Defense Health Agency

Program Integrity Operational Report

January 1, 2015
through December 31, 2015

"Guarding the Health Care of Those Who Guard Us"

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INTEGRITY • SAFEGUARD • OVERSIGHT • EXCELLENCE

Program Integrity Office

Mission

Our mission is to manage anti-fraud and abuse activities for the Defense Health Agency to protect benefit dollars and safeguard beneficiaries. Program Integrity develops and executes anti-fraud and abuse policies and procedures, provides oversight of contractor program integrity activities, coordinates investigative activities, develops cases for criminal prosecutions and civil litigations, and initiates administrative measures.

Vision

Our vision is to ensure the Defense Health Agency and its contractors have an effective anti-fraud program in place that can be considered a model of excellence for the industry, save valuable benefit dollars, and ensure high quality health care for beneficiaries.

Organization

Section 1.0 Defense Health Agency Program Integrity – General

On October 1, 2013, the Department of Defense (DoD) establish the Defense Health Agency (DHA) to manage the activities of the Military Health System (MHS). These activities include those previously managed by TRICARE Management Activity, which was disestablished on the same date.

TRICARE is the DoD health care program serving Uniformed Service members, retirees and their families. As a major component of the MHS, TRICARE brings together the worldwide health care resources of the Uniformed Services (often referred to as "direct care") and supplements this capability with network and non-network civilian health care professionals, institutions, pharmacies, and suppliers (often referred to as "purchased care").

The DHA Program Integrity (PI) Division is responsible for anti-fraud activities to protect benefit dollars and safeguard beneficiaries. This includes both the purchased care and direct care settings. DHA PI develops and executes anti-fraud and abuse policies and procedures, provides oversight of contractor program integrity activities, coordinates investigative activities, develops cases for criminal prosecution and civil litigation, and initiates administrative measures.

DHA PI reports to the DHA Business Support Directorate. This reporting structure facilitates DHA PI's anti-fraud activities. Because of the nature and scope of the work performed by DHA PI, its reporting line is separate and distinct organizationally from the day-to-day operational activities of other departments to avoid the appearance or potential of undue influence or conflict of interest.

To encourage the early identification of fraud, DHA PI engages in multiple proactive activities designed to identify areas that may be vulnerable to fraudulent and abusive billings. DHA PI develops areas of focus and analyzes claims data to identify outliers. Recognizing the importance of sharing information with the investigative community, DHA PI (often a presenter) regularly attends task force meetings, information sharing meetings, and healthcare anti-fraud meetings. These meetings foster collaborative anti-fraud efforts across government agencies and private organizations.

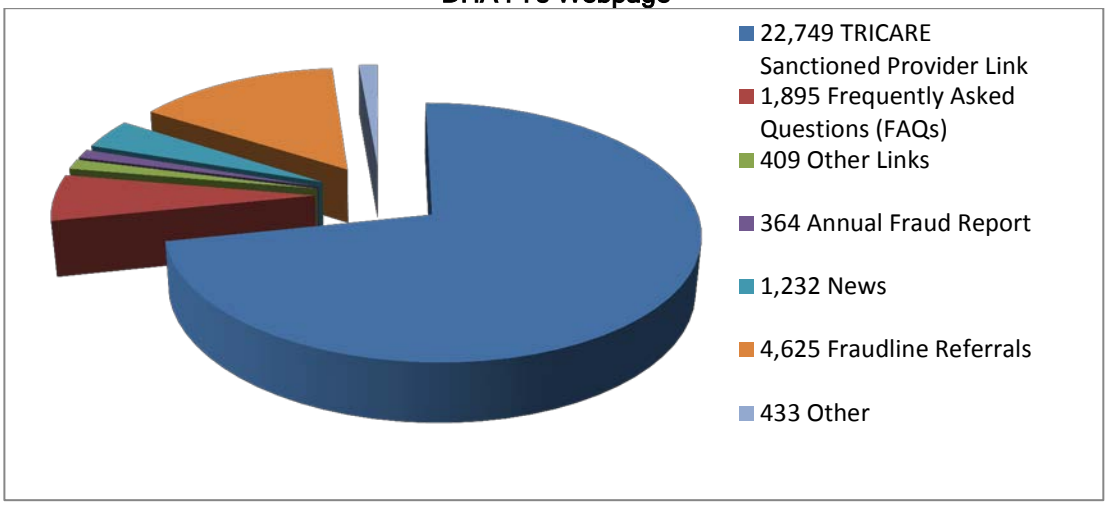
Through a Memorandum of Understanding, DHA PI refers its fraud cases to the Defense Criminal Investigative Service (DCIS). DHA PI also coordinates investigative activities with Military Criminal Investigative Offices (MCIOs), as well as other federal, state, and local agencies. DHA PI provides technical assistance, subject matter expertise, and support to U.S. Attorney Offices (USAOs), law enforcement agencies, and others in developing cases for criminal prosecution, civil litigation and/or settlements. This includes providing witness testimony related to the TRICARE program and range of benefits. This support is continuous and ongoing throughout the investigative, settlement, and/or prosecutorial phases of cases.

In addition to saving and recovering benefit dollars, DHA PI actions contribute to patient safety. In the course of investigations, DHA PI may become involved in coordinating notification alerts for beneficiaries who may have potential exposure arising from re-use of syringes, the use of single dose vials of medication on multiple patients, watering down of immunizations, dilution of chemotherapy solutions, and other such potentially harmful situations.

Section 1.1 TRICARE's Fraud and Abuse Website

In 2015, DHA PI's homepage which is located at www.health.mil/fraud continued to experience significant access by the public. The number of visits on DHA PI's homepage was 27,270[1]. Our most popular feature was a Fraud Alert titled, "TRICARE Beneficiaries Being Targeted by Fraudulent Secret Shopper Offers" with 12,248 pageviews. Fraudulent activities may be reported through the above homepage and directly to the DHA PI Office by clicking the "Report Health Care Fraud" button.

DHA PI's Webpage



Additionally, DHA PI developed and maintains its own Fraud and Abuse Basic 101 course which is accessible through our Homepage. In 2015, 124 individuals successfully completed the course.

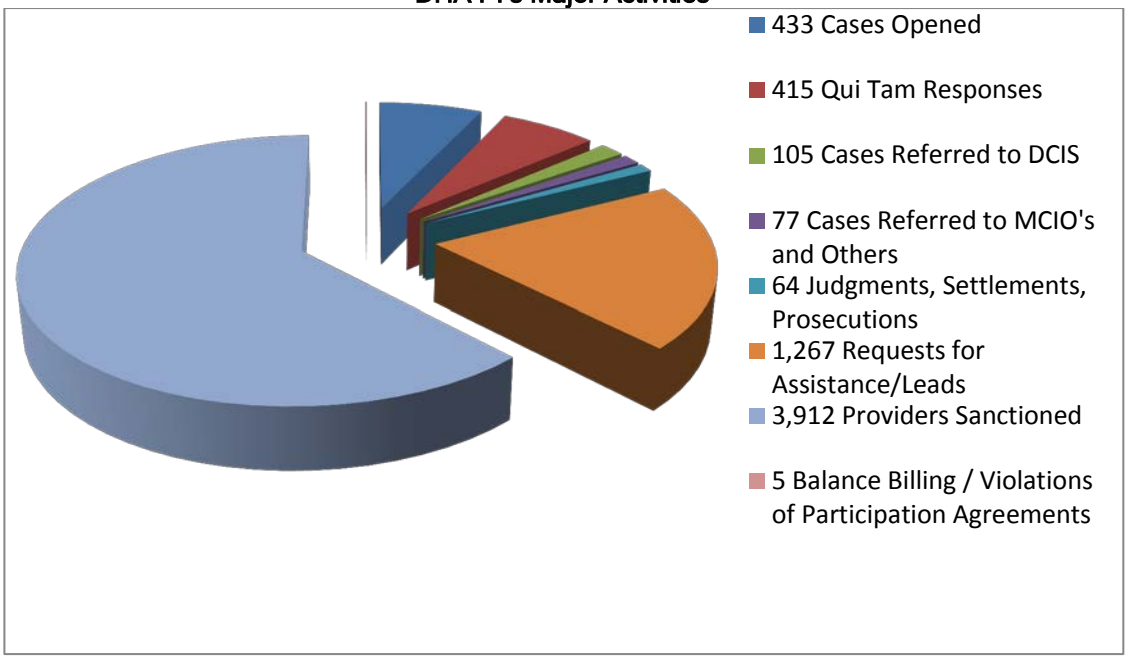
Section 2.0 DHA PI Activity Report

DHA PI had another milestone year. During calendar year 2015, 564 active investigations were managed, 433 new cases were opened, and 1,267 leads/requests for assistance were responded to. DHA PI received and evaluated a record number of 415 new *qui tam*s. A *qui tam* is a provision of the Federal Civil False Claims Act (FCA) that allows private citizens, known as relators, to file lawsuits in the name of the U.S. Government alleging that private companies–usually their employer–have submitted

[1] In 2015, DHA switched to a more accurate tracking measure for visits to a homepage site. Previous year measurements were based on "hits" which included automated "bot crawls", "image loads", and "body content copy loads". DHA is now tracking through a more accurate "Pageviews" which is the number of actual views and repeated views and removes "bot crawl, "image load", and "body content copy load" counts.

fraudulent claims for government payment. The private whistleblowers who file these *qui tam* lawsuits receive a percentage of the settlement or judgment amount if a settlement or judgment is reached.

DHA PI's Major Activities



Section 3.0 Cost Avoidance

This section details the results of cost avoidance activities.

3.1 Prepayment Duplicate Denials

TRICARE's MCSC's along with ISOS, TDEFIC, ESI, UCCI and Met Life utilize claim software that screens and audits claim coding. One significant area reviewed is that of duplicate claims submissions. When duplicate claims submissions are identified the duplicate claim is denied. For calendar year 2015 prepayment duplicate denials amounted to $699,673,100.

3.2 Rebundling/Mutually Exclusive Edits

TRICARE's MCSC's and ISOS, TDEFIC, ESI, UCCI and Met Life are required to use prepay claims processing software that utilizes rebundling and mutually exclusive edits. The rebundling edits are designed to detect and correct the billing practice known as unbundling, fragmenting, or code gaming. Unbundling involves the separate reporting of the component parts of a procedure instead of reporting a single code, which includes the entire comprehensive procedure. This practice is improper and is a misrepresentation of the services rendered. Providers are cautioned that such a practice can be considered fraudulent and abusive. For calendar year 2015, the prepayment claims processing software in use by the MCSCs accounted for $119,512,566[2] in cost avoidance for TRICARE.

3.3 Prepayment Review

Prepayment review prevents payment for questionable billing practices or fraudulent services. Providers/beneficiaries with atypical billing patterns may be placed on prepayment review. Once on prepayment review their claims and supporting documentation are subjected to prepayment screening to verify that the claims are free of billing problems. The results of a review may result in a reduction of what

[2] Data Acquired from TRICARE Claims Data Repository.

was claimed or a complete denial of the claim. The following chart shows by contractor, cost avoided as a result of prepayment review activities.

Calendar Year 2015 Prepayment Review[3]

CONTRACTORS	COSTS AVOIDED
Health Net Federal Services, North	$2,757,886
United Healthcare Military & Veterans, West	$3,098,849
Humana Military Healthcare Services, South	$25,932,711
International SOS, Overseas	$1,551,112
WPS TDEFIC, National	$134,411
UCCI, National	$1,196
Met Life, National	$0
ESI	$29,231
TOTALS:	$33,505,396

3.4 Pharmacy Daily Claims Audits

Express Scripts Inc. Retail Pharmacy Contract claims processing is "real" time. While not an actual pre-payment review process, the daily claims audit process identified and prevented $176,533 of inappropriate pharmacy billing errors prior to payment.

3.5 Excluded Providers

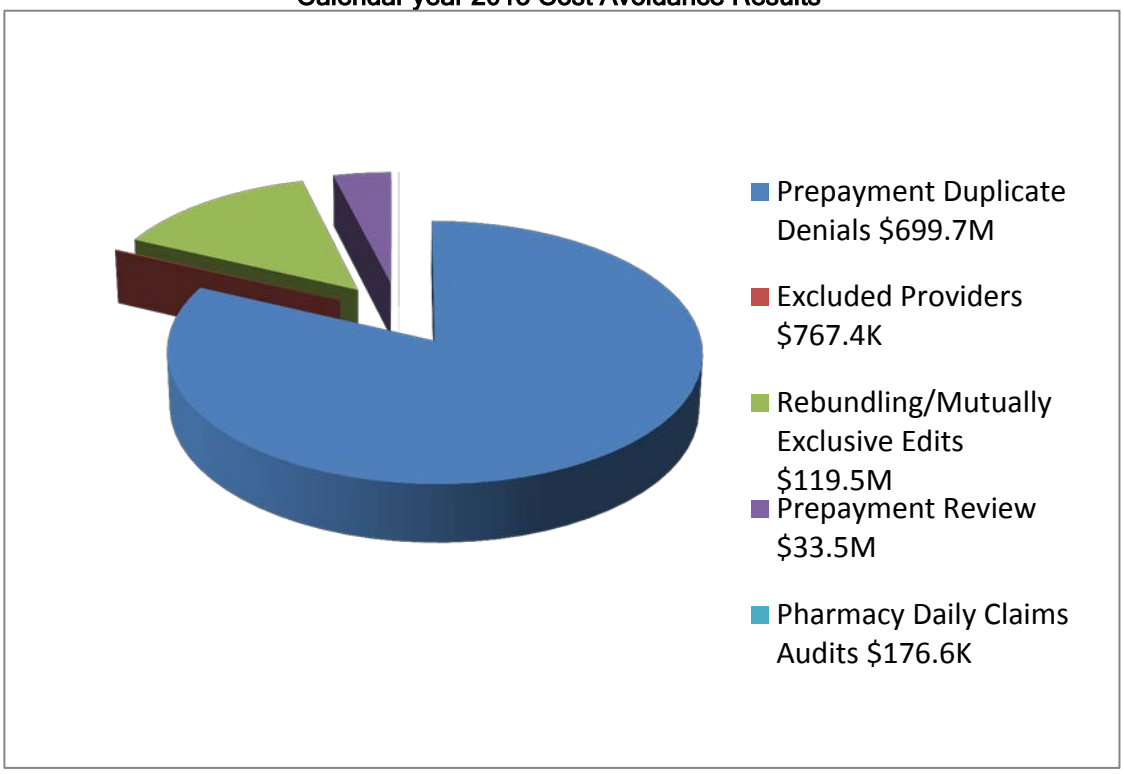
DHA has exclusion and suspension authority based on Title 32, Code of Federal Regulations (CFR), Part 199.9. DHA PI works with the DHA Office of General Counsel to recommend sanctions when necessary. TRICARE's sanction list is available on the internet at www.health.mil/fraud. This online searchable database allows searches by provider or facility name.

From this website users may also access the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE). The LEIE is an online searchable database which allows searches by provider or facility name.

An agreement between DHA PI and the DHHS OIG enables sharing of information between our two agencies. As part of the agreement, DHHS OIG provides DHA PI with updates from its LEIE on a monthly basis, which lists providers who have been excluded, terminated, or suspended, as well as a list of providers who have been reinstated. This list is used by TRICARE contractors to flag sanctioned providers to ensure that no payments are made for services prescribed or provided by sanctioned providers. DHA PI also provides the sanction list to the Surgeons General (SGs), TRICARE Regional Offices (TROs), Uniformed Services Family Health Plan (USFHP), Pharmacy Operation Center (POC), National Quality Monitoring Contract (NQMC), DCIS, and the Defense Logistics Agency (DLA). DHHS OIG took sanction action against 3,912 providers in calendar year 2015. The basis for exclusion includes convictions for program-related fraud, patient abuse, and state licensing board actions.

[3] Data as reported by TRICARE Contractors.

Calendar year 2015 Cost Avoidance Results[4]



Section 4.0 Recoveries and Recoupments

This section details recoveries and recoupments. Money recovered and recouped is applied towards funding our beneficiaries' healthcare entitlements.

4.1 Fraud Judgments and Settlements

TRICARE judgments and settlements for calendar year 2015 totaled $61,191,395. Depending on ability to pay, a partial or full payment for any given judgment or settlement may carry over into future fiscal years. Total payments actually received in 2015 from past and present settlements and judgments were $22,671,723.15.[5]

4.2 Post-payment Duplicate Claims Denials

Post-payment duplicate claim software was developed by the DHA Policy and Operations Directorate and is used by the MCSCs. This software was designed as a retrospective auditing tool to identify paid duplicate claims. While most duplicate claims are identified through prepayment screening $23,663,504[6] was identified for recoupment or offset on a post payment basis.

4.3 Pharmacy Post Payment Audits

Post pay audits represent amounts recovered from paid pharmacy claim submission errors identified as part of Express Scripts' audit and monitoring activities. In 2015, $18,301,622 was recovered.

[4] Rebundling/Mutually Exclusive Edits amount acquired from TRICARE's data repository. All other categories as reported by TRICARE contractors.
[5] Payments received in calendar year 2015 as reported by DHA Office of General Counsel, Appeals, Hearings and Claims Collection Division.
[6] Post Payment Duplicate Claims Denials as reported by DHA Purchase Care Integration Branch.

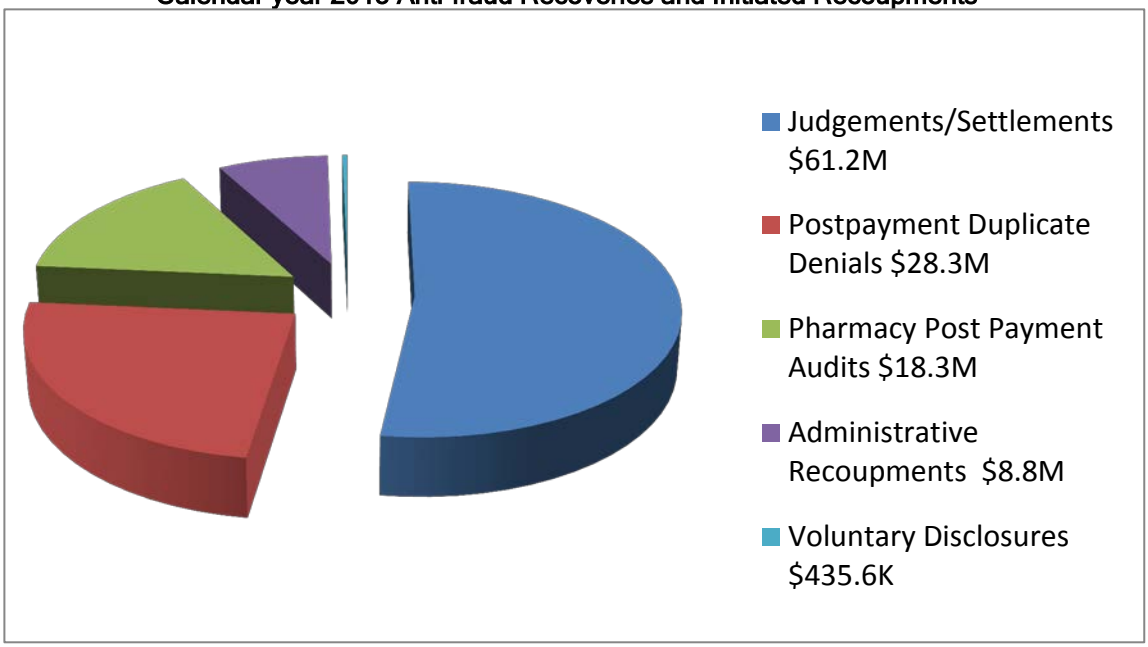
4.4 Administrative Recoupments

On occasion a payment may be issued resulting in an overpayment. Overpayments occur for a variety of reasons including: erroneous calculation of the allowable charge, erroneous coding of a procedure, erroneous calculation of the cost-share or deductible, a payment made for services rendered by unauthorized provider, etc. The general rule for determining liability for overpayments is that the person who received the payment is responsible for the refund. In 2015, $8,846,425 was recovered through administrative recoupments.

4.5 Voluntary Disclosures

In its continuing efforts to protect the integrity of its program from provider fraud and abuse, DHA encourages providers to "police" themselves by conducting voluntary self-evaluations and making voluntary disclosures. By participating in voluntary disclosure programs, providers hope to avoid being subjected to criminal penalties and civil actions. While not protected from civil or criminal action under the FCA, the disclosure of fraud or self-reporting of wrongdoing by a provider could be a mitigating factor in recommendations to prosecuting agencies. Self-reporting offers providers the opportunity to minimize the potential cost and disruption of a full scale audit and investigation, and to negotiate a fair monetary settlement. Because a provider's disclosure may involve anything from a simple error to outright fraud, full disclosure and cooperation generally benefits the individual or company. As a result of the voluntary compliance and self-audits by medical providers under the current program, DHA receives voluntary disclosures of overpayments. In 2015, TRICARE received three voluntary disclosures from medical providers totaling $435,664 returned to the TRICARE Program.

Calendar year 2015 Anti-fraud Recoveries and Initiated Recoupments[7]



Section 5.0 Balance Billing and Violation of Participation Agreements

In addition to handling the more familiar types of health care fraud against the program, DHA PI is also dedicated to addressing issues involving billing violations of participation agreements.

In 2015, the majority of balance billing and violation of participation cases were resolved at the contractor level, resulting in a cost savings to our beneficiaries totaling $233,199.

[7] Post payment Duplicate Claims Denials as reported by DHA Purchase Care Integration Branch. Pharmacy Post Payment Audits as reported by TRICARE's Pharmacy Benefit Management Contractor.

5.1 Balance Billing

When TRICARE's MCSC's cannot resolve Balance Billing issues at their level, DHA PI takes steps to ensure that non-participating providers comply with Public Law 102-396, Section 9011, passed by Congress as part of the DoD Defense Authorization Act of 1993. The text of this Public Law limits the billed charges to no more than 115% of the allowable rate. This law specifies that non-participating providers are allowed to collect a maximum of 15% over the CHAMPUS Maximum Allowable Charge (CMAC) from a TRICARE beneficiary. The term "Balance Billing" has been derived from this limitation.

Balance Billing matters that TRICARE's MCSC's are unable to resolve are referred to DHA PI. Five Balance Billing matter was referred to DHA PI and resolved with $1,524 recovered for our beneficiaries.

5.2 Violation of the Participation Agreement

DHA PI is also responsible for ensuring participating providers do not collect more than the CMAC when participating on a claim. Participating providers (those marking "yes" to accept assignment on the claim form) are prohibited from collecting from beneficiaries any amount in excess of the CMAC. This is commonly referred to as a "Violation of the Participation Agreement".

Violations of Participation Agreement matters that TRICARE's MCSC's are unable to resolve are referred to DHA PI. TRICARE received no referrals from the MCSC's in 2015.

Section 6.0 Eligibility Fraud

TRICARE and Uniformed Service regulations require changes in eligibility under a sponsor record to be reported to the Services within 30 days. Each branch of the Uniformed Services is responsible for determining eligibility for its members, dependents and retirees. The Defense Manpower Data Center (DMDC) maintains eligibility information in the Defense Eligibility and Enrollment Reporting System (DEERS). TRICARE's claim processors use DEERS to determine whether a beneficiary is eligible for benefits on the dates services were received.

A TRICARE beneficiary, parent or legal representative, when appropriate, must provide the necessary evidence to establish and update dependent eligibility in DEERS. Sponsors are responsible for reporting eligibility changes within 30 days to the appropriate Uniformed Service. Failure to timely report changes may result in the sponsor being held financially liable for the cost of any health care services that are received through the MTF's or TRICARE. Fraudulent use of DoD health care entitlements is a violation of federal law.

In 2015, DHA PI received 78,939 names from DMDC to review for potential eligibility fraud and abuse related to late-reported eligibility changes. As of 31 December 2015, this resulted in 88 referrals to law enforcement and $37,141,142 in recoupment actions.

Section 7.0 Compound Pharmacy Fraud – An Outlier in 2015

Beginning in calendar year 2015, DHA identified a significant increase in compounding pharmaceutical costs to the Program. A review of the increased cost revealed a pattern where TRICARE was targeted, largely through organized marketing campaigns, by individuals pursuing potentially fraudulent schemes.

In general, these campaigns involved direct marketing of high cost compound medications to beneficiaries, typically to sell anesthetic or cosmetic creams. Prescriptions were often written by physicians who had never seen or communicated with the beneficiary and failed to establish a valid patient physician relationship. The prescriptions were written primarily for financial gain. Many prescribing physicians practiced telemedicine, but did not follow TRICARE's policy and or state licensure rules making the prescriptions invalid. Often these schemes involved illegal kickbacks.

In many cases the medications provided had not been proven safe or effective. In May 2015, TRICARE adopted strict screening procedures that reduced spending to sustainable levels while ensuring that beneficiaries who require safe and effective compounds received them. The screening procedures have been successful in controlling costs and deterring fraud.

DHA is engaged with DCIS, DOJ, and other law enforcement partners in pursuing pharmacies and physicians involved in fraudulent activities. Thus far civil and criminal enforcement efforts have resulted in significant collection or avoidance of payments. Several pharmacies have gone out of business as the result of these collection efforts and State Medical Boards have been notified of physicians who participated in the illegal activity.

Criminal prosecutions are now moving forward to enhance efforts to deter these fraud schemes. These efforts will take some time, but initial successes and the strict screening program indicate that the DHA is making strides in controlling the problem and DHA is successfully receiving civil settlements, claim reversals[8] from pharmacies, and recouping tax payer dollars due to fraudulent activities that had targeted the TRICARE

Section 8.0 Program Integrity Affiliations

DCIS is the primary investigative agency for the Department of Defense TRICARE Program. DHA PI and DCIS work in close cooperation in the fight against health care fraud and abuse. In 2015, DCIS continued to recognize health care fraud as one of its investigative priorities. In doing so, DCIS strongly supports DHA PI's anti-fraud program. DCIS commitment to investigating health care fraud resulted in increased numbers of cases accepted for investigative purposes.

DHA PI also routinely collaborates with Military Criminal Investigative Offices, Federal prosecutors and investigators (e.g., DOJ, HHS-IG, FBI, and DEA) as well as those on state and local levels. Additionally, DHA PI participates in public-private sector partnerships with the NHCAA, NICB, and private plan Special Investigative Units. DHA PI also actively participates on health care task forces throughout the United States.

Section 9.0 Program Integrity Snapshot of Cases Involving TRICARE

This section reviews a sampling of significant fraud cases involving TRICARE in calendar year 2015. During this calendar year five individuals/entities were criminally convicted and seven individuals were incarcerated for committing health care fraud against the TRICARE program.

Case Study: U.S. v. Blanding Health Mart Pharmacy – False Claims and Medically Unnecessary Services

On July 15, 2015 the U.S. Attorney's Office, Middle District of Florida and Blanding Health Mart Pharmacy (Blanding), settled allegations that the Jacksonville-based compounding pharmacy knowingly billed the government for improper and medically unnecessary compounding pain prescriptions. The allegations resolved included liability under the False Claims Act. From February 9, 2015, to April 13, 2015, Blanding sought reimbursement for compounding pharmaceutical prescriptions that were not medically necessary and were written by physicians that had never actually seen the patients. TRICARE restitution was $8,441,107.

Case Study: U.S. v. Warner Chilcott – Criminal Conviction and Civil Settlement of Violations of Federal Anti-Kickback Statute and False Claims Act

[8] When a prescription is filled, billed and adjudicated and needs to be reversed ("unbilled").

On October 29, 2015, the U.S. Attorney's Office, District of Massachusetts entered into a civil settlement agreement in which Warner Chilcott agreed to pay $102,006,000 to the federal government and the states to resolve claims arising from its conduct, which allegedly caused false claims to be submitted to government health care programs. Additionally, Warner Chilcott agreed to plead guilty and pay an additional $22,900,000 regarding criminal charges that the company committed a felony violation by paying kickbacks to physicians. The civil settlement resolved allegations that Warner Chilcott violated the federal Ant-Kickback Statute by paying illegal remuneration to prescribing physicians in connection with the so-called "Medical Education Events" and speaker programs and caused the submission of false prior authorization requests for Atelvia and Actonel. Total Settlement Amount was $125,000,000. TRICARE restitution was $7,281,703.

Case Study: U.S. v. Kevin Powers and QMedRX- Waiver of CoPays and Non-Covered Services

On December 4, 2016, Kevin Powers, former co-owner and CEO of Home Care Solutions d/b/a compounding pharmacy QMedRx, entered into a settlement agreement with the U.S. Attorney's Office, Middle District of Florida. The allegations were that QMedRx waived patient copays and sought reimbursement from TRICARE for compound drug prescriptions delivered to states QMedRx was not licensed to operate. Additionally, from January 1, 2013, and January 22, 2014, QMedRX submitted claims for compounded prescriptions that violated the Anti-Kickback Statute because the marketers who obtained the prescriptions from physicians were paid through improper and illegal incentive compensation arrangements. Kevin Powers will pay TRICARE restitution in the amount of $6,529,077.

Case Study: U.S. v. MedMatch Pharmacy – Non-covered Services and Kickbacks

On October 23, 2015, MedMatch Pharmacy, a compounding pharmacy in Jacksonville, Florida, entered into a settlement agreement with the U.S. Attorney's Office, Middle District of Florida. The allegations were that MedMatch Pharmacy entered into kickback arrangements with marketing company Rx LLC, mailed prescriptions to beneficiaries in Alabama, a state MedMatch Pharmacy was not licensed to operate, and sought reimbursement from TRICARE for compound drug prescriptions written by Dr. Saman Soleymani, a Jacksonville physician. The USAO contended that MedMatch Pharmacy knew or should have known Dr. Soleymani did not have a bona fide patient/physician relationship as the sheer magnitude and volume of Dr. Soleymani's prescriptions was far in excess of any provider and because the prescriptions were for the same compound prescription substance, despite the patient's age, condition, or health record. TRICARE restitution was $4,736,134.

Case Study: U.S. v. Daiichi Sankyo, Inc. – Kickbacks

On January 9, 2015 the U.S. Attorney's Office, District of Massachusetts and Daiichi Sankyo, a global pharmaceutical company, entered into a settlement agreement in which Daiichi Sankyo agreed to pay $39,000,000 to resolve allegations that it violated the False Claims Act by paying kickbacks to induce physicians to prescribe Daiichi drugs, including Azor, Benicar, Tribenzor and Welchol. As part of the settlement, they entered into a Corporate Integrity Agreement with the Department of Health and Human Services, Office of Inspector General. TRICARE restitution was $4,600,000.

Case Study: U.S. v. OHM Pharmacy – Excessive Billings and Non-Covered Services

On October 16, 2015, OHM Pharmacy, a compounding pharmacy, entered into a settlement agreement with the U.S. Attorney's Office, Middle District of Florida. It was alleged that OHM Pharmacy sought reimbursement for medically unnecessary compound drug prescriptions that it knew, or should have known, that it was filling prescriptions from a doctor who was writing them outside the ordinary course of practice. OHM Pharmacy knew, or should have known, this because the sheer magnitude and volume of prescriptions exceeded any other provider. In addition, the prescriptions were for the same compounded prescription substance, despite the patient's age, condition, or health record. TRICARE restitution was $3,465,232.

Case Study: U.S. v. Topical Specialist, LLC – Services Not Provided and Excessive Billing, Kickbacks

On Dec 30, 2015, Topical Specialist, LLC, a pharmacy in Jacksonville, Florida, entered into a settlement agreement with the U.S. Attorney's Office, Middle District of Florida. The settlement was a result of allegations that Topical Specialist caused compounding pharmacy WELL Health Pharmacy to submit claims and seek reimbursement for compound drug prescriptions written by referral sources which had a financial interest in the prescriptions. It was also contended that Topical Specialist paid indirectly, through a third party company, remunerations in the form of research fees that exceeded fair market value, to several referring physicians who prescribed compound prescription medications through Tropical Specialist. TRICARE restitution was $2,243,509.

Case Study: U.S. v. Durbin Pharmacy – Improper Billings, Kickbacks and Non-Covered Services

On October 14, 2015, Durbin Pharmacy, a compounding pharmacy in Jacksonville, Florida, entered into a settlement agreement with the U.S. Attorney's Office, Middle District of Florida. The allegations are Durbin Pharmacy entered into kickback arrangements with various marketing companies, and sought reimbursement from TRICARE for compound drug prescriptions written by multiple prescribing providers. The USAO contends Durbin Pharmacy knew or should have known the prescribing providers did not have a bona fide patient/physician relationship as the sheer magnitude and volume of prescriptions was far in excess of any provider and because the prescriptions were for the same compound prescription substance, despite the patient's age, condition, or health record. TRICARE restitution was $2,100,000.

Case Study: U.S. v. WELL Health Pharmacy – Kickbacks, Services Not Provided, Excessive Billing, and Kickbacks

On November 25, 2015, WELL Health, a compounding pharmacy in Jacksonville, Florida, entered into a settlement agreement with the U.S. Attorney's Office, Middle District of Florida. The allegations are WELL Health sought reimbursement for compound pharmaceutical prescriptions written by referral sources which had a financial interest in the prescriptions. The USAO contends WELL Health filled prescriptions from an affiliated pharmacy that paid indirectly, through a third party company, remuneration in the form of research fees that exceeded fair market value, to several referring physicians. TRICARE restitution was $1,881,565.

Case Study: U.S. v. North Country Emergency Medical Consultants – Improper Billings

On December 28, 2015, a settlement was obtained by the U.S. Attorney's Office, Northern District of New York, with North Country Emergency Medical Consultants in Watertown, New York. The allegations were that from 2006 through 2014, the practice submitted claims to TRICARE with an "AQ" modifier, certifying its providers rendered services in an area designated as a "Health Professional Shortage Area" (HPSA), entitling them to a 10% physician "bonus payment." In the settlement North Country acknowledged they should not have added the AQ modifier because the practice was not located in a HPSA eligible for physician bonus payments. TRICARE restitution was $991,338.

Case Study: U.S. v. NuVasive – Improper Billings, Non-Approved Devices, and Kickbacks

On June 30, 2015, the U.S. Attorney's Office, District of Maryland has settled with California-based medical device manufacturer, NuVasive, to resolve allegations that the company caused health care providers to submit false claims to Medicare and other federal healthcare programs for spine surgeries by marketing the company's CoRoent System for surgical uses that were not approved by the U.S. Food and Drug Administration. The settlement agreement also resolves allegations that NuVasive knowingly offered and paid illegal remuneration to certain physicians to induce them to use the CoRoent System in spine fusion surgeries, in violation of the federal Anti-Kickback Statute. TRICARE restitution was $938,588.

Case Study: U.S. v. Farid Fata, M.D. – Patient Harm, Medically Unnecessary Services, Kickbacks, and Money Laundering

On July 10, 2015, a Detroit area oncologist, Dr. Fata, was sentenced to 45 years in prison for a fraud scheme that involved making fraudulent diagnoses, prescribing oncology drugs for healthy patients and

bilking patients and insurance companies out of millions of dollars. Dr. Fata admitted to fraudulently billing Medicare, insurance companies and at least 553 patients through misdiagnoses, over-treatment, and under-treatment. In some cases, he gave nearly four times the recommended dosage amount of aggressive cancer drugs. U.S. District Judge Borman commented, "This is a huge, horrific series of criminal acts committed by the defendant…" before handing down the doctor's sentence and called Dr. Fata's actions unprecedented. Dr. Fata, pled guilty to 16 counts to health care fraud, money laundering and conspiracy to give or receive kickbacks, and gave up $17,600,000 in cash as part of his sentencing. He also forfeited property, life insurance policies, interest in investments and numerous other properties, according to the federal prosecutor. After his release, Dr. Fata will be under supervision for three years and undergo mandatory drug testing. DHA PI identified 98 patients who received services from Dr. Fata. Total Settlement was $34,000,000. TRICARE's restitution was $483,986.

Case Study: U.S. v. Coastal Dermatology – Non-Covered Services and Medically Unnecessary Services, Falsified Medical Documentation

On March 17, 2015, the U.S. Attorney's Office, Middle District of Florida and Coastal Dermatology agreed to a civil settlement with Coastal Dermatology and its owner Dr. Sanjiva Goyal, Jacksonville, Florida. Dr. Goyal agreed to repay the U. S. Government for services not medically necessary, cosmetic dermatology procedures disguised as covered services, and false documentation. Total Settlement was 787,814. TRICARE restitution was $357,668.

Case Study: U.S. v. Rebecca Rabon and Tiffany Thompson - Criminal Conviction, Medically Unnecessary Services, and Services Not Provided

On March 20, 2015, Speech Therapist Rebecca Rabon, owner of Rabon Communication Enhancement (RCE), a speech therapy clinic for children, pled guilty to one count of conspiracy to commit health care fraud and five counts of health fraud. Ms. Rabon admitted she worked together with co-worker Tiffany Thompson, to submit claims to insurance providers for services not medically necessary and not provided. Ms. Rabon further admitted that between March 2009 and November 2013, her clinic did not have equipment or supplies to provide treatment for dysphagia - a swallowing and oral feeding dysfunction - and that neither she, nor any speech therapist employed at RCE, provided any of those treatments to children at the clinic. Ms. Rabon further admitted she submitted false and fraudulent claims for herself and Ms. Thompson and three unsuspecting RCE employees for various medical and speech therapy services that were not provided, and including false and fraudulent claims under the medical insurance of one unsuspecting employee. Ms. Rabon was ordered to federal prison for 151 months following her conviction related to a health care fraud scheme that billed Tricare and Blue Cross and Blue Shield of Texas. Also, as a result of her conviction, Ms. Rabon forfeited her house. Co-defendant and office manager Tiffany Nicole Thompson also plead guilty for her role in the scheme and was sentenced to serve 51 months. Both defendants must also serve three-year-terms of supervised release following completion of their sentences and were further ordered to pay a total of $1,200,000 in restitution. TRICARE restitution was $334,203.

Case Study: U.S. v. Ageless Men's Health, LLC – Medically Unnecessary Evaluation and Management Services

On February 4, 2015, the U.S. Attorney's Office, Western District of Tennesse entered into a civil settlement with Ageless Men's Health, LLC (AMH) and agreed to pay $1,600,000 to resolve allegations that it billed Medicare and TRICARE for medically unnecessary office visits while administering testosterone replacement therapy shots. In addition to the payment, AMH entered into a Corporate Integrity Agreement which requires enhanced accountability and monitoring activities to be conducted by both internal and independent external reviewers. Total Settlement was $1,600,000. TRICARE restitution was $210,128.

Case Study: U.S. v. Pediatric Services of America Health Care – Kickbacks

On August 4, 2015, the Atlanta U.S. Attorney's Office settled with Pediatric Services of America Healthcare, Pediatric Services of America, Inc., Pediatric Healthcare, Inc., Pediatric Home Nursing

Services, and Portfolio Logic, LLC and agreed to pay the U.S. Government $6,882,387. The defendants entered into the settlement to resolve allegations that they failed to disclose and return overpayments that it received from federal health care programs, submitted claims without documenting the necessary monthly supervisory visits by a registered nurse, and submitted claims to federal health care programs that overstated the length of time their staff had provided services. TRICARE's restitution was $141,000.

Case Study: U.S. v. Associates in Dermatology and Dr. Michael Steppie – Misrepresentation of the Provider, Medically Unnecessary Services

On January 25, 2015, the U.S. Attorney's Office, Middle District of Florida and Associates in Dermatology agreed to a civil settlement totaling $3,000,000. Dr. Steppie who operated the dermatology practice had unlicensed, uncredentialed, and unsupervised employees performing radiation therapy without proper supervision. In addition, the allegations included that the clinic performed unnecessary destructions of skin lesions and that these destructions lacked proper documentation. In addition to the monetary payment, Associates in Dermatology has entered into a corporate integrity agreement with the U.S. Department of Health and Human Services. The TRICARE restitution was $98,000.

Case Study: U.S. v. SPC Vanessa Campos, USA – Eligibility Fraud, Larceny, Conspiracy

On 6 May 2015, SPC Campos pled guilty to larceny of Basic Housing Allowance and conspiracy to commit larceny to obtain TRICARE benefits under false pretenses via a sham marriage. SPC Campos entered into sham/contract marriages for the sole purpose of obtaining extra marital pay and TRICARE medical benefits for a spouse she never lived with nor had a legitimate marital relationship. DHA PI assisted the Army in this case providing claims data and associated documents, and testifying at sentencing how the misuse of military medical benefits can financially impact the TRICARE program, and impacts the legitimate family members of our military men and women. SPC Campos was sentenced to a Bad Conduct Discharge, 10 months confinement, and a $10,000 fine. The total loss for the healthcare services used by the illegitimate spouse was $70,833.

Case Study: U.S. v. Inman – Conspiracy, Fraud, False Official Statement to Obtain Healthcare Benefits

DHA PI provided testimony in support of a 20 January 2015 General Court-Martial trial against Army Major William Inman, assigned to Fort Hood, Texas. Inman was found guilty by an officer panel in matters related to entitlement fraud when he failed to report the July 2008 divorce from his ex-spouse until April 2013. Inman was found guilty of conspiracy, dereliction of duty, false official statement, larceny; fraud, conduct unbecoming of an officer, false pretenses and communicating a threat. Inman was sentenced to a reprimand, a $50,000 fine, and 20 months confinement. TRICARE restitution was $38,265.

For more information on the content of this report, please contact the DHA PI Office in writing at the address below.

Defense Health Agency
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Aurora, CO 80011-9066

APPENDIX A: ACRONYM INDEX

ABA	Applied Behavior Analysis	ESI	Express Scripts, Inc.
ASD (HA)	Office of the Assistant Secretary of Defense for Health Affairs	FAQ	Frequently Asked Questions
BAQ	Basic Allowance for Quarters	FBI	Federal Bureau of Investigation
BCAC	Beneficiary Counseling and Assistant Coordinator	FCA	False Claims Act Administration
CAP/DME	Capital Expense and Direct Medical Education	FDA	Food and Drug Administration
CFR	Code of Federal Regulations	FDCA	Food, Drug, and Cosmetic Act
CHAMPVA	Civilian Health and Medical Program of the Veterans Administration	HB&FP	Uniform Business Office
CIA	Corporate Integrity Agreement	HCSR	Health Care Service Record
CMAC	CHAMPUS Maximum Allowable Charge	KEPRO	Keystone Peer Review Organization
CMS	Centers for Medicare and Medicaid	ISOS	International SOS
DCIS	Defense Criminal Investigative Service	LEIE	List of Excluded Individuals/Entities
DEA	Drug Enforcement Administration	MCIO	Military Criminal Investigative Organizations
DHHS	Department of Health and Human Services	MCSC	Managed Care Support Contractor
DHP	Defense Health Program	MHS	Military Health System
DLA	Defense Logistics Agency	MOU	Memorandum of Understanding
DMDC	Defense Manpower Data Center	MTF	Military Treatment Facility
DoD	Department of Defense	NCIS	Naval Criminal Investigative Service
DoDI	Department of Defense Instruction	NDC	National Drug Code
DOJ	Department of Justice	NHCAA	National Health Care Anti-Fraud Association
DRG	Diagnosis Related Group	NICB	National Insurance Crime Bureau
EOB	Explanation of Benefits	NQMC	National Quality Monitoring Contract

OIG	Office of Inspector General	TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contractor
OPM	Office of Personnel Management	TED	TRICARE Encounter Data
PCDIS	Purchased Care Detail Information System	TED	TRICARE Encounter Data
PCDW	Purchased Care Data Warehouse	DHA	TRICARE Management Activity
PDTS	Pharmacy Data Transaction Service	TOM	TRICARE Operations Manual
PEC	Pharmacoeconomic Center	TQMC	TRICARE Quality Monitoring Contract
PI	Program Integrity	TRDP	TRICARE Retiree Dental Program
POC	Pharmacy Operation Center	TRO	TRICARE Regional Office
ProDUR	Prospective Drug Utilization Review	USAO	United States Attorney's Office
SG	Surgeon General	USFHP	United States Family Health Plan
SIU	Special Investigation Unit	VA	Department of Veterans Affairs
SME	Subject Mater Expert	WPS	Wisconsin Physician Services