various types of research, leverage internal and external datasets, and tie those different analytic results together to further the investigation. The faculty will focus on Open-Source Intelligence (OSINT), Social Media, and manual research techniques and address the creation of visualizations to ensure the results of the analytics are transformed into link charts, reports, maps, and graphs that easily convey the findings to the specific audience.

- Donna Jallits, AHFI, CPMA, Business Analytics Senior Advisor, Evernorth
- Shawn Lipsey, Business Analytics Advisor, Evernorth

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GLP-1's Misuse: Addressing Health Plan's Responsibility for Patient Safety
Due to unexpected spikes on the Rx trend reports, the Financial Investigations Department (FID) and Analytics, Pharmacy and Quality Improvement teams at BCBSLA coordinated to create a pilot study to determine the causality. Based upon a review of both pharmacy and medical data, it was suspected that BCBSLA was paying for various Glucagon-like peptide 1 medications (GLP-1) for non-covered diagnoses. Learn how the investigative team uncovered a suspected scheme whereby providers were using a third-party entity that completed their prior authorizations. The faculty will share the lessons learned and the steps taken to correct the matter with Medicare and Commercial lines of business.

- Alan Lofton, Manager, Special Investigations, Blue Cross and Blue Shield of Louisiana
- Kandyce Cowart, Manager, Special Investigations, Blue Cross and Blue Shield of Louisiana

The More Things Change, The More They Stay The Same
Dentistry has taken several hits in the last few years. If money is tight, going to the dentist gets put at the bottom of the list. This scenario has driven some dentists to become creative to keep their businesses profitable. The presentation will present new schemes in recent years as well as some of the golden oldies that never go away. You will see how a scheme is discovered, the investigation process, and the results of the investigation. Recently, our research showed dentists are misusing CDT codes for procedures to increase revenue for all categories of treatment, not just the higher reimbursement procedures which have always been areas that are misused. Our studies show that dentists are submitting or charging patients for CDT codes that were often never charged to the patient or submitted on a claim because they are considered by most dentists to be routine parts of other dental procedures.

- Patricia Shifflett, Clinical Fraud Analyst, Delta Dental of Virginia
- Carmen Hardin, Clinical Fraud Analyst, Delta Dental of Virginia

The Thrill of the Doc Chase: Unraveling Newfound Fraud Mechanisms in the Post-"Double Helix" Era
Following the shockwave of multiple back-to-back nationwide healthcare fraud enforcement operations, including Operation Brace Yourself, Operation Double Helix, and Operation Rubberstamp, the co-conspirators transitioned into the laboratory ownership space. They opened multiple shell laboratories and call centers to implement a new "doc chase" method to generate orders for cardiac genetic tests that were then processed by a reference laboratory and billed through the shell laboratories. In just over 10 months, the conspirators caused over $67 Million in loss to the Medicare program from the false claims that were submitted as a result of their cardiac genetic testing fraud scheme. This presentation gives an in-depth look at how the healthcare marketing world in South Florida has a global impact on healthcare fraud, how Daniel Carver and his co-conspirators revolutionized fraud by employing the newfound doc chase method, and how to identify these fraud schemes using data analytics to aid in the prevention of their proliferation.

- Jasmine Walker, Special Agent, U.S. Department of Health & Human Services, Office of Inspector General
- Monique Butler, Special Agent, U.S. Department of Health & Human Services, Office of Inspector Genera
- Tony Senat, Special Agent, FDIC-OIG, and former U.S. Department of Health & Human Services, Office of Inspector General
- Reginald Cuyler, Jr., Trial Attorney, U.S. Department of Justice

Mind Your Ps and .... Well, Maybe Just your Qs.... *AAPC Approved*
Presented by Healthcare Fraud Shield, a NHCAA Platinum Supporting Member
This presentation will empower investigators and analysts to identify and understand common FWAE (Fraud, Waste, Abuse, and Error) schemes associated with improper Q billing. This includes exploring examples of upcoding, unbundling, and medically unnecessary services and more. The session will teach techniques to recognize red flags that signal potential misuse of Q codes, enabling you to flag suspicious billing practices. For example, many plans may unknowingly be the target of FWAE surrounding wound care billing using Q4205 which may be miscoded and may not be a covered service. Attend this session to learn about the different Q codes of concern.

- Margaret Cox, AHFI, CFE, CPC, Program Integrity Solutions Expert , Healthcare Fraud Shield
- Karen Weintraub, AHFI, CPC-P, CPMA, CDC, Executive Vice President, Healthcare Fraud Shield

Get The Complete Picture Fast: Provider-Centric FWA Prevention & Investigation
Presented by 4L Data Intelligence, a NHCAA Platinum Supporting Member
SIU leaders can agree that many investigations are too time-consuming, too labor-intensive, and usually too late to stop fraud and abusive billing from occurring. And one more rules-based, claims data-centric editing technology in the stack isn't going to solve the problem of not being able to see dynamic provider behaviors, relationships, and outliers that lead to overpayments. This session will cover the benefits of the provider-centric approach to FWA prevention & detection powered by a dynamic, behaviors and threat-detection based platform like Integr8 AI Risk Detection™ technology. This "Know Your Provider" (KYP) capability provides insights into provider integrity, behaviors, and relationships in near real-time, around a claim and all claims. This next generation AI technology, coupled with continuously (daily) updated provider demographic, ownership and integrity data, enables payment integrity and fraud/SIU teams to quickly initiate investigations with access to comprehensive supporting data. The result is more timely and efficient investigations, along with the ability to reduce exposure by making pre-adjudication and pre-payment determinations.

- Greg Lyon, Senior Fraud Advisor, 4L Data Intelligence, Inc.
- Karthik Govindan, Chief Product & Transformation Officer, 4L Data Intelligence, Inc.

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

Team Motivation: Lighting a fire that doesn't burn out
According to a 2024 Global Talent Trends report, more than eight out of ten employees are at risk for burnout. Healthcare fraud professionals are feeling the pressure as fraud trends continue to evolve and case numbers rise. As leaders, how can we promote an environment that not only motivates our teams but helps to overcome feelings of burnout. This is particularly challenging with virtual work environments and teams dispersed nationwide. The geographical spread can hinder meaningful connections among employees, often leading to isolation, burnout, and a dip in motivation. This session aims offer insights on how to bridge this gap by focusing on virtual team unity, providing a platform for idea exchange, and utilizing Artificial Intelligence (AI) to ease the administrative burden placed on investigators and enhancing team culture to combat burnout. Lastly, the faculty will share their leadership style, which has helped to energize staff and ward off burnout.

- Jacquelyn Edwards, Investigations Manager, UHC
- Samantha Osbon, Investigations Manager, UHC

Navigating Potential Prior Auth Roadblocks: A DME Case Study
Often investigators encounter roadblocks when there is an existing prior authorization on a claim and may not feel they can pursue an investigation believing their hands are tied. Through a case study, this presentation will illustrate the importance of overcoming these hurdles and highlight useful strategies to navigate roadblocks associated with prior authorizations. The presentation features a durable medical equipment case where the provider appeared to demonstrate adherence to prior authorization standards, but had crafted a scheme, built on submitting falsified medical records & information to obtain prior authorization approvals. The presentation will explore the data analytics used to uncover the provider's scheme and monitor evolving tactics, while emphasizing collaborative discussions surrounding prior authorizations. The presentation will also discuss the importance of collaborating across multiple teams and to showcase the attention to detail in uncovering critical evidence.

- Whitney Organ, Investigator, Humana, Inc.
- Kerry Spencer, Senior Investigator, Humana Inc.

What's New in Remote Patient Monitoring *AAPC Approved*
The rapid rise of Remote Patient Monitoring (RPM) is driving trends across the health care industry. The faculty will provide updates to RPM and Remote Therapeutic Monitoring (RTM) services, including coding/billing issues of interest to both the private and public sector. Updated summary data and statistics will be presented along with geographical analysis. Participants will learn about the current clinical application of RPM and RTM along with new service types due to advancements in technology. Recent developments and future fraud trends will be presented across a broad scope of related service types and will include a discussion of other health care categories at risk for duplicate billing with RPM. Attendees will be presented with an overview of current enforcement efforts including completed cases and sanitized investigative examples.

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The presentation will include new educational products developed to assist members with program integrity efforts in this area.

- Jennifer Trussell, Fraud Prevention Consultant, SMP Resource Center
- Michael Cohen, DHSc, JD, PA-C, Operations Officer, U.S Department of Health and Human Services, Office of Inspector General, Office of Investigations

Inside the Mind of a Health Care Fraud Offender
From 2012 until 2016, Alec Burlakoff was the Vice President of Sales for a large pharmaceutical company. He and six co-conspirators were indicted and arrested on RICO charges stemming from bribing physicians to prescribe Subsys. Subsys is a sublingual fentanyl spray indicated for opioid tolerant patients 18 years or older who suffered from cancer pain. The pharmaceutical company set up a call center that misled insurance companies regarding the patient's diagnosis in an effort to obtain a prior approval of Subsys. Alec Burlakoff plead guilty to the charges and agreed to testify for the government. Alec Burlakoff served 26 months in federal prison. Alec Burlakoff will be interviewed about his motivations to commit the scheme, and potential schemes he may have perpetrated had he not been arrested. Alec Burlakoff will discuss and provide advice on how to build rapport with targeted individuals and how payors can effectively identify fraudulent activity.

- Paul Baumrind, Specialist Master, Deloitte
- Alec Burlakoff, former Vice President of Sales

Stopping New FWA in Medicare Advantage with Context-Aware AI
Presented by Health at Scale, a NHCAA Platinum Supporting Member
With rising medical utilization, diminished prior auth, and greater regulatory scrutiny, Medicare Advantage plans now more than ever must adopt new technologies to uncover emerging FWA schemes. But with these new ways of uncovering more leads, how do SIU teams cut through the noise of false positive leads to prioritize those that are actual fraud and abuse? During this presentation, Health at Scale and SIU leaders will discuss the impact seen from implementing precise, context-aware artificial intelligence into pre-adjudication – and how the team was successfully able to reduce overall medical spend by 1.8% through real-time flagging of a highly targeted and prioritized set of fewer than 0.1% of claims.

- Mohammed Saeed, MD, Chief Medical Officer, Health at Scale

Atherectomies and Other Endovascular Procedures: Don't Let This Cleaning Procedure Clean You Out *AAPC Approved*
Presented by GDIT, a NHCAA Platinum Supporting Member
Lower extremity Peripheral Artery Disease (PAD) is the narrowing or blockage of the arteries that carry blood from the heart to the legs. The number of individuals with PAD is expected to grow with treatment costs estimated to exceed $20 billion a year. Originally addressed via open surgical techniques in a hospital setting, further advances made it possible to safely perform these procedures in office-based laboratories (OBLs) which led to changes in reimbursement policy. During this presentation, faculty will review

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Healthcare Fraud Prevention Partnership study results conducted against its cross-payer data. They will examine providers submitting claims for endovascular procedures that might indicate excessive services per member. Changes in payer reimbursement rates for PAD procedures may lead to the performance of unnecessary services that could also result in patient harm. The data analysis includes angioplasties, atherectomies, stents, and intravascular ultrasounds performed in the lower extremities.

- Jessie Silverman, AHFI, CFE, CPC, CEMC, Partner Liaison, Trusted Third Party (TTP), Healthcare Fraud Prevention Partnership (HFPP)

5:00 pm – 6:30 pm **Reception in the Anti-Fraud Expo Hall**

Thursday, Nov 21

7:30 am – 4:30 pm **Information Desk Open**

8:00 am – 9:15 am **General Session**

Annual Panel: Federal Agencies Fighting Health Care Fraud

- Dara A. Corrigan, Deputy Administrator and Director, Center for Program Integrity, Centers for Medicare and Medicaid Services
- Christian Schrank, Deputy Inspector General for Investigations, Office of Inspector General, U.S. Department of Health and Human Services
- Laura Walker, CPA, CFE, Unit Chief, Health Care Fraud Unit, U.S. Department of Justice, Federal Bureau of Investigation

9:15 am – 9:30 am **Coffee Break**

9:30 am – 10:30 am **General Session**

Artificial Intelligence: Changing the Fraud Fighting Landscape

- Matthew H. Berls, MA, AHFI, Vice President, SIU & Data Intelligence, UnitedHealthcare Investigations
- Michael Cohen, DHSc, JD, PA-C, Operations Officer, U.S Department of Health and Human Services, Office of Inspector General, Office of Investigations
- Timothy Dineen, CFE, Sr. Director, Special Investigations, Discovery & Recovery, and Payment Integrity, Horizon Blue Cross Blue Shield of New Jersey (moderator)
- Kurt Spear CFE, CISSP, Vice President, Financial Investigation and Provider Review at Highmark Blue Cross Blue Shield

10:45 am – 11:45 am **Concurrent Sessions**

A Strategic Approach to Fraud Risk Management and Assessment

Creating a strategy for managing health care fraud risk by implementing an effective compliance risk assessment process can be crucial for an effective compliance program. This session will demonstrate how to conduct risk assessment using a simple

four step process, including identifying and analyzing various risk inputs or data sources. The presentation will include analyzing different data inputs (internal organizational data and external sources e.g., reviewing regulatory requirements, investigation data, policies, audit results, CMS updates, OIG work plan, NHCAA, etc.) to assess risk. The results of the risk assessment are used to develop an annual work plan to mitigate fraud risks.

- Maryann Blume, Manager, Investigations Strategy and Decision Unit, Kaiser Permanente
- Jeff Fairbanks, Sr. Manager, Special Investigations Unit, Kaiser Permanente

Beyond Random Chance: Effective Sampling Techniques for FWA Investigations
AAPC Approved
This presentation delves into the world of Fraud, Waste, and Abuse (FWA) investigations, exploring the critical role of sampling techniques in uncovering misconduct and the impacts on the investigation. The faculty will move beyond the limitations of random chance by examining real-world case studies, with a specific focus on ambulance codes and other case examples. Through these case studies, we'll unveil how strategic sampling methods can significantly enhance the effectiveness of FWA investigations. They will explore various techniques and delve into the strengths and weaknesses of each, demonstrating how the chosen approach can dramatically impact the outcome of your investigation.

- Kristin Griego, Program Director, Molina Healthcare
- Karen Weintraub, Executive Vice President, Healthcare Fraud Shield

SMP Super Scams
In this session, representatives of the Senior Medicare Patrol (SMP) Program will provide an in-depth look at the program's top Medicare fraud trends. These trends include new variations on common schemes such as hospice, home health, and durable medical equipment, and unique emerging trends such as urinary catheters and care management scams. The faculty will highlight the continued prevalence of COVID test kit fraud, despite an end to the public health emergency, along with analysis of the suspected involvement by criminal enterprises. The session will include a discussion of remote patient monitoring and how this trend is mingling with other service types. New medical identity theft strategies will be discussed and recent red flag indicators that scammers are building and sharing identity theft portfolios will be addressed. The presentation will also include new products and processes created by the SMP to for community partners, law enforcement, and the public.

- Jennifer Trussell, Fraud Prevention Consultant, SMP Resource Center
- Marissa Whitehouse, Senior Medicare Patrol (SMP) Program Manager, Administration for Community Living (ACL)

JAWS: Financial Penetration with Oral Surgeries *AAPC Approved*
Maxillofacial surgery advancements with cutting edge technologies has evolved into an area of signficant abuse for cosmetic and non-covered services billed to medical plans. Complicating this are the differences between CPT and CDT codes. Dental insurance

only allows CDT codes and have financial caps less than $2000, where medical insurance has no limit and CPT codes don't specifically identify the dental procedures performed. Venture capitalists are disrupting the dental industry by financing and purchasing large practices, often promoting unnecessary procedures. This presentation will identify the most common oral surgery procedures billed to medical plans, identify the most common codes misrepresented and clinical schemes. Medical review staff will gain an understanding into the complex language of dentistry to enhance investigations.

- Rae A. McIntee, DDS, MD, MBA, FACS, CPE, Medical Director Clinical Solutions, Blue Cross and Blue Shield of Louisiana
- Lawrence Simon, MD, MBA, FACS, Medical Director, Blue Cross and Blue Shield of Louisiana

ABC, It's (Not as) Easy as 123: Genetic Testing Meets the AKS
In December 2019, twelve individuals from three states were charged for their roles in a healthcare kickback conspiracy. According to information presented in court, the defendants conspired with each other to pay and receive kickbacks in exchange for the referral of, and arranging for, health care business, specifically pharmacogenetic (PGx) tests. This complicated case was built through a partnership between the agents working with claims data and financial data. The faculty will share how the investigative team reviewed administrative investigations conducted by HHS-OCIG to gain insight on the referral sources to generate leads and leverage OCIG settlements to facilitate witness interviews. They will also share how the team mined data to identify and locate other referral sources and then conducted financial investigations to corroborate the data and provide more information about the financial arrangements between referral sources, "marketing" organizations, and providers. Finally, the faculty will share their lessons learned from this complex, nationwide case.

- Nathaniel Kummerfeld, Branch Chief, United States Department of Justice, United States Attorney's Office for the Eastern District of Texas
- Jason Rennie, Special Agent, Federal Bureau of Investigation
- Adrian Garcia, Assistant United States Attorney, United States Department of Justice, United States Attorney's Office for the Eastern District of Texas

Electronic Visit Verification (EVV) Challenges and Opportunities
Presented by Deloitte, a NHCAA Platinum Supporting Member
Medicaid Home and Community-Based Services (HCBS) have long been vulnerable to abuse. The 21st Century Cures Act attempted to address that by requiring states to implement Electronic Visit Verification (EVV) for all Medicaid personal care service visits by January 1, 2020; and home health care visits by January 1, 2023. From a program integrity standpoint, there is much to like about EVV – a system that confirms the time and place that a provider or caregiver rendered services. As in other Medicaid Enterprise System projects, states can apply for federal financial participation (FFP) match. So how has the first year of EVV been going? This session examines the current state of EVV programs across the nation, challenges states are facing in this complex integration of mobile apps, data aggregation, claims reconciliation, typical fraud schemes that impact

home-based care, and opportunities to enhance program oversight once EVV programs are up and running.

- Gary Cantrell, Specialist Leader, Deloitte, and former HHS OIG, Deputy IG for Investigations

Ah the Miracle of Childbirth…in Two Different Settings? *AAPC Approved*
Presented by Codoxo, a NHCAA Platinum Supporting Member
This session will discuss how MVP Healthcare discovered a scheme involving a birthing center and midwifes billing for childbirth in the facility setting and in the home setting. The scheme involves one specific birthing center, several midwife providers, and nearly 100 patients over several years. This session will outline how MVP reviewed providers involved with this scheme using AI tools and the steps taken to identify the claims at risk, all involved providers, the medical records review process, financial recoveries and pre-pay assignment for the facility, and coordination with law enforcement.

- Sandra Caffarella, RN, CPC, AHFI, Leader of Investigations, Special Investigations Unit, MVP Health Care
- Derik Ciccarelli, Director, Fraud Scope Operations, Codoxo

11:45 am – 1:15 pm **Lunch in Expo Hall**

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

Balancing Effective Analysis and Investigation with Compliance and Audit Preparation
Medicare and Medicaid investigators navigate a sea of expectations defined by the CMS, state agencies, and the health plans they support. Adhering to these expectations requires a multitude of best practices designed to satisfy them. This presentation will identify the SIU's role in compliance program effectiveness. We will highlight the difference in an SIU's dotted or straight-line relationship with compliance. We will identify best practices in the SIU regarding compliance reporting while isolating the necessary elements of compliance program effectiveness. Next, we will define expectations in Medicare and Medicaid program integrity audits. We will address lead development, resource management, and timeline expectations. We will define the HPMS memo process and how to integrate it into audit-effective investigation methods. We will navigate the Medicaid audit process and discuss best practices for effective compliance. In short, we will identify and address effective SIU administration through the audit process of government healthcare programs.

- Wayne Fisher, MBA, AHFI, CFE, Manager, SIU, Elevance Health (formerly Anthem Inc.)
- Shannon Zabo, MPA, AHFI, CPC, Investigator Lead, SIU, Elevance Health (formerly Anthem Inc.)

Agenda

(updated September 3, 2024)

Inside the Black Box: Understanding AI for Modern Investigations
This presentation is designed to explore new developments in artificial intelligence (AI) and examine how they can be leveraged for investigative work. These developments include Large Language Models like ChatGPT, and generative models such as Stable Diffusion. The primary goal of this presentation is to provide a clear understanding of how AI models function and the underlying mechanisms that drive their results, thereby empowering users with the knowledge needed to effectively and responsibly use AI tools in their work. The session will begin with an introduction to basic AI concepts and terminologies, ensuring that all participants have a foundational understanding of what AI is and is not. The faculty will cover how different types of AI models are trained, how they process data, and how they make decisions. Each model will be broken down to explain its specific applications, strengths, and limitations within investigative contexts. Participants will gain insight into the critical challenges and ethical considerations involved in implementing AI in investigative work.

- Josh Myers, Business Analytics Advisor, Evernorth

Breaking Boundaries: Exploring the Potential of Off-Label Ketamine Assisted Psychotherapy *AAPC Approved*
This presentation will address an emerging trend with off label use of Ketamine for behavioral health diagnoses. Magellan will highlight a behavioral health (BH) scheme where providers misrepresent the patient's condition and/or treatment provided, resulting in payment for medically unnecessary and/or non-covered treatment. This scheme involves billing for Spravato nasal treatment (billable) while administering Ketamine IV infusion treatment (non-billable). Additional schemes will be discussed to include upcoding practices; billing for impossible days; services not rendered by the billing provider; and billing duplicative services. This presentation will include a discussion of the use of Spravato and Ketamine for BH members, review how the provider scheme was uncovered, how to proactively data mine for this issue, and identifying red flags in claims data and medical records.

- Michelle Coates, LMSW, SIU Investigator, Magellan Healthcare
- Allison Smith-Holness, LCSW, AHFI, CPC, Senior SIU Investigator, Magellan Healthcare

Dental Data Mining Through the Eyes of an Investigator to Maximize Performance.
In this session, participants will gain insight into how data analytics has been used to identify offices billing for codes often abused, or other patterns that show possible FWA. For example, D2391 & D2392 restorations vs. preventative resin restorations, endo code D3910, and D7140 vs. D7111. The faculty will review what to look for in the data and show in the records received from the offices that support the initial data mining. The faculty will also discuss the possible next steps after the abused codes have been verified through data mining. The participants will hear what steps can be taken to increase recoveries, bolster referrals, and provide much needed education to the providers.

- Amber M Wallisch, Lead Investigator, DentaQuest

- Kimberly Ericson, Lead Clinical Investigator, DentaQuest

Whack a Mole: Identifying suspicious providers involved in the shell game
Every city, county, and state across the country is experiencing an increase in unhoused populations many of whom are Medicaid members in need of behavioral health care services. In this session participants can gain a strong understanding of how to look at the provider billing practices targeting these vulnerable populations. The faculty will share lessons learned about this scheme, discuss how to identify those providers and their tactics, and share insights from case scenarios. Participants will gain insight from the MFCU perspective through stories of successful prosecutions involving this scheme. The goal of the session is to shed light on this issue that impacts many Medicaid programs across the nation, provide investigators with some tools to look at these scenarios, and hopefully spark conversation and engagement amongst our peers regarding this issue so we can all develop more expertise.

- Teresa Cooper, Program Integrity Manager, Elevance Health
- Andrew Schulke, JD, Chief Deputy Attorney General, State of Nevada Office of the Attorney General

Vendors – The risk hiding in plain sight
Presented by SAS, a NHCAA Platinum Supporting Member
While SIUs focus on risks from providers and members, there is a huge amount of spending that happens with all types of health care organizations, be it payers, facilities or pharmaceutical firms. That spending flies just under the radar in the form of the procurement to payment life cycle with all of their other vendors. From capital expenditures to IT, purchasing cards and travel to goods and supplies, organizations of size are sending billions of dollars out the door with little in place besides an ERP system and approval processes. We will highlight the significant risks posed by lax internal controls, separation of duties to collusion and kickbacks, payments without any goods received to vendor identity theft that are making headlines. We will discuss an approach using data and AI to close the gap, identifying risks that are easy to take rapid action on to gain ROI and without the external barriers as traditional provider cases.

- Tom Wriggins, Sr. Manager, Health Care and Social Benefits Fraud and Compliance, SAS
- Carl Hammersburg, Sr. Manager, Government and Health Care Fraud and Compliance, SAS

Best practices for using machine learning to optimize SIU decision-making
Presented by Optum, a NHCAA Platinum Supporting Member
Conducting fraud investigations can be complex, expensive and time-consuming for health plans. Plans need to consider innovative ways to support their SIU teams to improve efficiency and maximize fraud prevention and recovery while maintaining accuracy and consistency. In this session, Optum experts will share how health plans can leverage machine learning and natural language processing technology to support their SIU teams' decision-making in fraud investigations. Attendees will learn best practices for leveraging historical data to identify missing or mismatching information

on medical records associated with a high volume of denials. The speakers will share their AI-derived insights to assist the SIU team in making a pay or deny decision and implementing machine learning-enabled decision support into your existing fraud programs.

- Daniel Robinson, Product Director, Payment Integrity, Optum

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

Transforming Your Role as a Leader

The idea of leadership may seem easy until you are faced with situations that force you to pivot from your typical thought patterns and challenge your ability to lead through change, strengthen communication, and enhance your team dynamic. This presentation will focus on building a cohesive team, retaining talent, and navigating the barriers you might face as a leader. Faculty will discuss ways to build an effective team from how you approach job candidate selection to navigating the evolving work environment. The faculty will address employee retention strategies, change management, and expectation setting. Through interactive discussion, participants will work through real world leadership scenarios.

- Jessi Clark, LMHC, CHC, AHFI, Senior Director, Clinical Investigations, Centene Corporation
- Courtney Rhodes, MA, LPC, AHFI, Manager, Clinical Investigations, Centene Corporation
- Lindsey Sanny, MA, LIMHP, LADC, CPC, Manager, Clinical Investigations, Centene Corporation

The Current Landscape of A.I. Generated Fraud Schemes

This presentation will showcase examples of how Artificial Intelligence can aid bad actors in carrying out large-scale fraud schemes with minimal financial investment and experience. The examples provided can be replicated by anyone with internet access and a connection to a healthcare provider. Large language models (LLMS) and generative AI platforms have made it easier than ever to carry out a variety of schemes. This presentation will show how specific AI platforms available the public can be used to submit fraudulent claims for service in Medicare, Medicaid, and private insurance settings. Replicating voices of real people to create coached calls for telemedicine, creating digital X-Rays, and even generating a provider's S.O.A.P. style patient care notes are just scratching the surface. AI is rapidly advancing in areas healthcare that provide excellent and legitimate results; but in the hands of bad actors, it can create a proverbial firestorm for program integrity units.

- Nicholas Palino, Investigative Analyst, U.S. Department of Health and Human Services, Office of Inspector General, Office of Investigations
- Shibin Shaji, Investigative Analyst, U.S. Department of Health and Human Services, Office of Inspector General, Office of Investigations
- Carlos Baixauli, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General, Office of Investigations, Office of Audit Services

Agenda

(updated September 3, 2024)

Admission Impossible: Identifying, Investigating, and Indicting Health Care Fraud Schemes

The presenters will discuss the criminal health care fraud case against Recovery Connection Centers of America, Inc. and how the agents worked closely with the CDC's Opioid Rapid Response Program (ORRP) to mitigate impacts to a multi-clinic practice in Rhode Island and Massachusetts with 1,800 patients taking buprenorphine and sublocade. This case is a real-world example of the importance of recognizing and anticipating interruptions in care for patients in recovery treatment, coordinating with public health officials to minimize the impact on patient care, and how law enforcement/program integrity units can work successfully with state public and behavioral health official to protect vulnerable patients without negatively impacting a criminal case. Participants will gain insight into the analytics that identified Recovery Connections and its employees as a concern. The discussion will go in-depth on the measures and coordinated efforts that took place months before criminal charges were filed and the execution of multiple arrests to mitigate harmful impacts on the patients and the partnership between public health and public safety, which all payors can utilize and develop within their organizations.

- Lindsay Walford, Special Agent, U.S. Department of Health and Human Services, Office of Inspector General
- Patrick Neubert, Opioid Rapid Response Coordinator, U.S Department of Health and Human Services, Office of Inspector General
- James Crowley, Special Agent, Federal Bureau of Investigation

Building Successful Investigative Teams Requires Collaboration, Communication and Initiative

Collaboration between state, federal and private sector health care fraud investigators can create a successful investigative team as long as there is communication and initiative to act on allegations. The panel will give examples of how they initiate health care fraud investigations, experiences collaborating with fellow panelist, what they have learned through these experiences and take aways to keep in mind through trial prep and testifying in federal court.

- Morning Johnson, Special Agent, OI IIJA Oversight Coordinator, U.S Department of Health and Human Services, Office of Inspector General
- Jacob Foster, Principal Assistant Chief, U.S. Department of Justice, Criminal Division, Fraud Section
- James Gawrych, Special Agent, Federal Bureau of Investigation
- Alex Kondratenko, CPC, AHFI, Manager, Special Investigations Unit, Blue Shield California
- Lauren McNulty, Senior Program Analyst, Division of Data Analytics, U.S Department of Health and Human Services, Office of Inspector General

Agenda

(updated September 3, 2024)

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

Unlocking Insights: Building Effective Collaboration between Analysts and Investigative Teams
Effective collaboration is essential in any fraud investigations, and can be the critical component in accurately identifying and proving a fraud allegation. Through a multipronged telefraud case study, the faculty will demonstrate how the SIU was able to adapt and modify the way they work to mitigate risk, reduce exposure and share information with law enforcement. The collaboration led to innovations in data storage and management, as well as the teams' ability to streamline identification leading to quicker actions. The faculty will highlight the importance of persistent and open dialogue between analysts and investigative teams to achieve successful investigations. Using the lessons learned, the faculty will also discuss ways in which they have learned to successfully break down barriers between teams with different primary functions. Attendees will gain insight on varying factors in an SIU that can obstruct teams from being able to effectively collaborate.

- Blake Stockwell, CPhT, AHFI, Fraud Senior Manager, Evernorth
- Bryan Kayser,MBA, Business Analytics Senior Advisor, Evernorth

Program Integrity in the Marketplace (Exchanges)
Over the last twelve months, CMS has received over 140,000 complaints from consumers alleging fraud in the ACA established, Federally-facilitated Marketplace. CMS has worked with Qualified Health Plans (QHP) to cancel thousands of policies for fraud based on consumer complaints and QHP investigations. In this session, participants will learn about the efforts of the Center for Program Integrity (CPI) to protect consumers, safeguards taxpayer dollars, and maintain the integrity of the Marketplace by preventing, identifying, and mitigating fraud, waste, and abuse. The CPI Marketplace Program Integrity team reviews Marketplace enrollments for outliers and trends related to large use of Special Enrollment Periods, a large number of zero-dollar plan premiums, and duplicate data across all consumers enrolled in the Marketplace. Additionally, the speaker will provide insight on how the CPI risk model identifies outliers, anomalies, and enrollment patterns that may indicate fraud.

- Beth Freshcorn, Marketplace Team Lead, Center for Program Integrity, Centers for Medicare and Medicaid Services

Hospice Fraud – Investigating the wrongful billing of Revenue Code 0650
AAPC Approved
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), the 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 fund that were wrongfully paid due to fraudulent billing practices by various hospice providers. The initiative demonstrates the advantage of a collaborative approach to addressing and solving a problem. 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 initiative and potentially apply aspects of it for their own organization.

- Michael J. Devine, PhD, Director, Special Investigations Unit, L.A. Care
- Frank Arteaga, MPA, AHFI, Lead Investigator, Special Investigations Unit, L.A. Care

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.

Friday, Nov 22

8:30 am – 11:00 pm **Information Desk Open**

9:00 am – 12:00 pm **Seminars**

Emotional Intelligence Deep Dive
"Emotional-social intelligence is a cross-section of interrelated emotional and social competencies, skills and facilitators that determine how effectively we understand and express ourselves, understand others and relate with them, and cope with daily demands." - Reuven Bar-On, 2005 Emotional Intelligence (EQ) is a predictor of happiness and overall well-being. Unlike your intelligence quotient (IQ) which is pretty set by the age of 17, your EQ continues to evolve with time and experience. Increasing one's EQ empowers the individual both professionally and personally by taking responsibility to enable growth and understanding. You move from "you made me feel X" to "I felt X" which allows a person to change perspectives. Luckily, you can fast-track this growth through targeted work. In this interactive session, the attendees will learn about EQ with a deep dive into each component. Attendees will have the opportunity to self-assess their own EQ and work on a development plan in the area of EQ interest.

- Aneta Andros, ACC, AHFI, Senior Director - Fraud Analytics, Evernorth-Cigna

Effective Preparation and Presentation Strategies for a Fraud Investigator's Civil Deposition Testimony
Testifying in a civil case can be challenging, but if you are prepared, it will be a less daunting and more successful endeavor. You will learn practical tips to improve performance when it counts the most, including skills to truthfully and artfully answer deposition questions, deal with problem areas and weaknesses in your case, and

protect yourself from credibility attacks, document ambush, fishing expeditions and other tricks and traps of opposing counsel. You will also hear practical tips to maintain your cool, avoid guesswork, and redirect attention back to your helpful facts and case themes.

- Patricia Lee, Partner Liaison Manager, Connell Foley LLP

Comprehend the Parallels and Distinctions between Commercial and Public Sector Dental Plans *AAPC Approved*
The annual revisions to the CDT Code frequently introduce new avenues that could potentially be exploited for dental fraud, waste, and abuse. These new possibilities, combined with emerging trends and persistently prevalent dental fraud schemes, necessitate investigators to continually alter and enhance their skill sets. This pivotal session aims to enhance investigative skills through the presentation of case examples involving traditional and emerging dental fraud schemes, prevalent in both Commercial and Public sectors, and potentially linked to the latest and upcoming CDT code updates. The session will also delve into potential teledentistry-related schemes and pinpoint medical cross coding highlighted in the provided case examples.

- Stewart Balikov, Director of Dental Special Investigations, National Dental Director Utilization Review, Elevance Health

Investigation of the Year Case Study
The recipients of NHCAA's 2024 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.

Annual Ethics Seminar *(under development)*

12:00 pm **Conference Adjourns**