



The Department of Health and Human Services
And
The Department of Justice
Health Care Fraud and Abuse Control Program
Annual Report For FY 2003

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(EXCERPT)

ACCOMPLISHMENTS

Overall Recoveries

In 2003, the Federal government won or negotiated more than \$1.8 billion in judgments and settlements in health care fraud matters. As a result of enforcement actions, judgments, settlements, and administrative proceedings, the Federal government was able to distribute during 2003 \$1.03 billion of the funds collected. Approximately \$723 million of this amount was returned to the Medicare Trust Fund, and \$151.6 million was recovered as the Federal share of Medicaid restitution. Some of the judgments, settlements, and administrative impositions in 2003 will result in distributions in future years, just as some of the distributions in 2003 are attributable to actions from prior years. As noted previously, over \$500 million collected in fiscal year 2003 was distributed early in fiscal year 2004.

This fiscal year, HHS and DOJ have brought to successful conclusion the investigation and prosecution of numerous health care fraud schemes. These achievements confirm once again the importance of coordination between HHS and DOJ to maximize recoveries for taxpayer-funded health care programs victimized by fraud and/or abuse, and to promote prompt detection, punishment and deterrence of those who exploit health care programs for personal or corporate gain. In addition to the enforcement actions described in this report, numerous audits, evaluations and other coordinated efforts have yielded substantial recoveries of overpaid funds, protected vulnerable beneficiaries, and prompted changes in Federal health care programs that reduce susceptibility to fraud. During FY 2003, the many significant accomplishments of the HCFAC Program included the following:

Pharmaceutical Companies

- **AstraZeneca Pharmaceuticals and Zeneca, Inc. (AstraZeneca)**, a major pharmaceutical manufacturer, pled guilty and agreed to pay \$355 million to resolve criminal and civil fraud allegations arising from its marketing of Zoladex, a drug used to treat prostate cancer. As a result of an investigation conducted by the United States Attorney for the District of Delaware, working with the HHS/OIG, the Food and Drug Administration (FDA), the Defense Criminal Investigative Service and the FBI, AstraZeneca pled guilty to violating the Prescription Drug Marketing Act by causing false claims to be filed for Zoladex that was furnished to urologists as free samples. In addition, the company agreed to pay more than \$265 million to settle allegations that it caused false claims to be filed with Medicare, Medicaid, TRICARE

and the Railroad Retirement Board, and another \$24.9 million for failing to pay proper rebates owed to states under the Medicaid Drug Rebate Program. AstraZeneca also entered into a rigorous 5-year Corporate Integrity Agreement (CIA) with the HHS/OIG, under which the company agreed to affirmatively report certain drug prices to Medicare and Medicaid, and to take other steps to promote proper billing practices.

- **Bayer Corporation** paid more than \$257 million in global settlement of the FCA and criminal allegations that it attempted to evade paying required rebates to state Medicaid programs for sales of two drugs, Cipro (an antibiotic) and Adalat (an anti-hypertensive). In what is known as a "lick and stick scheme," Bayer allegedly sold re-labeled drugs to a large HMO at significant discount, then concealed the discounts and so avoided having to pay millions of dollars in rebates to Medicaid. Bayer also pled guilty to charges filed by the United States Attorney for the District of Massachusetts that it violated the Federal Food, Drug and Cosmetic Act by failing to notify FDA that it was producing private label Cipro. The company also agreed to extend an ongoing CIA with the HHS/OIG, and strengthen its terms to ensure that Bayer will accurately report its best price information to the government.
- **GlaxoSmithKline (GSK)**, In a similar case, GSK settled its civil liability under the FCA for repackaging Paxil (an anti-depressant) and Flonase (a nasal spray) for sale at deep discounts to the same large HMO. Again, the company concealed these discounts, and so underpaid rebates due to the Medicaid program. GSK agreed to pay more than \$87 million, and to comply with the terms of a CIA designed to ensure that GSK will accurately reports its "best price" information to the government in the future.

The monies recovered in the AstraZeneca, Bayer and GlaxoSmithKline settlements were shared among the Federal Government, 49 states, the District of Columbia, and the Public Health Service.

- **Pfizer Corporation and Subsidiaries, Warner-Lambert and Parke-Davis (Pfizer)**, agreed to pay \$49 million to resolve alleged false claims arising from sale of the cholesterol-lowering drug, Lipitor. The company allegedly failed to report accurately to CMS its "best price" as required under the Medicaid Drug Rebate Program. By overstating its price, the company allegedly retained more than \$20 million in rebates owed to the Medicaid program. Pfizer also entered into a five-year CIA under which Pfizer must certify its process for determining best price, and adopt internal safeguards to prevent improper reporting in the future.

Prescription Drug Fraud

- A South Florida defendant was sentenced after conviction at trial to 10½ years' incarceration for her role as the mastermind behind a conspiracy that fraudulently billed Medicare for over \$20 million worth of prescription drugs. The conspiracy centered around four Miami pharmacies that illegally manufactured prescription aerosol drugs. The pharmacies sold the illegally manufactured drugs although in some cases, only labels or half-portions were actually delivered to DME companies that billed Medicare directly under Medicare rules that allow for payment for drugs taken by way of medical equipment. The fraudulently manufactured drugs were intended for bogus patients who had been paid for use of their Medicare numbers; approximately 1400 patients in the Miami area were involved in the scam. To enable the fraud, physicians were paid to sign blank prescriptions, and, in almost every case, the physicians never examined the patients or even looked at fraudulent charts that were concocted to fool Medicare inspectors. Five other individuals were also convicted at trial and sentenced to terms of incarceration for their participation

in the conspiracy; eighteen other defendants entered pleas of guilty and were sentenced in connection with the scheme.

- A South Florida urologist pleaded guilty to 59 counts of health care fraud and unlawful distribution of prescription drugs. Between July 2000 and November 2001, he prescribed Lupron, a drug used for the palliative treatment of advanced prostatic cancer, to a number of patients, and undertook to administer it to the patients in the form of injections. However, the defendant did not administer the prescribed and requisite dosages of Lupron to at least 32 patients who came to him for treatment. The physician billed the patients and their health insurance carriers for the cancer treatments, regardless of whether the drug was actually administered. In addition, he unlawfully distributed Lupron wholesale through a series of sales totaling more than \$1.5 million. In pleading guilty, he was sentenced to 51 months of incarceration and 3 years of supervised release in addition to also surrendering his medical license.

Internet Pharmacy Fraud

- In October 2003, a Texas pharmacist was convicted of a drug king-pin count and for money laundering for his role in conspiring to illegally dispense hydrocodone in an Internet pharmacy operation he ran. The pharmacist, who owned Friendly Pharmacy located in Texas and MainStreet Pharmacy located in Oklahoma, employed three doctors and paid them \$40-100 per signed prescription. Customers of the internet websites would fill out a simple questionnaire, request their drug of choice (in most cases, hydrocodone - a Schedule III controlled substance) and then pay both a "doctor consultation fee" and the fee for the prescription drugs. The doctors reported they never declined a prescription, and never examined the patients. One doctor admitted at trial that he never reviewed the questionnaires filled out by the customers and another doctor fell asleep while signing the prescriptions. Neither of the online pharmacies had any way of verifying the age of the recipient. Unlike when the patient sees the doctor, a minor can easily log onto a website and fill out an inaccurate age. Tragically, a La Mesa, California high school honors student and athlete died at home from an overdose of Vicodin ordered from one of the pharmacies.

The pharmacist faces a mandatory 20 year to life sentence. All of the other participants were either found guilty by a jury or pled guilty. The government also obtained a \$5.6 million asset forfeiture judgment against the pharmacist.

- A South Florida husband and wife were sentenced to terms of 37 months and 24 months imprisonment, respectively, after being convicted by a jury of unlawfully distributing prescription drugs through the Internet. The defendants sold powerful prescription pain killers through web sites operated from their home without requiring a physician's review or a prescription and placed no restrictions on the quantities or frequency with which customers could purchase drugs. In an effort to evade detection by law enforcement, the defendants cut out the manufacturer's lot numbers placed on each of the drug containers they sold, thereby making the drugs untraceable; concealed their identities through using false names; used 32 variations of false return addresses on packages; and advertised that they were an overseas company. In little over a year, the defendants earned in excess of \$1.2 million in gross revenues, all of which went to an off-shore bank account in the Cayman Islands.

Hospitals

- **HCA Inc.** (formerly known as Columbia/HCA and HCA-The Healthcare Company), entered a settlement agreement with the Federal government, marking the end of

the most comprehensive multi-agency health care fraud investigation of a provider ever undertaken by federal enforcement authorities. Under the agreement, HCA paid \$631 million plus interest to resolve civil liability for alleged false claims arising from a variety of practices, including false cost reports to Medicare, Medicaid and TRICARE, and kickbacks. When added to earlier criminal pleas and a 2001 FCA settlement, and a separate settlement with the CMS, the government recovered a total of \$ 1.7 billion from HCA. The settlement agreement also incorporates the terms of a Corporate Integrity Agreement with the HHS/OIG, under which HCA will maintain comprehensive compliance measures into the year 2009.

- **Lovelace Health Systems, Inc.** (Lovelace) agreed to pay the government \$24.5 million and implement certain integrity requirements to resolve its liability under the FCA. The Cigna-owned hospital and health maintenance organization allegedly falsified its Medicare cost reports for the ten years ending in 1998. Among the allegations, Lovelace improperly shifted costs of its health maintenance organization (HMO) patients to Medicare and otherwise inflated Medicare reimbursement. The investigation stemmed from a *qui tam* filed by an employee of a financial consultant that prepared cost reports for Lovelace.
- **St. Luke's Subacute Hospital and Nursing Center, Inc.** and its president and CEO were convicted of six counts of Medicare fraud. The officer directed his employees to manipulate the company's books to inflate the amount of reimbursable nursing time spent on Medicare patients. In 1997, 1998 and 1999, he submitted reimbursement claims to Medicare for nursing costs that overstated St. Luke's Hospital's entitlement by nearly \$3 million. He then directed an employee to create false nursing schedules in an attempt to hide inflated nursing costs from Medicare auditors, a fraud that was uncovered when law enforcement compared the false nursing schedules to true nursing schedules that were seized during a 1996 search warrant.
- **Rapid City Regional Hospital** paid \$6 million to settle civil allegations arising from unlawful patient referrals from oncologists with whom the hospital had financial relationships. The parties allegedly violated the Ethics in Patient Referrals Act, better known as the "Stark" law, which is designed to ensure that patients receive the benefit of unbiased medical judgment from their physicians. The statute prohibits doctors from referring patients to clinical laboratories, diagnostic centers, and other facilities in which they hold financial interests, and prohibits hospitals from paying for referrals from physicians with whom they have financial relationships. The FCA case involved allegations that the hospital had supplied Oncology Associates with office space, staff services, and other benefits to induce the oncologists to refer their cancer patients to the hospital. The physician practice, Oncology Associates, also paid the United States an additional \$525,000 for overbilling Medicare for their patients' office visits.
- **Public Health Trust of Miami-Dade County, d.b.a. Jackson Memorial Hospital** paid the United States \$16.8 million to settle civil allegations that it had submitted duplicate claims for the same services as both outpatient clinic and inpatient services.
- **McLeod Regional Medical Center of Pee Dee, Inc.** paid the United States \$15.9 million to settle civil allegations that it submitted false claims to the Medicare, Medicaid and TRICARE programs for hospital and home health services ordered by physicians with whom McLeod, and its for-profit subsidiary, McLeod Physician Services, had unlawful compensation arrangements. The FCA suit alleged that McLeod's financial relationships with the physicians violated the Stark law and the Anti-Kickback Statute because the hospital had agreed to pay the physicians more than fair market value for their practices, then paid them salaries exceeding fair

market value, to induce and maintain referral relationships with the physicians. The Government also alleged that McLeod included false claims for Medicare reimbursement of unallowable costs on the hospital's cost reports as a means to offset losses incurred in acquiring the practices.

- Five hospital subsidiaries of **Tenet Healthcare Corporation** agreed to pay over \$4.15 million to settle civil allegations that they "upcoded" Medicare patients' pneumonia and septicemia diagnoses. Hospitals receive Medicare reimbursement by assigning codes that reflect a patient's diagnosis at the time of discharge. Upcoding is the practice of assigning a code that reflects a falsely high level of patient acuity and medical service in order to generate higher reimbursement than the provider otherwise would receive. The five Florida hospitals involved were Coral Gables Hospital, Coral Gables; Florida Medical Center, Fort Lauderdale; Hialeah Hospital, Hialeah; Hollywood Medical Center, Hollywood; and Parkway Regional Medical Center, Miami.
- **Columbia University** paid \$5.1 million to settle civil charges that, for more than a decade, the university improperly billed the Medicaid program for deliveries and other obstetrical procedures conducted at New York-Presbyterian Hospital's Allen Pavilion. The Government alleged that the Obstetrics and Gynecology Department at the hospital routinely had physicians whose services would be reimbursed by Medicaid claim they themselves had treated patients when, in fact, the patients were seen by health care providers ineligible for reimbursement, such as midwives.

Durable Medical Equipment

- 20 defendants pleaded guilty in Arizona to engaging in a fraud scheme in which they falsely billed Medicare for more than \$25 million in DME. The defendants created approximately 30 sham DME entities in the western United States. For 3½ years, they used unlawfully obtained Medicare information to falsely bill Medicare for DME either not provided or not ordered by a physician, including expensive motorized wheelchairs, hospital beds with special mattresses, and products used for delivering nutrients directly into the gastrointestinal tract.
- A South Florida DME supplier was sentenced to 84 months in prison and ordered to pay nearly \$14.5 million in restitution for two schemes to defraud the Medicare and Medicaid programs. The court also entered a more than \$14.8 million forfeiture order. The defendant and others fraudulently billed Medicare and Medicaid for items such as motorized wheelchairs and alternating pressure mattresses. To date, 12 corporations and 14 individual defendants have pleaded guilty in connection with the schemes, and one person was convicted after a jury trial. The supplier also entered into a civil settlement agreement with the United States on behalf of himself and 15 business entities, resulting in a consent judgment being entered against him and the entities for more than \$29 million.
- The Texas owner and operator of two DME companies was convicted at trial, sentenced to 120 months incarceration, and ordered to pay \$384,984 in restitution for defrauding the Medicare and Medicaid programs. The defendant billed Medicare and Medicaid for items that were never supplied to patients, including alternating pressure mattresses, hydraulic patient lifts, and lymphedema pumps. In other instances in which items were supplied, she submitted billings with false patient diagnoses for patients who had not been evaluated by a physician and did not qualify for the product. The defendant's husband pled guilty in connection with the same scheme and was sentenced to 12 months and one day of incarceration.

- A physician convicted for obstruction of justice and mail fraud was sentenced to nearly 3 years imprisonment, and ordered to pay a \$7,500 fine and be deported upon his release. A fugitive since 1988, the physician performed cursory physical exams for a DME company which used these exams to justify prescriptions for transcutaneous electrical nerve stimulation (TENS) units to Medicare beneficiaries. However, the physician never actually performed the thorough examination required, nor did he advise the beneficiaries on the use and risks of the TENS units. The physician also signed blank certificates of medical necessity so that the TENS units could be billed to Medicare. His codefendants were previously sentenced for their roles in the scheme.

Physicians

- A Coral Gables, Florida, eye surgeon was convicted of 90 counts of Medicare fraud and ordered to pay \$812,216 in restitution and \$50,000 in fines for billing the Medicare program for services he did not provide. The surgeon fabricated medical charts and billing records, and submitted claims to Medicare, for various diagnostic tests he never conducted and laser eye surgeries that he never rendered. In many instances, elderly Medicare patients were led to believe that they had serious eye diseases that could result in blindness if not treated when in fact they did not have such illnesses. At one of the clinics, the defendant regularly claimed to have performed ophthalmic services when the equipment necessary to perform the procedures was not even present at the medical clinic on the claimed dates of service.
- Six Southern California physicians pleaded guilty to health care fraud for engaging in a scheme to defraud United States insurance companies. The defendants, who were Mexican nationals who practiced in Mexico, filed claims with United States insurance companies for medical treatment, services, and supplies supposedly provided to United States citizens in Mexico; in reality, the treatment, services, and supplies were not provided as claimed. The defendants were arrested as part of an FBI undercover operation dubbed "Operation Golden Tooth" in which the undercover agent - posing as a participant in the scam - persuaded the doctors to travel to the United States, where they were arrested upon arrival.

Home Health

- **Caremark, Rx, Inc.** (formerly MedPartners, Inc.) paid the United States \$7.5 million to settle civil allegations that false home health care claims had been submitted by a former MedPartners' subsidiary, AmCare, Inc., a Florida home health agency.

Home Health

- **Dialysis Holdings, Inc.** paid \$4,102,098 to settle an FCA action alleging that the company knowingly submitted requests to Medicare for medically unnecessary laboratory tests and blood draws. Dialysis Holdings, Inc. and its predecessor corporations provided dialysis services to thousands of terminally ill Massachusetts patients afflicted with end stage renal disease (ESRD), whose laboratory costs are covered by Medicare. Dialysis conspired with a clinical laboratory to perform unnecessary blood draws on ESRD patients, create thousands of referrals for laboratory tests that were not needed, split automated chemistry panels of tests so as to avoid a Medicare rule designed to control lab test costs, and deceive physicians and laboratory employees into unknowing participation in the scheme.

- **Dianon Systems, Inc.** paid \$4.8 million to resolve allegations of Medicare and TRICARE billing fraud under the FCA. Dianon, which conducts tests to detect various types of cancer, had billed for medically unnecessary DNA tests and second-opinion consultations and reports it failed to provide.
- **Mediq, Inc.** and its subsidiaries (collectively, Mediq), agreed to pay \$1 million to resolve their civil liability under the FCA. The case stemmed from allegations that Mediq billed Medicare for transtelephonic electrocardiograms (ECGs) when no such tests were performed. Instead, Mediq performed standard ECGs, a service that is reimbursed at a significantly lower rate.

Ambulance Services

- A New York ambulance company operator was sentenced to 78 months in prison, was ordered to pay restitution of more than \$57 million, and was subject to an \$8 million forfeiture order for health care fraud arising from his fraudulent operation of several ambulance and ambulance services. In March 1990, the HHS/OIG excluded the individual from participation in the Medicare and Medicaid programs for a period of 25 years. In order to evade this program exclusion, he established secret ownership of five ambulance and ambulance companies in Brooklyn, New York, and continued to bill Medicare and Medicaid for patient transportation. He also offered and paid bribes and kickbacks to employees of various hospitals to induce them to order ambulance and ambulance services from his companies.

Physical Therapists

- Two former operators of Texas medical clinics pleaded guilty to conspiracy to commit health care fraud, and paying kickbacks for the referral of Medicare and Medicaid patients in connection with several schemes that resulted in more than \$11 million of false billings to Medicare and Medicaid. The defendants and others operated six physical therapy clinics in the Houston area, and billed Medicare and Medicaid for claims for physical therapy services never performed, claims using a false diagnosis, and claims for services not ordered by a licensed physician or not performed under the supervision of a licensed physician. As part of the scheme, the defendants hired patient recruiters, known as "marketers," who were paid a kickback for each patient referred to the clinics for physical therapy; clinic employees were also paid kickbacks for referrals. Four co-defendants also pleaded guilty to health care fraud in connection with this matter; three other defendants, including two doctors, have proceeded to trial.

Medicare Contractors

- **Blue Cross of California (Blue Cross)**, a former Medicare fiscal intermediary, and its parent company, **Wellpoint Health Networks, Inc.**, agreed to pay \$9.3 million to resolve their potential civil and administrative liability for false claims. For ten years ending in 2000, Blue Cross allegedly falsified data regarding its performance of health care provider audits while under contract with CMS. The intermediary primarily falsified audit start and completion dates entered into an audit tracking database. The government alleged that these erroneous entries were intended to mislead CMS regarding its performance of required audit work so as to obtain a favorable annual evaluation, and to ensure renewal of its Medicare contract.
- In Missouri, a director and manager for a former Medicare contractor were sentenced for conspiring to falsify and conceal information about errors made by the contractor. The director was sentenced to 27 months in prison and fined \$6,000; the

manager was sentenced to 3 months in prison. These former executives ordered the falsification of records, beneficiary files, claims and other official documents, which, when reviewed by CMS, gave the contractor the appearance of performing at a higher level of efficiency and quality than was actually the case. This appearance of exemplary performance enabled the contractor to secure and maintain its contract with the government by being ranked for many years as one of the top 10 in the country. In June 2002, the contractor agreed to pay the government \$76 million for its alleged misconduct.

Quality of Care

One area in which collaboration among the federal authorities responsible for health oversight has proved most effective has been in enforcement and oversight of issues relating to quality of care, as demonstrated by the following:

Prosecution:

- **Endo Vascular Technologies, Inc. (EVT)**, a wholly-owned subsidiary of the medical device manufacturer Guidant Corporation, pled guilty to 10 felonies and agreed to pay \$92.4 million as part of a global resolution of charges that it covered up malfunction of its device used to treat aortic aneurysms. These incidents of malfunction included 12 deaths and more than 50 emergency surgeries. Under Federal law, a company must submit a Medical Device Report to FDA every time its device may have caused serious injury or death. EVT filed 172 such reports, but in its guilty plea, admitted to failing to file reports in 2,600 additional incidents. Moreover, the government contended that the company was aware of the incidents, since a company representative was required to be present in the operating room each time the device was inserted.

This global resolution is among the first felony convictions for failing to file Medical Device Reports with the FDA, and represents the largest dollar amount ever paid by a defendant for such failure. The investigation was conducted by the FDA and the FBI. In addition to the settlement agreement, Guidant and EVT agreed to enter into a comprehensive compliance agreement with the HHS/OIG.

- **Redding Medical Center, Inc. (RMC)**, a hospital owned by Tenet Health Systems Hospitals, Inc., agreed to pay \$54 million in settlement of liability for performing and billing Medicare, Medicaid and TRICARE for unnecessary cardiac services for the time period 1997 through 2002. This represents the government's largest recovery ever in a case alleging lack of medical necessity for surgeries. RMC agreed to implement certain corporate compliance steps; nonetheless, possible exclusion from Federal health care programs was not waived in the settlement.
- **The University of Chicago and Northwestern Memorial Hospitals**, agreed to settle charges in connection with their organ transplant programs. The hospitals agreed to pay \$115,000 and \$23,587 respectively, to resolve charges that the hospitals falsely diagnosed certain patients as more ill than they actually were. Based on these exaggerated diagnoses, the patients were allegedly moved ahead of others who were waiting for organs in that transplant region. The government also charged that the hospital billed Medicare or Medicaid for medically unnecessary services related to the overstated diagnoses.

Exclusions:

One important mechanism for safeguarding the care provided to program beneficiaries is through exclusions of providers and suppliers who have engaged in patient abuse or neglect

or fraud. During 2003, the HHS/OIG excluded more than 3,000 such individuals from participation in Medicare, Medicaid and other Federal health care programs, among them:

- A Missouri pharmacist was sentenced to 30 years in prison and ordered to pay more than \$10 million in restitution and fines for diluting chemotherapy drugs he prepared for cancer patients. In 2003, both the pharmacist and his pharmacy were excluded from Medicare, Medicaid and other Federal health care programs the pharmacist for 50 years and his pharmacy for 25 as a result of this conviction. Such lengthy exclusions were justified by the pharmacist's reckless disregard for the life-threatening consequences of his conduct.
- A Kansas physician was excluded for 25 years based on his conviction for longstanding fraud against Medicare and TRICARE. His scheme involved luring patients into unnecessary surgeries based on false representations. The physician was also convicted of perjury. The court sentenced him to 6 years in jail, and the state suspended and then summarily revoked his medical license.

Nursing Home Studies:

Quality of nursing home care remains an area of intense interest for HHS/OIG. In recent years, the HHS/OIG conducted numerous studies assessing facets of the quality of life and care in nursing homes. In 2003, these studies included the following:

- **Quality Assurance Committees (QA Committees):** QA Committees are internal organizations that provide a key point of accountability for ensuring quality of care. Nearly all nursing homes were found to meet CMS requirements for committee membership and frequency of meetings. QA Committees had access to information they needed to assess care, but were nonetheless hampered by staff shortages, turnover, and members who are inexperienced in committee work.
- **Psychosocial Services Oversight:** Another inspection examined whether residents receive required psychosocial services, including a comprehensive initial assessment and periodic evaluations. Though most facilities employed a qualified social worker as required, more than one third of residents had incomplete care plans. Where plans existed, 46 percent of residents did not receive all the psychosocial services outlined in those plans. The HHS/OIG recommended enhanced oversight of this aspect of the residential assessment and care plan.
- **National Ombudsman Reporting System:** Data was examined in the National Ombudsman Reporting System. It was found that the data corroborated deficiencies in resident care. Complaints to Ombudsmen are on the rise, with the highest frequency of nursing home complaints involving resident care. Accidents and requests for assistance were the most common. Others in the top dozen were: complaints of personal hygiene, medication administration and symptoms unattended, and categories that include complaints of unexplained bruises, medications not given, or failure to address a resident's changed condition.

The prosecutions and settlements discussed above and throughout this report reflect the culmination of investigations that have been ongoing for several years. A more detailed description of other accomplishments of the major Federal participants in the coordinated effort established under HIPAA follows. While information in this report is presented in the context of a single agency, most of the accomplishments described herein reflect the combined efforts of HHS, DOJ and other partners in the anti-fraud efforts.

SUMMARY

Results

In 2003, the Federal government won or negotiated more than \$1.8 billion in judgments and settlements in health care fraud matters. As a result of enforcement actions, judgments, settlements, and administrative proceedings, the Federal government collected more than \$1.4 billion and distributed more than \$1.03 billion during FY 2003. Over \$500 million that was collected during the FY 2003 reporting period was distributed in early 2004 and the distribution of these funds will be described in greater detail in the Annual Report for 2004⁽²⁾. Of the amount distributed to victim agencies in FY 2003, approximately \$723 million was returned to the Medicare Trust Fund and \$151.6 million was returned to the Centers for Medicare and Medicaid Services ("CMS") as the Federal share of Medicaid restitution. The HCFAC account has returned over \$5.69 billion to the Medicare Trust Fund since the inception of the program in 1997.

Enforcement Actions

Federal prosecutors filed 362 criminal indictments in health care fraud cases in 2003. A total of 437 defendants were convicted for health care fraud-related crimes during the year. There were also 1,277 civil matters pending, and 231 civil cases filed in 2003. HHS excluded 3,275 individuals and entities from participating in the Medicare and Medicaid programs, or other federally sponsored health care programs, most as a result of convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of licensure revocations.