

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Office of the Inspector General



**Semiannual Report
to Congress**

April 1, 2010 – September 30, 2010



Office of the Inspector General



PRODUCTIVITY INDICATORS

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds	\$57,627,455
Management Commitments to Recover Funds	\$24,169,503
Recoveries Through Investigative Actions.	\$25,688,842

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.	28
Investigative Cases Closed	89
Indictments and Informations	35
Arrests.	30
Convictions	37
Hotline Contacts and Complaint Activity	591
Health Care Provider Debarments and Suspensions	261
Health Care Provider Debarment and Suspension Inquiries	1,267

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INSPECTOR GENERAL'S MESSAGE

As those who are familiar with our office's activities are aware, we have for many years focused our efforts on safeguarding the health and life insurance and retirement trust funds entrusted to the U.S. Office of Personnel Management (OPM). Our pursuit of improper, erroneous, and fraudulent payments during the past ten years has resulted in recovery of over \$1.4 billion of OPM funds. This represents an average return of approximately \$8 for each dollar our office expends to conduct its audit and investigative programs.

While we are continually seeking to improve our record of positive financial impact, we have also begun to strengthen our capability to serve as a proactive force in recommending legislative action and operational improvements to strengthen the efficiency and integrity of OPM's programs. I am particularly pleased to report that our active participation with both OPM program officials and a Congressional subcommittee during the past two years has achieved very substantial progress toward a successful outcome of our initiative to promote full disclosure of costs associated with pharmaceutical benefits provided to Federal Employees Health Benefits Program (FEHBP) subscribers.

It has been our office's longstanding position that the FEHBP's interest in obtaining the best possible value in pharmaceutical services demands that its health carriers' contracts with pharmacy benefits managers (PBM) embody transparency—that is, disclosure, subject to Office of the Inspector General's (OIG) audit—of the actual costs of pharmaceutical products and services provided to the FEHBP enrollees. Based on the experience of private sector entities and Government agencies that have required transparency from the PBMs serving their health benefits plans, there is reason to believe that such arrangements will generate savings over nontransparent contracts. Because pharmaceutical benefits comprise such a large portion of the FEHBP's expenditures (in excess of 25 percent, representing over \$8 billion annually), even relatively small marginal cost reductions, or limitations in the future growth of costs, can be expected to produce large savings.

The lack of transparency in the FEHBP pharmaceutical services contracts largely reflected the prevailing practices in the health insurance industry. However, over the past 10 years, our office has become increasingly concerned about the risks inherent in the absence of information available to OPM regarding the true costs of pharmaceutical services provided to enrollees by the PBMs under their contracts to the FEHBP carriers. To a substantial extent, the agency shared our misgivings. In response, we formed a working group of OIG and OPM employees who were most knowledgeable about this problem to identify approaches to resolving it. As part of this effort, OPM contracting officials took steps to provide the OIG auditors with access to the actual PBM contracts, which we had not previously been allowed to review. Nonetheless, because these contracts did not require the PBMs to disclose their actual costs, our office became even more convinced that full cost transparency was essential.

During 2009, an OIG member of the group was requested by the House Subcommittee on the Federal Workforce, Postal Service, and the District of Columbia to serve on a detail to their staff. In this role, she organized two hearings on PBM cost issues at which I testified strongly in favor of requiring full transparency from PBMs that contract with FEHBP carriers. Our office also participated in a roundtable which brought together experts from the health insurance carriers, other Federal agencies, State and local Government agencies, and representatives of



Inspector General's Message

the pharmaceutical services industry. On this basis, the subcommittee drafted legislation to mandate that FEHBP obtain pharmaceutical services through transparent PBM contracts.

At the subcommittee's markup hearing for this bill, the newly appointed OPM health care policy director indicated that OPM wanted to achieve disclosure of cost data from PBMs through the contracting process. Subsequently, the OIG team worked closely with the OPM policy official, his staff, and FEHBP contracting officials to identify means of obtaining PBM cost transparency in the FEHBP. The OIG contributed to a set of "transparency principles" that were incorporated into guidance that OPM issued to the FEHBP carriers regarding solicitation of PBM contract proposals for implementation in 2011. Our team is continuing to work with OPM's policy and contracting offices to confirm that the FEHBP carriers implement the transparency concepts in a manner that assures full disclosure of pharmaceutical cost data, and we will incorporate these costs as a principal focus of our health insurance carrier audits.

As part of other legislative developments, the OIG has developed a set of proposals which we have forwarded for action through OPM's legislative affairs program. All of our initiatives would improve the integrity of OPM's benefits programs through statutory amendments to strengthen their protections against fraud and abuse, including enhanced levels of audit and investigative oversight by the OIG. Our principal proposal would end the exemption of the FEHBP from the Federal anti-kickback law. The OIG considers this to be the single most valuable measure that can be taken to combat fraud and abuse against the FEHBP by health care providers. This would correct a situation arising from a provision of the Health Insurance Portability and Accountability Act (HIPAA) that effectively removed the FEHBP from being protected against conduct that, if committed against any other Federally-funded health care program, would constitute a criminal offense. Congress passed the Anti-Kickback Statute in 1972, making it illegal for health care providers, including doctors, to knowingly and willfully accept bribes or other forms of remuneration in return for generating Medicare or Medicaid business. While these prohibitions were originally limited to the Medicare or Medicaid programs, the HIPAA legislation later expanded its coverage to include any Federal health care program, with the notable exception of the FEHBP, which was excluded just prior to passage of the legislation, without significant discussion or debate.

The Anti-Kickback provisions were enacted to prevent health care providers from inappropriately profiting from referrals. The payment of incentives for referrals drives up health care costs and may place patients at risk of harm, as health care providers are tempted to profit from referrals that are not medically necessary. The Anti-Kickback Statute is a felony statute, punishable by imprisonment up to five years and fines up to \$25,000, which affects anyone engaging in business with a Federal or State health care program (except the FEHBP). In addition to the Federal Anti-Kickback Statute, many States, including Florida and Texas, have adopted their own anti-kickback statutes.

The FEHBP was not simply left out of the anti-kickback legislation; it was specifically excluded. This is extremely problematic from the OIG's perspective, and has compromised the OIG's ability to prevent the FEHBP's victimization from conduct that, when committed against any other Federally-funded health care program, would constitute criminal behavior. As the former Department of Health and Human Services Inspector General June Gibbs Brown stated in November 1999, "The federal anti-kickback statute is the guarantor of objective medical advice for federal health care program beneficiaries and helps ensure that providers refer patients based on the patients' best medical interests and not because the providers stand to profit from the referral." The FEHBP lacks this guarantee of medical objectivity enjoyed by all other Federally-funded health care programs. We believe the FEHBP's exclusion from the Anti-Kickback Act should be revoked.


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 the U.S. Office of Personnel Management (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 OPM'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 OPM.
- Ensure that OPM is following best business practices by operating in an effective and efficient manner.
- Determine whether OPM 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 OPM programs.
- Identify, through proactive initiatives, areas of concern that could strengthen the operations and programs administered by OPM.

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FIELD OFFICES



AUDIT ACTIVITIES

Health Insurance Carrier Audits

The United States Office of Personnel Management (OPM) contracts with private sector firms to provide health insurance through the Federal Employees Health Benefits Program (FEHBP). Our office is responsible for auditing the activities of this program to ensure that the insurance carriers meet their contractual obligations with OPM.

The Office of the Inspector General's (OIG) insurance audit universe contains approximately 260 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations. 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 premium payments for the health insurance program 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 BlueCross and BlueShield 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 24 final reports on organizations participating in the FEHBP, of which 11 contain recommendations for monetary adjustments in the amount of \$57.6 million due the trust funds.



COMMUNITY-RATED PLANS

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

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

Community-rated audits focus on ensuring that:

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

Loading is a rate adjustment that 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 18 audit reports on community-rated plans. These reports contain recommendations to require the health plans to return over \$49.5 million to the FEHBP.

Group Health Cooperative Seattle, Washington

Report No. 1C-54-00-09-048

SEPTEMBER 8, 2010

Group Health Cooperative (Plan) has participated in the FEHBP as a community-rated health plan since 1960 and provides comprehensive medical services to its members throughout most of Washington State and Northern Idaho. This audit of the Plan covered contract years 2006 through 2008. During this period, the FEHBP paid the Plan approximately \$621.3 million in premiums.

We identified \$33,122,807 in inappropriate health benefit charges to the FEHBP; including \$30,636,448 in 2007 and \$2,486,359 in 2008. In addition, we determined the FEHBP is due \$4,693,752 for investment income lost as a result of the overcharges.

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

The overcharges occurred because the Plan did not select the correct SSSG in 2007 and in consequence did not apply the largest discount to the FEHBP rates. The Plan also failed to correctly identify and apply an SSSG discount to the FEHBP rates in 2008.

**INAPPROPRIATE
CHARGES
AMOUNT TO
\$38 MILLION**

Blue Choice Rochester, New York

Report No. 1C-MK-00-10-005

JULY 22, 2010

Blue Choice has participated in the FEHBP as a community-rated health plan since 1989 and provides



comprehensive medical services to its members throughout the Rochester, New York area. This audit of the plan covered contract years 2006 through 2009. During this period, the FEHBP paid the plan approximately \$99.3 million in premiums.

Our auditors identified \$2,301,947 in inappropriate health benefit charges to the FEHBP consisting of \$607,957 in 2007, \$462,788 in 2008, and \$1,231,202 in 2009. In addition, we determined the FEHBP is due \$184,102 for investment income lost as a result

**\$2.5 MILLION
TO BE RETURNED
TO THE FEHBP**

of the overcharges. The overcharges occurred because Blue Choice did not correctly identify the SSSGs nor identify the largest SSSG

discounts in 2007 through 2009. Because Blue Choice failed to include experience-rated preferred provider option groups and point-of-service groups when selecting SSSGs, the FEHBP did not receive appropriate premium discounts.

Blue Choice agreed with our findings and will return \$2,486,049 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 HMOs fall into this category.

The universe of experience-rated plans currently consists of approximately 100 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 five experience-rated audit reports. In these reports, our auditors recommended that the plans return \$8.2 million in inappropriate charges and lost investment income to the FEHBP.

BLUECROSS BLUESHIELD SERVICE BENEFIT PLAN

The BlueCross BlueShield Association (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 BlueCross BlueShield (BCBS) operations center in Washington, D.C. Approximately 60 percent of all FEHBP subscribers are enrolled in the BCBS plans.

We issued two BCBS 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. Our auditors identified \$5.6 million in questionable costs charged to the FEHBP contract, including lost investment income. The BCBS Association and/or plans agreed with \$5.4 million of the identified overpayments.

**CareFirst BlueCross BlueShield
Owings Mills, Maryland
Report No. 1A-10-85-09-023
MAY 21, 2010**

CareFirst BCBS includes the Washington, D.C. (DC) and Maryland (MD) service areas and overseas claims. Our audit of the FEHBP operations at CareFirst BCBS covered claims from January 1, 2006 through October 31, 2008, as well as miscellaneous health benefit payments and credits, administrative expenses, and cash management activities from 2004 through 2008. During this period, CareFirst BCBS paid



approximately \$6.8 billion in FEHBP health benefit charges and \$412 million in administrative expenses for the DC and MD service areas and overseas claims.

AUDITORS QUESTION OVER \$1.3 MILLION IN OVERCHARGES AND LOST INVESTMENT INCOME

Our auditors questioned \$1,364,595, consisting of \$1,304,034 in health benefit overcharges and \$60,561 in administrative expense

overcharges. The findings included the following:

- \$1,098,688 in overpayments due to claim pricing errors or duplicate claim payments;
- \$220,139 in overpayments and \$50,742 in underpayments because claims were not paid in accordance with the Omnibus Budget Reconciliation Act of 1990 pricing requirements, which limit benefit payments for certain inpatient services provided to annuitants age 65 and older who are not covered under Medicare Part A;
- \$56,846 for duplicate administrative expense charges and \$3,715 for lost investment income on these charges;
- \$15,564 in claim payments to debarred providers;
- \$15,249 in commission recovery fees paid to a provider audit vendor for overpayments that were not recovered; and,
- \$5,136 for lost investment income on a fraud recovery that was not returned to the FEHBP in a timely manner.

Of these questioned charges, the Association agreed with \$1,333,921. Additionally, lost investment income on the questioned charges totaled \$1,554.

EXPERIENCE-RATED COMPREHENSIVE MEDICAL PLANS

Comprehensive medical plans 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 plans have the option of using a designated network of providers or using non-network providers. A member's choice in selecting one health care 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 two experience-rated comprehensive medical plan audit reports during this reporting period.

**Altius Health Plan
South Jordan, Utah
Report No. 1D-9K-00-09-026
JUNE 28, 2010**

The Altius Health Plan (Plan) is an experience-rated health plan offering comprehensive medical benefits to Federal enrollees and their families. Enrollment is open to all Federal employees and annuitants in the Plan's service area, which includes Utah and select counties in Idaho and Wyoming.

The audit of the Plan's FEHBP operations covered debarred provider payments, miscellaneous health benefit payments and credits, administrative expenses, and cash management

activities from 2004 through 2008. During this period, the Plan paid approximately \$441 million in FEHBP health benefit charges and \$26 million in administrative expenses.

PLAN AGREES WITH OVER \$245,000 IN QUESTIONED CHARGES



Our auditors questioned \$245,612, consisting of \$57,831 in health benefit charges, \$88,521 in administrative expenses, and \$99,260 in cash management activities. The Plan agreed with the questioned charges. Additionally, lost investment income on the questioned charges totaled \$9,313.

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

We issued one employee organization plan audit report during this reporting period for Coventry Health Care as underwriter and administrator for the Mail Handlers Benefit Plan.

Coventry Health Care as Underwriter and Administrator for the Mail Handlers Benefit Plan Rockville, Maryland

Report No. 1B-45-00-09-062

APRIL 14, 2010

The Mail Handlers Benefit Plan (Plan) is an experience-rated employee organization plan. Enrollment in the Plan is open to all FEHBP eligible employees and annuitants who are members or associate members of the National Postal Mail Handlers Union (Union). The Union is the sponsor of

the Plan. However, Coventry Health Care (Coventry) is the underwriter and administrator for the Plan.

We performed a limited scope performance audit to determine whether Coventry complied with contract claim provisions relative to coordination of benefits, duplicate payments, and patient enrollment eligibility. Our audit of the FEHBP operations at Coventry covered claims from October 1, 2007 through August 31, 2008 for the Plan. During this period, Coventry paid approximately \$1.6 billion in FEHBP health benefit charges for the Plan.

Our auditors performed computer searches on the Plan's claims database using our data warehouse function to identify:

- Claims for services that were paid and potentially not coordinated with Medicare;
- Potential duplicate claim payments; and,
- Claims paid that were potentially incurred when no patient enrollment records existed during gaps in patient coverage or after termination of patient coverage with the Plan.

**COVENTRY AGREES
WITH \$2.3 MILLION IN
QUESTIONED CLAIM
OVERCHARGES**

The audit questioned \$2,300,076 in claim overcharges as follows:

- \$1,594,882 in overpayments because claims were not properly coordinated with Medicare as required by the FEHBP contract;
- \$509,559 in claim payments for patients who were not eligible for benefits;
- \$175,942 for duplicate claim payments; and,
- \$19,693 due to other claim overpayment errors.

Coventry agreed with all of these questioned overcharges.



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 for Federal employment. 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 personally identifiable information, privacy has emerged as a major management challenge for most Federal agencies and OPM is no exception.

Our auditors examine the computer security and information systems of private health insurance carriers participating in the FEHBP by performing general and application controls audits. *General controls* refer to the policies and procedures that apply to an entity's overall computing environment. *Application controls* are those directly related 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. In addition, we are responsible for performing an independent evaluation of OPM's information technology (IT) security environment, as required by the Federal Information Security Management Act of 2002.

During the current reporting period, we issued two final reports on information systems for OPM programs and health insurance carriers.

Information Technology Security Controls of the Benefits Financial Management System Washington, D.C.

Report No. 4A-CF-00-10-018
SEPTEMBER 10, 2010

The Federal Information Security Management Act of 2002 (FISMA) is designed to ensure that the information systems and data supporting operations are adequately protected. FISMA emphasizes that agencies implement security planning as part of their information systems. A critical aspect of security planning involves annual program security reviews conducted or overseen by each agency's Inspector General.

Consequently, we audited OPM's compliance with FISMA requirements defined in the Office of Management and Budget's fiscal year (FY) 2010 Reporting Instructions for the Federal Information Security Management Act and Agency Privacy Management. Our audit encompassed FISMA compliance for two OPM systems and the agency's



overall information security program. One of the systems we audited was the Benefits Financial Management System (BFMS), which is one of OPM's 43 critical IT systems comprised of multiple applications that provide management and accounting support to OPM programs.

Our audit revealed that the system owners did not have a complete understanding of the applications included in the BFMS umbrella of systems. As a result, the BFMS independent security control test, the internal self-assessment of security controls, and the system's contingency plan did not cover all applications that should have been included in the scope of these activities.

In addition to the concerns related to the BFMS application inventory, we documented the following opportunities for improvement:

- The information system security plan for the BFMS is missing several critical elements required by the National Institute of Standards and Technology (NIST) Special Publication 800-18.
- The security controls classified were not consistent with the control classification used by the system owner during the security control self-assessment.
- The BFMS self-assessment indicated that there were no security weaknesses in the system; however, our review identified multiple weaknesses in the BFMS security control structure. Therefore, aspects of the self-assessment process are not functioning as intended.
- We independently tested 25 of the NIST 800-53 controls for the BFMS and found that 6 of these security controls were not in place during the fieldwork phase of the audit.

Information Systems General and Application Controls at BlueCross BlueShield of Florida

Jacksonville, Florida

REPORT NO. 1A-10-41-09-063

MAY 21, 2010

Our audit focused on the claims processing applications used to adjudicate FEHBP claims for BlueCross BlueShield of Florida (BCBSFL), as well as the various processes and IT systems used to support these applications.

Application Controls

There are 63 independent BCBS plans that process health benefits claims for FEHBP members. At most plans, claims are initially processed through a local claims processing system and then sent to the FEP Express national system for final adjudication. These local systems typically include validation edits that prevent inappropriate health benefit claims transactions from being entered and processed, and are primarily designed to detect abusive billing activity. Some plans use internally developed edits, while others use commercially available medical edit software. Our audits have demonstrated that there is considerable inconsistency among the BCBS plans regarding the scope and effectiveness of edits being used for FEHBP claims processing.

At the BCBSFL, we evaluated medical edits in the local claims processing system and in the FEP Express by testing a set of claims with known defects and comparing expected results with the actual results obtained during the exercise. While the BCBSFL had implemented many controls in its claims adjudication process, the system lacks edits to prevent common types of invalid health benefit claims transactions. The system processed test claims with inconsistent



combinations of procedure and diagnosis codes, and invalid procedure codes for the type of provider, without encountering edits that would suspend the transactions pending further review.

A more significant finding, however, is that the FEP Express national claims processing system is lacking all but the most basic edits to prevent invalid transactions. We recommended that the Association implement medical edits at the national level instead. The Association did not fully concur with our recommendations; however, after further advice from OPM, they agreed to evaluate the feasibility of centrally located medical edits.

General Controls

The BCBSFL established a comprehensive series of IT policies and procedures to create an awareness of IT security at the Plan. The BCBSFL has also implemented an adequate risk assessment methodology and IT security-related human resources controls. We documented adequate controls to prevent unauthorized access to the BCBSFL physical facilities; however, we found two areas where logical access controls could be improved: weak password requirements for one critical information system, and problems with content filters designed to encrypt sensitive data.

To prevent unauthorized changes to application and system software, BCBSFL established policies and procedures to ensure that modifications occur in a controlled environment. BCBSFL's business continuity plans contain most of the key elements suggested by relevant guidance and publications, and are periodically reviewed, updated, and tested.



Internal Audits

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 activity is the audit of OPM's consolidated financial statements required under the Chief Financial Officers (CFO) Act of 1990. Our staff also conducts performance audits covering other internal OPM programs and functions.

Quality Assurance Process Over Background Investigations Washington, D.C.

Report No. 4A-IS-00-09-060

JUNE 22, 2010

We conducted a performance audit to determine if OPM's Federal Investigative Services (FIS) has effectively implemented controls for the quality assurance process over background investigations. FIS is responsible for conducting background investigations on Federal applicants, employees, and contractor personnel to determine their fitness and suitability to hold security clearances. Background investigations are conducted to resolve issues, enforce the civil service laws, rules and regulations, and verify the qualifications of applicants for certain high level administrative and professional positions. FIS conducts approximately 90 percent of all personnel background investigations for the Federal government.

During FY 2009, FIS contracted with US Investigations Services, Inc. (USIS); KeyPoint Government Solutions (KGS), formerly Kroll; and CACI International, Inc. (CACI), hereafter referred to as the "contractors", to assist with completing background investigations. FIS currently has almost 8,600 Federal and contract staff devoted to the background investigations program, including 6,800 Federal and contractor field background investigators, hereafter referred to as "investigators".

To ensure that FIS was adhering to the quality assurance process and to determine its efficiency, our auditors tested the:

- policies for reviewing closed cases;
- training records for investigators and reviewers; and,
- falsification and integrity process.

Our auditors determined that FIS has an adequate quality control process over background investigations except for the following areas which require improvement:

- The areas of training, the quality case review initiative, and the use of an integrity statement could be strengthened to have a more positive impact on the quality assurance process;
- Random quality assurance reviews of cases were not in place for the last half of FY 2009;
- USIS and KGS did not provide an OPM approved training course to employees who conduct record checks;
- Eighteen of the 20 mentors we reviewed at FIS did not complete a mentor training course;
- Two of the 50 investigators that we sampled from KGS and USIS did not meet all qualifications needed to perform their duties as a background investigator;



- USIS did not conduct check rides for 2 of the 25 new investigators that we sampled;
- Seven of the 25 experienced FIS investigators we sampled did not have a check ride assessment conducted during the period October 1, 2008 to September 4, 2009;
- CACI does not have a process in place to document the results of their evaluations of investigators;
- FIS does not have controls in place to ensure that the contractors are submitting their evaluation results to the Contracting Officer's Representative;
- USIS did not forward misconduct issues to OPM within the required timeframe for 7 of the 40 investigators we sampled;
- The contractors did not have controls in place to conduct record source validations;
- FIS did not conduct the required number of record check reviews for all investigative assistants;
- CACI and KGS did not conduct re-contacts for 12 of the 50 new investigators that we sampled. In addition, CACI was unable to demonstrate whether their re-contacts were performed within the required timeframe; and,
- FIS did not conduct the required 3 re-contacts for 11 of the 80 investigators we sampled.

**QUALITY CONTROL
OVER BACKGROUND
INVESTIGATIONS
NEEDS IMPROVEMENT**



Special Audits

In addition to health insurance, OPM administers various other benefit programs for Federal employees which include the: Federal Employees' Group Life Insurance (FEGLI) program; Federal Flexible Spending Account (FSAFEDS) program; Federal Long Term Care Insurance Program (FLTCIP); and, Federal Employees Dental and Vision Insurance Program (FEDVIP). Our office also conducts audits of Pharmacy Benefit Managers (PBMs) that coordinate pharmacy benefits for the FEHBP carriers. The objective of these audits is to ensure that costs charged and services provided to Federal subscribers are in accordance with the contracts and applicable Federal regulations. Additionally, our staff performs audits of the Combined Federal Campaign (CFC) to ensure that monies donated by Federal employees are properly handled and disbursed to charities according to the wishes of the employees.

DENTAL AND VISION INSURANCE PROGRAM

The Federal Employees Dental and Vision Benefits Enhancement Act of 2004 established a dental and vision benefits program for Federal employees, annuitants, and their eligible family members. OPM awarded 10 carriers with 7 year contracts to provide dental and vision insurance services for the FEDVIP.

During this reporting period, we issued one report on the program for contract years 2007 and 2008.

Federal Employees Dental and Vision Insurance Program Operations as Administered by Government Employees Health Association, Inc. Lee's Summit, Missouri

Report No. 1B-31-00-10-006

SEPTEMBER 27, 2010

In August 2006, OPM awarded a contract to the Government Employees Health Association, Inc. (GEHA) to administer dental benefits under the FEDVIP. We tested application controls over claim benefit payments, administrative expenses, premiums, and cash management activities for contract years 2007 and 2008. In addition, we reviewed Health Insurance

Portability and Accountability Act compliance, fraud and abuse policies, and subcontracts for conformance with the terms of the OPM contract. During this period, benefit charges totaled \$71.2 million and premiums received totaled \$81 million.

We developed 22 dental claim case scenarios based on information provided by GEHA and the best practices of health insurance carriers. We reviewed the results from the test cases to determine whether GEHA had proper application controls in place over its claims processing and check writing systems to ensure that FEDVIP transactions were valid, properly authorized, and accurately processed. We also reviewed \$353,841 in administrative expenses paid during 2007 and 2008 to determine whether the expenses were actual, necessary, reasonable, and allocable to the program.

Finally, we reviewed approximately \$8.5 million in premiums received during 2008 to determine whether the premium costs and relative components were derived from amounts that are allowable, allocable, and reasonable. FEDVIP transactions were traced to GEHA's bank statements to ensure that they were received timely and were accurately transferred into the appropriate accounts. Our review of cash management activities included an examination of bank statements and accounting procedures to ensure that FEDVIP funds were maintained separately from GEHA's other lines of business.



Our review revealed that GEHA administers FEDVIP dental benefits in accordance with the OPM contract.

LIFE INSURANCE PROGRAM

The Federal Employees' Group Life Insurance (FEGLI) program was created in 1954 by the Federal Employees' Group Life Insurance Act. OPM's Retirement and Benefits (R&B) office has overall responsibility for administering the FEGLI program, including the publication of program regulations and agency guidelines, and the receipt, payment, and investment of agency withholdings and contributions. The R&B office contracts with the Metropolitan Life Insurance Company (MetLife) to provide life insurance coverage to employees, annuitants, and their family members. Employee agencies are responsible for enrolling, informing and advising employees of program changes, determining eligibility, maintaining insurance records, withholding premiums from pay, remitting and reporting withholdings to OPM, and certifying salary and insurance coverage upon separation or death of the employee. MetLife's responsibilities under the contract are carried out by the Office of FEGLI, a separate unit of MetLife.

During this reporting period, we issued one report on the program operations for FYs 2007 and 2008.

Federal Employees' Group Life Insurance Program Operations at Metropolitan Life Insurance Company Oriskany, New York and Bridgewater, New Jersey Report No. 2A-II-00-09-065 JULY 20, 2010

This audit covered claim benefit payments, administrative expenses and cash management activities for FYs 2007 and 2008 concerning FEGLI's operations at MetLife. We also reviewed

MetLife's fraud and abuse program policies and procedures. During this period, benefit charges totaled approximately \$4.9 billion and administrative expenses totaled \$14.5 million.

In conducting the audit, we reviewed approximately \$21.8 million in benefit payments in FY 2008 for proper adjudication. We also reviewed approximately \$4.3 million in benefit overpayments, approximately \$2.8 million in administrative expenses and approximately \$907.6 million in letter of credit drawdowns for compliance with cash management policies and procedures. Finally, we examined MetLife's internal fraud and abuse policies and procedures to determine whether they met the contract requirements.

The audit identified \$708,518 in program undercharges related to administrative expenses. Specifically, we found:

- (\$98,646) in pension expense not calculated in accordance with Federal regulations;
- (\$609,872) in IT services that were inappropriately allocated to MetLife's other lines of business; and,
- MetLife commingled FEGLI cash and investment funds with its corporate cash and investment funds resulting in FEGLI assets not being separately identifiable from other MetLife assets.

As a result of our prior audit recommendations and changes in the economic environment in 2008, MetLife closed out all FEGLI investments in their pooled investment portfolio in December 2008, and transferred these funds to a separate investment portfolio established exclusively for the investment of FEGLI funds.

MetLife agreed with all undercharged amounts. Also, because of the actions undertaken by MetLife to open a separate investment portfolio for FEGLI funds, we considered the commingling issue to be resolved.

ENFORCEMENT ACTIVITIES

Investigative Cases

The Office of Personnel Management administers benefits from its trust funds, with approximately \$850 billion in assets for all Federal civilian employees and annuitants participating in the Civil Service Retirement System, the Federal Employees Retirement System, FEHBP, and FEGLI. These programs cover over eight million current and retired Federal civilian employees, including eligible family members, and disburse about \$101 billion annually. The majority of our OIG criminal investigative efforts are spent examining potential fraud against these trust funds. However, we also investigate OPM employee misconduct and other wrongdoing, such as fraud within the personnel security and suitability program administered by OPM.

During the reporting period, our office opened 67 criminal investigations and closed 89, with 249 still in progress. Our criminal investigations led to 30 arrests, 35 indictments and informations, 37 convictions and \$25,688,842 in monetary recoveries to OPM trust funds. Our criminal investigations, many of which we worked jointly with other Federal law enforcement agencies, also resulted in \$639,220,835 in criminal fines and penalties returned to the general fund of the Treasury, asset forfeitures, and court fees and/or assessments. For a complete statistical summary of our office's investigative activity, refer to the table on page 24.

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. We are participating members of health care fraud task forces across the nation. Where resources permit, we also



participate in DOJ and Department of Health and Human Services (HHS) sponsored Health Care Fraud Prevention and Enforcement Action Team (HEAT) Strike Forces. We work directly with U.S. Attorney's Offices nationwide to focus investigative resources in areas where fraud is most prevalent.

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

HEALTH CARE FRAUD CASES

FEHBP Recovers Over \$4.7 Million from AstraZeneca Settlement

In April 2010, AstraZeneca, a pharmaceutical manufacturer, entered into a settlement agreement to pay the Government \$520 million to resolve false claims allegations in connection with the marketing of the psychotropic drug Seroquel. The settlement will be split between the Federal government and state Medicaid programs.

The United States alleged that the company aggressively marketed Seroquel to psychiatrists and other physicians for certain uses that were not approved by the Food and Drug Administration (FDA) as a long term cure-all for a broad spectrum of psychiatric maladies including: anger management, dementia, post-traumatic stress, mood disorders, refractory depression, Parkinson's disease; and cognitive dysfunction, hostility, aggression and agitation in children. These unapproved uses were not medically accepted indications for which the United States and the state Medicaid programs provided coverage for Seroquel. Seroquel's FDA-approved use is limited to the treatment of schizophrenia and acute bipolar disorder.

The FEHBP received \$4,749,249 in the civil settlement.

This was a joint investigation with the HHS OIG, United States Postal Service (USPS) OIG, FDA Office of Criminal Investigations (OCI), and the OPM OIG.

Cardiologist Involved in False Billing Scheme

A cardiologist with privileges at three Chicago area hospitals was charged with health care fraud in a criminal information filed in January 2009, in U.S. District Court. Between January 2002 and July 2007, he received approximately \$13.4 million in reimbursements for claims involved in the billing scheme.

The cardiologist used his hospital privileges to access and obtain information about patients without their knowledge or consent. He then hired individuals to bill Medicare and other insurance carriers, including FEHBP carriers, for medical services that he purportedly rendered to patients he never treated. He typically waited a year after the patient left the hospital to submit the false claims for reimbursement for the highest level of cardiac care that required hands-on treatment in an intensive care unit on multiple days during the patients' hospital stays.

In August 2009, the cardiologist pled guilty to health care fraud. He was sentenced in August 2010, to five years in prison and ordered to pay restitution totaling approximately \$13 million. The Government has seized approximately \$11.3 million in various bank and investment accounts held by the cardiologist.

The FEHBP will receive \$184,229 of the restitution.

This case was investigated by the Federal Bureau of Investigation (FBI), HHS OIG, Department of Labor (DOL) OIG, DOL Employee Benefits Security Administration, and the OPM OIG.



FEHBP Recovers \$6.5 Million from Novartis Settlement

In September 2010, Novartis, a pharmaceutical manufacturer, agreed to pay the Government \$422.5 million in penalties and pled guilty to distribution of a misbranded drug to resolve criminal and civil liabilities arising from the illegal marketing of certain pharmaceutical products, including the epilepsy drug Trileptal. The company caused false claims for payment to be submitted to Federal insurance programs including Medicaid, Medicare, TRICARE programs, and the FEHBP.

The civil settlement resolves allegations that Novartis illegally promoted Trileptal for a variety of uses, including psychiatric and pain uses, which were not FDA-approved. In addition, the agreement resolves allegations that the company paid kickbacks to health care professionals to induce them to prescribe Trileptal and five other drugs: Diovan, Zelnorm, Sandostatin, Exforge, and Tekturna.

As a result of this settlement, the FEHBP will receive \$6,540,763.

This was a joint investigation by the FBI, HHS OIG, FDA OCI, USPS OIG, and the OPM OIG.

FEHBP Recovers \$2.4 Million from Ortho McNeil Settlement

This case was based on two *qui tams* filed in Massachusetts. Ortho-McNeil Pharmaceutical, LLC and Ortho-McNeil-Janssen Pharmaceuticals, Inc., both subsidiaries of Johnson & Johnson, have agreed to pay more than \$81 million to resolve criminal and civil liabilities arising from the illegal promotion of the epilepsy drug Topamax.

In accordance with the qui tam provisions of the False Claims Act, a private party can file an action on behalf of the United States and receive a portion of the settlement if the

government takes over the case and reaches a monetary agreement with the defendant(s).

Ortho-McNeil Pharmaceutical, LLC has also agreed to plead guilty to a misdemeanor and pay a \$6.14 million criminal fine for the misbranding of Topamax in violation of the Food, Drug and Cosmetic Act (FDCA). The FDA approved Topamax as an anti-epileptic drug for the treatment of partial onset seizures, but not for any psychiatric use. Once a pharmaceutical product is approved by the FDA, a manufacturer may not market or promote it for any use not specified in its new drug application. The unauthorized uses are also known as “unapproved” or “off-label uses.”

The Government alleged that Ortho-McNeil Pharmaceutical promoted the sale of Topamax for off-label psychiatric uses through a practice known as the “Doctor-for-a-Day” program. Using this program, Ortho-McNeil hired outside physicians to join sales representatives to promote Topamax for unapproved uses and doses; specifically, the promotion of Topamax to psychiatrists for psychiatric uses. However, Ortho-McNeil never applied for FDA approval of Topamax to treat any psychiatric disorders. There was no data from any well-controlled clinical trial to demonstrate that Topamax was safe and effective to treat any psychiatric conditions, thus creating the potential for patient harm.

In addition to the criminal fine, Ortho-McNeil-Janssen Pharmaceuticals will pay \$75.37 million to resolve civil allegations under the False Claims Act that it illegally promoted Topamax and caused false claims to be submitted to Government health care programs for a variety of psychiatric uses that were not medically approved and therefore not covered by those programs.

As a result of this settlement, the FEHBP received a recovery in the amount of \$2,354,931.

This case was investigated by the U. S. Attorney’s Office for the District of Massachusetts, HHS OIG, and the OPM OIG.



Settlement of Drug Manufacturer's Off-Label Marketing of Botox Returns \$5 Million to the FEHBP

In September 2010, Allergan, Inc., a pharmaceutical manufacturer, agreed to plead guilty and pay \$600 million to resolve allegations of the off-label promotion of Botox.

This case developed as the result of a *qui tam* lawsuit filed in Georgia. Allergan was the manufacturer of Botox, a prescription biological product containing botulinum toxin type A, that the FDA approved to treat crossed eyes, involuntary eyelid muscle contraction, involuntary neck muscle contraction, excessive underarm sweating, and adult upper-limb spasticity.

The Government alleged that, from 2000 to 2005, Allergan aggressively promoted Botox as a treatment for headache, pain, spasticity, and juvenile cerebral palsy. Allergan's off-label marketing tactics included calling on doctors who typically treat patients with off-label medications. In 2003, Allergan doubled the size of its reimbursement team to assist doctors in obtaining payment for off-label Botox injections. Allergan conducted workshops to teach doctors and their staff how to bill for off-label uses; performed detailed audits of doctors' billing records to demonstrate how they could make money by injecting Botox; and operated the Botox Reimbursement Solutions Hotline, which provided a wide array of free services to doctors for off-label uses. Allergan also lobbied Government health care programs to expand coverage for off-label uses, directed physician workshops and dinners focused on off-label uses, paid doctors to attend "advisory boards" promoting off-label uses, and created a purportedly independent online neurotoxin education organization to stimulate increased use of Botox for off-label indications.

The FEHBP received \$5,008,730 from the \$375 million civil settlement.

This was a joint investigation with the FBI, FDA OCI, HHS OIG, and the OPM OIG.

Drug Manufacturer Ignores FDA Regulations on Drugs Marketed for Pediatric Disorders Settlement Returns \$1.5 Million to FEHBP

This case was based on a *qui tam* lawsuit filed in Massachusetts. Forest Pharmaceuticals, Inc., a subsidiary of New York City-based Forest Laboratories, Inc., agreed to plead guilty to charges relating to obstruction of justice, the distribution of Levothroid, an unapproved new drug used to treat hypothyroidism; and, the illegal promotion of Celexa, an anti-depressant drug for use in treating children and adolescents. Forest Pharmaceuticals agreed to pay more than \$313 million to resolve criminal and civil liabilities arising from these matters.

Forest Pharmaceuticals agreed to plead guilty to obstructing justice, distributing an unapproved new drug in interstate commerce, and distributing a misbranded drug in interstate commerce. Under the plea agreement, Forest Pharmaceuticals will pay a criminal fine of \$150 million and will forfeit an additional \$14 million in assets.

Forest also will pay over \$149 million to resolve allegations under the False Claims Act, including a civil complaint filed by the United States in February 2009. This settlement concerns three drugs distributed by Forest: Levothroid, Celexa, and Lexapro. Levothroid was an orally administered drug used to treat a thyroid deficiency. The anti-depressant drugs Celexa and Lexapro were approved only for use in treatment of adult depression.

As a result of this settlement, the FEHBP recovered \$1,501,180.

This was a joint investigation with the FBI, FDA, HHS OIG, and the OPM OIG.



Novartis Settles Off-Label Promotion Allegations Over \$1.9 Million Returned to the FEHBP

In April 2010, Novartis Vaccines and Diagnostics, Inc. entered into a settlement agreement with the Government to pay a total of \$72.5 million to resolve allegations that Novartis knowingly promoted the sale and use of the drug Tobramycin, known under the brand name as TOBI, for off-label uses not approved by the FDA. Novartis merged with the Chiron Corporation to form Novartis Vaccines and Diagnostics. Prior to the merger, Chiron manufactured the medication TOBI as an FDA-approved treatment for cystic fibrosis.

The Government alleged that Novartis Vaccines illegally marketed and promoted TOBI, and defrauded the Government by causing doctors to prescribe the drug for uses that were not approved by the FDA; specifically, for diseases other than cystic fibrosis.

As a result of the settlement, the FEHBP recovered \$1,960,036.

This case was investigated by the HHS OIG, Department of Veterans' Affairs (VA) OIG, the Defense Criminal Investigative Service, and the OPM OIG.

Two Sentenced in "Phantom Provider" Medical Fraud

Two defendants who worked for a medical laboratory stole thousands of patients' medical insurance information to falsely bill insurance companies, including the identities of over 1,300 FEHBP members.

The investigation was initiated after a referral from an FEHBP contractor alleged that medical insurance

information was being used fraudulently by "phantom" or fictitious providers in the Los Angeles area. There was a common link amongst the Federal employee members whose identities had been stolen; all were billed by a local laboratory after having routine medical tests ordered by their physician.

The defendants, employees of the local laboratory, created a fictitious company with a name similar to the laboratory they worked for, and opened a business bank account and a merchant account to authorize online credit card payment processing.

They then ordered thousands of false return payment envelopes addressed to the fictitious company at a Post Office box, and they inserted the false return payment envelopes into legitimate patient bills for the employer's laboratory. Patients would receive the bills and use the false return payment envelopes to submit their payments. Patients could pay via a check or credit card. The defendants intercepted these payments and deposited the money into the fictitious business account.

The defendants are allegedly connected to criminal organizations in the Los Angeles area. It is believed the subjects also were involved in "selling" FEHBP members insurance information to the criminal organizations.

In August 2009, the defendants were indicted and subsequently pled guilty in Federal court to five counts of wire fraud and five counts of mail fraud. Both defendants were sentenced in May 2010, to 18 months and 12 months imprisonment and ordered to pay a combined \$252,000 in restitution. The affected FEHBP plans were able to recover funds by canceling checks issued to the fictitious company.

The case was investigated by the United States Secret Service, the California Department of Insurance, and the OPM OIG.



Husband and Wife Physicians Convicted of 10-Year Conspiracy to Commit Health Care Fraud

In April 2010, husband and wife physicians pled guilty to conspiracy charges related to health care fraud. This case involved a pain management clinic and the two physicians who owned and operated the clinic. The rheumatologist and allergist primarily treated pain management patients allegedly suffering from various debilitating medical conditions, including rheumatoid arthritis.

The physicians billed Medicare, Medicaid, FEHBP carriers, and numerous private health insurance carriers for services not rendered. For over 10 years, the doctors fraudulently billed insurance providers for performing paravertebral facet joint injections and blocks, facet joint nerve blocks, intercostal nerve blocks, and other procedures. Claims filed relating to these procedures totaled \$122.5 million. The total loss to the insurance providers is in excess of \$62.5 million.

The investigators determined that the doctors did not perform the billed procedures. At best, the patients were receiving trigger point injections. Thousands of records were obtained through search warrants executed in June 2009, and by subsequent subpoenas. In total, approximately 1,000 boxes of records were either seized or subpoenaed and reviewed and over 100 interviews conducted. Financial records revealed that the physicians owned and/or controlled 90 bank and investment accounts. Prior to the search warrants, the accounts and various residential and commercial properties were placed under a temporary restraining order, which prohibited the physicians from spending, selling, or moving the assets totaling approximately \$44 million.

The agents seized a total of \$1,514,666 in cash from the physicians' two clinic locations, their residence, and two safe deposit boxes. The seized cash was found packed in letter-sized envelopes placed in plastic grocery bags.

Prior to their trial, the physicians agreed to plead guilty and to forfeit over \$44 million in assets. The proceeds from the sale of those assets will be returned proportionately to the public and private health care insurers victimized by their fraud scheme. Potential losses to the FEHBP are approximately \$2.1 million.

This case was a joint investigation with the HHS OIG, Railroad Retirement Board (RRB) OIG, the FBI, Drug Enforcement Agency, Medicaid Fraud Control Unit, the National Insurance Crime Bureau, and the OPM OIG.

RETIREMENT FRAUD

Under the law, entitlement to annuity payments ceases upon the death of an annuitant or survivor annuitant (spouse). Retirement fraud involves intentional receipt and use of CSRS or FERS annuity benefit payments by an unentitled recipient.

Our Office of Investigations uses a variety of approaches to identify potential cases for investigation. We coordinate closely with OPM's Retirement and Benefits office to identify and address program vulnerabilities. Routinely, OPM's Retirement and Benefits office refers to our office potential fraud cases identified through computer death matches with the Social Security Administration (SSA). We also liaison with the Department of the Treasury's Financial Management Service to obtain payment information. Other referrals come from Federal, state, and local agencies, as well as private citizens.

Retired Federal Employee Concealed Mother's Death to Obtain Retirement Benefits

In December 2008, our office received a referral from OPM's Retirement and Benefits office requesting an investigation into the payment of a post-death annuity. OPM became aware of the death of a Federal survivor annuitant as a result of a computer death match with Social Security records. Because OPM was never notified of the annuitant's death in January



1991, the annuity payments continued, resulting in an overpayment of \$114,246.

Our investigators found that the annuitant's daughter, who was also a retired Federal annuitant, accessed her mother's bank account where the annuity payments were deposited. She admitted to taking the annuity money after her mother's death and using it for personal living expenses. The daughter stated that electronic funds transfer deposits continued to be applied to her mother's bank account and that she obtained checks in her mother's name, forged her mother's signature, and transferred the annuity benefits to her personal accounts. She also told investigators that she was the only person who had access to the account; that she thought she was entitled to the money, and that she thought the annuity would continue to be hers until the "money ran out." In her interview however, she admitted that she had attended Federal retirement seminars, where eligibility for an annuity or survivor annuity is thoroughly covered, making it very clear that she was not eligible to receive any benefit from her mother's annuity.

In January 2010, the daughter entered a guilty plea to a charge of theft of public money.

In May 2010, the daughter was sentenced to five months incarceration and 36 months of supervised release. During the first five months of her supervised release, she will be confined to her home. She was also ordered to make full restitution of \$114,246 to the FEHBP.

Man Sentenced for Stealing His Deceased Mother-in-Law's Retirement

This investigation was initiated in April 2009, with allegations that a Federal annuitant died in November 1997, but that annuity payments continued to be made until January 2007. OPM was never notified of the annuitant's death and received false statements in the form of an address verification letter attesting that she was alive.

The investigators determined that all payments to the deceased annuitant were hard copy checks mailed to an address belonging to her son-in-law. A forged address verification letter was sent to OPM in March 1998, listing the address of the son-in-law.

A review of copies of the hard copy checks revealed that the checks reflected the forged signature of the deceased annuitant and signature of the son-in-law. The checks also contained a Social Security number and date of birth that was traced back to the son-in-law.

The son-in-law admitted to cashing the checks of his deceased mother-in-law. During the time he fraudulently received the benefits, he was gainfully employed and receiving pension payments. He used his deceased mother-in-law's annuity payments to support his gambling habit. Since the payments were not part of his communal finances and were not deposited in his joint checking account with his wife, he was able to hide his gambling addiction. The investigation determined that his wife had no knowledge her husband was stealing her deceased mother's annuity payments.

In November 2009, the son-in-law pled guilty to theft of public money.

In May 2010, the son-in-law was sentenced to five years probation, a special assessment of \$100, and total restitution of \$91,779.

Daughter Pled Guilty to Theft of Public Money

Through a computer match conducted between OPM's active annuity roll and SSA's death records, OPM determined that a retired Federal annuitant died in November 1986. However, benefits continued to be paid after her death, resulting in an overpayment of \$184,196.

Our investigators interviewed the deceased annuitant's daughter, who admitted to taking the funds from the joint bank account she shared with her mother.



In August 2009, the daughter was indicted for theft of public money and pled guilty in October 2009.

In April 2010, the daughter was sentenced to six years probation, with 500 hours of community service within the first two years, and an additional 500 hours to be completed in the third year. She was also ordered to pay full restitution of \$184,196 to the Government.

Elementary School Teacher Convicted for Stealing Her Deceased Mother's Retirement Benefits

In April 2011, an elementary school teacher was sentenced to six months of home confinement and ordered to pay \$278,003 in restitution to OPM for fraudulently receiving her deceased mother's retirement benefits.

The deceased annuitant was also a teacher. She worked for the Bureau of Indian Affairs, Phoenix Indian School and retired after 36 years of Federal civil service. In addition, she received an annuity as a result of her husband's Federal service.

The annuitant died in January 1999; however, OPM was not notified of her death until June 2006 and her Federal retirement and survivor annuity continued to be paid electronically into a checking account.

The investigators determined that the annuitant's daughter was a co-signer on the bank account where her mother's retirement and survivor benefits were deposited. The mailing address for the bank statements corresponded back to the address of the daughter.

The daughter pled guilty, subsequent to her indictment for theft of public money.

SPECIAL INVESTIGATIONS

Our office investigates OPM employee misconduct and other wrongdoing, including allegations of fraud within OPM's personnel security and suitability program. OPM's Federal Investigative Services (FIS) conducts background investigations on

Federal applicants, employees, military members, and contractor personnel for suitability and security purposes. FIS conducts approximately 90 percent of all personnel background investigations for the Federal government. With a staff of over 8,600 Federal and contract employees, FIS processed approximately two million investigations in FY 2009. Agencies use the reports of investigations conducted by OPM to determine individuals' suitability for employment and eligibility for access to national security classified information.

The violations investigated by our special agents include fabrication by background investigators (i.e., the submission of work products that purport to represent investigative work which was not in fact performed). We consider such cases to be a serious national security concern. If a background investigation contains incorrect, incomplete, or fraudulent information, a qualified candidate may be wrongfully denied employment or an unsuitable person may be cleared and allowed access to Federal facilities or classified information.

Former OPM Contractor Charged with Falsifying Records

A former Illinois background investigator employed by a contracting firm that conducts background investigations for OPM's Federal Investigative Services pled guilty to one count of fraud.

The contract background investigator admitted to fabricating at least two source interviews involving potential Government employees requiring Top Secret clearances. However, investigators later confirmed that he fabricated 57 source interviews.

Between October 2005 and August 2006, in more than two dozen reports of background investigations, the contract investigator represented that he had interviewed an individual or reviewed a record regarding the subject of the background investigation when, in fact, he had not conducted the interview or obtained the record.



In January 2010, the contract investigator pled guilty to making a false statement. In April 2010, the contract investigator was sentenced to serve five months in prison, followed by 150 days of home confinement with monitoring to include voice recognition (only allowed out for work, religious services, and medical appointments). He was also ordered to serve 36 months of supervised release, and is required to pay \$69,611 in restitution to OPM.

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 591 formal complaints and calls on these hotlines during the reporting period. The table on page 24 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 310 contacts, including telephone calls, emails, 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 281 complaints during this reporting period, including telephone calls, emails, and letters.

OIG-INITIATED COMPLAINTS

Based on our knowledge of OPM program vulnerabilities, we initiate our own inquiries into possible cases involving fraud, abuse, integrity issues, and occasionally malfeasance.

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

CORRECTION OF PRIOR PERIOD SEMI-ANNUAL REPORT

In our semiannual report for the period ending March 31, 2010, we inadvertently underreported the amount that the FEHBP received in a civil settlement with Alpharma, Inc., a pharmaceutical manufacturer. The actual recovery to the FEHBP was \$485,000 instead of the \$416,000 that was reported. The \$69,000 adjusted increase is reflected in recoveries for this reporting period.



Administrative Sanctions of FEHBP 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 31,267 active suspensions and debarments from the FEHBP.

During the reporting period, our office issued 261 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 1,267 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, through it, their health insurance coverage. 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.



Colorado Anesthesiologist Debarred After Felony Drug Conviction

In June 2010, we debarred a Colorado licensed anesthesiologist for three years after he was convicted for distribution and unlawful possession with intent to distribute a controlled substance. This case was referred to the administrative sanctions staff by our Office of Investigations.

According to the plea agreement, the anesthesiologist illegally wrote and sold a prescription for Oxycodone to undercover police officers. He later supplied an undercover police officer with Methylendioxy-methamphetamine, commonly referred to as MDMA or “Ecstasy”. On both occasions, the anesthesiologist used his professional license to illegally obtain and distribute the controlled substances. He also admitted to regularly abusing opioids and other controlled substances, even during office hours.

In August 2009, the anesthesiologist pled guilty to two counts of distribution and unlawful possession with intent to distribute a controlled substance. Based on his guilty plea the Colorado State Board of Medical Examiners ordered that the anesthesiologist relinquish his medical license for a period of two years.

He was sentenced to 10 years probation; 180 days home detention; participation and completion of a drug abuse treatment program; and 150 hours of community service.

The FEHBP administrative sanctions statute makes debarment of providers convicted of these types of offenses mandatory. Information developed by our investigators established that the anesthesiologist was paid for services to FEHBP enrollees. We concluded that sufficient evidence existed to debar.

Washington State Physician Assistant Debarred for Health Care Fraud

During a prior reporting period, we reported our suspension of a Washington physician assistant, after his indictment for controlled substances violations and health care fraud. The case was jointly referred by our Office of Investigation and a FEHBP carrier.

In February 2010, the physician assistant pled guilty to three counts of health care fraud. In a plea agreement, the physician assistant admitted to submitting claims for reimbursement to a Federal health care program. The claims, which contained materially false statements and misrepresentations, were for services rendered at a higher rate than the provider would otherwise have been eligible. The claims also falsely stated that at the time the services were rendered, a medical doctor was present.

The conviction is the basis for a mandatory debarment under OPM’s statutory administrative sanctions authority. Accordingly, we proposed debarment of this provider for a period of three years, commencing August 2010.



Statistical Summary of Enforcement Activities

JUDICIAL ACTIONS:

Arrests	30
Indictments and Informations	35
Convictions	37

JUDICIAL RECOVERIES:

Restitutions and Settlements	\$25,688,842
Fines, Penalties, Assessments, and Forfeitures	\$639,220,835 ¹

RETIREMENT AND SPECIAL INVESTIGATIONS

HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry	25
Referred to:	
OPM Program Offices	184
Other Federal Agencies	101
Total	310

HEALTH CARE FRAUD HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry	70
Referred to:	
OPM Program Offices	54
Other Federal/State Agencies	52
FEHBP Insurance Carriers or Providers	105
Total	281

Total Hotline Contacts and Complaint Activity 591

ADMINISTRATIVE SANCTIONS ACTIVITY:

Debarments and Suspensions Issued	261
Health Care Provider Debarment and Suspension Inquiries	1,267
Debarments and Suspensions in Effect at End of Reporting Period	31,267

¹ This figure represents criminal fines and criminal penalties returned not to OPM, but to the general fund of the Treasury. It also includes asset forfeitures and court assessments and/or fees resulting from criminal investigations conducted by our office. Many of these criminal investigations were conducted jointly with other Federal agencies, who share the credit for the fines, penalties, assessments, and forfeitures.

APPENDICES

APPENDIX I Final Reports Issued With Questioned Costs for Insurance Programs April 1, 2010 to September 30, 2010

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	5	\$20,443,424
B. Reports issued during the reporting period with findings	11	57,627,455
Subtotals (A+B)	16	78,070,879
C. Reports for which a management decision was made during the reporting period:	9	23,267,333
1. Disallowed costs	N/A	24,169,503
2. Costs not disallowed	N/A	(902,170) ²
D. Reports for which no management decision has been made by the end of the reporting period	7	54,803,546
E. Reports for which no management decision has been made within 6 months of issuance	0	0

²Represents the net of allowed costs, which includes overpayments and underpayments to insurance carriers.



APPENDIX II – A
Final Reports Issued with Recommendations
for All Other Audit Entities
April 1, 2010 to September 30, 2010

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	1	\$85,328
B. Reports issued during the reporting period with findings	0	0
Subtotals (A+B)	1	85,328
C. Reports for which a management decision was made during the reporting period:	1	85,328
1. Disallowed costs	N/A	85,328
2. Costs not disallowed	N/A	0
D. Reports for which no management decision has been made by the end of the reporting period	0	0
E. Reports for which no management decision has been made within 6 months of issuance	0	0

APPENDIX II – B
Final Reports Issued with Recommendations
for Better Use of Funds
April 1, 2010 to September 30, 2010

Subject	Number of Reports	Dollar Value
No activity during this reporting period	0	\$0



APPENDIX III

Health Insurance Audit Reports Issued

April 1, 2010 to September 30, 2010

Report Number	Subject	Date Issued	Questioned Costs
1B-45-00-09-062	Mail Handlers Benefit Plan in Rockville, Maryland	April 14, 2010	\$ 2,300,076
1D-53-00-09-029	HealthPartners in Bloomington, Minnesota	April 29, 2010	7,279
1C-EE-00-09-057	Humana Health Plan, Inc. of South Florida in Louisville, Kentucky	May 6, 2010	0
1C-2N-00-10-020	PacifiCare of Oklahoma in Cypress, California	May 7, 2010	0
1C-A3-00-10-001	PacifiCare of Arizona in Cypress, California	May 21, 2010	0
1C-D6-00-10-003	PacifiCare of Colorado in Cypress, California	May 21, 2010	0
1A-10-85-09-023	CareFirst Blue Cross Blue Shield in Owings Mills, Maryland	May 21, 2010	1,366,149
1C-CY-00-10-024	PacifiCare of California in Cypress, California	June 3, 2010	0
1D-9K-00-09-026	Altius Health Plan in South Jordan, Utah	June 28, 2010	254,925
1C-51-00-10-051	Health Insurance Plan of New York in New York, New York Proposed Rate Reconciliation	July 15, 2010	0
1A-99-00-09-046	Global Omnibus Budget Reconciliation Act of 1990 Claims for BlueCross and BlueShield Plans in Washington, D.C.	July 19, 2010	4,237,986
1C-JG-00-10-049	Fallon Community Health Plan in Worcester, Massachusetts Proposed Rate Reconciliation	July 20, 2010	0
1C-59-00-10-028	Kaiser Foundation Health Plan, Inc., Northern California in Burbank, California	July 20, 2010	0
1C-62-00-10-029	Kaiser Foundation Health Plan, Inc., Southern California in Burbank, California	July 20, 2010	0



APPENDIX III Health Insurance Audit Reports Issued

April 1, 2010 to September 30, 2010

(Continued)

Report Number	Subject	Date Issued	Questioned Costs
1C-E9-00-10-054	United Healthcare in Hartford, Connecticut Proposed Rate Reconciliation	July 21, 2010	0
1C-MK-00-10-005	Blue Choice in Rochester, New York	July 22, 2010	2,486,049
1C-9F-00-09-064	OSF HealthPlans, Inc. in Peoria, Illinois	July 22, 2010	325,592
1C-GG-00-10-052	Geisinger Health Plan in Danville, Pennsylvania Proposed Rate Reconciliation	July 22, 2010	0
1C-22-00-10-010	Aetna HealthFund in Blue Bell, Pennsylvania	July 27, 2010	0
1C-GV-00-10-004	Preferred Care in Rochester, New York	July 27, 2010	746,845
1C-54-00-09-048	Group Health Cooperative in Seattle, Washington	September 8, 2010	37,816,559
1C-SW-00-09-047	HealthAmerica Pennsylvania, Inc. in Harrisburg, Pennsylvania	September 23, 2010	4,860,216
1B-31-00-10-006	Government Employees Health Association, Inc. in Lee's Summit, Missouri	September 27, 2010	0
1C-Q1-00-10-026	Lovelace Health Plan in Albuquerque, New Mexico	September 27, 2010	3,225,779
TOTALS			\$57,627,455



APPENDIX IV

Life Insurance Audit Reports Issued

April 1, 2010 to September 30, 2010

Report Number	Subject	Date Issued	Questioned Costs
2A-II-00-09-065	Federal Employees' Group Life Insurance Program's Operations at Metropolitan Life Insurance Company in Oriskany, New York and Bridgewater, New Jersey	July 20, 2010	\$(708,518)
TOTAL			\$(708,518)

APPENDIX V

Internal Audit Reports Issued

April 1, 2010 to September 30, 2010

Report Number	Subject	Date Issued
4A-IS-00-09-060	Quality Assurance Process over Background Investigations in Washington, DC	June 22, 2010

APPENDIX VI

Information Systems Audit Reports Issued

April 1, 2010 to September 30, 2010

Report Number	Subject	Date Issued
1A-10-41-09-063	Information Systems General and Application Controls at BlueCross BlueShield of Florida in Jacksonville, Florida	May 21, 2010
4A-CF-00-10-018	Information Technology Security Controls for OPM's Benefits Financial Management System in Washington, D.C.	September 10, 2010



APPENDIX VII

Summary of Audit Reports More Than Six Months Old Pending Corrective Action

April 1, 2010 to September 30, 2010

Report Number	Subject	Date Issued
1A-10-15-02-007	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee; 13 total recommendations; 1 open recommendation	October 1, 2002
1A-10-41-03-031	BlueCross BlueShield of Florida in Jacksonville, Florida; 19 total recommendations; 3 open recommendations	May 3, 2004
1A-10-29-02-047	BlueCross BlueShield of Texas in Dallas, Texas; 13 total recommendations; 2 open recommendations	July 28, 2004
1A-10-55-04-010	Independence BlueCross in Philadelphia, Pennsylvania; 5 total recommendations; 1 open recommendation	December 15, 2004
4A-IS-00-05-026	Information Technology Security Controls of OPM's Electronic Questionnaire for Investigative Processing; 20 total recommendations; 1 open recommendation	June 16, 2005
1A-10-85-04-007	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 1 open recommendation	July 27, 2005
1A-99-00-04-027	Global Duplicate Claim Payment for BlueCross and BlueShield Plans in Washington, D.C.; 1 total recommendation; 1 open recommendation	February 7, 2006
1A-10-32-05-034	BlueCross BlueShield of Michigan in Detroit, Michigan; 12 total recommendations; 1 open recommendation	March 24, 2006
1A-10-47-05-009	BlueCross BlueShield of Wisconsin in Milwaukee, Wisconsin; 6 total recommendations; 2 open recommendations	June 5, 2006
1A-10-78-05-005	BlueCross BlueShield of Minnesota in Eagan, Minnesota; 11 total recommendations; 1 open recommendation	September 15, 2006
4A-CI-00-06-016	Federal Information Security Management Act for FY 2006; 12 total recommendations; 1 open recommendation	September 22, 2006
1A-10-69-06-025	Regence BlueShield of Washington in Seattle, Washington; 2 total recommendations; 1 open recommendation	January 3, 2007
4A-CI-00-07-015	The Privacy Program at OPM; 7 total recommendations; 3 open recommendations	January 25, 2007
1A-10-58-06-038	Regence BlueCross BlueShield of Oregon in Portland, Oregon; 5 total recommendations; 2 open recommendations	January 31, 2007
1A-10-09-05-087	BlueCross BlueShield of Alabama in Birmingham, Alabama; 14 total recommendations; 2 open recommendations	February 27, 2007
1A-99-00-05-023	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 2 total recommendations; 1 open recommendation	March 29, 2007



APPENDIX VII

Summary of Audit Reports More Than Six Months Old Pending Corrective Action

April 1, 2010 to September 30, 2010

(Continued)

Report Number	Subject	Date Issued
4A-CF-00-05-028	Administration of the Prompt Payment Act at OPM; 12 total recommendations; 8 open recommendations	April 16, 2007
1A-10-15-05-046	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee; 11 total recommendations; 2 open recommendations	July 25, 2007
1A-10-33-06-037	BlueCross BlueShield of North Carolina in Durham, North Carolina; 19 total recommendations; 2 open recommendations	August 28, 2007
4A-CI-00-07-007	Federal Information Security Management Act for FY 2007; 9 total recommendations; 3 open recommendations	September 18, 2007
1A-10-41-06-054	BlueCross BlueShield of Florida in Jacksonville, Florida; 11 total recommendations; 4 open recommendations	October 12, 2007
1A-10-42-07-004	BlueCross BlueShield of Kansas City in Kansas City, Missouri; 5 total recommendations; 2 open recommendations	December 14, 2007
1A-10-07-07-016	BlueCross BlueShield of Louisiana in Baton Rouge, Louisiana; 13 total recommendations; 2 open recommendations	January 18, 2008
1C-3U-00-05-085	UnitedHealthcare of Ohio, Inc., in West Chester, Ohio; 2 total recommendations; 2 open recommendations	January 18, 2008
1A-10-18-06-052	Anthem Midwest in Mason, Ohio; 16 total recommendations; 2 open recommendations	February 20, 2008
4A-RI-00-05-037	OPM's Reclamation Process in Washington, D.C.; 10 total recommendations; 1 open recommendation	March 18, 2008
1A-99-00-06-001	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 1 open recommendation	March 20, 2008
1C-G2-00-07-044	Arnett HMO Health Plan in Lafayette, Indiana; 2 total recommendations; 2 open recommendations	June 12, 2008
1A-99-00-08-007	Global Coordination of Benefits for BlueCross and BlueShield Plans (Contract Year 2006) in Washington, D.C.; 3 total recommendations; 1 open recommendation	June 25, 2008
1C-SV-00-07-056	Coventry Health Care of Iowa, Inc. in St. Louis, Missouri; 2 total recommendations; 2 open recommendations	June 25, 2008
1A-99-00-08-009	Global Coordination of Benefits for BlueCross and BlueShield Plans (Contract Year 2005) in Washington, D.C.; 3 total recommendations; 1 open recommendation	August 11, 2008
4A-CA-00-07-054	The Agreement between the OPM and the National Archives and Records Administration for Storage and Servicing of Records in Washington, D.C.; 8 total recommendations; 3 open recommendations	August 26, 2008



APPENDIX VII

Summary of Audit Reports More Than Six Months Old Pending Corrective Action

April 1, 2010 to September 30, 2010

(Continued)

Report Number	Subject	Date Issued
1A-99-00-07-043	Health Care Service Corporation in Chicago, Illinois and Richardson, Texas; 22 total recommendations; 3 open recommendations	September 5, 2008
1A-99-00-08-008	Global Duplicate Claim Payments for BlueCross and BlueShield Plans (Contract Years 2004 and 2005) in Washington, D.C.; 2 total recommendations; 1 open recommendation	September 11, 2008
1C-6Q-00-07-029	Universal Care, Inc., of California in Signal Hill, California; 2 total recommendations; 2 open recommendations	September 15, 2008
4A-CI-00-08-022	Federal Information Security Management Act for FY 2008; 19 total recommendations; 11 open recommendations	September 23, 2008
4A-CF-00-08-025	OPM's FY 2008 Consolidated Financial Statements; 6 total recommendations; 6 open recommendations	November 14, 2008
1A-10-83-08-018	Health Care Service Corporation in Tulsa, Oklahoma; 16 total recommendations; 4 open recommendations	January 9, 2009
1B-45-00-08-016	Coventry Health Care as Underwriter and Administrator for the Mail Handlers Benefit Plan in Rockville, Maryland; 16 total recommendations; 11 open recommendations	March 26, 2009
4A-CI-00-09-053	Flash Audit Report – Information Technology Security Program at OPM in Washington, D.C.; 4 total recommendations; 2 open recommendations	May 27, 2009
4A-CA-00-08-036	Inventory and Management of OPM's Sensitive Property; 7 total recommendations; 4 open recommendations	June 15, 2009
1A-99-00-08-065	Global Claims-to-Enrollment Match for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 4 open recommendations	June 23, 2009
1A-99-00-09-011	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 3 open recommendations	July 20, 2009
1A-99-00-09-036	Global Duplicate Claim Payments for BlueCross and BlueShield Plans in Washington, D.C.; 2 total recommendations; 2 open recommendations	October 14, 2009
4A-CI-00-09-031	Federal Information Security Management Act for FY 2009; 30 total recommendations; 24 open recommendations	November 5, 2009
4A-CF-00-09-037	OPM's FY 2009 Consolidated Financial Statements; 3 total recommendations; 3 open recommendations	November 13, 2009
4A-CF-00-10-021	Service Credit Redeposit and Deposit System; 8 total recommendations; 8 open recommendations	January 8, 2010



APPENDIX VII

Summary of Audit Reports More Than Six Months Old Pending Corrective Action

April 1, 2010 to September 30, 2010

(Continued)

Report Number	Subject	Date Issued
1A-10-49-09-025	Horizon BlueCross BlueShield of New Jersey in Newark, New Jersey; 24 total recommendations; 1 open recommendation	February 12, 2010
3A-CF-00-09-041	The 2006 and 2007 Illowa Bi-State Combined Federal Campaigns in Davenport, Iowa; 15 total recommendations; 6 open recommendations	February 25, 2010
3A-CF-00-09-040	The 2006 and 2007 Fort Hood Combined Federal Campaigns in Killeen, Texas; 7 total recommendations; 4 open recommendations	March 11, 2010
1A-99-00-09-061	Global Assistant Surgeon Claims Overpayments for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 2 open recommendations	March 30, 2010
1A-99-00-10-009	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 4 open recommendations	March 31, 2010

APPENDIX VIII

Most Recent Peer Review Results

Subject	Date of Report	Result	Status
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the U.S. Office of Personnel Management <i>(Issued by the Office of Inspector General, U. S. Agency for International Development)</i>	June 2, 2010	Full Compliance	One recommendation not fully implemented ³
System Review Report for the U.S. Office of Personnel Management's Office of the Inspector General Audit Organization <i>(Issued by the Office of Inspector General, U. S. Agency for International Development)</i>	September 25, 2009	Pass	All recommendations fully implemented

³The U. S. Agency for International Development OIG suggested that we "obtain and utilize a case management system that has real time access with the ability to load investigative documents." We have recently procured new investigative case management system software. We are currently working with the software vendor to design the new system. We plan to fully implement the system after the certification and accreditation process is completed.



Index of Reporting Requirements

(Inspector General Act of 1978, As Amended)

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Section 4 (a) (2):	Review of legislation and regulations. No Activity
Section 5 (a) (1):	Significant problems, abuses, and deficiencies 1-23
Section 5 (a) (2):	Recommendations regarding significant problems, abuses, and deficiencies 1-12
Section 5 (a) (3):	Recommendations described in previous semiannual reports on which corrective action has not been completed. No Activity
Section 5 (a) (4):	Matters referred to prosecutive authorities 13-23
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. 27-32
Section 5 (a) (7):	Summary of particularly significant reports. 2-23
Section 5 (a) (8):	Audit reports containing questioned costs. 25-29
Section 5 (a) (9):	Audit reports containing recommendations for better use of funds. No Activity
Section 5 (a) (10):	Summary of unresolved audit reports issued prior to the beginning of this reporting period 30-33
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
Section 5 (a) (14) (A):	Peer reviews conducted by another OIG 33
Section 5 (a) (16):	Peer reviews conducted by the OPM OIG No Activity



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