

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT



**Office of the
Inspector General**
**SEMIANNUAL
REPORT**
TO
CONGRESS

APRIL 1, 2007 – SEPTEMBER 30, 2007

OFFICE OF THE INSPECTOR GENERAL



PRODUCTIVITY INDICATORS

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds	\$33,929,019
Management Commitments to Recover Funds	\$34,189,798
Recoveries Through Investigative Actions	\$11,160,677

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	44
Inspections Completed	2
Investigative Cases Closed.	53
Indictments and Informations	41
Arrests	21
Convictions	27
Hotline Contacts and Complaint Activity	505
Health Care Provider Debarments and Suspensions	408
Health Care Provider Debarment and Suspension Inquiries	1,629

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THE INSPECTOR GENERAL'S MESSAGE

Ofentimes emphasis is placed on monetary recoveries when we speak about the success of the Office of the Inspector General (OIG). While this measure will continue to illustrate our accomplishments, it is equally important to note that those actions we take to address systemic problems within agency programs could actually reduce our future findings.

For example, a little over a year ago, my office documented a series of concerns related to our on-going oversight of the Federal Employees Health Benefits Program (FEHBP). These concerns related to high risk contract areas, repetitive audit findings, and other issues resulting from oversight of this \$35 billion program. In our opinion, many were the result of contract weaknesses, insufficient program guidance, and/or difficulties in trying to keep pace with the very dynamic healthcare industry, making the resolution of these concerns difficult.

In order to raise awareness of these significant issues, I formally presented them to the Office of Personnel Management's (OPM) Director. In an immediate response, she implemented a plan to address the concerns, starting with the most significant. She charged her individual senior staff members with the responsibility of working with our Office of Audits to resolve specific concerns or develop an appropriate action plan to address each situation.

The results to date have been impressive. Collectively, we have resolved or developed agreed-upon solutions for most of the program concerns, with reasonable progress being made on the others. These positive results are clearly the reflection of a cooperative effort between OPM's program office staff and the OIG staff. They could not have been accomplished without the support of OPM's senior management. We believe that this process has and will continue to enhance the oversight of the FEHBP, as well as OPM's other critical programs. In light of the FY 2007 success, we are currently finalizing our overall "Program Concerns" for FY 2008.

By successfully resolving these issues, future audit findings should be decreased. For example, the recent resolution of a premium benefit loading issue resulted in \$5 million in recoveries to the FEHBP for FY 2007. Since part of the solution was to identify the root cause of the problem and correct it, participating plans will no longer be allowed to charge the program for these costs. The result is a significant savings to the FEHBP. In this case, we estimate annual savings to be approximately \$12 million. However, future audit recoveries are also reduced by this amount. While statistically this may reduce our reported monetary results for audit effectiveness, in actuality our mutual efforts have resulted in a better and more efficient program.

In connection with this effort, I would like to commend Deputy Assistant Inspector General for Audits Jeffrey Cole for his exemplary work in organizing and spearheading this project. He has tirelessly worked to ensure that each of the issues is addressed and that the appropriate staff from both our office and the agency program office had the



Office of the Inspector General

opportunity to participate in the development of solutions. From the program office, Lorraine Dettman, Assistant Director for Insurance Services Programs, has been instrumental in leading this effort and I want to acknowledge her contributions in this endeavor.

On another note, I want to congratulate three special agents in our Office of Investigations for the recognition they recently received:

- Amy Parker has been awarded an Annual Special Agent Award by the Eastern District of Pennsylvania United States Attorney's Office for her work on the Medco Health Solutions, Inc. (Medco) investigation. This case involved an \$155 million settlement from the pharmacy benefits manager as the result of a compliant filed by the United States Attorney's Office charging Medco with destroying and canceling prescriptions, failure to provide patients prescriptions on a timely basis, soliciting kickbacks from pharmaceutical manufactures to favor their drugs, and paying kickbacks to health plans to obtain business.
- Casey Howard was honored by the criminal and civil divisions of the Southern District of Texas United States Attorney's Office for his work on the case involving a doctor who fraudulently billed the FEHBP for over \$2.3 million. Casey was actively involved in the seizing of the doctor's assets to satisfy the court ordered forfeiture to the government of \$10 million. The court has ordered over \$22 million in restitution, fines, and forfeitures.
- Paul Kimball was recognized for his work on a joint investigation that investigated a doctor in Louisiana who routinely billed for services he did not perform and illegally issued prescriptions for controlled substances. In many cases, the physician addicted the patients to these narcotic drugs purely for the purpose of obtaining a reimbursement from the health carrier. Paul's efforts helped save the lives of many patients who had become addicted to schedule II narcotics due to the physician's illegal prescribing practices. The BlueCross BlueShield Association designated the investigation as their "Case of the Year."

A handwritten signature in black ink that reads "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 United States 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 Office of the Inspector General (OIG) insurance audit universe contains approximately 280 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 \$35 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 26 final reports on organizations participating in the FEHBP, of which 21 contain recommendations for monetary adjustments in the aggregate amount of \$33.5 million due the FEHBP.

Appendix III (page 32) 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 170 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 the 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 20 audit reports on community-rated plans. These reports contain recommendations to require the plans to return over \$25.6 million to the FEHBP.

MVP Health Care – Central Region

Schenectady, New York

Report No. 1C-M9-00-06-064

MAY 17, 2007

MVP Health Care – Central Region provides comprehensive medical services to its FEHBP members throughout Upstate New York. This audit covered contract years 2002 through 2004 and 2006. During this period, the FEHBP paid the plan approximately \$133.5 million in premiums.

We identified a total of \$5,120,826 in inappropriate health benefit charges to the FEHBP:

including \$307,981 in 2002; \$1,643,378 in 2004; and \$2,833,313 in 2006. In addition, we determined the FEHBP is due \$336,154 for lost

investment income as a result of the overcharges.

**AUDITORS
QUESTION
\$5.1 MILLION IN
OVERCHARGES**

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

The overcharges occurred because MVP Health Care:

- included an inappropriate charge for brokers fees in the FEHBP rates;
- charged duplicate costs for continuation of coverage; and,
- failed to give the FEHBP an appropriate premium discount.



UPMC Health Plan

Pittsburgh, Pennsylvania

Report No. 1C-8W-00-05-036

JUNE 14, 2007

UPMC Health Plan provides comprehensive medical services to its members throughout Western and Northwestern Pennsylvania. This audit covered contract years 2000 through 2004. During this period, the FEHBP paid the plan

**APPROXIMATELY
\$4 MILLION
RETURNED TO
THE FEHBP**

approximately \$163 million in premiums.

The audit identified \$3,997,639 in inappropriate health benefit charges to the

FEHBP: consisting of \$233,174 in 2000; \$41,054 in 2001; and \$3,292,146 in 2004. In addition, we determined the FEHBP is due \$431,265 for lost investment income as a result of the overcharges. The overcharges occurred because the plan:

- applied incorrect rates to the FEHBP in 2004;
- added an inappropriate overage dependent children loading in 2000 and 2001;
- included an unallowable extension of coverage loading (loading for temporary health coverage when an employee separates from the government) in 2004; and,
- failed to give the FEHBP an appropriate discount on premiums in 2000 and 2004.

UPMC returned the full amount to the FEHBP.

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, associations, 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 six experience-rated audit reports. In these reports, our auditors recommended that the plans return \$8.3 million in inappropriate charges and lost investment income to the FEHBP.

BLUECROSS BLUESHIELD SERVICE BENEFIT PLAN

The BlueCross BlueShield Association (BCBS Association), which administers a fee-for-service plan known as the Service Benefit Plan, 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 59 percent of all FEHBP subscribers are enrolled in BCBS plans.



We issued five BlueCross BlueShield experience-rated reports during the reporting period. Experience-rated audits normally address health benefit payments, miscellaneous payments and credits, administrative expenses, and cash management activities. The auditors identified \$6 million in questionable contract costs charged to the FEHBP, including lost investment income on these questioned costs. The BCBS Association agreed with \$4.3 million of the questioned costs.

annuitants age 65 and older who are not covered under Medicare Part A; and,

- \$313,278 in other claim payment errors.

Of the questioned charges, the BCBS Association agreed with \$1,300,744.

WellPoint BlueCross BlueShield of Colorado

Indianapolis, Indiana and Mason, Ohio
Report No. 1A-10-30-05-069
APRIL 25, 2007

Our audit of the FEHBP operations at WellPoint BlueCross BlueShield of Colorado covered claim payments for 2002 through 2004, as well as miscellaneous health benefit payments, credits, and cash management activities from 2000 through 2004. During the period 2000 through 2004, the plan paid approximately \$494 million in FEHBP health benefit charges.

Our auditors questioned \$2,451,691 in health benefit overcharges. Lost investment income on the questioned charges totaled \$5,858.

The most significant findings were:

- \$1,075,709 for unreturned health benefit refunds and recoveries;
- \$1,062,704 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

BlueCross BlueShield of Tennessee

Chattanooga, Tennessee
Report No. 1A-10-15-05-046
JULY 25, 2007

Our audit covered the FEHBP operations at BlueCross BlueShield of Tennessee for contract years 2001 through 2003. During the audited period, the plan paid approximately \$488 million in FEHBP health benefit charges, \$28 million in administrative expenses, and \$25 million in statutory reserve payments. We reviewed \$13 million in claims from 2001 through 2003 for proper processing of health benefit payments. We also reviewed miscellaneous health benefit payments and credits, such as refunds and recoveries, administrative expenses, statutory reserve payments (insurance carriers are required to put aside a specific amount of funds into a restricted reserve), and cash management activities for 2001 through 2003.

BCBS ASSOCIATION AGREES WITH \$1.8 MILLION IN QUESTIONED CHARGES

Our auditors questioned \$1,787,081, consisting of \$1,467,743 in health benefit charges and \$319,338 in administrative expenses. We questioned:

- \$1,028,899 in overpayments and \$42,595 in underpayments because claims were not paid in accordance with the OBRA 90 pricing requirements;



- \$481,439 due to other claim payment errors;
- \$165,228 for plan employee pension cost overcharges; and,
- \$154,110 for other administrative expense overcharges.

The BCBS Association agreed with all of the questioned charges. Lost investment income on the questioned charges totaled \$61,236.

EMPLOYEE ORGANIZATION PLANS

Employee organization plans 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: American Postal Workers Union, Association of Retirees of the Panama Canal Area, Government Employees Hospital Association, National Association of Letter Carriers, National Postal Mail Handlers Union, and Special Agents Mutual Benefit Association.

We issued no audit reports on employee organization plans during this reporting period.

EXPERIENCE-RATED COMPREHENSIVE MEDICAL PLANS

Comprehensive medical plans (HMOs) fall into one of two categories: community-rated or experience-rated. As we previously explained on page 1 of this report, the key difference between the categories stems from how premium rates are calculated for each.

Members of experience-rated HMOs have the option of using a designated network of providers or using non-network providers. A member's choice in selecting one healthcare provider over another has monetary and medical implications. For example, if a member chooses a non-network provider, the member will pay a substantial portion of the charges and covered benefits may be less comprehensive.

We issued one experience-rated comprehensive medical plan audit report during this reporting period.

Federal Blue HMO

Mason, Ohio

Report No. 1D-R5-00-06-069

JULY 25, 2007

Federal Blue HMO (Plan) is an experience-rated health maintenance organization providing health benefits to federal enrollees in the Cincinnati, Cleveland, and Dayton, Ohio metropolitan areas. Our audit of the Plan's FEHBP operations covered health benefit payments from 2003 through May 2006; and administrative expenses, miscellaneous payments and cash management from 2001 through 2005. During this period, the Plan paid approximately \$641 million in health benefit charges and \$32 million in administrative expenses.

AUDITORS QUESTION \$2.2 MILLION IN FEHBP CHARGES

The audit identified \$2,246,447 in questionable charges to the FEHBP, including \$1,480,957 in health benefit charges and \$649,017 in administrative expenses. Lost investment income on the questioned charges totaled \$116,473.

The most significant findings were:

- \$749,531 for pharmacy drug rebates not returned to the FEHBP;



- \$354,825 for plan employee pension cost overcharges;
- \$267,244 for health benefit refunds not returned to the FEHBP in a timely manner;
- \$252,771 because the plan did not properly coordinate claim payments with Medicare; and,
- \$151,633 due to contractually unallowable cost of capital charges.

The Plan agreed with \$1,843,096 of the findings.

FEDERAL LONG TERM CARE INSURANCE PROGRAM

Long Term Care Partners, LLC

Portsmouth, New Hampshire

Report No. 1G-LT-00-07-005

SEPTEMBER 26, 2007

The Federal Long Term Care Insurance Program (FLTCIP) was established by the Long Term Care Security Act of 2000 for federal employees and annuitants, current and retired members of the uniformed services, and qualified relatives.

In December 2001, OPM awarded a contract to Long Term Care Partners, LLC (LTCP) to provide and administer the FLTCIP benefits. The company was formed as a joint venture, equally owned by John Hancock and Metropolitan Life Insurance Company (referred to as the Carriers). Program operations began on March 25, 2002. LTCP is responsible for all administrative functions of the FLTCIP. The contract with the company expires in December 2008.

The purpose of the audit was to determine if charges to the FLTCIP and services provided to its mem-

bers were in accordance with the terms of the contract and applicable regulations. The audit covered claim payments, administrative expenses, and cash management for fiscal year 2005, and investment income from July through September 2005.

We found that one of the Carriers, John Hancock, retained premiums collected from enrollees in a general account for several days before transferring the funds to its FLTCIP separate account. While in the general account, the FLTCIP funds were commingled with funds from John Hancock's other lines of business.

Because this process delayed the investment of the funds, the FLTCIP lost approximately \$42,000 in investment income. The audit also showed that LTCP did not report over \$26 million in income earned on the FLTCIP investments on the financial statements.

**AUDITORS FIND
\$26 MILLION IN
EARNED INCOME
NOT PROPERLY
REPORTED**

To remedy this situation, we recommended that John Hancock adopt the procedures used by Metropolitan Life Insurance Company, which does not commingle funds, but instead transfers FLTCIP funds to a separate account on the same day the funds are deposited into its general account. Prudent business practices dictate that the full value of the investment funds should be reported on the FLTCIP financial statements.

LTCP contends that the enabling legislation, federal regulations, and its contract with OPM permit the commingling of funds. LTCP stated that John Hancock uses the general funds to recoup amounts due to it from FLTCIP for expenses, profit, and taxes. LTCP officials disagree with our position regarding the value of the FLTCIP investments; however, they are taking steps to fully disclose the value of the investments in the future.



Information Systems Audits

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. OPM systems also assist in the management of background investigations for federal employees, contractors, and applicants. Any breakdowns or malicious attacks (e.g., hacking, worms or viruses) affecting these federal systems could compromise the privacy of the individuals whose information they maintain, as well as the efficiency and effectiveness of the programs that they support. With recent high-profile security incidents involving personal information, privacy has emerged as a major management challenge for most Federal agencies. OPM is no exception.

We conduct information systems audits of FEHBP and FEGLI health and life insurance carriers. For FEHBP health insurance carriers, our office examines the computer security and information systems 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.

Also, we audit OPM's computer security environment to ensure that it is designed to prevent unauthorized system access or disclosure of sensitive information protected by the Privacy Act.

Information Systems General and Application Controls At Mid-Atlantic Health Plans of United Healthcare

Frederick, Maryland

Report No. 1C-JP-00-07-011

JULY 18, 2007

We audited the FEHBP claims processing system for the M.D. Individual Practitioners Association (M.D.IPA) Plan, as well as the business structure and control environment operations. The M.D.IPA Plan was originally part of Mid-Atlantic Medical Services, LLC Life and Health Insurance Company (MAMSI), which was purchased by United Healthcare in 2004 and renamed Mid-Atlantic Health Plans of United Healthcare (MAHP).

We evaluated the confidentiality, integrity, and availability of MAHP's health insurance claims processing operations, as well as, the information technology (IT) resources that support this process. In addition, we assessed MAHP's efforts to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).



Audit Activities

The MAMSI Live claims processing system runs on the Solaris operating system. Therefore, the general controls portion of our audit focused on Solaris security features and the network environment that enables MAHP employees to access the claim processing system. The application controls portion of our audit evaluated the input, processing, and output controls associated with MAMSI Live and related IT systems.

We found the following:

- MAHP has a comprehensive series of IT policies and procedures to promote IT security in the company. However, we found that United Healthcare's risk assessment policy is not being followed at lower levels of the organization. We recommended that MAHP conduct periodic risk assessments on all of its information systems to identify, evaluate, and mitigate threats and vulnerabilities.
- MAHP has adequate physical controls to prevent unauthorized access to its facilities, logical controls to prevent unauthorized access to its information systems, and procedures for granting, adjusting, monitoring and removing access to information systems.
- Policies and procedures exist to ensure that modifications to application software occur in a controlled environment. This includes the use of an automated tool to manage software modifications, required approvals of software modifications at several stages of the development life cycle, and segregation of duties along organizational lines.
- The operating system is securely configured. In addition, there are appropriate controls in place to monitor access to system software and control changes to the operating system.

- MAHP's business continuity plan contains many of the key elements suggested by relevant guidance and publications. However, the business continuity plan does not cover the back-end system procedures (system outputs, i.e., printing of checks and explanation of benefits). We also found that the disaster recovery testing is weak, and the plan is not updated in accordance with company policy and other relevant criteria.
- There are many controls in MAMSI Live to ensure that FEHBP claims are processed accurately. However, we recommended that MAHP implement additional clinical edit controls to prevent the system from processing inappropriate medical claims.
- MAHP is in compliance with HIPAA regulations. We did note, however, that the company could improve procedures for maintaining its HIPAA-related IT security policies.

MAHP agreed to implement the majority of our recommendations.

Information Systems General and Application Controls at American Postal Workers Union Health Plan

Glen Burnie, Maryland

Report No. 1B-47-00-06-072

MAY 18, 2007

We audited the American Postal Workers Union Health Plan (APWU) to evaluate controls associated with its HealthSuite claims processing system. We also looked at the overall environment in which the systems operate, including software development and change management controls, separation of duties, system software, access controls, and service continuity.



APWU had recently implemented HealthSuite and was still working on configuring the system at the time of our audit. Therefore, we were able to make a number of recommendations to improve this process and controls in other areas. We identified the following significant findings and recommendations:

- APWU has IT policies and procedures to promote IT security. However, we found that the policies are not uniformly enforced and awareness of the policies is lacking. Therefore, we recommended that APWU improve its incident response, risk management, and training procedures.
- There are controls to prevent unauthorized access to facilities and computer systems; however, password and user account controls could be improved. We recommended that APWU improve data center security by limiting access, creating a visitors log, and installing video cameras.
- APWU has configuration management controls for the HealthSuite system; however, we found that the testing methodology could be improved and that policies need to be updated.
- The HealthSuite system is generally secure, but we recommended improvements to procedures for accessing the system.
- APWU's business continuity plan contains many of the elements suggested by relevant guidance and publications; however, several important items were missing. We recommended that APWU test the plan at least annually.
- We recommended several enhancements to the HealthSuite system to ensure that claims are processed accurately, including additional clinical edits, and edits for handling workers compensation, coordination of benefits, and OBRA 90 claims.
- APWU is not in full compliance with OPM regulations related to special investigations and sanctions implementations. The sanctions implementation plan does not explain how APWU identifies FEHBP debarred providers, and the special investigations unit needs to publish an anti-fraud statement, establish fraud hotlines, and develop fraud awareness educational material.
- We reasonably believe that APWU is in compliance with HIPAA regulations. However, we did note that procedures for maintaining HIPAA-related IT security policies could be improved.

Federal Information Security Management Act – FY 2007

Washington, DC

Report No. 4A-CI-00-07-007

SEPTEMBER 18, 2007

The Federal Information Security Management Act of 2002 (FISMA) requires that the information resources and assets supporting federal operations are appropriately protected. FISMA emphasizes that agencies implement security planning as part of the life cycle of their information systems. A critical aspect of security planning involves annual program security reviews conducted or overseen by each agency's inspector general.

We audited OPM's overall computer security program and practices in accordance with the Office of Management and Budget's (OMB) FISMA reporting instructions. We also performed a follow-up audit of the recommendations made in our 2006 FISMA report, as well as a review of several OPM systems and the compliance efforts of individual program offices responsible for these systems.



Audit Activities

Our audit of OPM's overall computer security program and practices revealed significant progress and continued commitment by OPM to manage and secure its information resources. We found that:

- OPM has implemented a comprehensive certification and accreditation (C&A) process to ensure that the C&A of each agency system remains active. An active C&A exists for all 41 OPM systems.
- OPM has established a process for conducting privacy impact assessments (PIAs). As of September 2007, PIAs have been completed for each of the required 25 systems. However, 20 of the 25 PIAs have not been published on OPM's website.
- OPM has issued a combined IT security and privacy policy in its efforts to implement the requirements of the OMB Memorandum M-06-15, "Safeguarding Personally Identifiable Information." However, OPM has not developed policies and procedures specific to the protection of personally identifiable information, and has not completed its efforts in implementing technical controls to protect sensitive information.
- OPM has created an "Incident Response and Reporting Policy" that describes the responsibilities of OPM's Computer Incident Response Team, and documents procedures for reporting all abnormal IT security events to the appropriate entities. However, several instances of policy violations indicate that OPM should pursue additional education and training for its employees and contractors related to incident response.

- At the time of the audit, OPM's IT security policies had not been updated since November 2004. We reported this as a material weakness in the internal control structure of OPM's IT security program. As a result of our audit, the agency issued an updated IT security and privacy policy; however, there are a number of related IT security related policies that have still not been updated.

During our follow up review, we determined that OPM had addressed the majority of recommendations made in 2006. We also determined that OPM is in agreement with all outstanding recommendations and is continuously working toward implementing several resolutions.

Our review of systems under the responsibility of OPM's program offices revealed substantial compliance with FISMA requirements, including:

- performing self-assessments to determine the current security posture of OPM 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.

Appendix V on page 34 lists the six FISMA reports we issued in FY 2007.



Internal Audits

COMBINED FEDERAL CAMPAIGN

Our office audits the Combined Federal Campaign (CFC), the only authorized charitable fundraising drive conducted in federal installations throughout the world. OPM is responsible, 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 charities' compliance with federal regulations and OPM guidelines. As part of our review, we assess the controls that local campaigns have concerning eligibility of the charities. 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. The audit must be in the form of an agreed-upon procedures engagement to be completed by an IPA. We review the IPA's work 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 Office of CFC Operations works with the auditee to resolve the findings after the final audit report is issued.

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 six audit reports on local CFCs. These reports identified numerous violations of regulations and guidelines governing local CFC operations. The most frequently occurring problems for the local CFCs were as follows:

■ *Campaign Expenses*

The PCFOs for five local campaigns charged the 2004 CFC \$176,376 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.

■ *Local Application Review Process*

For three campaigns reviewed, 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 2004 local CFCs. Specifically, the LFCC's review checklist did not clearly show that all eligibility requirements were examined during their approval process.

■ *Inappropriate Cutoff Procedures*

The PCFOs for three local campaigns did not have appropriate procedures in place to determine the cutoff dates for payroll deductions received in January of each year.

■ *Undistributed Campaign Receipts*

The PCFOs for three local campaigns did not distribute \$62,382 in campaign receipts to the 2004 CFCs. Regulations require that at the close of each disbursement period, the PCFO's CFC account shall have a balance of zero.

■ *Agreed-Upon Procedures*

The PCFO's IPA for three of the campaigns did not comply with the March 2005 CFC Audit Guide, which contains agreed-upon procedures that the IPA must conduct.

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.

2004 Combined Federal Campaign Activities for the National Black United Federation of Charities

Newark, New Jersey

Report No. 3A-CF-00-06-074

JULY 5, 2007

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 eligibility requirements contained in the CFC regulations. 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 requirements expressed in the CFC regulations. The OPM Director may elect to review the national federation's eligibility certifications. She can either accept or reject the certifications.



Our audit identified instances where the National Black United Federation of Charities (NBUFC) did not fulfill its responsibilities as a national federation. Our auditors found that:

- NBUFC did not distribute to member agencies \$11,457 of CFC receipts that were wire transferred to its operating account by local campaigns.
- NBUFC overcharged a member agency for administrative fees for the 2004 campaign.
- NBUFC did not record charitable designations sent by two PCFOs for the 2004 campaign.
- The application checklist NBUFC used to evaluate member agencies for the 2004 campaign was inadequate to grant eligibility to organizations.
- NBUFC did not comply with its by-laws for the 2004 campaign. Specifically:
 - Seven Directors of NBUFC's Board have a conflict of interest with the National Black United Funds, Inc. (NBUF). These individuals served on both the NBUFC's Board of Directors and NBUF's Executive Committee.
 - NBUFC was not in compliance with the requirements concerning the number of members on the board and the terms served.



OPM INTERNAL PERFORMANCE AUDITS

Our internal auditing staff focuses on improving the efficiency and effectiveness of OPM’s operations and their corresponding internal controls. One critical area of this audit activity is OPM’s consolidated financial statements required under the Chief Financial Officers Act of 1990 (CFO Act). Our staff also conducts performance audits covering other internal OPM programs and functions.

Transfer of the Department of Defense’s Personnel Security Investigation Function to the U.S. Office of Personnel Management

Washington, DC

Report No. 4A-IS-00-06-049

SEPTEMBER 27, 2007

The Department of Defense (DoD) and OPM signed a memorandum of agreement (MOA) on October 16, 2004 which transferred, in accordance with applicable law, the Personnel Security Investigation (PSI) function of the Defense Security Service (DSS) to OPM’s Federal Investigative Services Division (FISD). FISD conducts background investigations on a reimbursable basis. FISD also operates the Federal Investigations Processing Center located in Boyers, Pennsylvania.

The MOA states that beginning February 20, 2005, DoD must purchase from FISD the services that were previously performed by the PSI. It sets forth the general terms and conditions for the functional transfer, as well as, the goals for a joint process improvement plan for the security investigation function.

The Acting Director for DSS requested that we, in coordination with DoD/OIG, determine whether the payments made to OPM for PSI services were made in accordance with the MOA. As part of

the joint audit team, we agreed to collaborate with DoD/OIG on some fieldwork and testing of investigative files, but to issue separate audit reports.

Our auditors found that FISD implemented the transfer of the DoD’s PSI function, as it relates to the accuracy of financial reports and billings for DoD’s investigations, as well as the reduction in DoD’s surcharge, in accordance with the requirements of the MOA. However, we noted that OPM had not properly credited DoD \$15,684 for 13 instances involving investigations that had been ordered multiple times for the same person. This occurred because FISD personnel used manual overrides to process multiple DoD requests when the Personnel Investigations Processing System (PIPS) showed that a background investigation was already in progress.

FISD agreed and has issued

credits in the amount of \$15,684 to DoD. FISD further stated that they will take corrective actions by meeting with management to go over the proper use of manual overrides when scheduling investigations. They will also strengthen their oversight of this process by conducting weekly reviews of all investigations identified by PIPS as duplicate investigative requests.

THE FEDERAL INVESTIGATIVE SERVICES DIVISION HAS TAKEN CORRECTIVE ACTION ON THE WEAKNESS IDENTIFIED BY OUR AUDITORS



Administration of the Prompt Payment Act at the Office of Personnel Management

Washington, DC

Report No. 4A-CF-00-05-028

APRIL 16, 2007

We conducted a performance audit of the OPM's administration of the Prompt Payment Act (PPA) to determine whether OPM was in compliance with the PPA during FY 2004. The PPA establishes policy for executive departments and agencies to

OIG IDENTIFIED FIVE AREAS REQUIRING IMPROVEMENT IN OPM'S ADMINISTRATION OF THE PROMPT PAYMENT ACT

pay commercial obligations within certain time periods and to pay interest penalties when payments are late.

The OPM Office of the Chief Financial Officer (OCFO) is responsible for processing invoices for payment. The Government Financial Information System (GFIS), the mainframe application that supports general ledger accounting, includes an integrated purchasing subsystem that supports procurement of goods and services from requisition to payment. Once the invoice information is entered into GFIS, the system will make timeliness determinations, identify payments on which interest may be payable and compute the amount of interest due.

Our audit consisted of a sample of PPA transactions selected from OPM database files generated from GFIS during FY 2004. We reviewed the supporting documentation such as invoices and interest calculations for compliance with the laws, regulations, and policies and procedures.

Based on the results of our audit, we identified five areas requiring improvement:

- Prompt pay due dates were not calculated properly, resulting in late payments.
- GFIS did not calculate interest properly for untimely transactions.
- Invoices were paid early even though they did not meet accelerated or fast payment guidelines.
- Current written policies and procedures on accounts payable activities, including controls to ensure compliance with PPA, were not established at the beginning of our audit. However, written policies and procedures were finalized prior to our issuance of the report.
- Periodic quality control validations on payments to vendors were not performed because management reports on payments generated from GFIS were not used.

OCFO agreed with our findings and initiated their own internal review that built on our findings and recommendations. OCFO is working to address identified weaknesses and report they have made significant improvements toward achieving OPM's Prompt Pay goals and complying with the Prompt Payment Act. OCFO states they have initiated training for the Accounts Payable team and educated OPM program offices on how to process invoices and receiving reports in GFIS. They reorganized work assignments within the S&E Shared Services Group, developed detailed work instructions for staff, enhanced accountability, introduced a new process of scanning and emailing invoices to program managers for approval and used GFIS reports to closely monitor workload in order to prevent problems with backlogs before they occur.



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 \$91 billion annually. While we investigate OPM employee misconduct and other wrongdoing, the majority of our OIG investigative efforts are spent examining potential fraud involving these trust funds.

During the reporting period, our office opened 50 investigations and closed 53, with 284 still in progress at the end of the period. Our investigations led to 21 arrests, 41 indictments and/or informations, 27 convictions and \$11,160,677 in monetary recoveries. For a complete statistical summary of our office's investigative activity, refer to the table on page 29.

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

Texas Physician Sentenced to Over 11 Years in Jail

In our last semiannual report, we reported the November 2006 conviction of a Texas physician, who specialized in the treatment of Hepatitis C patients. This physician routinely billed for services not rendered, office visits at rates higher than the services provided, and unbundled laboratory tests. He also created false documentation to support his billing. His fraudulent billing scheme resulted in a \$2.3 million FEHBP overpayment.

During the legal proceeding, the court found the physician had obstructed justice when he allegedly conspired with jailhouse inmates to murder his wife, the Assistant United States Attorney prosecuting the case, and a Federal Bureau of Investigation (FBI) special agent investigating the case. Prior to sentencing, the judge noted that the state of Florida had a pending indictment against the physician for arson in an alleged attempt to murder his wife.

The physician was convicted of 18 counts of mail fraud and 26 counts of health care fraud. At that time, he was ordered to forfeit \$10 million to the U.S. government. In August 2007, he was sentenced to 11 years of incarceration and 3 years of supervised probation. He was also fined \$4,400 and ordered to make restitution of \$11.6 million to the insurance companies. The FEHBP will receive approximately \$650,000 of the court ordered restitution. This was a joint investigation between our office, the FBI and the Texas Department of Insurance.

FEHBP Receives \$7 Million Settlement

In May 2007, after a lengthy multi-agency investigation, Purdue Pharmaceuticals settled with the United States government for fraudulently marketing Oxycontin, a pain medication. The company and three of its executives admitted that they falsely claimed that Oxycontin was not as addictive or subject to abuse, and less likely to cause withdrawal symptoms experienced with other pain medications. However, there was no medical research to support these claims.

As a result of the settlement, Purdue and three of its executives pled guilty to misbranding, a violation of the Food, Drug, and Cosmetic Act, and will pay over \$634 million dollars in restitution, damages and fines to multiple federal and state benefits programs. The FEHBP will recover \$7 million from the settlement.

Owner of California DME Company Sentenced for Selling Inferior and Used Products

In May 2007, the owner of a Southern California durable medical equipment (DME) supply company was sentenced to two years probation and ordered to pay \$10,000 in restitution, which includes \$2,325 to the FEHBP. The owner pled guilty to one count of mail fraud, involving a scheme where she sold inferior, disposable or used products to sleep disorder patients and billed for new or unused products. As reported in the last semiannual report, the products she sold included continuous positive airway pressure devices, face masks, hoses, filters and related DME. The defendant falsely billed Medicare, the FEHBP and private health insurance companies.



The allegations were investigated jointly by the FBI, the Department of Health and Human Services OIG (HHS/OIG), and our office. Following her conviction, the defendant was debarred from FEHBP participation. Her company is currently suspended from FEHBP participation.

Three Subjects Indicted and Arrested for Illegal Steroid Distribution

A joint investigation by the Food and Drug Administration (FDA), Drug Enforcement Administration (DEA), and our office revealed that a pharmacy owner, his associate, and a sales representative of another company participated in a scheme to illegally sell and distribute steroids and human growth hormones (HGH) to fitness centers, gyms and individual bodybuilders. Evidence seized as a result of a search warrant revealed that they were acquiring counterfeit HGH from China. The pharmacy then repackaged and sold the counterfeit goods.

In August 2007, the three individuals were indicted on one count of conspiracy to facilitate the sale of smuggled goods, ten counts of mail fraud, four counts of distribution of HGH, one count of receiving smuggled goods, one count of facilitating the sale of smuggled goods, forfeiture allegations, and aiding and abetting. The pharmacy owner and his associate were arrested in Colorado, while the third individual was arrested in Texas.

The actions of the three individuals impacted the FEHBP because the pharmacy sold the illegal steroids and counterfeit HGH to FEHBP participating doctors. The doctors would then administer the counterfeit drugs to FEHBP patients.

Chiropractor Ordered to Pay Fines and Restitution of Over \$3 Million

In a previous semiannual report, we reported the indictment and subsequent guilty plea of a North Carolina chiropractor who operated a medical clinic in which chiropractors and less skilled providers, such as athletic trainers and massage therapists, performed services that were falsely billed as physical therapy furnished by a medical doctor.

In July 2007, the chiropractor was sentenced to two years incarceration and three years supervised release. In addition, the chiropractor was ordered to pay restitution of \$1.8 million, to forfeit \$1.3 million, and to pay a fine of \$50,000. The FEHBP portion of the restitution was \$33,000. The chiropractor also agreed to give up his North Carolina chiropractic license. Subsequently, he was debarred from the FEHBP.

This was a joint investigation with the FBI, the Internal Revenue Service, and the North Carolina Department of Insurance.

Nurse Sentenced to Jail Time in Drug Probe

As a result of a referral from the BlueCross BlueShield Federal Employees Program, we initiated a case against a nurse accused of stealing narcotic prescription drugs from an FEHBP retiree residing in an Oregon nursing home. The nurse had a prior history of drug theft. In 2003, she was caught diverting prescription narcotic drugs at a hospital, where she was fired and arrested on theft charges. She completed a deferred adjudication program and the criminal charge was vacated.



Enforcement

We determined that the nurse ordered pain medications that her patients did not need, then diverted the drugs to her own personal use. She did this at three different long term care facilities. The rehabilitation center where she was employed at the time of the investigation performed an internal audit, which revealed that in 2007 she stole over 1,000 pills, mostly pain medication from patients residing at the facility.

In April 2007, she was charged with four counts of theft of prescription drugs in violation of Oregon state law. The nurse pled guilty and was convicted on all four counts. She was:

- sentenced to spend 30 days in custody;
- placed on three years formal probation;
- required to undergo drug treatment;
- required to pay restitution to the nursing homes and pharmacies; and,
- required to pay a fine of \$300 or perform 60 hours of community service.

Additionally, she surrendered her nursing license as a condition of her plea.

Home Health Agency Staff Jailed for Administering Bogus Flu Vaccine

In October 2005, our agents, as members of the Houston Health Care Task Force (HCTF), became involved in a joint investigation with the FBI, HHS/OIG, and the Texas State Medicaid Fraud Control Unit. The investigation concerned the owner of a home health agency and his office manager who distributed adulterated flu vaccinations. The owner and the office manager injected saline solutions into patients while billing their health insurance provider for the flu vaccination.

In November 2006, the owner and the office manager were indicted and arrested. Both subsequently pled guilty to one count of health care fraud. In April 2007, the owner was sentenced to nearly four years incarceration, three years probation, and fined \$15,000. In May 2007, the office manager was sentenced to six months incarceration, five years probation, and fined \$5,000.

Texas Ambulance Companies Commit Multiple Fraud

In September 2006, Operation Easy Rider was initiated to investigate numerous ambulance companies accused of submitting false billings for advanced life support services throughout the state of Texas. The agencies involved in this operation were the HHS/OIG, FBI, IRS, the Texas State Medicaid Fraud Control Unit, and the OPM/OIG.

In December 2006, agents from the task force made two arrests and served search warrants on 22 locations that involved 10 ambulance companies. Further, in April 2007, five additional owners and operators were indicted on multiple counts of health care fraud. Subsequently, four owners and operators were arrested in June 2007.

The task force found that ambulance companies, among other offenses, falsely billed for:

- Up to five individuals riding in a single ambulance at one time;
- Unauthorized medical services; and,
- Transportation service for individuals who did not need an ambulance.

The task force is continuing its investigations and further arrests and indictments are expected.



Pharmaceutical Off-Label Fraud Criminal and Civil Settlement Nets Over \$1 Million for the FEHBP

Orphan Medical, Inc, a subsidiary of Jazz Pharmaceutical, marketed and sold the drug Xyrem for the treatment of cataplexy, a condition characterized by weak or paralyzed muscles associated with the sleep disorder known as narcolepsy. This drug is also known as gamma-hydroxybutyrate or “GHB”. GHB is a powerful and fast-acting central nervous system depressant that has been subject to abuse as a recreational drug and is classified by HHS as a “date rape” drug. Orphan Medical was accused of illegally marketing this drug for uses not approved by the Food and Drug Administration (FDA).

Orphan Medical admitted that its sales representatives and at least one medical doctor engaged in a scheme to expand the market for Xyrem by promoting the drug to physicians for “off-label” medical uses, including fatigue, insomnia, chronic pain, weight loss, depression, bipolar disorders, and movement disorders, such as Parkinson’s Disease.

In July 2007, to avoid prosecution, the company agreed to pay \$3.75 million to resolve criminal and civil allegations in the “off-label” marketing investigation. The FEHBP portion of this settlement is over \$1 million. The doctor, who was accused of aggressively marketing the drug, is still under investigation.

Ophthalmologist Sentenced for Over \$1 Million in Fraud

In May 2007, an ophthalmologist with medical offices in Washington, DC, and Annandale, Virginia pled guilty to health care fraud and filing a false tax return. He admitted that between 1999 and 2002, he billed Medicare, the FEHBP and private insurance carriers for diagnostic and surgical pro-

cedures that he either did not perform or were not medically necessary.

His most common practice was to diagnose his patients as “glaucoma suspect” so that he could continue to see the patients and falsely bill for more costly procedures. He also admitted to illegally claiming charitable donations to his nonprofit organization on his federal and District of Columbia tax returns. He actually used the donations to pay for his family vacations in the Cayman Islands.

The doctor admitted he fraudulently obtained over \$1 million. He also admitted that from 2000 through 2002, he paid personal expenses and salaries to his children and housekeeper with funds from his medical practice. He falsely recorded these payments in his corporate records as legitimate expenses. In July 2007, the doctor was sentenced to 18 months incarceration, followed by six months of home detention. He was also fined \$50,000 and ordered to make full restitution to the government, of which \$252,712 was returned to the FEHBP.

Maryland Physician Convicted for Illegal Drug Billings

In June 2007, a Maryland physician was sentenced in Federal court to three years probation, after pleading guilty to four counts of health care fraud and one count of obtaining drugs by fraud.

A joint investigation with our office, the HHS/OIG, and the DEA, revealed that the physician submitted claims for medical services that he never provided. He often billed for office visits at times when he was not in the office or when his patients were only picking up prescriptions. The physician also improperly billed for procedures, such as charging for more expensive injections than were provided. In addition, he submitted fraudulent claims for reimbursement for the cost of prescription medications, including prescriptions written



without a legitimate medical purpose and for fictitious patients. In some cases, narcotics were issued without any legitimate medical purpose in exchange for cash payment by the patient. The physician also obtained controlled substances for himself by keeping pills acquired from prescriptions written in the names of his patients.

In addition to three years probation, the provider had to return almost \$114,000 to several FEHBP carriers.

Couple Conspire to Defraud the FEHBP

A U. S. Postal Service employee and her boyfriend, a Cleveland police officer, conspired to represent themselves as a married couple to obtain health benefits coverage under the FEHBP. Shortly after the police officer was laid off from his department, he approached his girlfriend with a scheme to file his medical expenses under her FEHBP coverage as her husband. For documentation, they deceived his grandfather, a clergyman in Mississippi, into signing a fraudulent marriage certificate. The Postal employee then stopped reporting for work, which led to an internal Postal Service investigation, which revealed that the Postal employee was not married at the time. However, she was claiming medical benefits for a spouse. Although the couple later married, the police officer fraudulently received \$22,498 in medical expenses under the FEHBP.

In July 2007, both individuals pled guilty. The Postal worker received six months of home confinement and three years of supervised release. The police officer was sentenced to five months in jail and three years of supervised release. This was a joint investigation between the OPM/OIG and the Postal Service OIG.

Identity Thief Convicted for Prescription Fraud

In July 2007, a former nurse was sentenced in Arlington, Virginia to six years incarceration for obtaining fraudulent prescriptions. One month later, she was also convicted in Alexandria, Virginia on the same charge. She was sentenced to eight years incarceration, but the Alexandria judge suspended all but one year and three months. Both sentences are to run concurrent.

The case was referred to the OPM/OIG by BlueCross BlueShield Association, who conducted a random review of the prescription order history for the account belonging to an FEHBP enrollee. An interview with the enrollee revealed that she had never been prescribed or used any of the controlled drugs listed on her prescription profile.

In 2000, the enrollee's purse was stolen from her place of employment. The purse was later found on the employer's property with all items seemingly still inside. Subsequently, it was determined that the health insurance benefits card was missing. The investigation disclosed that the former nurse, who then used the card, had the same last name as the victim.

The scheme involved the former nurse visiting several unsuspecting doctors, complaining about neck and back pain. The doctors would prescribe Controlled Substance Schedule II drugs, including Hydrocodone, Oxycodone and Percocet. The former nurse would request that the doctors list the first name of the enrollee on her prescriptions. Since the pharmacies knew her by her real name, on several occasions, she had the pharmacies change the name on the prescriptions to the enrollee's name, because the enrollee's name was already in the pharmacies' computer systems. Therefore, the nurse would confirm the enrollee's name, date of birth and address as her own. The nurse also used other aliases to commit these crimes throughout Northern Virginia from March 2000 through June 2006.



FEGLI FRAUD

Two Convicted of Life Insurance Fraud Sentenced

As reported in a previous semiannual report, two defendants were convicted of life insurance fraud in the Federal Employees' Group Life Insurance program (FEGLI). One defendant was a payroll technician for the Department of Veterans Affairs Medical Center in the District of Columbia, and the other was a volunteer driver at the facility. The driver forged a FEGLI form designating himself as the beneficiary, and the payroll technician used her official position within the payroll office to access the official personnel folder of the deceased employee and cause the false beneficiary form to be placed in that folder. The payroll technician was subsequently dismissed from federal employment and the driver was banned from volunteering at the medical center.

In February 2006, the payroll technician received a sentence of 15 months in jail and two years of supervised release. In September 2007, the volunteer driver was sentenced to almost three years in prison and two years supervised release. The co-conspirators were ordered to jointly pay restitution of \$20,500 and a fine of \$200.

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 unentitled recipient.

Our 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, OPM's Center for Retirement and Insurance Services refers to our office potential fraud cases identified through computer death matches with the Social Security Administration. Other referrals come from federal, state, and local agencies, as well as private citizens.

Former Neighbor Steals Identity and Annuity of Deceased Federal Retiree

Through our proactive efforts to identify retirement fraud, we sent an investigator to a retired annuitant's home. We discovered the annuitant died on May 12, 2001. However, we found that following her death, her annuity payments were still being deposited into a bank account. Through analysis of bank records, we identified a former neighbor, who shared the same last name as the annuitant. At one time they lived in the same apartment complex in Portland, Oregon. After the annuitant died, the neighbor intercepted her mail and determined the deceased annuitant was receiving a Civil Service Retirement benefit. Instead of reporting the death, the neighbor assumed the annuitant's identity. On two separate occasions, the neighbor contacted OPM to divert the annuity payments to her own bank account.

The neighbor pled guilty to theft of government property. In April 2007, she was sentenced to six months incarceration, three years probation, and to pay full restitution of \$40,774.



Granddaughter to Serve Three Years in Jail for Stealing Retirement Benefits

Through our proactive retirement fraud initiative, we found a deceased survivor annuitant, who died in Houston, Texas in March 2003, but payment of retirement benefits continued. The investigator went to the last known address of the annuitant. The apartment manager informed the investigator that the annuitant had died several years earlier. In the investigator's initial contact with the annuitant's family, a family member attempted to deceive the investigator by stating that the annuitant was unavailable. Upon visiting the annuitant's granddaughter at her place of employment, she confessed to fraudulently receiving the annuity payments and using them for her own expenses.

In July 2007, the granddaughter was convicted of third degree theft and was sentenced to three years of incarceration, 10 years of probation, 180 hours of community service, and ordered to pay restitution of \$99,786 to both OPM and the Social Security Administration. OPM will receive \$72,211 of the ordered restitution.

Son Pled Guilty to Theft from Retirement Fund

In July 2007, the son of a CSRS annuitant pled guilty in Virginia to theft of government funds. He continued to collect his mother's civil service annuitant benefits, as well as her survivor annuitant benefits, after he failed to report to OPM that she died in 1997. The benefits were deposited directly into his bank account. This resulted in a fraudulent overpayment of \$156,429.

The son confessed to stealing the funds and that he spent the money on living expenses as well as several luxury items, including a large boat docked at a marina in Washington, DC. The marina's location was used as the residential address for the annuitant.

In May 2007, he was sentenced to six months house arrest, three years of supervised probation and to pay full restitution.

Cousin of Annuitant Returns Over \$180 Thousand to Retirement Fund

Through our proactive retirement fraud initiative, our investigators determined that the cousin of a deceased federal annuitant received retirement and survivor benefits after the death of the annuitant in October 1997. When we subpoenaed the bank where the annuitant payments were electronically deposited, the bank management notified the cousin, who jointly owned the account with the annuitant.

The District of Columbia U.S. Attorney's Office declined the criminal prosecution; however, the U.S. Attorney's Office, Civil Division contacted the cousin's legal counsel, and demanded full restitution. In July 2007, the cousin signed a civil settlement agreement with the U.S. Attorney's Office and the cousin reimbursed OPM the full amount of \$183,158.



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 505 formal complaints and calls on these hotlines during the reporting period. The table on page 29 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 185 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 FEHBP. The hotline number is listed in the brochures for all the FEHBP health insurance plans, as well as on our OIG Web site at 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 320 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, malfeasance. 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 reflects 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 30,028 active suspensions and debarments from FEHBP.

During the reporting period, our office issued 408 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 1,629 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 the 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.



Debarred Physician's Office Manager Proposed for Debarment

In August 2007, we notified a medical office manager who had been employed by a physician previously debarred by our office that we proposed to debar her. Our Office of Investigations had called this case to the debarring official's attention following the indictment of the physician, the office manager, and a medical equipment supplier for health care fraud, mail fraud, and associated conspiracy charges.

During a period of several years, the physician submitted over \$3.5 million in claims for medical services and supplies to FEHBP, and received approximately \$850,000 in payments. (Total payments from all federal sources to the physician amounted to more than \$8 million.) The office manager was instrumental to this scheme by preparing the fraudulent claims forms and forwarding them to insurance carriers. The FEHBP administrative sanctions statute includes offenses committed by persons, such as the office manager, who carry out or facilitate wrongdoing on the part of health care providers who are directly engaged in patient care.

The office manager was tried and convicted of aiding and abetting health care fraud in 2004, but the judge set aside the jury verdict and granted her a new trial. After a series of appeals and motions were filed by both the prosecution and defense, in 2006 she pleaded guilty to misprision of a felony, and a judgment was entered against her in 2007. In the plea agreement, she admitted that she had knowledge of the health care fraud committed by the physician who employed her, and that she concealed this information from law enforcement authorities. Her conviction was a mandatory basis for a three-year debarment from FEHBP.

Physician, Medical Practice and Surgical Assistant Suspended

In July and August 2007, we suspended a physician, his practice, and a surgical assistant employed by the practice, based on a referral from our Office of Investigations regarding the suspension of their professional licenses by their state medical board. The physician has participated in FEHBP plans as a provider of medical services.

According to the medical board, the physician's license was suspended because he allowed the surgical assistant, who was unlicensed as either a physician or a surgical assistant, to perform 32 breast augmentation and/or liposuction procedures in the practice's facility. The physician provided no supervision to the assistant, and was not present in the practice's facility during at least some of these procedures.

In addition, the medical board found that the doctor himself had no training in breast augmentation or liposuction techniques, so that he could not have provided effective supervision to the assistant, even if he had been present. Further, he was not registered to perform office-based anesthesia, did not keep proper records of drug and anesthesia use, and failed to assure that a person certified in Advanced Cardiac Life Support was present in the practice while the surgical procedures were being performed.

The surgical assistant represented himself as a physician to patients seeking breast augmentation or liposuction, even though he had no license to perform those procedures. He was also not certified in any cardiac life support procedures, and, in the words of the medical board, his actions "presented a continuing threat to the public health and safety."

Our suspensions are effective for an indefinite period pending the issuance of a further order by the medical board.



Plastic Surgeon Debarred

In March 2005, a state medical board summarily suspended the license of a plastic surgeon, following his arrest for felony intoxicated assault and failure to stop and render assistance. While driving home after dinner at a nearby restaurant, the doctor lost control of his vehicle, jumped a curb, and struck two pedestrians on the sidewalk. Both of the victims, who were filming a segment for the television series, “Animal Planet”, were critically injured.

In its suspension order, the board also noted that the doctor had previously been arrested for a DUI, but failed to inform them of the violation. Because he was a preferred provider for at least one major FEHBP fee-for-service plan and based on the licensing board’s action, we suspended him in July 2005.

In April 2006, the doctor was convicted of Intoxicated Assault with a Motor Vehicle, a third degree felony, and sentenced to a term of imprisonment for two years. Subsequent to the court’s adjudication, the board revoked the doctor’s medical license. Under the FEHBP sanctions statute, the debarring official has authority to debar providers whose professional licensure is revoked, suspended, or placed on probation by a state licensing body. In this case, taking into account the egregious nature of the doctor’s actions, the serious physical harm done to the two victims, the doctor’s history of prior alcohol-related violations, and his connection with an FEHBP carrier, we determined that debarment was clearly warranted. The debarment will be effective indefinitely, concurrent with the period during which the doctor’s license is revoked.



STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES

JUDICIAL ACTIONS:

Arrests	21
Indictments and Informations	41
Convictions	27

JUDICIAL RECOVERIES:

Fines, Penalties, Restitutions and Settlements	\$11,160,677
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RETIREMENT AND SPECIAL INVESTIGATIONS HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry	28
Referred to:	
OPM Program Offices	81
Other Federal Agencies	76
Total	185

HEALTH CARE FRAUD HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry	80
Referred to:	
OPM Program Offices	54
Other Federal/State Agencies	57
FEHBP Insurance Carriers or Providers	129
Total	320
Total Hotline Contacts and Complaint Activity	505

ADMINISTRATIVE SANCTIONS ACTIVITY:

Debarments and Suspensions Issued	408
Health Care Provider Debarment and Suspension Inquiries	1,629
Debarments and Suspensions in Effect at End of Reporting Period	30,028



APPENDICES

APPENDIX I

FINAL REPORTS ISSUED WITH QUESTIONED COSTS

APRIL 1, 2007 TO SEPTEMBER 30, 2007

Subject	Number of Reports	Questioned Costs	Unsupported Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	12	\$31,586,948	\$
B. Reports issued during the reporting period with findings	22	33,929,019	149,419
Subtotals (A+B)	34	65,515,967	149,419
C. Reports for which a management decision was made during the reporting period:	18	41,533,526	149,419
1. Disallowed costs		34,189,798	149,419
2. Costs not disallowed		7,343,728	
D. Reports for which no management decision has been made by the end of the reporting period	16	23,982,441	
E. 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, 2007 TO SEPTEMBER 30, 2007

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period		
B. Reports issued during the reporting period with findings	6	\$429,911
Subtotals (A+B)	6	429,911
C. Reports for which a management decision was made during the reporting period:		
1. Disallowed costs		
2. Costs not disallowed		
D. Reports for which no management decision has been made by the end of the reporting period	6	429,911
E. Reports for which no management decision has been made within 6 months of issuance		



APPENDIX III

INSURANCE AUDIT REPORTS ISSUED

APRIL 1, 2007 TO SEPTEMBER 30, 2007

Report Number	Audits	Issue Date	Questioned Costs
1A-10-30-05-069	WellPoint BlueCross BlueShield of Colorado in Mason, Ohio	April 25, 2007	\$2,457,549
1C-EE-00-05-071	Humana Medical Plan of the South Florida Area in Louisville, Kentucky	May 7, 2007	1,447,250
1C-M9-00-06-064	MVP Health Care of the Central Region in Schenectady, New York	May 17, 2007	5,120,826
1C-5E-00-06-004	Vista Health Plan of South Florida in Hollywood, Florida	May 17, 2007	91,158
1A-10-12-06-080	BlueCross BlueShield of Western New York in Buffalo, New York	May 21, 2007	161,190
1C-LX-00-06-048	Blue Care Network of Michigan—Southeast Region in Southfield, Michigan	May 22, 2007	506,171
1C-MS-00-05-044	Humana Health Plan of Kansas City in Louisville, Kentucky	May 23, 2007	4,464,989
1A-10-03-06-079	BlueCross BlueShield of New Mexico in Albuquerque, New Mexico	June 5, 2007	288,986
1C-VW-00-06-009	MVP Health Care of the Vermont Region in Schenectady, New York	June 7, 2007	225,865
1C-8W-00-05-036	UPMC Health Plan in Pittsburgh, Pennsylvania	June 14, 2007	3,997,639
1C-3A-00-06-003	AultCare Health Plan in Canton, Ohio	June 25, 2007	2,760,484
1C-64-00-05-082	Kaiser Foundation Health Plan of Ohio in Cleveland, Ohio	June 29, 2007	638,374
1C-LN-00-07-047	Blue Care Network of Michigan—Mid Region in Southfield, Michigan Proposed Rate Reconciliation	July 2, 2007	
1C-51-00-07-048	Health Insurance Plan of New York in Manhattan, New York Proposed Rate Reconciliation	July 3, 2007	



APPENDIX III

INSURANCE AUDIT REPORTS ISSUED

APRIL 1, 2007 TO SEPTEMBER 30, 2007

(Continued)

Report Number	Audits	Issue Date	Questioned Costs
1C-K5-00-07-046	Blue Care Network of Michigan—East Region in Southfield, Michigan Proposed Rate Reconciliation	July 17, 2007	
1C-F8-00-07-051	Kaiser Foundation Health Plan of Georgia in Atlanta, Georgia Proposed Rate Reconciliation	July 19, 2007	\$1,023,823
1C-IN-00-07-049	M Plan in Indianapolis, Indiana Proposed Rate Reconciliation	July 19, 2007	149,419
1C-DA-00-06-046	BlueChip Coordinated Health Partners in Providence, Rhode, Island	July 24, 2007	
1C-9F-00-07-050	OSF Health Plan in Peoria, Illinois Proposed Rate Reconciliation	July 25, 2007	
1D-R5-00-06-069	Federal Blue HMO in Mason, Ohio	July 25, 2007	2,246,447
1A-10-15-05-046	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee	July 25, 2007	1,848,317
1C-5M-00-06-006	SuperMed HMO in Cleveland, Ohio	August 28, 2007	254,898
1A-10-33-06-037	BlueCross BlueShield of North Carolina in Durham, North Carolina	August 28, 2007	1,274,015
1C-WQ-00-06-087	Aetna Health, Inc. in Phoenix and Tucson, Arizona	September 20, 2007	207,308
1C-UB-00-06-036	Aetna Health, Inc. in Memphis, Tennessee	September 20, 2007	1,119,981
1C-HA-00-06-005	Coventry Health Care of Kansas in Kansas City, Missouri	September 21, 2007	3,602,423
1G-LT-00-07-005	Long Term Care Partners, LLC in Portsmouth, New Hampshire	September 26, 2007	41,907
TOTALS			\$33,929,019



APPENDIX IV

INTERNAL AUDIT REPORTS ISSUED

APRIL 1, 2007 TO SEPTEMBER 30, 2007

Report Number	Subject	Issue Date
4A-CF-00-05-028	Administration of the Prompt Payment Act at the Office of Personnel Management	April 16, 2007
4A-IS-00-06-049	Transfer of the Department of Defense's Personnel Security Investigation Function to the U.S. Office of Personnel Management	September 27, 2007

APPENDIX V

INFORMATION SYSTEMS AUDIT REPORTS ISSUED

APRIL 1, 2007 TO SEPTEMBER 30, 2007

Report Number	Subject	Issue Date
4A-CF-00-07-010	Information Technology Security Controls of the Government Financial Information System	April 25, 2007
4A-RI-00-07-041	Information Technology Security Controls of the Actuaries Group System	May 16, 2007
1B-47-00-06-072	Information Systems General and Application Controls at American Postal Workers Union Health Plan in Glen Burnie, Maryland	May 18, 2007
4A-HR-00-07-009	Information Technology Security Controls of the Go Learn Learning Management System	May 31, 2007
1C-JP-00-07-011	Information Systems General and Application Controls at Mid-Atlantic Health Plans of United Healthcare in Frederick, Maryland	July 18, 2007
4A-HR-00-07-42	Information Technology Security Controls of the Learning Management System	August 24, 2007
4A-CI-00-07-007	Federal Information Security Management Act for Fiscal Year 2007	September 18, 2007
4A-CI-00-07-008	Federal Information Security Management Act Follow-Up for Fiscal Year 2007	September 18, 2007



APPENDIX VI

COMBINED FEDERAL CAMPAIGN AUDIT REPORTS ISSUED

APRIL 1, 2007 TO SEPTEMBER 30, 2007

Report Number	Subject	Issue Date
3A-CF-00-06-074	The 2004 Combined Federal Campaign Activities for the National Black United Federation of Charities in Newark, New Jersey	July 5, 2007
3A-CF-00-06-060	The 2003 and 2004 Combined Federal Campaigns for Long Island in Deer Park, New York	July 17, 2007
3A-CF-00-06-055	The 2003 and 2004 Combined Federal Campaigns for the Chicago Area in Champaign, Illinois	July 17, 2007
3A-CF-00-06-061	The 2003 and 2004 Combined Federal Campaigns for the Niagara Frontier Area in Buffalo, New York	July 25, 2007
3A-CF-00-06-058	The 2003 and 2004 Combined Federal Campaigns for Central and Northern New Mexico in Albuquerque, New Mexico	July 25, 2007
3A-CF-00-06-051	The 2003 and 2004 Combined Federal Campaigns of the Mid-South in Memphis, Tennessee	July 26, 2007
3A-CF-00-06-056	The 2003 and 2004 Combined Federal Campaigns for Central Iowa in Des Moines, Iowa	August 28, 2007



APPENDIX VII

SUMMARY OF AUDIT REPORTS MORE THAN SIX MONTHS OLD PENDING CORRECTIVE ACTION

APRIL 1, 2007 TO SEPTEMBER 30, 2007

Report Number	Subject	Issue Date
3A-CF-00-01-037	The 1998 and 1999 Combined Federal Campaigns of Long Island in Deer Park, New York; 14 open recommendations	July 26, 2001
3A-CF-00-04-042	The 2001 and 2002 Combined Federal Campaigns for the Northeast Ohio Area in Cleveland, Ohio; 3 open recommendations	September 26, 2005
4A-CF-00-05-043	Office of Personnel Management's Fiscal Year 2005 Consolidated Financial Statements	November 14, 2005
4A-CF-00-06-027	Office of Personnel Management's Fiscal Year 2005 Closing Package Special-Purpose Financial Statement	November 21, 2005
3A-CF-00-06-062	The 2003 and 2004 Combined Federal Campaigns for the Piedmont Triad in Greensboro, North Carolina; 8 open recommendations	January 18, 2006
3A-CF-00-04-038	The 2001 and 2002 Combined Federal Campaigns for Central Maryland in Baltimore, Maryland; 17 open recommendations	June 6, 2006
3A-CF-00-05-041	The 2002 and 2003 Combined Federal Campaigns for Central Indiana in Indianapolis, Indiana; 1 open recommendation	June 13, 2006
3A-CF-00-05-078	The 2002 and 2003 Combined Federal Campaigns for the Southeastern Wisconsin in Milwaukee, Wisconsin; 3 open recommendations	June 23, 2006
3A-CF-00-05-042	The 2002 and 2003 Combined Federal Campaigns for Northern Nevada in Las Vegas, Nevada; 11 open recommendations	July 3, 2006
3A-CF-00-05-039	The 2002 and 2003 Combined Federal Campaigns for Southern Nevada in Las Vegas, Nevada; 11 open recommendations	July 3, 2006
3A-CF-00-05-079	The 2003 Combined Federal Campaign Activities for the Medical Research Charities Federation in Springfield, Virginia; 2 open recommendations	July 14, 2006
3A-CF-00-05-049	The 2002 and 2003 Combined Federal Campaigns for the Research Triangle Area in Morrisville, North Carolina; 9 open recommendations	August 10, 2006



APPENDIX VII

SUMMARY OF AUDIT REPORTS MORE THAN SIX MONTHS OLD PENDING CORRECTIVE ACTION

APRIL 1, 2007 TO SEPTEMBER 30, 2007

(Continued)

Report Number	Subject	Issue Date
3A-CF-00-05-076	The 2002 and 2003 Combined Federal Campaigns for Central Texas in Austin, Texas; 7 open recommendations	August 14, 2006
3A-CF-00-05-052	The 2002 and 2003 Combined Federal Campaigns for Fresno-Madera County in Fresno, California; 4 open recommendations	August 22, 2006
4A-IS-00-06-021	Information Technology Security Controls of the Office of Personnel Management's Fingerprint Transaction System; 7 open recommendations	August 29, 2006
4A-CA-00-05-086	OPM's Post-Most Efficient Organization Review of the Computer Assistants and Building Management Assistant Competition; 6 open recommendations	September 8, 2006
4A-CI-00-06-015	Federal Information Security Management Act Follow-up for Fiscal Year 2006; 10 open recommendations	September 15, 2006
4A-CI-00-06-016	Federal Information Security Management Act for Fiscal Year 2006; 12 open recommendations	September 22, 2006
4A-CF-00-06-045	Office of Personnel Management's Fiscal Year 2006 Consolidated Financial Statements	November 13, 2006
3A-CF-00-05-040	The 2002 and 2003 Combined Federal Campaigns for San Bernardino in San Bernardino, California; 19 open recommendations	December 26, 2006
4A-CI-00-07-015	The Privacy Program at the Office of Personnel Management; 5 open recommendations	January 25, 2007
3A-CF-00-05-077	The 2002 and 2003 Combined Federal Campaigns for New Hampshire and Southern Maine in Portsmouth, New Hampshire; 18 open recommendations	February 12, 2007
3A-CF-00-05-075	The 2002 and 2003 Combined Federal Campaigns for the Smoky Mountain Region in Knoxville, Tennessee; 21 open recommendations	March 30, 2007



Index of Reporting Requirements

(Inspector General Act of 1978, As Amended)

Section 4 (a) (2):	Review of legislation and regulations	No Activity
Section 5 (a) (1):	Significant problems, abuses, and deficiencies	1-28
Section 5 (a) (2):	Recommendations regarding significant problems, abuses, and deficiencies	1-15
Section 5 (a) (3):	Recommendations described in previous semiannual reports on which corrective action has not been completed	30, 31, 36-37
Section 5 (a) (4):	Matters referred to prosecutive authorities	17-24
Section 5 (a) (5):	Summary of instances where information was refused during this reporting period	No Activity
Section 5 (a) (6):	Listing of audit reports issued during this reporting period	32-35
Section 5 (a) (7):	Summary of particularly significant reports	2-15
Section 5 (a) (8):	Audit reports containing questioned costs	32-35
Section 5 (a) (9):	Audit reports containing recommendations for better use of funds	31
Section 5 (a) (10):	Summary of unresolved audit reports issued prior to the beginning of this reporting period	30
Section 5 (a) (11):	Significant revised management decisions during this reporting period	No Activity
Section 5 (a) (12):	Significant management decisions with which the OIG disagreed during this reporting period	No Activity



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