



OIG NEWS

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Office of Inspector General
Department of Health
and Human Services
330 Independence Ave., SW
Washington, DC 20201

OIG Reports More Than \$2 Billion in Recoveries From Fighting Fraud, Waste, and Abuse for First-Half FY 2008

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) “Semiannual Report to Congress” announced expected recoveries of \$2.2 billion for the first half of fiscal year (FY) 2008 from efforts to reduce fraud, waste, and abuse in HHS programs.

Specifically, OIG’s \$2.2 billion in expected recoveries encompasses \$1.1 billion in audit-related recoveries and another \$1.1 billion in investigative-related recoveries. Additional savings from implemented recommendations are calculated annually and will be reported in the final FY 2008 Semiannual Report.

“OIG’s accomplishments reflect a robust oversight agenda implemented through audits, evaluations, and compliance and enforcement activities,” said Inspector General Daniel R. Levinson. “It is through a combination of vigilant oversight, outreach to the health care community, and partnership with government agencies at all levels that we are able to fulfill our mission to protect the integrity of HHS programs and beneficiaries.”

Also for this period, OIG reported exclusions of 1,291 individuals and organizations for fraud or abuse of Federal health care programs; 293 criminal actions against individuals or organizations that engaged in crimes against HHS programs; and 142 civil actions, which include False Claims Act (FCA) and unjust enrichment suits filed in district court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters.

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OIG accomplishments for this first half of FY 2008 include:

Medicare Part D Sponsors: Estimated Reconciliation Amounts for 2006

In our analysis of the Centers for Medicare & Medicaid Services' (CMS) Medicare Part D preliminary reconciliation data estimates (as of August 2007) and data from 16 sponsors with high enrollments, we estimated that Part D sponsors owed Medicare a net total of \$4.4 billion for the 2006 program year. Eighty percent of the sponsors owed CMS money and 20 percent were due money. We also found that CMS had no mechanism to collect funds or adjust prospective payments prior to the reconciliation that is conducted after the close of the plan year. As a result, sponsors had the use of billions of dollars for a significant length of time. In response to our recommendations, CMS agreed to use data collected from 2006 and subsequent plan years in reviewing future bids, acknowledged its authority to change certain payment methodologies, and agreed to examine related options. CMS did not agree to implement an interim process or to seek legislation delaying changes to risk corridors.

Bristol-Myers Squibb Co. Pays More Than \$499 Million To Resolve Allegations of Illegal Drug Marketing and Pricing

As part of a civil settlement, the Bristol-Myers Squibb Co. (BMS) and its wholly owned subsidiary, Apothecon, Inc., agreed to pay \$499 million plus interest to resolve allegations relating to a variety of Federal and State claims. The Government alleged that BMS fraudulently set and maintained inflated prices for a wide assortment of oncology and generic drug products, paid various forms of illegal kickbacks to physicians and pharmacies, promoted off-label uses of the antipsychotic drug Abilify, and knowingly misreported its best price for the antidepressant drug Serzone. BMS entered into a 5-year corporate integrity agreement (CIA) with OIG as part of the resolution of this FCA case.

National Institutes of Health: Conflicts of Interest in Extramural Research

In our review of financial conflicts of interest reported by grantee institutions to the National Institutes of Health (NIH), we found that the agency needed to improve its oversight of such conflicts. For FYs 2004–2006, NIH could not provide an accurate count of the financial conflict-of-interest reports that it received from grantees; of 438 financial conflict-of-interest reports received from grantee institutions in 2006, at least 89 percent did not state the nature of the conflicts or the way in which they would be managed; regarding oversight, NIH's institutes most often relied on grantees' assurances that financial conflict-of-interest regulations were being followed. NIH agreed with our recommendations to increase oversight of grantee compliance with regulations, require Institutes to forward grantee conflict-of-interest reports, and ensure that all of the reports are included in its database. NIH did not agree with our recommendation to require grantees to provide details about financial conflicts of interest.

Artificial-Joint Makers Pay \$310 Million To Settle Kickback Case

Medical device makers Zimmer Holdings, Inc.; DePuy Orthopaedics, Inc. (a unit of Johnson & Johnson); Smith & Nephew, Inc.; and Biomet, Inc., agreed to pay a total of approximately \$310 million to resolve allegations of anti-kickback statute and FCA violations.

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The four companies allegedly used consulting deals with orthopedic surgeons to induce the purchase of their respective artificial hip and knee products. As part of the settlement, the companies entered into 5-year CIAs with OIG.

Medicare Part D Payments to Local Community Pharmacies

In our review of the relationship between Medicare Part D payments to local community pharmacies and the pharmacies' drug acquisition costs, we found that in September 2006 pharmacies almost always (97 percent of the time) acquired drugs for less than the reimbursement amounts. We performed this review at the request of 33 Senators who raised concerns about the sufficiency of reimbursement to local community pharmacies. We estimated that, excluding dispensing fees and including rebates that drug wholesalers paid to pharmacies, Medicare Part D payments to local, community pharmacies exceeded the pharmacies' drug acquisition costs by 18.1 percent. We recommended that Congress and CMS consider the results of the review in deliberations regarding Medicare Part D reimbursement, and CMS agreed.

Dermatologist Sentenced for Upcoding Surgical Procedures

A Michigan dermatologist was sentenced to 10 years and 6 months in prison and ordered to pay approximately \$1.3 million in restitution and a \$175,000 fine for upcoding surgical procedures, billing for medically unnecessary procedures, and improperly billing for follow-up office visits. The dermatologist falsely informed patients that they had cancer when, in fact, laboratory results indicated that their tissue specimens were benign. He then performed surgeries based on these false diagnoses.

Temporary Assistance for Needy Families Improper Payment Pilot Reviews

In our pilot reviews of Temporary Assistance for Needy Families (TANF) basic assistance payments during a 6-month period in 2005, we found that three States—Michigan, New York, and Pennsylvania—collectively claimed an estimated \$95 million in improper payments. The estimated error rates ranged from 11.5 percent to 40 percent of the Federal dollars expended. Our recommendations focused on State compliance with requirements, enrollee eligibility, and recalculating improperly paid benefits. Michigan disagreed, New York did not address the recommendations, and Pennsylvania agreed.

Payments for Outpatient Services in Skilled Nursing Facility Stays

We found that Medicare Part B made a total of \$106.9 million in potential overpayments to suppliers of outpatient services on behalf of beneficiaries in Part A-covered skilled nursing facilities (SNF) during calendar years (CY) 2001 and 2002. These potential overpayments occurred because CMS did not have system edits in place during most of this period. For CY 2003, when the edits were fully implemented, potential overpayments were reduced to \$22.7 million. CMS agreed with our recommendations about reviewing overpayments, testing and refining edits, and establishing recovery controls.

To read the full Semiannual Report go to:

http://oig.hhs.gov/publications/docs/semiannual/2008/semiannual_spring2008.pdf