

United States Office of Personnel Management
**SEMIANNUAL REPORT
TO CONGRESS**



Office of the Inspector General



PRODUCTIVITY INDICATORS

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds	\$39,622,791
Management Commitments to Recover Funds	\$21,908,910
Recoveries Through Investigative Actions	\$46,341,768

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

ACCOMPLISHMENTS:

Audit Reports Issued	28
Evaluation Reports Issued	0
Investigative Cases Closed	36
Indictments and Informations	29
Arrests	8
Convictions	18
Hotline Contacts and Preliminary Inquiries Complaints	1,369
Health Care Provider Debarments and Suspensions	417
Health Care Provider Debarment and Suspension Inquiries	2,496

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MESSAGE FROM THE INSPECTOR GENERAL

"The operative word for the Office of Personnel Management's (OPM) Office of Inspector General (OIG) is accountability."

I wrote those words during my first year as the Inspector General for OPM, and they are no less true today than they were then.

In April 2014, we celebrated the 25th anniversary of the passage of the Inspector General Act Amendments of 1988, which established a Presidentially-appointed, Senate-confirmed Inspector General for OPM (as well as in several other agencies and Cabinet-level departments). The world has changed dramatically since that time, and our office has grown and adapted in order to meet the ever-changing needs of OPM and to combat new forms of fraud, waste, and abuse of taxpayer dollars.

When we first opened our doors, we had fewer than 50 staff members, dedicated almost exclusively to conducting audits. By the end of 1991, we had a fully operational Office of Investigations with 15 full-time staff members. Today, we have an office-wide staff of 143. Until 2000, all OIG employees were located at OPM's headquarters in Washington, D.C. It was in that year that we reassigned our first criminal investigator to a domicile outside of Washington, D.C. Today, we have 20 criminal investigators domiciled in 17 states throughout the country. In 2004, we established our first audit field office located in Cranberry, Pennsylvania, and today we have another in Jacksonville, Florida. In 2005, we established a field office for OIG criminal investigators in Laguna Niguel, California.

Since 1989, this office has issued 1,842 audit reports recommending the recovery of approximately \$1.9 billion and our investigations have led to 715 convictions and the recovery of \$951 million to the OPM Trust Funds. The OIG has also debarred 39,400 health care providers from participating in the Federal Employees Health Benefits Program.

Transparency is the vehicle by which accountability is achieved. Our work helps the American people better understand OPM's operations and how their tax dollars are being spent. Dramatic changes in information technology (IT) have allowed us to expand our presence far beyond our physical resources. With the passage of the Inspector General Reform Act of 2008, we began posting reports on our website so that the public may easily access this information. To further increase public awareness of our work, we established an email listserv that notifies subscribers when these reports are posted. As an additional step, we are now digitalizing all archived Semiannual Reports, dating back to the first one issued in September 1989, and will soon also be posting them on our website.



MESSAGE FROM THE INSPECTOR GENERAL

OCTOBER 1, 2013 – MARCH 31, 2014

In addition to better utilizing ever-evolving IT capabilities, we have also focused upon working more closely with Congress, not only as another means of keeping the public informed, but also to assist them in carrying out their own oversight responsibilities.

I have had the privilege of being the first, and thus far only, Presidentially-appointed OPM Inspector General. As I look back over my time here, I am amazed at the scope and magnitude of our accomplishments to date. I am also sincerely humbled by the unwavering dedication to the goal of efficient, effective, and honest government that I have witnessed *all* OIG employees demonstrate throughout the years. I am deeply honored to work with people who possess such a strong dedication to fulfilling our office's mission of combatting fraud, waste, and abuse within OPM. I particularly want to mention Director Katherine Archuleta's ongoing strong support of our independence and of our programs.

I see nothing but a bright future for our office and I look forward to continuing to serve the American people and fulfilling the responsibilities with which I have been entrusted.

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 Office of the Inspector General will:

- Combat fraud, waste and abuse in programs administered by OPM.
- Ensure that OPM is following best business practices by operating in an effective and efficient manner.
- Determine whether OPM complies with applicable Federal regulations, policies, and laws.
- Ensure that insurance carriers and other service providers for OPM program areas are compliant with contracts, laws, and regulations.
- Aggressively pursue the prosecution of illegal violations affecting OPM programs.
- Identify, through proactive initiatives, areas of concern that could strengthen the operations and programs administered by OPM.



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FIELD OFFICES





AUDIT ACTIVITIES

HEALTH INSURANCE CARRIER AUDITS

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

The Office of the Inspector General's (OIG) insurance audit universe contains approximately 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 \$45 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 20 final audit reports on organizations participating in the FEHBP, of which 10 contain recommendations for monetary adjustments in the amount of \$39.6 million due the OPM administered trust funds.

COMMUNITY-RATED PLANS

The community-rated HMO audit universe covers approximately 136 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 employer 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 SSSGs. 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 11 final audit reports on community-rated plans and recommended over \$4.9 million in premium recoveries to the FEHBP. A report summary is provided below to highlight notable audit findings.

Lovelace Health Plan

ALBUQUERQUE, NEW MEXICO

Report No. 1C-Q1-00-13-011

OCTOBER 10, 2013

Lovelace Health Plan (Plan) provides comprehensive medical services to its FEHBP members in the state of New Mexico. This audit covered contract years 2010 through 2012. During this period, the FEHBP paid the Plan approximately \$270 million in premiums.

In 2010 and 2012, we identified inappropriate health benefit charges to the FEHBP totaling

\$4,944,103. In addition, we determined the FEHBP is due \$111,985 for lost investment income as a result of the overcharges.

***Lost investment income (LII)** 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 overstated its step-up factor using incorrect enrollment in the 2010 FEHBP rate development. A *step-up factor* is developed using actual enrollment statistics and is used to convert the per-member-per-month premium requirement to the self and family premium rates. In addition, the Plan did not apply the largest SSSG discount to the FEHBP rates in contract year 2012.

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 eight experience-rated final audit reports. In these reports, our auditors recommended that the plans return \$32.3 million in inappropriate charges and lost investment income to the FEHBP.

BLUECROSS BLUESHIELD SERVICE BENEFIT PLAN

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.

INAPPROPRIATE CHARGES
AMOUNT TO OVER
\$4.9 MILLION



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 63 percent of all FEHBP subscribers are enrolled in BCBS plans.

We issued seven 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 \$32.1 million in questionable costs charged to the FEHBP contract. BCBS agreed with \$22.2 million of the identified overcharges. Summaries of five final reports are provided below to highlight our notable audit findings.

Global Audit of Claims Where Amounts Paid Exceeded Covered Charges for BlueCross and BlueShield Plans

WASHINGTON, D.C.

Report No. 1A-99-00-13-003

NOVEMBER 22, 2013

We performed a limited scope performance audit to determine whether the BCBS plans complied with contract provisions relative to claims where the amounts paid exceeded covered charges.

Our auditors performed a computer search on the BCBS claims database, using our SAS data warehouse function, to identify inpatient and outpatient facility claims that were paid from February 2010 through July 2012, where the amounts paid exceeded covered charges. For this period, we identified 150,221 facility claims where the amounts paid exceeded covered charges by a total of \$221,799,437. Of these, we reviewed all inpatient facility claims where the amounts paid exceeded covered charges by \$10,000 or more, and determined whether the BCBS plans paid these claims correctly. Additionally, we reviewed all outpatient facility claims where the amounts paid exceeded covered charges by \$4,000 or more. In total, our sample selections included 5,341 facility claims; of which 3,542 were inpatient facility claims and 1,799 were outpatient facility claims.

**FEHBP OVERCHARGED
\$4.1 MILLION FOR FACILITY
CLAIM PAYMENTS**

Based on our testing, we determined that 217 of the claims in our sample were paid incorrectly, resulting in net overcharges of \$4,077,968 to the FEHBP. Specifically, the BCBS plans overpaid 195 claims by \$4,422,397 and underpaid 22 claims by \$344,429.

The Association and BCBS plans agreed with \$2,090,681 and disagreed with \$1,987,287 of the questioned net overcharges.

Global Audit of Coordination of Benefits for BlueCross and BlueShield Plans

WASHINGTON, D.C.

Report No. 1A-99-00-13-032

NOVEMBER 22, 2013

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

Coordination of benefits occurs when a patient has coverage under more than one health insurance plan or program. In such a case, one insurer normally pays its benefits as the primary payer and the other insurer pays



a reduced benefit as the secondary payer. Medicare is usually the primary payer when the insured is also covered under an FEHBP plan.

Using our SAS data warehouse function, we performed a computer search on the BCBS claims database to identify payments that were incurred on or after March 15, 2012, paid from April 2012 through January 2013, and potentially not coordinated with Medicare. We determined that 60 of the 64 BCBS plans did not properly coordinate claim charges with Medicare and; as a result, the FEHBP incorrectly paid 16,406 claim lines when Medicare was the primary insurer.

Our audit disclosed the following COB errors:

- Due to retroactive adjustments, the BCBS plans incorrectly paid 64 percent of the claim lines questioned. Specifically, no information existed in the FEP Direct Claims System to identify Medicare as the primary payer when the claims were paid. Additionally, even after the Medicare information was added to the claims system, the BCBS plans did not adjust the patients' prior claims retroactively to the Medicare effective dates. Consequently, these costs continued to be charged entirely to the FEHBP as a result of these mistakes;
- The BCBS plans incorrectly paid these claims due to manual or systematic processing errors for 29 percent of the claim lines questioned; and,
- For the remaining 7 percent of the claim lines questioned, the BCBS plans incorrectly paid these claims due to provider billing errors.

We determined that the FEHBP was overcharged \$7,717,615 for these COB errors. In addition to COB errors we reported, we also identified 260 claim line payments that contained other types of claim payment errors, resulting in overcharges of

\$80,026 to the FEHBP. In total, we determined that the BCBS plans incorrectly paid 16,666 claim lines, resulting in overcharges of \$7,797,641 to the FEHBP.

The Association and/or BCBS plans agreed with \$3,057,218 and disagreed with \$4,740,423 of our questioned claim overcharges. Regarding the

contested charges, even though the Association and/or BCBS plans disagree with our questioning of these charges in the final report, they agree that the charges were not properly coordinated with Medicare, resulting in overcharges to the FEHBP. The majority of the contested amounts represent COB errors where the BCBS plans initiated recovery efforts on or after receiving our notice of audit and; for these COB errors the plans identified, they contested our inclusion of the COB findings. However, since the BCBS plans initiated recoveries for these COB errors on or after our audit notification date, we continue to question these overpayments in our final report.

BlueCross BlueShield of Arizona

PHOENIX, ARIZONA

Report No. 1A-10-56-13-047

FEBRUARY 25, 2014

Our audit of the FEHBP operations at BCBS of Arizona (Plan) covered miscellaneous health benefit payments and credits, cash management activities, and administrative expenses from 2008 through 2012. In addition, we reviewed the Plan's Fraud and Abuse Program for the period 2008 through May 2013. For contract years 2008 through 2012, the Plan processed approximately \$1.4 billion in FEHBP health benefit payments and charged the FEHBP \$113 million in administrative expenses.

Our auditors questioned \$1,901,078 in net administrative expense overcharges and identified a procedural finding regarding the Plan's Fraud and Abuse Program. The monetary findings included the following:

- \$1,107,107 for administrative expense charges that were unreasonable and/or did not benefit the FEHBP;
- \$802,171 for the Plan's employee post-retirement benefit cost overcharges; and,
- \$8,200 for the Plan's employee pension-cost undercharges.

Regarding the procedural finding, we determined that the Plan is not in compliance with the communication and reporting requirements for fraud and abuse cases contained in the FEHBP contract and the applicable

**FEHBP OVERCHARGED
\$7.8 MILLION FOR CLAIM
PAYMENT ERRORS**



FEHBP Carrier Letters. Specifically, the Plan did not report, or report judiciously, all fraud and abuse cases to OPM's OIG. The Plan's non-compliance may be due in part to:

- Incomplete or untimely reporting of fraud and abuse cases to the FEP Director's Office, and,
- Inadequate controls at the FEP Director's Office to monitor and communicate the Plan's cases to OPM's OIG.

Without notification of the Plan's probable fraud and abuse issues, we cannot investigate the broader impact of these potential issues on the FEHBP.

The Plan agreed with the questioned administrative expense charges and generally agreed with

the procedural finding regarding the Fraud and Abuse Program.

AUDITORS QUESTION
OVER \$1.9 MILLION
IN ADMINISTRATIVE
EXPENSE OVERCHARGES

Supplemental Audit of CareFirst BlueCross BlueShield

OWINGS MILLS, MARYLAND

Report No. 1A-10-85-14-011

MARCH 14, 2014

During our recent global audit of facility claims where the amounts paid exceeded covered charges (Report No. 1A-99-00-13-003), we determined that CareFirst BlueCross BlueShield (CareFirst) did not identify, review and/or adjust claims that were potentially affected by three system processing errors nor initiate recoveries for the applicable overpayments. Due to the potentially significant financial impact of these system processing errors, we requested CareFirst to identify and review all FEP claims that were potentially paid incorrectly as a result of these system errors.

As a result of our supplemental audit, our auditors questioned \$1,865,071 in claim overcharges from June 2010 through February 2013 due to system processing errors.

Bundle Pricing Error

We identified \$1,652,087 in claim overcharges to the FEHBP due to a system processing error resulting in the incorrect bundling and pricing of outpatient facility claims. Corrective actions were implemented by CareFirst in September 2012 to fix this system error.

Non-Covered Services

We identified \$212,984 in claim overcharges as a result of two system processing errors that allowed payments for non-covered services. CareFirst implemented corrective actions in February 2013 to fix the system errors.

CareFirst agreed with \$1,402,741 of the questioned overcharges.

AUDITORS QUESTION
OVER \$1.8 MILLION IN
CLAIM OVERCHARGES

Health Care Service Corporation

CHICAGO, ILLINOIS

Report No. 1A-10-17-13-019

MARCH 28, 2014

Health Care Service Corporation (HCSC) includes the BCBS plans of Illinois, New Mexico, Oklahoma, and Texas. For contract years 2009 through 2012, HCSC processed approximately \$10.3 billion in FEHBP health benefit payments and charged the FEHBP \$536 million in administrative expenses for these four BCBS plans.

Our audit of the FEHBP operations at HCSC covered administrative expenses from 2009 through 2011 for the Illinois, New Mexico, Oklahoma, and Texas BCBS plans; as well as miscellaneous health benefit payments and credits from 2009 through September 2012. We also reviewed HCSC's cash management activities and practices related to FEHBP funds from 2009 through September 2012, and HCSC's Fraud and Abuse Program from January through June 2013. Due to a significant error identified in HCSC's letter of credit account (LOCA) drawdown adjustment process, we expanded the audit scope for this specific LOCA drawdown error to cover the period April 2002 through June 2013.



We questioned \$14,413,248 in health benefit charges, cash management activities, and LII, and our auditors identified a procedural finding regarding HCSC's Fraud and Abuse Program. The monetary findings included the following:

- \$12,236,424 for LOCA overdraws (representing overcharges to the FEHBP) from April 2002 through June 2013 and \$2,080,627 for LII on these overdraws;
- \$75,472 for unreturned refunds and \$6,083 for LII on these refunds; and,
- \$14,642 for LII on medical drug rebates that were not returned to the FEHBP in a timely manner.

For the procedural finding, we determined that HCSC is not in compliance with the communication and reporting requirements for fraud and abuse cases contained in the FEHBP contract and the applicable FEHBP Carrier Letters. Specifically, HCSC did not report, or report appropriately, all fraud and abuse cases to our office. HCSC's non-compliance may be due in part to:

- Incomplete or untimely reporting of fraud and abuse cases to the FEP Director's Office, and,
- Inadequate controls at the FEP Director's Office to monitor and communicate HCSC's cases to OPM's OIG.

Without awareness of these existing potential fraud and abuse issues, OPM's OIG cannot investigate the broader impact of these potential issues on the FEHBP.

HCSC agreed with \$12,776,725 of the questioned amounts and partially agreed with the procedural finding regarding the Fraud and Abuse Program.

HCSC AGREES WITH \$12.8 MILLION OF THE \$14.4 MILLION QUESTIONED AMOUNTS

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 issued one employee organization plan audit report during this reporting period for the National Association of Letter Carriers Health Benefit Plan.

National Association of Letter Carriers Health Benefit Plan

ASHBURN, VIRGINIA

Report No. 1B-32-00-13-017

DECEMBER 23, 2013

The National Association of Letter Carriers Health Benefit Plan (Plan) is an experience-rated employee organization plan. Specifically, this Plan is a fee-for-service plan with a preferred provider organization (PPO). Enrollment is open to all Federal government, postal employees, and annuitants who are eligible to enroll in the FEHBP and who are, or become, members of the National Association of Letter Carriers (NALC). NALC is the sponsor and administrator of the Plan. Members may choose to enroll in a High Option, a Consumer Driven Health Plan, or a Value Option plan.



The audit of the Plan's FEHBP operations covered miscellaneous health benefit payments and credits, such as refunds, fraud recoveries and pharmacy drug rebates, from 2007 through September 2012, as well as administrative expenses from 2007 through 2011. In addition, we reviewed the Plan's cash management activities and practices related to FEHBP funds and the Plan's Fraud and Abuse Program from 2007 through September 2012.

For contract years 2007 through 2011, the Plan processed approximately \$4.9 billion in FEHBP

health benefit payments and charged the FEHBP \$311 million in administrative expenses.

Our auditors questioned \$204,222 in administrative expense charges and LII; and identified procedural

findings for the Plan's travel expenses and the Plan's Fraud and Abuse Program.

We determined that the Plan does not have the basic processes and procedures to detect, prevent, investigate, and report all potential fraud and abuse cases to OPM, to our office, and/or other law enforcement entities, as required by the FEHBP contract and applicable FEHBP Carrier Letters. Additionally, we concluded that the effectiveness of the Plan's Fraud and Abuse Program could not be accurately measured and, therefore, we could not determine the benefits of this program to the FEHBP.

However, we strongly believe that this finding allows the Plan to have a high probability of permitting undetected and unreported fraud and abuse within the FEHBP, further diminishing the overall effectiveness of the Plan's Fraud and Abuse Program.

The Plan agreed with the questioned administrative expense charges and LII. The Plan also agreed with the procedural finding for travel expenses, but disagreed with the procedural finding for the Fraud and Abuse Program.

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.

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

We did not issue any audit reports on experience-rated comprehensive medical plans during this reporting period.

NALC HEALTH BENEFIT PLAN
AGREES WITH \$204,222
FOR QUESTIONED
CHARGES AND LII



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 as well as provide Government-wide recruiting tools for Federal agencies and individuals seeking Federal jobs. 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. During this reporting period we issued two final audit reports. Summaries of these audits are provided below.

Information System General and Application Controls at Health Care Service Corporation

CHICAGO, ILLINOIS

Report No. 1A-10-17-13-026

JANUARY 28, 2014

Our audit focused on the claims processing applications used to adjudicate FEHBP claims for Health Care Service Corporation (HCSC), as well as the various processes and IT systems used to support these applications. We documented controls in place and opportunities for improvement in each of the areas below.

Security Management

HCSC has established a series of IT policies and procedures to create an awareness of IT security. Nothing came to our attention to indicate that HCSC does not have an adequate security management program.

Access Controls

HCSC has implemented numerous controls to grant and remove physical access to its data center, as well as logical controls to protect sensitive information. Several minor weaknesses identified during the audit were immediately remediated.



Network Security

HCSC has implemented a thorough incident response and network security program. However, we noted several opportunities for improvement related to HCSC's network security controls. Several specific servers containing Federal data are not subject to routine vulnerability scanning. The results of the vulnerability scans also indicated that these servers contained outdated system patches and software. Additionally, HCSC has not implemented a process to monitor and audit

the activity of privileged users on their information systems.

Configuration Management

HCSC has developed formal policies and procedures that provide guidance to ensure that system software is appropriately configured and updated, as well as for controlling system software configuration changes. However, HCSC has not documented a formal baseline configuration outlining the approved settings for its mainframe installation and therefore cannot effectively audit its mainframe security settings. HCSC has also not developed a process to audit its server configuration settings to ensure compliance with the approved standard images.

Contingency Planning

We reviewed HCSC's business continuity and disaster recovery plans and concluded that they contained the key elements suggested by relevant guidance and publications. We also determined that these documents are reviewed, updated, and tested on a periodic basis.

Claims Adjudication

HCSC has implemented many controls in its claims adjudication process to ensure that FEHBP claims are processed accurately. However, we noted several weaknesses in HCSC's claims application controls.

Health Insurance Portability and Accountability Act (HIPAA)

Nothing came to our attention that caused us to believe that HCSC is not in compliance with the HIPAA security, privacy, and national provider identifier regulations.

Common Security Controls Collection

WASHINGTON, D.C.

Report No. 4A-IS-00-13-036

OCTOBER 10, 2013

The Office of Personnel Management (OPM) operates approximately 50 major applications that support the agency's mission. This includes three general support systems (GSS) that host several smaller systems that leverage the centralized hardware, software, and personnel resources offered by the GSS. The GSSs are owned and operated by the Office of the Chief Information Officer (OCIO).

FISMA requires that all major applications be subject to routine security control testing. However, when a security control is provided by a GSS to all of the applications that it hosts (referred to as a "common" control), the individual application owners are not required to independently test this control, as that would be a redundancy of the OCIO's testing efforts.

In an effort to streamline the management of common controls, the OCIO created the Common Security Controls Collection (CSCC). The CSCC is intended to be a shared resource for all OPM security professionals and management, designed to reduce duplicative efforts in the information system security control testing process. In addition to the common controls provided by the GSSs, the CSCC identifies the security controls that are addressed by agency-wide policies and procedures and by facilities management, and various OPM buildings.

Our assessment of the quality of the CSCC and the effectiveness of its use by information systems owners and application is documented below.

OPPORTUNITIES FOR
IMPROVEMENTS EXIST
IN NETWORK SECURITY,
CONFIGURATION
MANAGEMENT, AND
CLAIMS ADJUDICATION



CSCC Policies and Procedures

We believe that OPM's CSCC offers a conceptually comprehensive approach to effectively utilizing and testing a set of common information security controls.

CSCC Implementation

The CSCC adequately reflects the common controls that are provided by agency-wide policies and by physical facilities management. However, we do not believe that the CSCC accurately reflects the common controls provided by the agency's general support systems.

Use of the CSCC

The owners of OPM's major applications that reside on the GSSs labeled at least several security controls as common that were not identified as common on the CSCC. As a result, these controls were inappropriately omitted from testing by the application owners.

Federal Information Security Management Act FY 2013

WASHINGTON, D.C.

Report No. 4A-CI-00-13-021

NOVEMBER 21, 2013

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

Consequently, we audited OPM's compliance with FISMA requirements defined in the Office

of Management and Budget's Fiscal Year (FY) 2013 Reporting Instructions for the Federal Information Security Management Act and Agency Privacy Management. Over the past several years, the OCIO made noteworthy improvements to OPM's IT security program. However, we are concerned that these efforts have recently stalled due to resource limitations.

In the FY 2007 FISMA report, we noted a material weakness related to the lack of IT security policies and procedures. In FY 2009, we expanded the material weakness to include the lack of a centralized security management structure necessary to implement and enforce IT security policies.

Little progress was made in the subsequent years to address these issues. However, in FY 2012, the OPM Director issued a memorandum mandating the centralization of IT security duties to a team of Information System Security Officers (ISSO) that report to the OCIO. This change was a major milestone in addressing the material weakness.

However, as of the end of FY 2013, the centralized ISSO structure has only been partially implemented. The OCIO had filled three ISSO positions and assigned security responsibility for approximately one third of OPM's information systems to these individuals. The OCIO plans to hire enough ISSOs to manage the security of all agency systems, but this plan continues to be hindered by budget restrictions.

We acknowledge that the existing ISSOs are effectively performing security work for the limited number of systems they manage, but there are still many OPM systems that remain unassigned.

The findings in this audit report highlight the fact that OPM's decentralized governance structure continues to result in many instances of non-compliance with FISMA requirements. Therefore, we again report this issue as a material weakness for FY 2013.



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.

During this reporting period we issued two final internal audit reports, which are summarized below.

OPM's FY 2013 Consolidated Financial Statements

WASHINGTON, D.C.

The CFO Act requires that audits of OPM's financial statements be conducted in accordance with Government Auditing Standards (GAS) issued by the Comptroller General of the United States. OPM contracted with the independent certified public accounting firm KPMG LLP (KPMG) to audit the consolidated financial statements as of September 30, 2013 and for the FY then ended. The contract requires that the audit be performed in accordance with generally accepted government auditing standards (GAGAS) and the Office of Management and Budget (OMB) Bulletin No. 14-02, *Audit Requirements for Federal Financial Statements*, as amended.

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

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

- Opinions on the consolidated financial statements and the individual statements for the three benefit programs;
- An internal controls report; and,
- A compliance report highlighting certain laws and regulations.

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

Specifically, we were involved in the planning, performance, and reporting phases of the audit; participating in key meetings; reviewing KPMG's work papers; and coordinating the issuance of audit reports. Our review disclosed no instances where KPMG did not comply, in all material respects, with GAGAS, the contract, and all other authoritative references.

In addition to the consolidated financial statements, KPMG performed the audit of the closing package financial statements as of September 30, 2013 and 2012. The contract requires that the audit be performed in accordance with GAGAS and the OMB Bulletin No. 14-02, *Audit Requirements for Federal Financial Statements*, as amended. The U.S. Department of the Treasury and the Government Accountability Office review the closing package in preparing and auditing the *Financial Report of the United States Government*.



OPM's FY 2013 Consolidated Financial Statements

WASHINGTON, D.C.

Report No. 4A-CF-00-13-034

DECEMBER 11, 2013

KPMG audited OPM's balance sheets as of September 30, 2013 and 2012 and the related consolidated financial statements. KPMG also audited the individual balance sheets of the Retirement, Health Benefits and Life Insurance programs (Programs), as of September 30, 2013 and 2012 and the Programs' related individual financial statements. The Programs, which are essential to the payment of benefits to Federal civilian employees, annuitants, and their respective dependents, operate under the following names:

- Civil Service Retirement System (CSRS)
- Federal Employees Retirement System (FERS)
- Federal Employees Health Benefits Program (FEHBP)
- Federal Employees' Life Insurance Program (LP)

KPMG reported that OPM's consolidated financial statements and the Programs' individual financial statements, as of and for the years ended September 30, 2013 and 2012, were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. KPMG's audits generally include identifying internal control deficiencies, significant deficiencies, and material weaknesses.

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

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

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

KPMG's report identified no material weaknesses in the internal controls. However, KPMG identified one significant deficiency that remains unresolved from prior years. The area identified by KPMG is:

Information Systems Control Environment

In FY 2012, a significant deficiency was reported related to OPM's internal control environment due to persistent deficiencies in OPM's information system security program. These deficiencies included incomplete security authorization packages, weaknesses in testing of information security controls, and inaccurate Plans of Action and Milestones (POA&Ms). During FY 2013, OPM's management demonstrated progress in addressing some long-standing issues by reviewing and updating the security authorization package for one of its larger and most complex systems and continuing to improve the administration of its information security program. Nevertheless, KPMG identified that the weaknesses persist in OPM's processes for identifying, documenting, and monitoring information system security controls.

OPM agreed with the findings and recommendations reported by KPMG.

NO MATERIAL WEAKNESSES REPORTED IN FY 2013



KPMG's report on compliance with certain provisions of laws, regulations, and contracts disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget Bulletin No. 14-02, *Audit Requirements for Federal Financial Statements*, as amended.

- The Additional Note No. 31 (discloses other data necessary to make the Closing Package Financial Statements more informative); and
- The Trading Partner balance sheets, the statements of net cost, and the statements of changes in net position (showing the funds due between OPM and other agencies) as of September 30, 2013.

OPM's FY 2013 Closing Package Financial Statements

WASHINGTON, D.C.

Report No. 4A-CF-00-13-035

DECEMBER 16, 2013

The closing package financial statements are required to be audited in accordance with GAGAS and the provisions of OMB's Bulletin No. 14-02. OPM's Closing Package Financial Statements include:

- The reclassified balance sheets, the statements of net cost, the statements of changes in net position, and the accompanying financial report notes report as of September 30, 2013 and 2012;

KPMG reported that OPM's closing package financial statements are presented fairly, in all material respects.

KPMG noted no matters involving the internal control over the financial process for the closing package financial statements that are considered a material weakness or significant deficiency. In addition, KPMG disclosed no instances of noncompliance or other matters that are required to be reported. The objectives of KPMG's audits of the closing package financial statements did not include expressing an opinion on internal controls or compliance with laws and regulations, and KPMG, accordingly, did not express such opinions.

FY 2013 CLOSING PACKAGE
STATEMENTS RECEIVE
ANOTHER CLEAN OPINION



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, the Federal Employees Dental and Vision Insurance Program (FEDVIP). Our office also conducts audits of Pharmacy Benefit Managers (PBMs) that coordinate pharmacy benefits for the FEHBP carriers. The objective of these audits is to ensure that costs charged and services provided to Federal subscribers comply with established 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, and audits of Tribal enrollments into the FEHBP.

During this reporting period we issued one final audit report, which is summarized below.

BlueCross and BlueShield's Retail Pharmacy Member Eligibility in 2006, 2007, and 2011

WASHINGTON, D.C.

Report No. 1H-01-00-12-072

NOVEMBER 8, 2013

We conducted a member-eligibility audit of the BCBS Association's (Association) retail pharmacy claims for contract years 2006, 2007, and 2011. The audit's primary objective was to determine whether BCBS complied with its contractual requirements contained within its contract with OPM and CVS Caremark, BCBS's Pharmacy Benefit Manager (PBM). In addition to member eligibility, the audit also covered compliance with the Health Insurance Portability and Accountability Act and the Fraud and Abuse Program requirements for contract year 2011.

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.

Although the Association's pharmacy operations and responsibilities are carried out by CVS Caremark, the responsibilities related to maintaining and updating member eligibility are the responsibility of the Association. The Association provides CVS Caremark with the membership eligibility data and updates when changes occur. The Association must also provide CVS Caremark notice of the claims affected by the changes before a refund request is initiated. If claims have been paid in error, then CVS Caremark is responsible for initiating recovery efforts.

We used statistical sampling software to select a sample for each year audited. A statistical sample is randomly selected from a universe of claims using random numbers, in which each claim has an equal chance of being selected for review. The use of statistical sampling also allows us to project the error rates identified in our samples to the universe of claims. Using this tool, we projected the results of our 2011 claims review to the entire 2011 universe of potential errors.



Our audit identified improper claim payments for member eligibility claims totaling \$2,305,973, including \$6,465 for lost investment income. Specifically, we identified the following improper claim payments:

- A total of 1,617 claims for contract years 2006, 2007, and 2011, totaling \$680,093, that were paid by the Association for members that were ineligible due to retroactive member eligibility changes received by the Association after the date of the claim (making them ineligible for coverage after the claim was originally processed). After projecting the 2011 results to the 2011 universe, we are also questioning an additional \$681,496 in claim payments.
- A sum of 912 claims, totaling \$386,497, for contract years 2006, 2007, and 2011 where the Association's claims system indicated that recovery had not been initiated. The 2011 results were projected to the 2011 universe, resulting in additional questioned costs of \$478,133.
- A total of 142 claims, totaling \$49,089, for contract years 2006, 2007, and 2011 that were improperly paid because the Association's claims system indicated that these members were ineligible for coverage at the date of service. Again, we projected the 2011 results to the 2011 claims universe, revealing additional questioned costs of \$24,200.
- Finally, the FEHBP is due \$6,465 for lost investment income related to claims paid for members who were ineligible at the time of service. The lost investment income was calculated through August 31, 2013. Additionally, the contracting officer should recover lost investment income on amounts due for the period beginning September 1, 2013, 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. However, the results of this audit raise three specific concerns which we list below:

- The results of our very thorough claims review were provided to the Association and we requested that it provide a detailed response on a claim-by-claim basis. While we allowed them numerous extensions to respond, the responses the Association provided were very generic and did little to help us determine the cause of the errors identified;
- Documentation provided by the Association to support its recovery efforts did not demonstrate due diligence to comply with its contractual requirements. Additional requests for explanation of its recovery efforts yielded no response from the Association. As a result of not replying to our request, \$1,361,589 remained questioned in our final report (this amount represents over 50 percent of the costs questioned in the final report).
- The Contract between OPM and the Association requires that an internal controls system be maintained. However, as a result of this audit we became aware of a systemic error in the Association's claims system that allowed many of the questioned claims to be paid for individuals who were no longer covered. This is of great concern because the error would not only be limited to pharmacy claims, but would extend to all claims processed by the Association. This error has been in existence at least as far back as 2006, as it was identified in all years covered in the scope of this audit (2006, 2007, and 2011). The Association has informed us that the error has not been corrected and that the claims affected must be manually identified and adjusted.

**\$2.3 MILLION IN IMPROPER
CLAIM PAYMENTS RELATED
TO MEMBER ELIGIBILITY
CHARGED TO THE FEHBP**



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 charity lists, 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.

During this reporting period, we issued three audit reports of local CFCs.

- Due to the numerous audit findings and the nature of the identified issues in one of the three audits, we recommended that the Central Pennsylvania CFC be merged with another geographically adjacent campaign, administered and conducted by a new PCFO and LFCC that were more equipped to handle the responsibilities of the CFC.

Of continued concern to the OIG is the consistent identification of similar issues from audit to audit. The causes for these issues are, more often than not, attributed to one of the following program concerns:

- The PCFO was either not aware of, did not understand its responsibilities as defined in the regulations and CFC memoranda, or simply did not follow said regulations and memoranda;

- The LFCC was either not aware of or did not understand its responsibilities as defined in the regulations;
- The LFCC is inactive and does not perform the needed oversight of the PCFO; or
- The IPAs hired to perform the agreed-upon procedures audit, which is paid for out of campaign funds, do not understand the requirements of the audit, which results in findings not being identified and communicated to the PCFOs and LFCCs.

It is for these reasons that the OIG supports the changes to the CFC that OPM identified in the final regulations published in April of 2014. We believe the changes will help eliminate many of the recurring findings we identify and will help ensure that a larger percentage of the Federal employees' donations go towards their intended purposes.

We provided our audit findings and recommendations for corrective action to OPM for each of the three audits. OPM notified the audited PCFOs of our recommendations and are monitoring corrective actions. If the audited PCFOs do not comply with the recommendations, the Director of OPM can deny the organizations' future participation in the CFC.

**RECOMMEND MERGER OF
CAMPAIGN DUE TO SIGNIFICANT
NON-COMPLIANCE WITH
PROGRAM REGULATIONS**



ENFORCEMENT ACTIVITIES

INVESTIGATIVE CASES

The Office of Personnel Management administers benefits from its trust funds, with approximately \$955 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 nine million current and retired Federal civilian employees, including eligible family members, and disburse over \$124 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 and contractor misconduct and other wrongdoing, such as fraud within the personnel security and suitability program administered by OPM.

During the reporting period, our office opened 38 criminal investigations and closed 36, with 98 still in progress. Our criminal investigations led to 8 arrests, 29 indictments and informations, 18 convictions and \$46,341,768 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 \$420,807,000 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 CASES

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 and civil 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 cases that involve harm to the patients, the growth of medical identity theft and organized crime in health care fraud, all of which have affected the FEHBP.

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

Drug Manufacturer Agrees to Pay More than \$2.2 Billion to Resolve False Claims Allegations

In November 2013, Janssen Pharmaceuticals (Janssen), a subsidiary of Johnson & Johnson (J&J), agreed to pay more than \$2.2 billion to resolve criminal and civil liability arising from allegations relating to the prescription drugs Risperdal, Invega and Natrecor. This multi-billion dollar payment includes Janssen Pharmaceuticals drug promotion for uses not approved as safe and effective by the Food and Drug Administration (FDA), along with payment of kickbacks to physicians and to one of the largest long-term care pharmacy providers. This global resolution represents one of the largest health care fraud settlements in U.S. history, including criminal fines and forfeitures totaling \$485 million; and civil settlements with the Federal Government and states totaling \$1.72 billion.

Janssen also admitted that it promoted Risperdal to health care providers for treatment of psychotic symptoms and associated behavioral disturbances exhibited by elderly, non-schizophrenic dementia patients. In addition to promoting Risperdal for elderly patients, from 1999 through 2005, Janssen allegedly promoted the antipsychotic drug for use in children and individuals with mental disabilities. Janssen instructed its sales representatives to call on child psychiatrists, as well as mental health facilities that primarily treated children, and to market Risperdal as safe and effective for symptoms of various childhood disorders, such as attention deficit hyperactivity disorder, oppositional defiant disorder, obsessive-compulsive disorder and autism. Until late 2006, Risperdal was not approved for use in children for any purpose, and the FDA repeatedly warned the company against this promotion.

In addition to allegations relating to Risperdal, the settlement also resolves allegations relating to Invega, a newer antipsychotic drug also sold by Janssen. Although Invega was approved only for the treatment of schizophrenia and schizoaffective disorder, from 2006 through 2009, J&J and Janssen marketed the drug for off-label indications and made false and misleading statements about its safety and efficacy.

The civil settlement also resolves allegations that J&J and another of its subsidiaries, Scios Inc., caused false and fraudulent claims to be submitted to Federal health care programs for the heart failure drug, Natrecor. In August 2001, the FDA approved Natrecor to treat patients with acutely decompensated congestive heart failure who have shortness of breath at rest or with minimal activity. This approval was based on a study involving hospitalized patients experiencing severe heart failure who received infusions of Natrecor over an average 36-hour period.

As a result of the settlement, the FEHBP will receive \$37,012,750 in restitution. This joint investigation was conducted by Defense Criminal Investigative Services (DCIS), the Federal Bureau of Investigations (FBI), the FDA, and the OIGs of the Department of Health and Human Services (HHS), the Department of Veterans Affairs (VA), the Department of Labor (DOL), United States Postal Service (USPS,) and our office.

Pharmaceuticals Manufacturers Agree to \$192.7 Million Settlement for Misbranded Drugs

In February 2014, pharmaceutical manufacturer, Endo Health Solutions Inc. and its subsidiary, Endo Pharmaceuticals Inc. (Endo), agreed to pay \$192.7 million to resolve criminal and civil liabilities arising from Endo's marketing of the prescription drug Lidoderm for uses not approved by the FDA. The resolution includes a deferred prosecution agreement, forfeiture totaling \$20.8 million, and civil false claims settlements with the Federal Government, states, and the District of Columbia totaling \$171.9 million.

Between 2002 and 2006, Endo Pharmaceuticals Inc. introduced the drug, Lidoderm, into interstate commerce. Lidoderm that was misbranded by Endo under the Federal Food, Drug, and Cosmetic Act (FDCA). The FDCA requires a company, to specify the intended uses of a product in its new drug application to the FDA. Once approved, the drug may not be introduced into interstate commerce for unapproved or "off-label" uses until the company receives FDA approval for the new intended use.

During the period of 2002 to 2006, Lidoderm was approved by the FDA only for the relief of pain associated with Post-Herpetic Neuralgia (PHN), a complication of shingles. During this period,



Lidoderm was distributed nationwide by Endo and misbranded because its label instructions provided directions for use in the treatment of non-PHN related pain, including low back pain, diabetic neuropathy and carpal tunnel syndrome. These uses were never approved by the FDA.

As a result of the settlement, the FEHBP will receive approximately \$6.4 million. This was a joint investigation performed by the FBI, FDA, DCIS, the HHS OIG and our office.

Chiropractor Pleads Guilty Convicted of Fraud

A chiropractor in Manassas, Virginia billed over \$896,943 to FEHBP carriers and numerous private health insurance carriers for services not rendered to include bills for therapeutic exercise, manual therapy, and chiropractic manipulation to extremities, whirlpool therapy, and mechanical traction. The chiropractor also engaged in upcoding, which is a fraudulent billing scheme in which providers bill insurance companies for more services or a longer duration of services than were actually provided.

This case was investigated jointly by the FBI and our office. Investigators substantiated the initial allegations after they reviewed insurance claims, conducted undercover and surveillance operations, and interviewed patients and confidential informants.

In October 2013, the chiropractor pled guilty to theft from a Health Care Benefit Program and was sentenced to 60 days of incarceration, ordered to pay a combined restitution payment totaling \$161,554, and fined \$5,000. The FEHBP's share of the combined restitution payment was \$7,261.

Pediatric Cardiology Group Agrees to Pay \$175,000 to Resolve False Claims Allegations

A pediatric cardiology practice with locations in Northern Virginia and Maryland agreed to pay \$175,000 to resolve Federal False Claims Act allegations of upcoding medical claims. The group billed for congenital echocardiograms while providing echocardiograms that are non-congenital in nature and billed for 24-hour monitoring recorders which were not monitored for the billed duration. In

addition, the group allegedly unbundled services by billing for office visits in addition to billing separately for stress tests when performed the same day, when an office visit is included in the charge for a stress test.

Unbundling is the use of more than one Current Procedural Terminology (CPT) codes for a service when one inclusive code is available.

In March 2014, the group entered into a settlement agreement with the United States Government pursuant to a *qui tam*. The FEHBP recovered \$66,627 as part the settlement.

This case was investigated by the FBI, DCIS, HHS OIG and our investigators.

Former Congressional Staffer Convicted of Felony Prescription Fraud

A former Congressional staff member was sentenced for knowingly and intentionally engaging in a scheme to fill fraudulent controlled substance prescriptions.

Our investigation revealed that the former employee submitted prescriptions to local pharmacies for controlled substances by forging his doctor's signature. He obtained these prescriptions in his and his wife's name in order to satisfy his addiction.

The staff member was sentenced in November 2013, and was separated from the Federal Government. He was sentenced to two years of probation for knowingly and intentionally engaging in a scheme to fill fraudulent controlled substance prescriptions.

The FEHBP's pharmaceutical claims loss of \$260 remains unrecovered. This case was investigated by the FBI and our office.

Orthopedic Group Settles with Government for Use of Non-FDA Approved Drugs

An orthopedic group entered into a settlement agreement with the Government to resolve allegations that they knowingly utilized drugs from Canada, including Hyalgan and Synvisc, to treat patients with non-U.S. Food and Drug Administration (FDA) approved medications.



The investigation revealed that the group sought discounted versions of Hyalgan from a distributor outside the United States and made as many as 27 separate purchases from an overseas vendor. The physicians at the group spent a combined amount of approximately \$195,445 on the purchase of Hyalgan and at least 1,850 Hyalgan syringes from Canada.

Further investigation also revealed that between November 1, 2005 and April 18, 2012, the group purchased discounted versions of the drug Synvisc from a distributor located outside of the United States. In October 2013, the group entered into a settlement agreement with the Government to pay a total of \$1,126,218 million to resolve allegations that they knowingly utilized drugs from Canada.

As a result of this settlement, the FEHBP recovered \$298,651. This was a joint investigation with the FDA's Office of Criminal Investigations, the FBI, the DCIS, HHS OIG, and our office.

Health Care Clinic Owners Guilty of False Claims Allegations Fined \$190,306

We initiated this investigation after receiving allegations of health care fraud from a FEHBP carrier and found that from April 2010 through July 2011, a Miami, Florida health care clinic submitted over \$5 million in false claims for services that were not provided.

The health care clinic opened under the guise of providing physical therapy services when in actuality they were billing for vitamin injections to alleviate pain. Through our investigation, it was discovered that not only were the vitamin injections not being administered to the patients, but also that the clinic never ordered the amount of vitamin injections supplies for which they submitted claims.

In April 2013, the clinic's two owners were indicted in the Southern District of Florida on ten counts of Health Care Fraud. In October 2013, one owner was sentenced to 30 months imprisonment to be followed by three years of supervised release after pleading guilty to health care fraud. In August 2013, the other owner went to trial and was subsequently found guilty and sentenced to serve 41 months imprisonment followed by three years of supervised release.

The FEHBP will receive \$190,306 in restitution. This was a joint investigation conducted by the FBI and our office.

Doctor Pleads Guilty to Health Care Fraud Scheme

In 2011, a physician and two former postal workers were indicted for their involvement in a health care fraud scheme. In February 2014, the physician was sentenced for overcharging workers compensation patients. In an agreement with prosecutors, the doctor pled guilty to one count of fraud and six other counts were dismissed. He was sentenced to five years' probation with the first 12 months on home confinement and electronic monitoring. Additionally, he must pay restitution of \$172,754.

The former postal employees reached plea agreements and were sentenced in August 2013 and September 2013, respectively. They were sentenced to probation and restitution and also charged with filing false statements to obtain Federal employee compensation from the U.S. Postal Service for medical claims.

The physician said during his sentencing hearing that he was grateful that Federal agents caught him. The 72-year-old physician told the judge he overbilled patients whose costs were covered by the Government so he could treat those who could not pay.

As a result of the settlement, the FEHBP will receive approximately \$172,754. This was a joint investigation conducted by the Offices of Inspector General of the United States Postal Service (USPS) and OPM.

Advanced Cardiology Guilty of Overbilling Ordered to Pay Restitution

In February 2014, a settlement agreement was reached with Advanced Cardiology of Rockville, Maryland and multiple cardiologists regarding the overbilling of nuclear stress tests performed between July 2007 and March 2011. The billings in question involved nuclear stress tests designed to assess a patient's cardiac function. Stress tests were systematically billed twice, using a CPT modifier intended to be used when the service is repeated



by the same physician or when a distinct service was performed on the same day. However, the investigation revealed that none of the tests were repeated, nor were the tests performed for a distinct procedural service.

Advanced Cardiology and its associated cardiologists also billed a CPT code that was intended to be used for interpreting and reporting images, even though the physician was already compensated for this service under the CPT code for the nuclear stress test. This scheme is called unbundling and occurs when services already included in one CPT code are billed separately under another code.

The settlement awards the FEHBP approximately \$216,000, resulting from the joint OIG investigative efforts performed by HHS and our office.

Endogastric Solutions Violates the False Claims Act Accepts Settlement Agreement

The case originated as a *qui tam* complaint filed in the District of Montana alleging Endogastric Solutions (EGS) marketed a device and procedure for the experimental treatment of Gastroesophageal Reflux Disease (GERD) and advised physicians to use the incorrect procedure code in order to circumvent claims processing flags.

Qui tam is an action brought by an informer, under a statute which establishes a penalty for the commission or omission of a certain act, and provides that the same shall be recoverable in a civil action, part of the penalty to go to any person who will bring such action and the remainder to the state or some other institution.

EGS's medical device and its associated experimental medical procedure is designed and used to treat acid reflux, specifically GERD. This outpatient procedure called Transoral Incisionless Fundoplication (TIF) costs hospitals approximately \$6,500 per treatment. EGS does not have an approved CPT code for their device and procedure. Therefore, the only CPT code that can be used to bill properly for this procedure is the unlisted CPT Code, 43499. While aggressively marketing its medical device, EGS induced hospitals and physicians to improperly bill for the TIF procedure

under the wrong CPT code, specifically CPT 43280, which is for a laparoscopic procedure associated with a higher degree of morbidity and mortality. This resulted in significantly higher reimbursement, as the TIF procedure does not involve laparoscopy.

EGS has entered into a settlement agreement with the DOJ to resolve the allegations. The settlement was structured in two parts, which includes both a fixed financial payment to the FEHBP and a variable portion based on future EGS sales which could result in additional funds awarded to the FEHBP. Part one of the settlement, the fixed financial payment, calls for a fixed settlement amount of \$2.5 million plus interest to be made in quarterly payments over five years beginning in March 2014. Of this sum, the FEHBP was awarded \$452,649, minus the three percent DOJ allocation of \$13,579, leaving a net recovery to the FEHBP of \$439,069.

The second part of the settlement is a contingency settlement amount of no more than \$2.75 million to be paid annually over five years if EGS obtains a CPT code for their TIF procedure within five years of the effective date of the settlement. If the contingency is met, the amount to be paid annually will be two percent of revenues exceeding \$20 million and three percent of revenues exceeding \$30 million. All Federal programs, including the FEHBP, will share in a pro-rata manner based on claim payments. The FEHBP calculated share was established to be 16.6 percent of the settlement amount based on a review by the DOJ of Federal health programs exposure.

This was a joint investigation with the OIGs of HHS and our office.

RETIREMENT FRAUD

Under the law, entitlement to annuity payments ceases upon the death of an annuitant or survivor annuitant (spouse). The most common type of retirement fraud involves the intentional receipt and use of Civil Service Retirement System (CSRS) or Federal Employees Retirement System (FERS) annuity benefit payments by an unentitled recipient. However, retirement fraud can also include incidents of elder abuse.

Our Office of Investigations uses a variety of approaches to identify potential retirement fraud cases for investigation. We coordinate closely with



OPM's Retirement Services office to identify and address program vulnerabilities. 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. The OIG also works proactively to identify retirement fraud.

The following retirement fraud investigations represent some of our activities during the reporting period.

RETIREMENT FRAUD CASES

Daughter Steals Deceased Annuitant's Benefit Payments

We initiated this investigation in May 2010, after receiving allegations from OPM's Office of Retirement Inspections that a survivor annuitant died in July 2000 and benefit payments continued to be deposited into her account until December 2009. This resulted in an overpayment of \$125,262.

Our investigation revealed that the survivor annuitant's daughter was illegally using the benefits and when interviewed she admitted to stealing the payments. In August 2013, the daughter pled guilty to theft of public money and was sentenced in December 2013. She was sentenced to 60 months of probation and ordered to pay \$125,262 in restitution to OPM.

Grandson Conceals Grandmother's Death Collects Annuity Payments

Social Security Administration (SSA) OIG officials interviewed a grandson who admitted that he had been collecting SSA and annuity checks in his grandmother's name since she died in 1998.

On November 13, 2013, the grandson was sentenced to 48 months of probation and ordered to pay OPM \$182,203 in restitution. This case was investigated jointly by the SSA OIG and our office.

Daughter Steals Deceased Mother's Annuity Checks

We initiated this investigation in April 2010, after receiving allegations from OPM's Retirement Inspections (RI) office that a survivor annuitant died in November 2004 and payments continued to be processed until December 2009. This resulted in an overpayment of \$92,682. Research revealed that the informant listed on the death certificate was the survivor annuitant's daughter.

A subpoena for bank records confirmed that the daughter was a joint account holder with the survivor annuitant prior to her death. However, the daughter continued to receive and use the annuity funds after her mother's passing. In an interview with our agents in June 2012, the daughter admitted she withdrew her deceased mother's CSRS benefits to pay her household bills. She also acknowledged that she forged her deceased mother's name on two OPM Address Verification Letters (AVLs) in order to continue receiving benefits.

In December 2013, the daughter was sentenced to five years probation and 100 hours of community service in Sacramento, California. In addition, she was ordered to pay restitution to OPM in the amount of \$92,682 and a forfeiture money judgment in the amount of \$92,682.

Daughter Conceals Mother's Death to Collect Annuity Payments

We initiated this investigation after receiving allegations that the daughter of a deceased Federal annuitant disclosed that she fraudulently obtained retirement payments from OPM.

OPM was not notified of the annuitant's death in October 2009 and the annuity payments continued, resulting in the daughter receiving \$43,826, to which she was not entitled. For over three years, the daughter collected her mother's annuity benefits sent via electronic funds transfer to a joint bank account in the names of the deceased annuitant and her daughter.



When the daughter was interviewed, she stated that she knew that taking the money was wrong. She attempted to justify why she waited so long to contact OPM by saying she was scared and needed the money for living expenses and bills.

In March 2014, the daughter pled guilty to larceny and was sentenced to 84 months of probation. Additionally, the daughter was ordered to pay \$43,826 in restitution to OPM. This was a joint investigation by the United States Secret Service (USSS), the SSA OIG, and our office.

REVOLVING FUND PROGRAM INVESTIGATIONS

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

OPM's 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 9,400 Federal and contract employees, FIS processed over 2.3 million background investigations in FY 2013. 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 criminal investigators include fabrications by OPM 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 criminal investigators include employee misconduct, regulatory violations, and contract irregularities.

The following Revolving Fund investigations represent some of our activities during the reporting period.

Former OPM Background Investigator Sentenced for Falsifying Numerous Background Investigations

In January 2012, the OIG received an allegation from the FIS Integrity Assurance Group regarding misconduct and false statements made by an OPM Background Investigator.

From September 2010 through November 2011, in multiple background Reports of Investigation, the background investigator misrepresented that he had interviewed a source or reviewed a record regarding the subject of the background investigation, when in fact, he had not conducted an interview or obtained a record. These reports were utilized and relied upon by Federal agencies to determine whether these subjects were suitable for positions having access to classified information, for positions impacting national security, or for receiving or retaining security clearances. These false representations required FIS to reopen and reinvestigate numerous background investigations assigned to the background investigator, which cost OPM \$159,918.

The background investigator pled guilty to making false statements and was sentenced in November 2013, in the U.S. District Court for the District of Columbia, to serve six months incarceration, 200 hours of community service; 36 months of supervised probation, and ordered to pay full restitution of \$159,918 to OPM. In addition, the background investigator was debarred by OPM.



OIG HOTLINE AND COMPLAINT ACTIVITY

The OIG's Fraud Hotline also contributes to identifying fraud and abuse. The Hotline telephone number, email address, and mailing address are listed on our OIG Web site at www.opm.gov/oig, along with an online anonymous complaint form. Contact information for the Hotline is also published in the brochures for all of the FEHBP health insurance plans. Those who report information to our Hotline can do so openly, anonymously, and confidentially without fear of reprisal.

The information we receive on our OIG Hotline generally concerns customer service issues, FEHBP health care fraud, retirement fraud, and other complaints that may warrant investigation. 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.

We received 796 hotline inquires during the reporting period, with 281 pertaining to health care and insurance issues, and 488 concerning retirement or special investigation. The table on page 31 reports the summary of hotline activities including telephone calls, emails, and letters.

OIG AND EXTERNAL INITIATED COMPLAINTS

Based on our knowledge of OPM program vulnerabilities, information shared by OPM program offices and contractors, and our liaison with other law enforcement agencies, we initiate our own inquiries into possible cases involving fraud, abuse, integrity issues, and occasionally malfeasance.

During this reporting period, we initiated 54 preliminary inquiry complaints related to retirement fraud and special investigations. We also initiated 546 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.

DEBARMENT INITIATIVE UPDATE

As discussed in previous reporting periods, the agency implemented a new Suspension and Debarment program, which became effective March 2013. During this reporting period, the OIG referred five cases to the agency for debarment action, for a total of 27 referrals since the inception of the program. OPM issued Debarment letters to eight individuals between October 2013 and March 2014, and had an additional five proposed debarment letters pending at the end of this reporting period. The majority of cases we refer for debarment action are former Federal Investigative Service employees and contractors. These individuals have been removed from Government employment or from the relevant OPM contract; however, we feel Government-wide contract debarment action for these individuals is necessary to protect the integrity of Federal programs.

Our office will continue to develop and refer cases where we believe a Government-wide debarment is necessary in order to protect the integrity of OPM, as well as other Federal agencies and programs.



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 32,753 active suspensions and debarments from the FEHBP.

During the reporting period, our office issued 417 administrative sanctions – including both suspensions and debarments – of health care providers who have committed violations that impact the FEHBP and its enrollees. In addition, we responded to 2,496 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.*

The following is a summary of our debarment actions.

Michigan Physician Debarred for Child Pornography

In July 2013, the Michigan Department of Licensing and Regulatory Affairs (LARA) revoked a physician's (limited) medical license. LARA's actions were based on a February 2012 affidavit stating that the physician, who was a pediatric medical resident at the University of Michigan Hospital (hospital), was involved in activities related to material involving the sexual exploitation of minors.

An investigation of the physician was launched after a thumb drive containing child pornography was found plugged into his computer. In addition, multiple electronic devices were retrieved from the physician's home containing several images of suspected child pornography and depictions of real children engaged in sexually explicit conduct.



The physician was found guilty of possession of child pornography and sentenced to three years imprisonment. He was ordered to be placed on probation where he will have five years of supervision with conditions.

Our debarment of the physician is for an indefinite period pending full reinstatement of his medical license.

California Physician and His Practice Suspended for Physician's Sexual Misconduct

We suspended a California licensed physician and his practice in October 2013. Our suspension was based on Superior Court of California for the County of Riverside Superior Court's (Court) order to restrict the physician's practice of medicine, as sought by the California Board of Medicine (Board). The Court's July 2013 "Order Restricting the Practice of Medicine" (Order) states that the physician shall immediately discontinue the consultation, examination, treatment, the touching of and/or otherwise practicing medicine

on any and all female patients without a female chaperone present at all times.

The Board appealed to the Court for the Order to restrict the physician's license based on the results of a March 2013 police investigation into a complaint that the physician, on several occasions, intimately touched his patients and interns in his practice without their consent. The physician admitted that he acted unprofessionally when he inappropriately touched three interns between the spring and summer of 2012. In April 2013, a misdemeanor complaint was issued against the physician for five counts of sexual battery by an employer for willingly and unlawfully touching an intimate part of another person's body against their will.

Based on the Court's decision to place restrictions on the physician's medical license to protect the health and safety of the public, we suspended the physician and his practice to protect the FEHBP enrollees and their family members. Our suspension will remain in effect for an indefinite period pending the resolution of the physician's medical license.



LEGISLATIVE ACTIVITIES

LEGISLATIVE PROPOSALS

Under the Inspector General Act of 1978, as amended, each statutory Inspector General has the right to obtain his or her own independent legal counsel in order to preserve the independence of the office and avoid possible conflicts of interest in conducting IG audits and investigations. Not only does the Office of Legal Affairs advise the Inspector General and other OIG offices on legal and regulatory matters, but it also works to develop and promote legislative proposals to prevent and reduce fraud, waste, and abuse in OPM programs.

Since 2008, the OIG has sought to gain access to OPM's Revolving Fund in order to finance oversight activities of the programs that are financed by the Revolving Fund, including Federal Investigative Services and Human Resources Solutions. As discussed in previous Semiannual Reports, this Fund totaled approximately \$2 billion in the past several years, and yet the OIG had only approximately \$3 million to conduct oversight of not only the Revolving Fund programs, but also all other non-trust fund programs, such as the Combined Federal Campaign and the Federal Employees Dental and Vision Insurance Program.

After years of pursuing the support and assistance of OPM and the Office of Management and Budget (OMB), a legislative proposal which would grant our office statutory access to the Revolving Fund was included in the President's Budget for Fiscal Year 2014.

Over the course of the year, our Congressional appropriations and authorizing committees also took action to provide the OIG access to the Revolving Fund. First, in June 2013, subcommittees of both the House Committee on Oversight and Government Reform and the Senate Committee on Homeland Security and Governmental Affairs held hearings examining the need for greater oversight of the Revolving Fund programs.

Just weeks after these hearings, in July 2013, Senator Jon Tester, Chairman of the Subcommittee on the Efficiency and Effectiveness of Federal Programs and the Federal Workforce, introduced S.1276, the Security Clearance Oversight and Reform Enhancement (SCORE) Act, on behalf of Senators Rob Portman, Claire McCaskill, Ron Johnson, and Tom Coburn. Shortly after, also in July, Congressman Blake Farenthold, Chairman of the Subcommittee on the Federal Workforce, U.S. Postal Service and the Census, introduced a similar bill, H.R. 2860, the OPM IG Act, on behalf of Congressman Stephen Lynch, the subcommittee's Ranking Member. Both the SCORE Act and the OPM IG Act granted the OIG permanent statutory access to the Revolving Fund for purposes of conducting oversight of those programs financed by the Fund and both were passed unanimously by their respective chambers.



LEGISLATIVE ACTIVITIES

OCTOBER 1, 2013 – MARCH 31, 2014

Our appropriations committees were just as supportive of our goal. Both the House and Senate Committees on Appropriations introduced bills that granted the OIG access to the Revolving Fund for Fiscal Year 2014. Their work came to fruition when the Consolidated Appropriations Act for Fiscal year 2014, containing this provision, was passed in January 2014.

The authorizing committees continued their pursuit of a statutory amendment, and on February 12, 2014, the President signed the OPM IG Act into law. This Act, Public Law 113-80, is available at: <http://www.gpo.gov/fdsys/pkg/PLAW-113publ80/pdf/PLAW-113publ80.pdf>.

With these new resources, the OIG is expanding its investigative and audit capabilities. We have started the process to expand the Office of Investigation's Special Investigations Group as well as the Office of Audits' Internal Audits Group so that the OIG can finally provide an adequate level of oversight to these large programs through which OPM interacts with nearly every other Federal agency. We fully expect our oversight activities to increase efficiency and better protect taxpayer dollars from those who wish to defraud the Government.



STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES

JUDICIAL ACTIONS:

Indictments and Informations	29
Arrests	8
Convictions	18

JUDICIAL RECOVERIES:

Restitutions and Settlements	\$46,341,768
Fines, Penalties, Assessments, and Forfeitures	\$420,807,000 ¹

RETIREMENT AND SPECIAL INVESTIGATIONS HOTLINE AND PRELIMINARY INQUIRY ACTIVITY:

HOTLINE

Referred to:	
OPM Program Offices	187
Other Federal Agencies	137
Informational Only	132
Inquiries Initiated	6
Retained for Further Inquiry	26
Total Received:	488

PRELIMINARY INQUIRY COMPLAINTS

Total Received:	54
Total Closed:	26

(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.



STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES

OCTOBER 1, 2013 – MARCH 31, 2014

HEALTH CARE FRAUD HOTLINE AND PRELIMINARY INQUIRY COMPLAINT ACTIVITY:

HOTLINE

Referred to:

OPM Program Offices	80
FEHBP Insurance Carriers or Providers	117
Other Federal Agencies	14
Informational Only	44
Inquiries Initiated	0
Retained for Further Inquiry	26
Total Received:	281

PRELIMINARY INQUIRY COMPLAINTS

Total Received:	546
Total Closed:	492

HOTLINE CONTACTS AND PRELIMINARY INQUIRY COMPLAINTS:

Total Hotline Contacts and Preliminary Inquiries Received:	1,369
Total Hotline Contacts and Preliminary Inquiries Closed:	1,235

ADMINISTRATIVE SANCTIONS ACTIVITY:

FIS Cases Referred for Debarment and Suspension	5
Health Care Debarments and Suspensions Issued	417
Health Care Provider Debarment and Suspension Inquiries	2,496
Health Care Debarments and Suspensions in Effect at End of Reporting Period	32,753



APPENDICES

APPENDIX I-A

Final Reports Issued With Questioned Costs for Insurance Programs

OCTOBER 1, 2013 TO MARCH 31, 2014

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	2	\$(1,472,818)
B. Reports issued during the reporting period with findings	10	39,622,791
Subtotals (A+B)	12	38,149,973
C. Reports for which a management decision was made during the reporting period:	7	21,556,241
1. Disallowed costs	N/A	21,908,910
2. Costs not disallowed	N/A	(352,669) ²
D. Reports for which no management decision has been made by the end of the reporting period	5	16,593,732 ²
E. Reports for which no management decision has been made within 6 months of issuance	1	(3,454,305)

²Represents the net costs, which include overpayments and underpayments, to insurance carriers. While management decisions may have been made on underpayments, they are not recorded and implemented until recovery of overpayments.



APPENDIX I-B

Final Reports Issued With Questioned Costs for All Other Audit Entities

OCTOBER 1, 2013 TO MARCH 31, 2014

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	1	\$32,955
B. Reports issued during the reporting period with findings	3	6,162
Subtotals (A+B)	4	39,117
C. Reports for which a management decision was made during the reporting period:	0	0
1. Disallowed costs	N/A	0
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	39,117
E. Reports for which no management decision has been made within 6 months of issuance	1	32,955

APPENDIX II

Final Reports Issued With Recommendations for Better Use of Funds

OCTOBER 1, 2013 TO MARCH 31, 2014

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



APPENDIX III
Insurance Audit Reports Issued
OCTOBER 1, 2013 TO MARCH 31, 2014

Report Number	Subject	Date Issued	Questioned Costs
1C-UR-00-13-042	Humana Health Plan of Texas in Louisville, Kentucky	October 4, 2013	\$ 0
1C-Q1-00-13-011	Lovelace Health Plan – Plan Code Q1 in Albuquerque, New Mexico	October 10, 2013	5,056,088
1C-75-00-13-041	Humana Health Plan, Inc. of Chicago in Louisville, Kentucky	October 10, 2013	0
1C-52-00-13-044	Health Alliance Plan in Detroit, Michigan	October 10, 2013	0
1H-01-00-12-072	Blue Cross and Blue Shield’s Retail Pharmacy Member Eligibility in 2006, 2007, and 2011 in Washington, D.C.	November 8, 2013	2,305,973
1A-99-00-13-032	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.	November 22, 2013	7,797,641
1A-99-00-13-003	Global Claims where Amounts Paid Exceeded Covered Charges for BlueCross and BlueShield Plans in Washington, D.C.	November 22, 2013	4,077,968
1A-10-07-13-005	Blue Cross Blue Shield of Louisiana in Baton Rouge, Louisiana	December 19, 2013	454,085
1C-63-00-13-045	Kaiser Foundation Health Plan, Inc. of Hawaii Region in Honolulu, Hawaii	December 20, 2013	0
1B-32-00-13-017	National Association of Letter Carriers Health Benefit Plan in Ashburn, Virginia	December 23, 2013	204,222
1C-3A-00-13-054	AultCare Health Plan in Canton, Ohio	December 23, 2013	0
1C-CY-00-13-029	United Healthcare of California in Cypress, California	January 8, 2014	0
1A-99-00-13-018	Cash Management Activities for a Sample of BlueCross and BlueShield Plans in Washington, D.C.	January 17, 2014	1,547,417
1A-10-56-13-047	BlueCross BlueShield of Arizona in Phoenix, Arizona	February 25, 2014	1,901,078
1C-DG-00-14-013	Humana Employers Health Plan of Georgia, Inc., in Louisville, Kentucky	March 10, 2014	0
1C-YE-00-13-067	Aetna Open Access of Pittsburgh and Western Pennsylvania in Blue Bell, Pennsylvania	March 14, 2014	0



APPENDIX III

Insurance Audit Reports Issued

OCTOBER 1, 2013 TO MARCH 31, 2014

(Continued)

Report Number	Subject	Date Issued	Questioned Costs
1C-IK-00-13-068	Aetna Open Access of Chicago, Illinois and Northern Indiana in Blue Bell, Pennsylvania	March 14, 2014	\$ 0
1C-GV-00-13-066	MVP Health Plan, Inc. of Western Region in Schenectady, New York	March 14, 2014	0
1A-10-85-14-011	CareFirst BlueCross BlueShield in Owings, Mills, Maryland	March 14, 2014	1,865,071
1A-10-17-13-019	Health Care Service Corporation in Chicago, Illinois	March 28, 2014	14,413,248
TOTALS			\$39,622,791

APPENDIX IV

Internal Audit Reports Issued

OCTOBER 1, 2013 TO MARCH 31, 2014

Report Number	Subject	Date Issued
4A-CF-00-13-034	The U.S. Office of Personnel Management's Fiscal Year 2013 Consolidated Financial Statements in Washington, D.C.	December 13, 2013
4A-CF-00-13-035	The U.S. Office of Personnel Management's Fiscal Year 2013 Closing Package Financial Statements in Washington, D.C.	December 16, 2013



APPENDIX V

Combined Federal Campaign Audit Reports Issued

OCTOBER 1, 2013 TO MARCH 31, 2014

Report Number	Subject	Date Issued
3A-CF-00-13-048	The 2010 and 2011 Greater Indiana Combined Federal Campaigns in Indianapolis, Indiana	January 10, 2014
3A-CF-00-13-049	The 2010 and 2011 Atlantic Coast Combined Federal Campaigns in Boynton Beach, Florida	February 3, 2014
3A-CF-00-13-050	The 2010 and 2011 Central Pennsylvania Combined Federal Campaigns in Enola, Pennsylvania	February 3, 2014

APPENDIX VI

Information Systems Audit Reports Issued

OCTOBER 1, 2013 TO MARCH 31, 2014

Report Number	Subject	Date Issued
4A-CI-00-13-036	The U.S. Office of Personnel Management's Common Security Control Collection in Washington, D.C.	October 10, 2013
4A-CI-00-13-021	Federal Information Security Management Act for Fiscal Year 2013 in Washington, D.C.	November 21, 2013
1A-10-17-13-026	Information Systems General and Application Controls at Health Care Service Corporation in Chicago, Illinois	January 28, 2014



APPENDIX VII

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

OCTOBER 1, 2013 TO MARCH 31, 2014

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; 2 open recommendations	April 16, 2007
4A-CI-00-08-022	Federal Information Security Management Act for Fiscal Year 2008 in Washington, D.C.; 19 total recommendations; 3 open recommendations	September 23, 2008
4A-CF-00-08-025	OPM's Fiscal Year 2008 Consolidated Financial Statement in Washington, D.C.; 6 total recommendations; 1 open recommendation	November 14, 2008
4A-CI-00-09-031	Federal Information Security Management Act for Fiscal Year 2009 in Washington, D.C.; 30 total recommendations; 3 open recommendations	November 5, 2009
4A-CF-00-09-037	OPM's Fiscal Year 2009 Consolidated Financial Statement in Washington, D.C.; 5 total recommendations; 1 open recommendation	November 13, 2009
4A-IS-00-09-060	Quality Assurance Process Over Background Investigations in Washington, D.C.; 18 total recommendations; 1 open recommendation	June 22, 2010
4A-CF-00-10-015	OPM's Fiscal Year 2010 Consolidated Financial Statement in Washington, D.C.; 7 total recommendations; 3 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; 4 open recommendations	November 10, 2010
4A-CF-00-10-043	Payroll Debt Management Process for Active and Separated Employees in Washington, D.C.; 8 total recommendations; 1 open recommendation	March 4, 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; 1 open recommendation	May 16, 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 Fiscal Year 2011 in Washington, D.C.; 29 total recommendations; 7 open recommendations	November 9, 2011
4A-CF-00-11-050	OPM's Fiscal Year 2011 Consolidated Financial Statement in Washington, D.C.; 7 total recommendations; 1 open recommendation	November 14, 2011



APPENDIX VII

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

OCTOBER 1, 2013 TO MARCH 31, 2014

(Continued)

Report Number	Subject	Date Issued
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
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
1B-31-00-10-038	Government Employees Health Association, Inc. in Lee's Summit, Missouri; 16 total recommendations; 7 open recommendations	March 12, 2012
4A-CF-00-09-014	OPM's Interagency Agreement Process in Washington, D.C.; 8 total recommendations; 6 open recommendations	March 28, 2012
1A-99-00-12-001	Global Omnibus Budget Reconciliation Act of 1993 Claims for BlueCross and BlueShield Plans in Washington, D.C.; 6 total recommendations; 1 open recommendation	July 16, 2012
4A-OP-00-12-013	Information Technology Security Controls of OPM's Audit Report and Receivables Tracking System in Washington, D.C.; 24 total recommendations; 21 open recommendations	July 16, 2012
1B-31-00-11-066	Information Systems General and Application Controls at Government Employees Health Association, Inc. in Lee's Summit, Missouri; 26 total recommendations; 1 open recommendation	August 9, 2012
4A-CF-00-11-067	Administration of the Prompt Payment Act at OPM in Washington, D.C.; 12 total recommendations; 7 open recommendations	September 13, 2012
4A-CI-00-12-016	Federal Information Security Management Act for FY 2012 in Washington, D.C.; 18 total recommendations; 9 open recommendations	November 5, 2012
4A-CF-00-12-039	OPM's Fiscal Year 2012 Consolidated Financial Statement in Washington, D.C.; 3 total recommendations; 1 open recommendation	November 15, 2012
1D-80-00-12-045	Information Systems General and Application Controls at EmblemHealth in New York, New York; 12 total recommendations; 4 open recommendations	December 10, 2012
1K-RS-00-12-031	OPM's Voice over the Internet Protocol Phone System Interagency Agreement with the District of Columbia in Washington, D.C.; 2 total recommendations; 1 open recommendation	December 12, 2012
1A-10-67-12-004	BlueShield of California in San Francisco, California; 13 total recommendations; 5 open recommendations	January 10, 2013



APPENDIX VII

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

OCTOBER 1, 2013 TO MARCH 31, 2014

(Continued)

Report Number	Subject	Date Issued
1A-99-00-12-055	Global Assistant Surgeon Claim Overpayments for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 2 open recommendations	February 21, 2013
1C-22-00-12-065	Information Systems General and Application Controls at Aetna Inc. in Hartford, Connecticut; 9 total recommendations; 2 open recommendations	March 18, 2013
1A-99-00-12-029	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 7 total recommendations; 6 open recommendations	March 20, 2013
4A-CF-00-12-066	Assessing the Relevance and Reliability of the U.S. Office of Personnel Management's Performance Information in Washington, D.C.; 5 total recommendations; 1 open recommendation	April 1, 2013
1A-10-32-12-062	BlueCross BlueShield of Michigan in Detroit, Michigan; 11 total recommendations; 5 open recommendations	July 19, 2013
1A-10-15-13-002	Information Systems General and Application Controls at BlueCross BlueShield of Tennessee in Chattanooga, Tennessee; 8 total recommendations; 6 open recommendations	August 6, 2013
1A-99-00-13-004	Global Continuous Stay Claims for BlueCross and BlueShield Plans in Washington, D.C.; 6 total recommendations; 6 open recommendations	August 20, 2013
1A-10-00-13-012	Information Systems General and Application Controls at WellPoint, Inc. in Roanoke, Virginia; 10 total recommendations; 6 open recommendations	September 10, 2013
1A-10-41-12-050	Florida Blue in Jacksonville, Florida; 13 total recommendations; 10 open recommendations	September 10, 2013
1C-P2-00-13-015	Presbyterian Health Plan in Albuquerque, New Mexico; 3 total recommendations; 2 open recommendations	September 26, 2013
1C-WJ-00-13-007	Group Health Cooperative of South Central Wisconsin in Madison, Wisconsin; 6 total recommendations; 3 open recommendations	September 26, 2013



APPENDIX VIII Most Recent Peer Review Results

OCTOBER 1, 2013 TO MARCH 31, 2014

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 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. Department of State)</i>	February 5, 2014	Compliant ⁴

³A peer review rating 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. The Peer Review does not contain any deficiencies or significant deficiencies.

⁴A rating of **Compliant** conveys that the reviewed Office of 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 IX Investigative Recoveries

OCTOBER 1, 2013 TO MARCH 31, 2014

OIG Case Number ⁵	Case Category	Action ⁵	OPM Recovery (Net)	Total Recovery (All Programs/Victims)	Fines, Penalties, Assessments, and Forfeitures
C 2011 00002	Federal Investigative Services Fraud	Administrative	\$ 89,321	\$ 89,321	\$ -
I 2009 00859	Federal Investigative Services Fraud	Administrative	136,531	136,531	0
I 2010 00228	Federal Investigative Services Fraud	Administrative	170,132	170,131	0
I-12-00222	Federal Investigative Services Fraud	Criminal	159,918	159,918	100
TOTAL	Federal Investigative Services Fraud		\$ 555,902	\$ 555,901	\$ 100
I 2006 00103	Health Care Fraud	Civil	627,372	184,000,000	0
I 2008 00128	Health Care Fraud	Civil	14,426	3,050,550	0
I 2009 00091	Health Care Fraud	Civil	37,012,750	1,273,024,000	0
I 2010 00808	Health Care Fraud	Civil	6,430,989	171,910,153	0
I 2011 00090	Health Care Fraud	Civil	26,581	1,000,000	0
I 2011 00403	Health Care Fraud	Civil	87,663	1,894,550	0
I 2011 00403	Health Care Fraud	Civil	89,789	659,726	0
I 2011 00814	Health Care Fraud	Civil	32,441	4,190,000	0
I-12-00127	Health Care Fraud	Civil	298,651	1,126,218	0
I-12-00696	Health Care Fraud	Civil	439,069	2,500,000	0
I-13-00392	Health Care Fraud	Civil	66,627	175,000	0
I-14-00041	Health Care Fraud	Civil	11,495	1,300,000	0
I-14-00290	Health Care Fraud	Civil	271	13,837	0
I-14-00555	Health Care Fraud	Civil	2,776	76,700	0
I 2007 00104	Health Care Fraud	Criminal	0	172,754	0
I 2009 00091	Health Care Fraud	Criminal	0	0	400,000,125
I 2010 00808	Health Care Fraud	Criminal	0	0	20,800,000
I 2011 00058	Health Care Fraud	Criminal	7,261	161,554	5,025



APPENDIX IX

Investigative Recoveries

OCTOBER 1, 2013 TO MARCH 31, 2014

(Continued)

OIG Case Number ⁵	Case Category	Action ⁵	OPM Recovery (Net)	Total Recovery (All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
I 2011 00668	Health Care Fraud	Criminal	\$ 190,306	\$ 3,153,262	\$ 100
I 2011 00668	Health Care Fraud	Criminal	0	976,476	100
I-12-00767	Health Care Fraud	Criminal	0	0	100
I-13-00722	Health Care Fraud	Criminal	3,426	87,852	0
I-13-00853	Health Care Fraud	Criminal	0	130,262	100
I-13-00853	Health Care Fraud	Criminal	0	0	200
I-13-00853	Health Care Fraud	Criminal	0	0	300
I-13-00853	Health Care Fraud	Criminal	0	47,026	200
I-13-00853	Health Care Fraud	Criminal	0	19,522	100
I-13-00853	Health Care Fraud	Criminal	0	0	200
TOTAL	Health Care Fraud		\$45,341,893	\$1,649,669,442	\$420,806,550
I 2010 00092	Retirement Fraud	Criminal	125,262	125,262	100
I 2010 00561	Retirement Fraud	Criminal	92,682	92,682	100
I-13-00022	Retirement Fraud	Criminal	182,203	265,604	100
I-13-00504	Retirement Fraud	Criminal	43,826	63,053	50
TOTAL	Retirement Fraud		\$ 443,973	\$ 546,601	\$ 350
GRAND TOTAL			\$46,341,768	\$1,650,771,944	\$420,807,000

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



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