

SEMIANNUAL REPORT *to* CONGRESS



April 1, 2012 – September 30, 2012



OFFICE OF THE INSPECTOR GENERAL
United States Office of Personnel Management

OFFICE OF THE INSPECTOR GENERAL



Productivity Indicators

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds.....	\$16,084,754
Management Commitments to Recover Funds.....	\$28,664,830
Recoveries Through Investigative Actions.....	\$169,034,321

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

ACCOMPLISHMENTS:

Audit Reports Issued	31
Evaluation Reports Issued	0
Investigative Cases Closed.....	36
Indictments and Informations.....	31
Arrests.....	30
Convictions.....	29
Hotline Contacts and Preliminary Inquiries Complaints	999
Health Care Provider Debarments and Suspensions	473
Health Care Provider Debarment and Suspension Inquiries	1,626

SEMIANNUAL REPORT *to* CONGRESS



April 1, 2012 – September 30, 2012



OFFICE OF THE INSPECTOR GENERAL
United States Office of Personnel Management



In Memoriam

It is with heartfelt sadness that I report the loss of one of our staff members. Russell Phillips came to work for our Experience-Rated Audits Group in September 1999, and was proud to serve as a senior auditor until his passing on April 23, 2012. His personality and outgoing nature were welcome additions to the office, and all who came in contact with Russell during his time here remember him with fondness. Through his extensive travels auditing the BlueCross BlueShield health plans, he made numerous business and personal connections and bridged the gap between our office and the health plans. Many of our junior auditors were mentored by Russell. His coworkers will forever recall the joy with which Russell lived his life. His positive outlook, constant smile, and kind or funny words for everyone made him a magnet for coworkers. Russell loved sports and was quick to share his thoughts on why his Ohio State Buckeyes, Cleveland Indians, Browns, or Cavaliers were better than your teams. He was not only a friend to all in our office, but in fact he was a friend to all in OPM, and even to those at the health insurance companies he was auditing. Russell will be sorely missed, but never forgotten.



INSPECTOR GENERAL'S MESSAGE



During this reporting period, I informed our office's Congressional oversight committees, the Director of the U.S. Office of Personnel Management (OPM), and our liaison contacts at the U.S. Office of Management and Budget (OMB), of recent events that have rendered us unable to provide adequate audit and investigative oversight of programs supported by OPM's Revolving Fund.

The Revolving Fund finances programs through which OPM provides commercial-like services, such as personnel background investigations and various human resources management services, to approximately 150 Federal entities on a reimbursable basis. Through the Revolving Fund programs, primarily OPM's Human Resources Solutions (HRS) and the Federal Investigative Services (FIS), **OPM obligates almost \$2 billion annually on behalf of its client agencies. Under the statute that created the Revolving Fund**, OPM recovers all its costs of operating the Revolving Fund programs from the Revolving Fund itself.

The Revolving Fund programs began a period of explosive growth about six years ago. Our office recognized almost immediately that their growth curve would ultimately pose a critical problem for us if we could not obtain the resources necessary to expand our oversight capacity in these large, wide-reaching programs. Beginning in 2007, I have on multiple occasions proposed that our office also be authorized to finance its Revolving Fund oversight activities from the Revolving Fund itself. However, OPM has taken the position that the Office of the Inspector General (OIG) is not part of the agency for these purposes and therefore that our oversight costs do not constitute the type of costs that the Revolving Fund statute allows to be reimbursed. Several issues arose during this reporting period that transformed our chronic underfunding problem into an immediate and tangible risk to the integrity of the Revolving Fund programs. We had been contacted by Inspectors General from OPM's client agencies because they are reviewing and/or investigating their agencies' participation in and interaction with OPM's Revolving Fund programs. There was also a rapid escalation in reports of integrity-related concerns within the Revolving Fund programs.

This was in addition to the current backlog of Revolving Fund oversight work that the OIG is currently facing. Over the last year alone, requests **from OPM** for us to audit and/or investigate different parts of the Revolving Fund programs have increased dramatically. For example, at the Director's request, we conducted an extensive—and ongoing—investigation into improper procurement actions by HRS to provide human resources consulting services to at least two agencies. In another matter, we analyzed and reported information about a forensic audit of documents relating to improprieties in HRS's interagency agreements with 29 other Federal agencies, and we continue to monitor the situation. After the challenges OPM encountered during its launch of the new USAJOBS website in 2011, we performed two audits involving its security and development issues. In addition, as Congress has focused increased attention on conferences sponsored by Federal agencies, we began to study the scope of





HRS's contracting with other Federal agencies to arrange the educational content and presentation of conferences. We also continue to devote considerable investigative resources to address fraud in Revolving Fund programs, including criminal cases against FIS background investigators who have falsified investigative reports, as well as a very substantial contract fraud matter.

In my urgent communications to Congress, OMB, and OPM in this reporting period, I raised several points that, in my estimation, strongly justify my office's access to Revolving Fund monies for oversight purposes. First, the OIG is part of the agency for all other budgetary purposes. Our budget is submitted to the OPM Director just as that of any other OPM program office. By virtue of the Inspector General Act, we are part of OPM's Congressional appropriation and its allocation from OMB. It is illogical to include the OIG as part of the agency for all budgetary matters save this one.

Moreover, the OIG's oversight costs are included in the calculation of the administrative costs associated with the retirement, health insurance, and life insurance programs. It is illogical for these Trust Fund programs to fund oversight work while Revolving Fund programs that were designed to operate in a commercial manner—and recover their costs from the Revolving Fund—do not.

There is no reason to exclude oversight costs from the definition of administrative costs. The Revolving Fund was established because the activities it funds are commercial in nature. In the private sector, oversight, especially financial oversight, is indisputably a legitimate business cost. Indeed, the vast majority of private companies are required by law to have their financial statements audited annually and internal controls examined and certified. Moreover, many companies have either their own divisions or hire outside consultants or law firms to ensure that they are in compliance with applicable laws and regulations.

The solution that I have proposed is both simple and practical: amending the statute establishing the Revolving Fund to clarify that OIG oversight costs must be considered part of the "actual costs" of administering the Revolving Fund programs, which are accounted for in setting the prices charged to the users of services provided by the Revolving Fund. This would allow the OIG to charge the Revolving Fund for the costs of its oversight.

This is not a radical proposal; it is not uncommon for Federal OIGs to be funded by a program-specific fund (such as the OPM Trust Funds) or to be reimbursed by an agency for specific oversight work. Further, Federal entities that are funded through licensing and user fees usually include their OIGs' oversight costs when setting those fees.

I have been encouraged and gratified by the supportive responses from Congressional staff, OPM, and OMB to our critical situation. We must work quickly together in order to provide the OIG with immediate access to the Revolving Fund so that we may carry out the duties and responsibilities with which we have been entrusted. Congress and the Administration must no longer tolerate inadequate oversight of \$2 billion appropriated tax dollars that flow between OPM and nearly every other Federal agency.

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.



TABLE OF CONTENTS



Productivity Indicators	Inside Cover
Inspector General’s Message	i
Mission Statement	iii
Field Offices	vii
Audit Activities	1
Health Insurance Carrier Audits.....	1
Information Systems Audits.....	5
Internal Audits.....	10
Special Audits.....	12
Enforcement Activities	17
Investigative Cases.....	17
Administrative Sanctions of FEHBP Health Care Providers.....	28
Statistical Summary of Enforcement Activities	31
APPENDIX I:	
Final Reports Issued With Questioned Costs for Insurance Programs.....	33
APPENDIX II-A:	
Final Reports Issued With Recommendations for All Other Audit Entities.....	34
APPENDIX II-B:	
Final Reports Issued With Recommendations for Better Use of Funds.....	34





APPENDIX III:
Insurance Audit Reports Issued 35

APPENDIX IV:
Internal Audit Reports Issued 37

APPENDIX V:
Combined Federal Campaign Audit Reports Issued 37

APPENDIX VI:
Information Systems Audit Reports Issued 38

APPENDIX VII:
Evaluation Reports Issued 38

APPENDIX VIII:
Summary of Audit Reports More Than Six Months Old Pending Corrective Action 39

APPENDIX IX:
Most Recent Peer Review Results 42

APPENDIX X:
Investigative Recoveries 43

Index of Reporting Requirements 46



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 230 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 health insurance plan mergers and acquisitions. The premium payments for the health insurance program are over \$43 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 22 final audit reports on organizations participating in the FEHBP, of which 12 contain recommendations for monetary adjustments in the amount of \$14.6 million due the OPM administered trust funds.

COMMUNITY-RATED PLANS

The community-rated HMO audit universe covers approximately 120 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 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 Federal annuitants. Many Federal annuitants may also be enrolled in Medicare. Therefore, the FEHBP rates may be adjusted to account for the coordination of benefits with Medicare.

During this reporting period, we issued 17 final audit reports on community-rated plans. These reports contain recommendations that require the health plans to return over \$13.1 million to the FEHBP.

New West Health Services

HELENA, MONTANA

Report No. 1C-NV-00-11-047

JUNE 4, 2012

**Inappropriate
Charges
Amount to
\$996,943**

New West Health Services provides comprehensive medical services to its members throughout most of Montana. This audit of the plan covered contract years 2006 through 2011.

During this period, the FEHBP paid the plan approximately \$19.3 million in premiums.

We identified \$996,943 in inappropriate health benefit charges to the FEHBP in 2006, 2007, 2009, and 2011. In addition, we determined the FEHBP is due \$116,542 for investment income lost as a result of the overcharges.

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

The overcharges occurred because the plan did not apply the largest SSSG discount to the FEHBP rates.

Health Insurance Plan of New York Rate Reconciliation Audit

NEW YORK, NEW YORK

Report No. 1C-51-00-12-058

AUGUST 2, 2012

The Health Insurance Plan of New York provides comprehensive medical services to its members throughout the greater New York City area. This rate reconciliation audit of the plan covered contract year 2012.

**Health Insurance
Plan of New York
Agrees with
\$7.9 Million in
Questioned Charges**

We identified \$7,966,352 in inappropriate health benefit charges to the FEHBP in contract year 2012. The FEHBP was overcharged because the plan incorrectly calculated a FEHBP Medicare loading. The plan agreed with all of our questioned charges.

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 three experience-rated final audit reports. In these reports, our auditors recommended that the plans return \$856,318 in inappropriate charges and lost investment income to the FEHBP. A summary of two final reports is provided to highlight our notable audit findings.

BLUECROSS BLUESHIELD SERVICE BENEFIT PLAN

The FEHBP was established by the Federal Employees Health Benefits (FEHB) Act, enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents. The BlueCross BlueShield Association (Association), on behalf of participating BlueCross BlueShield (BCBS) plans, entered into a Government-wide Service Benefit Plan with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its Federal subscribers.

The Association has established a Federal Employee Program (FEP) Director’s Office, in Washington, D.C., to provide centralized management for the Service Benefit Plan. The FEP Director’s Office coordinates the administration of the contract with the Association, BCBS plans, and OPM. The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst BlueCross BlueShield, located in Washington, D.C. These activities include acting as fiscal intermediary between the Association and member plans, verifying subscriber eligibility, approving or disapproving the reimbursement of local plan payments of FEHBP claims, maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

The Association, which administers a fee-for-service plan known as the Service Benefit Plan, contracts with OPM on behalf of its member plans throughout the

United States. The participating plans independently underwrite and process the health benefits claims of their respective Federal subscribers and report their activities to the national BCBS operations center in Washington, D.C. Approximately 62 percent of all FEHBP subscribers are enrolled in BCBS plans.

We issued three BCBS experience-rated reports during the reporting period. Experience-rated audits normally address health benefit payments, miscellaneous payments and credits, administrative expenses, and/or cash management activities. Our auditors identified \$856,318 in questionable costs charged to the FEHBP contract. The BCBS agreed with \$602,558 of the identified overcharges.

Global Omnibus Budget Reconciliation Act of 1993 Claims for BlueCross and BlueShield Plans

WASHINGTON, D.C.

Report No. 1A-99-00-12-001

JULY 16, 2012

We performed a limited scope performance audit to determine whether the BCBS plans complied with contract provisions relative to claims that were subject to the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) pricing guidelines.

OBRA 93 limits the benefit payment for certain physician services provided to annuitants age 65 or older who are not covered under Medicare Part B. The FEHBP fee-for-service plans are required to limit the claim payment to the lesser of either the amount Medicare Part B pays or the billed charge. Palmetto GBA, an OBRA 93 pricing vendor, calculates the pricing amounts for the OBRA 93 claim lines on behalf of BCBS.

**FEHBP
Overcharged
\$631,605
for OBRA 93
Claims**

Using our healthcare claims data warehouse, our auditors identified BCBS claim lines paid from August 2008 through July 2011 that were subject to the OBRA 93 pricing guidelines and potentially paid incorrectly. We determined that the BCBS plans overpaid 1,825



claim lines by \$643,932 and underpaid 289 claim lines by \$77,323 that were priced, or potentially should have been priced, under the pricing guidelines. This resulted in net overcharges of \$566,609 to the FEHBP. In addition to these claim payment errors, we identified 465 claim lines requiring retroactive overpayment adjustments of \$87,283 and 135 claim lines requiring retroactive underpayment adjustments of \$22,287 due to OBRA 93 pricing changes that were not updated timely in Palmetto GBA's pricing system. This resulted in net overpayments of \$64,996.

In total, we determined that 2,155 claim lines were overpaid by \$731,215 and 424 claim lines were underpaid by \$99,610, resulting in net overcharges of \$631,605 to the FEHBP for these 2,579 claim lines. The Association and/or BCBS plans agreed with \$377,845 of the questioned net overcharges.

Capital BlueCross

HARRISBURG, PENNSYLVANIA

Report No. 1A-10-36-12-003

AUGUST 23, 2012

Our audit of the FEHBP operations at Capital BlueCross covered miscellaneous health benefit

Auditors Question

**\$123,608 in
Administrative
Expense
Overcharges**

payments and credits and cash management activities from January 2006 through June 2011, as well as administrative expenses from 2006 through 2010.

For contract years 2006 through 2010, Capital BlueCross processed approximately \$559 million in FEHBP health benefit payments and charged the FEHBP \$32 million in administrative expenses.

Our auditors questioned \$123,608 in administrative expense charges for plan employee pension cost overcharges. The BCBS Association agreed with the questioned charges. Additionally, lost investment income on the questioned charges totaled \$19,798.

EMPLOYEE ORGANIZATION PLANS

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

The largest employee organizations are Federal employee unions and associations. Some examples are the: American Postal Workers Union; Association of Retirees of the Panama Canal Area; Government Employees Health Association, Inc.; 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.

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.

We did not issue any audit reports on experience-rated comprehensive medical 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.

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 also responsible for performing an independent oversight of OPM's internal information technology and security program.

We perform an annual independent audit of OPM's information technology (IT) security environment, as required by the Federal Information Security Management Act of 2002 (FISMA). We also complete routine audits of OPM's major IT systems to ensure management has implemented appropriate security controls. When necessary, our auditors review system development projects to ensure adherence to best practices and disciplined system development lifecycle processes.

Information Technology Security Posture of OPM's USAJOBS System

WASHINGTON, D.C.

Report No. 4A-HR-00-12-037

JULY 26, 2012

USAJOBS is the Federal Government's official one-stop source for Federal jobs and employment information. The USAJOBS website provides public notice of Federal employment opportunities and is cooperatively owned by the Federal Chief Human Capital Officer (CHCO) Council.

In 2003, OPM contracted with Monster Government Services (MGS) to host and maintain the USAJOBS system. In 2010, OPM and the CHCO Council made the decision to terminate its contract with MGS and bring USAJOBS in-house at OPM. Two separate security breaches at MGS that led to the disclosure of sensitive data were factors that led to this decision.

In October 2011, OPM launched USAJOBS 3.0. This new release was developed by various members of the CHCO council with primary contributions from OPM, the Department of Homeland Security, and the Department of Defense.

The objectives of this audit were to assess the system's information security controls and to evaluate OPM's overall efforts to protect its most sensitive data. We contracted with an information security professional services provider, FishNet Security, Inc. (FishNet),



to perform a thorough vulnerability assessment and penetration test of the USAJOBS application and network environment.

The goal of FishNet’s assessment was to thoroughly document the overall security posture of USAJOBS through a series of tests, to include:

- Network architecture review;
- Internal vulnerability assessment including server and database configuration review;
- External vulnerability and web application assessment;
- Source code review; and,
- Mobile application security assessment.

Overall, USAJOBS was found to be in good security standing and does not appear to pose any significant risk to OPM or its constituents. There were no critical vulnerabilities discovered during the multi-discipline assessment that required immediate escalation. Additionally, the large majority of issues found from each assessment phase were of the medium to low/informational severity ranking. Low-severity rated vulnerabilities comprised nearly half of the adverse findings.

We believe that there is clear intent by OPM to ensure the confidentiality, integrity, and availability of the

**USAJOBS
Improves
Performance**

USAJOBS environment. Throughout the testing it became obvious that there were some security weaknesses, but nothing that put the USAJOBS environment at immediate

risk. Many of the findings are similar to those found in other organizations facing similar operational challenges.

However, we do have some concerns about the design of the supporting infrastructure. We discovered that the domain hosting USAJOBS is shared with other services and applications hosted by OPM’s Macon data center. USAJOBS is widely considered a flagship information system at OPM. Any application with the size, visibility, and public importance of USAJOBS

should be operating in a dedicated, multi-tiered environment, thereby creating a defense-in-depth strategy for protecting the confidentiality, integrity, and availability of system resources and data.

The USAJOBS program office has already remediated many of the specific audit recommendations that were outlined in our report, including all three high-severity vulnerabilities. The program office has also developed a plan to segregate the supporting infrastructure into application specific networks for the major hosted applications.

USAJOBS System Development Lifecycle

WASHINGTON, D.C.

Report No. 4A-HR-00-12-044

SEPTEMBER 28, 2012

When USAJOBS 3.0 was deployed, the system became flooded with an unprecedented number of users trying to access the public website. The system’s communications lines did not have the bandwidth to manage the traffic and many users experienced a variety of errors that resulted from dropped network communications, or were unable to access the system altogether. These issues led to a public outcry from the media and by the general population via the USAJOBS social networking websites. Furthermore, the House of Representatives Committee on Oversight and Government Reform questioned the OPM Director about the agency’s ability to manage large information system development projects.

The objectives of this audit were to assess the system development lifecycle (SDLC) methodology of USAJOBS and to determine if any lessons learned from the USAJOBS 3.0 deployment could be applied to future system implementations. OPM has been historically plagued with failed and troubled system implementation projects, and we believe that weak SDLC practices have played a major role in this.

Our audit evaluated SDLC elements such as requirements gathering, infrastructure change management, application change management, and testing. We looked at both the controls that were in place at the time of system deployment



Information Technology Security Controls of the OPM's Service Credit Redeposit and Deposit System

WASHINGTON, D.C.

Report No. 4A-CF-00-12-015

AUGUST 9, 2012

in October 2011, and also the controls that have been implemented and improved in the time since deployment.

Although our audit revealed some specific weaknesses in the original USAJOBS SDLC and there were some recommendations to improve current procedures, we believe that the overall methodology has improved significantly and that the system is operating with a stable change management process. The system problems that were experienced just after initial deployment of USAJOBS 3.0 were primarily caused by an inadequate test environment and the unprecedented number of users accessing the system. Consequently, we recommended that the Office of the Chief Information Officer (OCIO) analyze and document the lessons learned from this experience and apply them to future system development projects at OPM.

The primary concern resulting from our audit is that the entire USAJOBS SDLC methodology was developed independent of any agency-wide requirements or

OCIO Should Establish an SDLC Review and Approval Process

guidance – because no current guidance exists at OPM. Although OPM's internal website contains policies and procedures related to SDLC, many of these documents have not been updated in over ten years, and they are not routinely used to manage current development projects.

After reviewing our draft audit report, the OCIO notified us of recent and ongoing efforts to create a current SDLC policy. While creating a policy is a significant first step in implementing a centralized SDLC methodology at OPM, the policy will need additional updating in order to address the specific deficiencies identified in this report. In addition, policy alone will not improve the historically weak SDLC management capabilities of OPM.

Therefore, we recommended that the OCIO establish an SDLC review process in which the OCIO must review and formally approve SDLC work at various milestones for all OPM system implementation projects.

We conducted a combination follow-up audit and FISMA compliance audit of OPM's Service Credit Redeposit and Deposit (SCRD) system. We found that significant problems that contributed to the system's recent failure have still not been corrected, and that there are numerous weaknesses in the system's technical environment.

Service Credit is a retirement program mandated by law (CFR Title 5, Part 831, Subpart 831.105) that provides Government employees an opportunity to make payments into the Civil Service Retirement System or Federal Employee Retirement System for periods of service during which they either did not contribute to the Civil Service Retirement and Disability Fund (CSRDF), or for which they received a refund of their retirement contributions. An employee may participate in the Service Credit program to ensure receipt of the maximum retirement benefits to which he or she is entitled. Eligible employees may pay a deposit into the CSRDF to cover any creditable Federal civilian service that was not subject to retirement deductions, or they may make a redeposit to cover any period of Federal service for which a refund of retirement contributions was received.

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. In April 2006, a newer, more modern version of the service credit system was released which was designed to allow most types of transactions to be automatically processed on users' desktop computers.

This system was plagued with problems until a stable replacement was finally put in place in December 2010. We conducted an in depth review of this replacement



system during the development and testing phase and issued Report No. 4A-CF-00-10-021 in January 2010. The 2010 report contained eight specific recommendations related to separation of duties, system requirements, and data entry errors.

Throughout this period there was intense focus on the replacement system development process by account holders, the media, Congress, and senior OPM management. The ability to effectively develop and manage IT systems at OPM was again called into question. Account holders were inconvenienced and agency resources were expended to rectify the situation.

The system that was put in place in December 2010 was not a properly developed billing and retirement system, but more of a patchwork effort to correct a system with a fundamentally flawed design. It is clear that at some point in the near future, the current system will need to be redeveloped from the ground up based on the many complex requirements of the business process.

However, at the beginning of this audit only two of the eight recommendations from our 2010 report were fully implemented. One of the most significant of the open recommendations relates to properly managing business requirements. During the original review, we found that the primary cause of the system’s failure to properly calculate account balances was the lack

OPM Must Address 2010 Recommendations and Coordinate Future System Developments

of a fully developed requirements traceability matrix. Almost three years after the problems were originally highlighted, the business requirements for this system are still not properly documented.

A fully developed requirements traceability matrix is especially important because of the myriad and complex retirement laws that impact processing service credit cases. In addition, when agency management decides that a new system is in order, the business process must be fully documented or there is a high risk of another failed system development project.

Furthermore, the 2010 recommendations are not effectively tracked and therefore their current status cannot be readily determined by the responsible group in OPM. For progress to be made in implementing the 2010 recommendations, each item needs to be tracked and specific program offices need to be assigned responsibility for each task/milestone required to address the overall weaknesses. Responsibility for coordinating this remediation is the responsibility of the OPM Chief Information Officer.

We also evaluated the degree to which IT security controls required by the National Institute of Standards and Technology’s Special Publication 800-53 Revision 3 were implemented. Although the majority of the tested security controls have been successfully implemented, some controls were not, including audit logging policies and procedures. In addition, we discovered numerous weaknesses from our vulnerability scan of the system’s technical environment.

**Information Systems
General and Application Controls
at the Government Employees
Health Association, Inc.**

LEE’S SUMMIT AND
INDEPENDENCE, MISSOURI

Report No. 1B-31-00-11-066

AUGUST 9, 2012

The Government Employees Health Association (GEHA) is the second largest experience-rated health plan participating in the FEHBP, paying about 6.4 percent of total FEHBP experience-rated medical claims. Our last audit of general and application controls at GEHA occurred in 2006. We completed a full review of all recommendations from this audit and determined that several weaknesses were not satisfactorily remediated until after 2009. In addition, several recommendations were rolled forward in this final audit report.

In 2006 a substantial number of recommendations were made that collectively identified a significant deficiency in GEHA’s management of IT security. GEHA lacked the critical policies and procedures necessary for an entity-wide security program.



Furthermore, they did not have the appropriate resources, both tangible and personnel, to ensure the protection of member data and successful processing of FEHBP claims. During our follow-up review, we determined that these long standing weaknesses had not been adequately addressed. While the audit work conducted during this review showed very recent steps taken by GEHA management to develop an improved IT security program, currently there are significant weaknesses that still threaten the privacy and security of FEHBP data and member Personally Identifiable Information (PII).

The most serious weaknesses that we found have to do with GEHA’s configuration management program. In our judgment, they represent a significant deficiency in GEHA’s ability to securely process FEHBP data in its IT environment:

- GEHA has not documented a secure baseline configuration for its servers or mainframe. New system software is currently configured using employees’ collective knowledge of best practices. However, no standard configuration documentation has been created for any system software used by the organization. This increases the risk that new systems will not be securely configured.
- GEHA’s management does not monitor system administrator activity, which means that unintended or malicious activity by an administrator will probably not be detected by anyone.
- GEHA performs configuration audits of its Windows servers, but they do not use the results of the audits to enhance system security. We used an automated tool to conduct a compliance audit

on over 150 production servers to determine if configuration settings were in compliance with industry standards. The results of the scan revealed major compliance issues in each server.

- GEHA does not perform routine vulnerability scans of its computer servers. We used an automated tool to conduct a vulnerability scan of GEHA’s server environment to determine if its servers were properly secured. We discovered numerous weaknesses related to missing or outdated critical patches in nearly every server that we scanned. These types of weaknesses are easily exploited by even novice hackers.
- We also scanned GEHA’s public member website and found that it is vulnerable to common cross-site scripting and Structured Query Language (SQL) injection attacks. Hackers exploiting these flaws could potentially gain access to member data, including medical claims information.
- GEHA is currently running a version of z/OS, an IBM mainframe operating system that is not supported by the vendor. Unsupported software is also vulnerable to exploitation.

Significant Deficiencies Identified in IT Security

GEHA management seems to be committed to improving its IT security program and has made progress in the last two years. However, much work remains to be done. We plan to closely monitor GEHA’s remediation activity as part of the audit resolution process.



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.

Administration of the Prompt Payment Act in OPM

WASHINGTON, D.C.

Report No. 4A-CF-00-11-067

SEPTEMBER 13, 2012

We conducted a performance audit of the Administration of the Prompt Payment Act (PPA) in OPM. The objectives of our audit were to determine if OPM is in compliance with the PPA and to validate the prompt payment information presented in OPM's fiscal year (FY) 2011 Annual Performance Report (APR).

The PPA governs the time that agencies have to make payments. The PPA states that payment is due (1) on the date specified in the contract; (2) in accordance with discount terms when discounts are offered and taken; (3) in accordance with Accelerated Payment Methods; or (4) 30 days after the start of a payment period, when a proper invoice is received. The PPA also governs the amount of interest penalties that must be paid when payments are not made within the required time period. Interest on late payments is automatically calculated in OPM's Consolidated Business Information System (CBIS).

The PPA also provides guidance to Federal agencies on when to make payments for the Government-wide commercial purchase cards. When a Government purchase card is used, the vendor providing the goods or service to OPM is paid by JP Morgan Chase Bank, who provides the credit services to OPM. OPM then reimburses JP Morgan Chase Bank in accordance with the terms and conditions of the Government commercial credit card contract and the PPA.

In FY 2004, the OIG conducted a performance audit of OPM's administration of the PPA. The final report was issued in 2007 and included 12 recommendations in 5 areas requiring improvement:

- Inaccurate prompt payment due dates and untimely payments;
- Incorrect interest calculations;
- Unallowable early payments;
- Lack of policies and procedures on accounts payable activities; and,
- Lack of quality controls on payments to vendors and no use of management reports on payments generated from the Government Financial Information System (OPM's prior financial system).



We have closed all of the open findings from the prior audit except for inaccurate prompt payment due dates, untimely payments, and unallowable early payments. Additionally, we determined that OPM needs to strengthen controls to ensure compliance with the PPA. This audit identified six areas requiring improvement.

- Sixty-six out of the 75 FY 2011 invoices we reviewed had incomplete or inaccurate information in CBIS;
- We determined that for 10 of 25 invoices received prior to FY 2011 and paid late, no interest was assessed or paid;
- OPM processed improper invoices for payment. We determined that 67 out of 75 invoices in our sample were missing some of the required attributes of a proper invoice and should have been deemed improper and returned to the vendor;

- During our review we identified 26 invoices that were coded in CBIS as *immediate* or *fast pay*. We determined that these invoices did not meet accelerated or fast pay method requirements as described in the PPA;
- OPM is not calculating the date most advantageous to the Government to pay the purchase card invoices, as required by the PPA; and,
- Facilities, Security, and Contracting calculated the percentage of payments made within the PPA Guidelines incorrectly for FY 2011.

**OPM Needs to
Strengthen Controls
to Ensure
Compliance
with the Prompt
Payment Act**



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 (PBM) 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 designations of contributing employees.

Federal Flexible Spending Account Program Operations as Administered by SHPS for Program Years 2008 through 2010

LOUISVILLE, KENTUCKY
Report No. 4A-RI-00-11-060
AUGUST 22, 2012

The Federal Flexible Spending Account Program (Program) was established at the direction of the President in October 2000. It was implemented by OPM as a Health Insurance Premium Conversion Plan under 5 Code of Federal Regulations Part 550. This program is available to active Federal employees who participate in the FEHBP. In March 2003, OPM contracted with SHPS, Inc. (SHPS), to administer the program.

During this reporting period, we issued a report on SHPS' operations for program years 2008 through 2010. Specifically, the audit covered SHPS' compliance with the Health Insurance Portability and Accountability Act, cash management activities, fraud and abuse policies and procedures, claim benefit payments, risk reserve transfers, and subcontracts.

The audit identified one procedural finding and \$1,470,246 in program overcharges, including \$163,206 in lost investment income. Specifically, we found:

- Five temporary employees with prior criminal convictions were improperly employed by SHPS in violation of the Health Insurance Portability and Accountability Act's Security Rule for workforce clearance;
- SHPS did not credit \$1,307,040 of investment income earned on FSAFEDS funds to the Program; and,
- The Program is due \$163,206 for lost investment income related to investment income not credited back to the Program, calculated through August 31, 2012. In addition, the contracting officer should recover lost investment income on amounts due for the period beginning September 1, 2012, until all questioned costs have been returned to the Program.

SHPS agreed to revise its current policies and procedures to address our procedural issue, and is currently implementing corrective actions. SHPS also



agreed that policies and procedures regarding the treatment of investment income should be developed and implemented. SHPS recommended that the treatment of investment income be addressed in the next contract modification. Finally, SHPS continues to work with OPM to resolve the \$1,307,040 in questioned costs for investment income not credited to the Program and the \$163,206 in lost investment income.

BlueCross BlueShield's Retail Pharmacy Operations Administered by CVS/Caremark

SCOTTSDALE, ARIZONA

Report No. 1H-01-00-11-063

AUGUST 8, 2012

We conducted an audit of BCBS's Retail Pharmacy Operations (Plan) as administered by CVS/Caremark, which covered retail pharmacy claims and the BlueCross BlueShield's (Association) adherence to contract CS 1039, for contract years 2006 and 2007. The Plan's pharmacy operations and responsibilities were carried out by the PBM, which is located in Scottsdale, Arizona. Retail pharmacy claim payments for FEHBP subscribers in both years totaled \$5,569,273,111.

To further enhance Federal employees' benefits under the FEHBP, insurance carriers have contracted with PBMs to provide both mail order and retail prescription drug benefits. PBMs are primarily responsible for processing and paying prescription drug claims. For this particular audit the PBM was used by the Association, on behalf of its participating BCBS plans, to develop, allocate, and control costs related to the pharmacy claims program.

The audit identified improper claim payments due to member eligibility issues totaling \$689,762, including

\$7,437 for lost investment income and two areas for program improvement. Specifically:

- We identified 7,212 claims totaling \$644,395 that should have been recovered after eligibility updates were received showing the members were ineligible at the time of service. Of the 7,212 claims questioned, the plan began the recovery process on only 3,165 (totaling \$315,795) claims, leaving 4,047 claims (totaling \$328,600), or 56 percent of the total claims questioned, with no recovery action begun prior to the issuance of the final report. Finally, we found significant delays in recoveries for the 3,165 claims that were initiated after the members' eligibility status was updated. In fact, the average delay in initiating recoveries was 207 days.
- We identified 652 claims, totaling \$37,930, paid for members who were ineligible at the time of service according to the Association's enrollment data.
- Our draft audit report identified potential errors based on non-covered drug listings provided by the PBM. These listings were unclear and resulted in the inadvertent questioning of claims that were properly paid.
- Due to the PBM not including all data fields/ indicators in the claims data provided, our draft audit report incorrectly identified claim adjustment records as duplicate claims.
- The FEHBP is due \$7,437 for lost investment income related to claims paid, totaling \$37,930, for members who were ineligible at the time of service. The lost investment income was calculated through June 30, 2012. Additionally, the contracting officer should recover lost investment income on amounts due for the period beginning July 1, 2012, until all questioned costs have been returned to the FEHBP.

The Association continues to work with OPM to resolve all audit issues addressed in this report.



Combined Federal Campaign

Our office audits the Combined Federal Campaign (CFC), the only authorized charitable fundraising drive conducted in Federal installations throughout the world. OPM 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 or counties. 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.

While CFC audits do not identify savings to the Government, because the funds involved are charitable donations made by Federal employees, the audits identify inappropriate expenses charged by the campaign administrators, recommend redistributing monies to the appropriate charities, and recommend program improvements to promote campaign efficiency and effectiveness. Additionally, our audit efforts occasionally generate an internal referral to our criminal investigators for potential fraudulent activity. OPM's Office of the Combined Federal Campaign (OCFC) works with the campaign administrators 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 Director of OPM to conduct the CFC in a particular community. It organizes the local CFC; determines the eligibility of local charities; selects and supervises the activities of the Principal Combined Fund Organization (PCFO); encourages Federal agencies to appoint employees to act as Loaned Executives who work directly on the local

campaign; ensures that Federal employees are not coerced to participate in the local campaign; 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. The primary goal of the PCFO is to administer an effective and efficient campaign in a fair and even-handed manner aimed at collecting the greatest amount of charitable contributions possible. Its responsibilities include collecting and distributing CFC funds, training volunteers, maintaining a detailed accounting of CFC administrative expenses incurred during the campaign, preparing pledge forms and brochures, and submitting to and cooperating fully with audits of its operations. The PCFO is reimbursed for its administrative expenses from CFC funds.

■ **Federations**

A federation is a group of 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.

The CFC celebrated its 50th anniversary in 2011. A commission, the CFC-50, was established in accordance with the Federal Advisory Committee Act and was charged with advising OPM on how it can strengthen the integrity, the operation, and the effectiveness of the CFC to ensure its continued



growth and success. The commission was comprised of 28 members who provided 24 recommendations, in a report dated July 20, 2012, for increasing the CFC’s accessibility, accountability, transparency, and affordability. Based on our major concern as discussed below, we strongly encourage OPM to consider the recommendations of the commission in developing a strategy for strengthening and ensuring the continued success of the CFC.

During this reporting period, we issued two audit reports of local CFCs that are discussed below.

funds, did not understand the requirements of the audit. As a result, findings were not identified and communicated to the PCFOs and LFCCs.

The 2008 and 2009 Greater New Orleans Area Combined Federal Campaigns

NEW ORLEANS, LOUISIANA

Report 3A-CF-00-11-040

MAY 2, 2012

The 2008 and 2009 Taconic Valley Combined Federal Campaigns

WHITE PLAINS, NEW YORK

Report 3A-CF-00-11-036

APRIL 26, 2012

Due to the numerous audit findings and the nature of the identified issues in this audit, we recommended that OPM merge the Taconic Valley CFC with another geographically adjacent campaign, administered and conducted by a new PCFO and LFCC, which is more equipped to handle the responsibilities of the CFC.

The Taconic Valley CFC audit highlights our office’s major concern with the CFC. Our audits repeatedly identify similar issues. We attribute this to the following deficiencies:

- The PCFO was unaware of, did not understand its responsibilities relating to, and/or simply did not follow the regulations and CFC Memoranda;
- The LFCC was not aware of and/or did not understand its responsibilities as defined in the regulations;
- The LFCC was inactive and did not perform the needed oversight of the PCFO; and,
- The IPAs hired to perform the agreed-upon procedures audit, which is paid for out of campaign

The second report issued during this reporting period was of an audit of the Greater New Orleans Area (GNOLA) CFC. This audit covered campaign years 2008 and 2009 and identified the following issues:

- **Unallowable Campaign Expenses**
The PCFO reimbursed itself \$21,080 for expenses that were either related to another campaign or did not reflect the actual cost of administering the campaign.
- **One-Time Disbursements**
The PCFO did not distribute the correct amount of funds to organizations receiving one-time disbursements.
- **Notification of Undesignated Funds**
The PCFO did not notify 2009 CFC organizations and federations of the undesignated funds due to them.
- **Release of Contributor’s Information**
The PCFO did not forward a contributor’s name and pledge amount to an organization after the individual indicated on the pledge form that they wished to have this information released.

We provided audit findings and recommendations for corrective action to the OCFC, and they notified the GNOLA’s PCFO of our recommendations. As of the end of this reporting period, all audit findings and recommendations have been resolved, and the OCFC has closed the audit.



ENFORCEMENT ACTIVITIES



Investigative Cases

The Office of Personnel Management administers benefits from its trust funds, with approximately \$920 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 over \$100 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 22 criminal investigations and closed 36, with 114 still in progress. Our criminal investigations led to 30 arrests, 31 indictments and informations, 29 convictions and \$169,034,321 in monetary recoveries to OPM administered trust funds. Our criminal investigations, many of which we worked jointly with other Federal law enforcement agencies, also resulted in \$321,902,390 in criminal fines and penalties which are returned to the General Fund of the Treasury, asset forfeitures, and court fees and/or assessments. For a complete statistical summary of our office's investigative activity, refer to the table on page 31.

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. Of particular concern are the growth of medical identity theft and organized crime in health care fraud, which has affected the FEHBP.

Whenever feasible, we coordinate our health care fraud investigations with the Department of Justice (DOJ) and other Federal, state, and local law enforcement



agencies. We are participating members of health care fraud task forces across the nation. We work directly with U.S. Attorney's Offices nationwide to focus investigative resources in areas where fraud is most prevalent.

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

HEALTH CARE FRAUD CASES

GlaxoSmithKline LLC (GSK) Agrees to \$3 Billion Settlement

GlaxoSmithKline LLC (GSK) agreed to plead guilty and to pay \$3 billion to resolve its criminal and civil liability arising from the company's unlawful promotion of certain prescription drugs, its failure to report certain safety data, and its civil liability for alleged false price reporting practices.

GSK agreed and pled guilty to two counts of introducing misbranded drugs, Paxil and Wellbutrin, into interstate commerce and one count of failing to report safety data about the drug Avandia to the Food and Drug Administration (FDA). Under the terms of the plea agreement, GSK will pay a total of \$1 billion, including a criminal fine of \$956,814,400 and forfeiture in the amount of \$43,185,600. The criminal plea agreement also includes certain non-monetary compliance commitments, and certifications by GSK.

GSK will also pay \$2 billion to resolve its civil liabilities with the Federal and state Governments under the False Claims Act. The civil settlement resolves claims relating to Paxil, Wellbutrin, and Avandia, as well as additional drugs, and also resolves pricing fraud allegations.

The Government alleges that, from April 1998 to August 2003, GSK unlawfully promoted Paxil for treating depression in patients under age 18, even

though the FDA never approved pediatric use. The United States alleges that, among other things, GSK participated in preparing and distributing a misleading medical journal article which misrepresented that a clinical trial of Paxil demonstrated efficacy in the treatment of depression in patients under age 18, when the study failed to demonstrate efficacy. GSK agreed to plead guilty to misbranding and false labeling of Paxil for patients under 18.

FDA approved Wellbutrin only for a major depressive disorder. However, the Government alleges that from January 1999 to December 2003, GSK promoted the drug for weight loss, the treatment of sexual dysfunction, substance addictions, and Attention Deficit Hyperactivity Disorder, among other off-label uses. The United States contends that GSK paid millions of dollars to doctors to endorse the use of the drug, sometimes at lavish resorts. The off-label uses of Wellbutrin were routinely promoted during these functions. GSK further promoted the drug using sales representatives, sham advisory boards, and supposedly independent Continuing Medical Education programs for these unapproved uses. GSK pled guilty to misbranding Wellbutrin for unapproved uses.

The United States alleges that, between 2001 and 2007, GSK failed to include certain safety data about Avandia, a diabetes drug, in reports to the FDA. These reports are meant to allow the FDA to determine if a drug continues to be safe for its approved indications and to monitor drug safety trends. GSK pled guilty to failing to report data concerning Avandia to the FDA.

As part of this global resolution, GSK agreed to resolve its civil liability for the following alleged conduct: (1) promoting the drugs Paxil, Wellbutrin, Advair, Lamictal, and Zofran for off-label, non-covered uses and paying kickbacks to physicians to prescribe those drugs, as well as the drugs Imitrex, Lotronex, Flovent, and Valtrex; (2) making false and misleading statements concerning the safety of Avandia; and (3) reporting false best prices and underpaying rebates owed under the Medicaid Drug Rebate Program.

This was a joint investigation by the Federal Bureau of Investigation (FBI); Defense Criminal Investigative Service (DCIS); the Food and Drug Administration (FDA); and the Offices of Inspector General (OIGs) for the Department of Health and Human Services (HHS), Veterans Administration (VA), United States Postal Service (USPS), Department of Labor; and our office.



The FEHBP received \$104,370,100 from this civil settlement.

Merck Pharmaceutical Pays \$950 Million for Illegal Marketing of Vioxx

Merck Pharmaceutical (Merck) agreed to pay \$950,000,000 to resolve criminal and civil charges for the illegal marketing of Vioxx by promoting the drug for treatment of rheumatoid arthritis and for misleading statements regarding the safety of Vioxx.

Merck pled guilty to one count of the Federal Food, Drug, and Cosmetic Act (FDCA) for introducing the misbranded drug into interstate commerce. The FDA originally approved the drug for three indications in 1999, but did not approve the use for rheumatoid arthritis until April 2002. Merck promoted Vioxx for off-label use over a three year period, even after the FDA sent a warning letter to Merck in September 2001. The criminal fine totaled \$321,636,000.

The civil settlement resolves allegations that Merck representatives made inaccurate, unsupported, and misleading statements about Vioxx's cardiovascular safety in order to increase sales. The civil settlement also included off-label promotion and resolved false claims that Merck made to Medicaid agencies about the safety of Vioxx. Under the civil settlement, Merck agreed to pay \$628,364,000.

The FEHBP received \$50,619,464. This was a joint investigation by the FBI; FDA; the VA and HHS OIGs; and our office.

Abbott Laboratories Unlawfully Markets, Engages in Illegal Remuneration, and Submits False Claims for Depakote

Abbott Laboratories (Abbott) violated the law by promoting the drug Depakote to control agitation and aggression in elderly dementia patients and to treat schizophrenia when neither of these uses was FDA approved.

In May 2012, Abbott agreed to settle the criminal and civil cases with the Government for \$1.5 billion. Abbott pled guilty to the misdemeanor charge of misbranding

Depakote. Abbott admitted in the criminal case that, from 1998 through 2006, the company maintained a special sales force trained to market Depakote in nursing homes for the control of agitation and aggression in elderly dementia patients, despite the absence of credible scientific evidence that Depakote was safe and effective for that use. In addition, from 2001 through 2006, the company marketed Depakote in combination with atypical antipsychotic drugs to treat schizophrenia, even after its clinical trials failed to demonstrate that adding Depakote was any more effective than an atypical antipsychotic drug taken alone.

The global resolution has criminal, civil, and administrative components including:

- Abbott pled guilty to a criminal misdemeanor for misbranding Depakote in violation of the FDCA.
- Abbott will pay a criminal fine of \$500 million, forfeit assets of \$198.5 million, and submit to a term of probation for five years. As a condition of probation, Abbott will report any probable FDCA violations to the probation office, its Chief Executive Officer will certify compliance with this reporting requirement, and its board will report annually on the effectiveness of the company's compliance program.
- In addition, Abbott agrees that during the term of probation, the company will:
 - not compensate sales representatives for off-label sales,
 - ensure that continuing medical education grant-making decisions are not controlled by sales and marketing,
 - require that letters communicating medical information to healthcare providers be accurate and unbiased, and,
 - have policies designed to ensure that clinical trials are approved by the company's medical or scientific organizations and published in a consistent and transparent manner.
- Abbott will also pay \$1.5 million to the Virginia Medicaid Fraud Control Unit.

Under the civil settlement, Abbott agreed to pay \$800 million to the Federal Government and the states that have opted to participate in the agreement. The settlement resolves claims related to unlawful



marketing and false claims for illegal remuneration submitted to Government health care programs such as Medicare; Medicaid; TRICARE; the FEHBP; the VA; and the Department of Labor’s Office of Workers’ Compensation Program.

In addition to the criminal and civil resolutions, Abbott has also executed a Corporate Integrity Agreement (agreement) with the HHS OIG. The five-year agreement requires that Abbott’s board of directors:

- Review the effectiveness of the company’s compliance program,
- Mandate that high-level executives certify compliance by performing standardized risk assessments and mitigation processes, and,
- Post information on its website about payments to doctors.

Abbott is subject to exclusion from Federal health care programs, including Medicare and Medicaid, for a material breach of the agreement and subject to monetary penalties for less significant breaches.

As a result of the settlement the FEHBP received \$4,703,851.

FEHBP Receives \$2.58 Million from Orthofix

Orthofix pled guilty to a felony for the obstruction of a Federal audit and has agreed to pay a \$7.65 million criminal fine and \$34.23 million plus interest to resolve civil allegations under the False Claims Act.

Orthofix manufactures medical devices including bone growth stimulators. Orthofix manipulated Certificates of Medical Necessity by having its sales representatives fill out the entire form, forging physicians’ signatures certifying that the device was medically necessary, and improperly coaching physicians’ staff on how to complete the forms. During a Medicare audit, Orthofix failed to disclose the above issues.

The civil settlement addresses four issues relating to Orthofix’s promotion of its bone growth stimulator products. These issues consist of:

- The improper waiver of patient co-payments to misstate true cost resulting in overpayments by Federal programs;
- Submission of falsified certificates of medical necessity to support Federal payments for products;
- Failure to advise patients of their right to rent rather than purchase products; and,
- Offering or paying kickbacks to induce the use of their products.

As part of this investigation, the former Orthofix Vice-President of Sales pled guilty to paying kickbacks to induce a doctor and a physician’s assistant to prescribe their products. A former Regional Sales Director also pled guilty to making a false declaration to a Federal grand jury about Orthofix’s conduct. A former Territory Manager pled guilty to falsifying patients’ medical records to fraudulently induce Medicare to pay for bone growth stimulators. A physician’s assistant pled guilty to accepting kickbacks in return for ordering bone growth stimulators.

As a result of the settlement, the FEHBP will receive \$2,580,328. This was a joint investigation with the FBI, DCIS, HHS OIG, and our office.

Pinnacle Medical Solutions Submits False Claims

In June 2012, Pinnacle Medical Solutions, a medical equipment company, agreed to pay the Government nearly \$1.8 million to settle allegations that the company defrauded Federal insurance groups out of money for delivery of diabetic supplies to patients.

According to the settlement agreement, from September 2006 through May 2009, Pinnacle submitted false claims to Medicare and the FEHBP for blood glucose monitoring strips and lancets that either were for different supplies or a larger quantity than Pinnacle had actually shipped, for more supplies than had been ordered, or that lacked supporting documentation for the supplies.

As a result of the settlement, the FEHBP will receive \$327,147. This was a joint investigation by DOJ, HHS OIG, and our office.



Physician Incarcerated and Fined for False Claims

In January 2007, the FBI and our office initiated a joint investigation involving allegations that a pharmacist, through his company, Najerausa International doing business as Continental Pharmacy, was billing for services not rendered. The investigation focused on allegations that the pharmacist submitted false claims to insurance companies to receive reimbursement for medications without valid prescriptions. Generally, as part of his scheme, after obtaining customer insurance information, the pharmacist would continue to electronically bill the customer's healthcare insurance carrier on a regular basis for various prescriptions; many of which were high priced and were neither prescribed by a physician nor received by the beneficiary. The pharmacist received reimbursement for most of the illegitimate and fraudulent claims that were submitted and amassed a substantial profit.

The pharmacist was charged with violations of the Controlled Substances Act. One aspect of the charged criminal activity involves possession with the intent to distribute; and the distribution of a controlled substance, namely hydrocodone. A pharmacy customer would initially visit Continental Pharmacy with a valid prescription. The pharmacist would fill the initial prescription and then offer the extra refills without a valid prescription, as long as customers were willing to pay for the medication with cash. After the expiration of the initial prescription, he would continue to distribute hydrocodone in violation of Federal law. To further the drug distribution scheme, he would often request that specific customers visit the pharmacy after 5:00 p.m.

In May 2012, the pharmacist pled guilty to one count of health care fraud for submitting false claims and was sentenced on the same date. He was sentenced to 63 months incarceration followed by 24 months of probation. On September 11, 2012, he was ordered to pay \$2,498,587 in restitution of which the FEHBP will receive \$158,565.

Physician Sentenced for Child Pornography and Health Care Fraud

Our office investigated health care fraud in which Intra-Op Monitoring Services, LLC (IOM), Physician's Analytical Services (PAS), and a physician located in Covington, Louisiana, submitted health care claims for services not rendered.

From 2004 through April 2010, the physician worked as the medical director of IOM. IOM employed physicians to remotely monitor, via internet connection, neurophysiological surgical procedures performed at hospital and surgical suites. An IOM-employed technician, meanwhile, was present in the operating suite to communicate with the telemonitoring physician. To appropriately bill for telemonitored surgery, an on-site technician had to be in contact with an operating physician, and the off-site physician had to be available during the surgery to interpret the data. PAS was owned by IOM and was responsible for billing-related matters.

PAS fraudulently billed various health care benefit programs for monitoring services that IOM-employed physicians did not provide and routinely overbilled for those monitoring services that were provided. Often the connection did not exist between the technician and the monitoring physician. Other times, technical difficulties prevented the physician from monitoring most, or all, of the surgery. Additionally, non-physicians would log onto the monitoring software using a physician's log-in information, including the log-in information of the medical director, pretend to be a physician, and monitor surgeries in the place of physicians.

PAS also regularly upcoded the billing by representing that surgeries were being monitored for longer periods of time than the Current Procedural Technology (CPT) codes permitted. For example, CPT codes provided for bills to be submitted for monitoring that took place between the time at which an electrophysiologic "baseline" was established and the "closing" of the surgery. PAS, however, would routinely bill for time spent prior to the establishment of a baseline, such as introducing the patient's history to the monitoring physician, or after closing.



When insurance carriers denied PAS' requests for payment, the company routinely appealed those denials. PAS frequently claimed that the rejection of the claim was "inappropriate and unjust," even though those claims were fraudulent since they represented surgeries that were not monitored and billing time was unreliable and unallowable.

A search warrant was executed on May 4, 2010, on multiple locations where medical records were located, including the medical director's residence, where work was primarily performed. Several computers were seized and placed into evidence.

On May 6, 2010, the U.S. Attorney's Office received a call from a local area attorney claiming to represent the medical director, who informed the U.S. Attorney's Office that one or more of the computers seized contained child pornography. Pursuant to that voluntary admission, the FBI opened an additional investigation and obtained a separate search warrant for the seized computers. Through a forensic examination, numerous images were found containing child pornography.

In January 2012, the medical director was charged and pled guilty to receipt of child pornography and health care fraud. On the same date, PAS was also charged and pled guilty to health care fraud.

In April 2012, the medical director was sentenced to 72 months incarceration for child pornography and health care fraud charges. On the same date, PAS also pled guilty and was sentenced to 12 months of probation, and ordered to pay restitution to the commercial carriers in the amount of \$500,000.

In May 2012, a civil false claims action against the parties involved in the criminal investigation was settled on behalf of the Government payers in the amount of \$903,984. The FEHBP portion of the settlement was \$142,254.

This was a joint investigation performed in conjunction with the FBI, HHS OIG, DCIS, VA OIG, and our office.

Husband and Wife Submit Non-Rendered Services Claims

Our office received a case referral from the United States Attorney's Office for the Eastern District of Virginia, alleging that a husband and wife who were co-owners of a dental practice billed for services not rendered to patients utilizing a variety of Current Dental Terminology (CDT) codes. The investigation revealed that both the husband and wife billed dozens of dental insurance providers for non-rendered services.

In exchange for the husband's and wife's plea agreements, the Government agreed to not criminally prosecute the wife for health care fraud. As a result of the civil settlement, the FEHBP and the FEDVIP received \$39,261. The husband pled guilty to health care fraud, was sentenced to serve 12 months and one day incarceration, and 36 months of supervised release. In addition, he is required to pay a special assessment of \$100, a fine of \$4,000, and restitution of \$102,835; of which \$731 will be returned to the FEHBP and the FEDVIP. The remaining restitution went to the health insurance carriers' commercial lines of business.

This was a joint investigation by the FBI and our office.

RETIREMENT FRAUD

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

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



RETIREMENT FRAUD CASES

Daughter-in-Law Conceals Death, Collects Stolen Annuity Payments, and Files False Tax Returns

A November 2009 death match conducted with SSA revealed that a retired Federal annuitant died in May 1989. Since OPM was never notified of the death, the annuity payments continued, resulting in an overpayment of over \$526,000.

Our investigation determined that the annuitant's daughter-in-law forged his name on four address verification letters (AVLs) sent by OPM to the annuitant. All four AVLs were returned indicating that the annuitant was still alive and bore the alleged signature of the annuitant.

During an interview with the daughter-in-law, she confessed to signing the AVLs and mailing them to OPM. Additionally, she admitted to taking the annuity money because she needed it.

In October 2011, the daughter-in-law was arrested and pled guilty to theft of public money and filing a false tax return. In May 2012, she was sentenced to 24 months home detention followed by 36 months of probation and ordered to pay over \$527,000 in restitution to OPM.

This was a joint investigation with the United States Secret Service, the Internal Revenue Service, and our office.

Son Conceals Death, Collects Stolen Annuity Payments

We initiated this investigation in April 2010, after receiving allegations that a deceased Federal survivor annuitant's son fraudulently obtained retirement payments from OPM. OPM was never notified of the survivor annuitant's death in July 1991.

OPM survivor annuity payments were sent via electronic funds transfer to a joint bank account shared by the survivor annuitant and her son. It was determined that the son received \$306,809 in improper benefits from OPM. OPM mailed five AVLs that were returned to OPM bearing the alleged signature of the survivor annuitant after her death.

Our investigators interviewed the survivor annuitant's son who admitted to signing his mother's name on the AVLs and mailing them to OPM. He stated that he knew that if he did not sign the letters, the money would stop. He added that he didn't see anything wrong with signing his mother's name since he had been doing it for years.

In November 2011, the son pled guilty to theft of public money. In April 2012, he was sentenced to 21 months in prison, followed by three years of supervised release. Additionally, he was ordered to pay \$306,809 in restitution to OPM.

This was a joint investigation by the FBI and OPM OIG.

Survivor Annuitant's Son Steals Over \$157,000 in Annuity Payments

This case was referred by OPM's Retirement Services in August 2010.

An OPM AVL was sent to a survivor annuitant in December 2000 after her death. The letter was mailed back to OPM signed by the annuitant implying to OPM that she was alive and her address was correct. Based on evidence obtained through a subpoena of bank records, the survivor annuitant's son was identified as the suspect in this theft.

The son was interviewed and admitted to forging his mother's name to the AVL in order to avoid discontinuation of the annuity payments. He further admitted he converted the funds to his personal use. He was also retired from the Federal Government and held various positions including staff accountant and comptroller.

The son fraudulently collected \$157,539 from November 2000 until September 2006, by taking monthly Civil Service Retirement System (CSRS) benefits intended for his mother.

In May 2011, the son pled guilty. Prior to sentencing, the son repaid the Retirement Trust Fund \$108,746. In July 2012, the son was sentenced to three months incarceration, three months of home detention, three years of supervised release, and he was also ordered to pay the balance of restitution in the amount of \$48,793.



Son Commits Forgery, Steals Father’s Annuity Payments

We initiated this investigation in February 2007, after receiving allegations that a deceased Federal annuitant’s son fraudulently obtained retirement benefits from OPM. OPM was never notified of the annuitant’s death.

From June 1999 to July 2006, the annuitant’s son received \$44,067 in improper payment benefits from OPM. In July 1999, he forged his father’s signature on an OPM AVL form indicating that his deceased father was still alive. Based on the OPM form bearing the alleged signature, OPM continued to pay the retirement annuity benefits.

Our investigators interviewed the annuitant’s son who admitted to forging his father’s signature on the OPM form. Furthermore, the son said he knew he was not entitled to his father’s retirement annuity benefits.

In March 2011, the annuitant’s son pled guilty to theft of public money. In September 2012, he was sentenced to 12 months of probation, the first 180 days to be served in GPS-monitored home confinement, a \$5,000 fine, a special assessment fee of \$100, and ordered to pay full restitution of \$44,067 to OPM.

Son Ordered to Return Over \$250,000 in Stolen Retirement Benefit Payments

We received a referral from OPM’s Retirement Services, Retirement Inspections Branch regarding a survivor annuitant who died in November 1997. However, benefits continued to be paid to the annuitant until June 2006, resulting in an overpayment of \$259,255.

Our investigation determined the survivor annuitant’s son had accessed his mother’s bank account where the monthly annuity benefits were deposited. Her son eventually removed the funds and deposited them into his own bank account. When interviewed by our investigators, the son admitted that he knew he was not entitled to the annuity benefits of his deceased mother.

The case was originally accepted for prosecution in the Eastern District of Virginia. The Assistant United States Attorney (AUSA) prosecuting the case met

with defense counsel and both parties agreed with the son making full restitution to OPM, and with the Government seeking Pretrial Diversion for theft of public money. In April 2012, OPM received a check in the amount of \$259,255, making full restitution to the Retirement Trust Fund.

SPECIAL INVESTIGATION CASES

OPM Employee Arrested for Manipulating Earnings and Leave Statements to Reduce Child Support Payments

Our investigators received a complaint that an OPM employee altered his earnings and leave statement. In response to a trial subpoena from the Circuit Court for Anne Arundel County, Maryland, the employee changed the statement to show a reduction of \$23,000 in income and submitted the altered earnings and leave statement to the court. The employee bragged to his coworkers that he had been able to change the earnings and leave statement in order to demonstrate lower wages to reduce his monthly child support obligation.

OIG criminal investigators presented the case to the State Attorney’s Office and it was accepted for prosecution.

In April 2012, the employee pled guilty to perjury and was subsequently sentenced to 20 days of incarceration (10 consecutive weekends) and 3 years of supervised release. He was also ordered to pay \$5,184 in restitution for child support.

During this investigation the employee was placed on indefinite suspension without pay. OPM is currently seeking administrative action and removal.

REVOLVING FUND PROGRAM INVESTIGATIONS

Our office investigates OPM employee misconduct and other wrongdoing, including allegations of fraud within OPM’s revolving funds programs, such as the background investigations and human resources products and services.

OPM’s Federal Investigative Services (FIS) conducts background investigations on Federal job applicants,



employees, military members, and contractor personnel for suitability and security purposes. FIS conducts over 90 percent of all personnel background investigations for the Federal Government. With a staff of over 9,300 Federal and contract employees, FIS processed over 2.2 million investigations in FY 2012. Federal 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.

OPM's Human Resources Solutions (HRS) provides other Federal agencies, on a reimbursable basis, with human resource products and services to help agencies develop leaders, attract and build a high quality workforce, and transform into high performing organizations. For example, HRS operates the Federal Executive Institute, a residential training facility dedicated to developing career leaders for the Federal Government. Cases related to HRS investigated by our special agents include employee misconduct, regulatory violations, and contract irregularities.

Former OPM Contract Background Investigator Sentenced for Falsifying Records

This case developed from a FIS referral to our office alleging misconduct and false statements by an OPM contract background investigator.

Between May 2007 and May 2008, in more than four dozen Reports of Investigations (ROI), the background investigator represented that he interviewed a source or reviewed a record regarding the subject of the background investigation when, in fact, he had not conducted the interview or obtained the record. These reports were used by the agencies requesting the background investigations to determine whether the subjects were suitable for positions having access to

classified information, impacting national security, or for receiving or retaining security clearances.

These false representations caused FIS to reopen and reinvestigate the casework assigned to the background investigator, which cost OPM \$192,071.

OIG criminal investigators interviewed the background investigator who admitted that he did not conduct interviews of individuals which he falsely reported that he had interviewed. Furthermore, he also admitted that he did not obtain or review documentary evidence, such as employment records, to verify and corroborate information provided by the subject of the background investigation.

In April 2012, the background investigator pled guilty to making a false statement. In June 2012, he was sentenced to three months in jail, followed by three years of supervised release. Additionally, he was ordered to pay \$192,071 in restitution to the Federal Government.

OPM Contract Background Investigator Falsified Numerous Background Investigations

In May 2009, the OIG received an allegation, from the Integrity Assurance Group of FIS, regarding misconduct and false statements by a former contract OPM background investigator.

We determined that the background investigator reported that she had interviewed a source or reviewed a record in more than 20 background investigation reports when she had not conducted the interview or obtained the record. These events occurred between March 2007 and November 2007. These false representations were material because they influenced the Government's personnel decisions. These false representations required FIS to reopen and reinvestigate numerous background investigations that cost OPM an estimated \$70,899.

In January 2012, the former OPM contract background investigator pled guilty to a charge of making a false statement. In April 2012, she was sentenced to serve 90 days of incarceration, 200 hours of community service, and ordered to pay full restitution to FIS in the amount of \$70,899 and a special assessment fee of \$100.



Former Background Investigator Sentenced for Threatening Federal Officer

A FIS background investigator was the subject of an administrative investigation that eventually resulted in his termination. After he exhausted his appeals and the Merit Systems Protection Board (MSPB) upheld the termination, the employee became angry, particularly with the FIS supervisor in charge of the investigation.

The employee used Google to search the name of the FIS supervisor. When the employee found a press release on an unrelated matter that mentioned the FIS supervisor, the employee posted two anonymous blogs. These blogs threatened to assault and murder the FIS supervisor.

An OIG investigator discovered the blogs, opened a case, and began an investigation to determine who posted the blogs. As the investigation continued, it was discovered the blogs were posted by a particular terminated FIS employee. A search warrant was executed at the residence of the former employee and investigators seized his personal computers. When interviewed, the former FIS employee admitted to posting the blogs and making the anonymous death threats. However, he said he did not have a firearm and did not intend to carry out the threats.

In February 2012, in the U.S. District Court for the District of Columbia, a criminal charge was filed against the former employee for threatening a Federal officer.

In April 2012, the former FIS employee pled guilty to threatening a Federal officer. The former FIS employee was sentenced to 45 days in a halfway house, 45 days of home confinement, and 3 years of probation. He was also ordered to perform 50 hours of community service and receive anger management counseling.

OIG HOTLINES AND COMPLAINT ACTIVITY

The OIG's Health Care Fraud Hotline, Retirement and Special Investigations Hotline, online anonymous complaint form, and mailed-in complaints also contribute to identifying fraud and abuse. We received 553 hotline inquiries during the reporting period. The table on page 40 reports the summary of hotline activities.

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 method for reporting waste, fraud, and abuse within the agency and its programs. During this reporting period, this hotline received a total of 348 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 FEHBP carriers.



The Health Care Fraud Hotline received 205 complaints during this reporting period, including telephone calls, emails, and letters.

OIG AND EXTERNAL INITIATED COMPLAINTS

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

During this reporting period, we initiated 86 preliminary inquiry complaints related to retirement fraud and special investigations. We also initiated 360 health care fraud preliminary inquiry complaints. These efforts may potentially evolve into formal investigations.

We believe that these OIG and external initiated complaints complement our hotline to ensure that our office continues to be effective in its role to guard

against and identify instances of fraud, waste, and abuse.

CORRECTION OF PRIOR PERIOD SEMIANNUAL REPORT

In our semiannual report for the period ending March 31, 2012, we published a statement in the audit of the Federal Long Term Care Insurance Program Operations (FLTCIP) on page 15 which reads, “The Long Term Care Partners (LTCP) agreed to all questioned amounts and has already addressed these identified issues.” This statement was incorrect, because OPM is still in the process of resolving the findings related to \$796,021 questioned in program maintenance costs and \$53,593 questioned as lost investment income.

We also underreported an OPM judicial recovery in the amount of \$105,747 involving a retirement fraud investigation.



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 32,109 active suspensions and debarments from the FEHBP.

During the reporting period, our office issued 473 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 1,626 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.*

Providers Attempt to Receive FEHBP Funds for Services Rendered While Under Debarment

The National Association of Letter Carriers (NALC) notified the OPM OIG Administrative Sanctions staff of two providers, a chiropractor and a podiatrist, who continued to submit claims for services rendered to FEHBP enrollees while under debarment.

In March 2012, NALC’s Special Investigative Unit (SIU) notified our office about a chiropractor’s submission of claims for payment of FEHBP funds for services furnished after his July 1995, debarment. As a result, the OPM Debarring Official cited the provider for directly violating the terms of his debarment and advised that an additional sanction period may be imposed.



The enrollees, who received the services from the debarred chiropractor, submitted a request to NALC for an exception to the scope of the provider’s debarment. NALC analyzed the request, as required by the OPM Debarment Guidelines, and forwarded it to our office accompanied by their recommendation for denial. Based on the information made available, the enrollees will be notified by the OPM Debarring Official that their request was denied because there were several other chiropractic offices within a reasonable distance from their residence and discontinuing treatment with their particular provider would not pose a health or safety risk to the enrollees.

In July 2012, NALC’s SIU referred a second case to our office, in which a podiatrist submitted claims for payment of FEHBP funds for services rendered to FEHBP enrollees after his November 2002 debarment.

The OPM Debarring Official issued a warning letter to the podiatrist in October 2009, regarding an earlier violation for submitting claims during his debarment. Based on the July 2012 NALC SIU referral, the Debarring Official issued a second warning to the provider. In his warning letter, the Debarring Official reiterated that the podiatrist’s actions are a direct violation of the terms of his debarment and advised that an additional sanction period may be imposed.

Debarred providers are not eligible to receive payment of FEHBP funds, thus continuing to submit claims may be considered as violations of the Federal false claims statutes. The chiropractor and podiatrist were advised to immediately cease filing such claims and/or causing them to be filed, until OPM terminates their debarment.

Maryland Physician Debarred for Sexual Misconduct

Based on research and analysis of electronically available information, we debarred a Maryland licensed physician in June 2012. The physician was cited for unprofessional conduct and violating Federal and state statutes.

Our office originally suspended the physician from participating in the FEHBP in August 2008. Our suspension was based on the Maryland Board of Physicians’ (MBP) suspension of the physician’s

professional license. The MBP based their decision on the physician’s action of sexual misconduct with patients and a criminal indictment based on those acts. Licensing authorities in the District of Columbia, Tennessee, and Virginia also took action against the physician’s eligibility to practice medicine.

Our debarment was based on the MBP’s decision to permanently revoke the physician’s medical license.

The specific offenses in which the physician engaged leading to his debarment included:

- sexually assaulting female patients while providing medical services;
- violating the Maryland Medical Practice Act;
- engaging in sexual improprieties and sexual misconduct; and,
- conducting himself in an immoral and unprofessional manner, of which he was cognizant of the criminal nature of his actions.

Our debarment of the physician is for an indefinite period pending resolution of his Maryland medical licensure.

North Carolina Physician Debarred for Loss of Medical License

In August 2012, we debarred a North Carolina physician from participating in the FEHBP. Our debarment was based on the North Carolina Medical Board’s (NCMB) indefinite suspension of the physician’s medical license.

In November 2011, the physician was indicted and charged with a felony violation for prescribing a controlled substance to an individual whom he did not see in his office, nor conduct a physical exam of, or create or maintain a patient chart. Prescribing a prescription of a controlled substance without a legitimate medical purpose and outside the normal course of professional practice is a violation of the North Carolina General Statutes.

Based on the physician’s misconduct and violations of North Carolina State law, the NCMD indefinitely



ENFORCEMENT ACTIVITIES

suspended the physician's medical license. The suspension and our debarment were based on the Board's conclusions and findings below:

- The physician conducted himself in an unprofessional manner, including the departure from or the failure to conform to the ethics of the medical profession, irrespective of whether a patient is injured thereby, or the committing of any dishonest, unjust or immoral act.

- The physician demonstrated that he was unable to practice medicine with reasonable skill and safety to patients by reason of illness, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality.

Our debarment of the physician is for an indefinite period pending resolution of his North Carolina medical licensure.



STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES



Judicial Actions:

Arrests	30
Indictments and Informations	31
Convictions	29

Judicial Recoveries:

Restitutions and Settlements	\$169,034,321
Fines, Penalties, Assessments, and Forfeitures	\$321,902,390 ¹

Retirement and Special Investigations Hotline and Preliminary Inquiry Activity:

HOTLINE

Referred to:

OPM Program Offices	179
Other Federal Agencies	112
Informational Only	40
Inquiries Initiated	2
Retained for Further Inquiry	15
Total Received:	348

PRELIMINARY INQUIRY COMPLAINTS

Total Received:	86
Total Closed:	36

(Continued on next page)

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



Health Care Fraud Hotline and Preliminary Inquiry Complaint Activity:

HOTLINE

Referred to:

OPM Program Offices	61
FEHBP Insurance Carriers or Providers	116
Other Federal Agencies	11
Informational Only	14
Inquiries Initiated.....	0
Retained for Further Inquiry.....	3
Total Received:	205

PRELIMINARY INQUIRY COMPLAINTS

Total Received:	360
Total Closed:	218

Hotline Contacts and Preliminary Inquiry Complaints:

Total Hotline Contacts and Preliminary Inquiries Received:	999
Total Hotline Contacts and Preliminary Inquiries Closed:.....	789

Administrative Sanctions Activity:

Debarments and Suspensions Issued	473
Health Care Provider Debarment and Suspension Inquiries	1,626
Debarments and Suspensions in Effect at End of Reporting Period	32,109

APPENDICES



APPENDIX I Final Reports Issued with Questioned Costs for Insurance Programs

APRIL 1, 2012 TO SEPTEMBER 30, 2012

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	7	\$13,165,418
B. Reports issued during the reporting period with findings	12	16,078,509
Subtotals (A+B)	19	29,243,927
C. Reports for which a management decision was made during the reporting period:	17	28,658,337
1. Disallowed costs	N/A	28,664,830
2. Costs not disallowed	N/A	(6,493) ²
D. Reports for which no management decision has been made by the end of the reporting period	1	585,590
E. Reports for which no management decision has been made within 6 months of issuance	0	0

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



APPENDIX II – A

Final Reports Issued with Recommendations for All Other Audit Entities

APRIL 1, 2012 TO SEPTEMBER 30, 2012

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	5	\$513,540
B. Reports issued during the reporting period with findings	2	6,245
Subtotals (A+B)	7	519,785
C. Reports for which a management decision was made during the reporting period:	3	169,106
1. Disallowed costs	N/A	169,106
2. Costs not disallowed	N/A	0
D. Reports for which no management decision has been made by the end of the reporting period	4	350,679
E. Reports for which no management decision has been made within 6 months of issuance	3	347,158

APPENDIX II – B

Final Reports Issued with Recommendations for Better Use of Funds

APRIL 1, 2012 TO SEPTEMBER 30, 2012

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	1	\$764,069
B. Reports issued during the reporting period with findings	0	0
Subtotals (A+B)	1	764,069
C. Reports for which a management decision was made during the reporting period:	1	764,069
D. Reports for which no management decision has been made by the end of the reporting period	0	0
E. Reports for which no management decision has been made within 6 months of issuance	0	0



APPENDIX III

Insurance Audit Reports Issued

APRIL 1, 2012 TO SEPTEMBER 30, 2012

Report Number	Subject	Date Issued	Questioned Costs
1C-EA-00-12-002	Capital Group Health Services of Florida, Inc., in Tallahassee, Florida	June 4, 2012	\$ 0
1C-NV-00-11-047	New West Health Services in Helena, Montana	June 4, 2012	1,113,485
1C-VR-00-11-064	Group Health Cooperative in Spokane, Washington	June 13, 2012	0
1A-10-11-11-058	BlueCross BlueShield of Massachusetts in Boston, Massachusetts	June 14, 2012	81,307
1C-75-00-12-038	Humana Health Plan, Inc. of Chicago in Louisville, Kentucky	June 21, 2012	0
1A-99-00-12-001	Global Omnibus Budget Reconciliation Act of 1993 Claims for BlueCross and BlueShield in Washington, D.C.	July 16, 2012	631,605
1C-JP-00-12-060	MD – Individual Practice Association, Inc. in Cypress, California 2012 Proposed Rate Reconciliation	July 17, 2012	0
1C-65-00-12-054	Kaiser Foundation Health Plan of Colorado in Aurora, Colorado 2012 Proposed Rate Reconciliation	July 18, 2012	0
1C-52-00-12-061	Health Alliance Plan in Detroit, Michigan 2012 Proposed Rate Reconciliation	July 18, 2012	0
1C-51-00-12-058	Health Insurance Plan of New York in New York, New York 2012 Proposed Rate Reconciliation	August 2, 2012	7,966,352
1C-57-00-12-052	Kaiser Foundation Health Plan of the Northwest in Portland, Oregon 2012 Proposed Rate Reconciliation	August 3, 2012	0
1C-LX-00-12-059	BlueCare Network of Michigan in Southfield, Michigan 2012 Proposed Rate Reconciliation	August 7, 2012	1,739,150
1H-01-00-11-063	BlueCross BlueShield's Retail Pharmacy Operations as Administered by CVS Caremark in Scottsdale, Arizona	August 8, 2012	689,762
1C-JC-00-12-042	Aetna Open Access of New York in Blue Bell, Pennsylvania	August 8, 2012	0
1C-P3-00-12-043	Aetna Open Access of the Mid-Atlantic Region in Blue Bell, Pennsylvania	August 8, 2012	0



APPENDIX III Insurance Audit Reports Issued

APRIL 1, 2012 TO SEPTEMBER 30, 2012

(Continued)

Report Number	Subject	Date Issued	Questioned Costs
1C-76-00-12-006	Union Health Service, Inc. in Chicago, Illinois	August 20, 2012	\$ 1,110,730
4A-RI-00-11-060	Federal Flexible Spending Account Program as Administered by SHPS, Inc. in Louisville, Kentucky.	August 22, 2012	1,470,246
1C-NM-00-12-018	Health Plan of Nevada, Inc. in Las Vegas, Nevada	August 23, 2012	0
1C-6V-00-12-010	GHI HMO Select, Inc., Plan Code 6V in New York, New York	August 23, 2012	282,614
1A-10-36-12-003	Capital BlueCross in Harrisburg, Pennsylvania	August 23, 2012	143,406
1C-X4-00-12-011	GHI HMO Select, Inc., Plan Code X4 in New York, New York	September 13, 2012	264,262
1C-A7-00-12-028	Health Net of Arizona, Inc. in Woodland Hills, California	September 27, 2012	585,590
TOTALS			\$16,078,509



APPENDIX IV

Internal Audit Reports Issued

APRIL 1, 2012 TO SEPTEMBER 30, 2012

Report Number	Subject	Date Issued
4A-CF-00-11-067	OPM's Administration of the Prompt Payment Act in Washington, D.C.	September 13, 2012

APPENDIX V

Combined Federal Campaign Audit Reports Issued

APRIL 1, 2012 TO SEPTEMBER 30, 2012

Report Number	Subject	Date Issued	Questioned Costs
3A-CF-00-11-036	The 2008 and 2009 Taconic Valley Combined Federal Campaigns in White Plains, New York	April 26, 2012	\$3,521
3A-CF-00-11-040	The 2008 and 2009 Greater New Orleans Area Combined Federal Campaigns in New Orleans, Louisiana	May 2, 2012	2,724
TOTALS			\$6,245



APPENDIX VI

Information Systems Audit Reports Issued

APRIL 1, 2012 TO SEPTEMBER 30, 2012

Report Number	Subject	Date Issued
4A-CI-00-12-014	Information Technology Security Controls of OPM's Local Area Network/Wide Area Network General Support System in Washington, D.C.	May 16, 2012
4A-OP-00-12-013	Information Technology Security Controls of OPM's Audit Report & Receivables Tracking System in Washington, D.C.	July 16, 2012
4A-HR-00-12-037	Information Security Posture of OPM's USAJOBS System in Washington, D.C.	July 26, 2012
4A-CF-00-12-015	Information Technology Security Controls of the OPM's Service Credit Redeposit and Deposit System in Washington, D.C.	August 9, 2012
1B-31-00-11-066	Information Systems General and Application Controls at the Government Employees Health Association in Washington, D.C.	August 9, 2012
4A-HR-00-12-044	USAJOBS System Development Lifecycle in Washington, D.C.	September 28, 2012

APPENDIX VII

Evaluation Reports Issued

APRIL 1, 2012 TO SEPTEMBER 30, 2012

Report Number	Subject	Date Issued
No activity during this reporting period		



APPENDIX VIII

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

APRIL 1, 2012 TO SEPTEMBER 30, 2012

Report Number	Subject	Date Issued
4A-CF-00-05-028	Administration of the Prompt Payment Act at OPM, in Washington, D.C.; 12 total recommendations; 3 open recommendations	April 16, 2007
4A-RI-00-05-037	OPM's Reclamation Process in Washington, D.C.; 10 total recommendations; 1 open recommendation	March 18, 2008
4A-CI-00-08-022	Federal Information Security Management Act for FY 2008; 19 total recommendations; 3 open recommendations	September 23, 2008
4A-CF-00-08-025	OPM's FY 2008 Consolidated Financial Statements in Washington, D.C.; 6 total recommendations; 6 open recommendations	November 14, 2008
1A-99-00-08-065	Global Claims-to-Enrollment Match for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 1 open recommendation	June 23, 2009
1A-99-00-09-011	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 1 open recommendation	July 20, 2009
1A-99-00-09-036	Global Duplicate Claim Payments for BlueCross and BlueShield Plans in Washington, D.C.; 2 total recommendations; 1 open recommendation	October 14, 2009
4A-CI-00-09-031	Federal Information Security Management Act for FY 2009 in Washington, D.C.; 30 total recommendations; 3 open recommendations	November 5, 2009
4A-CF-00-09-037	OPM's FY 2009 Consolidated Financial Statements in Washington, D.C.; 5 total recommendations; 5 open recommendations	November 13, 2009
4A-CF-00-10-021	Service Credit Redeposit and Deposit System in Washington, D.C.; 8 total recommendations; 24 open recommendations	January 8, 2010
1A-99-00-09-061	Global Assistant Surgeon Claims Overpayments for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 2 open recommendations	March 30, 2010
1A-99-00-10-009	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 1 open recommendation	March 31, 2010
1A-10-85-09-023	CareFirst BlueCross BlueShield in Owings Mills, Maryland; 18 total recommendations; 5 open recommendations	May 21, 2010
4A-IS-00-09-060	Quality Assurance Process Over Background Investigations in Washington, D.C.; 18 total recommendations; 4 open recommendations	June 22, 2010
1A-99-00-09-046	Global Omnibus Budget Reconciliation Act of 1990 Claims for BlueCross and BlueShield Plans in Washington, D.C.; 5 total recommendations; 1 open recommendation	July 19, 2010
4A-CF-00-10-018	Information Technology Security Controls for OPM's Benefits Financial Management System in Washington, D.C.; 15 total recommendations; 1 open recommendation	September 10, 2010



APPENDIX VIII

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

APRIL 1, 2012 TO SEPTEMBER 30, 2012

(Continued)

Report Number	Subject	Date Issued
4A-RI-00-10-014	OPM's Court Ordered Benefits Branch in Washington, D.C.; 7 total recommendations; 3 open recommendations	October 14, 2010
4A-CF-00-10-015	OPM's FY 2010 Consolidated Financial Statements in Washington, D.C.; 7 total recommendations; 7 open recommendations	November 10, 2010
4A-CI-00-10-019	Federal Information Security Management Act for FY 2010 in Washington, D.C.; 41 total recommendations; 6 open recommendations	November 10, 2010
4A-CF-00-10-047	Information Technology Security Controls for OPM's Annuity Roll System in Washington, D.C.; 13 total recommendations; 1 open recommendation	November 22, 2010
4A-CF-00-10-043	Payroll Debt Management Process for Active and Separated Employees in Washington, D.C.; 8 total recommendations; 5 open recommendations	March 4, 2011
1K-RS-00-11-034	Review of the Payroll Functions Related to the Federal Employees Health Benefits Program Enrollment Transactions for Annuitants in Washington, D.C.; 5 total recommendations; 2 open recommendations	March 14, 2011
4A-CF-00-10-023	OPM's Invoice Payment Process in Washington, D.C.; 3 total recommendations; 2 open recommendations	March 30, 2011
4A-CI-00-11-016	Information Technology Security Controls for OPM's Enterprise Server Infrastructure General Support System in Washington, D.C.; 3 total recommendations; 2 open recommendations	May 16, 2011
1A-99-00-10-055	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 1 open recommendation	June 8, 2011
1B-47-00-11-044	Follow-up Review of Information Systems General and Application Controls at American Postal Workers Union in Glen Burnie, Maryland; 6 total recommendations; 1 open recommendation	June 27, 2011
1A-99-00-10-061	Global Claims-to-Enrollment Match for BlueCross and BlueShield Plans in Washington, D.C.; 5 total recommendations; 1 open recommendation	September 8, 2011
1H-80-00-10-062	Group Health Incorporated's Pharmacy Operations in New York, New York; 14 total recommendations; 5 open recommendations	September 8, 2011
1K-RS-00-11-068	Stopping Improper Payments to Deceased Annuitants in Washington, D.C.; 14 total recommendations; 4 open recommendations	September 14, 2011
4A-CI-00-11-009	Federal Information Security Management Act for FY 2011 in Washington, D.C.; 29 total recommendations; 9 open recommendations	November 9, 2011
1G-LT-00-10-022	Long Term Care Partners, LLC in Portsmouth, New Hampshire; 11 total recommendations; 3 open recommendations	November 10, 2011



APPENDIX VIII

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

APRIL 1, 2012 TO SEPTEMBER 30, 2012

(Continued)

Report Number	Subject	Date Issued
4A-CF-00-11-050	OPM's FY 2011 Consolidated Financial Statements in Washington, D.C.; 7 total recommendations; 7 open recommendations	November 14, 2011
1A-99-00-11-022	Global Duplicate Claim Payments for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 1 open recommendation	January 11, 2012
1J-0L-00-11-033	Federal Employees Dental and Vision Insurance Program as Administered by OPM in Washington, D.C.; 8 total recommendations; 5 open recommendations	February 1, 2012
1H-01-00-11-011	BlueCross BlueShield's Mail Order Pharmacy Operations as Administered by CVS Caremark in 2006 and 2007 in Scottsdale, Arizona; 5 total recommendations; 3 open recommendations	February 2, 2012
1A-10-00-12-022	BlueCross BlueShield Association's Federal Employees Program Portability System in Washington, D.C.; 2 total recommendations; 2 open recommendations	February 2, 2012
4A-RI-00-12-034	Insecure Password Reset Process on Agency-owned Information Systems in Washington, D.C.; 3 total recommendations; 1 open recommendation	February 7, 2012
1A-10-91-11-030	BlueCross BlueShield Association in Washington, D.C and Chicago, Illinois; 13 total recommendations; 2 open recommendations	March 6, 2012
1B-31-00-10-038	Government Employees Health Association, Inc. in Lee's Summit, Missouri; 16 total recommendations; 13 open recommendations	March 12, 2012
1C-RL-00-11-042	Grand Valley Health Plan, Inc. in Grand Rapids, Michigan; 2 total recommendations; 2 open recommendations	March 13, 2012
1A-10-00-11-052	Information Systems General and Application Controls at Medco Health Solutions, Inc., in Franklin Lakes, New Jersey; 6 total recommendations; 2 open recommendations	March 14, 2012
4A-RI-00-12-009	OPM's FY 2011 Improper Payments Reporting for Compliance with the Improper Payments Elimination and Recovery Act of 2010 in Washington, D.C.; 4 total recommendations; 4 open recommendations	March 14, 2012
1A-99-00-11-055	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 6 total recommendations; 1 open recommendation	March 28, 2012
4A-CF-00-09-014	OPM's Interagency Agreement Process in Washington, D.C.; 8 total recommendations; 8 open recommendations	March 28, 2012
3A-CF-00-11-038	The 2008 and 2009 Capital Region Combined Federal Campaigns in Albany, New York; 27 total recommendations; 5 open recommendations	March 30, 2012



APPENDIX IX

Most Recent Peer Review Results

APRIL 1, 2012 TO SEPTEMBER 30, 2012

We do not have any open recommendations to report from our peer reviews.

Subject	Date of Report	Result
System Review Report for the U.S. Office of Personnel Management's Office of the Inspector General Audit Organization <i>(Issued by the Office of Inspector General, Board of Governors of the Federal Reserve System)</i>	September 26, 2012	Pass ³
Quality Control System Review of the U.S. Department of Commerce's Office of the Inspector General Audit Organization <i>(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)</i>	July 13, 2012	Pass ³
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the Tennessee Valley Authority <i>(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)</i>	December 14, 2010	Compliant ⁴
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the U.S. Office of Personnel Management <i>(Issued by the Office of Inspector General, U.S. Agency for International Development)</i>	June 2, 2010	Full Compliance ⁴

³A peer review of **Pass** is issued when the reviewing Office of Inspector General concludes that the system of quality control for the reviewed Office of Inspector General has been suitably designed and complied with to provide it with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. There are no deficiencies or significant deficiencies that affect the nature of the Peer Review and, therefore, the Peer Review does not contain any deficiencies or significant deficiencies.

⁴A rating of **Compliant** or **Full Compliance** conveys that the reviewed Office of the Inspector General has adequate internal safeguards and management procedures to ensure that the Council of the Inspectors General on Integrity and Efficiency standards are followed and that law enforcement powers conferred by the 2002 amendments to the Inspector General Act are properly exercised.



APPENDIX X

Investigative Recoveries

APRIL 1, 2012 TO SEPTEMBER 30, 2012

OIG Case Number ⁵	Case Category	Action ⁵	OPM Recovery (Net)	Total Recovery (All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
I 2012 00300	Federal Investigative Services	Criminal	\$ 10,000	\$ 10,000	\$ 0
I 2009 00869	Federal Investigative Services	Administrative	112,403	112,403	0
I 2009 00860	Federal Investigative Services	Administrative	143,425	143,425	0
C 2012 00409	Federal Investigative Services	Administrative	189,208	189,208	0
I 2009 00858	Federal Investigative Services	Criminal	192,071	192,071	0
I 2011 00065	Federal Investigative Services	Criminal	70,899	70,899	0
C 2012 00024	Federal Investigative Services	Administrative	90,323	90,323	0
I 2011 00065	Federal Investigative Services	Criminal	0	0	100
I 2009 00858	Federal Investigative Services	Criminal	0	0	100
IA 2011 00016	Federal Investigative Services	Criminal	0	0	100
I 2012 00300	Federal Investigative Services	Criminal	0	0	100
TOTAL	Federal Investigative Services		\$ 808,328	\$ 808,328	\$ 400
I 2011 00048	Health Care Fraud	Civil	\$50,689,531	\$1,000,000,000	\$ 0
I 2008 00002	Health Care Fraud	Civil	1,211	1,000,000	0
I 2011 00015	Health Care Fraud	Criminal	45,771	1,032,266	0
I 2008 00314	Health Care Fraud	Civil	40,852	1,262,975	0
I 2009 00051	Health Care Fraud	Civil	327,147	1,771,522	0
I 2010 00104	Health Care Fraud	Civil	1,731,268	10,000,000	0
I 2012 00183	Health Care Fraud	Criminal	731	102,835	0
C 2010 00634	Health Care Fraud	Civil	13,185	11,000,000	0
I 2012 00183	Health Care Fraud	Civil	39,261	120,000	0
I 2009 00074	Health Care Fraud	Criminal	21,189	153,536	0
I 2012 00022	Health Care Fraud	Civil	84,768	155,024	0
I 2011 00673	Health Care Fraud	Criminal	0	182,451	0
I 2011 00033	Health Care Fraud	Criminal	20,713	184,746	0
I 2004 00075	Health Care Fraud	Civil	53,680,569	2,000,000,000	0
I 2012 00037	Health Care Fraud	Criminal	161,077	2,021,141	0
I 2007 00109	Health Care Fraud	Criminal	158,565	2,498,587	0
I 2011 00775	Health Care Fraud	Criminal	0	30,504	0
I 2006 00075	Health Care Fraud	Civil	2,580,328	34,234,263	0
I 2010 00103	Health Care Fraud	Civil	50,619,464	628,364,000	0



APPENDIX X

Investigative Recoveries

APRIL 1, 2012 TO SEPTEMBER 30, 2012

(Continued)

OIG Case Number ^s	Case Category	Action ^s	OPM Recovery (Net)	Total Recovery (All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
I 2010 00974	Health Care Fraud	Civil	\$ 20,297	\$ 486,000	\$ 0
I 2010 00035	Health Care Fraud	Criminal	0	5,000	0
I 2010 00035	Health Care Fraud	Criminal	0	500,000	0
I 2011 00059	Health Care Fraud	Civil	19,255	514,000	0
C 2012 00373	Health Care Fraud	Administrative	592,354	592,354	0
I 2009 00020	Health Care Fraud	Civil	935,838	7,945,019	0
I 2008 00096	Health Care Fraud	Civil	4,703,851	800,000,000	0
I 2010 00035	Health Care Fraud	Civil	142,254	903,984	0
I 2007 00109	Health Care Fraud	Criminal	0	0	100
I 2011 00015	Health Care Fraud	Criminal	0	0	100
I 2011 00533	Health Care Fraud	Criminal	0	0	100
I 2011 00775	Health Care Fraud	Criminal	0	0	100
I 2012 00037	Health Care Fraud	Criminal	0	0	100
I 2012 00183	Health Care Fraud	Criminal	0	0	100
I 2011 00533	Health Care Fraud	Criminal	0	0	2,100
I 2010 00035	Health Care Fraud	Criminal	0	0	200
I 2012 00037	Health Care Fraud	Criminal	0	0	250,000
I 2010 00103	Health Care Fraud	Criminal	0	0	321,636,000
I 2012 00183	Health Care Fraud	Criminal	0	0	4,000
I 2010 00035	Health Care Fraud	Criminal	0	0	400
I 2011 00033	Health Care Fraud	Criminal	0	0	400
I 2009 00074	Health Care Fraud	Criminal	0	0	690
I 2011 00673	Health Care Fraud	Criminal	0	0	700
TOTAL	Healthcare Fraud		\$166,629,479	\$4,505,060,207	\$321,895,090
IA 2010 00012	OPM Employee Misconduct	Criminal	0	5,184	0
TOTAL	OPM Employee Misconduct		\$ 0	\$ 5,184	\$ 0



APPENDIX X
Investigative Recoveries
 APRIL 1, 2012 TO SEPTEMBER 30, 2012
 (Continued)

OIG Case Number ⁵	Case Category	Action ⁵	OPM Recovery (Net)	Total Recovery (All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
I 2010 00097	Retirement Fraud	Criminal	\$ 0	\$ 1,806,958	\$ 0
I 2011 00032	Retirement Fraud	Criminal	131,878	131,878	0
I 2011 00038	Retirement Fraud	Criminal	157,539	157,539	0
I 2010 00067	Retirement Fraud	Administrative	259,255	259,255	0
I 2010 00107	Retirement Fraud	Criminal	306,809	306,809	0
I 2011 00027	Retirement Fraud	Criminal	38,959	38,959	0
I 2010 00078	Retirement Fraud	Criminal	44,067	44,067	0
I 2010 00090	Retirement Fraud	Criminal	527,000	540,289	0
I 2009 00085	Retirement Fraud	Criminal	73,388	73,388	0
I 2011 00057	Retirement Fraud	Criminal	57,619	89,313	0
I 2010 00078	Retirement Fraud	Criminal	0	0	100
I 2009 00085	Retirement Fraud	Criminal	0	0	100
I 2011 00032	Retirement Fraud	Criminal	0	0	100
I 2011 00027	Retirement Fraud	Criminal	0	0	100
I 2010 00107	Retirement Fraud	Criminal	0	0	100
I 2011 00038	Retirement Fraud	Criminal	0	0	100
I 2010 00090	Retirement Fraud	Criminal	0	0	200
I 2011 00057	Retirement Fraud	Criminal	0	0	200
I 2010 00097	Retirement Fraud	Criminal	0	0	300
I 2010 00097	Retirement Fraud	Criminal	0	0	300
I 2010 00097	Retirement Fraud	Criminal	0	0	300
I 2010 00078	Retirement Fraud	Criminal	0	0	5,000
TOTAL	Retirement Fraud		\$ 1,596,514	\$ 3,448,455	\$ 6,900
GRAND TOTAL			\$169,034,321	\$4,509,322,174	\$321,902,390

⁵Cases that are listed multiple times indicate there were multiple subjects.



Index of Reporting Requirements

(Inspector General Act of 1978, As Amended)

	Page
Section 4 (a) (2):	Review of legislation and regulations No Activity
Section 5 (a) (1):	Significant problems, abuses, and deficiencies 1-30
Section 5 (a) (2):	Recommendations regarding significant problems, abuses, and deficiencies..... 1-16
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 17-27
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..... 35-38
Section 5 (a) (7):	Summary of particularly significant reports 1-30
Section 5 (a) (8):	Audit reports containing questioned costs 33-34
Section 5 (a) (9):	Audit reports containing recommendations for better use of funds 34
Section 5 (a) (10):	Summary of unresolved audit reports issued prior to the beginning of this reporting period 39-41
Section 5 (a) (11):	Significant revised management decisions during this reporting period No Activity
Section 5 (a) (12):	Significant management decisions with which the OIG disagreed during this reporting period..... No Activity
Section 5 (a) (14) (A):	Peer reviews conducted by another OIG 42
Section 5 (a) (16):	Peer reviews conducted by the OPM OIG..... 42



OIG HOTLINE

Report Fraud, Waste or Abuse to the Inspector General

Please Call the HOTLINE:

202-606-2423

Toll-free HOTLINE:

877-499-7295

Caller can remain anonymous • Information is confidential

<http://www.opm.gov/oig/html/hotline.asp>



MAILING ADDRESS:

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

Theodore Roosevelt Building

1900 E Street, N.W.

Room 6400

Washington, DC 20415-1100



For additional information or copies of this publication, please contact:

OFFICE OF THE INSPECTOR GENERAL
United States Office of Personnel Management

Theodore Roosevelt Building | 1900 E Street, N.W., Room 6400 | Washington, DC 20415-1100
Telephone: (202) 606-1200 | Fax: (202) 606-2153

WEB SITE:
www.opm.gov/oig