



Defense Health Agency



Program Integrity Operational Report

January 1, 2016
through December 31, 2016



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



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Office of Program Integrity

Mission

Our mission is to manage healthcare anti-fraud and abuse activities for the Defense Health Agency to safeguard beneficiaries and protect benefit dollars. 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 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.

Organization



Section 1.0 Defense Health Agency Program Integrity - General

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

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

The DHA Office of Program Integrity (PI) 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 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 as part of the DHA Special Support Staff reports directly to the DHA Deputy Director. This reporting structure facilitates DHA PI’s anti-fraud activities. Because of the nature and scope of the work performed by DHA PI, its reporting line is separate and distinct organizationally from the day-to-day operational activities of other departments to avoid the appearance or potential of undue influence or conflict of interest.

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

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

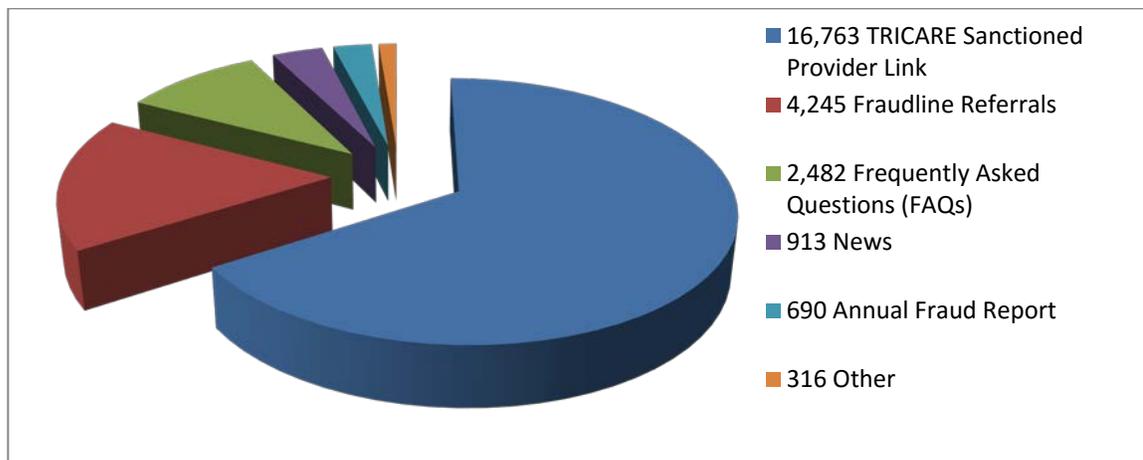
Through a Memorandum of Understanding, DHA PI refers its fraud cases to the Defense Criminal Investigative Service (DCIS). DHA PI also coordinates investigative activities with Military Criminal Investigative Offices (MCIOs), as well as other federal, state, and local agencies. DHA PI provides technical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

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

Section 1.1 TRICARE's Fraud and Abuse Website

In 2016, DHA PI's homepage which is located at www.health.mil/fraud continued to experience significant access by the public. The number of visits on DHA PI's homepage was 55,599¹. Our most popular feature was a Fraud Alert titled, "Ten Defendants Charged In \$100 Million TRICARE Fraud Scheme" with 10,272 pageviews. Fraudulent activities may be reported through the above homepage and directly to the DHA PI Office by clicking the "Report Health Care Fraud" button.

DHA PI's Webpage



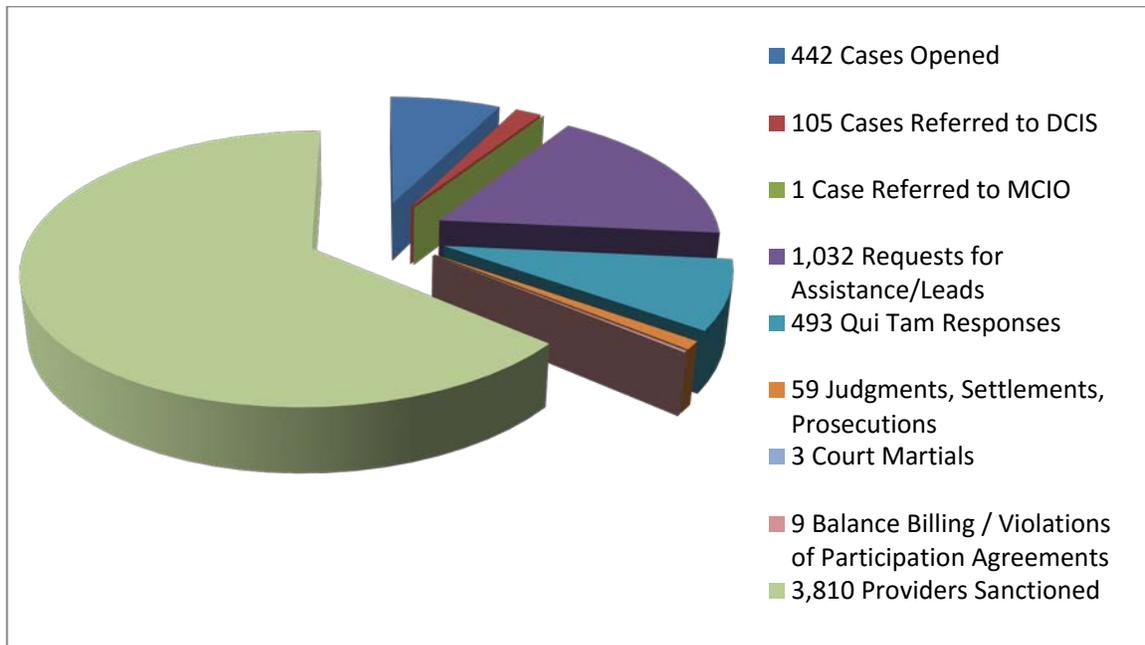
Section 2.0 DHA PI Activity Report

DHA PI had another milestone year. During calendar year 2016, 664 active investigations were managed, 442 new cases were opened, and 1,032 leads/requests for assistance were responded to. DHA PI received and evaluated a record number of 493 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

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

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

DHA PI's Major Activities



Section 3.0 Cost Avoidance

This section details the results of cost avoidance activities.

3.1 Prepayment Duplicate Denials

TRICARE's Managed Care Support Contractors (MCSC) along with International, SOS (ISOS), Wisconsin Physician Service (WPS), Express Scripts Incorporated (ESI), United Concordia Dental (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 2016 prepayment duplicate denials amounted to \$662,448,049.

3.2 Rebundling/Mutually Exclusive Edits

TRICARE's MCSC's and ISOS, WPS, 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 2016, the prepayment claims processing software in use by the MCSCs accounted for \$97,773,046² 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

² Data Acquired from TRICARE Claims Data Repository.

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 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 2016 Prepayment Review³

CONTRACTORS	COSTS AVOIDED
Humana Military Healthcare Services, South	\$24,557,290
Health Net Federal Services, North	\$4,745,682
International SOS, Overseas	\$1,324,267
United Healthcare Military & Veterans, West	\$1,018,230
WPS TDEFIC, National	\$241,363
UCCI, National	\$108
TOTALS:	\$31,886,940

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 \$88,892 of inappropriate pharmacy billing errors prior to payment.

3.5 Excluded Providers

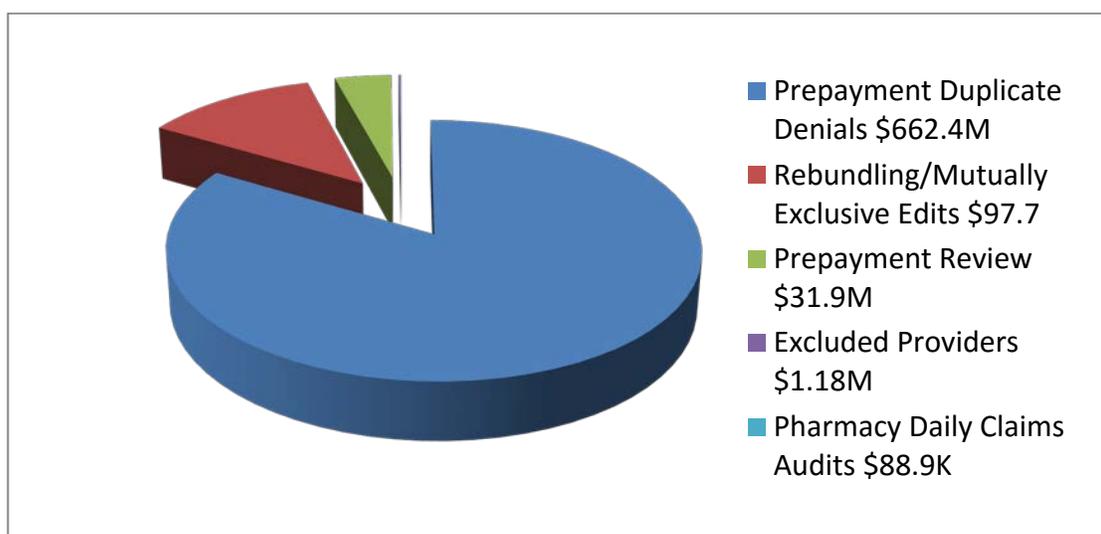
DHA has exclusion and suspension authority based on Title 32, Code of Federal Regulations (CFR), Part 199.9. DHA PI works with the DHA Office of General Counsel to recommend sanctions when necessary. TRICARE's sanction list is available on the internet at www.health.mil/fraud. This online searchable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

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

An agreement between DHA PI and the DHHS OIG enables sharing of information between our two agencies. As part of the agreement, DHHS OIG provides DHA PI with updates from its LEIE on a monthly basis, which lists providers who have been excluded, terminated, or suspended, as well as a list of providers who have been reinstated. This list is used by TRICARE contractors to flag sanctioned providers to ensure that no payments are made for services prescribed or provided by sanctioned providers. DHA PI also provides the sanction list to the Surgeons General (SGs), TRICARE Regional Offices (TROs), Uniformed Services Family Health Plan (USFHP), Pharmacy Operation Center (POC), National Quality Monitoring Contract (NQMC), DCIS, and the Defense Logistics Agency (DLA). DHHS OIG took sanction action against 3,810 providers in calendar year 2016. The basis for exclusion includes convictions for program-related fraud, patient abuse, and state licensing board actions.

³ Data as reported by TRICARE Contractors.

Calendar year 2016 Cost Avoidance Results⁴ Recoveries and Recoupments



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 2016 totaled \$92,747,488, making it the third highest year of recoveries on record for DHA PI. 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 2016 from past and present settlements and judgments were \$53,614,376.⁵

4.2 Post-payment Duplicate Claims Denials

Post-payment duplicate claim software was developed by the DHA Policy and Operations Directorate and is used by the MCSCs. This software was designed as a retrospective auditing tool to identify paid duplicate claims. While most duplicate claims are identified through prepayment screening \$24,703,667 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 2016, \$26,874,324 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, 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 2016, \$12,133,277 was recovered through administrative recoupments.

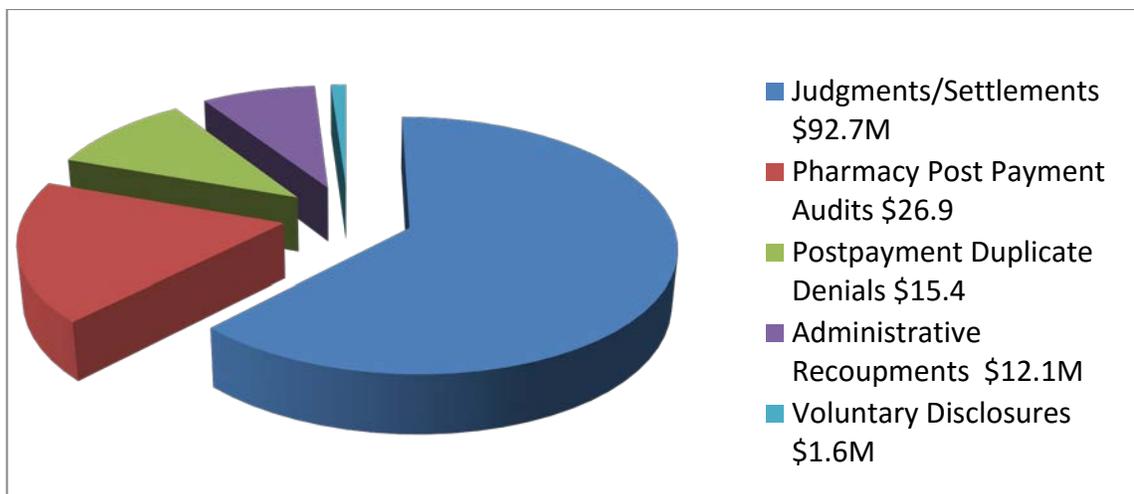
⁴ Rebundling/Mutually Exclusive Edits amount acquired from TRICARE's data repository. All other categories as reported by TRICARE contractors.

⁵ Payments received in calendar year 2016 as reported by DHA Office of General Counsel, Appeals, Hearings and Claims Collection Division.

4.5 Voluntary Disclosures

In its continuing efforts to protect the integrity of its program from provider fraud and abuse, DHA encourages providers to “police” themselves by conducting voluntary self-evaluations and making voluntary disclosures. By participating in voluntary disclosure programs, providers hope to avoid being subjected to criminal penalties and civil actions. While not protected from civil or criminal action under the FCA, the disclosure of fraud or self-reporting of wrongdoing by a provider could be a mitigating factor in recommendations to prosecuting agencies. Self-reporting offers providers the opportunity to minimize the potential cost and disruption of a full scale audit and investigation, and to negotiate a fair monetary settlement. Because a provider’s disclosure may involve anything from a simple error to outright fraud, full disclosure and cooperation generally benefits the individual or company. As a result of the voluntary compliance and self-audits by medical providers under the current program, DHA receives voluntary disclosures of overpayments. In 2016, TRICARE received six voluntary disclosures from medical providers totaling \$1,625,538 returned to the TRICARE Program.

Calendar year 2016 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 2016, 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 \$269,029.

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. Nine Balance Billing matter was referred to DHA PI and resolved with \$15,017 recovered for our beneficiaries.

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.

5.2 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 2016.

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 2016, MCSC and the PBM received 85,009 names from DMDC to review for potential eligibility fraud and abuse related to late-reported eligibility changes and initiated recoupments totaling \$33,951,895.

Eligibility matters that appear to be fraudulent in nature are referred to DHA PI by the MCSC and PBM. In 2016, this resulted in 7 referrals to law enforcement and \$120,702 in recoupment actions.

Section 7.0 Compound Pharmacy Fraud - An Outlier in 2016

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

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

In many cases the medications provided had not been proven safe or effective. In May 2016, TRICARE adopted strict screening procedures that reduced spending to sustainable levels while ensuring that beneficiaries who require safe and effective compounds received them. The screening procedures have been successful in controlling costs and deterring fraud.

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

Monies belonging to DHA have and are being successfully recovered through criminal judgements and civil settlements, claim reversals⁷ from pharmacies, and recouping tax payer dollars due to fraudulent activities that had targeted TRICARE. In 2016, DHA recovered \$52,977,367 in civil settlements from pharmacies and pharmacies owners, \$53,177,484 in criminal judgments, and \$45,350 from Service members.

Section 8.0 Program Integrity Affiliations

DCIS is the primary investigative agency for the Department of Defense TRICARE Program. DHA PI and DCIS work in close cooperation in the fight against health care fraud and abuse. In 2016, DCIS continued to recognize health care fraud as one of its investigative priorities. In doing so, DCIS strongly supports DHA PI's anti-fraud program. DCIS commitment to investigating health care fraud resulted in increased numbers of cases accepted for investigative purposes.

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

Section 9.0 Program Integrity Snapshot of Cases Involving TRICARE

This section reviews a sampling of significant fraud cases involving TRICARE in calendar year 2016. During this calendar year five individuals/entities were criminally convicted and seven individuals were incarcerated for committing health care fraud against the TRICARE program.

Case Study: U.S. v. Robert Pham – Non-Covered Services and Kickbacks

On 1 Mar 2016, Mr. Robert Pham was indicted for his role in a compound prescription fraud scheme. Specifically, Mr. Pham recruited physicians to write medically unnecessary prescriptions in return for kickbacks. He pled guilty and on 2 August 2016 was sentenced to 151 months incarceration, three years' probation, and a \$100 special assessment fee. In addition, the judge ordered Mr. Pham to pay \$21,293,201 in restitution to TRICARE.

Case Study: U.S. v. Fernando Garcia-Dorta, M.D. - Non-Covered Services and Kickbacks Criminal Conviction and Civil Settlement of Violations of Federal Anti-Kickback Statute and False Claims Act

On 19 October 2016, Dr. Garcia-Dorta was sentenced to 60 months incarceration, restitution of \$21,000,000 (joint and several with other defendants), supervised release of three years, 200 hours of community service and relinquishment of his medical license. Dr. Garcia-Dorta was responsible for generating \$19,989,987 in compound medication billings and received kickbacks from a marketer for doing so. Dr. Garcia-Dorta did not contact any patients he wrote prescriptions for and in some cases approved medications for young children. Dr. Garcia-Dorta forfeited \$110,000 to the U.S. Marshals Service, additional balances from his checking accounts, and a Harley Davidson motorcycle.

Case Study: U.S. v. Mark Messenger - Medically Unnecessary Services and Kickbacks

⁷ When a prescription is filled, billed and adjudicated and needs to be reversed ("unbilled").

On 27 June 2016, Dr. Mark Messenger, a Podiatrist, was indicted for his role in a compound medication fraud scheme. Specifically, Dr. Messenger received kickbacks for writing prescriptions for medically unnecessary high cost compound medications. On 11 July 2016, Dr. Messenger pled guilty to conspiracy to receiving health care kickback and agreed to a forfeiture money judgment against him in the amount of \$2.3 million. On 2 November 2016 he was sentenced to 60 months incarceration, three years' probation, ordered to pay a \$2,500 fine, a special assessment fee of \$100 and restitution in the amount of \$4,469,753 to TRICARE.

Case Study: U.S. v. Nigal Mitchell – Kickbacks

Mr. Nigal Mitchell was charged with paying and receiving kickbacks in return for recruiting beneficiaries to participate in a compounding medications fraud scheme. Once recruited the patients would receive kickback payments to be prescribed medically unnecessary high cost compound pain cream that would be billed to TRICARE. Mr. Mitchell pled guilty and on 29 November 2016 he was sentenced to one year and one day incarceration, three years' probation, restitution in the amount of \$948,740, and a special assessment fee of \$100.

Case Study: U.S. v. Andrea Rivera-Lorenzo - Kickbacks

Ms. Andrea Rivera-Lorenzo, Army Specialist, was charged with receiving kickbacks in return for recruiting TRICARE beneficiaries to participate in a compounding medications fraud scheme. Ms. Rivera-Lorenzo pled guilty and on 29 November 2016 was sentenced to 14 months incarceration, three years' probation, restitution in the amount of \$695,343, and a special assessment fee of \$100.

Case Study: U.S. v. Yorlenny Alford – Kickbacks and Mis-Branding

Ms. Yorlenny Alford, a DoD Dependent, was charged with receiving kickbacks in return for recruiting TRICARE beneficiaries to participate in a compounding medications fraud scheme. On 10 May 2016, she was criminally charged for her role in the compounding fraud scheme. She pled guilty and was sentenced to 12 months incarceration on two counts of Introduction of misbranded drugs into interstate commerce, one year probation, and a \$50 special assessment fee. In addition, she was ordered to pay \$18,246 in forfeiture.

Case Study: U.S. v. A1C Eric Demps – Kickbacks, Health Care Fraud, and Wire Fraud

A1C Eric Demps was charged with receiving kickbacks in return for recruiting TRICARE beneficiaries to participate in a compounding medications fraud scheme. In carrying out the scheme A1C Demps stole identity information from Airman in his unit that was used to bill for high cost compound prescriptions. On 21 December 2015, he agreed to plead guilty to one count of conspiracy to commit health care fraud and wire fraud. As part of the plea agreement, the United States agreed to dismiss seven remaining counts. On 22 February 2016, he was sentenced to six months incarceration and forfeiture in the amount of \$423,744. He was also discharged on 2 March 2016, under Other Than Honorable Conditions.

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

On 14 October 2016, Durbin Pharmacy, a compounding pharmacy in Jacksonville, Florida, entered into a settlement agreement with the U.S. Attorney's Office (USAO). The allegations are Durbin Pharmacy entered into kickback arrangements with various marketing companies, and sought reimbursement from TRICARE for compound drug prescriptions written by multiple prescribing providers. The USAO contends Durbin Pharmacy knew or should have known the prescribing providers did not have a bona fide patient/physician relationship as the sheer magnitude and volume of prescriptions was far in excess of any provider and because the prescriptions were for the same compound prescription substance, despite the patient's age, condition, or health record. TRICARE restitution was \$2,100,000.

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

On 25 November 2016, WELL Health, a compounding pharmacy in Jacksonville, Florida, entered into a settlement agreement with the USAO. The allegations are WELL Health sought reimbursement for compound pharmaceutical prescriptions written by referral sources which had a financial interest in the prescriptions. The USAO contends WELL Health filled prescriptions from an affiliated pharmacy that paid indirectly, through a third party company, remuneration in the form of research fees that exceeded fair market value, to several referring physicians. TRICARE restitution was \$1,881,565.

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

On 28 December 2016, a settlement was obtained by the USAO, with North Country Emergency Medical Consultants in Watertown, New York. The allegations were that from 2006 through 2014, the practice submitted claims to TRICARE with an “AQ” modifier, certifying its providers rendered services in an area designated as a “Health Professional Shortage Area” (HPSA), entitling them to a 10% physician “bonus payment.” In the settlement North Country acknowledged they should not have added the AQ modifier because the practice was not located in a HPSA eligible for physician bonus payments. TRICARE restitution was \$991,338.

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

On 30 June 2016, the USAO settled with California-based medical device manufacturer, NuVasive, to resolve allegations that the company caused health care providers to submit false claims to Medicare and other federal healthcare programs for spine surgeries by marketing the company’s CoRoent System for surgical uses that were not approved by the U.S. Food and Drug Administration. The settlement agreement also resolves allegations that NuVasive knowingly offered and paid illegal remuneration to certain physicians to induce them to use the CoRoent System in spine fusion surgeries, in violation of the federal Anti-Kickback Statute. TRICARE restitution was \$938,588.

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

On 10 July 2016, a Detroit area oncologist, Dr. Fata, was sentenced to 45 years in prison for a fraud scheme that involved making fraudulent diagnoses, prescribing oncology drugs for healthy patients and bilking patients and insurance companies out of millions of dollars. Dr. Fata admitted to fraudulently billing Medicare, insurance companies and at least 553 patients through misdiagnoses, over-treatment, and under-treatment. In some cases, he gave nearly four times the recommended dosage amount of aggressive cancer drugs. U.S. District Judge Borman commented, “This is a huge, horrific series of criminal acts committed by the defendant...” before handing down the doctor’s sentence and called Dr. Fata’s actions unprecedented. Dr. Fata, pled guilty to 16 counts to health care fraud, money laundering and conspiracy to give or receive kickbacks, and gave up \$17,600,000 in cash as part of his sentencing. He also forfeited property, life insurance policies, interest in investments and numerous other properties, according to the federal prosecutor. After his release, Dr. Fata will be under supervision for three years and undergo mandatory drug testing. DHA PI identified 98 patients who received services from Dr. Fata. Total Settlement was \$34,000,000. TRICARE’s restitution was \$483,986.

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

On 17 March 2016, the USAO and Coastal Dermatology agreed to a civil settlement with Coastal Dermatology and its owner Dr. Sanjiva Goyal, Jacksonville, Florida. Dr. Goyal agreed to repay the U. S. Government for services not medically necessary, cosmetic dermatology procedures disguised as covered services, and false documentation. Total Settlement was \$787,814. TRICARE restitution was \$357,668.

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

On 20 March 2016, Speech Therapist Rebecca Rabon, owner of Rabon Communication Enhancement (RCE), a speech therapy clinic for children, pled guilty to one count of conspiracy to commit health care fraud and five counts of health fraud. Ms. Rabon admitted she worked together with co-worker Tiffany Thompson, to submit claims to insurance providers for services not medically necessary and not provided. Ms. Rabon further admitted that between March 2009 and November 2013, her clinic did not have equipment or supplies to provide treatment for dysphagia - a swallowing and oral feeding dysfunction - and that neither she, nor any speech therapist employed at RCE, provided any of those treatments to children at the clinic. Ms. Rabon further admitted she submitted false and fraudulent claims for herself and Ms. Thompson and three unsuspecting RCE employees for various medical and speech therapy services that were not provided, and including false and fraudulent claims under the medical insurance of one unsuspecting employee. Ms. Rabon was ordered to federal prison for 151 months following her conviction related to a health care fraud scheme that billed Tricare and Blue Cross and Blue Shield of Texas. Also, as a result of her conviction, Ms. Rabon forfeited her house. Co-defendant and office manager Tiffany Nicole Thompson also plead guilty for her role in the scheme and was sentenced to serve 51 months. Both defendants must also serve three-year-terms of supervised release following completion of their sentences and were further ordered to pay a total of \$1,200,000 in restitution. TRICARE restitution was \$334,203.

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

On 4 February 2016, the USAO entered into a civil settlement with Ageless Men's Health, LLC (AMH) and agreed to pay \$1,600,000 to resolve allegations that it billed Medicare and TRICARE for medically unnecessary office visits while administering testosterone replacement therapy shots. In addition to the payment, AMH entered into a Corporate Integrity Agreement which requires enhanced accountability and monitoring activities to be conducted by both internal and independent external reviewers. Total Settlement was \$1,600,000. TRICARE restitution was \$210,128.

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

On 4 August 2016, the Atlanta USAO settled with Pediatric Services of America Healthcare, Pediatric Services of America, Inc., Pediatric Healthcare, Inc., Pediatric Home Nursing Services, and Portfolio Logic, LLC and agreed to pay the U.S. Government \$6,882,387. The defendants entered into the settlement to resolve allegations that they failed to disclose and return overpayments that it received from federal health care programs, submitted claims without documenting the necessary monthly supervisory visits by a registered nurse, and submitted claims to federal health care programs that overstated the length of time their staff had provided services. TRICARE's restitution was \$141,000.

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

On 25 January 2016, the USAO and Associates in Dermatology agreed to a civil settlement totaling \$3,000,000. Dr. Steppie who operated the dermatology practice had unlicensed, uncredentialed, and unsupervised employees performing radiation therapy without proper supervision. In addition, the allegations included that the clinic performed unnecessary destructions of skin lesions and that these destructions lacked proper documentation. In addition to the monetary payment, Associates in Dermatology has entered into a corporate integrity agreement with the U.S. Department of Health and Human Services. The TRICARE restitution was \$98,000.

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

On 6 May 2016, SPC Campos pled guilty to larceny of Basic Housing Allowance and conspiracy to commit larceny to obtain TRICARE benefits under false pretenses via a sham marriage. SPC Campos

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

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

DHA PI provided testimony in support of a 20 January 2016 General Court-Martial trial against Army Major William Inman, assigned to Fort Hood, Texas. Inman was found guilty by an officer panel in matters related to entitlement fraud when he failed to report the July 2008 divorce from his ex-spouse until April 2013. Inman was found guilty of conspiracy, dereliction of duty, false official statement, larceny; fraud, conduct unbecoming of an officer, false pretenses and communicating a threat. Inman was sentenced to a reprimand, a \$50,000 fine, and 20 months confinement. TRICARE restitution was \$38,265.

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

Defense Health Agency

ATTN: Program Integrity Office

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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
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