Compound Pharmacies: Civil and Criminal Enforcement

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• Since 2006, Assistant U.S. Attorney serving Southern District of Florida.

• From 2012 – 2017, served as Deputy Chief for Criminal Health Care Fraud

• Has tried a wide range of cases, including health care fraud related to compound pharmacies, mortgage fraud, and tax fraud

• State prosecutor from 1994 – 2006; tried over 100 cases
Sam Sheldon

• Current head of Quinn Emanuel Urquhart & Sullivan, LLP’s Health Care Practice group

• Practice focuses on health care fraud (civil and criminal), including claims brought under False Claims Act and Stark Act

• Former Deputy Chief of the Criminal Fraud Division and Chief of the Health Care Fraud Unit of United States Department of Justice

• Former Assistant U.S. Attorney for Southern District of Texas

Compound Drugs

• IN THEORY: customized drugs for patients with specific health needs that cannot be met by commercially available drugs

• REALITY: ineffective and medically unnecessary drugs of dubious quality.
  • E.g., scar creams, pain creams, and wellness capsules
By The Numbers

- From 2012 to 2015, the average cost for a compounded prescription increased from $170 to $2,135.

- Costs peaked in 2015: Tricare spent $1.6 billion on compound drugs, a **threefold increase** from 2014
  - Nearly $1 billion in first four months of 2015 alone

- Egregious price gouging
  - E.g., Pain cream that costs $20 to make was billed at over $3,000 tube
  - E.g., Diaper creams billed at over $1,000 for a OTC pill that costs $2.50

*Source: Evaluation of the TRICARE Program: Fiscal Year 2017 Report to Congress*

Reform in 2015

- May 2015: Tricare revised reimbursement policy to include only FDA-approved ingredients in compound drugs

- June 2015: compound claim spend decreased by almost 75%; number of filled prescriptions decreased from 105k to 42k.

- 2016: compound drug spend fell to $49.1 million
Spend Over Time

Source: Evaluation of the TRICARE Program: Fiscal Year 2017 Report to Congress
Indicia of Compound Pharmacy Fraud...

Hypo # 1 – Traditional Scheme

- Compound pharmacy partners with marketing co to promote compound drugs
- Marketer identifies Tricare beneficiaries, oftentimes through cold calling and by pretending to be affiliated with Tricare, and promotes pain creams, scar creams, and wellness capsules
- Marketer refers beneficiary to a doc employed by (or that contracts w/) the marketing co
- Doc authorizes prescriptions (over phone), sometimes without any prior relationship w/ patient and without regard for the medical necessity of the prescription
- Doc sends prescription back to compound pharmacy directly (eliminates risk of beneficiary selecting a different compound pharmacy)
- CP fills prescription at a very high cost; Tricare reimburses
- CP pays marketers a fixed amount per prescription, or a percentage of the reimbursements the CP receives
Hypo # 2 – Traditional Scheme

• CP selects formulas for compound drugs that are designed to maximize Tricare reimbursement (formulas not based on scientific effectiveness), aka “High-Yield Compound Meds”

• CP contracts with marketers and solicit docs to prescribe the High-Yield Compound Meds

• CP designs pre-printed prescription forms encouraging docs to prescribe High-Yield Compound Meds

• Kickbacks from CPs to marketers from CPs, and also from marketers to docs

• Marketers even give kickbacks to beneficiaries, and also waived co-payments (illegal)

Hypo # 3 – Sham Studies

• Marketer pays Tricare beneficiaries a fixed monthly payment for filling prescriptions at partner compound pharmacy

• Marketer disguises payments as “grants” for participating in sham medical study; marketer falsely presents study as approved by TRICARE

• Marketer creates bogus 501c to funnel “grants” through charity and even calls the grants “donations” in check memos

• Marketer also pays prescribing doctor for each prescription filled at a partner CP
  • Some of these payments were paid through the charity, disguised as “consulting fees” in connection with sham “study” noted above
### Hypo # 4– Gift cards for Specimens

- Lab owner offers low-income Tricare beneficiaries gift cards in exchange for giving specimens for testing billed to Tricare.
- At peak, lab owner collects 200 specimens - *per day* - from Tricare beneficiaries.
- Lab ownerpaydocs flat monthly fee to sign orders authorizing the testing; docs never saw the patients and had no prior relationship with them.
- The testing is almost always unnecessary, but labs put false diagnosis codes on the submission to justify testing.
- Beneficiaries not even get test results.

### Hypo # 5– Telemedicine Sites

- Telemedicine site operator contracts with doctors; sends the doctors blank compound drug prescription forms.
- Telemedicine site operator encourages doctor to prescribe the compound drugs on these forms.
  - In some instances, telemedicine site even refused to pay prescribing docunless s/he prescribed the compound drugs.
- Telemedicine site operator faxes prescription directly to CP (prescription is not given to patient).
- In exchange, telemedicine site operator receives payment from CPs for advertising/pushing the compound drugs.
Hypo # 6 – Overflow Prescriptions

• CP A has so many prescriptions that it refers prescriptions to another CP, i.e., CP B. AKA “Overflow Prescriptions”

• CP B receives over 200 Overflow Prescriptions in a three week period

• CP B pays CP A referral fees for the Overflow Prescriptions

• To avoid detection, CP A disguises the aggregated referral fee as an “advance” for another business

Hypo # 7 – Co-pay Waiver and Auto Refills

• Compound pharmacy reduces or waives co-pays (prevents patients from asking questions about expense of the drugs and from canceling prescriptions)

• Compound pharmacy encourages docs to sign “auto refill” authorization forms so that CP can continue to charge patients for refills

• As is typical, CP pays docs kickbacks (either flat fee per prescription, or a % of total reimbursement)
Hypo # 8– Valid Contract?

• CP wants to enter into contract with marketer. CP will pay marketer a % for each referred prescription that Tricare subsequently reimburses.

• CP wants to enter into contract with marketer. CP will pay marketer to cold call prospective patients; pay is not tied to number or size of referred prescriptions that Tricare subsequently reimburses.

• CP enters into contract with marketer. CP agreed to pay marketer for general marketing services, and as an extra incentive promises to pay marketer a “performance-based” bonus.
  • Questions to consider: Are fees tied to the number of patients involved? Are fees tied to whether patient is Tricare beneficiary?