



Health Care Fraud Division
Operational Report
Calendar Year 2022

“Guarding the Health Care of Those Who Guard Us”

Vision

DHA-OIG Health Care Fraud Division serves as a model of excellence for the industry ensuring high quality health care for beneficiaries balanced with the protection of benefit dollars.

Mission

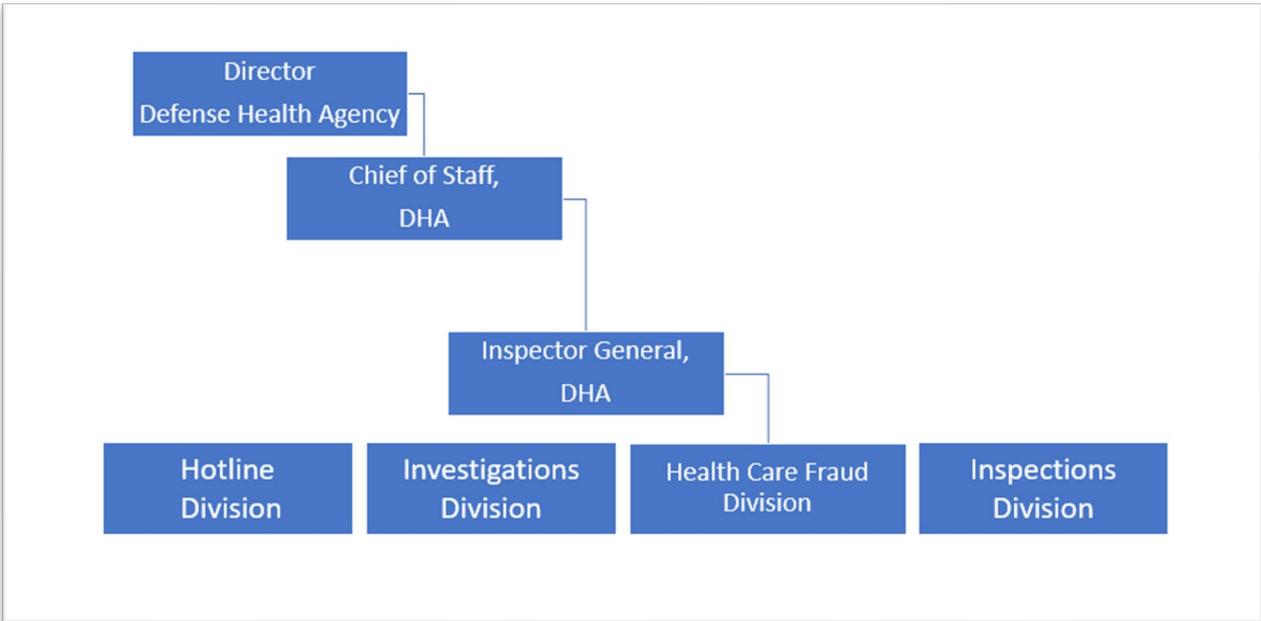
Safeguarding beneficiaries and protecting benefit dollars through the management of healthcare anti-fraud and abuse activities within the DHA.

1.0 Defense Health Agency, Office of the Inspector General, Health Care Fraud Division – General

As a joint, integrated Combat Support Agency, DHA leads the MHS integration of readiness and health to deliver the Quadruple Aim: improved readiness, better health, better care, and lower cost. DHA supports the delivery of integrated, affordable, and high-quality health services to MHS beneficiaries and is responsible for integration of clinical and business processes across the MHS. DHA supports the medical care of 9.6 million Department of Defense (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 through Military Medical Treatment Facilities (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 “private sector care”).

In December 2022, the Director of the Defense Health Agency supported an integration of the existing DHA Program Integrity Division under the umbrella of the DHA-Office of the Inspector General, rebranding the unit as the Health Care Fraud Division (HCFD). While the name has changed, the mission of Program Integrity remains the same it has over the last 40 years: developing and implementing healthcare anti-fraud activities to protect benefit dollars and safeguard beneficiaries. This includes both the private sector care and direct care settings. HCFD 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, initiates administrative measures, and identifies areas for cost containment and internal controls.

Through the integration under the Office of Inspector General, the HCFD has a direct reporting chain to the Director, DHA. This reporting structure facilitates HCFD’s anti-fraud activities without interference from competing agency priorities. Due to the nature and scope of the work performed by HCFD, 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.



The HCFD staff collectively has over 185 years of fraud fighting experience and 150 years of experience specific to TRICARE. HCFD team members hold credentials from the American Health Information Management Association (AHIMA), American Association of Professional Coders (AAPC), Association of Certified Fraud Examiners (ACFE), Health Care Compliance Association (HCCA), and National Health Care Anti-Fraud Association (NHCAA). Furthermore, the integration with DHA-OIG allows for even greater leverage of anti-fraud, investigations and inspection experience specific to the Department of Defense and DHA.

1.1 HCFD Vision 2025

In 2020, HCFD launched a strategic plan focused on modernizing Program Integrity and cost containment over the next 5 years. Though our division name has changed, the overall strategy remains the same. This strategy includes: rebalancing agency and beneficiary focus on fraud, waste and abuse; strengthening internal partnerships to enhance cost containment across the agency; and engaging with MTFs to enhance fraud, waste and abuse education, reporting and training. These strategic areas also align with the DHA priorities improving health and building readiness through making extraordinary experiences ordinary and exceptional outcomes routine.



Rebalance Focus on Fraud, Waste and Abuse



Internal Partnerships to Enhance Cost Containment and Cost Controls



Engage Direct-Care (MTFs) to enhance fraud, waste and abuse detection, reporting and training

The HCFD Vision 2025 focus contrasts the current environment which focuses on pay-and-chase, looking primarily for fraud while placing limited focus on areas of waste and abuse. HCFD Vision 2025 focuses on updating program requirements to fully realize pre-payment controls to detect and deter negative provider or

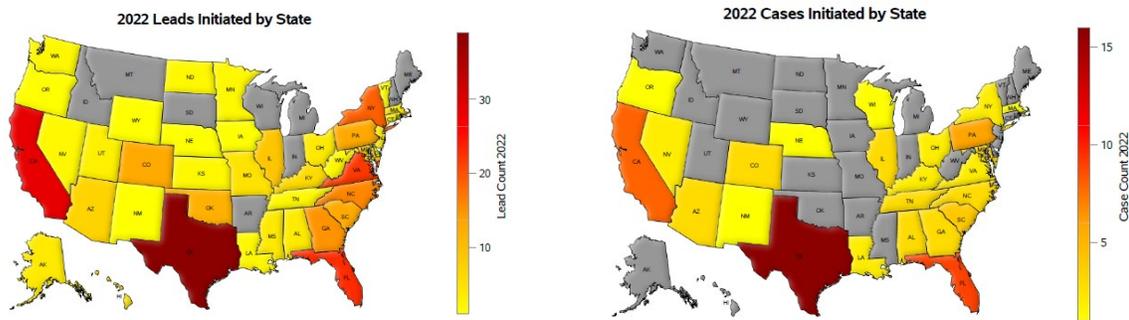
beneficiary behavior before it reaches the level of fraud. Pre-payment controls include education, pre-payment review, and peer comparison audit. This has, in part, been achieved through the updating of contract requirements in the T5 contracts, awarded in late 2022, which highlight pre-payment controls to enhance deterrence. Additional focus on enterprise education and understanding of fraud risks throughout military healthcare is underway through partnering with DHA Communications and developing an enterprise-wide communication plan.

Many issues of waste and abuse are due to program vulnerabilities in both policy and operational application. The current process is to share findings of program vulnerabilities with staff of Healthcare Operations (HCO), the DHA directorate responsible for the direct oversight and policy making within the TRICARE program. Additionally, HCFD is often omitted when new policies and benefits are determined. This introduces risk into the process by lacking a cohesive “anti-fraud” review of benefits before they are rolled out. HCFD Vision 2025 seeks to develop formal lines of communication between HCFD and HCO to identify and mitigate issues early in the process, and deter fraud, waste and abuse before it gets out of control. Additionally, it allows for integrated process teams to address cross-departmental concerns prior to policy implementation. This effort is further enhanced through the integration of HCFD into the DHA-OIG portfolio, allowing for partnership between the HCFD and Inspections Division to further highlight and track recommendations for improvement throughout the agency.

The third area of focus in HCFD Vision 2025 is enhanced focus and partnership with the Military Medical Treatment Facilities and Direct Care system in developing an enterprise approach to identifying and reporting fraud, waste and abuse. Working within the Market transition, HCFD has partnered with the Functional Champions to work towards an integrated anti-fraud, waste and abuse program. This includes partnering with the Risk Management Internal Controls (RMIC) team requiring attestations from the Markets and SSOs indicating anti-fraud controls are in place. HCFD also continues to solidify these efforts through the revision of the DoD Instruction (DoDI) 5505.12 and DHA Procedural Instruction which address anti-fraud, waste and abuse activities in the MTFs. The revision to the DoDI has been in process since its proposed deletion in 2016; however, it is currently being coordinated through the DHA and DoD Health Affairs for publication. It addresses fraud, waste and abuse in a holistic manner, and drives home the point that detecting and deterring fraud, waste and abuse throughout the program is everyone’s responsibility.

2.0 Fraud and Abuse Cases

During calendar year 2022, 445 investigative cases were actively managed by the team. A total of 103 new cases were opened, and the team responded to over 400 lead requests and fraud allegation inquiries. As documented in the maps below, allegations of fraud, waste and abuse within the DHA program continue to match national fraud trends, with most cases and leads coming out of Florida, California and Texas.

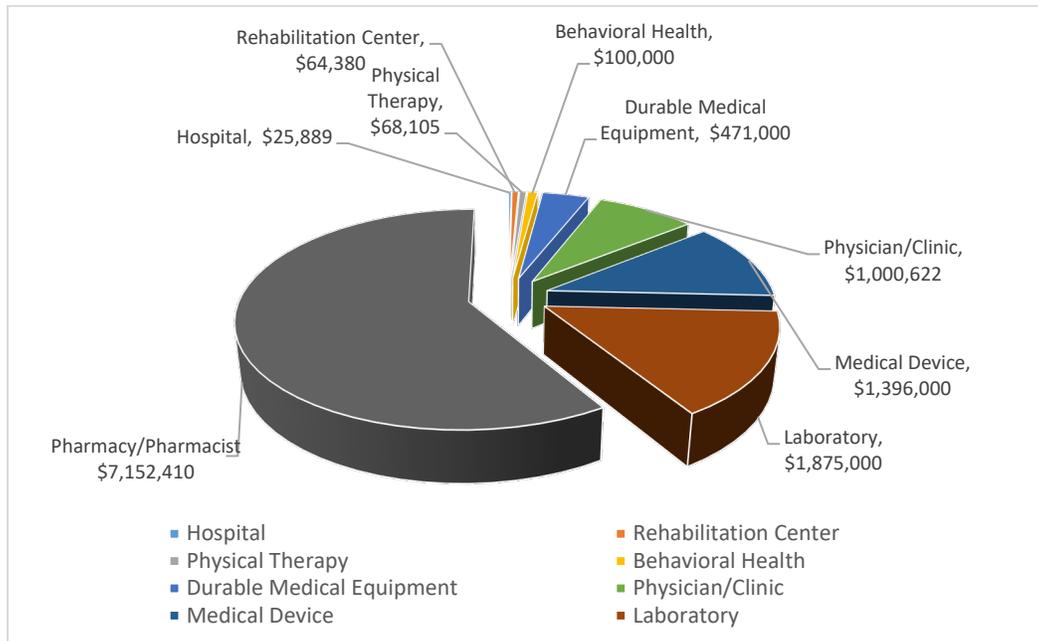


2.1. Fraud Judgements and Settlements

HCFD relies upon assistance from the Department of Justice (DOJ) and Defense Criminal Investigative Service (DCIS) to investigate and prosecute cases on behalf of DHA’s interests. Oftentimes TRICARE is also harmed when fraud is committed against other public benefit programs and private sector insurance. During the calendar year 2022, the TRICARE program received a total of \$134,468,807 in judgements and \$12,153,408 in settlements, with 45 civil settlements and 38 criminal judgements. Unique to DHA/TRICARE, all monies received are returned directly back to the program to fund continuing care for our beneficiaries.

2.2. Significant Civil Cases Involving TRICARE

Case development, support, investigation, and prosecution by DOJ, is an incredible demonstration of teamwork by many health care fraud staff and entities. These cases are highlighted in DOJ Press Releases, which serve to notify those who may attempt to defraud TRICARE or other government healthcare agencies of the potential monetary penalties or civil prosecution. The following charts and case summaries illustrate the most significant provider categories for civil settlements, court ordered restitution, and convictions.



Summaries of the most significant civil cases from 2022 are included the sections below.

2.2.1. Civil Settlement: Brett Markowitz

The U.S. Attorney’s Office for the Eastern District of Texas entered into a settlement agreement with Brett Markowitz, owner of Florida Rejuvenation Holdings, LLC, which operates medical practices in Tampa, FL. Markowitz received remuneration from True Health Diagnostics, LLC, a diagnostic laboratory, in return for arranging and/or recommending that physicians at the Tampa practices order from True Health Diagnostics in violation of the Anti-Kickback statute. TRICARE Restitution \$92,500.00.

2.2.2. Civil Settlement: Cockerell Dermatopathology

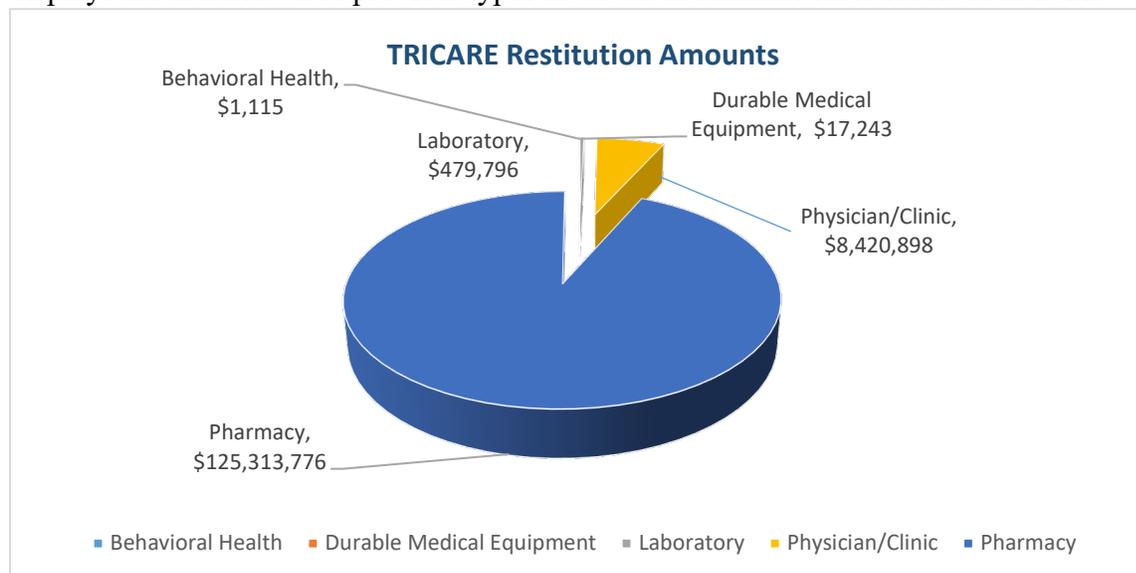
On August 19, 2022, the United States Attorney’s Office for the Northern District of Texas entered into a settlement agreement with Cockerell Dermatopathology, P.A. (CDP) and their founder to resolve allegations that CDP billed for false claims for toxicology and pharmacogenetic tests, and knowingly retained overpayments from March 2015 through November 2016. CDP has agreed to pay a settlement amount of \$3,750,000. TRICARE’s restitution is \$1,875,000.

2.2.3. Civil Settlement: Pharmacy Insurance Administrator

On October 6, 2022, the United States Attorney’s Office for the Northern District of Georgia entered into a settlement agreement with Pharmacy Insurance Administrators (PIA), the billing company for compounding pharmacy DermaTran Health Solutions, to resolve allegations PIA in 2012 waived patient copays, charged higher rates to the government than permitted, and traded federal healthcare business with other pharmacies. PIA has agreed to pay a settlement of \$6,500,000. TRICARE’s restitution is \$1,908,500.

2.3. Significant Criminal Cases involving TRICARE

The burden of proof is different for criminal cases, and criminal litigation is typically reserved for the most egregious of fraud or abuse matters. As such, penalties for criminal cases often include both restitution and incarceration. In calendar year 2022, the majority of criminal cases resolved in favor of TRICARE were related to pharmacy compounding cases. The chart below displays the breakdown of provider types involved in criminal cases resolved in 2022.



Summaries of the most significant criminal cases from 2022 are included in the sections below.

2.3.1. Criminal Case: Joe May, M.D.

On 9 June 2022, a federal jury found Dr. Joe May guilty on all 22 counts for which he was indicted. Nine other defendants previously pled guilty in this case except for Dr. May. Dr. May signed off on 226 illegitimate compound prescriptions, and received kickbacks for these prescriptions, which were prescribed to TRICARE beneficiaries. He was sentenced on 13 April 2023 to 102 months incarceration and ordered to pay \$4.630,000 in restitution to TRICARE.

2.3.2. Criminal Case: Merchant Card Solutions and The Med Brace Shop

The owner Frank Alosa and co-conspirator Giovanni Depaola of Merchant Card Solutions, LLC, d/b/a Med Brace Shop submitted false and fraudulent claims for reimbursement to federal health care programs, including TRICARE. Mr. Alosa was sentenced to 51 months imprisonment, 3 years supervised release, and a \$100 special assessment. A restitution order was also entered totaling \$3,942,414 that obligates Mr. Alosa and Mr. Depaola jointly and severally. On April 8, 2022, Mr. Depaola was sentenced to 62 months imprisonment, 3 years supervised release, and a

\$100 special assessment. A Consent Order of Forfeiture for \$4,078,221 was also entered. The TRICARE portion of that restitution is \$43,370.

2.3.3. Criminal Case: Spectrum Diagnostic Laboratory

Two months after being charged, all 11 defendants implicated in the \$300 million Spectrum/Reliable healthcare fraud pled guilty. According to court documents, the founders of lab companies including Unified Laboratory Services, Spectrum Diagnostic Laboratory, and Reliable Labs LLC, paid kickbacks to induce medical professionals to order medically unnecessary lab tests which were billed to Medicare and other federal health care programs. Total restitution ordered to TRICARE (jointly and separately) is \$110,122. The founder of Spectrum Diagnostics Laboratory, Jeffrey Paul Madison, was sentenced to a total of eleven years and six months imprisonment; internal medicine specialist Eduardo Carlos Canova to thirty months imprisonment; family medicine doctor Jose Roel Maldonado to twenty four months imprisonment; Chief Operating Officer Mark Christopher Boggess to three months imprisonment; investor Sherman Kennerson to eighteen months imprisonment; marketer Laura Ortis to ten months imprisonment; and nurse practitioner Keith Allen Wichinski to ten months imprisonment.

2.3.4. Criminal (and Civil) Case: Dr. Thomas Raley, Jr.

On November 18, 2022, Dr. Thomas Raley Jr., of Baltimore, MD, was sentenced in the Eastern District of Virginia to three years in Federal confinement for pleading guilty to charges of writing and referring compounded drug prescriptions in return for illegal kickback payments. In a parallel civil settlement, Raley and Advanced Spine and Pain, jointly paid \$3,159,379 to settle violations of false claims submitted to TRICARE Medicare, and Medicaid. The TRICARE portion of the settlement was \$2,837,863.

3.0 Cost Avoidance

Cost avoidance is a way to decrease costs by lowering potential increases in expenses. In the context of healthcare, cost avoidance includes administrative remedies and measures to ensure claims are paid appropriately. Within TRICARE, cost avoidance includes claims software that identifies duplicate claims, edits to identify mutually exclusive or unbundled claims, prepayment review, and claims audits. As claims processing is the responsibility of TRICARE contractors, the majority of cost containment savings are due to contractor administrative actions.

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 (UCCI) Dental, Inc. are required to check each claim for duplicate billing to prevent erroneous expenditures. Duplicate detection requires automated and manual procedures to identify and prevent duplicate payments. Each contractor is required, at a minimum, to compare specific fields on each claim line item to ensure appropriate payment. For calendar year 2022 prepayment duplicate denials reported by the contractors to Program Integrity amounted to \$506,924,035.¹

¹ Prepayment Duplicate Denial amounts as reported by TRICARE contractors.

3.2. Rebundling/Mutually Exclusive Edits

TRICARE’s MCSC’s, ISOS, and WPS are required to use prepayment 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 2022, the prepayment claims processing software in use by the MCSC’s accounted for \$111,029,383 in cost avoidance for TRICARE. ²

3.3. Prepayment Review

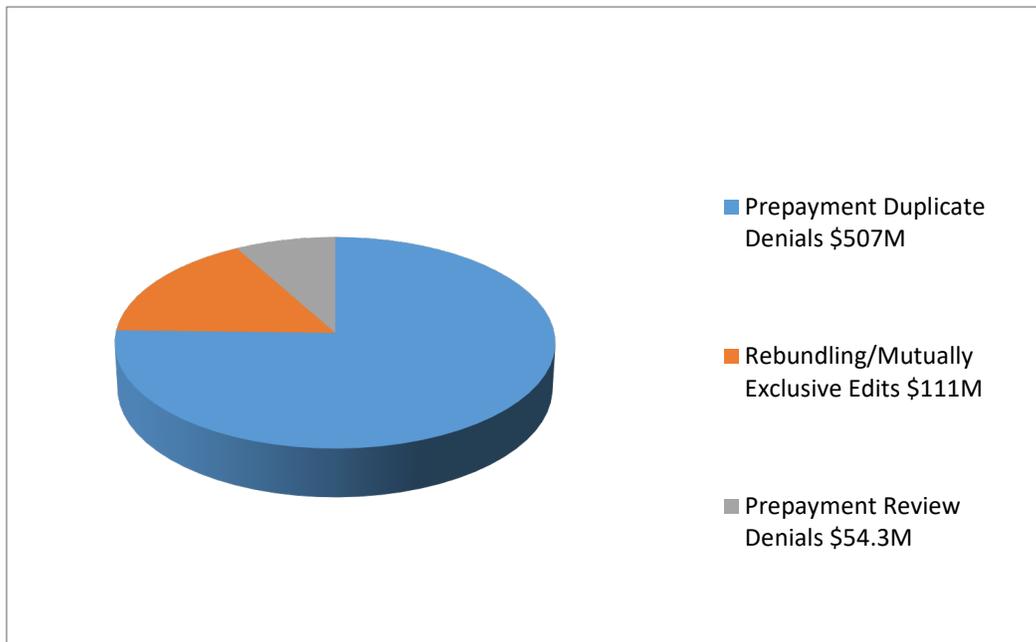
Prepayment review prevents payment for questionable billing practices or fraudulent services. As an administrative remedy, providers/beneficiaries with atypical billing patterns may be placed on prepayment review. Once on prepayment review, their claims and supporting documentation are subject to prepayment screening to verify that the claims are free of billing problems and the documentation supports services billed. The results of a review may result in a reduction of what was claimed or a complete denial of the claim. The following chart shows costs avoided that were a result of prepayment review activities by each contractor.

TRICARE Support Contractors	Cost Avoidance
Humana Military Healthcare Services, East Region	\$33,410,138
Health Net Federal Services, West Region	\$10,195,033
International SOS, Overseas	\$5,743,239
WPS TDEFIC	\$4,598,660
UCCI – Dental	\$383,279
TOTALS:	\$54,330,349

² Rebundling/Mutually Exclusive Edit amounts as reported by TRICARE contractors.

4.0. Contractor Recoveries and Recoupments

This section details recoveries and recoupments through anti-fraud initiatives at the support contractor level. Money recovered and recouped is applied back into the program to fund beneficiary healthcare entitlements.



4.1. Post-payment Duplicate Claims Denials (DCS)

A post-payment duplicate claim (DCS) software was developed by DHA and is used by the MCSC's. This software was designed as a retrospective auditing tool to identify paid duplicate claims and the initiation and tracking of recoupments. While most duplicate claims are identified through prepayment screening, \$16,070,702 was identified in 2022, for recoupment or offset on a post-payment basis.³

4.2. Pharmacy Post-payment Audits

Post-payment audits represent amounts recovered from paid pharmacy claim submission errors identified as part of ESI audit and monitoring activities. In 2022, \$10,346,449 was recovered.⁴

4.3. Administrative Recoupments/Offsets

The Federal Claims Collection Act (FCCA) provides authority for the collection of non-financially underwritten fund recoupments and was enacted to avoid unnecessary litigation in collecting debts owed to the United States. This authority extends to the TRICARE contracts and allows for contractors to recoup funds which have been incorrectly disbursed as an underpayment or overpayment for whatever reason. Administrative recoupment of inappropriately paid claims may be either recovered directly from the provider as a recoupment

³ Post payment Duplicate Claims Denials as reported by TRICARE contractors

⁴ Pharmacy Postpayment amounts as reported by TRICARE Pharmacy Benefit Manager.

or offset from a providers' future claims. In 2022, \$35,063,744 was recovered through administrative recoupments.⁵

5.0. Balance Billing and Violation of Participation Agreements

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

In 2022, 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 \$473,643 in Violation of Participating Agreement and Balance Billing efforts.⁶

5.1. Balance Billing

When TRICARE MCSC's cannot resolve Balance Billing issues at their level, HCFD 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 payment of 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 cannot be resolved are referred to HCFD. Four Balance Billing matters were referred to HCFD in 2022. Additionally, two other balance billing cases referred to HCFD in the previous year were resolved in 2022. Total resolution for Balance Billing was \$36,072 returned or collection actions ceased against beneficiaries in 2022.

5.2. Violation of the Participation Agreement

HCFD 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 rate. This is commonly referred to as a *Violation of the Participation Agreement*. Violations of Participation Agreement that TRICARE's MCSC's are unable to resolve are referred to HCFD. HCFD did not receive any violation of participation cases in 2022.

⁵ Data as reported by TRICARE Contractors.

⁶ Data as reported by TRICARE Contractors

6.0 Voluntary (Self) Disclosure Reporting

Identifying and addressing fraud, waste and abuse within the TRICARE program is everyone's responsibility. With this in mind, DHA encourages providers to "police" themselves by engaging in compliance and 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.

HCFD receives voluntary self-disclosures in two different ways. The first is through coordination with HHS, who refers self-disclosures impacting the TRICARE program to HCFD. The second is through the Program Integrity website and Self-Disclosure Program (SDP) for TRICARE <https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Program-Integrity/Voluntary-Self-Disclosure-Reporting>. In 2022, TRICARE did not receive any self-disclosures.

7.0. Provider Exclusions and Suspensions

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

HCFD works with the DHA Office of General Counsel to recommend exclusions when necessary. TRICARE's exclusion list is available on the internet at: <https://www.health.mil/About-MHS/OASDHA/Defense-Health-Agency/DHA-Office-of-the-Inspector-General/Fraud-and-Abuse/Sanctioned-Providers>. This online searchable database allows searches by provider or facility name. During 2022, DHA did not exclude any provider under its own authority, in part due to COVID-19 and the delays caused by not being able to meet in person.

From this website, users may also access the Department of Health and Human Services (HHS), 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 HCFD and the HHS OIG enables sharing of information between our two agencies. As part of the agreement, HHS OIG provides HCFD with updates from its LEIE monthly, 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. 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.

8.0 Civil Monetary Penalties

In late 2021, DHA and the TRICARE program received Civil Monetary Penalty (CMP) authority under Title 32 Code of Federal Regulations (CFR) 200, which allows the Secretary of Defense as the administrator of a Federal healthcare program to impose civil monetary penalties as described in section 1128A of the Social Security Act against providers and suppliers who commit fraud and abuse in the TRICARE program. This regulation provides authority to establish a program within the DoD to impose civil monetary penalties for certain such unlawful conduct in the TRICARE program. The program to impose civil monetary penalties in the TRICARE program is called the Military Health Care Fraud and Abuse Prevention Program, and was mandated in the passage of the National Defense Authorization Act (NDAA) for fiscal year 2022. HCFD continues to work with internal partners to develop a pilot process for CMPs, with the program anticipated to be self-funding within the next 10 years.

9.0. Program Integrity Affiliations

Defense Criminal Investigative Services (DCIS) is the primary investigative agency for the DoD TRICARE Program. HCFD and DCIS work in close cooperation in the fight against health care fraud and abuse. In calendar year 2022, DCIS continued to recognize health care fraud as one of its investigative priorities. In doing so, DCIS strongly supports HCFD's anti-fraud program. DCIS' commitment to investigating health care fraud resulted in increased numbers of cases accepted for investigative purposes.

HCFD also routinely collaborates with Military Criminal Investigative Offices (MCIO), Federal prosecutors and investigators (e.g., DOJ, HHS IG, FBI, and DEA) as well as those on state and local levels. Additionally, HCFD is engaged in public-private sector partnerships with the National Health Care Anti-Fraud Association (NHCAA), Healthcare Fraud Prevention Program (HFPP) and as a Government Liaison member with the Association of Certified Fraud Examiners. HCFD also actively participates on health care task forces throughout the United States.