



October 1, 2005

*through*

March 31, 2006

*Theodore Roosevelt*

*Commissioner*

*United States Civil Service Commission*

*May 13, 1889 – May 5, 1895*

**OFFICE OF THE  
INSPECTOR GENERAL**  
Semiannual Report  
to Congress

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

# OFFICE OF THE INSPECTOR GENERAL



## Productivity Indicators

### FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds . . . . .	\$29,613,171
Management Commitments to Recover Funds . . . . .	\$33,504,377
Recoveries Through Investigative Actions . . . . .	\$5,314,921

*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 . . . . .	31
Investigative Cases Closed. . . . .	44
Indictments and Informations . . . . .	24
Arrests . . . . .	21
Convictions . . . . .	13
Hotline Contacts and Complaint Activity. . . . .	550
Health Care Provider Debarments and Suspensions . . . . .	531
Health Care Provider Debarment and Suspension Inquiries. . . . .	2,688



**OFFICE OF THE  
INSPECTOR GENERAL**  
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# The Inspector General's Message

MAY 1, 2006

Since I became the Inspector General in 1990, two outstanding leaders have been instrumental in the growth of our organization from a small audit office in Washington, DC into a nationwide, multi-function organization. Therefore, it is with mixed emotions that I acknowledge the retirement of Deputy Inspector General Joseph Willever and Assistant Inspector General for Audits (AIGA) Harvey Thorp.

Following service in the U.S. Marine Corps, Joe began his civilian career with the Department of Defense. He came to what was then the Civil Service Commission in 1971 and became OPM's Deputy Inspector General for Audits in 1984. In 1989, when our statutory Office of the Inspector General was created, he was named the Deputy Inspector General. In that position he served as my principal advisor and alter ego, managing the office's operations and planning its future course. From my first contacts with this office until his retirement, I relied on Joe's advice and counsel about every aspect of the OIG's activities. He was the individual most responsible for the office's growth and continuing success as an audit and investigative organization. Successive OPM Directors as well came to trust and solicit his insight about critical issues facing the agency.

Joe's impact also extended well beyond our office and OPM. He cared deeply about the auditing profession and the inspector general community as a whole, and felt a strong sense of responsibility to apply his expertise on their behalf. He received numerous requests to serve those interests as a member of advisory groups, boards of directors, or steering committees, and he accepted as many as he could, consistent with his obligations as Deputy Inspector General. His professional and personal contributions gained him government-wide recognition and the respect of the entire federal IG and auditing community.

Mr. Willever and I were fortunate to have Harvey Thorp as the leader of our Office of Audits. Harvey began his federal career in 1968 as an entry-level auditor at the Civil Service Commission, and was appointed as OPM's Assistant IG for Audits in 1987. His professional skills and ability to work with managers throughout OPM and other agencies were essential to developing the wide range of capabilities that are represented in our audit organization. Harvey's professional vision enabled him to identify and respond to trends at a



## OFFICE OF PERSONNEL MANAGEMENT

very early stage. Among the issues, whose emerging importance he foresaw and addressed, were the importance of information systems audits as a separate specialty area, the growing cost of pharmacy benefits in Federal Employees Health Benefits Program (FEHBP) and the consequent need for improved audit oversight, and the importance of an audit field structure to bring our resources closer to work locations.

The Office of the Inspector General now faces a new era without these two men who contributed so much to shaping it into the professional organization it is today. I will miss them both as professional associates and as friends, and wish them God's continued blessings. They may be assured that the office will carry forward their commitment to serving the agency, their profession, and the American taxpayer.

A handwritten signature in black ink that reads "Patrick E. McFarland". The signature is written in a cursive, flowing style.

Patrick E. McFarland

Inspector General



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## Field Offices

# OFFICE OF THE INSPECTOR GENERAL







## Audit Activities

### Health and Life Insurance Carrier Audits

*The Office of Personnel Management (OPM) contracts with private-sector firms to provide health and life insurance through the Federal Employees Health Benefits Program (FEHBP) and the Federal Employees' Group Life Insurance program (FEGLI). Our office is responsible for auditing the activities of these programs to ensure that the insurance carriers meet their contractual obligations with OPM.*

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

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

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

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

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

During the current reporting period, we issued 22 final reports on organizations participating in the FEHBP, of which 19 contain recommendations for monetary adjustments in the aggregate amount of \$29.6 million due the FEHBP.

Appendix III (page 26) contains a complete listing of all health plan audit reports issued during this reporting period.



## AUDIT ACTIVITIES

### COMMUNITY-RATED PLANS

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

FEHBP regulations require each carrier to certify that the federal government is offered rates equivalent to the rates given to the two groups closest in subscriber size (“similarly sized subscriber groups,” or SSSGs) to the FEHBP. The rates are set by the FEHBP-participating carrier, which is responsible for selecting the two appropriate groups. When our auditors determine FEHBP did not receive equivalent rates, the FEHBP is entitled to a downward rate adjustment to compensate for any overcharges. Community-rated audits focus on ensuring that:

- The plans selected and rated the appropriate SSSGs;
- The FEHBP rates are equivalent to those charged to the SSSGs; and
- The loadings charged to the FEHBP are appropriate and reasonable.

*Loading is the rate adjustment for FEHBP’s modifications to the basic benefit package offered by a community-rated carrier. A loading may result in either an increase or reduction of the standard community rate charged by the carrier. For example, FEHBP permits coverage of all dependent children until age 22, while many plans provide such coverage only through age 19. In such a case, the FEHBP may receive an increase in its rate because of its extended coverage for children.*

During this reporting period, we issued 13 audit reports on community-rated plans. These reports contain recommendations to require the plans to return over \$7.7 million to the FEHBP.

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### Humana Health Plan, Inc.

Chicago

Louisville, Kentucky

Report No. 1C-75-00-04-084

NOVEMBER 23, 2005

Humana Health Plan, Inc. of Chicago provides primary health care services to its members throughout the Chicago metropolitan area. This audit of this plan covered contract years 2001 through 2004. During this period, the FEHBP paid the plan approximately \$292 million in premiums.

We found that Humana had overstated the FEHBP rates by \$2,980,146 for contract years 2003 and 2004 due to defective pricing. In each year, the plan gave a discount to a SSSG that was greater than the discount it gave to the FEHBP. In addition, we determined the FEHBP is due \$204,381 for investment income lost to the FEHBP as a result of the overcharges.

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

The plan agrees that it overcharged the FEHBP \$2,980,146 for defective pricing. It also agrees

that it owes the FEHBP lost investment

**FEHBP Overcharged  
\$3.2 Million**

income, but disagrees with the amount due because it disputes the method we used to calculate it.



**Aetna Health Inc.**  
**New Jersey and Southeastern Pennsylvania**  
**Blue Bell, Pennsylvania**  
**Report No. 1C-P3-00-05-029**  
**FEBRUARY 22, 2006**

Aetna Health Inc. of New Jersey and Southeastern Pennsylvania provides primary health care services to plan members throughout the State of New Jersey and Southeastern Pennsylvania. Our audit of the plan covered contract years 2001, 2003, and 2004. The FEHBP paid premiums of \$425 million to the plan during this period.

We identified \$1,714,920 in inappropriate health benefit charges to the FEHBP for contract year 2001, including \$284,680 for lost investment income. Contrary to the FEHBP regulations, the plan did not apply the largest discount it gave to a similarly sized subscriber group to the FEHBP. We determined that, although the plan applied a 5.66 percent discount to the FEHBP rates, the discount should have been 7.17 percent. The plan agreed with the report findings and fully reimbursed the FEHBP.

***Plan Returns  
Over \$1.7 Million  
to 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 or unions. In addition, experience-rated health maintenance organizations fall into this category.

The universe of experience-rated plans currently consists of approximately 110 audit sites. When

auditing these plans, our auditors generally focus on three key areas.

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

During this reporting period, we issued seven experience-rated audit reports. In these reports, our auditors recommended that the plans return \$12.4 million in inappropriate charges and lost investment income to the FEHBP.

## BLUECROSS BLUESHIELD SERVICE BENEFIT PLAN

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

We issued six BlueCross BlueShield experience-rated reports during the reporting period. Our auditors noted \$9.7 million in questionable contract costs charged to the FEHBP, including lost investment income on these questioned costs.



## AUDIT ACTIVITIES

### **BlueCross BlueShield of Michigan** **Detroit, Michigan** **Report No. 1A-10-32-05-034** **MARCH 24, 2006**

Our audit of the FEHBP operations at BlueCross BlueShield of Michigan addressed health benefit payments, miscellaneous payments and credits, administrative expenses, and cash management activities for contract years 2001 through 2004. During the audit period, the plan paid approximately \$445 million in FEHBP claims and \$55 million in administrative expenses.

***Auditors Question  
\$3.2 Million for  
Inappropriate Health  
Benefit Charges***

Our auditors determined that inappropriate charges to the FEHBP totaled \$2,929,440, as follows:

- \$2,321,511 for subcontracts for which OPM’s prior approval had not been obtained, as required by federal acquisition regulations;
- \$430,184 for claims not priced in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), which limits benefit payments for certain inpatient services provided to annuitants age 65 and older who are not covered under Medicare Part A;
- \$97,104 in other claim payment errors;
- \$50,237 for other overstated administrative expenses; and
- \$30,404 for unreturned refunds and recoveries.

We computed lost investment income of \$281,146 on the questioned charges. The BCBS Association agreed with \$519,880 of the findings, but disagreed with all of the questioned charges related to the unapproved subcontracts and with \$90,705 related to OBRA 90.

### **Global Duplicate Claim Payments for BlueCross BlueShield Plans** **Report No. 1A-99-00-04-027** **FEBRUARY 7, 2006**

We performed a limited-scope audit to determine whether the BlueCross BlueShield plans complied with contract provisions relative to duplicate claim payments.

Using our data warehouse, the auditors screened the BCBS national claims database to detect duplicate claims for services rendered from January 1, 2000 through December 31, 2002. This process identified 7,004 potentially duplicate claims, and revealed that all 63 BCBS plan sites had made duplicate payments. We noted that the BCBS claims system had failed to identify 59 percent of these claims as duplicates.

***BCBS Association  
Agrees with \$3 Million  
in Duplicate Claim  
Payments***

We determined that the FEHBP was overcharged \$2,994,477 for these duplicate payments. The BCBS Association agreed with the overcharges.



## EMPLOYEE ORGANIZATION PLANS

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

The largest employee organizations are federal employee unions and associations. Some examples are: the American Postal Workers Union, the Government Employees Hospital Association, the National Association of Letter Carriers, and the National Postal Mail Handlers Union.

We issued one employee organization plan audit report during this reporting period.

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### National League of Postmasters of the United States as Sponsor for the Postmasters Benefit Plan

Alexandria, Virginia

Report No. 1B-36-00-03-058

DECEMBER 5, 2005

The Postmasters Benefit Plan (Plan) was an employee organization plan sponsored by the National League of Postmasters of the United States (NLP). Enrollment in the plan was open to all federal employees and annuitants eligible to enroll in the FEHBP and who were members of the NLP. In November 2005, OPM advised the NLP that it intended to terminate the Plan's participation in the FEHBP. The NLP subsequently withdrew the Plan, effective January 23, 2006.

Our audit of the FEHBP operations at NLP covered administrative expenses for 1997 through 2001. During this period, NLP charged the FEHBP approximately \$40 million in administrative

***NLP Owes Over  
\$8 Million to the  
FEHBP***

expenses. Due to concerns raised in subscriber and provider complaints, we expanded our audit scope to also include costs related to NLP's subcontract with Medicare Plus, Inc. (Medicare) in 2002 and 2003. Medicare provided various medical, administrative, and management services to the Postmasters Benefit Plan.

Our auditors determined that inappropriate charges to the FEHBP totaled \$7,444,206, as follows:

- \$6,474,000 for a subcontract with Medicare that was not approved by OPM's contracting officer;
- \$873,786 for a pension credit that was not applied to the FEHBP; and
- \$96,410 for rental income that was not applied to the FEHBP.

Lost investment income on these questioned charges was \$1,006,793. In total, we determined that NLP owes \$8,450,999 to the FEHBP for overcharges and lost investment income.

This audit was still in process when OPM proposed to terminate the Plan. However, our office did provide OPM with analytical input and advice regarding the Plan's financial status.



## AUDIT ACTIVITIES

### LIFE INSURANCE PLANS

FEGLI provides life insurance coverage to federal employees and annuitants. OPM's Center for Retirement and Insurance Services (CRIS) has overall responsibility for administering the program, including the publication of program regulations and agency guidelines, and the receipt, payment, and investment of agency withholdings and contributions. CRIS contracts with Metropolitan Life Insurance Company (MetLife) to administer the claims process.

Federal agencies are responsible for enrolling, informing and advising their 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.

### Metropolitan Life Insurance Company

Jersey City, New Jersey

Report No. 2A-II-00-05-045

JANUARY 31, 2006

Our audit of FEGLI operations at MetLife covered claim payments for fiscal year 2004, and overpayment of claims, administrative expenses, and cash management activities for fiscal years 2000 through 2004. During these years, MetLife paid approximately \$10 billion in FEGLI claims and charged \$41 million in administrative expenses.

*MetLife Agrees with  
\$1.1 Million in  
Overcharges to the  
FEGLI Program*

Our auditors questioned \$1,116,587, including overcharges for pension costs and executive compensation, as well as lost investment income. MetLife agreed with these findings.





## Information Systems Audits

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

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

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

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

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

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### Information Systems General Application Controls at Government Employees Hospital Association Independence and Lee's Summit, Missouri Report No. 1B-31-00-04-090 JANUARY 13, 2006

Government Employees Hospital Association (GEHA) provides health insurance coverage to federal employees throughout the United States. We reviewed GEHA's claims processing and customer support operations in Independence, Missouri, as well as their data center and supporting operations in Lee's Summit, Missouri. This was our second audit of general and application controls at GEHA, and our first audit of the Plan's compliance with the privacy, security, and electronic transaction rules of the Health Insurance Portability and Accountability Act (HIPAA).

We confirmed GEHA's compliance with HIPAA requirements and documented significant progress toward future requirements. GEHA had addressed the majority of OIG's recommendations from our previous audit report, issued in 1999, and has also implemented the following controls to help promote a secure computing environment:



## AUDIT ACTIVITIES

- Adequate policies and procedures to ensure that system access is appropriately authorized;
- Intrusion detection capabilities and procedures for monitoring network activity; and
- Adequate application development and program change controls.

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

- Establish a formal security program plan that includes policies related to risk assessment methodology and incident response procedures;
- Improve policies and procedures related to user passwords of their claim processing system;
- Ensure that user accounts on critical systems are immediately deactivated for terminated employees;
- Maintain an isolated backup of the mainframe security software database;

- Add several critical elements to their corporate disaster recovery plan;
- Improve physical access controls of the print shop and uninterruptible power supply room;
- Maintain segregation of duties between application programmer and system software programmer responsibilities;
- Implement additional appropriateness of care and timely filing edits into their claims processing system; and
- Improve procedures for adjudicating Medicare Diagnosis Related Group claims.

***GEHA Will  
Enhance  
Information  
Security to  
Comply with OIG  
Recommendations***

GEHA officials have addressed or plan to address many of our recommendations. This should enhance GEHA's existing general and application controls, therefore, increasing the overall effectiveness and efficiency of information system security at the Plan.



## Internal Audits

### COMBINED FEDERAL CAMPAIGN

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

CFC campaigns are identified by geographical areas that may include only a single city, or encompass several cities or counties.

Our auditors review the eligibility of participating charities associated with a given campaign and the charities' compliance with federal regulations and OPM guidelines. In addition, all CFC organizations are required by regulation to have an independent public accounting firm (IPA) audit their respective financial activities for each campaign year. We review the IPA reports as part of our audits.

Combined Federal Campaign audits do not identify savings to the government, because the funds involved are charitable donations made by federal employees. Our audit efforts occasionally generate an internal referral to our OIG investigators for potential fraudulent activity.

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

### LOCAL CFC AUDITS

The local organizational structure consists of:

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



## AUDIT ACTIVITIES

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

During this reporting period we issued four audit reports of local CFCs of the Texas Gulf Coast, Puerto Rico, Utah, and North Central Kentucky/Southern Indiana/Fort Knox areas. These reports identified numerous violations of regulations and guidelines governing local CFC operations. The most frequently occurring problems were as follows:

- **Undistributed Campaign Receipts** – The PCFOs for two local campaigns did not distribute \$50,484 in campaign receipts to the 2001 and 2002 CFCs. OPM regulations require that at the close of each disbursement period, the PCFO's CFC account must have a zero balance.
- **Local/Federation Applications** – For the 2001 and 2002 CFCs, over 90 percent of the applications of local charities and federations we reviewed did not meet one or more of the regulatory eligibility requirements. Our findings did not necessarily imply that these charities were ineligible to participate in the campaigns, but did reveal shortcomings in the reviews conducted by the respective LFCCs.

- **Appeals Process** – OPM regulations establish a process through which charities may appeal a denial of participation to the LFCC. All four of the campaigns we reviewed failed to maintain their appeals processes in accordance with these regulations.
- **Campaign Brochure** – Three of the local campaigns failed to prepare their CFC brochures in compliance with OPM regulations.
- **Agreed-Upon Auditing Procedures** – The Independent Public Accountants (IPA) for two of the campaigns did not comply with the March 2003 CFC Audit Guide, which specifies procedures the IPA must follow.
- **CPA Audit Report** – The PCFO for three local campaigns submitted audited financial statements to the LFCC based on calendar years rather than campaign years. Since campaign years extend over more than one calendar year, these audits are not a complete reflection of the financial activities of the campaign.
- **Pledge Cards** – For the 2001 and 2002 CFCs, in three local campaigns, we identified a small number of pledge card processing errors in which the donor's requests were not honored.



## OPM INTERNAL PERFORMANCE AUDITS

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

### OPM's Compliance with Homeland Security Presidential Directive 12

Report No. 4A-HR-00-06-017

MARCH 29, 2006

Homeland Security Presidential Directive -12 (HSPD-12) mandated that all federal agencies adopt a common identification standard for their employees and contractors. Wide variations exist in the quality and security of forms of identification used to gain access to secure Federal and other facilities. HSPD-12 mandates the elimination of security variances among agencies.

The National Institute for Science and Technology issued guidelines for creating a common identification standard for federal employees and contractors.

This document consists of: (1) control and security objectives and (2) technical specifications for compatible identity verification

systems in all federal agencies. All agencies were required to be in compliance with the first set of requirements by October 27, 2005, and with the second set by October 27, 2006.

Our audit of OPM's compliance with the first set of requirements disclosed that the agency had

developed a process for issuing identity credentials that meet the internal control requirements of the directive.

### OPM'S CONSOLIDATED FINANCIAL STATEMENTS AUDITS

OPM's consolidated financial statements include the retirement, health and life insurance benefit programs, the revolving fund (RF), and the salaries and expenses accounts (S&E). The OPM program areas that participate in the RF provide a variety of human resource-related services to other federal agencies, such as pre-employment testing, background investigations, and employee training. The RF is not derived from congressionally-appropriated funds, but rather from reimbursements paid to OPM by other federal agencies. The S&E accounts, which represent congressionally-appropriated funds, cover the costs of administering the operations of the agency.

OPM contracts with an independent public accounting firm, KPMG LLP (KPMG), to audit the agency's annual consolidated financial statements. In performing these audits, KPMG is responsible for providing audit reports that contain its opinion as to the fair presentation of OPM's consolidated financial statements and their conformance with generally accepted accounting principles.

#### *OPM Meets Identification Security Requirements*



## OFFICE OF PERSONNEL MANAGEMENT

KPMG also reports on OPM’s internal control efforts concerning financial reporting and OPM management’s compliance with laws and regulations that could have a material impact on how the agency determines the financial statement amounts.

We monitor KPMG’s performance of these audits to ensure that they are conducted in accordance with the terms of the contract and in compliance with government auditing standards (GAS) and other authoritative references, such as OMB Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*. We are involved in the planning, performance and reporting phases of the audit through participation in key meetings, discussion of audit issues, and reviewing KPMG’s work papers and reports. Our review of the FY 2004 and FY 2005 audits disclosed no instances where KPMG did not comply, in all material respects, with the contract or GAS.

In addition to the consolidated financial statements, OPM is required to prepare special-purpose financial statements (closing package) for the Department of the Treasury and the Government Accountability Office (GAO). These agencies use the closing package in preparing and auditing the Financial Report of the U.S. Government.

- Civil Service Retirement System (CSRS)
- Federal Employees Retirement System (FERS)
- Federal Employees Health Benefits Program (FEHBP)
- Federal Employees’ Group Life Insurance (FEGLI)

### CONSOLIDATED & BENEFITS PROGRAMS FINANCIAL STATEMENTS

KPMG determined that the FY 2004 and 2005 consolidated financial statements and the individual statements of the programs that govern the retirement, health, and life benefits of federal employees and retirees, were presented fairly in all material respects, in conformity with generally accepted accounting principles.

*OPM Financial Statements Receive “Clean” Audit Opinion In FY 2005*

KPMG noted three reportable conditions in the internal controls for financial reporting during FY 2005. One of these conditions was downgraded from a material weakness in FY 2004 to a reportable condition in FY 2005, meaning that for FY 2005 no material weaknesses were reported.

The following definitions are drawn from the Government Accountability Office’s publication, *Government Auditing Standards*, 2003 revision:

*A reportable condition represents a significant deficiency in the design or operation of internal controls that could adversely affect OPM’s ability to record, process, summarize, and report financial data consistent with management assertions in the financial statements.*

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### OPM’s FY 2004 and 2005 Consolidated Financial Statements Report No. 4A-CF-00-05-043 NOVEMBER 15, 2005

KPMG audited the balance sheets of OPM as of September 30, 2004 and 2005 and the related consolidated financial statements. KPMG also audited the individual balance sheets of the retirement, health and life insurance benefit programs and the related individual statements. The benefits programs are essential to the payment of benefits to federal civilian employees, annuitants, and their respective dependents, and operate under the following names:



*A material weakness represents a condition in which an internal control does not reduce to a relatively low level the risk that misstatements, in amounts that would be material in relation to the financial statements being audited, may occur and not be detected within a timely period.*

Table 1 displays the internal control weaknesses that KPMG identified during its audit work on the financial statements for FY 2004 and 2005.

**No Material Weakness  
Reported by KPMG  
For FY 2005**

KPMG's report on compliance with laws and regulations disclosed two instances of non-compliance

that are required to be reported under GAS and the OMB Bulletin No. 01-02. These non-compliances are with the Prompt Payment Act and the Federal Financial Management Improvement Act, and are applicable to the RF and S&E only.

**CLOSING PACKAGE**

The closing package financial statements are required to be audited in accordance with GAS and the provisions of Office of Management and Budget (OMB) Bulletin No. 01-02, Audit Requirements for Federal Financial Statements. This audit covers the reclassified balance sheets, the statements of net cost, the statements of changes in net position, and the accompanying notes.

KPMG determined that the closing package fairly presents the financial position of OPM as of September 30, 2004 and 2005, and its costs and changes in net position for the years covered, in conformity with generally accepted accounting principles and the Department of Treasury's Financial Manual.

KPMG identified a reportable condition that partially repeated a condition that was also noted in FY 2004. It found that OPM does not have documented policies and procedures for reconciling the differences between its general ledger accounts and the United States Standard General Ledger for the financial statements required as part of the Treasury's closing package.

**TABLE 1: INTERNAL CONTROL WEAKNESSES**

<b>Title of Findings From FY 2005 Report</b>	<b>Program/ Fund</b>	<b>FY 2004</b>	<b>FY 2005</b>
Information Systems General Control Environment	All	Reportable Condition	Reportable Condition
Managerial Cost Accounting to Determine Full Cost Associated with Strategic Goals and Major Outcomes	RF and S&E	Reportable Condition	Reportable Condition
Segregation of Duties Over the Letter of Credit System for the Experience-Rated Carriers	HBP	Reportable Condition	Resolved
Financial Management and Reporting Processes of OCFO	RF and S&E	Material Weakness	Reportable Condition







## Enforcement

### Investigative Activities

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

**D**uring the reporting period, our office opened 72 investigations and closed 44, with 271 still in progress at the end of the period. Our investigations led to 21 arrests, 24 indictments and/or informations, 13 convictions and monetary recoveries totaling \$5,314,921. For a complete statistical summary of our office's investigative activity in this reporting period, 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. At the national level, we are participating members of DOJ's health care fraud

working groups. We also work with U.S. Attorney's offices nationwide to focus investigative resources in areas where fraud is most common.

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

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### Physician Indicted on 46 Counts of Health Care and Mail Fraud

In September 2003, our criminal investigators became involved in a joint investigation with the Federal Bureau of Investigation (FBI) and the Texas Department of Insurance regarding a physician specializing in the treatment of Hepatitis C patients in Houston, Texas. This doctor was suspected of



## ENFORCEMENT

submitting fraudulent claims to various health care insurance programs and companies for services not rendered. He also allegedly created false documentation to support the submitted medical claim forms. In June 2003, the investigative team executed a search warrant that uncovered evidence that the doctor had committed fraud against the FEHBP

***Physician Indicted for Defrauding the FEHBP of over \$2.3 million***

in an amount exceeding \$2.3 million.

In February 2006, the physician was indicted by a federal grand jury

in the Southern District of Texas on 46 counts of health care and mail fraud. He was subsequently arrested and is awaiting trial.

### **Third Subject Indicted in Cardiac Laboratory Case Lied to Investigators**

As reported in a previous semiannual report, the two owners of Cardiac Monitoring Services (Cardiac), a laboratory located in Irvine, California, were indicted in December 2003 on 27 counts of health care fraud. On the basis of the indictment, the OIG debarred official suspended Cardiac, its owners, and a second laboratory operated by the same parties.

Through our continuing investigation of the indicted owners' business activities, we learned that a Cardiac management employee had lied to investigators about medical claims submitted on his behalf in 2001. A physician claimed to have examined, diagnosed, treated and referred the employee for cardiac event monitoring services. When questioned by investigators, the employee lied to cover up the fraudulent claims. Ultimately, the physician denied that he treated the employee or referred him for cardiac event monitoring services. In addition, no medical records or test results existed to support the insurance claims.

On March 1, 2006, the employee was indicted by a federal grand jury on one count of providing false statements to a representative of the U.S. government and one count of providing false statements in regard to health care matters.

Our investigation has also revealed a third cardiac laboratory, located in Tustin, California, which is owned, operated and managed by a relative of Cardiac's owners. The investigation of this entity revealed evidence of a potentially fraudulent billing scheme almost identical to that used by Cardiac. Therefore, our office, in conjunction with the FBI, HHS-OIG and the Defense Criminal Investigative Service, served the laboratory with a search warrant that resulted in the seizure of evidence, including 25 computers.

Our analysis of the cardiac laboratories' billings revealed that fraudulent claims may constitute as much as 80 percent of all charges.

The FEHBP is estimated to have lost

approximately \$500,000, while total losses to federally funded health care programs are estimated to be approximately \$3,000,000.

***Continuing Investigation Reveals Extensive Fraudulent Billings in Cardiac Laboratories***

Prosecution of this case is pending in the U.S. District Court for the Central District of California.

### **Civil Settlement of Off-Label Marketing Pharmaceutical Fraud**

On October 14, 2005 Serono Laboratories, the manufacturer of the steroidal medication Serostim, reached a civil settlement with the U.S. government in which it admitted to encouraging doctors to prescribe the drug for uses that were not approved by the Food and Drug Administration.



Serostim is authorized for the treatment of patients who are HIV positive in order to help prevent the deterioration and wasting of the body. The

***FEHBP Receives  
\$2.4 million from  
Civil Settlement***

marketing programs to induce doctors to write prescriptions for “off-label” uses of the medication, such as body building. Serono’s actions resulted in thousands of improper claims for “off-label” uses of Serostim to federally funded health care programs. Serono agreed to pay over \$567 million in restitution, damages and fines. The FEHBP will recover \$2.4 million in the settlement.

government’s investigation of Serono Laboratories found that that the company had devised and promoted illegal

## **Retired Federal Employee Sentenced After Pleading Guilty to Defrauding the FEHBP**

In a previous semiannual report, we described the investigation of a retired Federal employee in Los Angeles, California, who had obtained Serostim through a series of forged and fraudulent prescriptions. These actions generated over \$350,000 in improper FEHBP payments. We also found that the subject had fraudulently obtained \$50,000 in duplicate payments from California’s Medicaid program (Medi-Cal) for the same medications. He

***Retired Federal  
Employee Sentenced  
to Restitution and 18  
Months Incarceration***

18 months of imprisonment, 3 years of probation and \$307,937 in restitution to the FEHBP. He is currently appealing his prison sentence.

pleaded guilty to two counts of health care fraud in 2005.

On February 27, 2006, he was sentenced to

## **Team Health, Inc.**

Team Health, Inc., provides emergency room physicians under contract to hospitals throughout the United States. As the result of an investigation of a complaint, the HHS - OIG determined that Team Health had been withholding credit balances from hundreds of private and government funded health plans. In a December 2005 settlement, Team Health agreed to pay these funds to the health insurance carriers. Our office, working with HHS – OIG and federal prosecutors, identified a balance of \$269,529 that was owed to the BlueCross Blue Shield plans participating in the FEHBP. Team Health completed these repayments in March 2006.

***Company Agrees to  
Refund \$269,529  
to the FEHBP***

## **RETIREMENT FRAUD**

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

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

We evaluate the referrals to determine if they merit further investigation by our office. These computer



## ENFORCEMENT

matches are an effective tool in stopping payments to deceased annuitants and a good source for our criminal investigative workload.

The following summaries provide examples of our work on retirement fraud issues during this reporting period:

- The daughter-in-law of a deceased survivor annuitant pled guilty in the U.S. District Court for the District of Idaho to an information charging her with theft of public property. The subject received her deceased mother-in-law's survivor benefit checks from October 1980 through September 2003, in a total amount of \$171,254. In order to continue to receive the benefits, she falsely claimed to be her mother-in-law and forged her signature on the Health Benefits Registration form and OPM's Address Verification form. She also forged her mother-in-law's signature on four U.S. Treasury annuity checks. Sentencing is scheduled for May 2006.
- The daughter of a survivor annuitant who died in 1984 pled guilty before a U.S. Magistrate Judge in the state of Washington to an information charging her with theft of public property. The daughter received a total of \$215,585 of her deceased mother's survivor benefit checks from November 1984 through August 2003. In order to continue to receive the benefits, the daughter falsely claimed to be her mother and forged her mother's signature on an OPM Address Verification form. In addition, she also forged her mother's signature on U.S. Treasury annuity checks. Sentencing is scheduled for April 2006.
- The adopted daughter of a deceased annuitant was indicted by a federal grand jury in the District of Arizona for theft of government property. Our investigation determined that the annuitant had died in April 1981. The adopted daughter, who had been the legal guardian of the deceased annuitant, began cashing U.S. Treasury checks from OPM in May 1981. In 2002, by

impersonating the deceased annuitant, she requested that the payments be made by electronic funds transfer.

Our investigators located the subject in Riverside, California, where we obtained a written confession. The total loss involved in this case is \$204,495. The subject's trial date is pending.

- A deceased annuitant's daughter failed to notify OPM of the mother's death in 1992, and continued to illegally receive the CSRS annuity payments until June 2005, by forging her mother's signature on the U.S. Treasury checks. She improperly received \$185,106. She pled guilty to theft charges in U.S. District Court in Maryland. Sentencing is scheduled for June 2006.

*Recoveries in Retirement Fraud Cases Exceed \$1.3 Million*

## SPECIAL INVESTIGATIONS

### Employee Commits Insurance and Employment Fraud

An employee of the Department of Labor (DOL) conspired to defraud her boyfriend's health insurance carrier. Using her government owned computer and fax machine, she created and submitted false invoices totaling \$5,596 for medical treatment for her boyfriend. The carrier paid the full amount of the claim.

DOL – OIG initiated an investigation of the insurance fraud and misuse of government equipment. Fearing the loss of her job at DOL, the employee applied for a position in OPM. In her application, she intentionally misrepresented her own telephone number as the contact point for her supervisor. When OPM called for an employment reference, the employee identified herself as the supervisor and provided an outstanding appraisal. Based on that reference, OPM selected the employee for a position.



Before she reported for work at OPM, DOL – OIG notified our office that this employee was the subject of an investigation. In coordination with OPM's human resources office, we determined that the employee had impersonated her supervisor. When confronted by OIG agents, she confessed. On January 5, 2006, she pled guilty to insurance fraud and forgery charges. She was sentenced to make

### *Employee Resigns after Guilty Plea*

restitution of the \$5,596 she received from her boyfriend's health insurance carrier and was placed on two years probation. She subsequently resigned her position at DOL.

## OIG HOTLINES AND COMPLAINT ACTIVITY

OIG's health care fraud hotline, retirement and special investigations hotline, and mailed-in complaints also contribute to identifying fraud and abuse. We received 550 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 is generally concerned with 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 199 contacts, including telephone calls, letters, and referrals from other agencies.

## HEALTH CARE FRAUD HOTLINE

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

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

The Health Care Fraud hotline received 351 complaints during this reporting period, including both telephone calls and letters.

## OIG INITIATED COMPLAINTS

We initiate our own inquiries by looking at OPM's automated systems for possible cases involving fraud, abuse, integrity issues and, occasionally, malfeasance. Our office will open an investigation if complaints and inquiries can justify further action.

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

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



## Administrative Sanctions of Health Care Providers

*Under the FEHBP administrative sanctions statute, we issue debarments and suspensions of health care providers whose actions demonstrate that they are not responsible to participate in the program. At the end of the reporting period, there were 29,285 active suspensions and debarments from FEHBP.*

**D**uring the reporting period, our office issued 531 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 2,668 sanctions-related inquiries. These numbers represent productivity increases of approximately 10 percent from the prior reporting period.

We develop our caseload from a variety of sources, including

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

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

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

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

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### Arkansas Physician Suspended after Fraud Conviction

In November 2005, a general practitioner in Arkansas was convicted in U.S. District Court in Dallas of health care fraud, money laundering, and paying and receiving kickbacks. This case, in which two co-defendants were also convicted, involved a scheme to obtain federal payments for power wheelchairs furnished to persons who did not meet Medicare standards to receive them.



The principals of this conspiracy were the co-defendants—two brothers who operated medical equipment distributorships in the Dallas, Texas area. They recruited sales representatives who visited nursing homes, assisted living facilities, and retirement communities, seeking elderly persons as potential recipients of “free” wheelchairs to be furnished by the brothers’ businesses. The sales personnel would frequently offer inducements of free meals or cash payments of up to \$100 for these “customers” to apply for the wheelchairs. Availability of insurance reimbursement for the wheelchairs was restricted to persons whose mobility was severely limited, but the brothers had identified several physicians who were willing to issue fraudulent certificates of medical necessity, attesting that the recruited persons met the Medicare standards for them. Insurance carriers—principally Medicare—would pay approximately \$5,000 for each wheelchair. During an approximately two year period, the brothers submitted over \$12,000,000 in fraudulent wheelchair claims. In many cases, the brothers would not deliver any equipment to the customers, or would substitute a much less expensive electric scooter, in lieu of a wheelchair.

The Arkansas doctor was one of the physicians who facilitated this conspiracy. He accepted a kickback of \$200 from the brothers for each certificate of medical necessity he issued. He was linked to FEHBP as a member of the preferred provider organizations (PPO) of two carriers, and he regularly submitted FEHBP claims. His actions placed patients directly

*Doctor Suspended  
for Role in Health Care  
Fraud Conspiracy*

at risk, because he knowingly altered and falsified medical records of his patients to justify the wheelchair claims, and ordered his office staff to make additional false entries in an attempt to avoid prosecution. Accordingly, we suspended him and his clinic in December 2005, pending his sentencing, which is scheduled for April 2006.

## California Physician and Associated Business Entities Suspended

In June 2005, the State of California Medical Board revoked the professional license of a Los Angeles-area surgeon for an indefinite period of time. The violations on which the Board based its action comprised numerous and repeated instances of professional misconduct, including submitting false and fraudulent claims to insurance carriers, creating false medical records to support such claims, providing treatment which his clinic was not licensed to perform, and failing to maintain adequate records of the services he furnished to his patients.

This physician became the subject of a multiagency investigation for health care fraud, in which our Office of Investigations participated. Because he and his clinic had submitted claims to FEHBP carriers, the investigators requested

*Doctor Suspended  
after Loss of  
Professional  
Licensure*

that we consider taking administrative action against the doctor while their case was in process. On the basis of the physician’s connection with the FEHBP and the risks that his violations created for his patients, we suspended him in January 2006, pending completion of the investigation and subsequent legal action. We also determined that this doctor owned or controlled several business entities, and we concurrently suspended three of them that he had used to provide health care services. The federal investigation of this provider, his professional associates, and certain of his businesses is continuing.



## Rhode Island Counselor Debarred After License Suspension

In October 2005, Rhode Island’s licensing board for mental health counselors issued a five-year suspension of a counselor who practiced in the Providence area. The violations underlying the board’s action included the provider’s admitted addiction to prescription medications; his refusal to adhere to a required drug treatment and screening plan; and his involvement in a personal relationship with a client during a period when the client was under his professional care. This counselor had been a member of the PPO of a large FEHBP carrier, and had submitted claims for services provided to FEHBP enrollees.

This matter was called to OIG’s attention by an FEHBP enrollee who reported the provider’s loss of

*Counselor Debarred after Licensure Suspension for Unprofessional Conduct*

licensure to the OIG Health Care Fraud Hotline. Since the case did not involve on-going criminal activity, it was appropriate to handle it directly through administrative action. Accordingly, in March 2006, our office debarred both the provider and the counseling service that he owned, for a period concurrent with his licensure suspension.

appropriate to handle it directly through administrative action. Accordingly, in March 2006, our office debarred both the provider and the counseling service that he owned, for a period concurrent with his licensure suspension.

## Virginia Podiatrist Debarred for Seven Years

In March 2006, our office debarred a Virginia podiatrist for a period of seven years, based on his guilty plea to fraud charges in the U.S. District Court for the Eastern District of Virginia, Richmond Division. We had previously suspended this provider in June 2005 because of his indictment on health care fraud charges.

This case arose from a multiagency federal investigation in which our Office of Investigations played a lead role. Over a five-year period from 1999 through 2003, the podiatrist developed and carried out a scheme to fraudulently increase the payments he received from health insurance carriers. He incorporated a fictitious surgical center, which he represented to be a freestanding facility separate from his office, and in which he asserted that he performed complex podiatric surgical procedures. Notwithstanding that no such surgical center existed, the provider billed insurance carriers for facility charges, in addition to his own professional charges. In fact, all of the treatments furnished by this provider took place in his own office, and none was so complex as to warrant the use of a specialized surgical facility. Over the period of this scheme, the fraudulent surgical center billings generated approximately \$270,000 in improper insurance payments to the podiatrist.

The investigation determined that the provider had submitted claims to several FEHBP insurance plans. Therefore, the investigators referred the case for consideration of interim administrative sanctions action after the indictment was handed down. Our office suspended the podiatrist pending the outcome of his prosecution. This decision was made based on his demonstrated connection with FEHBP and information furnished by a Virginia state health care regulatory official. This state official worked with the investigative team that reported the existence of patient safety problems in the provider’s office.

The podiatrist subsequently agreed to plead guilty to one of the fraud charges against him, and was sentenced to incarceration for 12 months and one day, three years of supervised

*Podiatrist and Clinics Debarred after Fraud Conviction*

release, and restitution of \$272,700, representing the fraudulent insurance claim payments. The FEHBP’s share of these monies was \$69,000.





While the FEHBP administrative sanctions statute sets a minimum three-year debarment period for providers convicted of this type of criminal offense, we determined that a seven-year debarment was appropriate in this case, based on the prolonged and repeated nature of the podiatrist's fraudulent scheme, the extent of the financial losses to FEHBP, and the provider's prior record of disciplinary action imposed by the Virginia Board of Medicine. In addition, because the podiatrist used his clinic and professional practice as instrumentalities of his scheme, we also debarred those entities for an equivalent seven-year period.

### **North Carolina Chiropractor Suspended after Health Care Fraud Indictment**

In October 2005, our office suspended a chiropractor who practiced in the Charlotte, North Carolina area after his indictment in U.S. District Court for the Western District of North Carolina. He was charged with conspiracy, mail fraud, bank fraud, health care fraud, and money laundering.

This provider and another chiropractor owned a clinic and a management services company that handled the clinic's billings. The clinic represented itself as an integrated practice, purporting to offer medical, chiropractic, and physical therapy services. As such, North Carolina law required that it be owned and operated by a medical doctor. However, the two chiropractors developed a scheme to circumvent this legal provision by hiring a physician to work part-time at the clinic, and to sign its insurance claims as the nominal owner, while the chiropractors maintained full ownership and actual operational control. In turn, all funds the clinic received for its services were routed through the billing company and profits were paid solely to them. The billing company was also owned by the chiropractors.

The chiropractors used the presence of the physician as a cover for widespread claims fraud. They routinely characterized the services that they performed as chiropractors as having been performed by, or under the supervision of the doctor, thus avoiding legal and insurance restrictions that required

#### ***Chiropractor Pleads Guilty to Health Care Fraud***

certain services to be provided by a physician. They also depicted their own services as having been performed by the medical doctor, in order to claim the higher reimbursement rates that were available for treatments furnished by physicians. In addition, although the clinic employed no licensed physical therapists, and used lower-paid and less skilled athletic trainers and technicians in their place—whose services would not be reimbursable by insurance—the clinic billed as if such services had been provided by fully licensed therapists, working under direct medical supervision. In total, the chiropractors exploited this scheme to submit over \$500,000 in fraudulent health insurance claims within a year's time.

Upon indictment, one of the chiropractors agreed to plead guilty and cooperate with the prosecution's case against his partner. Because the non-cooperating chiropractor had submitted claims to FEHBP carriers, our Office of Investigations referred the case for consideration of administrative sanctions action after the indictment was returned. Based on his FEHBP claims history and the risk to patients that resulted from the chiropractor's use of unqualified and unlicensed persons to perform patient care in the clinic, we suspended him from FEHBP pending the outcome of legal action against him. In March 2006, this person also agreed to plead guilty to bank and health care fraud charges. We will consider debarment of both chiropractors after they are sentenced.



OFFICE OF PERSONNEL MANAGEMENT

STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES

JUDICIAL ACTIONS:

Arrests . . . . .	21
Indictments and Informations . . . . .	24
Convictions . . . . .	13

JUDICIAL RECOVERIES:

Fines, Penalties, Restitutions and Settlements . . . . .	\$5,314,921
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RETIREMENT AND SPECIAL INVESTIGATIONS HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry . . . . .	22
Referred to:	
OPM Program Offices . . . . .	102
Other Federal Agencies . . . . .	75
<b>Total</b> . . . . .	199

HEALTH CARE FRAUD HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry . . . . .	97
Referred to:	
OPM Program Offices . . . . .	57
Other Federal/State Agencies . . . . .	54
FEHBP Insurance Carriers or Providers . . . . .	143
<b>Total</b> . . . . .	351
<b>Total Hotline Contacts and Complaint Activity</b> . . . . .	550

ADMINISTRATIVE SANCTIONS ACTIVITY:

Debarments and Suspensions Issued . . . . .	531
Health Care Provider Debarment and Suspension Inquiries . . . . .	2,688
Debarments and Suspensions in Effect at End of Reporting Period . . . . .	29,285



# Appendices

## APPENDIX I FINAL REPORTS ISSUED WITH QUESTIONED COSTS

October 1, 2005 to March 31, 2006

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	14	\$36,101,960
B. Reports issued during the reporting period with findings	19	29,613,171
Subtotals (A+B)	33	65,715,131
C. Reports for which a management decision was made during the reporting period:	16	40,235,582
1. Disallowed costs		33,504,377
2. Costs not disallowed		6,731,205
D. Reports for which no management decision has been made by the end of the reporting period	17	25,479,549
E. Reports for which no management decision has been made within 6 months of issuance		

## APPENDIX II

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

October 1, 2005 to March 31, 2006

No activity during this reporting period



OFFICE OF PERSONNEL MANAGEMENT

APPENDIX III

INSURANCE AUDIT REPORTS ISSUED

October 1, 2005 to March 31, 2006

Report Number	Audits	Issue Date	Questioned Costs
1C-K3-00-04-093	The Wellness Plan in Detroit, Michigan	October 7, 2005	\$1,221,172
1A-10-83-05-002	BlueCross BlueShield of Oklahoma in Tulsa, Oklahoma	October 17, 2005	2,074,455
1A-10-24-05-004	BlueCross BlueShield of South Carolina in Columbia, South Carolina	November 22, 2005	659,359
1C-75-00-04-084	Humana Health Plan, Inc of Chicago in Louisville, Kentucky	November 23, 2005	3,184,527
1B-36-00-03-058	National League of Postmasters of the United States as Sponsor for the Postmasters Benefit Plan in Alexandria, Virginia	December 5, 2005	8,450,999
1C-LB-00-04-012	Health Net of California in Woodland Hills, California	January 24, 2006	
1C-DF-00-05-031	HealthSpring of Alabama, Inc. in Birmingham, Alabama	January 24, 2006	
1A-10-67-05-012	BlueShield of California in San Francisco, California	January 25, 2006	123,406
1C-KF-00-04-082	Blue Care Network of Michigan, Inc. – West Region in Southfield, Michigan	January 30, 2006	432,383
1C-K5-00-04-032	Blue Care Network of Michigan, Inc. – East Region in Southfield, Michigan	January 30, 2006	230,833
1C-LN-00-05-011	Blue Care Network of Michigan, Inc. – Mid Region in Southfield, Michigan	January 30, 2006	270,325
1C-IN-00-05-035	M Plan in Indianapolis, Indiana	January 31, 2006	

OFFICE OF PERSONNEL MANAGEMENT



APPENDIX III

INSURANCE AUDIT REPORTS ISSUED

October 1, 2005 to March 31, 2006

(Continued)

Report Number	Audits	Issue Date	Questioned Costs
2A-II-00-05-045	Metropolitan Life Insurance Company in Jersey City, New Jersey	January 31, 2006	\$1,116,587
1A-99-00-04-027	Global Duplicate Claim Payment for BlueCross and BlueShield Plans in Washington, D.C.	February 7, 2006	2,994,477
1C-JC-00-05-030	Aetna Health Inc. of New York in Blue Bell, Pennsylvania	February 21, 2006	(219,724)
1A-10-52-05-021	BlueCross of California in Woodland Hills, California	February 22, 2006	685,197
1C-P3-00-05-029	Aetna Health Inc. of New Jersey and Southeastern Pennsylvania in Blue Bell, Pennsylvania	February 22, 2006	1,714,920
1C-JK-00-04-031	PacifiCare Asia Pacific in Tamuning, Guam	February 22, 2006	619,402
1C-7Z-00-04-092	PacifiCare of Oregon in Cypress, California	March 15, 2006	142,258
1C-WB-00-05-016	PacifiCare Health Plans of Washington in Cypress, California	March 21, 2006	97,045
1A-10-32-05-034	BlueCross BlueShield of Michigan in Detroit, Michigan	March 24, 2006	3,210,586
1H-01-00-04-100	AdvancePCS in Scottsdale, Arizona	March 30, 2006	2,604,964
<b>TOTALS</b>			<b>\$29,613,171</b>



OFFICE OF PERSONNEL MANAGEMENT

APPENDIX IV

INTERNAL AUDIT REPORTS ISSUED

October 1, 2005 to March 31, 2006

Report Number	Subject	Issue Date
4A-CF-00-05-043	Office of Personnel Management's Fiscal Year 2005 Consolidated Financial Statements	November 14, 2005
4A-CF-00-06-027	Office of Personnel Management's Fiscal Year 2005 Closing Package Special-Purpose Financial Statement	November 21, 2005
4A-CF-00-06-028	Office of Personnel Management's Fiscal Year 2005 Agreed-Upon Procedures for Intergovernmental Activity and Balances	December 2, 2005
4A-HR-00-06-017	Office of Personnel Management's Implementation of Homeland Security Presidential Directive – 12 Personal Identity Verification (PIV) Part I	March 29, 2006

APPENDIX V

INFORMATION SYSTEMS AUDIT REPORTS ISSUED

October 1, 2005 to March 31, 2006

Report Number	Subject	Issue Date
1B-31-00-04-090	Information Systems General and Application Controls at Government Employees Hospital Association in Lee's Summit, Missouri	January 13, 2006



**APPENDIX VI**  
**COMBINED FEDERAL CAMPAIGN AUDIT REPORTS ISSUED**  
**October 1, 2005 to March 31, 2006**

<b>Report Number</b>	<b>Subject</b>	<b>Issue Date</b>
3A-CF-00-04-044	The 2001 and 2002 Combined Federal Campaigns for the Texas Gulf Coast in Houston, Texas	October 28, 2005
3A-CF-00-04-049	The 2001 and 2002 Combined Federal Campaigns for North Central Kentucky, Southern Indiana and Fort Knox in Louisville, Kentucky	November 28, 2005
3A-CF-00-04-047	The 2001 and 2002 Combined Federal Campaigns for Puerto Rico in San Juan, Puerto Rico	December 2, 2005
3A-CF-00-04-052	The 2001 and 2002 Combined Federal Campaigns for the Utah South/West Region in Ogden, Utah	January 13, 2006



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(Inspector General Act of 1978, As Amended)

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