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").

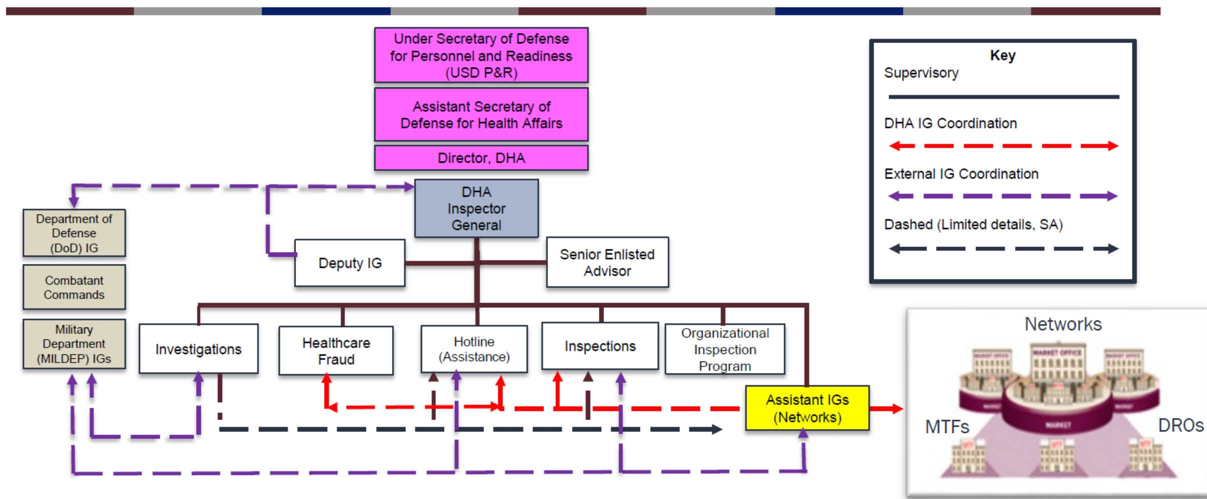
DHA DIRECTOR PRIORITIES

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 heath 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.



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

in healthcare fraud, waste and abuse prevention and detection. This DHAPI will codify the agency's commitment to combatting fraud, waste and abuse at all levels of the organization.

1.1.3. Internal Partnerships to Strengthen Early Detection

Many issues of waste and abuse are due to program vulnerabilities in both policy and operational application. The current process is to share findings of program vulnerabilities with staff of Healthcare Operations (HCO), the DHA directorate responsible for the direct oversight and policy making within the TRICARE program. Our strategic vision seeks to develop formal lines of communication between HCFD and HCO to identify and mitigate issues early in the process, and deter fraud, waste and abuse before it gets out of control. Additionally, it allows for integrated process teams to address cross-departmental concerns prior to policy implementation. This effort is further enhanced through the integration of HCFD into the DHA-OIG portfolio, allowing for partnership between the HCFD and Inspections Division to further highlight and track recommendations for improvement throughout the agency.

1.1.4. Enhanced Capabilities in Data Analysis Tools and Technology

As the industry evolved, HCFD is focusing on enhanced capabilities and leveraging of technology to better identify and prevent health care fraud and abuse. While data analysis is not new to HCFD, the application and technological advancements in data analytics, data visualization and safe use of artificial intelligence through modeling represent the emerging technology which will be a force multiplier for HCFD activities.

One-way HCFD is capitalizing on this technology wave is through an Information Analysis Center Multiple Award Contract (IAC-MAC) for data support and dashboard modeling. This contract vehicle allows for continuous research analysis support and facilitation of technical information generated to accelerate similar research and activities across the DoD, including modeling and simulation and data analysis[1], and builds upon the same expertise utilized for the DHA Digital Front Door project. Throughout 2023, the support from this contract allowed for better visualization of current reporting processes, restoration of routine spike reports and provider flags, support in development of future data concepts and models for potential fraud identification, and continuation of reporting efforts and data analysis to support ongoing healthcare fraud case initiatives.

HCFD has also established a solid partnership with the DODIG Data Analytics Team (DAT), and will continue to work collaboratively to develop reports, models and solutions to support DCIS, the investigative arm of the DOD for criminal health care fraud matters. This partnership extends to the federal health care fraud investigative agencies, through the reestablished National Health Care Fraud Working Group. Through these partnerships, HCFD will ensure the safe, effective and efficient implementation of technology solutions which are in-line with what is produced by federal partners in the combined fight against health care fraud.

1.1.5. Public/Private Partnerships within the Healthcare Industry

The HCFD also expanded capabilities through several public/private partnerships including the Healthcare Fraud Prevention Program (HFPP) funded through the Centers of Medicare. Beginning in 2023, DHA was able to begin integrating de-identified claims data into the HFPP

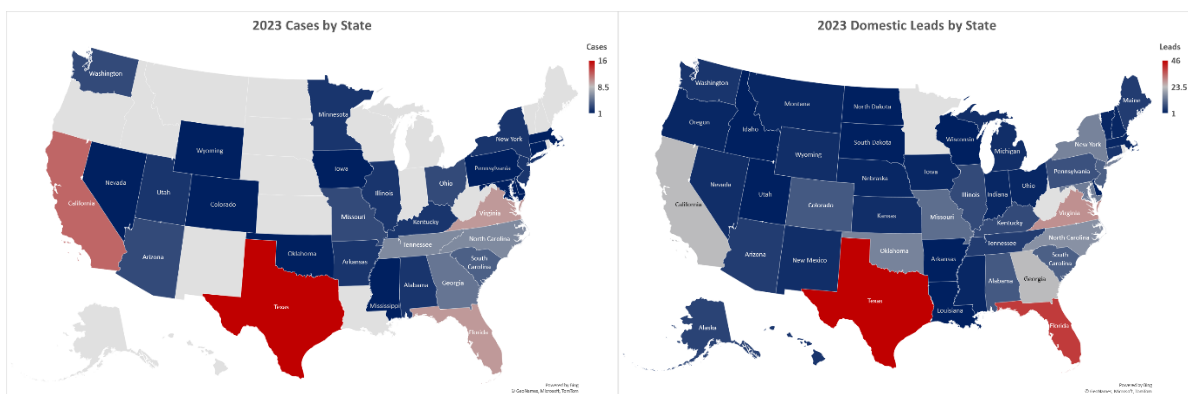
[1] IACMAC-onepager_v2.0 (dtic.mil)

database. This integration not only strengthens the Government's ability to look at fraud trends and suspect providers across the healthcare industry, but also provides studies specific to TRICARE data for use by HCFD in further identifying trends and aberrant behavior within the program. Through integration of information received from the HFPP, HCFD will continue to hone its data analytics, tools and models to capture emerging trends identified throughout the healthcare industry.

The Director, HCFD also participates as a Government Liaison on the National Health Care Anti-Fraud Association (NHCAA) Board of Directors. This position helps to inform the NHCAA of developments in the federal healthcare space and develop partnerships and critical communications between the public/private sector. In addition, the Director, HCFD supports continuing education of healthcare fraud investigators as faculty on the NHCAA Fraud Bootcamp for Health Care Fraud Investigators, providing the federal perspective on case development, investigative techniques and proposals for prosecution. The NHCAA is the premier partnership of healthcare anti-fraud activities and remains a crucial part of education and outreach related to healthcare fraud detection, deterrence, and investigation.

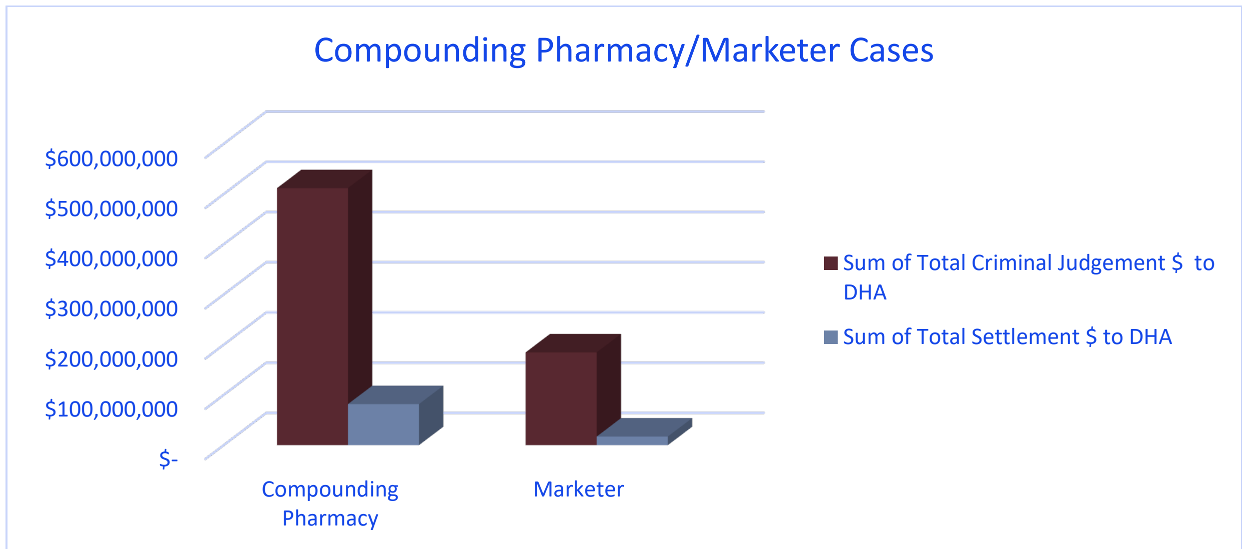
2.0 Fraud and Abuse Cases

During calendar year 2023, 546 investigative cases were actively managed by the team. A total of 119 new cases were opened, and the team responded to over 496 lead requests and fraud allegation inquiries. As documented in the maps below, allegations of fraud, waste and abuse within the DHA program continue to match national fraud trends, with most cases and leads coming out of Florida, California and Texas.



Several notable case resolutions this calendar year were related to the Compound Pharmaceutical Scheme which occurred between 2014 and 2015. Due to the statute of limitation for fraud, the last of these compound pharmaceutical cases are resolving this year and next. Starting in 2012, DHA detected spikes in payments to few, non-chain pharmacies, which were administratively handled through education, prepayment review and recoupment. These spikes became more frequent and larger in scope beginning in 2014, totaling $514M with compounding expenditures for the calendar year and eventually reaching close to $2B in 2015. In addition to the payment spikes, DHA began receiving numerous complaints from beneficiaries regarding unsolicited marketing, receiving compounds which they did not authorize, or the overall cost of compounds themselves.

Over the course of nine years, DHA HCFD has assisted in resolving numerous cases involving Compounding Pharmacies and Marketers totaling over $795M dollars returned to the program, $696M in criminal judgements and $98M in civil settlements.

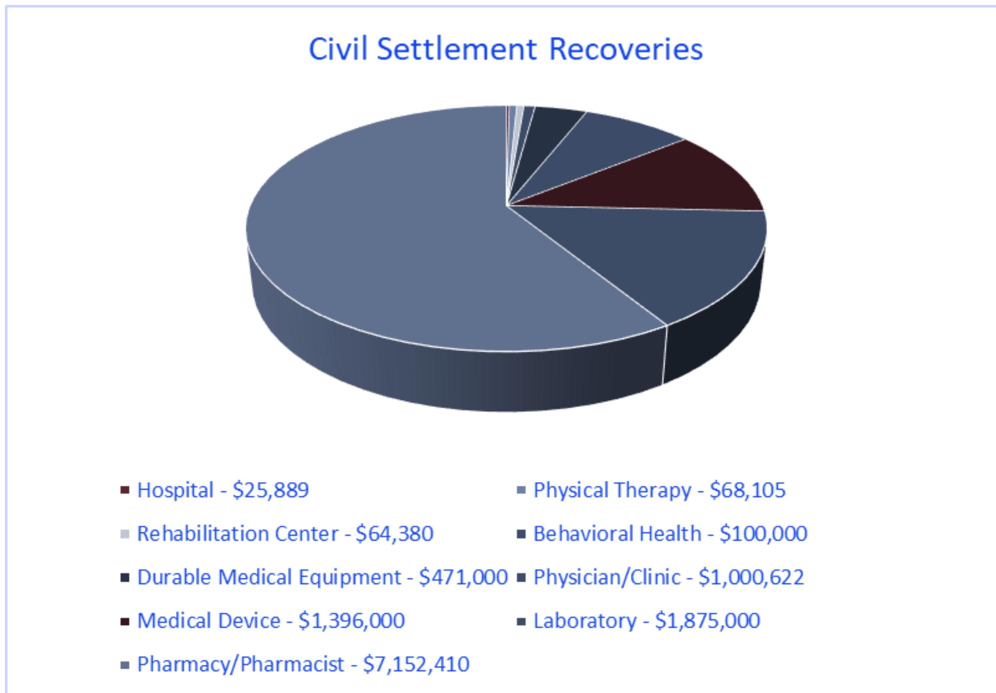


2.1. Fraud Judgements and Settlements

HCFD relies upon assistance from the Department of Justice (DOJ) and Defense Criminal Investigative Service (DCIS) to investigate and prosecute cases on behalf of DHA's interests. Oftentimes TRICARE is also harmed when fraud is committed against other public benefit programs and private sector insurance. During the calendar year 2023, the TRICARE program received a total of $98,946,802 in judgements and $12,718,124 in settlements, with 16 criminal judgement and 38 civil settlements. Unique to DHA/TRICARE, all monies received are returned directly back to the program to fund continuing care for our beneficiaries.

2.2. Significant Civil Cases Involving TRICARE

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



Summaries of the most significant civil cases from 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

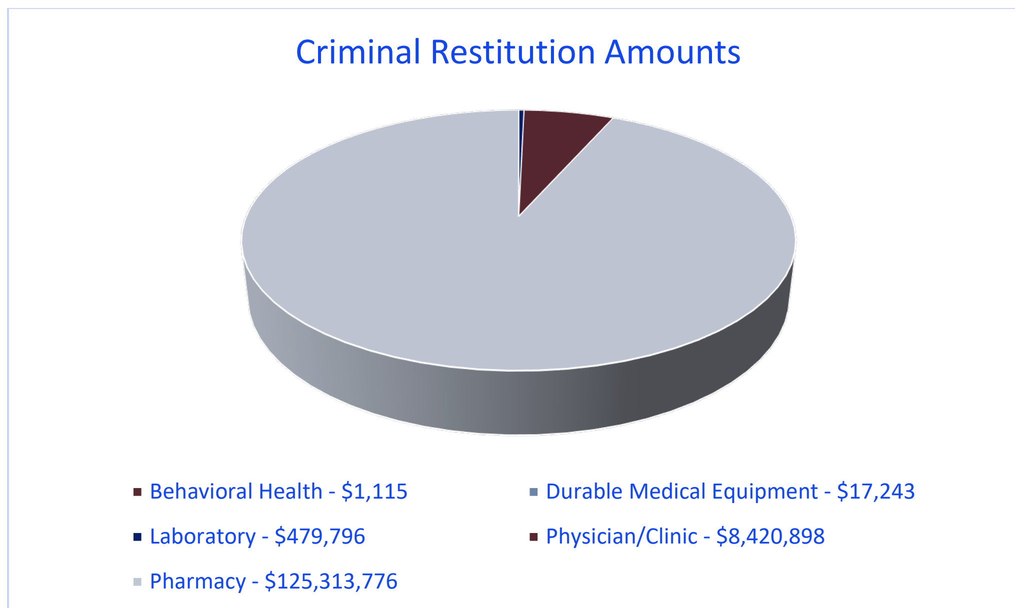
On 12 September 2023, BioTek reMEDys Inc., entered a civil settlement agreement. In 2019, relators filed a qui tam complaint in which they alleged kickbacks were being paid for allergy testing for claims submitted to Federal programs. BioTek argued an ability to pay issue during settlement negotiations, 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 Omidi, 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]

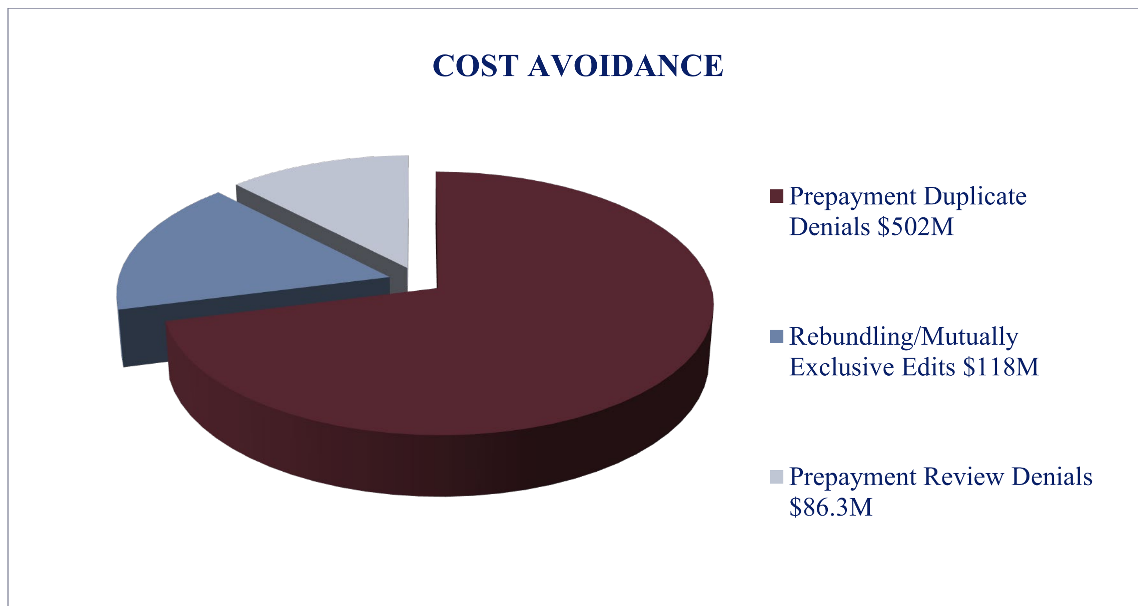
3.3. Prepayment Review

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

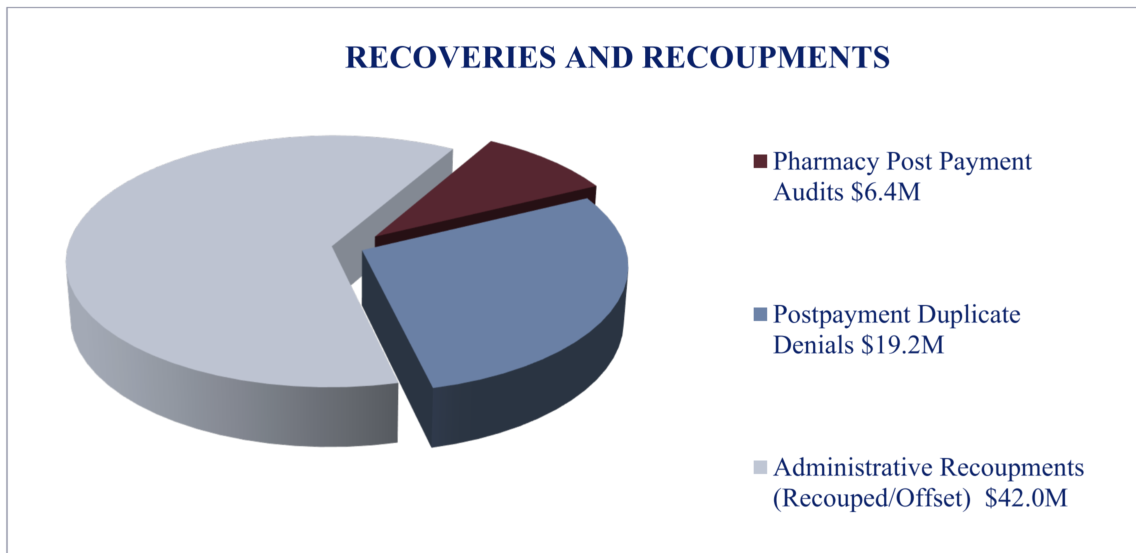
through prepayment screening, $19,296,978 was identified in 2023, for recoupment or offset on a post-payment basis. [4]

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]

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[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 TRICARE[8]. In 2023, TRICARE received $473,229[9] 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.

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[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.