

United States Office of Personnel Management
OFFICE OF THE INSPECTOR GENERAL

OCTOBER 1, 2009 - MARCH 31, 2010

Semiannual Report
TO
Congress



OFFICE OF THE INSPECTOR GENERAL



Productivity Indicators

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds	\$23,308,748
Management Commitments to Recover Funds	\$13,351,478
Recoveries Through Investigative Actions	\$4,445,799
Fines, Penalties, and Forfeitures Through Investigations	\$85,390

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	29
Investigative Cases Closed	70
Indictments and Informations	46
Arrests	45
Convictions	70
Hotline Contacts and Complaint Activity	679
Health Care Provider Debarments and Suspensions	421
Health Care Provider Debarment and Suspension Inquiries	1,219

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INSPECTOR GENERAL'S MESSAGE

In 2009, Federal Employees Health Benefits Program (FEHBP) carriers reported health benefits payments of approximately \$38.6 billion, including payments for pharmacy benefits. Since 2000, these payments have increased at an average annual rate of over 7 percent, mostly driven by significant increases in pharmaceutical claims costs. For many years, a major focus of my office has been to help “bend the cost curve” in this program by reducing fraud, waste, abuse, and improper payments.

One of our initiatives in this area is our FEHBP Claims Data Warehouse project. This system has been in progress for much of the last decade, slowly developing and expanding to include medical claims data for approximately 90 percent of the total FEHBP fee-for-service claims payments. In addition, we now have data for one of the two largest pharmacy benefit managers (PBM) in the FEHBP, and are very close to finalizing a data sharing arrangement with the other.

We use this data for a variety of purposes, including traditional analysis of typical error conditions such as duplicate payments; improper coordination of benefits with Medicare; assistant surgeon overpayments; invalid enrollment; and, other types of payment and pricing discrepancies. The data also supports exploratory analysis for developing new issues discovered during our routine audits of claims processing systems.

We have long recognized the potential of using our data for conducting advanced analysis using data mining techniques. By the end of fiscal year 2010, we will establish an Advanced Claims Analysis Team that will be dedicated to conducting advanced analyses.

We have also developed several data mining application prototypes. We anticipate implementing these applications by the end of this fiscal year. These applications were designed to discover abnormal provider billing patterns of medical procedure codes. Using sophisticated statistical algorithms, we compare providers to their peers in the same medical specialty and geographic region to identify extreme outliers that are potentially involved in fraudulent billing. Similarly, we have an application prototype that is geared toward detecting fraud and abuse associated with Drug Enforcement Administration schedule prescription drugs.



Analysts and auditors on our Advanced Claims Analysis Team will be the primary users of these tools. Cases of suspected fraud will be developed and, if appropriate, referred to our criminal investigators for potential prosecution.

Another major initiative for our data warehouse is to use prescription drug data to support our efforts toward improving transparency in the PBM industry. Transparency refers to information about the PBM's actual costs for prescription drugs, which is needed to determine whether the FEHBP is getting a fair deal on the cost of prescription drug benefits. To identify the most feasible means of increasing PBM transparency and limiting pharmaceutical cost increases to the FEHBP and its enrollees, my office continues to work with Office of Personnel Management officials and the Subcommittee on the Federal Workforce, Postal Service, and the District of Columbia of the House of Representative's Committee on Oversight and Government Reform.

One final initiative that I would like to discuss relates to OPM's plans for building its own data warehouse. This proposed system will be used to link health care claims to demographic data and provider information, and allow analysts to evaluate claims data based on various factors to help control FEHBP costs, promote wellness, and ensure better quality care. My office is working with the agency to leverage our data, expertise, and lessons learned to help ensure a successful project.

We have many exciting plans for our data warehouse as the system continues to mature. Our ongoing strategy is to focus on proactively identifying and preventing fraud and improper payments in the FEHBP. Even modest success in this area will result in significant taxpayer savings. I look forward to informing you of our progress in future reports.

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

Patrick E. McFarland

Inspector General



MISSION STATEMENT

Our mission is to provide independent and objective oversight of OPM services and programs.

WE ACCOMPLISH OUR MISSION BY:

- Conducting and supervising audits, evaluations and investigations relating to the programs and operations of 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 21 final reports on organizations participating in the FEHBP, of which 9 contain recommendations for monetary adjustments in the amount of \$23.3 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 nine audit reports on community-rated plans. These reports contain recommendations to require the plans to return approximately \$80,000 to the FEHBP. In addition, four of the nine reports identified instances where the plans paid for and included in the FEHBP rates claims for non-covered benefits, claims that were not properly bundled, and claims that were not properly coordinated with Medicare.

Health Net of Arizona, Inc. WOODLAND HILLS, CALIFORNIA

Report No. 1C-A7-00-09-030

NOVEMBER 4, 2009

Health Net of Arizona, Inc. provides comprehensive medical services to its members throughout the state of Arizona. This audit of the plan covered contract years 2006 through 2008. During this period, the FEHBP paid the plan approximately \$152 million in premiums.

We identified \$69,217 in inappropriate health benefit charges to the FEHBP in 2006. In addition, we determined the FEHBP is due \$11,530 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 incorrectly calculated the vision rider included in the FEHBP rates in 2006. The plan failed to apply the same service industry factor to the FEHBP's vision rider as it applied to the SSSGs' vision riders.

**\$80,747
Returned to
the FEHBP**

Further, our review of the claims data used to develop the FEHBP rates identified instances where



the plan included payments for non-covered services and instances where the plan failed to coordinate claims with Medicare. This review did not result in a significant overcharge to the FEHBP but was reported as a procedural finding.

Health Net of Arizona, Inc. agreed with our findings, both monetary and procedural, and subsequently returned \$80,747 to the FEHBP.

TakeCare Insurance Company, Inc. TAMUNING, GUAM

Report No. 1C-JK-00-09-045

FEBRUARY 22, 2010

TakeCare Insurance Company, Inc. provides comprehensive medical services to its members

Fraud and Abuse Measures Not Fully Implemented

throughout the island of Guam. This audit of the plan covered contract years 2005 through 2008. During this period, the FEHBP paid the plan approximately \$143.2 million in premiums.

The audit disclosed that the plan did not fully comply with FEHB Program Carrier Letter No. 2003-23, which lists eight industry standards OPM expects all plans to have in place to help address health care fraud and abuse within their organizations. During the time covered by this audit, the plan did not implement five of the eight standards.

TakeCare Insurance Company, Inc. did not agree that its fraud and abuse efforts were insufficient; however, the plan is implementing an anti-fraud program that should be fully operational by July 2010.

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 seven experience-rated audit reports. In these reports, our auditors recommended that the plans return \$22.7 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 six 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 \$22.6 million in questionable costs charged to the FEHBP contract, including lost investment income. The BCBS Association and/or plans agreed with \$16.2 million of the identified overpayments.



Global Duplicate Claim Payments for BlueCross and BlueShield Plans

WASHINGTON, D.C.

Report No. 1A-99-00-09-036

OCTOBER 14, 2009

We performed a limited scope performance audit to determine whether the BCBS plans complied with contract provisions relative to duplicate claim payments. Our auditors performed a computer search on the BCBS claims database, using our data warehouse function, to identify potential duplicate payments on claims that were paid during the period January 1, 2006 through March 31, 2009. We identified 15,294 duplicate claim payments, and found that all 63 plan sites had made duplicate payments. We also noted that the BCBS national

FEHBP Overcharged \$9.6 Million for Duplicate Claim Payments

claims system did not identify approximately 65 percent of these claims as potential duplicates.

As a result, we determined that the FEHBP was overcharged \$9,560,516 for

these duplicate claim payments. The Association and/or plans agreed with \$8,620,458 of the questioned overcharges.

Horizon BlueCross BlueShield of New Jersey

NEWARK, NEW JERSEY

Report No. 1A-10-49-09-025

FEBRUARY 12, 2010

Our audit of the FEHBP operations at Horizon BCBS of New Jersey covered claims from January 1, 2005 through October 31, 2008, as well as miscellaneous health benefit payments and credits, administrative expenses, and cash management activities from 2003 through 2007. From 2003 to 2007, the plan paid approximately \$1.3 billion in FEHBP health benefit charges and \$104 million in administrative expenses.

Our auditors questioned \$3,567,597, consisting of \$2,277,467 in health benefit charges and \$1,290,130 in administrative expenses.

The findings included the following:

BCBS Association Agrees with \$1.6 Million in Questioned Charges

- \$1,860,381 for unreturned health benefit refunds and recoveries from providers and subscribers, and \$48,919 for lost investment income on refunds and recoveries that were either not returned to the FEHBP or not returned in a timely manner;
- \$731,676 in administrative expense overcharges due to an error in the plan's allocation methodology;
- \$352,093 in net overpayments 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;
- \$251,682 for plan employee post-retirement benefit cost overcharges;
- \$251,241 for plan employee pension cost overcharges;
- \$52,442 in administrative expense charges that were unallowable and/or did not benefit the FEHBP;
- \$16,074 in net overpayments due to claim pricing errors; and,
- \$3,089 for other administrative expense overcharges.

Of these questioned charges, the BCBS Association agreed with \$1,639,848. Additionally, lost investment income on the questioned charges totaled \$231,737.



Global Coordination of Benefits for BlueCross and BlueShield Plans WASHINGTON, D.C.

Report No. 1A-99-00-10-009

MARCH 31, 2010

We performed a limited scope performance audit to determine whether the BCBS plans complied with contract provisions relative to coordination of benefits (COB) with Medicare.

Coordination of benefits occurs when a patient has coverage under more than one health insurance plan or program. In such a case, one insurer normally pays its benefits as the primary payer and the other insurer pays a reduced benefit as the secondary payer. Medicare is usually the primary payer when the insured is also covered under an FEHBP plan.

Using our data warehouse, we performed a computer search on the BCBS claims database to identify claims for services that were paid in 2008 and potentially not coordinated with Medicare. We determined that 59 of the 63 plan sites did not properly coordinate claim charges with Medicare.

As a result, the FEHBP incorrectly paid these claims when Medicare was the primary insurer.

For 76 percent of the 14,773 claim lines questioned, there was no information in the BCBS

Association's national claims system to identify Medicare as the primary payer when the claims were paid. However, even after the Medicare information was added to the claims system, the BCBS plans did not adjust the patients' prior claims retroactively to the Medicare effective dates. Consequently, these costs continued to be charged entirely to the FEHBP.

**Auditors
Question Over
\$7.4 Million for
Coordination
of Benefits
Errors**

We determined that the FEHBP was overcharged \$7,417,178 for these COB errors. The BCBS Association and/or plans agreed with \$4,296,158 of the questioned claim overcharges.

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

CareFirst BlueChoice OWINGS MILLS, MARYLAND

Report No. 1D-2G-00-09-028

FEBRUARY 25, 2010

CareFirst BlueChoice (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 Maryland, Northern Virginia, and Washington, D.C.

The audit of the Plan's FEHBP operations covered miscellaneous health benefit payments and credits,



administrative expenses, and cash management activities from 2004 through 2008. During this period, the Plan paid approximately \$235 million in FEHBP

health benefit charges and \$15 million in administrative expenses.

Our auditors questioned \$107,358 in program overcharges and lost investment income. Of this amount, \$100,234 relates to administrative expense

overcharges and \$7,124 to lost investment income. The Plan agreed with this questioned amount.

**Auditors
Question
\$107,000 in
Overcharges
and Lost
Investment
Income**

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

We did not issue any audit reports on employee organization plans during this reporting period.



Information Systems Audits

OPM relies on computer technologies and information systems to administer programs that distribute health and retirement benefits to millions of current and former Federal employees. OPM systems also assist in the management of background investigations for Federal employees, contractors, and applicants. Any breakdowns or malicious attacks (e.g., hacking, worms or viruses) affecting these Federal systems could compromise the privacy of the individuals whose information they maintain, as well as the efficiency and effectiveness of the programs that they support. With recent high-profile security incidents involving 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 three final reports on information systems for OPM programs and health insurance carriers.

Federal Information Security Management Act FY 2009

WASHINGTON, D.C.

Report No. 4A-CI-00-09-031

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 (OMB) fiscal year (FY) 2009 Reporting Instructions for the Federal Information Security Management Act and Agency Privacy Management. Our audit revealed significant concerns regarding the overall quality of the



information security program at OPM. Specifically, the agency has not fully documented information security policies and procedures or established appropriate roles and responsibilities.

The lack of policies and procedures was reported as a material weakness in the FY 2007 and FY 2008 FISMA audit reports. While some progress was made in FY 2009, detailed guidance is still lacking. An updated Information Security and Privacy Policy was finalized in August 2009. This policy outlines the IT security controls that should be in place for the major applications owned by the agency. However, the majority of the text in this policy is derived or copied directly from National Institute of Standards and Technology (NIST) guidance, and has not been tailored to specifically address OPM's IT environment. In addition, detailed procedures and implementing guidance are still missing.

This year we expanded the material weakness to include the agency's overall information security governance program and incorporated our concerns about the agency's information security management structure. As of September 2009, we determined that for nearly 18 months OPM did not have a permanent senior agency information security official (SAISO). During this time, we observed a serious decline in the quality of the agency's information security program.

The agency appointed a new SAISO in September 2009; however, the individual left in January 2010. Another new SAISO was appointed in late April 2010. With a new Chief Information Officer also recently selected, OPM may finally be in a position to make long needed improvements to its IT security program. However, given this turbulent history it remains to be seen whether senior management is fully committed to strong IT security governance for the long term.

In addition, at the time of our audit, there had been no permanent Privacy Program Manager assigned to manage the agency's privacy program. As a result, we

found many deficiencies in OPM's privacy program. A Privacy Program Manager has since been hired and has made limited progress in improving OPM's privacy program.

We will further evaluate these developments during our FY 2010 FISMA audit.

Information Systems General and Application Controls at BlueCross BlueShield of Alabama

BIRMINGHAM, ALABAMA

Report No. 1A-10-09-09-020

NOVEMBER 5, 2009

Our audit focused on the claims processing applications used to adjudicate FEHBP claims for BCBS of Alabama (BCBSAL or the Plan), as well as the various processes and IT systems used to support these applications. BCBSAL's local claims processing system is housed in a mainframe environment with the z/OS operating platform and IBM's Resource Allocation Control Facility (RACF) as its security server.

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 Federal Employee Program (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 BCBS plans regarding the scope and effectiveness of edits being used for FEHBP claims processing.



At BCBSAL, we evaluated medical edits in the local claims processing system and FEP Express by processing a set of test claims with known defects and comparing expected results with the actual results obtained during the exercise. While BCBSAL 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. BCBSAL should maintain a comprehensive set of consistently applied medical edits on the national claims processing system. Therefore, we have recommended that the BCBS Association implement medical edits at the national level. The Association resisted our recommendations; however, after further advice from OPM, they agreed to evaluate the feasibility of centrally located medical edits.

General Controls

BCBSAL has established a comprehensive series of IT policies and procedures to create an awareness of IT security. BCBSAL has also implemented an adequate risk assessment methodology, incident response capabilities, and IT security-related human resources controls. In addition, we documented strong controls to prevent unauthorized access to its physical facilities and computer information systems.

To prevent unauthorized changes to application and system software, BCBSAL has established policies and procedures to ensure that modifications occur in a controlled environment. The Plan uses a change management tool to control and track changes. BCBSAL's business continuity plans contain most of the key elements suggested by relevant guidance and publications, and are periodically reviewed, updated, and tested.

Service Credit Redeposit and Deposit System

WASHINGTON, D.C.

Report No. 4A-CF-00-01-021

JANUARY 8, 2010

In July 2009, OPM Director John Berry asked the OIG to investigate the circumstances that led to incorrect computations of amounts owed by employees to obtain credit for previous Federal service. Our review was limited to identifying the causes of the computational errors and validating whether the updated system is now correctly calculating initial balance, interest, and payments.

Under the Civil Service Retirement System (CSRS), employees may make optional deposits for periods of service during which retirement contributions were not withheld from their pay. They may also redeposit refunds of retirement contributions for previous periods of service. Employees who are covered by the Federal Employees Retirement System (FERS) may make optional deposits of retirement contributions that were not withheld from their pay; however, prior to October 28, 2009, they could not redeposit refunds of retirement contributions. Under either system, interest is due on the deposited or redeposited amounts, although interest rates and periods vary. The purpose of making these deposits or redeposits is to obtain credit toward retirement for previous periods of service.

Federal employees submit an application (Standard Forms 2803 or 3108) to participate in the program, and OPM staff gathers the necessary information to process the request, including prior periods of service, earnings, refund amounts, and other related data. They determine the initial balance, including interest, and set up an account. OPM's Chief Financial Officer (CFO) is responsible for processing service credit payments made after accounts have been established.



Until 2006, this process was facilitated by a mainframe-based information system that had been in place for many years. This system handled basic transactions, but was not designed to accommodate the many complexities of the business process, particularly the special retirement rules for various classes of federal employees. These more complex transactions were processed manually. However, in April 2006, a more modern version of the service credit system was released which allowed most types of transactions to be automatically processed on users' desktop computers.

In December 2007, OPM staff discovered anomalies in the payment and interest amounts and later discovered that in some cases the system was not properly calculating interest. Attempts to correct the problems were not successful. In July 2008, the system was eventually taken offline. In October 2008, a partially corrected version was brought back on-line and has been used to establish new accounts. OPM staff members manually calculate balances and update accounts to reflect payment activity while system development and testing of version 4.4 of the system continues.

Overall, nothing came to our attention that caused us to believe that the Service Credit Redeposit and Deposit (SCRD) system version 4.4 is not properly calculating initial interest or accruing interest when payments are made. However, we did note several areas of concern associated with the original and

continuing system development and maintenance process, as well as other system problems, unrelated to the computational module, that could result in accounts with understated or overstated balances.

- **Separation of duties.** There is an inadequate separation of duties related to the procedures for managing changes to the SCR D application. Software modifications can be programmed and compiled by the same person. This means that unauthorized programming changes can be made to the application without the knowledge or approval of the system owners. The Benefit Systems Group (BSG), within the Center for Information Services (CIS), has purchased new change management software that ensures separation of duties and is designing and implementing new procedures.
- **System requirements.** The system requirements (or business rules) were not fully developed and documented prior to system implementation. We identified a number of cases where either the business rules were incorrect or were not properly incorporated in the system.
- **Data entry errors.** We found a high percentage of errors that occurred during the manual process of establishing employees' service credit accounts. In most of these cases, either incorrect periods of service or earnings amounts were entered.



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.

OPM'S CONSOLIDATED FINANCIAL STATEMENTS AUDITS

The CFO Act requires that audits of OPM's financial statements be conducted in accordance with generally accepted government auditing standards (GAGAS) issued by the Comptroller General of the United States. OPM contracted with KPMG LLP (KPMG) to audit the consolidated financial statements as of September 30, 2009. The contract requires that the audit be done in accordance with GAGAS and the Office of Management and Budget (OMB) bulletin number 07-04, *Audit Requirements for Federal Financial Statements*.

OPM's consolidated financial statements include the Retirement Program (RP), Health Benefits Program (HBP), Life Insurance Program (LP), Revolving Fund Programs (RF), and Salaries and Expenses fund (S&E). The RF programs provide funding for a variety of human resource-related services to other Federal agencies, such as: pre-employment testing, background investigations, and employee training. The S&E funds provide the resources used by OPM for the administrative costs of the agency.

KPMG's responsibilities include, but are not limited to, issuing an audit report that includes:

- opinions on the consolidated financial statements and the individual statements for the three benefit programs;
- a report on internal controls; and,
- a report on compliance with certain provisions of laws, regulations, and contracts.

In connection with the audit contract, we oversee KPMG's performance of the audit to ensure that it is conducted in accordance with the terms of the contract and is in compliance with GAGAS and other authoritative references.

Specifically, we were involved in the planning, performance, and reporting phases of the audit through participation in key meetings, reviewing KPMG's work papers, and coordinating the issuance of audit reports. Our review disclosed that KPMG complied with GAGAS.

In addition to the consolidated financial statements, KPMG performed the audit of the special-purpose financial statements (closing package) in accordance with Chapter 4700 of the U.S. Department of the Treasury's Financial Manual. The U.S. Department of the Treasury and the Government Accountability Office use the closing package in preparing and auditing the government-wide Financial Report of the United States.



OPM's FY 2009 Consolidated Financial Statements WASHINGTON, D.C.

Report No. 4A-CF-00-09-037

NOVEMBER 10, 2009

KPMG audited OPM's balance sheets as of September 30, 2009 and 2008 and the related consolidated financial statements. KPMG also audited the individual balance sheets of the Retirement, Health and Life Insurance benefit programs (hereafter referred to as the Programs), as of September 30, 2009 and 2008 and the Programs' related individual financial statements for those years. The Programs, which are essential to the payment of benefits to Federal civilian employees, annuitants, and their respective dependents, operate under the following names:

No Material Weakness Reported in FY 2009

- Civil Service Retirement System
- Federal Employees Retirement System
- Federal Employees Health Benefits Program
- Federal Employees' Life Insurance Program

KPMG reported that OPM's consolidated financial statements and the programs' individual financial statements for FYs 2009 and 2008, as presented in OPM's FY 2009 Agency Financial Report, were presented fairly, in all material respects, in conformity with GAGAS. KPMG audits generally include identifying control deficiencies, significant deficiencies, and material weaknesses.

*An **internal control deficiency** exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis.*

*A **significant deficiency** is a deficiency, or combination of control deficiencies, in an internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.*

*A **material weakness** is a deficiency, or combination of significant deficiencies, in an internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.*

KPMG did not identify any deficiencies in internal controls over financial reporting that are considered to be a material weakness. However, KPMG identified two significant deficiencies that remain unresolved from prior years. The areas identified by KPMG are:

■ **Information Systems General Control Environment**

OPM has made continuous enhancements to its information technology and information security infrastructure; however, security policies and procedures including drafting risk assessments and security plans have not been updated to incorporate current authoritative guidance. In addition, sufficient independent oversight of certain certification and accreditation activities is not consistently performed, and the procedures performed to certify and accredit certain financial systems were not complete. OPM's application access permissions have not been fully documented to ensure effective systems controls. In addition, KPMG found that the Plans of Actions and Milestones were not always accurate and complete.

Significant Deficiencies Remain in OPM's IT and Security Infrastructure



■ *Financial Management and Reporting Processes of the CFO*

OPM has made improvements; however, certain deficiencies continue to exist in the operations of the CFO's internal controls over financial management and reporting, affecting the accuracy of the RF Program and S&E Fund.

Table 1 includes the significant deficiencies identified by KPMG during its audit of the financial statements for FY 2009 and 2008, respectively. OPM agreed to the findings and recommendations reported by KPMG.

Table 1: Internal Control Weaknesses

Title of Findings From FY 2009 Report	Program/Fund	FY 2009	FY 2008
Information Systems General Control Environment	All	Significant Deficiency	Significant Deficiency
Financial Management and Reporting Processes of the CFO	S&E and RF	Significant Deficiency	Significant Deficiency

KPMG's report on compliance with certain provisions of laws, regulations, and contracts disclosed one instance of noncompliance or other matter regarding the *Federal Financial Management Improvement Act of 1996* related to the RF and S&E Funds. In accordance with OMB Circular A-127, *Financial Management Systems*, as amended, OPM is required to record financial events consistent with the applicable definitions, attributes, and processing rules defined in the United States General Ledger (USGL) at the transaction level. KPMG found that the CFO does not consistently record RF Program and S&E Fund transactions at the USGL transaction level.

and the provisions of OMB's Bulletin No. 07-04. OPM's Closing Package Financial Statements include:

- The reclassified statements (formatted according to The Department of the Treasury's specifications) as of September 30, 2009 and 2008;
- The Additional Note No. 29 (discloses other data necessary to make the Special-Purpose Financial Statements more informative); and,
- The Trading Partner Statements (showing the funds due between OPM and other agencies) as of September 30, 2009.

**FY 2009
Closing Package
Financial
Statements
Receive Another
Clean Opinion**

OPM's FY 2009 Special-Purpose Financial Statements WASHINGTON, D.C.

Report No. 4A-CF-00-09-038
NOVEMBER 16, 2009

The audit of closing package financial statements, also referred to as special-purpose financial statements, is required in accordance with GAGAS

KPMG reported that these statements are presented fairly, in all material respects.

KPMG did not identify any material weaknesses or significant deficiencies involving the internal control over the financial process for the special-purpose financial statements, nor did they disclose any instances of non-compliance or other matters that are required to be reported.



OPM's Security Guard Contract WASHINGTON, D.C.

Report No. 4A-CA-00-09-043

JANUARY 21, 2010

We conducted a performance audit of OPM's security guard contract because of certain incidents of security breaches at Federal buildings and facilities and the government's emphasis on efforts to ensure the security of buildings and facilities.

OPM's Management Services Division's Center for Security and Emergency Actions (CSEA) is responsible for administering and providing oversight of its security guard contract, with the primary mission of ensuring a safe and secure work environment so that OPM business can proceed without interruption.

**Guard Post
Inspections Were
Not Conducted
in Accordance
with OPM Policy**

Our auditors reviewed security guard qualifications and certifications, CSEA's implementation of

the performance metrics contained in its Quality Assurance Surveillance Plan (QASP), and guard post inspection policies and procedures.

We identified three specific areas requiring improvement:

- Documented policies and procedures were not in place to ensure that all security guards working on the OPM contract received current training and certifications;
- The QASP's measurement of the true performance of the security guard contract was ineffective; and
- CSEA's post inspection policy to ensure that the security guards are properly protecting the Theodore Roosevelt Building was not appropriately followed. Our review of documented post inspections revealed that CSEA was unable to substantiate that post inspections were conducted in accordance with its policy.

OPM has implemented all except one of our recommendations. We will work with the agency to ensure the remaining recommendation is implemented.



Special Audits

In addition to health and life 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.

FEDERAL LONG TERM CARE INSURANCE PROGRAM AND VOLUNTARY BENEFITS PORTAL

The FLTCIP was established by the Long Term Care Security Act of 2000, which directed OPM to develop and administer a long term care insurance program for Federal employees and annuitants, current and retired members of the uniformed services, and qualified relatives.

In December 2001, OPM awarded a seven year contract to the Long Term Care Partners (LTCP) to offer long term care insurance coverage to eligible participants. Originally, the LTCP was a joint venture between the John Hancock Life Insurance Company (John Hancock) and the Metropolitan Life Insurance Company. The contract began on March 25, 2002,

and expired on April 30, 2009. A new contract was awarded to John Hancock upon the expiration of the original contract. The LTCP, with OPM oversight, is responsible for all administrative functions of the program, including marketing and enrollment, underwriting, policy insurance, premium billing and collection, and claims administration.

In March 2005, OPM amended the LTCP contract to include the development, maintenance and administration of a voluntary benefits portal to support the provisions of the FLTCIP, FEDVIP, and the FSAFEDS program. The voluntary benefits portal, known as BENEFEDS, has three major components: an enrollment website; a premium administration system; and, a customer service system.

During this reporting period, we issued one report on the program covering contract years 2005 through 2008.



**Federal Long Term Care Partners,
LLC/BENEFEDS Relating to the
Federal Employees Dental and
Vision Insurance Program**

PORTSMOUTH, NEW HAMPSHIRE

Report No. 1G-LT-00-08-062

NOVEMBER 4, 2009

This audit covered BENEFEDS premium payments, administrative expenses, and cash management activities related to the FEDVIP for contract years 2005 through July 2008. During this period, BENEFEDS collected approximately \$588 million in premiums and disbursed approximately \$550 million to participating health carriers. LTCP and OPM received approximately \$23 million and \$11 million, respectively, to administer the FEDVIP program. Additionally, LTCP was reimbursed \$2 million for the development of the FEDVIP portion of the BENEFEDS voluntary benefits portal.

The audit's primary objective was to determine if LTCP administered BENEFEDS in compliance with the contract and the FEDVIP regulations. We reviewed approximately \$17.6 million in premium payments collected during contract years 2007 and 2008 to determine if the amounts were paid to the appropriate carriers, and if the fees deducted from the premiums were calculated correctly. We also reviewed approximately \$809,000 in administrative expenses to determine if the expenses were actual, necessary, reasonable, and in accordance with the contract provisions. Finally, we examined bank accounts and flowcharts related to FEDVIP funds to ensure that LTCP/BENEFEDS was in compliance with the contract provisions relative to cash management activities.

Based on our review of administrative expenses, premium payments, and cash management activities, we found that the FEDVIP operations for contract years 2005 through July 2008, as administered by LTCP/BENEFEDS, were in accordance with the contract and regulations.

**FEDERAL 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
Metropolitan Life Insurance Program**

BRIDGEWATER, NEW JERSEY

Report No. 2A-II-00-09-019

JANUARY 12, 2010

In August 2006, OPM awarded a contract to Metropolitan Life Insurance Program (MetLife) to administer dental benefits under the FEDVIP. We tested application controls over claim benefit payments, premiums, and cash management activities for contract years 2007 and 2008. During this period, benefit charges totaled \$332 million and premiums received totaled \$361 million.

We developed 24 dental claim case scenarios based on information provided by MetLife and the best practices of health insurance carriers. We reviewed the results from the test cases to determine whether MetLife 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 approximately \$114 million in premiums for 2007 and 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 MetLife's bank statements to ensure that they were received timely and were accurately transferred into the appropriate accounts.

We found that MetLife's Explanation of Benefits (EOB) statements do not provide its members with sufficient details to determine amounts paid by the health carriers for services provided, nor the members' payment responsibility for covered services.

MetLife agreed with this finding and plans to revise the EOB to improve member understanding of covered expenses, coordination of benefits, if applicable, and out-of-pocket expenses.

COMBINED FEDERAL CAMPAIGN

The Combined Federal Campaign is the only authorized charitable fundraising drive conducted in Federal installations throughout the world. OPM has the responsibility, through both law and executive order, to regulate and oversee the conduct of fundraising activities in Federal civilian and military workplaces worldwide.

CFCs are identified by geographical areas that may include only a single city, or encompass several cities, counties, or states. Our auditors review the administration of local campaigns to ensure compliance with Federal regulations and OPM guidelines. In addition, all campaigns are required by regulation to have an independent public accounting firm (IPA) audit their respective financial activities for each campaign year. The audit must be in the form of an agreed-upon procedures engagement to be completed by an IPA. We review the IPA's work as part of our audits.

CFC audits do not identify savings to the government, because the funds involved are charitable donations made by Federal employees. Our audit efforts

occasionally generate an internal referral to our criminal investigators for potential fraudulent activity. OPM's CFC Operations (CFCO) works with the auditee to resolve the findings after the final audit report is issued.

LOCAL CFC AUDITS

The local organizational structure consists of:

- ***Local Federal Coordinating Committee (LFCC)***

The LFCC is a group of Federal officials designated by the OPM Director to conduct the CFC in a particular community. It organizes the local CFC, determines the eligibility of local charities to participate, supervises the activities of the Principal Combined Fund Organization (PCFO), and resolves issues relating to a local charity's noncompliance with the CFC policies and procedures.

- ***Principal Combined Fund Organization***

The PCFO is a federated group or combination of groups, or a charitable organization, selected by the LFCC to administer the local campaign under the direction and control of the LFCC and the Director of OPM. Their duties include collecting and distributing CFC funds, training volunteers, and maintaining a detailed accounting of CFC administrative expenses incurred during the campaign. The PCFO is reimbursed for its administrative expenses from CFC funds.

- ***Local Federations***

A local federation is a group of local voluntary charitable human health and welfare organizations created to supply common fundraising, administrative, and management services to its constituent members.

- ***Independent Organizations***

Independent Organizations are organizations that are not members of a federation for the purposes of the CFC.



During this reporting period, we issued three audit reports of local CFCs. Our auditors identified several violations of regulations and guidelines governing local CFC operations. Specifically, they identified the following types of errors:

■ ***Disbursement of CFC Funds from PCFO Account***

One PCFO inappropriately disbursed CFC funds from the PCFO's corporate checking account.

■ ***Approval of PCFO Expense Reimbursement***

Three PCFOs reimbursements for campaign expenses were not properly approved by the LFCC prior to payment.

■ ***Estimated Expense Charged to the Campaign***

One PCFO charged its administrative operating costs based on estimated costs and not the actual costs.

■ ***Campaign Expenses Charged to the Incorrect Campaign Year***

One PCFO charged the campaign for expenses related to other campaign years.

■ ***Pledge Card Errors***

Three PCFOs incorrectly: entered pledge information or misinterpreted the donor's intentions on pledge cards; applied donor designations; and, contacted a donor directly regarding an identified pledge card error.

■ ***Untimely CFC Distributions***

One PCFO did not make initial or final campaign disbursements by the dates required by the CFCO guidance and the Federal regulations.

■ ***Donor Lists***

One PCFO did not send donor lists to all agencies and federations by the required dates. Additionally, the PCFO incorrectly released donor information to the agencies.

■ ***CFC Receipts Applied to the Wrong Campaign Year***

Three PCFOs did not apply all incoming CFC receipts to the correct campaign year as required by CFC Memorandum 2006-5.

■ ***Accounting for CFC Funds***

One PCFO did not provide a detailed reconciliation to support the transfer of funds from the CFC account to cover campaign expenses and charity distributions.

■ ***Lack of Support for LFCC Eligibility Decisions***

One LFCC did not maintain documentation to support its eligibility decisions of local organizations' applications.

■ ***LFCC Eligibility Decisions Not Communicated Timely***

One LFCC did not communicate its eligibility decisions to the agencies and federations by the appropriate date or via the proper delivery method.

■ ***Local Eligibility Notification Letters Mailed Untimely***

One LFCC did not mail local agency and federation eligibility letters to applicants of the campaign by the required date.

■ ***Agreed-Upon Procedures Not in Compliance***

One IPA's campaign audit did not comply with all aspects of the applicable audit guide.

We provided audit findings and recommendations for corrective action to OPM management. OPM notified the various CFC organizations of our recommendations and monitored for corrective actions. If the CFC organizations do not take corrective action to comply with CFC regulations, applicable laws, and OPM directives or instructions, the OPM Director can impose sanctions and/or penalties, up to and including expulsion from the CFC.



ENFORCEMENT ACTIVITIES

Investigative Cases

The Office of Personnel Management administers benefits from its trust funds, with approximately \$825 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 79 criminal investigations and closed 70, with 311 still in progress. Our criminal investigations led to 45 arrests, 46 indictments and informations, 70 convictions and \$4,445,799 in monetary recoveries to the OPM Trust Fund. For a complete statistical summary of our office's investigative activity, refer to the table on page 30.

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 task forces. 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 debarment official when investigations of FEHBP health care providers reveal evidence of violations that may warrant administrative sanctions.

HEALTH CARE FRAUD CASES

Drug Manufacturer Enticed Physicians Through Paid Training and Speaking Engagements at Lavish Resorts to Push Drugs

In March 2010, Alpharma, Inc., a pharmaceutical manufacturer, entered into a settlement agreement to pay the government \$42.5 million to resolve false claims allegations in connection with the marketing of its morphine-based drug, Kadian. The settlement will be split between the Federal Government and several states.

The government filed charges against Alpharma for payments and kickbacks to physicians, and for misrepresenting Kadian's effectiveness in order to induce physicians to prescribe the drug. In addition, physicians were paid to attend speaker training events at lavish resorts. After completing the

training, Alpharma paid the physicians for speeches geared toward enhancing the benefits of Kadian.

The FEHBP received \$416,000 in the civil settlement.

This was a joint investigation with the Federal Bureau of Investigations (FBI), the HHS OIG, the Defense Criminal Investigative Service, and our office.

Husband of Federal Postal Employee Who Obtained Narcotic Prescriptions from 313 Physicians Sentenced

In our semiannual report ending March 31, 2009, we reported on the indictment of the husband of a Federal employee in Anchorage, Alaska.

The husband fraudulently obtained narcotic controlled substances (pain medications) from multiple physicians, dentists and a nurse practitioner. The husband lied to the health care professionals concerning whether he was already taking narcotic pain medication and he also lied about earlier medical procedures that required prescriptions for narcotic pain medication.

In over four years, the husband received prescriptions from at least 313 different medical providers and had the prescriptions filled at 62 different pharmacies. The cost to the FEHBP for illegal prescriptions and medical claims was over \$600,000.

In November 2009, the husband pled guilty to obtaining a controlled substance by misrepresentation or forgery and health care fraud. In January 2010, he was sentenced to nine months in prison; three years of supervised release; and, ordered to pay restitution of \$69,416 to the FEHBP.

The investigation was conducted jointly by the Drug Enforcement Administration's Office of Diversion Control and our office.



Postal Employee Convicted in “Doctor Shopping” Investigation

A United States Postal Service (USPS) letter carrier confessed to “doctor shopping,” a practice of secretly consulting with multiple physicians to obtain duplicate prescriptions. During a 25-month period, the letter carrier visited over 58 providers and 37 pharmacies, costing the FEHBP over \$250,000. The letter carrier also admitted to driving his postal vehicle under the influence of narcotic medications such as Vicodin and Percocet. During this period, he also operated the vehicle with a suspended driver’s license.

In January 2010, subsequent to his confession, a Federal Grand Jury indicted him for health care fraud and obtaining narcotic controlled substances by misrepresentation or forgery.

In March 2010, he pled guilty to obtaining narcotic controlled substances by misrepresentation or forgery. His sentencing is scheduled for later this year.

The BCBS Association referred the case to our office. This was a joint investigation by our office and the FBI.

Maryland Anesthesiologist Forfeits Assets

In March 2010, an anesthesiologist convicted on false statements in health care matters was ordered to pay the FEHBP Trust Fund through asset forfeiture of \$528,714. The anesthesiologist submitted numerous claims to health benefit programs to seek payment for transforaminal epidural injections (TEIs). The TEIs are complex injections made around the spinal area for pain relief, and require specialized equipment, including fluoroscopic image guidance and 3.5 inch long needles. The anesthesiologist did not have the necessary medical equipment to perform TEIs and later admitted that he did not actually perform the TEIs as part of his medical practice.

In February 2008, the anesthesiologist pled guilty to false statements in relation to health care matters. He was sentenced to 37 months incarceration and agreed to pay \$5 million in the civil settlement.

The anesthesiologist’s office manager pled guilty to false statements in relation to health care matters for her role as a conspirator. In April 2009, she was sentenced to three years probation and six months home detention. Additionally, an FEHBP member pled guilty to trafficking oxycodone within a school zone. He received the oxycodone prescriptions from the anesthesiologist. The member was sentenced to 57 months incarceration.

This case was investigated by the HHS OIG, FBI, Department of Labor OIG and our office.

We debarred the anesthesiologist from participation in the FEHBP. For additional details about this debarment action, refer to page 29 in our administrative sanctions activities section of this report.

Medical Equipment Provider Defrauds Cerebral Palsy Patient

In February 2010, the Maryland Attorney General charged the owner of a durable medical equipment (DME) company with Medicaid fraud for falsely billing the Medicaid and Medicare programs for wheelchairs that were never provided. The DME provider received payments totaling \$20,073 from CareFirst BCBS for a custom designed power wheelchair for an FEHBP member who has cerebral palsy. The patient’s family repeatedly attempted to obtain the wheelchair, which the patient desperately needed; however, it was never provided.

In March 2010, the owner pled guilty to Medicaid fraud. He was sentenced to two years incarceration and five years probation. As a special condition of probation, he will serve six months home detention; perform 200 hours of community service; and, pay \$36,370 in restitution. FEHBP will receive \$19,096 of the restitution.



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. One of our proactive initiatives is to review data to identify annuitant records with specific characteristics and anomalies that have shown, in the past, to be good indicators of retirement fraud. We also use automated data systems available to law enforcement agencies to obtain information on annuitants that may alert us of instances where payments should no longer be made. We confirm the accuracy of the information through follow-up inquiries. Routinely, OPM's Retirement and Benefits Office refers to our office potential fraud cases identified through computer death matches with the Social Security Administration (SSA). Other referrals come from Federal, state, and local agencies, as well as private citizens.

Son of Deceased Annuitant Sentenced in Retirement Fraud Scheme

In our semiannual report ending September 30, 2009, we reported the conviction of a deceased annuitant's son who failed to notify OPM of his father's death in October 1995. The son, following his father's death, continued to receive his father's benefits that were deposited electronically into the bank account he held jointly with his father. The son used the benefits for his personal use, including mortgage payments. The overpayment after OPM reclaimed \$60,814 from the bank account was \$547,669.

In August 2008, the 71 year old son pled guilty to theft of government funds. In October 2009, the son was sentenced to six months home confinement and ordered to pay restitution to OPM in the amount of \$547,669.

Woman Sentenced for Stealing Her Deceased Mother's Retirement

In August 2007, we received information from a confidential informant alleging that the daughter of a deceased Federal employee was stealing money from a bank account belonging to her mother, who died in October 2001. The informant also indicated that the daughter was cashing U.S. Treasury checks at a check cashing company in Los Angeles, California.

The security department at the check cashing company verified that checks had been cashed in the name of the deceased annuitant. The company provided copies of the cashed checks which were issued by the SSA.

The SSA OIG verified that the social security payments were issued to the deceased. In addition, the check cashing company's security agent provided a video recorded image of the daughter cashing the U.S. Treasury checks.

Our agents interviewed the daughter who provided a full confession. In September 2008, the daughter was indicted for wire and mail fraud, and theft of government property. In December 2008, the daughter pled guilty to the theft of government property.

In October 2009, the daughter was sentenced to 18 months incarceration, 36 months of probation, and ordered to pay full restitution of \$71,444. Of the restitution, OPM will receive \$59,955.

The investigation was conducted jointly by the SSA OIG and our office.



Daughter Concealed Mother's Death with Plastic Sheets and Deodorizers

In December 2009, following media reports of the concealed death in Wilmington, North Carolina of a Federal survivor annuitant, we initiated an investigation. After an anonymous 911 call, the annuitant was found dead in her bed. Local authorities believe the woman died eight months prior to the 911 call. The deceased annuitant's daughter lived in the home where the body was found, with her husband and three children. She was unemployed and her husband was on disability. The daughter concealed the death from other family members by covering the body with plastic sheets and deodorizers. She was later charged with failure to report a death. Local authorities believe the daughter did not report the death so that she could continue to collect Social Security and OPM retirement benefits.

Our agents confirmed the decedent's Federal annuitant status and coordinated with the SSA OIG and the Sheriff's Office, New Hanover County, North Carolina. The daughter confessed to not reporting her mother's death and to receiving the OPM and SSA retirement benefits intended for her mother. She illegally received nearly \$6,000 in OPM retirement benefits.

In March 2010, the daughter pled guilty and was convicted of failure to report a death and obtaining property by false pretense. She was sentenced to three consecutive five to six month jail terms, which were suspended. She was also sentenced to 36 months probation; ordered to pay \$4,961 in restitution to OPM; \$3,354 to SSA; a \$500 fine; 100 hours community service; and, to complete a mental health evaluation and treatment.

This case was prosecuted by the New Hanover County District Attorney's Office and investigated by the SSA OIG, the New Hanover County Sheriff's Office, and our office.

Deceased Annuitant's Son Used Money to Fund International Travel

A death match conducted with the SSA revealed that a retired Federal annuitant died in January 1992. OPM was not notified of his death until September 2007 and continued to issue annuity payments, resulting in an overpayment of \$256,935.

Our investigators interviewed the deceased annuitant's son, who admitted to forging his father's name on U.S. Treasury checks and the OPM address verification form. In addition, in November 1998, the son contacted OPM to convert paper check payments to electronic funds transfer. Through a review of bank records, our investigators determined that the son, while in Trinidad and Nigeria, made automated teller machine withdrawals of the annuity payments.

In August 2009, the son pled guilty to 44 counts of theft of government funds. In November 2009, he was sentenced to 18 months incarceration; 3 years of supervised probation; and, ordered to pay full restitution of \$256,953 to OPM.

Daughter Posed as Dead Father to Steal His Retirement Checks

In November 2008, we received an allegation that a deceased annuitant's daughter fraudulently received her father's annuity payments. Our investigators found that the father's annuity payments were terminated shortly after his death in March 2002. However, in April 2002, the daughter, posing as her father, contacted OPM and questioned why the annuity payments ceased. Because the daughter falsely affirmed that the annuitant was still alive, OPM reinstated him to the active annuity rolls and resumed his annuity payments. In addition, OPM issued a retroactive lump sum payment of \$1,122.



Also, the daughter forged her father's signature, opened a joint account, deposited and sometimes cashed the annuity checks, using the benefits for her personal use. Her false representations resulted in an overpayment of \$108,859. In July 2009, the daughter pled guilty to theft of public money, property, or records.

In October 2009, the daughter was sentenced to three years probation and ordered to pay OPM restitution of \$108,859.

Daughter Sentenced for Theft of Government Funds

As reported in our last semiannual report, the daughter of a deceased Federal annuitant pled guilty to theft of government funds. OPM was not notified that the Federal annuitant died in February 1982. Therefore, OPM continued to issue annuity payments resulting in an overpayment of \$235,737.

The daughter admitted that after her mother's death, she forged her mother's name on various OPM documents. In October 2009, she was sentenced to three years probation, and ordered to pay \$235,737 in restitution to OPM.

This was a joint investigation with the U.S. Secret Service and our office.

Daughter Steals Retirement Funds

A Federal survivor annuitant's daughter failed to notify OPM of her mother's death, and used annuity payments to which she was not entitled. After her mother's death in 1994, the daughter continued to fraudulently receive her mother's annuity checks for over 10 years. The daughter endorsed and cashed the checks by forging her deceased mother's name. The daughter admitted that she used the funds to meet her daily expenses.

In November 2009, the daughter pled guilty to theft of government funds. In March 2010, she was sentenced to 18 months imprisonment; 3 years of supervised release; and, ordered to pay \$240,899 in restitution to OPM.

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 8,400 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.



Material False Representations Influenced Government's Decisions

A background investigator employed by OPM FIS was removed from his position after verification letters confirmed that information in his Report of Investigation (ROI) was inaccurate. The fabricated background investigation reports involved Top Secret clearances for potential government employees in Indiana, Ohio, and Pennsylvania. When confronted by OPM FIS, the background investigator initially denied all allegations of the falsifications and resigned.

Between September 2005 and September 2006, in at least a dozen background investigations ROI's, the investigator represented that he had interviewed a source or reviewed a record regarding the subject of the background investigation when he had not. The background investigator ultimately admitted that he falsified these documents to satisfy productivity expectations and to receive favorable ratings on his performance evaluation. The investigator's false representations in his ROI required OPM FIS to reinvestigate numerous background investigations at an estimated cost of \$61,405.

In November 2009, the investigator pled guilty to making a false statement. In March 2010, he was sentenced to five months of imprisonment; five months house arrest with electronic monitoring via ankle bracelet; three years probation; and, ordered to pay full restitution of \$61,405.

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 679 formal complaints and calls on these hotlines during the reporting period. The table on page 30 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 317 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 362 complaints during this reporting period, including telephone calls, emails, and letters.



OIG-Initiated Complaints

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

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

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

Correction to Prior Period Investigative Reporting Error

In our semiannual report for the period ending March 31, 2009, we inadvertently reported that the FEHBP received \$1.9 million in a civil settlement with Eli Lilly and Company. We had been advised that we would collect lost investment income on the settlement; however, lost investment income was not recovered and the FEHBP actually received \$1.5 million. We regret the reporting error.



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 31,238 active suspensions and debarments from the FEHBP.

During the reporting period, our office issued 421 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 1,219 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.



Pennsylvania Physician and His Medical Practice Suspended from FEHBP after Guilty Plea

In March 2010, we suspended a physician and his practice, based on a referral from our Office of Investigations regarding the provider's guilty plea to health care fraud. The physician has participated in the FEHBP plans as a provider of medical services.

According to the Information which led to the guilty plea, the physician submitted false and fraudulent claims that he:

- performed treatment and provided other services to patients on certain dates, when he knew he did not render the treatment and other services, and,
- overstated the services he actually rendered to patients.

As a result of the false and fraudulent claims, the physician received payments of approximately \$1,083,358 from health care insurers.

The suspension is effective for an indefinite period pending the formal entry of judgment against the provider.

State Convicted Individual Not Licensed to Perform Chiropractic Services and His Practice Debarred

During a prior reporting period, our Office of Investigations referred to the administrative sanctions staff a case involving an individual not licensed to perform chiropractic services in Louisiana, who had been convicted of insurance fraud. According to the felony bill of indictment, the individual violated the felony laws of Louisiana by committing 42 counts of insurance fraud. At the time of the insurance fraud offenses, the individual was performing chiropractic treatments on patients. However, he was neither a chiropractor nor did he have training or licensure to perform chiropractic

services in Louisiana. He ran a clinic in Baton Rouge which provided braces for scoliosis patients. He expected upfront payments from his clients who thought they were being treated by a licensed medical doctor. From January 2000 to February 2006 the individual submitted claims to an FEHBP carrier totaling \$18,974, and was issued payments totaling \$2,555. From January 1, 2000 through March 31, 2006, he submitted claims to another FEHBP carrier for \$435,819, and received \$142,661 in total payments. He fraudulently billed yet another FEHBP carrier for approximately \$88,000. He was convicted of 8 of the 42 counts of insurance fraud.

We debarred the individual for five years based upon the aggravating factors associated with his offenses, including the financial loss to the FEHBP carriers, and the prolonged period during which he knowingly submitted false claims. In addition, based upon ownership and control, we debarred his clinic.

Texas Psychologist Debarred

In October 2009, we debarred a licensed psychologist, whose office was located in Corpus Christi, Texas. This case was referred to sanctions staff by our Office of Investigations.

From as early as January 2001 until May 2008, the psychologist submitted and/or caused the submission of fraudulent claims for psychological testing services he did not provide. Between 2001 and 2008, he submitted claims and received FEHBP payments totaling \$24,451.

The FEHBP administrative sanctions statute makes debarment mandatory for providers convicted of this type offense. We identified several aggravating factors in the psychologist's case. Based on the aggravating factors associated with his offenses, and the prolonged period during which he knowingly submitted false claims, we imposed a five year period of debarment.



Oklahoma Medical Doctor Suspended After Indictment

In March 2010, our office suspended an Oklahoma licensed medical doctor, specializing in psychiatry, with offices in Gretna, Louisiana. The doctor was indicted on 48 counts of health care fraud. Our Office of Investigations referred this case to the sanctions staff. We determined that during the period of the allegations, the doctor billed the FEHBP for amounts totaling \$259,781. The amount paid to the doctor was at least \$90,055.

The indictment alleges, among other things, that from 1999 until 2006 the doctor:

- Submitted false claims for payment for prolonged physician services for patients who were not in the office (patient by proxy); prolonged physician services that were not actually rendered by him or anyone on his staff because the patients were not present in the office for the total amount of time billed for extensions, such as:
- Billing for patients who were not physically present in his office, instead he discussed the absent patient's condition with a family member or other related or interested person.
- Billing for patients he claimed to have performed services for, both the absent patient and the interested person or family member, on the same date, when actually he met with an interested person or family member instead of the patient.
- Billing for prolonged physician services that were not actually rendered by him or anyone on his staff.

Billing for patient services as a continuation of services, on dates when the patients were not in his office.

The doctor's actions clearly pose a risk to the health and safety of his patients. His suspension is for an

indefinite period, pending the outcome of formal judicial proceedings resulting from his indictment.

Maryland Anesthesiologist and His Practice Debarred

During a prior reporting period, our Office of Investigations referred to the administrative sanctions staff a case involving an anesthesiologist who offered pain management treatment in several offices in Maryland.

Between January 2000 and April 2006, with assistance of his staff, the anesthesiologist submitted numerous false and fraudulent claims to health benefits programs for payment on services which he did not perform, such as: transforaminal epidural injections, myelography; and, "moderate" office visits.

In 2008, the anesthesiologist waived trial by jury, and prosecution by indictment. He consented that proceeding may be made by an Information. On the same date, he pled to false statements relating to health care matters. The FEHBP suffered a huge financial loss because of the anesthesiologist's fraudulent activities. The loss may have been as high as \$965,000.

We debarred the individual for seven years based upon the aggravating factors associated with his offenses, including the financial loss to the FEHBP carriers, and the prolonged period during which he knowingly submitted false claims. In addition, based upon ownership and control, we debarred his clinic which was used in committing the fraudulent activities.

More details concerning our investigation of this case and its legal consequences appear in the investigations activity section of this report on page 21.



Statistical Summary of Enforcement Activities

JUDICIAL ACTIONS:

Arrests	45
Indictments and Informations	46
Convictions	70

JUDICIAL RECOVERIES:

Restitutions and Settlements	\$4,445,799
Fines, Penalties, Assessments, and Forfeitures	\$85,390

RETIREMENT AND SPECIAL INVESTIGATIONS HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry	27
Referred to:	
OPM Program Offices	165
Other Federal Agencies	124
Total	317

HEALTH CARE FRAUD HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry	84
Referred to:	
OPM Program Offices	77
Other Federal/State Agencies	57
FEHBP Insurance Carriers or Providers	144
Total	362
Total Hotline Contacts and Complaint Activity	679

ADMINISTRATIVE SANCTIONS ACTIVITY:

Debarments and Suspensions Issued	421
Health Care Provider Debarment and Suspension Inquiries	1,219
Debarments and Suspensions in Effect at End of Reporting Period	31,238



APPENDICES

APPENDIX I Final Reports Issued With Questioned Costs for Insurance Programs OCTOBER 1, 2009 TO MARCH 31, 2010

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	12	\$10,576,494
B. Reports issued during the reporting period with findings	9	23,308,748
Subtotals (A+B)	21	33,885,242
C. Reports for which a management decision was made during the reporting period:	16	13,441,818
1. Disallowed costs	N/A	13,351,478
2. Costs not disallowed	N/A	90,340
D. Reports for which no management decision has been made by the end of the reporting period	5	20,443,424
E. Reports for which no management decision has been made within 6 months of issuance	0	0



APPENDIX II – A
Final Reports Issued with Recommendations
for All Other Audit Entities

OCTOBER 1, 2009 TO MARCH 31, 2010

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	3	\$173,258
B. Reports issued during the reporting period with findings	0	0
Subtotals (A+B)	3	173,258
C. Reports for which a management decision was made during the reporting period:	2	87,930
1. Disallowed costs	N/A	87,930
2. Costs not disallowed	N/A	0
D. Reports for which no management decision has been made by the end of the reporting period	1	85,328
E. Reports for which no management decision has been made within 6 months of issuance	1	85,328

APPENDIX II – B
Final Reports Issued with Recommendations
for Better Use of Funds

OCTOBER 1, 2009 TO MARCH 31, 2010

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



APPENDIX III

Insurance Audit Reports Issued

OCTOBER 1, 2009 TO MARCH 31, 2010

Report Number	Subject	Date Issued	Questioned Costs
1C-6U-00-09-059	FirstCare of Central Texas in Austin, Texas 2009 Proposed Rate Reconciliation	October 6, 2009	\$220,999
1C-CK-00-09-058	FirstCare of West Texas in Austin, Texas 2009 Proposed Rate Reconciliation	October 6, 2009	282,838
1A-99-00-09-036	Global Duplicate Claim Payments for BlueCross and BlueShield Plans in Washington, D.C.	October 14, 2009	9,560,516
1C-JC-00-09-049	Aetna Open Access in Blue Bell, Pennsylvania	October 28, 2009	0
1G-LT-00-08-062	Long Term Care Partners, LLC/ BENEFEDS in Portsmouth, New Hampshire	November 4, 2009	0
1C-A7-00-09-030	Health Net of Arizona, Inc. in Woodland Hills, California	November 4, 2009	80,747
1C-D6-00-09-005	PacifiCare of Colorado in Cypress, California	November 12, 2009	0
1C-HA-00-09-035	Coventry Health Care of Kansas, Inc. in Kansas City, Missouri	December 14, 2009	0
1C-64-00-09-003	Health Plan of Ohio in Cleveland, Ohio	December 17, 2009	0
2A-II-00-09-019	Metropolitan Life Insurance Company in Bridgewater, New Jersey	January 12, 2010	0
1A-10-49-09-025	Horizon BlueCross BlueShield of New Jersey in Newark, New Jersey	February 12, 2010	3,799,334
1C-LX-00-10-007	Blue Care Network of Michigan, Inc. in Southfield, Michigan	February 19, 2010	0
1C-JP-00-09-051	MD-Individual Practice Association, Inc. in Hartford, Connecticut	February 19, 2010	0
1C-MS-00-09-056	Humana Health Plan, Inc. in Louisville, Kentucky	February 19, 2010	0
1C-JK-00-09-045	TakeCare Insurance Company, Inc. in Tamuning, Guam	February 22, 2010	0
1D-2G-00-09-028	CareFirst BlueChoice in Owings Mills, Maryland	February 25, 2010	107,358



APPENDIX III
Insurance Audit Reports Issued
OCTOBER 1, 2009 TO MARCH 31, 2010
(Continued)

Report Number	Subject	Date Issued	Questioned Costs
1A-10-92-09-024	CareFirst BlueCross BlueShield in Owings Mills, Maryland	March 10, 2010	0
1A-99-00-09-061	Global Assistant Surgeon Claims Overpayments for BlueCross and BlueShield Plans in Washington, D.C.	March 30, 2010	1,806,296
1A-10-78-10-002	BlueCross BlueShield of Minnesota in Eagan, Minnesota	March 30, 2010	33,482
1A-99-00-10-009	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.	March 31, 2010	7,417,178
TOTALS			\$23,308,748



APPENDIX IV

Internal Audit Reports Issued

OCTOBER 1, 2009 TO MARCH 31, 2010

Report Number	Subject	Date Issued
4A-CF-00-09-037	OPM's FY 2009 Consolidated Financial Statements in Washington, D.C.	November 13, 2009
4A-CF-00-09-038	OPM's FY 2009 Special-Purpose Financial Statements in Washington, D.C.	November 18, 2009
4A-CA-00-09-043	OPM's Security Guard Contract in Washington, D.C.	January 21, 2010

APPENDIX V

Combined Federal Campaign Audit Reports Issued

OCTOBER 1, 2009 TO MARCH 31, 2010

Report Number	Subject	Date Issued
3A-CF-00-09-039	The 2006 and 2007 Volusia-Flagler-Putnam Combined Federal Campaigns in Daytona Beach, Florida	December 17, 2009
3A-CF-00-09-041	The 2006 and 2007 Illowa Bi-State Combined Federal Campaigns in Davenport, Iowa	February 25, 2010
3A-CF-00-09-040	The 2006 and 2007 Fort Hood Combined Federal Campaigns in Killeen, Texas	March 11, 2010

APPENDIX VI

Information Systems Audit Reports Issued

OCTOBER 1, 2009 TO MARCH 31, 2010

Report Number	Subject	Date Issued
1A-10-09-09-020	Information Systems General and Application Controls at BlueCross BlueShield of Alabama in Birmingham, Alabama	November 5, 2009
4A-CI-00-09-031	Federal Information Security Management Act for FY 2009 in Washington, D.C.	November 5, 2009
4A-CF-00-10-021	Service Credit Redeposit and Deposit System in Washington, D.C.	January 8, 2010



APPENDIX VII
Summary of Audit Reports More Than Six Months Old
Pending Corrective Action
OCTOBER 1, 2009 TO MARCH 31, 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-10-00-03-013	Global Coordination of Benefits (Tier 1) for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 1 open recommendation	March 31, 2004
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-10-00-03-102	Global Coordination of Benefits (Tier 2) for BlueCross and BlueShield Plans in Washington, D.C.; 2 total recommendations; 1 open recommendation	November 9, 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
1D-80-00-04-058	Group Health Incorporated in New York, New York; 21 total recommendations; 7 open recommendations	June 20, 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-10-83-05-002	BlueCross BlueShield of Oklahoma in Tulsa, Oklahoma; 16 total recommendations; 2 open recommendations	October 17, 2005
1A-99-00-04-027	Global Duplicate Claim Payment for BlueCross and BlueShield Plans in Washington, D.C.; 1 total recommendations; 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-10-11-04-065	BlueCross BlueShield of Massachusetts in Boston, Massachusetts; 14 total recommendations; 2 open recommendations	June 26, 2006



APPENDIX VII

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

OCTOBER 1, 2009 TO MARCH 31, 2010

(Continued)

Report Number	Subject	Date Issued
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, Washington, D.C.; 7 total recommendations; 4 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
4A-CF-00-05-028	Administration of the Prompt Payment Act at OPM, Washington, D.C.; 12 total recommendations; 8 open recommendations	April 16, 2007
1A-10-30-05-069	WellPoint BlueCross BlueShield of Colorado in Mason, Ohio; 18 total recommendations; 4 open recommendations	April 25, 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-10-40-07-022	BlueCross BlueShield of Mississippi in Jackson, Mississippi; 6 total recommendations; 2 open recommendations	December 14, 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



APPENDIX VII

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

OCTOBER 1, 2009 TO MARCH 31, 2010

(Continued)

Report Number	Subject	Date Issued
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; 2 open recommendations	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
1C-8W-00-07-028	UPMC (University of Pittsburgh Medical Center) Health Plan in Pittsburgh, Pennsylvania; 2 total recommendations; 2 open recommendations	July 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; 6 open recommendations	August 26, 2008
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



APPENDIX VII

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

OCTOBER 1, 2009 TO MARCH 31, 2010

(Continued)

Report Number	Subject	Date Issued
4A-CF-00-08-025	OPM's FY 2008 Consolidated Financial Statement; 6 total recommendations; 6 open recommendations	November 14, 2008
1A-10-92-08-021	Information Systems General and Application Controls at CareFirst BlueCross BlueShield and the Federal Employees Operations Center; 13 total recommendations; 13 open recommendations	November 28, 2008
1A-10-53-08-045	BlueCross BlueShield of Nebraska in Omaha, Nebraska; 6 total recommendations; 2 open recommendations	January 7, 2009
1A-10-83-08-018	Health Care Service Corporation in Tulsa, Oklahoma; 16 total recommendations; 4 open recommendations	January 9, 2009
3A-CF-00-07-039	The 2004 and 2005 Combined Federal Campaigns of New York City in New York, New York; 11 total recommendations; 3 open recommendations	February 4, 2009
1C-NM-00-08-049	Health Plan of Nevada in Las Vegas, Nevada; 2 total recommendations; 2 open recommendations	February 5, 2009
3A-CF-00-07-037	The 2004 and 2005 Greater Los Angeles Area Combined Federal Campaigns in Los Angeles, California; 13 total recommendations; 5 open recommendations	February 18, 2009
1A-10-44-08-046	BlueCross BlueShield of Arkansas in Little Rock, Arkansas; 7 total recommendations; 2 open recommendations	February 25, 2009
1A-10-63-08-044	WellPoint Southeast in Mason, Ohio; 7 total recommendations; 4 open recommendations	March 3, 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-IS-00-08-014	Security of Personally Identifiable Information in the Federal Investigative Services Division of OPM in Washington, D.C.; Boyers, Pennsylvania; Loveland, Colorado; and, Chantilly, Virginia; 9 total recommendations; 2 open recommendations	April 21, 2009
4A-CI-00-09-053	Flash Audit Report – Information Technology Security Program at OPM in Washington, D.C.; 4 total recommendations; 3 open recommendations	May 27, 2009



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

OCTOBER 1, 2009 TO MARCH 31, 2010

(Continued)

Report Number	Subject	Date Issued
4A-CA-00-08-036	Inventory and Management of OPM's Sensitive Property in Washington, D.C.; 7 total recommendations; 5 open recommendations	June 15, 2009
1B-43-00-08-066	Information Systems General and Application Controls at AXA Assistance as Administrator for the Panama Canal Area Benefit Plan in Panama City, Panama; 11 total recommendations; 3 open recommendations	June 18, 2009
3A-CF-00-08-031	The 2005 and 2006 North Central Texas Combined Federal Campaigns in Dallas, Texas; 10 total recommendations; 10 open recommendations	June 18, 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
4A-CI-00-09-052	Information Security Controls of OPM's Integrated Security Management System in Washington, D.C.; 6 total recommendations; 2 open recommendations	August 10, 2009



Index of Reporting Requirements

(Inspector General Act of 1978, As Amended)

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Section 5 (a) (1): Significant problems, abuses, and deficiencies	1-29
Section 5 (a) (2): Recommendations regarding significant problems, abuses, and deficiencies	1-18
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	19-26
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	31-35
Section 5 (a) (7): Summary of particularly significant reports	2-29
Section 5 (a) (8): Audit reports containing questioned costs.	31-34
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.	32
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



OIG HOTLINE

Report Fraud, Waste or Abuse to the Inspector General

Please Call the HOTLINE:

202-606-2423

Caller can remain anonymous • Information is confidential



MAILING ADDRESS:

OFFICE OF THE INSPECTOR GENERAL
U.S. Office of Personnel Management

Theodore Roosevelt Building

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