



Defense Health Agency



Program Integrity Operational Report

January 1, 2014
through December 31, 2014



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



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Director, Program Integrity
Business Support Directorate
Defense Health Agency
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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) 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.

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 health care fraud meetings. These meetings foster collaborative anti-fraud efforts across government agencies and private organizations.

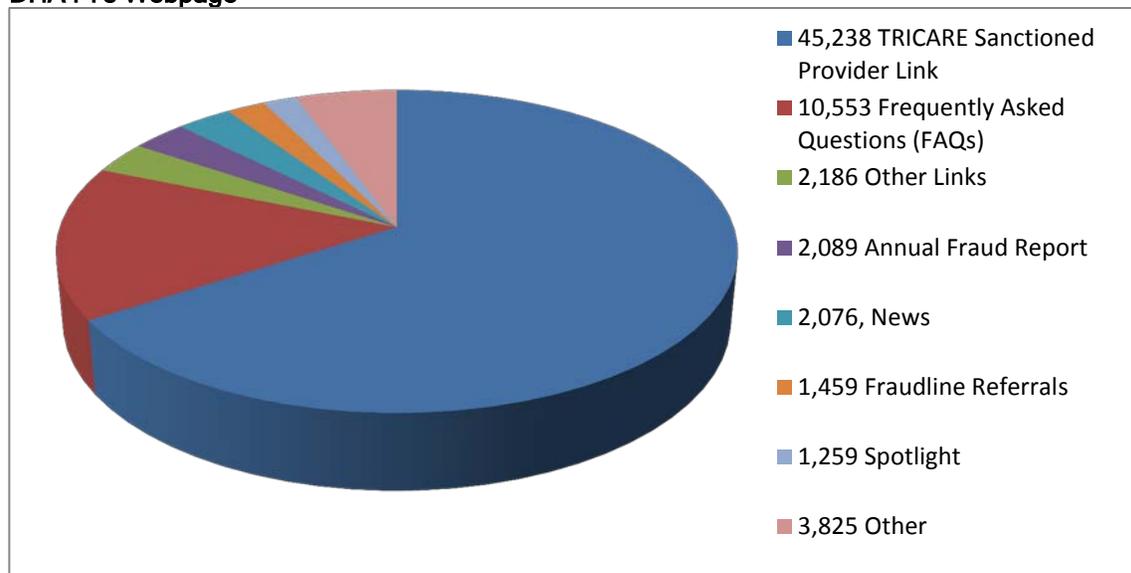
Through a Memorandum of Understanding, DHA PI refers its fraud cases to the Defense Criminal Investigative Service (DCIS). DHA PI also coordinates investigative activities with Military Criminal Investigative Offices (MCIOs), as well as other federal, state, and local agencies. DHA PI provides technical assistance, subject matter expertise, and support to U.S. Attorney Offices (USAOs), law enforcement agencies, and others in developing cases for prosecution 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 2014, DHA PI's homepage which is located at www.tricare.mil/fraud continued to experience significant access by the public. The number of visits on DHA PI's webpage was just over 102,880. Our most popular feature continues to be the TRICARE Sanctioned Provider page with 45,238 visits and Frequently Asked Questions (FAQs) with 10,533 visits. Fraudulent activities may be reported via the website directly to the DHA PI Office. The email address is: fraudline@DHA.mil.

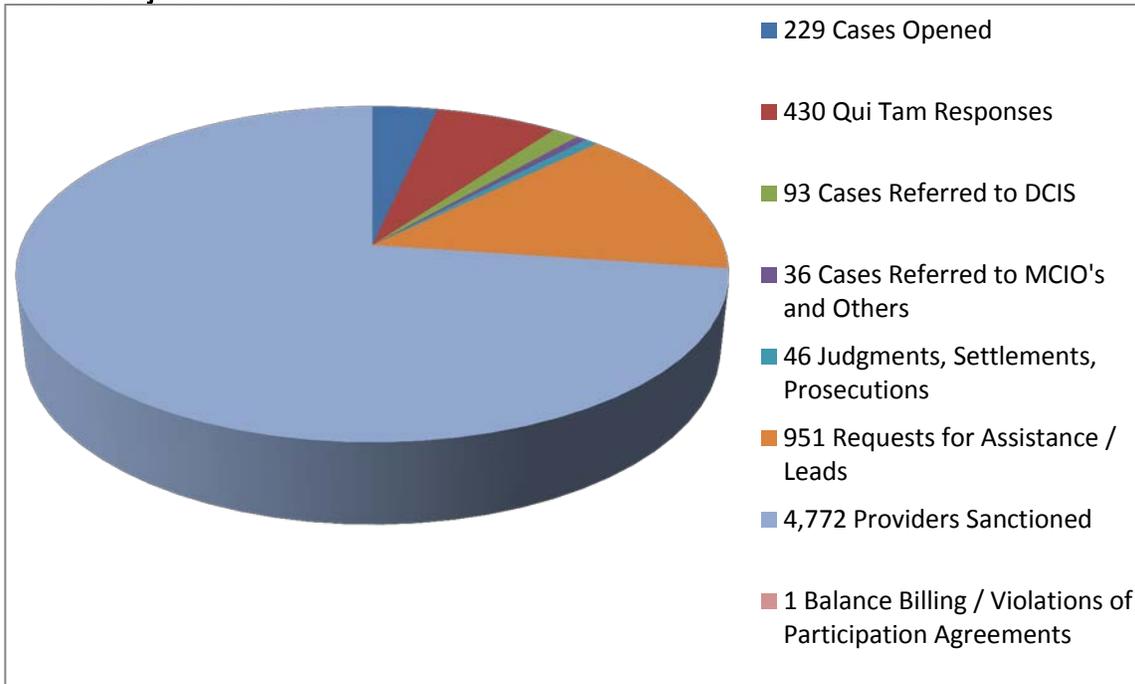
DHA PI's Webpage



Section 2.0 DHA PI Activity Report

DHA PI had another milestone year. During calendar year 2014, 354 active investigations were managed, 229 new cases were opened, and 951 leads/requests for assistance were responded to. DHA PI received and evaluated a record number of 430 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 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 2014 prepayment duplicate denials amounted to \$614,704,087.

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 2014, the prepayment claims processing software in use by the MCSCs accounted for \$132,384,836¹ 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 2014 Prepayment Review²

CONTRACTORS	COSTS AVOIDED
Health Net Federal Services, North	\$2,298,134
United Healthcare Military & Veterans, West	\$891,668
Humana Military Healthcare Services, South	\$11,222,054
International SOS, Overseas	\$3,091,188
WPS TDEFIC, National	\$174,267
UCCI, National	\$0
Met Life, National	\$1,273
ESI	\$71,820
TOTALS:	\$17,750,404

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 \$445,279 of inappropriate pharmacy billing errors prior to payment.

3.5 Excluded Providers

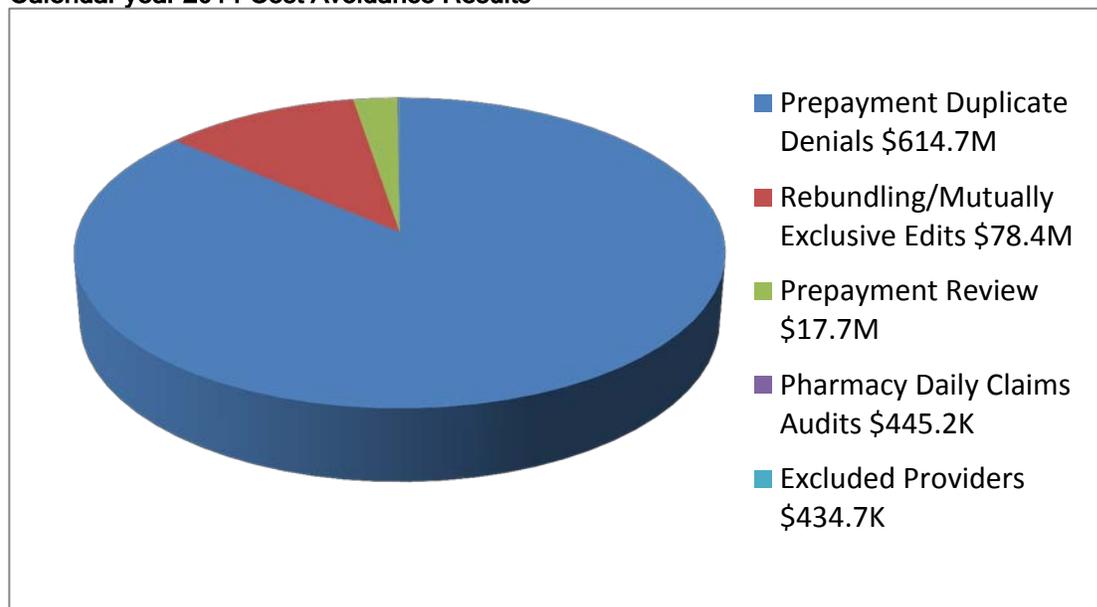
DHA has exclusion and suspension authority based on Title 32, Code of Federal Regulations (CFR), Part 199.9. DHA PI works with the DHA Office of General Counsel to recommend sanctions when necessary. TRICARE's sanction list is available on the internet at www.tricare.mil/fraud. This online searchable 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 4,772 providers in calendar year 2014. The basis for exclusion includes convictions for program-related fraud, patient abuse, and state licensing board actions.

² Data as reported by TRICARE Contractors.

Calendar year 2014 Cost Avoidance Results³



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 2014 totaled \$15,480,928. 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 2014 from past and present settlements and judgments were \$12,762,380.⁴

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 \$27,686,608.03⁵ 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 2014, \$15,887,605 was recovered.

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,

³ Rebundling/Mutually Exclusive Edits amount acquired from TRICARE's data repository. All other categories as reported by TRICARE contractors.

⁴ Payments received in calendar year 2014 as reported by DHA Office of General Counsel, Appeals, Hearings and Claims Collection Division.

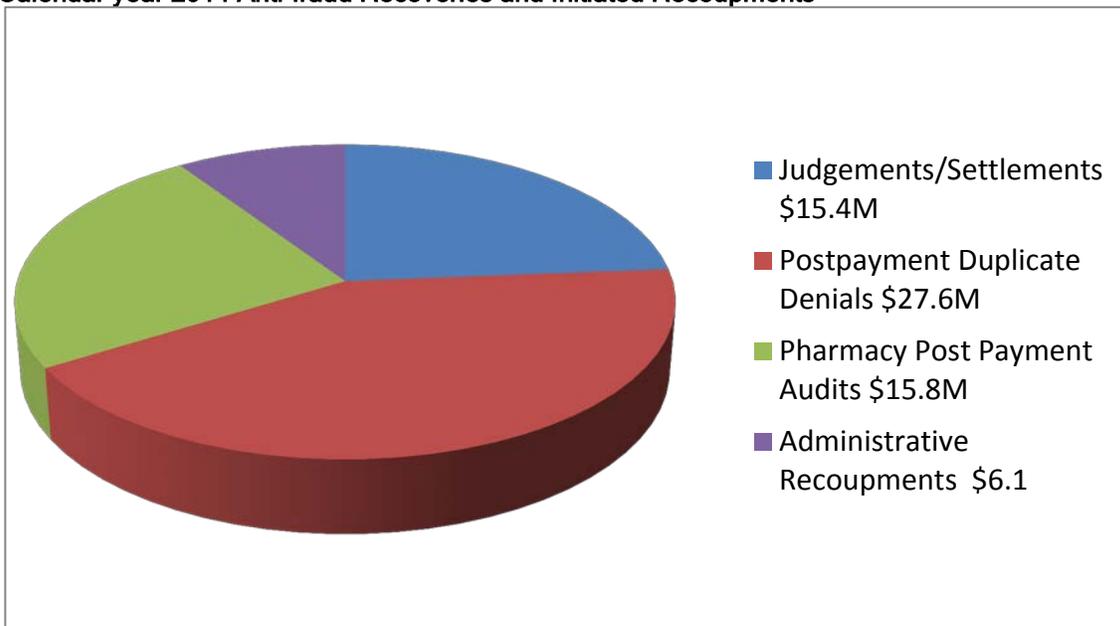
⁵ Post Payment Duplicate Claims Denials as reported by DHA Purchase Care Integration Branch.

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 2014, \$6,145,308 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, TRICARE receives voluntary disclosures of overpayments. In 2014, TRICARE received one voluntary disclosure from a medical provider.

Calendar year 2014 Anti-fraud Recoveries and Initiated Recoupments⁶



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 2014, 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 \$202,459.

⁶ 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. One Balance Billing matter was referred to DHA PI and resolved with \$615 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 2014.

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 2014, DHA PI received 66,860 names from DMDC to review for potential eligibility fraud and abuse related to late-reported eligibility changes. As of 31 December 2014, this resulted in 38 referrals to law enforcement and \$14,855,742 in recoupments.

Section 7.0 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 2014, 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, 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 8.0 Program Integrity Snapshot of Cases Involving TRICARE

This section reviews a sampling of significant fraud cases involving TRICARE in calendar year 2014. During this calendar year five individuals/entities were criminally convicted and ten individuals were incarcerated for committing health care fraud against the TRICARE program.

Case Study: U.S. v. Endo Pharmaceuticals - Unlawful Promotion of Certain Prescription Drugs

On February 21, 2014, Pharmaceutical company Endo Health Solutions Inc. and its subsidiary Endo Pharmaceuticals Inc. (Endo) agreed to settle criminal and civil liability for its actions to promote the drug Lidoderm for off label uses not approved by the FDA. Except as to conduct admitted in connection with the deferred prosecution agreement, the claims settled by the civil agreement are allegations only, and there has been no determination of civil liability. Lidoderm was approved to only treat pain associated with post-herpetic neuralgia, a complication of shingles. Endo marketed Lidoderm for a variety of off label indications such as low back pain, diabetic neuropathy, and carpal tunnel syndrome. As part of the settlement, Endo agreed to enter into a Corporate Integrity Agreement with the Department of Health and Human Services. Total settlement amount was \$192,700,000. TRICARE restitution was \$5,000,000.

Case Study: U.S. v. Alliance Rehabilitation - Misrepresentation of the Provider of Services

On April 9, 2014, Alliance Rehabilitation and its affiliated entities entered into a settlement agreement with the U.S. Attorney's Office for the District of Columbia. The claims settled by the agreement are allegations only, and there has been no determination of liability. Defendants submitted claims for payment that improperly represented who provided the actual physical therapy services. The defendants also used physical therapy assistants, not considered authorized providers under TRICARE. Consequently, all claims for the physical therapy services performed by a physical therapy assistant were not allowed. As part of the settlement agreement, the defendant entered into a Corporate Integrity Agreement. Total settlement amount was \$2,780,000. TRICARE restitution was \$1,200,000.

Case Study: U.S. v. CareFusion - Violations of Federal Anti-Kickback Statute and Unlawful Promotion of ChloraPrep Products

On January 9, 2014, CareFusion agreed to settle allegations with the U.S. Attorney's Office for the District of Kansas to pay the government \$40,100,000 for paying kickbacks for the purpose of inducing the co-chair of the National Quality Forum's Safe Practices Committee to endorse or promote and/or arrange for the purchase of their product, ChloraPrep, in violation of the Federal Anti-Kickback Statute. In addition, CareFusion (1) knowingly promoted the sale of ChloraPrep products for uses that were not approved by the Food and Drug Administration, some of which were not medically accepted indications; and (2) disseminated unsubstantiated representations about the use of ChloraPrep products. The claims resolved by the settlement are allegations only; there has been no determination of liability. The Total Settlement amount was \$40,100,000. TRICARE restitution was \$724,055.

Case Study: U.S. v. Elizabethtown Hematology and Oncology (EHO) - Medically Unnecessary Services

On June 3, 2014, the U.S. Attorney's Office for the Western District of Kentucky and EHO agreed to settle allegations that they were unnecessarily extending the duration of chemotherapy infusion treatment to patients and inappropriately billing office visits for infusion therapy treatments. Dr. Rafiq Ur Rahman and Dr. Yusuf K. Deshmukh, owners of EHO, billed for unnecessary office visit evaluations at the same time patients were receiving chemotherapy or other types of infusion treatments. As a condition of the settlement, EHO entered into a Corporate Integrity Agreement with HHS-OIG and will be monitored for three years. The settlement agreement is neither an admission of liability by Rahman and Deshmukh nor a concession by the United States and Commonwealth of Kentucky that its claims are not well founded. Total Settlement amount was \$3,739,325. TRICARE restitution was \$406,610.

Case Study: U.S. v. Dignity Health - Overcharging By Providing Services at a Higher Level than Medically Necessary

On October 30, 2014, the U.S. Attorneys' Offices for the Northern District of California and the Western District of New York and Dignity Health reached a Settlement on allegations that 13 of its hospitals in California, Nevada and Arizona knowingly submitted false claims by admitting patients who could have been treated on a less costly, outpatient basis to Medicare and TRICARE. The claims resolved by this settlement are allegations only and there has been no determination of liability. Total Settlement amount was \$37,000,000. TRICARE restitution was \$378,000.

Case Study: U.S. v. Endogastric Solutions - Misrepresentation of Services Provided

On February 19, 2014, Endogastric Solutions entered into a civil settlement with the U.S. Attorney's Office for the District of Montana to settle allegations that they knowingly caused false claims to be submitted by providers for a Laparoscopic Nissen Fundoplication, when in fact a less invasive Transoral Incisionless Fundoplication procedure was conducted utilizing their EsophyX. EGS also knowingly offered and paid illegal remuneration to certain physicians and hospital providers for participating in patient seminars and co-marketing arrangements with the intent to induce them to use EsophyX. The claims resolved by the settlement are allegations only, and there has been no determination of liability. Total Settlement Amount was \$5,250,000. TRICARE restitution was \$310,855.

Case Study: U.S. v. Concierge Compounding Pharmaceuticals, Inc. - Improper Waiving of Cost-Shares and Improper Sales

On January 10, 2014, the U.S. Attorney's Office for the District of Nevada and Concierge agreed settle allegations and pay the United States \$273,500. The investigation supported audit findings that Concierge was waiving patient cost-share. Concierge waived patient cost-shares and shipped prescriptions out of state to states for which Concierge had not complied with the state's pharmacy requirements. The claims resolved by the settlement are allegations only, and there has been no determination of liability. TRICARE's restitution was \$270,000.

Case Study: U.S. v. Gulf Region Radiation Oncology Centers, Inc. - Medically Unnecessary Services and Services Not rendered

On January 10, 2014, Gulf Region Radiation Oncology Centers, Inc. agreed to settle allegations that they submitted claims for services that were not rendered, were not medically necessary or were duplicative of other services rendered, or were upcoded to obtain a higher rate of reimbursement than appropriate for the services rendered. The claims settled by the agreement are allegations only, and there has been no determination of liability. Total Settlement Amount was \$3,500,000. TRICARE restitution was \$245,860.

Case Study: U.S. v. Gonzaba Medical Group - Disguising Non-Covered Services as Covered Services

The U.S. Attorney's Office for the Western District of Texas and Gonzaba Medical Group agreed to a civil settlement to settle allegations that it billed TRICARE and Medicare for chiropractic care as individual physical therapy. Gonzaba operates five clinics in the San Antonio, Texas area. The claims settled by the agreement are allegations only, and there has been no determination of liability. Total Settlement amount is \$413,891. TRICARE's restitution was \$176,118.

Case Study: U.S. v. George Mathews, M.D. - Illegal Distribution of Drugs and Billing For Services Not Rendered

On 7 February 2014, Dr. George Mathews of Prince Frederick, Maryland, pleaded guilty in the U.S. District Court of Maryland to the illegal distribution of drugs and health care fraud. Dr. Mathews had medical offices in Prince Frederick and in Waldorf, Maryland. From January 2007 to July 2011, Dr. Mathews repeatedly wrote prescriptions for drugs that he knew were without any legitimate medical purpose. On a number of occasions, Dr. Mathews prescribed drugs after being made aware that his

patients were either selling or abusing the prescribed drugs. In addition, numerous patients stated that Dr. Mathews performed little or no examination before writing the prescriptions. Dr. Mathews repeatedly wrote prescriptions for drugs without medical necessity and billed for services not provided. Dr. Mathews was sentenced to two years of probation with a condition requiring home monitoring for two years. He also agreed to forfeit \$615,000. TRICARE restitution was \$170,951.

Case Study: U.S. v. Vanessa Campos - Conspiracy to commit Larceny to Obtain Healthcare Benefits

On 6 May 2014, Specialist 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. Specialist 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. 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.

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

*Defense Health Agency
ATTN: Program Integrity Office
16401 East Centretech Parkway
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