

APRIL 1, 2006  
THROUGH  
SEPTEMBER 30, 2006

OFFICE  
OF THE  
INSPECTOR  
GENERAL

*Semiannual  
Report  
to Congress*



THEODORE ROOSEVELT  
COMMISSIONER  
UNITED STATES CIVIL SERVICE COMMISSION  
MAY 13, 1889 - MAY 5, 1895

UNITED STATES OFFICE OF  
PERSONNEL MANAGEMENT

# OFFICE OF THE INSPECTOR GENERAL



## *Productivity Indicators*

### **FINANCIAL IMPACT:**

Audit Recommendations for Recovery of Funds . . . . .	\$34,918,454
Management Commitments to Recover Funds . . . . .	\$25,786,010
Recoveries Through Investigative Actions . . . . .	\$5,410,451

*Note: OPM management commitments for recovery of funds during this reporting period reflect amounts covering current and past reporting period audit recommendations.*

### **ACCOMPLISHMENTS:**

Audit Reports Issued . . . . .	47
Investigative Cases Closed. . . . .	60
Indictments and Informations . . . . .	32
Arrests . . . . .	33
Convictions . . . . .	33
Hotline Contacts and Complaint Activity . . . . .	550
Health Care Provider Debarments and Suspensions . . . . .	482
Health Care Provider Debarment and Suspension Inquiries . . . . .	1,823

**OFFICE of the INSPECTOR GENERAL**

*Semiannual Report  
to Congress*

APRIL 1, 2006 – SEPTEMBER 30, 2006



**UNITED STATES OFFICE OF PERSONNEL MANAGEMENT**



## *The Inspector General's Message*

NOVEMBER 1, 2006

**T**he Office of the Inspector General (OIG) has seen major changes in top management in the last year due to retirements and new career opportunities. Our succession planning prepared us for a smooth transition to the next generation of managers. I believe, wholeheartedly, that these new leaders will continue the commitment we have made to safeguard and enhance the American taxpayers' expectations.

During this transition period, we renewed our commitment to a professional and objective mission. In light of this, we developed a new Office of the Inspector General Strategic Plan for fiscal years 2007 – 2011 to redefine the strategic and operational goals of our office. Our plan complements and supports the strategic plan of the agency and provides a clear roadmap for the next five years. It establishes a modern strategy that can respond to the technological and management changes within government.

In closing, I wish to acknowledge the contributions of Dan Marella, former Assistant Inspector General for Policy, Resources Management and Oversight, who recently left the OIG after 15 years of exemplary work. Dan joined this office as a budget analyst in 1991. As his responsibilities increased over the years, he displayed exceptional leadership qualities. Dan is now the Associate Chief Financial Officer for Budget and Performance at OPM. I congratulate Dan and look forward to working with him in his new position.

A handwritten signature in black ink, reading "Patrick E. McFarland".

Patrick E. McFarland

Inspector General



## *Mission Statement*

**OUR MISSION IS TO PROVIDE INDEPENDENT  
AND OBJECTIVE OVERSIGHT OF OPM SERVICES  
AND PROGRAMS.**

### **WE ACCOMPLISH OUR MISSION BY:**

- Conducting and supervising audits, evaluations and investigations relating to the programs and operations of OPM
- Making recommendations that safeguard the integrity, efficiency and effectiveness of OPM services
- Enforcing laws and regulations that protect the program assets that are administered by OPM

## *Guiding Principles*

### **WE ARE COMMITTED TO:**

- Promoting improvements in the agency's management and program operations
- Protecting the investments of the American taxpayers, federal employees and annuitants from waste, fraud and mismanagement
- Being accountable to the concerns and expectations of our stakeholders
- Observing the highest standards of quality and integrity in our operations

## *Strategic Objectives*

### **THE OIG WILL:**

- Combat fraud, waste and abuse in programs administered by the agency
- Ensure that the agency is following best business practices by operating in an effective and efficient manner
- Determine whether the agency complies with applicable federal regulations, policies and laws
- Ensure that insurance carriers and other service providers for OPM program areas are compliant with contracts, laws and regulations
- Aggressively pursue the prosecution of illegal violations affecting agency programs
- Identify through proactive initiatives, areas of concern that could strengthen the agency's operations and programs administered by OPM



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*Field Offices*

**OFFICE OF THE  
INSPECTOR GENERAL**





## Audit Activities

### Health and Life Insurance Carrier Audits

*The Office of Personnel Management (OPM) contracts with private-sector firms to provide health and life insurance through the Federal Employees Health Benefits Program (FEHBP) and the Federal Employees' Group Life Insurance program (FEGLI).*

*Our office is responsible for auditing the activities of these programs to ensure that the insurance carriers meet their contractual obligations with OPM.*

The OIG insurance audit universe contains approximately 270 audit sites, consisting of health insurance carriers, sponsors and underwriting organizations, as well as two life insurance carriers. The number of audit sites is subject to yearly fluctuations due to the addition of new carriers, non-renewal of existing carriers, or plan mergers and acquisitions. The combined premium payments for the health and life insurance programs are approximately \$34 billion annually.

The health insurance plans that our office audits are either community-rated or experience-rated carriers.

*Community-rated carriers are comprehensive medical plans, commonly referred to as health maintenance organizations (HMOs).*

*Experience-rated carriers are mostly fee-for-service plans, the largest being the Blue Cross and Blue Shield health plans, but also include experience-rated HMOs.*

The two types of carriers differ in the way they calculate premium rates. Community-rated carriers generally set their rates based on the average revenue needed to provide health benefits to each member of a group. Rates established by experience-rated plans reflect a given group's projected paid claims, administrative expenses and service charges for administering a specific contract.

During the current reporting period, we issued 22 final reports on organizations participating in the FEHBP, of which 14 contain recommendations for monetary adjustments in the aggregate amount of \$34.9 million due the FEHBP.

Appendix III (page 28) contains a complete listing of all health plan audit reports issued during this reporting period.





## COMMUNITY-RATED PLANS

The community-rated HMO audit universe covers approximately 160 health plans located throughout the country. Community-rated audits are designed to ensure that the premium rates plans charge the FEHBP are in accordance with their respective contracts and applicable federal laws and regulations.

Federal regulations require that the FEHBP rates be equivalent to the rates a plan charges the two groups closest in subscriber size, commonly referred to as *similarly sized subscriber groups (SSSGs)*. The rates are set by the plan, which is also responsible for selecting the two appropriate groups. When an audit shows that the rates are not equivalent, the FEHBP is entitled to a downward rate adjustment to compensate for any overcharges.

Community-rated audits focus on ensuring that:

- The plans select and rate the appropriate SSSGs;
- The FEHBP rates are equivalent to those charged the SSSGs; and,
- The loadings applied to the FEHBP rates are appropriate and reasonable.

*Loading is a rate adjustment that FEHBP makes to the basic benefit package offered by a community-rated plan. For example, the FEHBP provides coverage for dependent children until age 22, while the plan's basic benefit package may provide coverage through age 19. Therefore, the FEHBP rates may be increased because of the additional costs the plan incurs by extending coverage to age 22.*

During this reporting period, we issued 12 audit reports on community-rated plans. These reports contain recommendations to require the plans to return over \$15.2 million to the FEHBP.

## Kaiser Foundation Health Plan, Inc.

Northern California Region  
Oakland, California

Report No. 1C-59-00-04-019

MAY 17, 2006

Kaiser Foundation Health Plan, Inc., Northern California Region, has participated in the FEHBP as a community-rated health plan since 1960 and provides comprehensive medical services to its members throughout the Northern California area. This audit of the plan covered contract years 2000 through 2003. During this period, the FEHBP paid the plan approximately \$1.4 billion in premiums.

We identified a total of \$9,086,310 in inappropriate health benefit charges to the FEHBP; including \$4,007,763 in 2001, \$1,923,636 in 2002, and \$3,154,911 in 2003. In addition, we determined the FEHBP is due \$1,450,474 for investment income lost as a result of the overcharges.

*Lost investment income represents the potential interest earned on the amount the plan overcharged the FEHBP as a result of defective pricing.*

Kaiser inappropriately overcharged the FEHBP for late premium payments in contract years 2001, 2002, and 2003. In 2001, additional overcharges occurred because the FEHBP paid too much for its prescription drug benefit. Further, in finalizing its rates, Kaiser overstated the number of its FEHBP enrollees who would be over age 65. Because of the higher estimated health care costs for enrollees in this age group, as compared to the less expensive under-65 category, this had the effect of incorrectly increasing Kaiser's rates.

**Health Benefit  
Overcharges  
Exceed \$9 Million**

Kaiser agrees that it overcharged the FEHBP \$7,082,301, plus lost investment income.



**University of Pittsburgh Medical  
Center Health Plan  
Pittsburgh, Pennsylvania  
Report No. 1C-8W-00-06-070  
AUGUST 8, 2006**

The University of Pittsburgh Medical Center Health Plan (UPMC) provides primary health care services to plan members throughout Western Pennsylvania. This audit was one of seven rate reconciliation audits (RRA) we conducted in 2006.

RRA audits are performed during OPM's rate reconciliation process. This process allows plans to adjust their proposed rates for the year to the rates that should actually be charged. The adjustment is necessary because each year plans must submit their rates to OPM seven months before the rates take effect. As a result, some of the information used to establish the rates is based on preliminary or estimated data. The rate reconciliation process allows plans to subsequently submit revised rates to OPM and allows OPM to adjust the premiums paid to the plan for the current year.

***Inappropriate  
Charges Amount  
to \$2.6 Million***

The audit identified \$2,620,458 in inappropriate health benefit charges to the FEHBP. The overcharges occurred because the plan:

- understated the pharmacy rebate due the FEHBP,
- overstated the cost for the vision benefit,
- understated the catastrophic claim credit,
- used an incorrect benefit adjustment factor, and,
- gave the FEHBP an inappropriate premium discount.

UPMC does not agree with our findings.

## EXPERIENCE-RATED PLANS

The FEHBP offers a variety of experience-rated plans, including a service benefit plan and health plans operated or sponsored by federal employee organizations or unions. In addition, experience-rated health maintenance organizations fall into this category.

The universe of experience-rated plans currently consists of approximately 110 audit sites. When auditing these plans, our auditors generally focus on three key areas.

- Appropriateness of FEHBP contract charges and the recovery of applicable credits, including refunds;
- Effectiveness of carriers' claims processing, financial and cost accounting systems, and
- Adequacy of carriers' internal controls to ensure proper contract charges and benefit payments.

During this reporting period, we issued seven experience-rated audit reports. In these reports, our auditors recommended that the plans return \$6.5 million in inappropriate charges and lost investment income to the FEHBP.

## BLUECROSS BLUESHIELD SERVICE BENEFIT PLAN

The BlueCross BlueShield Association (BCBS Association) administers a fee-for-service plan, known as the Service Benefit Plan, which contracts with OPM on behalf of its member plans throughout the United States. The participating plans independently underwrite and process the health benefits claims of their respective federal subscribers and report their activities to the national BCBS operations center in Washington, DC. Approximately 56 percent of all FEHBP subscribers are enrolled in BCBS plans.



## AUDIT ACTIVITIES

We issued six BlueCross BlueShield experience-rated reports during the reporting period. These experience-rated audits normally address health benefit payments, miscellaneous payments and credits, administrative expenses, and cash management activities. Our auditors noted \$5.8 million in questionable contract costs charged to the FEHBP, including lost investment income on these questioned costs.

- \$63,270 in other claim payment errors; and,
- \$30,472 for other overstated administrative expenses.

We computed lost investment income of \$7,085 on the questioned charges.

The BCBS Association agreed with \$2,842,553 of the findings.

### BlueCross BlueShield of Minnesota Eagan, Minnesota Report No. 1A-10-78-05-005 SEPTEMBER 15, 2006

Our audit covered FEHBP operations at BlueCross BlueShield of Minnesota for contract years 1999 through 2003. During the audited period, the plan

paid approximately \$625 million in FEHBP claims and \$45 million in administrative expenses.

***BCBS Association  
Agrees with \$2.8 Million  
in Inappropriate Health  
Benefit Charges***

Our auditors determined that inappropriate charges to the FEHBP totaled \$2,945,133, as follows:

- \$1,402,209 for claims not priced in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), which limits benefit payments for certain inpatient services provided to annuitants age 65 and older who are not covered under Medicare Part A;
- \$1,085,706 for miscellaneous income not properly credited;
- \$264,442 for improper billings for assistant surgeons;
- \$99,034 for unreturned refunds and recoveries;

### BlueCross BlueShield of Massachusetts Boston, Massachusetts Report No. 1A-10-11-04-065 JUNE 26, 2006

Our audit covered FEHBP operations at BlueCross BlueShield of Massachusetts for contract years 2000 through 2003. During the audited period, the plan paid approximately \$866 million in FEHBP claims and \$73 million in administrative expenses.

Our auditors determined that inappropriate charges to the FEHBP totaled \$1,554,341, as follows:

- \$457,339 for overstated pension costs;
- \$439,217 for other overstated administrative expenses;
- \$273,474 for claims not priced in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), which limits benefit payments for certain inpatient services provided to annuitants age 65 and older who are not covered under Medicare Part A;

***Auditors Question  
\$1.55 Million for  
Inappropriate Health  
Benefit Charges***



- \$262,058 for inappropriate allocation of the gain from the sale of the headquarters building;
- \$118,517 in other claim payment errors; and,
- \$3,736 for miscellaneous income not properly credited.

We computed lost investment income of \$24,341 on the questioned charges.

The BCBS Association agreed with \$1,292,283 of the findings.

## AdvancePCS

Scottsdale, Arizona

Report No. 1H-01-00-06-063

SEPTEMBER 7, 2006

The BCBS Association contracts with AdvancePCS to provide retail pharmacy benefits, process pharmacy claims, and make payments to retail pharmacy providers. For the period 2003 through 2005, AdvancePCS paid approximately \$7 billion in retail pharmacy drug charges for the BCBS plans.

Our auditors performed a limited scope audit of the FEHBP's Retail Pharmacy Drug Benefit Program operations at AdvancePCS. The audit covered pharmaceutical manufacturer reimbursements, such as drug rebates and administrative fees, that AdvancePCS received from 2003 through 2005. We reviewed approximately \$333 million of the \$450 million in pharmaceutical manufacturer reimbursements for proper calculation and/or allowability.

*Pharmacy drug rebates are payments made by pharmaceutical drug manufacturers to the pharmacy drug program plan (AdvancePCS) for achieving a certain target market share with respect to a particular drug. Rebate amounts and specific*

*market share requirements are detailed in contracts between the manufacturers and AdvancePCS. AdvancePCS sends the rebates earned by the FEHBP to the BCBS Association. The Association is required to credit these amounts to the FEHBP. These rebates should reduce overall pharmacy drug costs.*

*Administrative fees are payments to AdvancePCS from pharmaceutical manufacturers to cover the cost of maintaining the manufacturer drug rebate program.*

Our auditors determined that \$10,661,804 of the pharmaceutical manufacturer reimbursements retained by Advan-

cePCS as administrative fees should have been considered drug rebates and returned to the FEHBP.

The BCBS Association agreed with this audit finding.

*Auditors Question  
\$10.7 Million in  
Administrative  
Fees Retained by  
AdvancePCS*

## EMPLOYEE ORGANIZATION PLANS

Employee organization plans also fall into the category of experience-rated plans. These plans either operate or sponsor participating federal health benefits programs. As fee-for-service plans, they allow members to obtain treatment through facilities or providers of their choice.

The largest employee organizations are federal employee unions and associations. Some examples are: the American Postal Workers Union, the Association of Retirees of the Panama Canal Area,



## AUDIT ACTIVITIES

the Government Employees Hospital Association, the National Association of Letter Carriers, the National Postal Mail Handlers Union, and the Special Agents Mutual Benefit Association.

We issued audit reports on two employee organization plans during this reporting period: the Special Agents Mutual Benefit Association and the Panama Canal Area Benefit Plan, respectively. A summary of the report on the Panama Canal Area Benefit Plan, including our audit findings, follows.

### Health Network America as Administrator for the Panama Canal Area Benefit Plan

Eatontown, New Jersey

Report No. 1B-43-00-05-081

AUGUST 22, 2006

The Panama Canal Area Benefit Plan (Plan) is an employee organization plan sponsored and administered by the Association of Retirees of the Panama Canal Area (Association). Enrollment in the Plan is open to members of the Association who are eligible for coverage under the FEHBP, and annuitants who reside in Panama.

Health Network America (HNA) administered the claim payments for the Plan during contract

years 1998 through 2005. Starting in contract year 2006, AXA-Assistance assumed administration of claim payments for the Plan.

***Auditors Question  
\$58,863 for  
Inappropriate Health***

Our audit of the FEHBP operations at HNA covered claim payments for 2001 through 2004, as well as miscellaneous health benefit payments and credits, administrative expenses, and cash management activities for 1999 through 2004. During the period 1999 through 2004, HNA paid approxi-

mately \$266 million in health benefit charges and incurred \$24 million in administrative expenses.

Our auditors questioned inappropriate health benefit charges to the FEHBP totaling \$58,863, as follows:

- \$34,786 for duplicate claim payments; and,
- \$24,077 for claim overpayments.

HNA agreed with \$55,257 and is reviewing \$3,606 of the questioned charges.

### FEDERAL LONG TERM CARE INSURANCE PROGRAM

Long Term Care Partners, LLC

Portsmouth, New Hampshire

Report No. 1G-LT-00-05-080

MAY 17, 2006

The Federal Long Term Care Insurance Program (FLTCIP) was established by the Long Term Care Security Act of 2000. Under this act, OPM developed and has oversight of a long term care insurance program for Federal employees and annuitants, current and retired members of the uniformed services, and qualified relatives.

Long Term Care Partners, LLC (Company) was formed as a joint venture, owned equally by John Hancock Life Insurance Company and Metropolitan Life Insurance Company (referred to as the Carriers), to provide and administer the FLTCIP benefits. In December 2001, OPM awarded a contract to the Company, which expires on September 30, 2008. Operations began on March 25, 2002. The Company, with Carrier assistance and OPM oversight, is responsible for all administrative functions of the FLTCIP, including marketing and enrollment programs, underwriting,

## OFFICE OF PERSONNEL MANAGEMENT



policy issuance, premium billing and collection, and claim administration.

Our audit objectives were to determine whether the Company charged costs to the FLTCIP and provided services to FLTCIP members in accordance with the terms of the contract and applicable regulations. We reviewed long term care claim payments and disbursements for the period October 1, 2003 through September 30, 2004, as well as the carrier's and Company's procedures related to cash management of FLTCIP funds for this period.

Due to concerns regarding unreported investment income, we expanded our audit scope to include investment income earned for the periods October 1, 2002 through September 30, 2003 and October 1, 2004 through June 30, 2005. Due to concerns with commingling of funds, we

expanded our audit scope to also include the flow of FLTCIP funds for the periods August 28, 2003 through September 30, 2003 and October 1, 2004 through June 30, 2005.

The Company incorrectly calculated interest on the outstanding balances owed to the Carriers. Our auditors identified \$3,150,188 in interest overcharges to the FLTCIP. The Company subsequently corrected the overcharges.

*Auditors Identify  
\$3.2 Million in  
Interest Overcharges*

Further, our auditors identified procedural issues related to cash management and financial reporting. OPM is currently addressing these issues with the Company and the Carriers.



## Information Systems Audits

*Computer-based information systems have become increasingly important to OPM as the means of carrying out its programs efficiently and accurately. We perform information systems audits of health and life insurance carriers that participate in the FEHBP and FEGLI, and audit elements of OPM's computer security environment.*

OPM relies on computer technologies and information systems to administer programs that distribute health and retirement benefits to millions of current and former federal employees. Any breakdowns or malicious attacks (e.g., hacking, worms or viruses) affecting these federal computer-based programs could compromise efficiency and effectiveness and ultimately increase the cost to the American taxpayer.

Our office examines the computer security and information systems of private health insurance carriers participating in the FEHBP by performing general and application controls audits.

*General controls are the policies and procedures that apply to an entity's overall computing environment.*

*Application controls apply to individual computer applications, such as a carrier's payroll system or benefits payment system. General controls provide a secure setting in which computer systems can operate, while application controls ensure that the systems completely and accurately process transactions.*

---

### Information Systems General and Application Controls at the National Association of Letter Carriers

Ashburn, Virginia

Report No. 1B-32-00-04-060

APRIL 26, 2006

The National Association of Letter Carriers Health Plan (NALC) offers health insurance coverage to federal employees throughout the country. We evaluated the confidentiality, integrity, and availability of NALC's operations related to processing health insurance claims, as well as the information technology resources that support this process. In addition, we confirmed NALC's efforts to meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA). We performed this audit at NALC's offices in Ashburn, Virginia.

NALC utilizes a "mid-range" IBM AS/400 computer to house its claim processing system. Therefore, the general controls portion of our audit focused on the security features related to the OS/400 operating system, as well as the network environment that enables NALC employees to access the claim processing system. The application controls portion of our audit focused on the input, processing, and output controls associated with



NALC's claims processing and enrollment systems. Some of the controls that NALC has implemented to help promote a secure computing environment are:

- Logging and auditing of activity on the operating system and other applications in the network environment.
- Procedures for controlling changes to the operating system.
- Periodic testing of disaster recovery capabilities.

However, we also found information system controls that could be improved, and recommended that NALC:

- Implement a formalized program of Information Technology security policies, procedures, and standards that include detailed risk assessment procedures.
- Implement an incident response capability, to include intrusion detection devices.
- Limit the number of employees with 'Administrator' privileges on the operating system.
- Develop edits in the claim processing system to properly identify the following: unbundled services, procedure and diagnosis code inconsistencies, and gender specific procedures.
- Implement procedures to ensure that the most recent version of the mandatory Centers for Medicare & Medicaid Services (CMS) PRICER program is used to price OBRA90 claims.

## Information Systems General and Application Controls at BlueCross BlueShield of North Carolina

Durham, North Carolina

Report No. 1A-10-33-05-027

JULY 3, 2006

BlueCross BlueShield of North Carolina (BCBSNC) offers health insurance coverage to federal employees in the state of North Carolina, and processes FEHBP claims on a mainframe computer. We evaluated the general IT security controls, as well as the claims system input, processing, and output application controls. In addition, we confirmed BCBSNC's compliance with the Health Insurance Portability and Accountability Act (HIPAA).

This was our first audit of general and application controls at BCBSNC. We determined that BCBSNC had implemented a number of controls to help promote a secure computing environment. Some of these controls include:

- Procedures for identifying and documenting problems with the mainframe operating system.
- Implementation of technical controls to prevent unauthorized access to the network environment (firewalls, intrusion detection systems, antivirus software).
- Well documented disaster recovery and business continuity capabilities.

*OIG identified security weaknesses in the configuration of BCBSNC's mainframe operating environment*





## AUDIT ACTIVITIES

However, we found there were opportunities for improvement of BCBSNC's internal controls, and recommended that they:

- Implement stronger password requirements for the security software that governs access to mainframe applications.
- Improve procedures for monitoring access to computing resources.
- Make several changes to the configuration of the mainframe operating system to improve security.
- Expand the clinical edit rules in the claims processing system to ensure appropriate billing; for example, we found that a female patient was billed for a vasectomy.
- Improve controls that ensure the claims processing system's debarment file is adequately maintained.
- Implement the necessary technical controls to identify and process workers compensation/ coordination of benefit claims in accordance with the FEHBP contract.

BCBSNC officials implemented several of our recommendations during the reporting phase of the audit, and were required to provide supporting documentation to OPM's audit resolution group. This group will continue to monitor BCBSNC's efforts to address the remaining recommendations.

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### **Information Systems General and Application Controls at Mutual of Omaha Omaha, Nebraska Report No. 1B-38-07-05-048 SEPTEMBER 8, 2006**

Mutual of Omaha (Mutual) provides underwriting services for three FEHBP health plans: Foreign

Service Benefit Plan, Association Benefit Plan, and Rural Carrier Benefit Plan. These three plans cover over 66,000 current and former federal employees with a total subscription income of over \$530 million.

Our general and application controls audit focused on Mutual's claim processing system, in an IBM AIX computer and the supporting resources. In addition, we confirmed Mutual's compliance with the Health Insurance Portability and Accountability Act (HIPAA).

We identified several controls that Mutual has implemented to help promote a secure computing environment. Some of these controls include:

- A well documented security management structure, and clearly defined job descriptions for individuals with security related responsibilities.
- Remote system access is adequately controlled and monitored.
- Processes in place for making and documenting changes to the claim processing application.

We also found opportunities for Mutual to improve its internal controls. We recommended that they:

- Ensure that all systems and applications are compliant with the corporate password policy.
- Reconcile the enrollment databases of all three Plans to Mutual's universal enrollment database.
- Implement the necessary claim processing system changes to ensure that pre-certification rules are properly enforced for all FEHBP OBRA90 claims.
- Implement technical controls to ensure that a code is printed on all explanation of benefits for claims submitted by debarred/suspended providers.



- Implement procedures to ensure that the most recent version of the mandatory Centers for Medicare and Medicaid Services (CMS) PRICER program is used to price OBRA90 claims.

Mutual of Omaha has agreed to work with OPM to resolve the issues and recommendations highlighted in the report.

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## OPM's Compliance with the Federal Information Security Management Act Washington, DC SEPTEMBER 25, 2006

The Federal Information Security Management Act of 2002 (FISMA) ensures that the information resources and assets supporting federal operations are appropriately protected. FISMA requires agencies to implement security planning for their information systems. A critical aspect of security planning is the inspectors general annual program security reviews.

FISMA reviews for this reporting period included:

- An assessment of OPM's overall computer security program in accordance with the Office of Management and Budget's FISMA reporting instructions.
- A follow up on recommendations in our 2005 FISMA report.
- Four reviews of OPM systems to assess compliance with FISMA.

Our review of OPM's overall computer security program revealed significant progress and OPM's continued commitment to manage and secure its information resources. The agency has established:

- A process for conducting an annual review of system security controls.

- An agency-wide plan of action and milestones process, which incorporates the known IT security weaknesses associated with information systems.
- A documented agency-wide computer security configuration policy.

We also identified opportunities for improvement and recommended that OPM:

- Ensure the contingency plan for its systems addresses the critical elements in National Institute of Standards and Technology (NIST) guidelines.
- Implement a documented process to update OPM's IT security policies and procedures.
- Complete the Certification and Accreditation process for all systems in accordance with the agency's IT security policies and procedures.

During our follow up review, we determined that OPM has addressed most of the recommendations in our 2005 FISMA report. OPM agrees with all the outstanding recommendations and continues to work toward resolving them.

The four reviews of OPM's program offices' systems covered the following FISMA requirements:

- performing self-assessments to determine the current security posture of their systems;
- conducting risk assessments to identify, manage and mitigate security risks; and
- documenting the security measures and associated controls required to protect a system in an Information System Security Plan.

Our review revealed substantial compliance with these FISMA requirements.

The 2006 FISMA review resulted in a total of six reports. Appendix V on page 30 provides a listing of these reports.



## Internal Audits

### COMBINED FEDERAL CAMPAIGN

*Our office audits local organizations of the Combined Federal Campaign (CFC), the only authorized charitable fundraising drive conducted in federal installations throughout the world. OPM has responsibility, through both law and executive order, to regulate and oversee the conduct of fund-raising activities in federal civilian and military workplaces worldwide.*

Combined Federal Campaigns are identified by geographical areas that may include only a single city, or encompass several cities or counties. Our auditors review the eligibility of participating charities associated with a given campaign and the charities' compliance with federal regulations and OPM guidelines. In addition, all CFC organizations are required by regulation to have an independent public accounting firm (IPA) audit their respective financial activities for each campaign year. We review the IPA reports as part of our audits.

CFC audits do not identify savings to the government, because the funds involved are charitable donations made by federal employees. Our audit efforts occasionally generate an internal referral to our OIG investigators for potential fraudulent activity. OPM's CFC office works with the auditee to resolve the findings after the audit report is issued.

A total of 298 local campaigns operating in the United States and overseas participated in the 2005 campaign. For that year, federal employee contributions reached \$268.5 million, while campaign expenses totaled \$25.6 million.

### LOCAL CFC AUDITS

The local organizational structure consists of:

- **Local Federal Coordinating Committee (LFCC)**  
The LFCC is comprised of federal employees nominated by their respective agencies. It organizes the local CFC, determines local charities' eligibility to participate, supervises the activities of the Principal Combined Fund Organization, and resolves issues relating to a local charity's noncompliance with the policies and procedures of the CFC.
- **Principal Combined Fund Organization (PCFO)**  
The PCFO is a charitable organization selected by the LFCC to administer the local campaign. Their duties include collecting and distributing CFC funds, training volunteers, and maintaining a detailed accounting of CFC administrative expenses incurred during the campaign. The PCFO is reimbursed for its administrative expenses from CFC funds.
- **Local Federations**  
A local federation is an association of local charitable organizations with similar objectives and interests that provides common fundraising and administrative services to its members.



- ***Individual Charities***

Individual charities are non-profit, human health and welfare organizations that provide charitable services in local geographical areas.

During this reporting period we issued 15 audit reports of local CFCs. These reports identified numerous violations of regulations and guidelines governing local CFC operations. The most frequently occurring problems were as follows:

- ***Undistributed Campaign Receipts***

The PCFOs for six local campaigns did not distribute \$343,551 in campaign receipts to the 2001, 2002 and 2003 CFCs. OPM regulations require that at the close of each disbursement period, the PCFO's CFC account must have a zero balance.

- ***Campaign Expenses***

The PCFOs for six local campaigns charged the 2002 and 2003 CFCs \$121,935 in unsupported and unallowable campaign expenses. Regulations require that they recover expenses as approved by the LFCC, reflecting the actual costs of administering the campaign.

- ***Pledge Cards***

For the 2002 and 2003 CFCs, we identified various pledge card processing errors where the donor's requests were not honored and the cards were not processed in accordance with OPM regulations.

- ***PCFO Application***

The PCFO application for seven campaigns did not comply with the regulations. Approving applications that do not comply with CFC regulations could result in an ineligible charity serving as the PCFO.

- ***Local Application Review Process***

For 11 campaigns, we found that the LFCC's process for reviewing local applications was inadequate to approve the eligibility of those agencies applying to be included in the 2002 and 2003 local CFCs. Specifically, the LFCC's review

***Campaigns did not  
Disburse \$343,551 in  
Campaign Receipts***

checklist did not clearly show that all eligibility requirements were examined during their approval process. In addition, we found that 80 percent of the applications of local charities and federations we reviewed did not meet one or more of the regulatory eligibility requirements.

- ***Agreed-Upon Procedures***

The PCFO for two campaigns did not have an IPA perform agreed-upon procedures. In addition, one campaign did not comply with the March 2003 CFC Audit Guide and five campaigns did not comply with the March 2004 CFC Audit Guide, which specifies procedures the IPA must follow.

## NATIONAL CHARITABLE FEDERATION AUDITS

We also audit national charitable federations that participate in the CFC. National federations provide services to other charities with similar missions. They are similar to local federations in that they provide common fundraising, administrative and management services to their members. Our audits of the national federations focused on the eligibility of member charities, distribution of funds, and allocation of expenses. During this reporting period, we issued one report on a national charitable federation that participated in the CFC.



## AUDIT ACTIVITIES

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**2003 Combined  
Federal Campaign Activities  
for The Medical Research  
Charities Federation  
Springfield, Virginia  
Report No. 3A-CF-00-05-079  
JULY 14, 2006**

National federations that are approved to participate in the CFC are responsible for certifying member applications for campaign eligibility, acting as a fiscal agent for its members, and assuring that donor designations are honored. A federation must have 15 or more member charities that meet the CFC regulatory eligibility requirements. After obtaining

status as a national federation from OPM, it must re-establish eligibility each year and certify and/or demonstrate that its members meet all eligibility requirements expressed in the CFC regulations.

Our audit identified two instances where Medical Research Charities did not fulfill its responsibilities as a national federation. We found that:

- The federation charged its members minimum and maximum fees for the 2003 CFC expenses, which were not discussed in their agreement with its members.
- Eligibility was granted to two of their member agencies that did not meet one or more of the eligibility requirements for participation in the CFC.



## OPM INTERNAL PERFORMANCE AUDITS

*Our internal auditing staff focuses on improving the efficiency and effectiveness of OPM's operations and their corresponding internal controls. Two critical areas of this audit activity are OPM's consolidated financial statements required under the Chief Financial Officers Act of 1990 (CFO Act), as well as the agency's work required under the Government Performance and Results Act of 1993 (Results Act or GPRA). Our staff also conducts performance audits covering other internal OPM programs and functions.*

### Computer Assistants and Building Management Assistant Competition

Washington, DC

Report No. 4A-CA-00-05-086

SEPTEMBER 8, 2006

The Office of Management and Budget Circular A-76 establishes policy for determining whether certain activities should be performed under contract with commercial sources or in-house using government facilities and personnel.

In 2004, OPM conducted a competition for its "Computer Assistants and Building Management Assistant" (CABMA) services. As a first step, the agency developed a Most Efficient Organization (MEO) for its in-house government personnel. The MEO realigned the existing workforce, and reduced staff positions (sometimes referred to as FTEs) from 22 to 18. The MEO won the competition to perform the CABMA functions and activities. The new organization began operating on January 1, 2005.

After a year of operation, the OPM contracting office was required to review the new organization to determine if it was performing or could perform

at the estimated lower cost. Our auditors examined the contracting office's implementation of the MEO.

We identified the following:

- OPM did not monitor performance of the Computer Assistants and Building Management Assistant MEO.
- The employee's grade changes outlined in the MEO proposal did not become effective until March 20, 2005 although the new organization was implemented on January 1, 2005. This resulted in higher operational costs than projected.
- The agency's estimated cost for the first performance period included an unsupported cost of \$7,086.
- OPM's calculation of labor costs was understated by \$19,696 because overtime was not considered.

Despite these findings, the auditors found the MEO's performance was more cost effective than the private sector proposal. OPM agreed with our findings and will take corrective actions to improve its administration of MEOs.



## Enforcement

### Investigative Activities

*The Office of Personnel Management administers benefits from its trust funds for all federal civilian employees and annuitants participating in the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS), FEHBP, and FEGLI. These programs cover over eight million current and retired federal civilian employees, including eligible family members, and disburse about \$77 billion annually. While we investigate employee misconduct and other wrongdoing, the majority of our OIG investigative efforts are spent examining potential fraud involving these trust funds.*

**D**uring the reporting period, our office opened 70 investigations and closed 60, with 461 still in progress at the end of the period. Our investigations led to 33 arrests, 32 indictments and/or informations, 33 convictions and \$5,410,451 in monetary recoveries. For a complete statistical summary of our office's investigative activity, refer to the table on page 25.

### HEALTH CARE FRAUD

Health care fraud cases are often time-consuming and complex, and may involve several health care providers who are defrauding multiple health insurance plans. Our criminal investigations are critical to protecting federal employees, annuitants, and members of their families who are eligible to participate in the FEHBP.

Whenever feasible, we coordinate our health care fraud investigations with the Department of Justice (DOJ) and other federal, state and local law enforcement agencies. At the national level, we are participating members of DOJ's health care fraud working groups. We work directly with U.S.

Attorney's offices nationwide to focus investigative resources in areas where fraud is most common.

OIG special agents are in regular contact with FEHBP health insurance carriers to identify possible fraud by health care providers and subscribers. Additionally, special agents work closely with our auditors when fraud issues arise during carrier audits. They also coordinate with the OIG debaring official when investigations of health care providers reveal evidence of violations that may warrant administrative sanctions.

### HEALTH CARE FRAUD CASES

#### Civil Settlement of Off-Label Marketing Pharmaceutical Fraud Nets \$1.2 Million for the FEHBP

On August 8, 2006, a civil settlement was reached between the United States government and a pharmaceutical manufacturer. The pharmaceutical manufacturer allegedly defrauded FEHBP by encouraging doctors to prescribe certain medica-



## ENFORCEMENT

tions for uses that were not FDA approved. In addition, the manufacturer was accused of providing illegal remunerations to physicians who prescribed the medications for other than accepted uses (off-label). The civil settlement included over \$255 million in restitution, damages and fines. The FEHBP will recover \$1,195,000 from the settlement.

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### Settlement Follows Excessive Billing for Cardiac Monitoring

A company that performed cardiac monitoring recently settled with the United States government for \$637,446. Investigation revealed that between 2001 and 2004, the company repeatedly billed for five instances of cardiac monitoring per thirty day service period, although the current procedural terminology code restricts billing to once every thirty days. System edits at one of the FEHBP insurance carriers failed to detect the frequency of the billing. The cardiac monitoring company submitted claims for payment to the FEHBP which resulted in an overpayment. The FEHBP recovered \$637,446 as a result of the settlement.

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### Federal Employee Fraudulently Obtained Growth Hormone in Attempt to Prevent Aging

On September 14, 2006, a federal employee was indicted on 36 counts of health care fraud. From 2001 through early 2006, the employee obtained medically unnecessary prescriptions from physicians for Nutropin, a human growth hormone. The employee convinced the physicians by providing them information, including Internet articles, about the use of human growth hormones as a supplement and an aid for anti-aging purposes. FEHBP insurance carriers believed the growth hormone was for medically valid purposes because of the false diagnoses. The employee obtained 36 prescriptions and refills for Nutropin. The FEHBP

paid \$306,641 for the fraudulent and medically unnecessary prescriptions.

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### False Billing Scheme Results in FEHBP Settlement

Our office, with the Department of Health and Human Services OIG, and Defense Criminal Investigative Service, conducted an investigation of a medical group's network of affiliated physicians that provides services in neonatal internal care units. The investigators determined that the group falsely billed Medicaid, TRICARE and the FEHBP for services and procedures that did not correspond to the medical condition of the infants. In September 2006, the group agreed to pay the government \$25,078,918 under the False Claims Act. The settlement included \$454,596 to the FEHBP.

## RETIREMENT FRAUD

Under the law, entitlement to annuity payments ceases upon the death of an annuitant. Retirement fraud involves intentional receipt and use of CSRS or FERS benefits payments by an individual not entitled to them.

The Office of Investigations uses a variety of approaches to identify potential cases for investigation. One of our proactive initiatives is to review data to identify annuitant records with specific characteristics and anomalies that have shown, in the past, to be good indicators of retirement fraud. We also use automated data systems available to law enforcement agencies to obtain information on annuitants that may alert us of instances where payments should no longer be made. We confirm the accuracy of the information through follow-up inquiries. Routinely, the Center for Retirement and Insurance Services refers to our office potential fraud cases identified through computer matches with the Social Security Administration. Other referrals come from federal, state, and local agencies as well as private citizens.





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## **Daughter Pleads Guilty to Receipt of Mother's Annuity for 22 Years After her Death**

On May 16, 2006, the daughter of a deceased annuitant pled guilty to concealing her mother's death from OPM to receive benefits to which she was not entitled. The subject received her deceased mother's survivor benefit payments of \$728,175 from September 1983 through October 2005. To continue receiving the benefits, she falsely claimed to be her deceased mother and forged her signature on various correspondences submitted to OPM. On September 27, 2006, she was sentenced to 14 months in jail, 36 months of supervised probation and ordered to make complete restitution to OPM.

foster mother's signature on annuity checks totaling \$185,106. She also sent a letter to OPM verifying that the deceased annuitant's address had changed so that the benefit checks were diverted to her home. She was sentenced on July 17, 2006 to 12 months in jail and 36 months of supervised probation. She was also ordered to make complete restitution to OPM.

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## **Adopted Daughter Sentenced in Retirement Fraud Case**

The adopted daughter and legal guardian of a deceased annuitant who died in April of 1981 pled guilty to theft of government property. The subject initially cashed U.S. Treasury checks intended for the deceased annuitant. Subsequently, in December 2002, she used her status as legal guardian to change the method of payment to direct deposit. She was sentenced to eight months of home confinement, five years probation, and ordered to pay full restitution of \$204,497 to OPM.

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## **Friend's Theft of Retirement Annuity Results in Guilty Plea**

A friend of a deceased annuitant pled guilty to theft of public money. After the annuitant's death, the friend contacted OPM with the identifying information of the annuitant and directed OPM to forward the payment into her personal bank account. She received survivor benefits totaling \$306,946 from April 1986 to September 2003. She used most of the funds toward the mortgage on her home. As a condition of the plea, the suspect re-mortgaged the home to make complete restitution to OPM prior to sentencing. On June 30, 2006, the subject was sentenced to 5 years of supervised probation.

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## **Father's Corpse Abandoned: Son Continued to Collect Retirement Annuity**

A state prosecutor's office requested our assistance in an investigation regarding a deceased annuitant's son. The annuitant died in November 2005. In July 2006, his body was found in the trailer he shared with his son. Following his father's death, the son continued to collect his deceased father's annuity payments. In July 2006, he was arrested. The prosecutor's office charged the son with abandonment of a corpse and theft. In September 2006, the son pled guilty and was sentenced to 132 months of incarceration. He was also ordered to pay restitution in the amount of \$11,906 to the OPM retirement trust fund.

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## **Foster Daughter Forged Checks After Annuitant's Death**

A foster daughter of a deceased annuitant pled guilty to theft of government funds. From December 1992 until June 2004, the daughter forged her



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## Caretaker Pleads Guilty in Retirement Fraud Case

As reported previously, on February 1, 2006, a caretaker working in an adult care home was indicted by a federal grand jury on theft of government property. The caretaker deceptively obtained approximately \$30,536 in retirement benefits paid to an annuitant who resided where he worked. The annuitant was convinced to turn over his finances to the caretaker who was supposed to use the money to pay for the monthly care of the annuitant. Instead, he used the money for his personal benefit. On June 8, 2006, the caretaker pled guilty to fraud and is awaiting sentencing.

## SPECIAL INVESTIGATIONS

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### VA Employee Conspires to Fraudulently Obtain FEGLI Benefits

Our office and the Department of Veterans Affairs (VA) OIG conducted an investigation of a VA payroll technician and a volunteer driver. The two subjects were convicted of conspiracy and bribery involving FEGLI. The two conspired to illegally file a FEGLI form designating the driver as the life insurance beneficiary for a seriously-ill employee. The forged form was placed in the employee's official personnel file. When she died, the driver was paid \$20,500 in FEGLI benefits that should have been paid to the deceased employee's parents. The driver then paid the payroll technician \$1,000 for her assistance. Sentencing for the subjects is scheduled for December 2006.

## OIG HOTLINES AND COMPLAINT ACTIVITY

The OIG's health care fraud hotline, retirement and special investigations hotline, and mailed-in complaints also contribute to identifying fraud and abuse. We received 487 formal complaints and calls on these hotlines during the reporting period. The table on page 25 reports the activities of each hotline.

The information we receive on our OIG hotlines generally concerns FEHBP health care fraud, retirement fraud and other complaints that may warrant special investigations. Our office receives inquiries from the general public, OPM employees, contractors and others interested in reporting waste, fraud and abuse within OPM and the programs it administers.

In addition to hotline callers, we receive information from individuals who report through the mail or have direct contact with our investigators. Those who report information can do so openly, anonymously and confidentially without fear of reprisal.

### RETIREMENT FRAUD AND SPECIAL INVESTIGATIONS HOTLINE

The Retirement Fraud and Special Investigations hotline provides a channel for reporting waste, fraud and abuse within the agency and its programs. During this reporting period, this hotline received a total of 192 contacts, including telephone calls, letters, and referrals from other agencies.

### HEALTH CARE FRAUD HOTLINE

The Health Care Fraud Hotline receives complaints from subscribers in the Federal Employees Health Benefits Program. The hotline number is listed in the brochures for all the health insurance plans associated with the FEHBP, as well as on our OIG Web site at [www.opm.gov/oig](http://www.opm.gov/oig).



While the hotline was designed to provide an avenue to report fraud committed by subscribers, health care providers or FEHBP carriers, callers frequently request assistance with disputed claims and services disallowed by the carriers. Each caller receives a follow-up call or letter from the OIG hotline coordinator, the insurance carrier, or another OPM office as appropriate.

The Health Care Fraud hotline received 295 complaints during this reporting period, including both telephone calls and letters.

### OIG INITIATED COMPLAINTS

We initiate our own inquiries by looking at OPM's automated systems for possible cases involving fraud, abuse, integrity issues and, occasionally, mal-

feasance. Our office will open an investigation if complaints and inquiries can justify further action.

An example of a complaint that our office will initiate involves retirement fraud. When information generated by OPM's automated annuity roll systems reflect irregularities such as questionable payments to annuitants, we determine whether there are sufficient grounds to justify an investigation. At that point, we may initiate personal contact with the annuitant to determine if further investigative activity is warranted.

We believe that these OIG initiated complaints complement our hotline and outside complaint sources to ensure that our office can continue to be effective in its role to guard against and identify instances of fraud, waste and abuse.



## Administrative Sanctions of Health Care Providers

*Under the FEHBP administrative sanctions statute, we issue debarments and suspensions of health care providers whose actions demonstrate that they are not responsible to participate in the program. At the end of the reporting period, there were 29,577 active suspensions and debarments from FEHBP.*

**D**uring the reporting period, our office issued 482 administrative sanctions—including both suspensions and debarments—of health care providers who have committed violations that impact the FEHBP and its enrollees. In addition, we responded to 1,823 sanctions-related inquiries.

We develop our sanctions caseload from a variety of sources, including:

- Administrative actions issued against health care providers by other federal agencies;
- Cases referred by the OIG's Office of Investigations;
- Cases identified by our office through systematic research and analysis of electronically-available information about health care providers, referred to as E-debarment; and
- Referrals from other sources, including health insurance carriers and state government regulatory and law enforcement agencies.

Sanctions serve a protective function for FEHBP and the federal employees who obtain their health insurance coverage through it. The following articles, highlighting a few of the administrative sanctions handled by our office during the reporting period, illustrate their value against health care providers who have placed the safety of enrollees at risk or have obtained fraudulent payment of FEHBP funds.

*Debarment disqualifies a health care provider from receiving payment of FEHBP funds for a stated*

*period of time. The FEHBP administrative sanctions program establishes 18 bases for debarment. The ones we cite most frequently are for criminal convictions or professional licensure restrictions or revocations. Before debarring a provider, our office gives prior notice and the opportunity to contest the sanction in an administrative proceeding.*

*Suspension has the same effect as a debarment, but becomes effective upon issuance, without prior notice or process. FEHBP sanctions law authorizes suspension only in cases where adequate evidence indicates that a provider represents an immediate risk to the health and safety of FEHBP enrollees.*

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### California Physician, Clinics, and Employee Suspended After Indictment

In July 2005, a federal grand jury indicted an internal medicine specialist practicing in southern California on 26 counts of health care fraud and additional counts of false statements and conspiracy. An employee of the doctor's clinics, who assisted in carrying out the fraudulent activities, was also indicted on the same counts. We identified this case through our e-debarment research. We determined that the doctor regularly submitted claims to FEHBP plans.



A significant portion of the doctor's practice was devoted to treating patients suffering from AIDS,

***Doctor Suspended  
for Role in  
Health Care Fraud***

HIV infection, and hepatitis with medications that must be administered by injection or intravenously.

The doctor ordered his employees to "subdose" this group of patients (i.e., administer doses of medications that were below the recommended therapeutic dosage level), or in some cases to administer only saline solution or water, with no medicinal content at all.

The doctor and his employees fabricated medical records to make it appear the patients had actually received full doses of the medications, but assured the patients they were administering the full dosage levels. He ordered his employees to prepare fraudulent claims for these treatments to health insurance carriers, certifying that the medically-prescribed dosages had been given to his patients. The insurance companies paid him substantially more than was actually warranted by the treatments.

The doctor's actions clearly placed many of his patients directly at risk, both through depriving them of the proper doses of medication and creating false medical records regarding their treatment. Accordingly, we suspended him in September 2006, pending the outcome of his trial. The suspension also covered the two wholly-owned clinics at which the alleged offenses took place, and the employee who was indicted with the doctor.

## **New York Dentist Debarred After Guilty Plea to Health Care Fraud**

We debarred a dentist who practices in the New York City area after his June 2006 sentencing for his guilty plea to health care fraud. One of the FEHBP plans brought this case to our attention.

This dentist specialized in periodontal treatment for tooth and gum conditions. From 1998 through 2004, he submitted fraudulent claims to numerous health insurance carriers representing both federal and private-sector health benefit programs. These claims represented items and services that were never performed, or claimed multiple instances of services that were performed only once. The dentist admitted these offenses and agreed to pay restitution of more than \$245,000. In addition to the restitution, he was sentenced to three and a half years' probation.

The dentist's plea to the health care fraud offense constitutes a mandatory basis for his debarment from FEHBP for at least three years. However, we determined that the protective purposes of our administrative sanctions authority warranted a longer period of debarment. Therefore, we debarred him from participation in FEHBP for five years after considering the prolonged and repeated nature of his fraudulent scheme and the magnitude of the financial loss.

***Dentist Debarred  
After Guilty Plea***

## **Tennessee Doctor Debarred After Fraud Conviction**

In April 2006, a Tennessee oncologist was sentenced to 188 months incarceration followed by two years of supervised release and \$432,238 in restitution as a result of her conviction on health care fraud charges.

Over a period of more than three years, she subdosed, by one-half to two-thirds, patients who were receiving the drugs Taxol or Camptosar as part of their chemotherapy treatment for cancer. She also administered partial doses of the drug Procrit, used



to counteract the side effects of chemotherapy. The doctor claimed reimbursement from health insurance carriers as if she had provided the full prescribed doses of these medications, receiving over \$500,000 in payments to which she was not entitled.

After the jury returned a guilty verdict, the United States Attorney whose office prosecuted the doctor characterized the case as involving "...despicable

***Oncologist Debarred after Conviction Involving Subdosing of Chemotherapy Drugs***

conduct reflect[ing] not only common thievery, but also a callous disregard for human suffering on the part of someone

who took a solemn oath to put medical care above all other interests."

This is another case our office identified through our e-debarment research. The doctor was initially suspended in May 2005, pending the outcome of the legal proceedings against her. We determined that, before her arrest, the doctor had been an active member of the PPOs of two FEHBP fee-for-service health care plans. In addition, she had submitted numerous claims to FEHBP plans over a period of several years. Taking into account her association with FEHBP, the repeated nature of her offenses, and the risks that her subdosing had created for her patients, we imposed an eight-year term of debarment, to include the period of her suspension.

**Texas Physician Debarred for Fifteen Years**

In September 2006, our office debarred a Texas cardiologist who pled guilty to conspiracy, false statements, and health care fraud and was sentenced to 21 months' incarceration in 2005. This case was previously described in the OIG semiannual report for the period April 1 – September 30, 2005.

Our Office of Investigations initially referred this case for administrative sanctions in late 2002. Accordingly, we debarred him from FEHBP for a three-year period in March 2003 because of his guilty plea to a felony in connection with the programs of three other federal agencies.

While debarred, the doctor conspired with his wife, a psychiatrist, to submit claims to FEHBP carriers in her name for services that he provided. During the same period, both doctors also submitted false and fraudulent claims to other federally-funded health care programs, including Medicare and the Texas Medicaid program.

In 2005, the doctor pled guilty to submitting false and fraudulent claims, which constituted a mandatory basis for his second debarment. Upon review of the entire administrative record from 2002 to 2005, we concluded that he defrauded the programs of at least five federal agencies.

***Cardiologist Receives Second Debarment for 15 Years***

His offenses reflected significant deliberation and planning, including the use of other persons to carry out the doctor's fraudulent schemes. The doctor's convictions resulted in the revocation or suspension of his right to practice medicine by the three states in which he was licensed. In consideration of these factors, and after an administrative appeal by the doctor, we debarred him from participating in FEHBP for a period of 15 years.



## STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES

### JUDICIAL ACTIONS:

Arrests . . . . .	33
Indictments and Informations . . . . .	32
Convictions . . . . .	33

### JUDICIAL RECOVERIES:

Fines, Penalties, Restitutions and Settlements . . . . .	\$5,410,451
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### RETIREMENT AND SPECIAL INVESTIGATIONS HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry . . . . .	17
Referred to:	
OPM Program Offices . . . . .	107
Other Federal Agencies . . . . .	68
<b>Total</b> . . . . .	192

### HEALTH CARE FRAUD HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry . . . . .	90
Referred to:	
OPM Program Offices . . . . .	48
Other Federal/State Agencies . . . . .	32
FEHBP Insurance Carriers or Providers . . . . .	125
<b>Total</b> . . . . .	295
<b>Total Hotline Contacts and Complaint Activity</b> . . . . .	487

### ADMINISTRATIVE SANCTIONS ACTIVITY:

Debarments and Suspensions Issued . . . . .	482
Health Care Provider Debarment and Suspension Inquiries . . . . .	1,823
Debarments and Suspensions in Effect at End of Reporting Period . . . . .	29,577



# Appendices

## APPENDIX I FINAL REPORTS ISSUED WITH QUESTIONED COSTS

April 1, 2006 to September 30, 2006

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	17	\$25,479,549
B. Reports issued during the reporting period with findings	14	34,918,454
Subtotals (A+B)	31	60,398,003
C. Reports for which a management decision was made during the reporting period:	25	37,888,274
1. Disallowed costs		25,786,010
2. Costs not disallowed		12,102,264
D. Reports for which no management decision has been made by the end of the reporting period	6	22,509,729
Reports for which no management decision has been made within 6 months of issuance		

## APPENDIX II FINAL REPORTS ISSUED WITH RECOMMENDATIONS FOR BETTER USE OF FUNDS

April 1, 2006 to September 30, 2006

No activity during this reporting period





OFFICE OF PERSONNEL MANAGEMENT

APPENDIX III

INSURANCE AUDIT REPORTS ISSUED

April 1, 2006 to September 30, 2006

Report Number	Audits	Issue Date	Questioned Costs
1C-D2-00-05-008	Humana Health Plan, Inc. in Louisville, Kentucky	April 26, 2006	\$686,417
1C-57-00-04-088	Kaiser Foundation Health Plan of the Northwest in Portland, Oregon	May 5, 2006	591,122
1C-JN-00-05-059	Aetna Open Access Blue Bell, Pennsylvania	May 11, 2006	
1C-59-00-04-019	Kaiser Foundation Health Plan, Inc. Northern California Region in Oakland, California	May 17, 2006	10,536,784
1G-LT-00-05-080	Long Term Care Partners, LLC in Portsmouth, New Hampshire	May 17, 2006	3,150,188
1B-44-00-06-020	Special Agents Mutual Benefit Association in Rockville, Maryland	May 22, 2006	
1A-10-31-05-068	Wellmark BlueCross BlueShield of Iowa and South Dakota in Des Moines, Iowa	May 22, 2006	528,150
1A-10-47-05-009	BlueCross BlueShield of Wisconsin in Milwaukee, Wisconsin	June 5, 2006	601,139
1C-CY-00-05-018	PacificCare of California in Cypress, California	June 23, 2006	
1A-10-11-04-065	BlueCross BlueShield of Massachusetts in Boston, Massachusetts	June 26, 2006	1,578,682
1A-10-88-06-012	BlueCross of Northeastern Pennsylvania in Wilkes-Barre, Pennsylvania	July 3, 2006	135,348
1C-JP-00-06-071	MD Individual Practice Plan, Inc. in Hartford, Connecticut Proposed Rate Reconciliation	July 18, 2006	



## APPENDIX III

## INSURANCE AUDIT REPORTS ISSUED

April 1, 2006 to September 30, 2006

*(Continued)*

Report Number	Audits	Issue Date	Questioned Costs
1C-Q8-00-06-065	Univera Healthcare in Buffalo, New York Proposed Rate Reconciliation	July 18, 2006	\$805,487
1C-BJ-00-06-077	Coventry Health Care of Louisiana in Bethesda, Maryland Proposed Rate Reconciliation	July 26, 2006	
1C-51-00-06-066	Health Insurance Plan of New York in New York, New York Proposed Rate Reconciliation	July 26, 2006	
1C-ML-00-06-068	Av-Med Health Plans in Gainesville, Florida Proposed Rate Reconciliation	July 26, 2006	
1C-52-00-06-075	Health Alliance Plan in Detroit, Michigan Proposed Rate Reconciliation	July 27, 2006	
1C-8W-00-06-070	UPMC Health Plan in Pittsburgh, Pennsylvania Proposed Rate Reconciliation	August 8, 2006	2,620,458
1A-10-34-06-010	BlueCross BlueShield of North Dakota in Fargo, North Dakota	August 22, 2006	11,794
1B-43-00-05-081	Health Network America as Administrator for the Panama Canal Area Benefit Plan in Eatontown, New Jersey	August 22, 2006	58,863
1H-01-00-06-063	Advance PCS in Scottsdale, Arizona	September 7, 2006	10,661,804
1A-10-78-05-005	BlueCross BlueShield of Minnesota in Eagan, Minnesota	September 15, 2006	2,952,218
<b>TOTALS</b>			<b>\$34,918,454</b>



## OFFICE OF PERSONNEL MANAGEMENT

### APPENDIX IV

#### INTERNAL AUDIT REPORTS ISSUED

April 1, 2006 to September 30, 2006

Report Number	Subject	Issue Date
4A-CA-00-05-086	OPM's Post-Most Efficient Organization Review of the Computer Assistants and Building Management Assistant Competition	September 8, 2006

### APPENDIX V

#### INFORMATION SYSTEMS AUDIT REPORTS ISSUED

April 1, 2006 to September 30, 2006

Report Number	Subject	Issue Date
1B-32-00-04-060	Information Systems General and Application Controls at National Association of Letter Carriers in Ashburn, Virginia	April 26, 2006
4A-RI-00-06-022	Information Technology Security Controls of the Electronic Individual Retirement Record	June 23, 2006
1A-10-33-05-027	Information System General and Application Controls at BlueCross BlueShield of North Carolina in Durham, North Carolina	July 3, 2006
4A-IS-00-06-024	Information Technology Security Controls of the Office of Personnel Management's Personnel Investigations Processing Imaging System	July 11, 2006
4A-CA-00-06-023	Information Technology Security Controls of the Human Resources Historical Data Warehouse	July 11, 2006
4A-IS-00-06-021	Information Technology Security Controls of the Office of Personnel Management's Fingerprint Transaction System	August 29, 2006
1B-38-07-05-048	Information Systems General and Application Controls at Mutual of Omaha in Omaha, Nebraska	September 8, 2006
4A-CI-00-06-015	Federal Information Security Management Act Follow-Up for Fiscal Year 2006	September 15, 2006
4A-CI-00-06-016	Federal Information Security Management Act for Fiscal Year 2006	September 22, 2006



## APPENDIX VI

### COMBINED FEDERAL CAMPAIGN AUDIT REPORTS ISSUED

**April 1, 2006 to September 30, 2006**

<b>Report Number</b>	<b>Subject</b>	<b>Issue Date</b>
3A-CF-00-05-038	The 2002 and 2003 Combined Federal Campaigns for Central Florida in Orlando, Florida	April 17, 2006
3A-CF-00-04-038	The 2001 and 2002 Combined Federal Campaigns for Central Maryland in Baltimore, Maryland	June 6, 2006
3A-CF-00-05-051	The 2002 and 2003 Combined Federal Campaigns for the Northeast Florida – Southeast Georgia Region in Jacksonville, Florida	June 12, 2006
3A-CF-00-05-041	The 2002 and 2003 Combined Federal Campaigns for the Central Indiana Area in Indianapolis, Indiana	June 13, 2006
3A-CF-00-05-078	The 2002 and 2003 Combined Federal Campaigns for the Southeastern Wisconsin in Milwaukee, Wisconsin	June 23, 2006
3A-CF-00-04-045	The 2001 and 2002 Combined Federal Campaigns for Columbia River/Willamette Valley in Portland, Oregon	July 3, 2006
3A-CF-00-05-042	The 2002 and 2003 Combined Federal Campaigns for the Northern Nevada in Las Vegas, Nevada	July 3, 2006
3A-CF-00-05-039	The 2002 and 2003 Combined Federal Campaigns for the Southern Nevada in Las Vegas, Nevada	July 3, 2006
3A-CF-00-05-079	The 2003 Combined Federal Campaign Activities for the Medical Research Charities Federation in Springfield, Virginia	July 14, 2006
3A-CF-00-05-049	The 2002 and 2003 Combined Federal Campaigns for the Research Triangle Area in Morrisville, North Carolina	August 10, 2006
3A-CF-00-05-050	The 2002 and 2003 Combined Federal Campaigns for the Coastal Bend Area in Corpus Christi, Texas	August 11, 2006
3A-CF-00-05-076	The 2002 and 2003 Combined Federal Campaigns for Central Texas, in Austin Texas	August 14, 2006
3A-CF-00-05-052	The 2002 and 2003 Combined Federal Campaigns for Fresno-Madera County in Fresno, California	August 22, 2006
3A-CF-00-04-043	The 2001 and 2002 Combined Federal Campaigns for Southwestern Pennsylvania in Pittsburgh, Pennsylvania	September 6, 2006
3A-CF-00-05-074	The 2002 and 2003 Combined Federal Campaigns for Kitsap-Mason Counties in Bremerton, Washington	September 28, 2006



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