



Health Care Fraud Division
Operational Report
Calendar Year 2023

“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. 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”).

DHA DIRECTOR PRIORITIES

- 1 Enabling combat support to the Joint Force in competition, crisis, or conflict.
- 2 Building a modernized, integrated, and resilient health delivery system.
- 3 Dedicated and inspired teams of professionals driving military health's next evolution.

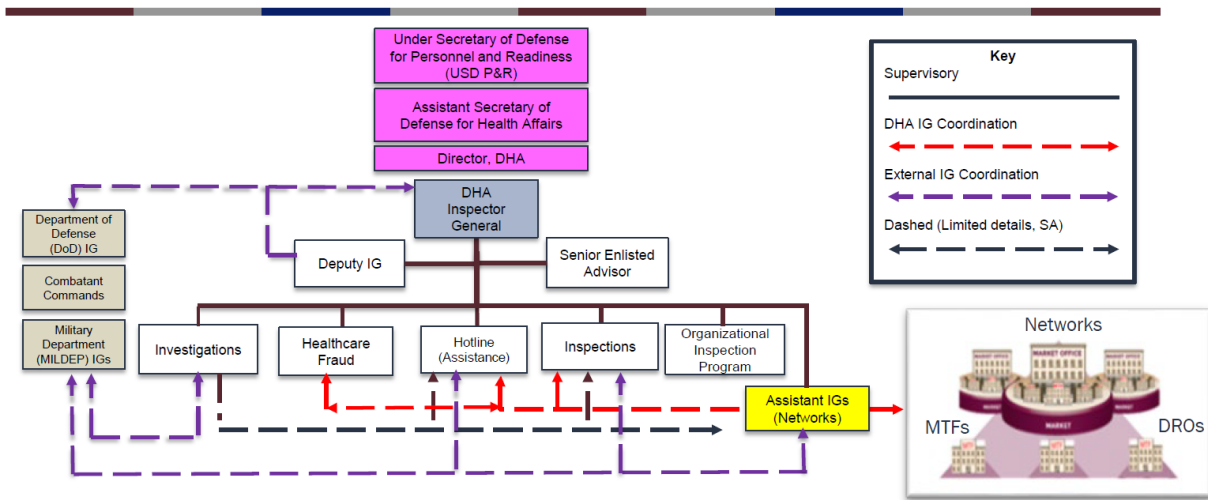


Aligning with the DHA Director’s priority of *Building a modernized, integrated and resilient health delivery system and dedicated and inspired teams of professionals driving military health’s next evolution*, the existing DHA Program Integrity Division was integrated with the DHA Office of the Inspector General (DHA OIG) in April 2023, and rebranded as the Health Care Fraud Division (HCFD). Though the mission remains the same as it has over the last 40 years, the integration more appropriately aligns the activities of identifying, investigating and deterring fraud, waste, abuse and mismanagement within the DHA program. 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 OIG, the HCFD retains 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.

DHA OIG Organizational Structure Overview



The HCFD staff collectively has over 195 years of fraud fighting experience and 165 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

As a follow-on to the previous Program Integrity strategic plan of rebalancing focus on fraud, waste and abuse; strengthening internal partnerships; and engaging with MTFs to enhance education, reporting and training, the HCFD has launched a follow-on plan to continue great work started in 2020. The latest strategic plan focuses on bringing the HCFD and DHA into alignment with other federal healthcare payors by shifting the primary focus from pay and chase to proactive detection and prevention. This strategy aligns with DHA's priorities of improving health and building readiness through "making extraordinary experiences ordinary and exceptional outcomes routine", ensuring rapid identification and response to areas of potential fraud and abuse to safeguard beneficiaries and finances in a timely manner.

1.1.1. Proactive Detection and Prevention in TRICARE T5 Contracts

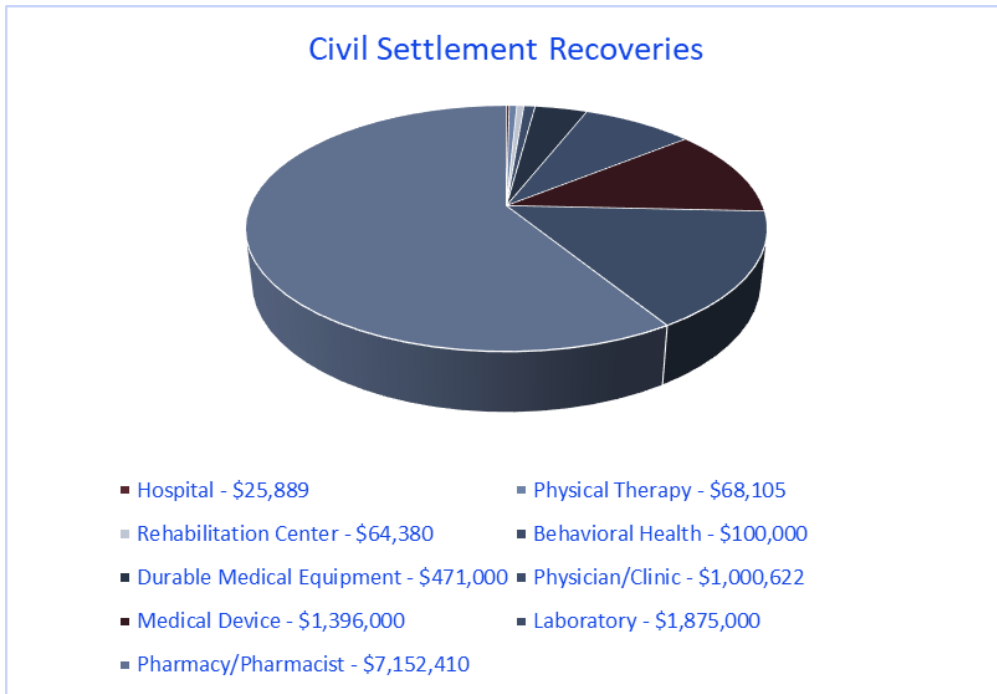
The T5 contracts (awarded in 2022 and transitioning in 2024, with an anticipated start of healthcare delivery on 1 January 2025) play an integral role in aligning the TRICARE program with industry best practices. The Program Integrity requirements in the T5 contract and manuals highlight pre-payment controls to enhance deterrence. These controls include targeted measures of prepayment anti-fraud review, post-payment fraud detection, investigative anti-fraud auditing and provider and beneficiary education. Cost controls associated with Program Integrity contract requirements also include review of outlier payments, spikes in dollars paid, high utilization of supplies, verification of beneficiary submitted claims for high dollar items to validate appropriateness and new benefit monitoring. Additionally, certification requirements were added for all contractor Program Integrity staff.

In alignment with industry best practices, the T5 contracts require predictive analytics and data mining software built into the contractor's anti-fraud strategies. This includes advanced analytical techniques such as artificial intelligences (AI), machine learning and regression techniques to flag providers for further evaluation. Additionally, the required technology must assign predictive risk scores to claims on a prepayment basis to detect potential patterns of fraud, abuse or billing errors. These requirements are not intended to replace the work done at the DHA level; rather, it is designed to be a force multiplier with a focus on anti-fraud, waste and abuse within the TRICARE program.

1.1.2. Enterprise Educational Efforts for Fraud Prevention

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. This plan will include standardized training on DHA health care fraud, waste and abuse prevention which will be applicable to the entire agency. In addition, it will highlight ways to appropriately report concerns and provide teaching and training opportunities on the role of not only the Health Care Fraud Division, but also the role of DHA Office of the Inspector General as a whole.

Additionally, the DHA Procedural Instruction (DHAPI) 5505.01 is currently being drafted and will serve as a guide for all parts of DHA, including the direct care system, to identify and assist



Summaries of the most significant civil cases from 2023 are included the sections below.

[Central District of Illinois | Illinois Hospital Agrees to Pay \\$12.5 Million to Settle Allegations of Billing Error | United States Department of Justice](#)

On 19 January 2023, St. Elizabeth’s Hospital of the Hospital Sisters of the Third Order of St. Francis entered into a settlement agreement for their role in overcharging the government. The lawsuit alleged that the hospital submitted claims for urgent care services as if they were received in an emergency department, resulting in greater reimbursement. Once brought to the attention of St. Elizabeth, the hospital fully cooperated with the Department of Justice’s investigation. St. Elizabeth’s has agreed to pay \$12,500,000 of which TRICARE will receive \$1,860,000.

[Western District of New York | Cardiac Monitoring Company Settles Fraudulent Billing Allegations | United States Department of Justice](#)

On 3 February 2023, Beyond Reps, Inc. (d/b/a) IronRod Health and Cardiac Monitoring Services, LLC entered into a settlement agreement to resolve allegations that IronRod billed for remote cardiac monitoring services purportedly rendered from a facility before it was operational, and for services rendered by non-physician personnel who lacked appropriate licenses or credentials. IronRod has agreed to pay a settlement amount of \$673,201, of which TRICARE will receive \$84,150.

[Southern District of Indiana | U.S. Attorney's Office Recovers \\$2 Million From Autism Therapy Provider for Alleged False Healthcare Claims in District's Largest TRICARE Settlement | United States Department of Justice](#)

On 2 February 2023, ABA Programming Inc., Applied Behavior Center for Autism, and its owner, Sherry Michael entered into a settlement agreement for their role in upcoding beneficiaries claims that also included duplication of billing submissions, claiming payment for services not covered and/or claiming payment for services already paid by third-party sources. ABCA has agreed to pay \$2,000,000 of which TRICARE will receive \$626,796.

[Office of Public Affairs | Two Jacksonville Compounding Pharmacies and Their Owner Agree to Pay at Least \\$7.4 Million to Resolve False Claims Act Allegations | United States Department of Justice](#)

On 15 June 2023 Smart Pharmacy, Inc., SP2, LLC, and co-owner Gregory Balotin of Jacksonville, Florida, agreed to enter into a civil settlement agreement with the Department of Justice to resolve two whistleblower lawsuits filed in the Middle District of Florida. The defendants agreed to pay a settlement of \$7,400,000 over a period of years plus interest and contingencies, to resolve allegations they violated the False Claims Act by adding the antipsychotic drug aripiprazole to topical compounded pain creams to increase reimbursement, and by routinely waving patient copayment obligations.

The \$7,400,000 settlement amount is based on the defendant's ability to pay. As part of the settlement the defendants have agreed to enter into a three-year Corporate Integrity Agreement with the Medicare/Medicaid's Health and Human Services Office of the Inspector General and have agreed not to bill TRICARE for a period of eight years in exchange for non-exclusion in the Medicare and TRICARE Programs. The whistleblower relators will receive 20% or \$1,480,00 of the \$7,400,000 settlement. Medicare's settlement portion is \$3,728,600 and TRICARE's settlement portion is \$2,190,400.

Over the period of this case investigation (2015 to present) TRICARE suspended the defendant pharmacy's from receiving TRICARE claim payments for submitted claims. During the period TRICARE implemented a patient-prescriber review of the pharmacy's submitted claims to determine if a doctor examined the patients to justify the medical necessity of compound drug prescriptions. A total of 8,269 compound drug prescriptions costing over \$6.4 million were identified as not being medically necessary. Over the suspension period TRICARE withheld payment for 16,423 claims totaling \$7,747,572, including prescriptions identified as not being medically necessary. Because of the final civil settlement TRICARE will lift the claims payment suspension and recoupment actions will take place to reconcile the over \$7,740,000 in withheld TRICARE payments, with the likely net result of no payment to the defendant pharmacies.

Office of Public Affairs | United States Settles Kickback Allegations with BioTek reMEDys Inc., Chaitanya Gadde and Dr. David Tabby | United States Department of Justice

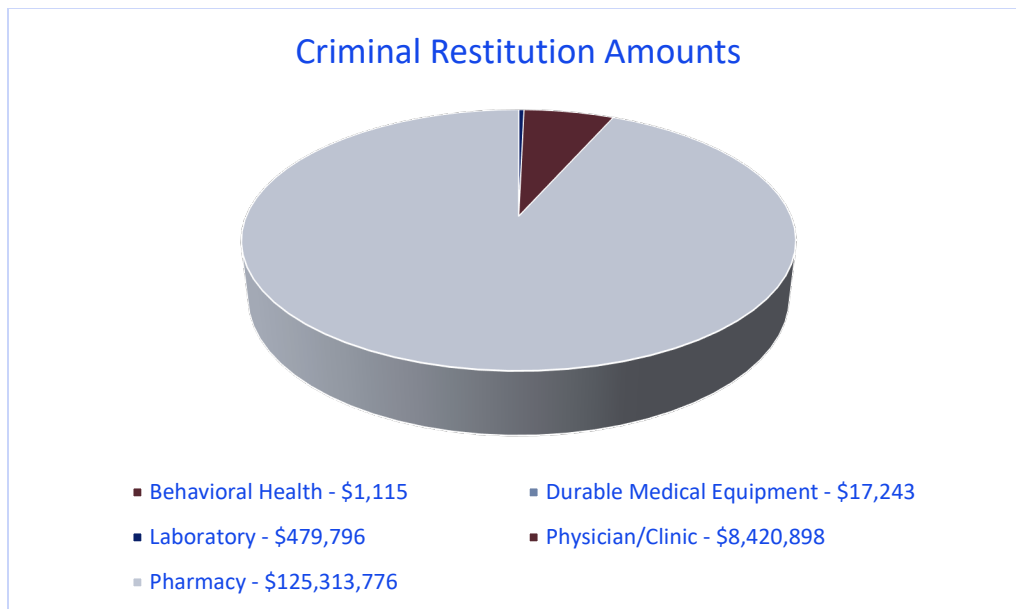
On 12 September 2023, BioTek reMEDys Inc., entered a civil settlement agreement. In 2019, relators filed a qui tam complaint in which they alleged kickbacks were being paid for allergy testing for claims submitted to Federal programs. BioTek argued an ability to pay issue during settlement negotiations, which was determined to be valid. Total settlement amount was reduced due to this factor. Total settlement is \$20,000,000 and TRICARE’s restitution is \$461,961.

Southern District of Texas | Cardiac imaging company and founder to pay historic \$85M settlement | United States Department of Justice

Cardiac Imaging Inc., and its founder, owner and CEO Sam Kancherlapalli have agreed to pay a total of \$85M to resolve False Claims Act allegations that they paid referring cardiologist excessive fees to supervise PET scans in violation of the Anti-Kickback Statute and Stark Law. TRICARE will receive \$2,073,085.

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 2023, 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 2023.



Summaries of the most significant criminal cases from 2023 are included in the sections below.

[Western District of Washington | Former Co-Owner and Sales Manager of defunct medical testing lab sentenced to prison | United States Department of Justice](#)

Richard Reid, founding member of Northwest Physician Laboratories, was convicted of obtaining over \$3.7 million in kickback payments by steering urine drug test specimens to two labs that billed the government for testing, resulting in more than \$6.5 million in government payments to two labs. Following his conviction by jury trial, Mr. Reid was sentenced to 24-months in jail, 12-months supervised release, a special assessment fine of \$500 and restitution in the amount of \$8,114,417. Reid was also ordered to forfeit an additional \$114,600 from illegal kickbacks. TRICARE will receive \$316,544 (civil), and \$479,796 (criminal restitution).

[Southern District of California | Husband and Wife Sentenced for Defrauding TRICARE and Medicare out of \\$75 Million | United States Department of Justice](#)

Mr. Ronald “Ronnie” Green and his wife, Melinda Elizabeth Green, were sentenced to 27 months each, five years probation, a \$100 fine and restitution in the amount of \$26,085 (based on ability to pay) for fraudulently billing government healthcare programs more than \$125 million for unnecessary treatments. The Greens conspired to submit false and fraudulent claims to TRICARE for expensive and medically unnecessary pain creams, scar creams, and multi-vitamins as compound pharmaceutical products. Pharmacies were paid millions of dollars in illegal kickbacks in exchange for the referral of false and fraudulent prescriptions for compounded medications to TRICARE beneficiaries.

[Central District of California | Former Director of Operations for O.C. Pharmacy Sentenced to 9½ Years in Prison for Defrauding the U.S. Military’s Health Care Plan | United States Department of Justice](#)

On 3 April 2023, Sandy Mai Trang Nguyen, pharmacist in charge of Irvine Wellness Pharmacy was sentenced to 180 months in federal prison for her roll in the supervision of filling compounded prescriptions for pain, scarring and migraines that were medically unnecessary. Nearly all prescriptions were sent to the pharmacy by “marketers” who were paid kickbacks. Beneficiaries were solicited to provide their TRICARE information for medications they did not seek out or need, and most were never examined by a physician. In November, Nguyen was found guilty of 21 counts of health care fraud and one count of obstruction of a federal audit. TRICARE will receive \$11,098,756 in restitution.

[Office of Public Affairs | Podiatrist and Patient Recruiter Convicted for \\$8.5M Compounding Fraud Scheme | United States Department of Justice](#)

On 14 April 2023 Doctor of Podiatric Medicine (DPM) Brian Carpenter of Bridgeport, Texas, and patient recruiter Jerry Hawrylak of Lake Worth, Texas, were found guilty at a criminal trial held in the Northern District of Texas. The pair were convicted on one count conspiracy to commit health care fraud and six counts of health care fraud.

On 4 April 2023, DHA provided agency testimony at the Carpenter/Hawrylak criminal trial. From November 2014 to January 2017, Carpenter and Hawrylak engaged in kickback and bribery schemes to cause a Fort Worth pharmacy to bill TRICARE over \$8.5 million in compounded pain and scar crème prescriptions. Hawrylak recruited Carpenter to sign prescriptions using his DPM credentials. Hawrylak also convinced TRICARE beneficiaries to accept the medically unnecessary prescriptions by providing kickbacks. Carpenter signed medically unnecessary compound drug prescriptions for TRICARE beneficiaries he never saw.

[Central District of California | Former Physician Associated with 1-800-GET-THIN Sentenced to 7 Years in Federal Prison for Massive Fraud Against Health Insurers | United States Department of Justice](#)

On 17 April 2023, in the Center District of California, Dr. Julian Omid, of 1-800-GET-THIN and Surgery Center Management LLC, was sentenced to seven (7) years of prison and three (3) years' probation for his role in a scheme in the early 2000s wherein beneficiaries sleep studies and/or diagnoses of sleep disorders were misrepresented in order to approve the beneficiary for subsequent weight loss surgery.

As part of the scheme, 1-800-GET-THIN established procedures requiring prospective Lap-Band patients to have at least on sleep study to find a “co-morbidity” of obstructive sleep apnea in order to get pre-approval for Lap-Band procedures. Results were often falsified, in addition to patients' weight and other factors. Even if the Lap-Band procedure was not pre-authorized, bills were submitted for sleep studies and other services that were either not medically necessary or not performed. In all, TRICARE paid approximately \$41M for Lap-Band procedures, sleep studies, and CPAP devices and accessories related to this fraud scheme.

This case, and the involvement of both DHA and DCIS, were highlighted at the National Health Care Anti-Fraud Conference in November 2023, and recognized as the SIRIS Case of the Year.

[Eastern District of Louisiana | Baton Rouge Man Sentenced to 18 Months Imprisonment for Health Care Fraud Scheme | United States Department of Justice](#)

On 15 June 2023, Christopher Blackstone of Baton Rouge, Louisiana, was sentenced to 18 months in prison followed by two years supervised release, after pleading guilty to conspiracy to commit health care fraud. Blackstone was the owner of Prime Pharmacy Solutions located (PPS) in Slidell, LA. From March 2014 to October 2016 Blackstone along with his co-conspirators, acting on behalf of PPS, were instrumental in submitting medically unnecessary compound drug prescriptions to TRICARE resulting in payments of over \$14,800,000 in false claims. In March 2021 Blackstone pled guilty to the one count bill of information, and at the time agreed to pay TRICARE \$10,700,000 restitution upon sentencing.

[Office of Public Affairs | Medical Director Convicted in Health Care Fraud Scheme | United States Department of Justice](#)

On June 26, 2023, Dr. Shekar Rao was sentenced to 48 months in prison, 3 years supervised release, \$25,000 in fines, \$2,533,911 in restitution (all TRICARE dollars) and a \$200 special assessment due to his role in a scheme to defraud TRICARE. Dr. Rao authorized toxicology and

genetic testing, including cancer genetic testing, for TRICARE beneficiaries without seeking, speaking to or treating patients and without incorporating test results into ongoing treatment. In some cases, TRICARE beneficiaries were enticed to provide urine or saliva specimens in exchange for gift cards.

[Office of Public Affairs | Three Men Sentenced for \\$54M Fraudulent Prescriptions Scheme | United States Department of Justice](#)

David Byron Copeland, James Wesley Moss, and Michael Gordon were sentenced to prison following guilty pleas to kickback and fraud conspiracy. Moss, part-owner and CEO of Florida Pharmacy Solutions (FPS), Copeland who was part owner of FPS, and Gordon the lead sales representative, along with their accomplices engaged in the practice of “test billing” to develop the most expensive combination of compounded drugs to maximize reimbursement from TRICARE. They targeted physicians who treated TRICARE beneficiaries, paying bribes and kickbacks to encourage referral of prescriptions to FPS. From late 2012 through mid-2015, FPS billed over \$54M to TRICARE for compounded pharmaceuticals.

[Southern District of California | Husband and Wife Plead Guilty to \\$65 Million TRICARE Fraud | United States Department of Justice](#)

On 28 July 2023 the Collins’s pled guilty to their roles in the compounding medications scheme as patient recruiters/marketers. They were responsible for recruiting TRICARE beneficiaries willing to receive expensive compounded medications. This information was then sent to physicians such as Susan Vergot M.D., who was the second highest prescriber overall for compound medications for the TRICARE program. Prescriptions were then filled at Medicine Shoppe in Utah. The Collins’s are the last individuals in this case to plead guilty. Jimmy Collins is facing up to ten years’ incarceration. Ashley Collins is facing five years’ incarceration. Sentencing is scheduled for 27 October. Both will be responsible for restitution back to TRICARE totaling \$65,679,512.

[Northern District of Oklahoma | Compounding pharmacy owner sentenced to 18 months and over \\$6 million in restitution | United States Department of Justice](#)

On 4 October 2023 Christopher Parks, owner of Oklahoma Compounding Pharmacy, in Tulsa, Oklahoma, was sentenced after pleading guilty to one count of conspiracy to offer and pay health care kickbacks. From November 2012 to June 2019 Parks knowingly and willfully paid physicians to refer compound drug prescriptions to Oklahoma Compounding Pharmacy. Parks was sentenced to 18 months imprisonment, 24 months supervised release, and ordered to pay a total of \$6,400,651 restitution to four federal health care programs. The TRICARE portion of the \$6.4M restitution is \$5,246,534.

[Office of Public Affairs | Man Convicted of \\$55M Fraud Scheme | United States Department of Justice](#)

On 26 October 2023 Quintan Cockerell, medical marketer from Palos Verdes Estates, California, was convicted by a federal jury in the Dallas U.S. District Court, Northern District of Texas. The jury convicted Cockerell on one count of conspiracy to defraud the United States, one count of receiving unlawful kickbacks, and one count of money laundering. He faces a maximum

penalty of five years in prison for the conspiracy to defraud, five years in prison for receiving unlawful kickbacks and ten years for money laundering.

From May 2014 to September 2016 Cockerell and his codefendants engaged in kickback schemes to bill TRICARE over \$55 million in false compound drug prescription claims through the Fort Worth, TX, pharmacy's Xpress Compounding and Rxpress Pharmacy. Cockerell was paid over \$2.4 million for his part in the false claim's kickback schemes. A sentencing date has not yet been scheduled. DHA-OIG Health Care Fraud Division provided witness testimony at the Cockerell trial.

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 2023 prepayment duplicate denials reported by the contractors to Program Integrity amounted to \$501,987,735.²

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 2023, the prepayment claims processing software in use by the MCSC's accounted for \$118,634,735 in cost avoidance for TRICARE.³

3.3. Prepayment Review

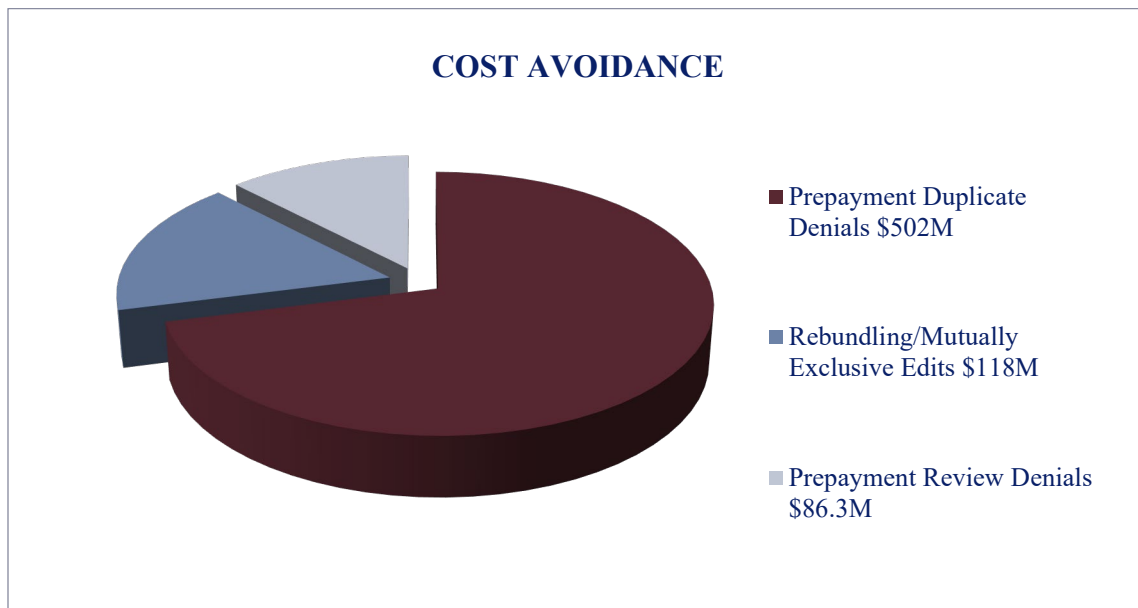
Prepayment review prevents payment for questionable billing practices or fraudulent services. As an administrative remedy, providers/beneficiaries with atypical billing patterns may be placed on prepayment review. Once on prepayment review, their claims and supporting documentation are subject to prepayment screening to verify that the claims are free of billing problems and the

² Prepayment Duplicate Denial amounts as reported by TRICARE contractors.

³ Rebundling/Mutually Exclusive Edit amounts as reported by TRICARE contractors.

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	\$26,485,268
Health Net Federal Services, West Region	\$11,263,311
International SOS, Overseas	\$7,589,751
WPS TDEFIC	\$40,787,514
UCCI – Dental	\$198,900
TOTALS:	\$86,324,744



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

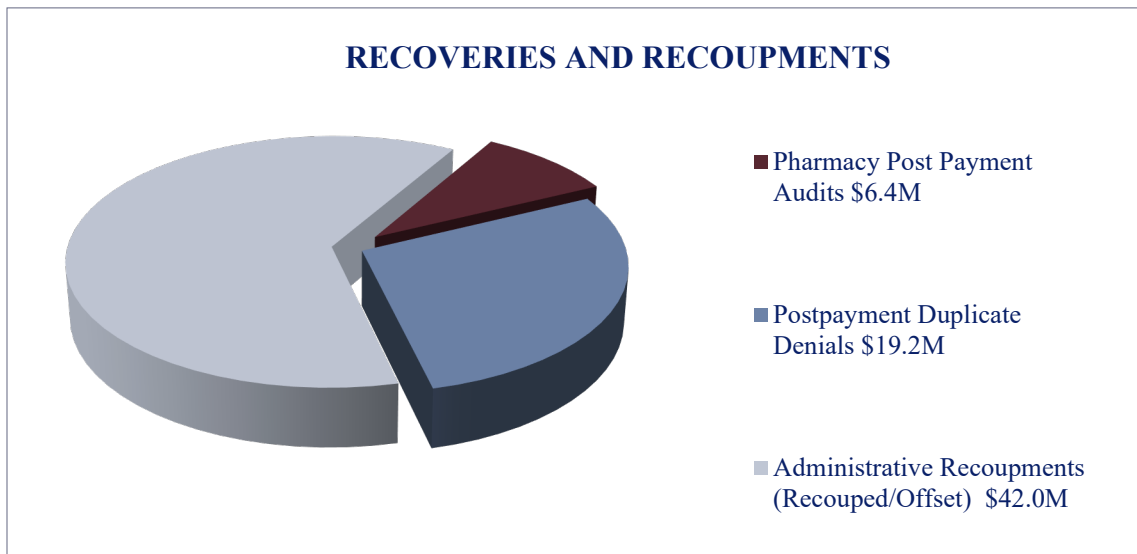
through prepayment screening, \$19,296,978 was identified in 2023, for recoupment or offset on a post-payment basis. ⁴

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 2023, \$6,399,601 was recovered. ⁵

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 or offset from a providers' future claims. In 2023, \$42,007,168 was recovered through administrative recoupments. ⁶



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 2023, most 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. ⁷

⁴ Post payment Duplicate Claims Denials as reported by TRICARE contractors

⁵ Pharmacy Postpayment amounts as reported by TRICARE Pharmacy Benefit Manager.

⁶ Data as reported by TRICARE Contractors.

⁷ Data as reported by TRICARE Contractors

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 2023 and final resolution is still pending.

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 received two violation of participation agreement case referrals in 2023. Total resolution for Violation of the Participation Agreement was \$19,000 returned to beneficiaries in 2023.

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 TRICARE⁸. In 2023, TRICARE received \$473,229⁹ returned to the program with cases coordinated with HHS.

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 2023, DHA did not exclude any provider under its own authority.

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.

⁸ <https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Program-Integrity/Voluntary-Self-Disclosure-Reporting>

⁹ DHA OGC Source Report

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 2023. 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. 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 2023, 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.