



Defense Health Agency



**Program Integrity
Division
Operational Report**



**January 1, 2018
through December 31, 2018**



*"Guarding the Health Care
of Those Who Guard Us"*



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Defense Health Agency



Program Integrity Division

Mission

Our mission is to manage healthcare anti-fraud and abuse activities for the Defense Health Agency to safeguard beneficiaries and protect benefit dollars. The Program Integrity Division develops and executes anti-fraud and abuse policies and procedures, provides oversight of contractor program integrity activities, supports and 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 healthcare anti-fraud program in place that can be considered a model of excellence for the industry, ensure high quality health care for beneficiaries and protect benefit dollars.



Section 1.0 Defense Health Agency, Program Integrity Division - General

On 1 October 2013, the Department of Defense (DoD) established 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.

As a Combat Support Agency, the DHA leads the MHS integration of readiness and health to deliver the Quadruple Aim: increased readiness, better health, better care and lower cost. The DHA takes care of 9.6 million DoD beneficiaries comprised of Uniformed Service members, retirees and their families. The TRICARE benefit 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 Division (PID) is responsible for healthcare anti-fraud activities to protect benefit dollars and safeguard beneficiaries. This includes both the purchased care and direct care settings. DHA PID develops and executes anti-fraud and abuse policies and procedures, provides oversight of contractor program integrity activities, supports and coordinates investigative activities, develops cases for criminal prosecution and civil litigation, and initiates administrative measures.

DHA PID is part of the DHA Special Staff and reports directly to the DHA Chief of Staff. This reporting structure facilitates DHA PID’s anti-fraud activities. Because of the nature and scope of the work performed by DHA PID, 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 PID engages in proactive activities designed to identify areas that may be vulnerable to fraudulent and abusive billings. DHA PID develops areas of focus and analyzes claims data to identify outliers. Recognizing the importance of sharing information with the investigative community, DHA PID (often a presenter) regularly attends task force meetings,

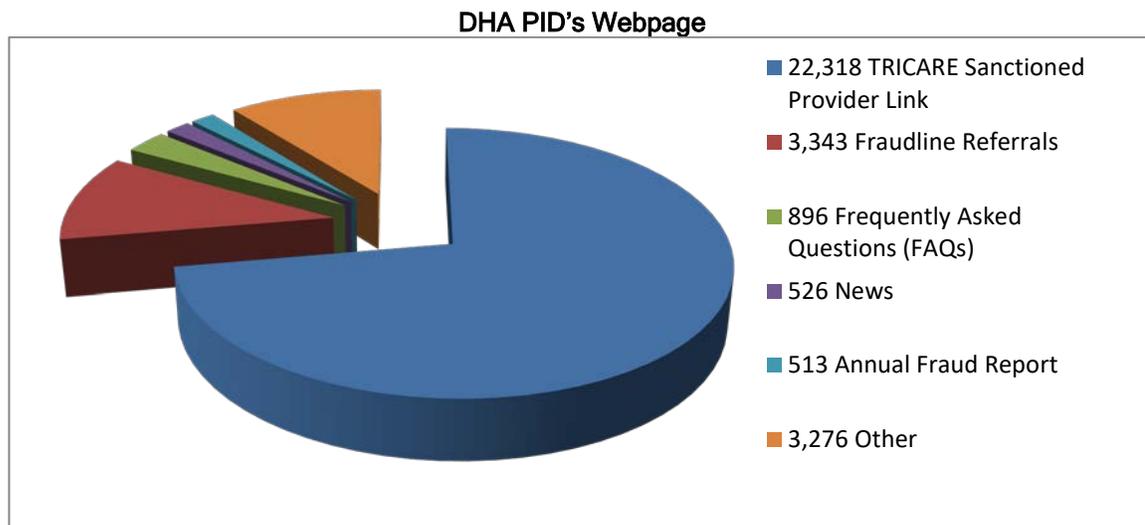
information sharing meetings, and healthcare anti-fraud meetings. These meetings foster collaborative anti-fraud efforts across government agencies and private organizations.

Through a Memorandum of Agreement, DHA PID refers its fraud cases to the Defense Criminal Investigative Service (DCIS). DHA PID also coordinates investigative activities with Military Criminal Investigative Offices (MCIOs), as well as other federal, state, and local agencies. DHA PID 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 PID actions contribute to patient safety. In the course of investigations, DHA PID 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.

1.1 DHA PID's Fraud and Abuse Website

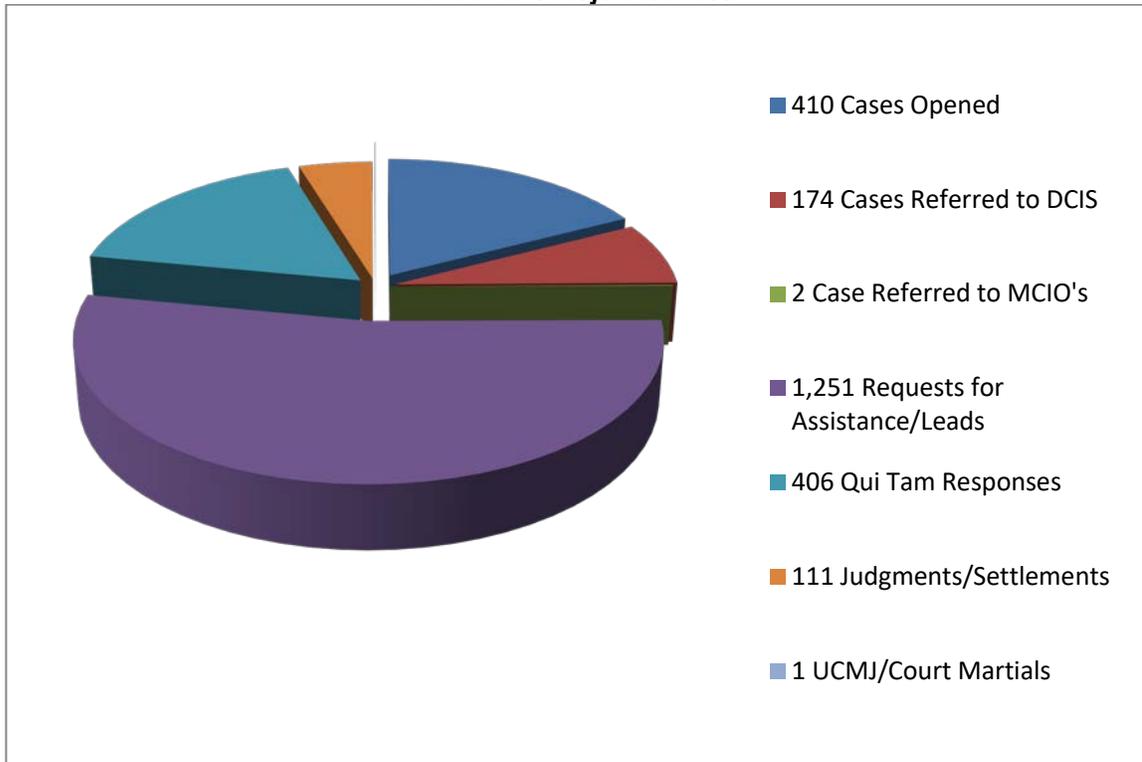
In 2018, DHA PID's homepage which is located at www.health.mil/fraud continued to experience significant access by the public. The number of visits on DHA PID's homepage during 2018 was 30,872. Our most popular feature was our listing of Sanctioned Providers with 22,318 pageviews. Fraudline Referrals identifying alleged fraudulent or abusive activities may be reported through the above homepage directly to the DHA PID Office by clicking the "Report Health Care Fraud" button. During 2018 a total of 3,343 Fraudline Referral visits were made to the DHA PID through our homepage.



Section 2.0 DHA PID Activity Report

During calendar year 2018, 735 investigative cases were actively managed, 410 new cases were opened, 353 cases were closed, and 1,251 leads/requests for assistance were responded to. DHA PID received and evaluated 406 new *qui tams*. 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 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 PID's Major Activities



Section 3.0 Cost Avoidance

This section details the results of cost avoidance activities.

3.1 Prepayment Duplicate Denials

TRICARE's Managed Care Support Contractors (MCSC) along with International SOS (ISOS), Wisconsin Physician Service (WPS), Express Scripts Incorporated (ESI), and United Concordia Dental, Inc. 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 2018 prepayment duplicate denials amounted to \$852,290,249.

3.2 Rebundling/Mutually Exclusive Edits

TRICARE's MCSC's, ISOS, and WPS 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 2018, the prepayment claims processing software in use by the MCSCs accounted for \$90,210,713¹ 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

¹ 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 2018 Prepayment Review²

CONTRACTORS	COSTS AVOIDED
Humana Military Healthcare Services, South	\$29,354,041
Health Net Federal Services, North	\$16,723,307
International SOS, Overseas	\$2,053,902
WPS TDEFIC, National	\$266,955
UCCI, National	\$133,511
TOTALS:	\$48,531,716

3.4 Pharmacy Daily Claims Audits

Express Scripts Inc. Retail Pharmacy Contract claims processing is "real" time. While not an actual prepayment review process, the daily claims audit process identified and prevented \$38,079 of inappropriate pharmacy billing errors prior to payment.

3.5 Excluded Providers

DHA has exclusion authority based on Title 32, Code of Federal Regulations (CFR), Part 199.9(f). No payment will be made for any item or service furnished during the exclusion period.

DHA PID works with the DHA Office of General Counsel to recommend exclusions when necessary. TRICARE's exclusion 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.

During 2018, DHA excluded one provider under its own authority. The following provider was excluded:

Dr. Terry J. Dubrow and Rox Surgery Center, California – 10 Year Exclusion.

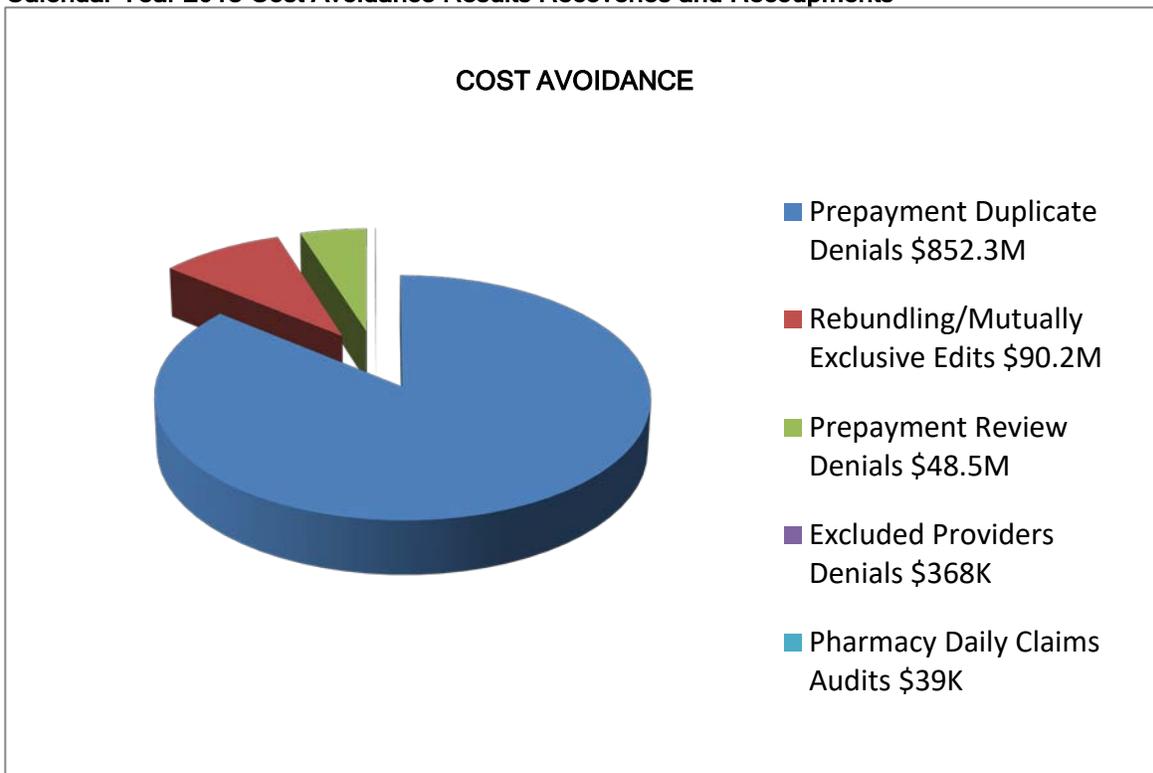
On 5 October 2018, Dr. Terry J. Dubrow was excluded as a TRICARE Authorized Provider for a period of 10 years. The exclusion is based on Dr. Dubrow retained the beneficiary's advance payment, despite being made aware on multiple occasions that his actions were contrary to Federal regulations put in place for our military members who have sacrificed so much for their country. This administrative action was invoked under 32 CFR 199.9(f)(1)(v), which is in the best interest of TRICARE and its beneficiaries.

An agreement between DHA PID and the DHHS OIG enables sharing of information between our two agencies. As part of the agreement, DHHS OIG provides DHA PID 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 PID also provides the sanction list to the Military Department's Surgeons General, Uniformed Services Family Health Plan, Pharmacy Operations Center, National Quality Monitoring Contract, DCIS, and the Defense Logistics Agency. Additionally, DHA provides a listing of providers

² Data as reported by TRICARE Contractors.

excluded by DHHS OIG. Those providers identified on the HHS List of Excluded Individuals and Entities (LEIE) are excluded from the TRICARE Program as well and do not require separate DHA exclusion notification. The basis for exclusion includes convictions for program-related fraud, patient abuse, and state licensing board actions.

Calendar Year 2018 Cost Avoidance Results Recoveries and Recoupments ³



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 2018 totaled \$125,905,105. 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 2018 from past and present settlements and judgments were \$39,661,675.⁴

4.2 Post-payment Duplicate Claims Denials

Post-payment duplicate claim software was developed by DHA 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 \$31,198,964⁵ was identified for recoupment or offset on a post payment basis.

³ Rebundling/Mutually Exclusive Edits amount as reported by TRICARE contractors.

⁴ Payments received in calendar year 2018 as reported by DHA Office of General Counsel, Appeals, Hearings and Claims Collection Division.

⁵ Post payment Duplicate Claims Denials as reported by DHA Health Plan/health Care Operations.

4.3 Pharmacy Post Payment Audits

Post pay audits represent amounts recovered from paid pharmacy claim submission errors identified as part of ESI audit and monitoring activities. In 2018, \$8,895,810 was recovered.

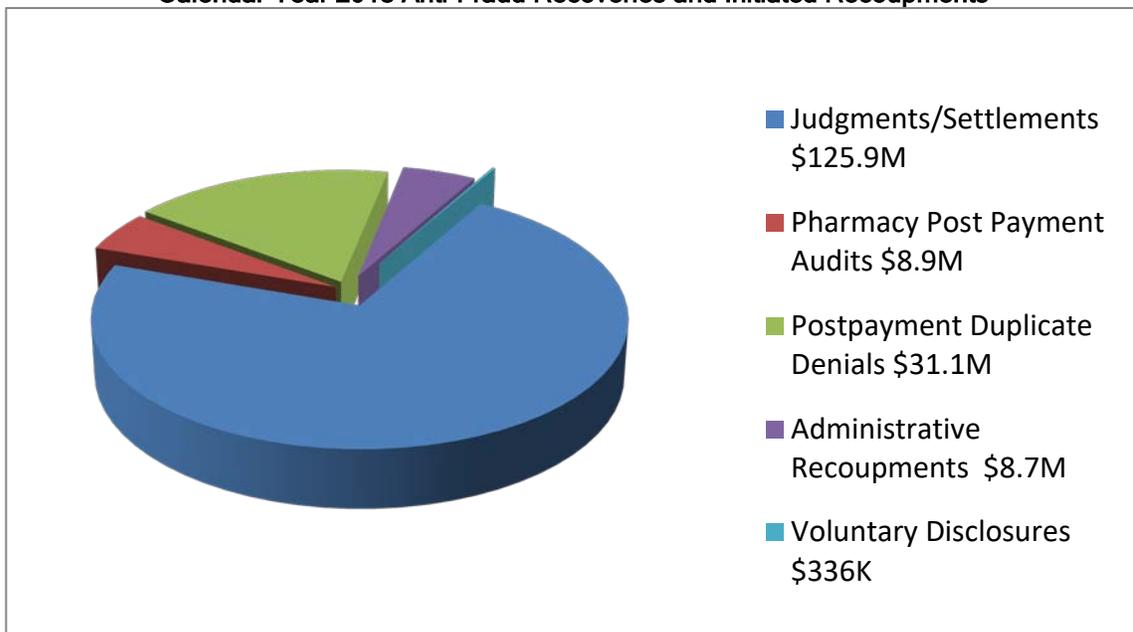
4.4 Administrative Recoupments/Off-Sets

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 2018, \$8,776,376 was recovered through administrative recoupments.

4.5 Voluntary (Self) 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 by reaching a settlement with the government. 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 2018, TRICARE received four voluntary disclosures from medical providers totaling \$336,300 returned to the TRICARE Program.

Calendar Year 2018 Anti-Fraud Recoveries and Initiated Recoupments



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 PID is also dedicated to addressing issues involving billing violations of participation agreements.

In 2018, 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 \$146,531.

5.1 Balance Billing

When TRICARE's MCSC's cannot resolve Balance Billing issues at their level, DHA PID 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 PID. Two Balance Billing matters were referred to DHA PID in 2018. Additionally three other balance billing cases referred to DHA PID in the previous year were resolved in 2018. Total resolution for Balance Billing was \$33,159 returned or collection actions ceased against beneficiaries in 2018.

5.2 Violation of the Participation Agreement

DHA PID 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 PID. TRICARE received two referrals from the MCSC's in 2018, resolving one with a recoupment initiated for \$145,420. In the other case the provider was excluded.

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 2018, MCSC's and the PBM received 56,790 names from DMDC to review for potential eligibility fraud and abuse related to late-reported eligibility changes and initiated recoupments totaling \$14,707,740.

Eligibility matters that appear to be fraudulent in nature are referred to DHA PID by the MCSC and PBM. In 2018, this resulted in 2 referrals to law enforcement and \$19,036 in recoupments.

Section 7.0 Program Integrity Affiliations

DCIS is the primary investigative agency for the DoD TRICARE Program. DHA PID and DCIS work in close cooperation in the fight against health care fraud and abuse. In 2018, DCIS continued to recognize health care fraud as one of its investigative priorities. In doing so, DCIS strongly supports DHA PID's anti-fraud program. DCIS commitment to investigating health care fraud resulted in increased numbers of cases accepted for investigative purposes.

DHA PID 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 PID participates in public-private sector partnerships with the National Health Care Anti-Fraud Association (NHCAA), National Insurance Crime Bureau (NICB), and private plan Special Investigative Units. DHA PID also actively participates on health care task forces throughout the United States.

Section 8.0 Program Integrity Snapshot of Cases Involving TRICARE

This section reviews a sampling of significant fraud cases involving TRICARE in calendar year 2018. During this record setting calendar year, 53 individuals/entities were criminally convicted and 48 individuals were incarcerated for committing health care fraud against the TRICARE program.

Case Study: U.S. v. Patrick Tonge – Healthcare Fraud Conspiracy, Healthcare Fraud, Kickbacks and Money Laundering – Criminal Conviction

Patrick Tonge was sentenced to 15 ½ years incarceration and three years' supervised release in U.S. District Court, Southern District of Florida. Mr. Tonge was an employee of Atlantic Pharmacy a compounding pharmacy. The jury found Patrick Tonge guilty of eleven counts of health care fraud, three counts of paying kickbacks, and two counts of money laundering. He was also ordered to repay TRICARE \$15,629,626 in restitution.

Case Study: U.S. v. AmerisourceBergen Corporation – Misbranded Drugs and Kickbacks – Civil Settlement

The U.S. Attorney's Office, Eastern District of New York, entered into a civil settlement agreement with AmerisourceBergen Corporation (ABC) and its subsidiaries AmerisourceBergen Specialty Group, AmerisourceBergen Drug Corporation, Oncology Supply Company, and Medical Initiatives Inc., to resolve allegations arising from its operation of a facility that improperly repackaged oncology-supportive injectable drugs into pre-filled syringes and improperly distributing those syringes to physicians. The drugs involved in ABC's scheme were Procrit®, Aloxi®, Kytril® and its generic form Granisetron, Anzemet® and Neupogen®. The scheme enabled ABC to increase its market share by offering various product discounts and provide kickbacks to physicians to induce them to purchase Procrit®. Last year, AmerisourceBergen Specialty Group, a wholly-owned subsidiary of ABC, pled guilty to illegally distributing misbranded drugs and agreed to pay \$260 million to resolve criminal liability for its distribution of these drugs from a facility that was not registered with the Food and Drug Administration. AmerisourceBergen paid TRICARE restitution of \$9,164,749.

Case Study: U.S. v. Steven Chalker – Healthcare Fraud and Conspiracy to Commit Healthcare Fraud – Criminal Conviction

On 7 September 2018, a Federal jury in U.S. District Court, Southern District of Florida, found Steven Chalker, a pharmacist with Pop's Pharmacy, LLC, guilty on 1 count of conspiracy to commit health care fraud and guilty on 2 other counts of health care fraud in regard to a criminal indictment filed against him. On 29 November 2018, Mr. Chalker, was sentenced to 6 years and 5 months incarceration, 3 years supervised release, and ordered to pay a \$300 penalty assessment fee and restitution to TRICARE in the amount of \$4,980,679.

Case Study: U.S. v. Jody Sheffield – Conspiracy to Commit Healthcare Fraud, Kickbacks and Billing for Non-Covered Services – Criminal Conviction

On 18 May 2018, Jody Sheffield sentenced to 2 years and 9 months in prison in the U.S. District Court, Northern District of Texas. Sheffield was sentenced on one count of conspiracy to commit health care fraud stemming from a scheme to defraud TRICARE through the submission of unnecessary toxicology and DNA cancer screening tests. Sheffield was ordered to pay \$4,700,000 in restitution to TRICARE.

Case Study: U.S. v. Larry Howard – Kickbacks and False Claims – Criminal Conviction

On 30 March 2018, Pharmacist Larry Howard, owner and operator of Fertility Pharmacy in Orlando, Florida appeared in the United States District Court, Middle District of Florida and was sentenced for his role in a compounding kickback scheme resulting in over \$4,300,000 in TRICARE payments for false

claims to Fertility Pharmacy. The false claims were submitted by Fertility pharmacy for compound drug pain and scar creams. Howard was sentenced to 13 years and 3 months in prison and ordered to pay \$4,300,000 in restitution to TRICARE.

Case Study: U.S. v. DJO Global – False Claims and Medically Unnecessary Equipment, False Claims, Kickbacks and Billing for Non-Covered Services – Civil Settlement

DJO Global, Inc. entered into a settlement agreement on 18 January 2018, with the United States Attorney's Office for the District of Minnesota. The settlement resolves allegations that its subsidiary, EMPI Inc., a now-defunct medical device company, submitted false claims to TRICARE for excessive, unnecessary transcutaneous electrical nerve stimulation (TENS) electrodes that TRICARE beneficiaries did not need or use. The settlement also resolves allegations that EMPI used inappropriate techniques such as "assumptive selling" to persuade some TRICARE beneficiaries to seek and accept unjustifiably large quantities of TENS electrodes from 2010 through 2015, with a particularly steep increase in the number of beneficiaries receiving unnecessary quantities in 2014 and 2015. TRICARE restitution was \$3,810,000.

Case Study: U.S. v. Natera – Billing for Misrepresented Services – Civil Settlement

The U.S. Attorney's Office Western District of Kentucky, entered into a civil settlement agreement with laboratory genetic testing provider Natera to resolve claims alleging Natera misrepresented services by billing for unapproved prenatal tests known as Panorama®. During the same period, Natera improperly billed TRICARE, Federal Employees Health Benefits Program, and Medicaid for its Panorama® test and for its non-invasive prenatal screening of certain microdeletion syndromes, by using an improper code which misrepresented the services Natera was billing to these programs. The TRICARE restitution was \$2,119,000.

Case Study: U.S. v. Abbott Labs – Off-Label Marketing of Non-FDA Approved Drugs and Kickbacks – Civil Settlement

In the U.S. District Court for the Eastern District of Pennsylvania, Abbott Labs entered into a settlement agreement to pay \$25,000,000 for its actions to promote the drug TriCor® for uses that were not FDA approved and were not covered by Federal Healthcare programs. Allegations also included that it employed kickbacks to induce physicians to prescribe the drug TriCor®. TRICARE restitution was \$1,901,350.

Case Study: U.S. v. Michael Bobrick – Kickbacks – Criminal Conviction

On 17 August, 2018, Michael Bobrick was sentenced, based on his previous guilty plea, to one count of conspiracy to pay and receive healthcare kickbacks. Mr. Bobrick was sentenced to 2 years and 6 months incarceration followed by 3 years of supervised release. Mr. Bobrick was a compound pharmaceutical marketer for Poste Haste Pharmacy. He was also ordered to pay a special assessment of \$100 and \$1,444,373 in restitution to TRICARE.

Case Study: U.S. v. RS Compounding, LLC d/b/a Westchase Pharmacy – Excessive Charges for Compound Prescriptions – Civil Settlement

The U.S. Attorney's Office, Middle District of Florida, entered into a civil settlement agreement with RS Compounding LLC d/b/a Westchase Pharmacy to resolve allegations RS Compounding misstated the usual and customary price to TRICARE from 1 January 2012 to 31 January 2014. RS Compounding instead reported an inflated wholesale price in place of the usual and customary price. TRICARE restitution was \$936,000.

Case Study: U.S. v. Elizabeth Salie – Kickbacks – Criminal Conviction

On 26 April, 2018, Elizabeth Salie was sentenced to 1 year and 10 months incarceration and 3 years probation. She was also ordered to pay restitution to TRICARE for \$689,180, and ordered to forfeit \$47,034, which represents the gross proceeds she received as a compound pharmaceutical marketer.

Salie was further ordered to surrender to immigration authorities for removal from the United States after imprisonment.

Case Study: U.S. v. Asciano Serna, Jr. – Conspiracy to Commit Healthcare Fraud – Criminal Conviction

On 29 November 2017, Asciano Serna, Jr. appeared in United States District Court, Southern District of Florida, Miami, Florida, and was sentenced to 5 years and 3 months in prison, followed by 3 years of supervised release for his role in a compound fraud scheme. A forfeiture money judgment was also issued against Mr. Serna (as the owner of ASC Pharmacy) for \$3,400,000. From the \$3,400,000 judgment issued, he was ordered to pay restitution to Medicare in the amount of \$402,810 and TRICARE in the amount of \$670,240.

Case Study: U.S. v. Jaspan Medical Systems – Kickbacks and Billing for Non-Covered Services – Criminal Conviction

In the U.S. District Court, Western District of Tennessee a federal jury convicted a married couple and their son, of health-care fraud offenses that led to millions of dollars lost to federal health care programs. A federal judge sentenced them to a total of 20 years and 7 months in federal prison. In the case against Jaspan Medical Systems, 6 defendants were criminally convicted. Bryan Bailey received 84-months in prison. Sandra Bailey received 120-months in prison and Calvin Bailey received 48-months in prison. The Baileys will jointly pay \$1,951,080 in restitution, \$8,577 of which will be returned to TRICARE.

Case Study: U.S. v. Sheila Harris – Wire Fraud, Aggravated Identity Theft, Falsified Medical Records, and Misrepresented Providers – Criminal Conviction

On 10 May 2018, Sheila Harris was convicted in US District Court, District of Hawaii, of wire fraud, aggravated identity theft, and false statements involving healthcare matters for her role in submitting false claims and documents to TRICARE. Ms. Harris owned and operated Harris Therapy, Inc., which provided therapeutic services, including speech, physical, and occupational therapy on the island of Oahu. From 2008 through 2012, she submitted false claims and documents to TRICARE for payment for speech therapy services that were not performed, falsified medical records, and misrepresented the provider of services. TRICARE restitution was \$403,079.⁶

Case Study: U.S. v. Stephen Z. Gervin – Misrepresenting Services, Misrepresentation of Provider, and Overutilization of Services – Civil Settlement

On 12 January 2018, the U.S. Department of Justice, Southern District of Florida completed a settlement agreement with Dr. Gervin. Allegations were misrepresenting VAX-D as physical therapy, misrepresenting the rendering provider of services, and overutilization of nerve conduction testing. TRICARE restitution was \$379,553.

Case Study: U.S. v. Allergan – False Claims, Faulty Medical Devices and Kickbacks – Civil Settlement

The U.S. Attorney's Office, District of Maryland, entered into a civil settlement agreement with medical device manufacturer Allergan to resolve allegations that Allergan caused health care providers to submit false claims to Federal healthcare programs relating to the LAP-BAND Adjustable Gastric Banding System. Allegedly, between 2008 and 2010, Allergan knowingly sold LAP-BANDs with defective or flawed access ports. To conceal the defect and to induce health care professionals to continue using the LAP-BAND, Allergan misrepresented facts concerning the cause of access port leaks to the public, health care professionals, and the FDA; failed to collect or maintain required data and complaint files; and offered and provided remuneration to health care professionals who reported access port leaks. It was additionally alleged that Allergan knowingly advertised, marketed, and distributed the LAP-BAND for use in two off-label two procedures. To market and induce health care professionals to use the LAP-BAND for these uses, Allergan provided remuneration to health care professionals in connection with proctoring,

⁶ Sheila Harris was sentenced on 18 January 2019 to 5 years and 10 months incarceration.

workshops, advisory boards, and training events in which these two uses were discussed and/or demonstrated. TRICARE restitution was \$337,750.

Case Study: U.S. v. Advanced Pain Management Specialist – Medically Unnecessary Services and Kickbacks – Civil Settlement

The U.S. Attorney's Office, Middle District of Florida, entered into a civil settlement agreement with Dr. Michael Frey on 11 May 2018. Dr. Frey was one of two principal owners of Advanced Pain Management & Spine Specialists, in Lee County, FL. Allegedly, between 2010 and 2017, Dr. Frey accepted kickbacks for referrals of durable medical equipment, accepted kickbacks in exchange for referrals of compound pharmaceutical pain cream prescriptions, received remuneration in the form of speaker fees paid to him by Insys Therapeutics Inc., ordered medically unnecessary definitive urine drug tests, and received kickbacks in the form of ownership interest, for referrals to Anesthesia Partners. TRICARE restitution was \$309,745.

Case Study: U.S. v. Alere, Inc. – Fraudulent Claims – Civil Settlement

The United States Attorney's Office District of Maryland, entered into a civil settlement agreement with Massachusetts-based medical device manufacturer Alere, Inc. The settlement with Alere, Inc., was to resolve allegations that they submitted fraudulent claims to Medicare, Medicaid, and TRICARE between January 2006 and March 2012 for selling materially unreliable point-of-care diagnostic testing devices marketed under the trade name Triage®. TRICARE restitution was \$256,000.

Case Study: U.S. v. Ryan Long – Kickbacks – Criminal Conviction

On 22 October 2018, Ryan Long a former Marketer for MGTEN Marketing and Patient Care America, a compounding pharmacy, were sentenced to 5 years' probation with the first 12 months in the Home Detention Program. Long had previously pled guilty to Conspiracy to Receive Health Care Kickbacks. In addition he was ordered to pay a criminal penalty of \$100 and restitution to TRICARE for \$251,730.

Case Study: U.S. v. FWC Urogynecology, LLC – Overcharging a Government Program – Civil Settlement

The U.S. Attorney's Office, Middle District of Florida, entered into a civil settlement agreement with FWC Urogynecology, LLC, to resolve allegations that it violated the False Claims Act by knowingly billing the government for services that were inflated or that it did not provide. TRICARE restitution was \$168,652.

Case Study: U.S. v. Gulf South Physicians Group – Illegally Dispensing and Distributing Controlled Substances, Threats of Assault or murder, and Health Care Fraud – Criminal Conviction

The United States Attorney's Office, Eastern District of Louisiana announced that Shannon C. Ceasar, M.D. was sentenced after pleading guilty for his role in illegally dispensing and distributing controlled substances, threatening to assault or murder federal law enforcement officers, and health care fraud. He pled guilty to all 3 counts. Dr. Ceasar was sentenced to 10 years imprisonment on all 3 counts, to be served concurrently, followed by a 3-year term of supervised release. CEASAR was also ordered to pay restitution in the amount of \$150,788. As part of his plea agreement, CEASAR also agreed to suspension of his Louisiana medical license and, among other property, the voluntary forfeiture of 33 firearms seized by Louisiana authorities.

Case Study: U.S. v. 1st Class Sleep Study Clinic – Healthcare Fraud and Conspiracy to Commit Healthcare Fraud – Criminal Conviction

On 7 December 2018, in the U.S. District Court of Eastern Virginia, Young Yi, former owner of 1st Class Sleep Diagnostic Center and 1st Class Medical, was sentenced to 7 years in prison, followed by 3 years supervised release for charges related to health care fraud and tax fraud. Co-defendant Dannie Ahn was sentenced to 3 years in prison, followed by 3 years supervised release for his involvement. According to court documents and evidence presented at trial, Yi defrauded Medicare, TRICARE, private insurance, and the IRS of more than \$10 million during the conspiracy. After law enforcement searched Yi's businesses in February 2014, Yi formed a purported charity, the "New Covenant Foundation", and

transferred millions of dollars in office properties into the foundation to protect them from recovery from law enforcement. It was ordered that the properties be turned over as part of Yi's sentence, and her sentencing range under the advisory guidelines was enhanced for obstructing justice related to that conduct, on 30 July 2018, Yi was sentenced to 7 years incarceration. TRICARE's restitution was \$83,707.

Case Study: U.S. v. Liberty Ambulance – Upcoded Claims, Fraudulent Claim, and Medically Unnecessary Services – Civil Settlement

The United States Attorney's Office Middle District of Florida, entered into a civil settlement agreement with Liberty Ambulance to resolve allegations that they submitted fraudulent claims to Medicare, Medicaid, and TRICARE for ambulance transports that were not medically necessary, that did not qualify as specialty care transports, and upcoded claims for life support services. TRICARE restitution was \$71,184.

Case Study: U.S. v. Gary Marder – Patient Harm and Medical Unnecessary Services – Civil and Criminal Conviction

On 22 February 2018, Dr. Gary Marder, a Port St. Lucie, Florida dermatologist pleaded guilty of misdiagnosing patients with cancer and performing unnecessary cancer treatments on these patients. The U.S. District Court, Southern District of Florida, sentenced Dr. Marder to 3-years in prison, followed by 1-year supervised release, ordered him to pay a \$200,000 fine, and \$200 assessment fee. No criminal restitution was ordered, as Dr. Marder had previously entered into a civil settlement of which TRICARE received \$55,000.

Case Study: U.S. v. Northwest ENT Surgery Center, LLC – Kickbacks and Billing for Non-Covered Services – Criminal Conviction

The U.S. Attorney's Office, District of Northern District of Georgia, entered into a civil settlement agreement with Northwest ENT Surgery Center, LLC (Northwest ENT), Northwest ENT Associates, P.C., and Shatul Parikh, M.D., resolving allegations regarding Northwest ENT re-using balloon sinus dilation devices, when the FDA only authorized the device for single use. Additionally, Northwest ENT did not adequately clean the sinus dilation devices between uses by different patients. TRICARE restitution was \$35,403.

Case Study: U.S. v. Carlene Taylor and Lighthouse Healthcare – Non-Covered Services and Utilizing Non-Authorized Providers – Civil Settlement

On 27 November 2017, Carlene Taylor and Lighthouse Healthcare, Inc. entered into a civil consent judgment with the United States Attorney's Office, Southern District of Georgia. Allegedly between 1 January 2013 through 30 November 2015, defendant submitted claims to Government healthcare programs for services billed as if a physician provided the service when, in fact, the services were provided by a non-physician professional who was not eligible for reimbursement or did not meet supervision requirements and billed for services by unlicensed providers. TRICARE's restitution was \$16,973.

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

*Defense Health Agency
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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
DHA	Defense Health Agency	MHS	Military Health System
DHP	Defense Health Program	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		

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	Pharmacoeconomics Center	TQMC	TRICARE Quality Monitoring Contract
PID	Program Integrity Division	TRDP	TRICARE Retiree Dental Program
POC	Pharmacy Operations Center	UCCI	United Concordia Dental, Inc.
ProDUR	Prospective Drug Utilization Review	USAO	United States Attorney's Office
SG	Surgeon General	VA	Department of Veterans Affairs
SIU	Special Investigation Unit	WPS	Wisconsin Physician Services
SME	Subject Matter Expert		