

OFFICE OF THE
INSPECTOR GENERAL



SEMIANNUAL REPORT TO CONGRESS

October 1, 2004 – March 31, 2005



UNITED STATES *Working for America*
OFFICE OF PERSONNEL MANAGEMENT

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OFFICE OF
THE INSPECTOR GENERAL

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D.C. 20415

May 1, 2005

*Honorable Dan G. Blair
Acting Director
U.S. Office of Personnel Management
Washington, D.C. 20415*

Dear Mr. Blair:

I respectfully submit the Office of the Inspector General's Semiannual Report to Congress for the period October 1, 2004 to March 31, 2005. This report describes our office's activities during the past six-month reporting period.

Should you have any questions about the report or any other matter of concern, please do not hesitate to call upon me for assistance.

Sincerely,


*Patrick E. McFarland
Inspector General*



TABLE OF CONTENTS

SEMIANNUAL REPORT TO CONGRESS
October 1, 2004 – March 31, 2005

OFFICE OF THE INSPECTOR GENERAL FIELD OFFICES	i
INSPECTOR GENERAL’S MESSAGE.....	iii
PRODUCTIVITY INDICATORS	v
ADMINISTRATIVE SANCTIONS OF HEALTH CARE PROVIDERS.....	1
AUDIT ACTIVITIES .	7
Health and Life Insurance Carrier Audits	7
Information Systems Audits.....	11
Combined Federal Campaigns	13
OPM Internal Audits	16
Table 1: FY 2004 Internal Control Weaknesses.....	18
INVESTIGATIVE ACTIVITIES	21
Health Care Fraud	21
Retirement Fraud .	23
OPM Employee Integrity	24
Table 2: Investigative Activities	26
STATUTORY AND REGULATORY REVIEW.....	27
INDEX OF REPORTING REQUIREMENTS.....	28
APPENDIX I: Final Reports Issued With Questioned Costs	29
APPENDIX II: Final Reports Issued With Recommendations for Better Use of Funds	29
APPENDIX III: Insurance Audit Reports Issued.....	30
APPENDIX IV: Internal Audit Reports Issued.....	32
APPENDIX V: Information Systems Audit Reports Issued.....	32
APPENDIX VI: Combined Federal Campaign Audit Reports Issued.....	33



THE INSPECTOR GENERAL'S MESSAGE

SEMIANNUAL REPORT TO CONGRESS
October 1, 2004 – March 31, 2005

During FY 2003, at the request of OPM and the Office of Management and Budget (OMB), our office participated in a Program Assessment and Rating Tool (PART), process that addressed our FY 2005 audit and enforcement plans for health care and health insurance issues. PART is a structured, self-administered evaluation methodology developed by OMB, can be applied on a consistent basis governmentwide, yielding data to support comparisons of program effectiveness across agency lines. PART examines the processes through which program goals and structure, operational planning, and resource allocations are linked with specific, verifiable measures of accomplishments. Each completed PART instrument is reviewed and graded by a team of senior OMB officials.

With the support and assistance of OMB staff, our office produced a PART analysis that was graded among the very best governmentwide by the OMB review team. Further, the exercise was valuable for us in a highly immediate and practical sense, sharpening our focus on short- and long-term goals that directly contribute to the effectiveness of our programs.

We believe that the accomplishments we are highlighting in this report, as well as the indications of future results from work now in process, support the validity of the planning decisions we generated through our PART exercise two years ago. At that time, we had received the first of a series of funding increments to support the expansion of our audit and investigative activities. One of our goals was to transform ourselves from an organization principally based in Washington, DC into one which had a sizeable presence throughout the United States. PART helped to validate our plans to locate field offices on the basis of their proximity to the subjects of our health care audits and investigations—health care providers and health insurance carriers. As noted in this report, we now have 23 field offices coast-to-coast, all of which are located in areas having significant concentrations of federal agencies, employees, and annuitants. We have fully realized our expectations of greater operational efficiency and flexibility, and have found that the nationwide scope of our field structure improves our ability to attract and retain well-qualified professional personnel.

PART also supported our plans to focus on important issues that, for a variety of structural reasons, we had not previously been able to address adequately. Among these were audits of contracts for FEHBP prescription drug benefits. Pharmaceutical-related expenditures comprise over one-quarter of all FEHBP costs, most of them handled through third-party firms called pharmacy benefit managers (PBMs). During the period covered by this report, we initiated a series of audits that deal, for the first time, directly with the PBMs. Based on our experiences to date, we believe that the reports of these audits will contain large findings related to handling of the complex series of refunds, rebates, credits, and incentives that characterize the relationships among pharmaceutical manufacturers, PBMs, health insurance carriers, and the FEHBP.



THE INSPECTOR GENERAL'S MESSAGE

One of the articles in this report describes the improved procedures that allow our administrative sanctions program to determine, on a nationwide basis, the relevance to the FEHBP of offenses (such as criminal convictions or licensure violations) by health care providers. The methodology underlying this innovation was generated by the results of the PART exercise. As part of that process, we determined that the effectiveness of administrative sanctions in meeting the goal of protecting the FEHBP and its enrollees from untrustworthy health care providers depended on our ability to sanction providers who were associated with the FEHBP. We were able to apply technology that had originally been developed for other purposes in order to identify providers who are connected to the FEHBP either through membership in a preferred provider network or by submitting claims to an FEHBP carrier. As a result, we are now able to assure that all of our administrative sanctions actions are directly relevant to the FEHBP.

Finally, the PART analysis supported our long-standing belief that positive financial impact on OPM programs was our most significant productivity indicator. As demonstrated in this report, we have continued to be successful in identifying funds that have been paid wrongfully or fraudulently from the health benefit and retirement trust funds. During the current reporting period, we made audit-related recommendations for OPM to recover \$32,368,006 and achieved recoveries of \$1,616,989 through investigative actions. For the three semiannual reporting periods that have elapsed since we completed the PART exercise, our cumulative financial results have totaled \$134,906,769 in recommendations for recovery of funds and \$9,947,700 in investigative recoveries.

Patrick E. McFarland
Inspector General



PRODUCTIVITY INDICATORS

SEMIANNUAL REPORT TO CONGRESS
October 1, 2004 – March 31, 2005

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds	\$32,368,006
Recoveries Through Investigative Actions	\$1,616,989
Management Commitments to Recover Funds.....	\$41,178,719

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	38
Investigative Cases Closed	21
Indictments.....	10
Convictions	6
Hotline Contacts and Complaint Activity	507
Health Care Provider Debarments and Suspensions.....	1,811
Health Care Provider Debarment and Suspension Inquiries	2,521



ADMINISTRATIVE SANCTIONS OF HEALTH CARE PROVIDERS

SEMIANNUAL REPORT TO CONGRESS

October 1, 2004 – March 31, 2005

Under the Federal Employees Health Benefits Program (FEHBP) administrative sanctions law, we issue suspensions and debarments against health care providers whose actions demonstrate that they are not responsible practitioners.

WORKLOAD INDICATORS

During this reporting period, our office:

- Issued 1,811 debarments and suspensions of health care providers.
- Responded to 2,521 inquiries related to FEHBP administrative sanctions from insurance carriers, health care providers, and members of the public.

At the end of the reporting period, there were 28,705 active FEHBP suspensions and debarments of health care providers.

MANAGING AND IMPROVING ADMINISTRATIVE SANCTIONS OPERATIONS

In this reporting period, our long-term project to apply electronically-accessible information to administrative sanctions cases (“e-debarment”) became fully operational. We have demonstrated that we can consistently and quickly obtain, from online sources, virtually all of the information we need to issue sanctions. This capability allows us to identify and target potentially sanctionable violations against the FEHBP by health care providers

on a nationwide basis. Most of these involve criminal convictions in federal and state courts, licensure revocations or suspensions by state regulatory bodies, and ownership of entities such as clinics by providers who have themselves been debarred.

The array of potential cases available to us poses the challenge of selecting those which contribute most directly to our objective of protecting the FEHBP and its enrollees against untrustworthy health care providers. We are focusing our sanctions activity on providers who have a specific nexus with FEHBP, particularly those who are the subjects of investigation by OIG’s Office of Investigations or have submitted claims to FEHBP carriers. During the reporting period, as the result of our improved access to provider-related information, we also developed the capability to quickly identify violators who are members of preferred provider networks (PPO) of FEHBP insurance carriers.

While we have no reason to believe that untrustworthy providers are any more numerous in FEHBP carrier networks than they are in the American health care system in general, we regard PPO providers as an especially important part of our sanctions workload because of their connections with OPM. Their



names appear in program-related literature produced with FEHBP funds, and OPM's FEHBP web pages provide links to the carriers' PPO lists, with remarks indicating that prospective enrollees should consult the lists as part of their decision to select a carrier. FEHBP plans offer their enrollees financial incentives to use network providers, or, in the case of health maintenance organizations (HMOs), require use of such providers.

Therefore, FEHBP enrollees are likely to come into contact with PPO members, and thus experience a greater risk of incurring physical or financial harm from untrustworthy providers in the PPOs. Finally, carriers do not routinely review providers for violations that would disqualify them from the FEHBP before placing them in their PPO networks, so our efforts represent a critical protective mechanism with this group of providers.

The FEHBP administrative sanctions statute also contains provisions for civil monetary penalties of up to \$10,000 and assessments of double damages on health care providers who knowingly submit false, fraudulent, or wrongful claims to FEHBP carriers. We have issued final regulations to implement these authorities, and have identified cases with potential financial sanctions exposure. At this time, we are deferring financial sanctions actions pending the outcome of criminal proceedings.

ADMINISTRATIVE SANCTIONS ISSUED DURING THE REPORTING PERIOD

The following articles describe a representative sample of administrative sanctions issued during this reporting period.

Debarments

Debarments disqualify health care providers from receiving payment of FEHBP funds for a stated period of time. The FEHBP administrative sanctions statute establishes 18 bases for debarment. The ones most frequently used are for criminal convictions and professional licensure restrictions. Before imposing a debarment, our office gives the affected providers written notice and the opportunity to contest the proposed sanction in an administrative proceeding.

Conspiracy Involving Pharmacist, Pharmacies, and Physicians

A San Antonio, Texas pharmacist organized a criminal conspiracy to distribute controlled substances online, involving two pharmacies he owned and three physicians who were recruited as part of the scheme. An Internet site ("Physician Referral 2000") operated by a co-conspirator solicited customers online throughout the United States and abroad with the promise of quick access to all types of drugs. Individuals visiting the site would be scheduled for telephonic or e-mail "consultations" with the physicians, who would prescribe controlled substances without any form of physical examination, testing, or followup to monitor the patients' response to the drugs.

Prescriptions would be filled by one of the pharmacies owned by the principal conspirator and shipped to the individuals. In addition to the cost of the drugs, the physicians charged a consultation fee of \$80 - \$100, which they split with the pharmacist. In the 21-month period during which the scheme was in full operation, it generated approximately 60,000 prescriptions and netted millions of dollars of illegal proceeds.



The conspirators pleaded guilty to violations of federal narcotics statutes, and were sentenced to prison terms ranging from five years of probation to 40 months of incarceration. These violations constitute a basis for mandatory debarment under the FEHBP sanctions

Four Conspirators and Two Pharmacies Debarred after Conviction for Distributing Controlled Substances Online

statute. Taking into account the severity of their crimes and their respective roles in the conspiracy, we debarred the principal conspirator for eight years and two of the physicians for seven years each. We debarred the other physician, who had a prior record of professional licensure infractions and criminal convictions, for 15 years. The pharmacies owned by the principal conspirator, which were convicted of criminal violations in their own right, were debarred for the same term as the pharmacist.

Drug Violations by Employee at Government Hospital

A registered nurse who was employed as a civilian in the emergency room of a military hospital in Colorado diverted painkilling medication—including the narcotics morphine and Demerol—from the hospital's supplies to his own use on at least 300 separate occasions over a seven month period. To deceive his supervisors and the hospital's automated drug control system, the nurse refilled the prepackaged syringes of medication that he had taken with saline solution or antihistamines and returned them to the hospital's inventory as if they were still intact and sterile. As a result of his actions, many persons who visited the emergency room failed to receive painkilling medications for injuries or other conditions. The nurse ultimately pleaded guilty in August 2004 to federal criminal charges of tampering

with products in interstate commerce, and was sentenced to five years incarceration.

While our office normally does not issue sanctions against nurses, we departed from our customary policy in this case because the violations involved federal employees and facilities. This case reflected a number of issues that our regulations treat as serious aggravating factors. Most prominent was the harm that the nurse's conduct caused to patients. As stated in the indictment, his actions displayed "reckless disregard" and "extreme indifference" to the risks of pain and injury that were suffered by the unwitting victims. In addition, the nurse directly betrayed the skills, trust, and access to medications associated with his status as a health care professional.

The Colorado Nursing Board revoked his licensure as a result of his actions. Taking into account all of the aggravating factors, we debarred this individual for a period of 10 years, effective in December 2004.

Nurse Debarred after Conviction for Diverting Drugs from Hospital Inventory

Conviction of Suspended Neurologist Leads to Debarment

In our semiannual report for the period April 1 – September 30, 2003, we reported our suspension of a Northern Virginia neurologist and his wife on the basis of their indictment in federal court for 61 counts of health care fraud and one count of conspiracy to commit health care fraud. This case was tried during the current reporting period, resulting in conviction of the couple on all of the charged counts. The convictions triggered our action to convert the suspensions into debarments. More information about this case is provided in the Investigative Activities section of this report.



ADMINISTRATIVE SANCTIONS OF HEALTH CARE PROVIDERS

In applying our debarment authority, we noted that, while neither the doctor nor his wife had any record of prior criminal violations, several aggravating factors were present in the case. These included:

- Prolonged and repeated nature of the offenses, involving a large number of false and fraudulent claims filed over a period of seven years (1996 – 2003);
- Significant financial losses incurred by federal health care programs as the result of the providers’ actions; and
- Risk that was generated for patients by the provider having knowingly created inaccurate and misleading medical records to support the fraudulent claims to health insurance carriers.

In recognition of these factors, we debarred the neurologist for eight years. His wife served as the office manager of their clinics, and participated in creating fraudulent records and billing documents.

Neurologist Debarred after Healthcare Fraud Conviction

Under our sanctions regulations,

she is therefore considered to be an indirect provider of health care services, subject to debarment on an equal basis as a direct, “hands-on” medical practitioner. Thus, we also debarred her for an equivalent eight year period. The length of the debarments includes the prior periods of suspension.

Florida Psychiatrist’s License Revoked

In August 2004, the Florida State Board of Medicine revoked the medical license of a psychiatrist who practiced in the Miami area.

The Board’s action was based on its determination that the provider improperly exercised his influence within the context of a physician/patient relationship to engage in a sexual relationship with a female patient. The doctor’s exploitative behavior continued for a seven year period.

The patient had a history of serious bipolar disorder, and required medication and therapy to function in society. According to the Florida Board’s disciplinary records, the provider would threaten to withhold her prescriptions if she did not continue to participate in the improper relationship. Ultimately, the patient revealed the doctor’s conduct to an attorney, who retained private investigators to verify her accusations.

In contrast to criminal convictions, which are mandatory bases for debarment under the FEHBP sanctions statute, debarment based on licensure revocation is permissive. Our regulations and policies establish criteria for issuing permissive sanctions, at least two of which were present in this case. First, the evidentiary record compiled by the Florida Board clearly established that the patient was harmed both physically and psychologically by the psychiatrist’s misconduct. Second, we determined that FEHBP enrollees had used this provider, and that he had received payment of FEHBP funds.

Psychiatrist Debarred after License Revoked for Patient Abuse

These factors reflected sufficiently serious risks to warrant debarment of the provider for an indefinite period, corresponding to the loss of his professional licensure. The debarment became effective in January 2005.



Suspensions

Suspensions have the same effect as debarments, but become effective immediately, without prior notice or process. The FEHBP sanctions statute and regulations authorize suspensions only in cases where reliable evidence indicates that a provider has committed a violation for which he could ultimately be debarred, and that he poses a risk to the health or safety of FEHBP enrollees.

Pediatrician Organizes Conspiracy to Defraud Health Insurance Carriers

A Memphis, Tennessee federal grand jury indicted a local pediatrician, two family members, and an associate on conspiracy, health care fraud, and money laundering charges in May 2004. For purposes of carrying out this scheme, the pediatrician established three corporations with herself as executive officer.

Two of them employed unqualified and unlicensed persons to perform physical therapy services. Moreover, a member of the pediatrician's family represented himself as a physician and "medical director" of the corporations,

Four Conspirators, Pediatric Clinic Suspended on Basis of Indictment for Health Care Fraud and Money Laundering

These two corporations billed federal health care programs for amounts exceeding \$7 million, and actually received improper payments of approximately \$3.5 million. The third corporation, ostensibly a medical consulting service,

although he did not hold a medical license and did not provide any guidance to the persons who were administering the physical therapy sessions.

in fact served as a conduit for distributing these illegal proceeds among the conspirators.

This case fully met the regulatory criteria for suspension. The indictment itself constitutes a finding of probable cause that the conspirators committed the crimes with which they were charged. If convicted, the pediatrician would be subject to mandatory debarment from FEHBP. Further, the scheme itself placed patients at risk by subjecting them to physical therapy procedures administered by unqualified personnel who were acting without professional supervision. Finally, the pediatrician, as a member of the PPO networks of several large FEHBP carriers, is likely to have significant contacts with FEHBP enrollees. Therefore, we suspended the pediatrician and the clinic which she owns and operates, effective in March 2005.

Dermatologist Indicted for Fraud and Conspiracy

In March 2005, a Boston area dermatologist was indicted by a federal grand jury on charges of money laundering, health care fraud, and obstruction of justice. This physician, who was nationally recognized as an expert on certain skin diseases, drew his patients from across the United States. He also owned and operated the dermatology clinic where he practiced. The indictment charged that, over a period of at least four years, he falsified laboratory reports and diagnoses of patients to justify administering expensive treatments for which he received a high rate of health insurance reimbursement.

In several of these cases, the patients did not have the disease for which they were treated, but were knowingly misdiagnosed by the physician so that he could obtain insurance payments that would not otherwise be authorized. He supported some of the misdiagnoses by actually mixing infected blood samples into



ADMINISTRATIVE SANCTIONS OF HEALTH CARE PROVIDERS

the blood tests of uninfected persons. It was estimated that the doctor obtained fraudulent payments in excess of \$5.4 million through this scheme.

This provider is a PPO network physician for at least three large FEHBP plans, and has received substantial payments of FEHBP funds. To date, none of these payments have been definitively linked with the scheme for which he was indicted. However, he created serious risks for individ-

Physician and Clinic Suspended after Indictment in \$5.4 Million Health Care Fraud

ually by administering unnecessary treatments and creating inaccurate tests and diagnoses. Further, the offenses with which he is charged would mandate his debarment from FEHBP upon conviction. Accordingly, we suspended the physician and his clinic, which he used as an instrument of his scheme.

Orthopedist and Clinic Suspended after Indictment on Drug Charges

In January 2005, a Chesapeake, Virginia orthopedist, his clinic, and his wife (who served as the clinic's office manager) were indicted in federal court on 91 counts of conspiracy, distribution of controlled substances, and drug trafficking resulting in death. The indictment noted that, although the physician practiced as an orthopedic surgeon, 90 percent of his clientele was comprised of persons seeking medication for "chronic pain." It charged that the doctor prescribed highly addictive controlled substances such as morphine, Oxycontin, and Dilaudid without a legitimate medical purpose.

Many patients visited the provider's clinic on a regular monthly basis to obtain prescriptions for large quantities of narcotics. He often issued prescriptions without examining patients, conducting diagnostic tests, or checking for signs of possible drug abuse. The indictment also charged that, within the preceding 18 months, four persons had died as the result of using controlled substances that the doctor had prescribed.

The Office of the Inspector General's investigative unit supported the Drug Enforcement Administration and local law enforcement authorities that conducted this investigation. They determined that, during the five year period preceding the doctor's indictment, the three largest FEHBP insurance carriers had paid him over \$166,000 in FEHBP funds. Consistent with the indictment, approximately 80 percent of this amount represented prescription drug claims, of which a significant portion had no corresponding claim for an office visit or other medical service.

Orthopedist, Spouse, and Clinic Indicted for Drug Trafficking and Conspiracy

We determined from these facts that the provider had improperly prescribed controlled substances to FEHBP enrollees. Therefore, we concluded that this doctor, and his clinic where the acts charged in his indictment took place, represented health and safety risks that warranted their immediate suspension.



AUDIT ACTIVITIES

SEMIANNUAL REPORT TO CONGRESS
October 1, 2004 – March 31, 2005

HEALTH AND LIFE INSURANCE CARRIER AUDITS

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

The OIG insurance audit universe contains approximately 260 audit sites, consisting of health insurance carriers, sponsors and underwriting organizations, as well as two life insurance carriers. The number of audit sites is subject to yearly fluctuations due to the addition of new carriers, non-renewal of existing carriers, or plan mergers and acquisitions. Annual premium payments are approximately \$27 billion.

The health insurance plans that our office is responsible for auditing are either community rated or experience-rated carriers.

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

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

The two types of carriers differ in the way they calculate premium rates. Community rated

carriers generally set their subscription 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 group's contract.

During the current reporting period, we issued 27 final reports on organizations participating in the FEHBP, of which 21 contain recommendations for monetary adjustments in the aggregate amount of \$32.4 million due the FEHBP.

A complete listing of all health plan audit reports issued during this reporting period can be found in Appendices III (page 30) and V (page 32).

COMMUNITY-RATED PLANS

Our community-rated HMO audit universe covers approximately 150 rating areas throughout the country. Community-rated audits are designed to ensure that plans charge the appropriate premium rates in



AUDIT ACTIVITIES

accordance with their respective contracts and applicable federal regulations.

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

These audits are conducted to determine if:

- The plans offer the FEHBP market price rates by selecting appropriate similar sized subscriber groups.
- The loadings to the FEHBP are reasonable and equitable.

Loading is the cost for additional benefits purchased by a group to enhance the basic benefits package for its members.

- The plans develop premium rates in accordance with the FEHBP laws and regulations.

During this reporting period, we issued 18 audit reports on community-rated plans. These reports contain recommendations to require the plans to return approximately \$11.3 million to the FEHBP.

HealthGuard of Lancaster, Inc.

Lancaster, Pennsylvania

Report No. 1C-NQ-00-03-057

December 23, 2004

HealthGuard of Lancaster, Inc. provides primary health care services to its members throughout southeastern and south central Pennsylvania. Our audit covered contract years 2000 through 2002. During this period, the FEHBP paid the plan approximately \$19.5 million in premiums.

In conducting the audit, we found that the FEHBP was overcharged a total of \$2,718,679 for inappropriate health benefit charges. We also determined that the FEHBP was due \$530,468 for lost investment income.

Inappropriate Health Benefit Charges Exceed \$2.7 Million

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

The FEHBP did not receive a rate discount equivalent to the largest discount the plan gave to one of the similarly sized subscriber groups in contract years 2000 through 2002. Moreover, the plan did not identify one of the correct SSSGs in 2000 and 2001. We also found in all three years that the FEHBP was rated using a different rating methodology than was used to rate the SSSGs. Finally, the Plan did not appropriately calculate the FEHBP’s benefit loadings.

We recalculated the FEHBP’s rates using the same methodology as was used to rate the SSSGs. We also adjusted the loadings to reflect the actual benefits purchased by the FEHBP. After making the above adjustments, we applied the largest discount granted to an SSSG to the FEHBP’s rates. Through this process, we found that the FEHBP was overcharged \$1,416,307 in 2000, \$1,169,153 in 2001, and \$133,219 in 2002.

The plan agreed with all questioned charges.



CareFirst BlueChoice, Inc.

Owings Mills, Maryland

Report No. 1C-2G-00-03-007

November 4, 2004

CareFirst BlueChoice, Inc. provides primary health care services to its members throughout Maryland, Northern Virginia, and Washington D.C. The audit covered contract years 2000 through 2002, during which time the FEHBP paid the plan approximately \$78 million in premiums.

Our audit identified \$2,901,265 in questioned costs for defective pricing and an additional \$279,617 for lost investment income.

In 2000 and 2001, CareFirst BlueChoice, Inc. did not provide the FEHBP the same premium rate discounts it gave to the two subscriber groups closest in size, and did not identify one of the correct SSSGs in those years. For all three audited years, numerous adjustments

Plan Agrees to Return Over \$3 Million to FEHBP

related to changes in benefit levels, numbers of enrollees, and claims paid had to be made to determine the rates

that should have been charged to the FEHBP. After applying the correct SSSG discounts for 2000 and 2001 to the recomputed FEHBP rates, we determined that the FEHBP was overcharged \$668,290 in 2000, \$215,290 in 2001, and \$2,017,685 in 2002.

The Plan agreed with these findings.

EXPERIENCE-RATED PLANS

The Federal Employees Health Benefits Program offers a variety of experience-rated plans, including fee-for-service plans, which constitute the majority of federal contracts in this plan category. Several experience-rated

plans are operated or sponsored by federal employee organizations.

The universe of experience-rated plans currently consists of approximately 110 audit sites. When auditing these plans, our auditors generally focus on three key areas:

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

During this reporting period, we issued eight experience-rated audit reports. In these reports, our auditors recommended that the plans return \$21 million in inappropriate charges and lost investment income to the FEHBP.

BlueCross BlueShield Service Benefit Plan

The BlueCross BlueShield Association (BCBS Association) administers a fee-for-service plan, which contracts with OPM on behalf of its member plans throughout the United States. The participating plans independently underwrite and process the health benefits claims of their respective federal subscribers and report their activities to the national BCBS operations center in Washington, D.C. Approximately 50 percent of all FEHBP subscribers are enrolled in BlueCross and BlueShield plans.

We issued seven BlueCross and BlueShield experience-rated reports during the reporting period. Our auditors noted \$20.9 million in questionable contract costs charged to the FEHBP including lost investment income on these questioned costs. The BCBS Association has agreed with \$16 million.



AUDIT ACTIVITIES

Global Coordination of Benefits for BlueCross and BlueShield Plans

Report No. 1A-10-00-03-102

November 9, 2004

We performed a limited-scope audit to determine whether the Blue Cross and Blue Shield plans complied with contract provisions relative to coordination of benefits (COB) with Medicare.

Coordination of benefits is required 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.

The auditors using our data warehouse screened the BCBS national claims database to identify claims for services rendered prior to October 1, 2000 that were not coordinated with Medicare. We determined that 54 of the 55 plans reviewed did not properly coordinate their claim charges. As a result, the FEHBP

BCBS Association Agrees with \$10.9 Million for Uncoordinated Benefit Claims

incorrectly paid as the primary insurer for these claims.

For 16,554 of the questioned claims, there was no information in the BCBS

Association's national claims system to identify Medicare as the primary payer when the claims were paid. Moreover, even when BCBS later added Medicare information to its system, the plans did not adjust the patients' prior claims retroactive to their Medicare effective dates. Consequently, these costs continued to be charged to the FEHBP in their entirety.

We estimated that the FEHBP was overcharged \$11,805,906 for these COB errors. The BCBS Association agreed with \$10,964,942 and disagreed with \$840,964 of the questioned claim overcharges.

Anthem BlueCross and BlueShield of Kentucky

Mason, Ohio and Indianapolis, Indiana

Report No. 1A-10-45-03-012

November 17, 2004

Our audit of the FEHBP operations at Anthem BlueCross and BlueShield of Kentucky addressed health benefit payments, miscellaneous payments and credits, and cash management activities for contract years 1999 through 2001. During the audited period, the plan paid \$229 million in FEHBP claims.

Auditors Determine Nearly \$3 Million Owed the FEHBP

Our auditors determined that inappropriate charges to the FEHBP totaled \$2,970,719, as follows:

- \$2,184,970 for claims not priced in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), which limits benefit payments for certain inpatient services provided to annuitants age 65 and older who are not covered under Medicare Part A;
- \$695,766 in other claim payment errors; and,
- \$89,983 for unreturned audit recoveries.

The BCBS Association agreed with \$622,993 of the questioned charges related to the other claim payment errors and the unreturned audit recoveries. The BCBS Association also agreed with the OBRA 90 claim payment errors, but did not provide any information regarding the overcharge amount. Lost investment income on the questioned charges totaled \$3,782.



INFORMATION SYSTEMS AUDITS

Computer-based information systems have become increasingly important to the Office of Personnel Management as the means of carrying out its programs efficiently and accurately. We perform information systems audits of health and life insurance carriers that participate in the Federal Employees Health Benefits Program and the Federal Employees' Group Life Insurance program, and audit elements of OPM's computer security environment.

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

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

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

Application controls 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.

Information Systems General and Application Controls at Health Care Service Corporation

Chicago, Illinois and Abilene and Richardson, Texas

Report No. 1A-99-00-04-015

January 19, 2005

Health Care Service Corporation (HCSC), a licensee of the BlueCross BlueShield Association, is the umbrella organization for the BlueCross BlueShield plans of Texas, Illinois, and New Mexico.

Our auditors reviewed general and application controls associated with the claims systems and evaluated HCSC's compliance with the privacy, security, and electronic transactions requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We also examined the confidentiality, integrity, and availability of HCSC's computer-based information systems.

We determined that HCSC had made significant progress toward complying with HIPAA requirements, and had a number of security controls that helped promote a secure computer environment, including:

- Controls over the configuration and administration of the mainframe operating platform and access control software;



AUDIT ACTIVITIES

- Adequate policies and procedures in place to ensure that system access is appropriately authorized and monitored; and,
- Adequate application development and program change controls.

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

- Implement a formal risk assessment methodology;
- Approve and implement its “Corporate Incident Response Policy;”
- Update its personnel policies and procedures to require rotation of duties and periodic background reinvestigations;
- Continue working towards implementing the Security Awareness Program;
- Implement a policy on continuing professional education for those employees with specialized security responsibilities;

- Update its business continuity and disaster recovery plans;
- Review its current medical edit software to ensure that it is effectively identifying claims with billing irregularities;
- In cooperation with the Blue Cross Blue Shield Association, review and revise, as appropriate, its claims pricing methodology of OBRA 90 claims; and,
- Implement system changes to ensure that pre-certification rules are properly enforced at all times.

Plan Agrees with OIG Recommendations to Improve Information Systems Controls

HCSC officials have agreed to carry out our recommendations.



COMBINED FEDERAL CAMPAIGN

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

CFC campaigns are identified by geographical areas that can be defined as a single city, or several cities or counties. Our auditors review the eligibility of participating charities associated with a given campaign and the charities' compliance with federal regulations and OPM guidelines. In addition, all CFC organizations are required by regulation to have an independent public accounting firm (IPA) audit their respective financial activities for each campaign year. As part of our audits, we review the IPA reports.

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

A total of 313 local campaigns operating in the United States and overseas participated in the 2004 Combined Federal Campaign. For that year, federal employee contributions reached \$256,919,778, while campaign expenses totaled \$24,824,383.

During this reporting period we issued seven audit reports on local CFCs and one report on national charitable federations that participated in the CFC.

Local CFC Audits

The local organizational structure consists of:

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



2001 and 2002 Combined Federal Campaigns for Maricopa County

Phoenix, Arizona

Report No. 3A-CF-00-04-040
January 11, 2005

The Valley of the Sun United Way, located in Phoenix, Arizona, served as the PCFO for the 2001 and 2002 CFCs for Maricopa County. In each year, the campaign received approximately \$1.4 million in pledges. Administrative expenses were \$87,000 for 2001 and \$93,000 for 2002.

Our audit identified eight instances of violations of CFC regulations, including:

- The LFCC did not maintain documentation to detail the solicitation timeframes for the campaigns or the procedures used in the appeal process to allow denied agencies to resubmit their eligibility applications.
- The PCFO used investment income to partially offset budgeted expenses, instead of applying for reimbursement from campaign funds. This caused campaign expenses to be underreported in the PCFO applications for the 2001 and 2002 campaigns.

Auditors Cite Violations of CFC Regulations

- Local applications for both federations and independent charities did not comply with all eligibility requirements contained in the CFC regulations.
- The PCFO's 2002 application did not affirm that the applicant would abide by the directions, decisions or supervision of the Director of OPM, and that it would be subject to the CFC regulations that govern penalties and sanctions.

- The PCFO's IPA did not complete its review of pledge cards for the 2001 campaign, as required by the 2003 CFC Audit Guide.

National Charitable Federation Audits

We also audit national charitable federations that participate in the CFC. National federations provide services to other charities with similar missions. Our audits of the national federations focused on the eligibility of member charities, distribution of funds and allocation of expenses.

2001 and 2002 Combined Federal Campaign Activities of United Way of America

Alexandria, Virginia

Report No. 3A-CF-00-03-054
November 9, 2004

This audit report documented numerous instances where United Way of America (UWA) did not fulfill its responsibilities as a national federation. CFC regulations require federations to certify member applications for campaign eligibility, act as a fiscal agent for its members, and assure that donor designations are honored.

Our auditors found that UWA:

- Could not document that it made payments to all member agencies that the auditors selected for review;
- Failed to prove that it deposited all of the funds received from 18 PCFO's into the CFC account;

Federation Found Lacking Procedures and Controls Required by OPM Regulations



- Improperly made distributions to agencies that were not members of its federations; and,
- Incorrectly certified that eight out of a sample of 15 member agencies, from each campaign, met all eligibility requirements.

Based on these issues, we concluded that the UWA lacked the procedures and controls needed to perform effectively as a federation. We recommended that OPM ensure that UWA resolve the weaknesses identified by the audit. If UWA fails to take appropriate corrective action, we further recommended that OPM take steps to decertify it as a federation.



OPM INTERNAL AUDITS

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

OPM'S CONSOLIDATED FINANCIAL STATEMENTS AUDITS

OPM's consolidated financial statements include the retirement, health and life insurance benefit programs, the revolving fund (RF) and the salaries and expenses accounts (S&E). The 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 RF resources are not derived from congressionally-appropriated funds, but rather from reimbursements paid to OPM by other federal agencies. The S&E accounts, which represent congressionally-appropriated funds, cover the costs of administering the operations of the agency.

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

KPMG also reports on OPM's internal control efforts related to financial reporting and OPM management's compliance with laws and regulations that could have a material impact on the presentation of the financial statement amounts.

We monitor KPMG's performance of these audits to ensure that they are conducted in accordance with the terms of the contract and in compliance with government auditing standards (GAS) and other authoritative references, such as OMB Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*. Specifically, we are involved in the planning, performance and reporting phases of the audit through participation in key meetings, discussion of audit issues, and reviewing KPMG's work papers and reports. Our review of the FY 2004 and FY 2003 audit disclosed no instances where KPMG did not comply, in all material respects, with the contract or GAS.

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

During FY 2004, OMB modified its audit requirements to mandate an opinion on the closing package within three days after the consolidated financial statement audit due date. KPMG performed the audit of the closing package to obtain reasonable assurance that it was free of material misstatement.



**OPM’s FY 2004 and 2003
Consolidated Financial
Statements**

Report No. 4A-CF-00-04-030
November 15, 2004

KPMG audited OPM’s FY 2004 and FY 2003 consolidated financial statements. KPMG also performed audits of the individual benefits programs financial statements, including:

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

**Consolidated & Benefits Programs
Financial Statements**

KPMG determined that the FY 2004 and 2003 consolidated financial statements and individual statements were presented fairly in all material respects and were prepared in conformance with generally accepted accounting principles.

**OPM’s Financial
Statements
Receive “Clean”
Audit Opinion**

KPMG noted four reportable conditions in the internal controls in the various program areas (see left column of Table 1 on the following page). Three of these conditions existed in the prior year and remained uncorrected, one of which KPMG considered a material weakness in FY 2004.

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

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

Table 1 (see page 18) displays the reportable conditions that KPMG identified during its audit work on the FY 2004 financial statements. KPMG reported no instances of non-compliance that must be reported under government auditing standards or OMB requirements.

**KPMG Reports One
Material Weakness
Affecting Two
Program Areas**

Closing Package

KPMG determined that the closing package fairly presents, in all material respects, the financial position of OPM as of September 30, 2004. They noted one reportable condition related to internal control over the financial reporting process. The OCFO did not document accurate crosswalks between its general ledger accounts and the United States Standard General Ledger for each of the financial statements required for the Treasury closing package. In addition, OPM accounting staff did not perform a comprehensive review of the Treasury closing package information prior to submitting it to OPM management.



AUDIT ACTIVITIES

TABLE 1: FY 2004 INTERNAL CONTROL WEAKNESSES

	CSRS/ FERS	FEHBP	FEGLI	Revolving Fund	Salaries & Expenses Accounts
Information Systems General Control Environment	Reportable Condition	Reportable Condition	Reportable Condition	Reportable Condition	Reportable Condition
Managerial Cost Accounting to Determine Full Cost Associated with Strategic Goals and Major Outcomes	No Reportable Condition	No Reportable Condition	No Reportable Condition	Reportable Condition	Reportable Condition
Segregation of Duties Over the Letter of Credit System for the Experience-Rated Carriers	Not Applicable	Reportable Condition	Not Applicable	Not Applicable	Not Applicable
Financial Management and Reporting Processes of Office of the CFO (OCFO)	No Reportable Condition	No Reportable Condition	No Reportable Condition	Material Weakness	Material Weakness

GOVERNMENT PERFORMANCE AND RESULTS ACT AUDITS

The Results Act was enacted to improve government performance and accountability through better planning and reporting of agency results. The Results Act seeks to improve the efficiency, effectiveness, and public accountability of federal agencies, as well as the information used for congressional decision-making.

Each agency is required under the Results Act to develop five-year strategic plans, annual performance plans and annual performance reports. These requirements create a recurring cycle, beginning with setting a strategic direction, followed by defining annual goals and measures, and, finally, reporting on performance.

The OPM Strategic Plan 2002-2007 was issued in November 2002. The strategic plan provides the framework for implementing the

Results Act. OPM implements its strategic plan through an annual performance plan that includes goals and measures for key program offices. OPM describes its achievement of the goals and measures through the annual performance report.

OPM's FY 2003 Annual Performance Data Report No. 4A-CF-00-03-113 October 5, 2004

During FY 2003, OPM implemented an agencywide restructuring effort, and realigned its performance plan accordingly. This involved establishing new agency performance measures. The objectives of this audit were to determine the accuracy and reliability of performance data for selected FY 2003 performance measures and to evaluate the effectiveness of controls over that data. We selected 30 per



formance measures to verify and validate from the following major OPM offices:

- Human Capital Leadership and Merit System Accountability
- Strategic Human Resources Policy
- Human Resources Products and Services
- Management and Chief Financial Officer.

Our auditors found that OPM needs to improve controls over the performance reporting process by:

- Developing policies and procedures to obtain and compile performance data for some program performance measures;
- Improving oversight over program performance data; and,
- Maintaining documentation to support performance results.

Recommendations Made to Improve Controls Over Performance Reporting

OPM management has taken steps to implement the improvements cited in our audit recommendations.

OTHER INTERNAL PERFORMANCE AUDITS

**Internal Controls over Non-Recurring Payment Actions in the Retirement Services Program
Report No. 4A-RI-00-02-071
November 2, 2004**

In a joint effort with the Center for Retirement and Insurance Service's (CRIS) Quality Assur-

ance Group, we conducted a review of the internal controls over the calculation and payment authorization for non-recurring payment actions (NRPAs).

NRPAs are one-time payments made to federal annuitants or their survivors that provide immediate retroactive benefits or adjustments to regular annuity benefits.

This review was initiated in response to the discovery of offenses in which three OPM employees authorized fraudulent NRPAs and shared in almost \$4 million in illegal proceeds. Our investigators obtained 17 convictions for fraud in these cases. The joint review addressed concerns that processing procedures and the automated systems lacked adequate internal controls to identify and prevent this type of fraud.

Six Recommendations to Identify and Prevent Future Fraudulent Activity

We made the following recommendations to improve OPM's controls over NRPA activity:

- Evaluate each employee's authority to process NRPAs;
- Develop appropriate reports for review of unusual NRPA activity;
- Update the policies and procedures for NRPA transactions;
- Provide employees with the appropriate guidance on access, use, documentation and authorization;
- Review employees' work on a regular basis; and,
- Reiterate the agency's policy on employee misconduct.



INVESTIGATIVE ACTIVITIES

SEMIANNUAL REPORT TO CONGRESS
October 1, 2004 – March 31, 2005

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

The OIG's investigative activities produced significant results during the reporting period. We opened 96 investigations and closed 21, with 190 still in progress at the end of the period. Our investigations led to nine arrests, 10 indictments, six convictions and monetary recoveries totaling \$1,616,989. For a complete statistical summary of our office's investigative activity in this reporting period, refer to Table 2 on page 26.

HEALTH CARE FRAUD

Health care fraud is the single largest area of investigations by our office. These cases are often time-consuming and complex, and may involve several health care providers who are defrauding multiple health insurance plans. They are critical to protecting federal employees, annuitants, and members of their families who are eligible to participate in the FEHBP.

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

level, we are participating members of DOJ's health care fraud working groups. We also work with U.S. Attorney's offices nationwide to focus investigative resources in areas where fraud is most common.

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

Outpatient Surgical Facility Billed the FEHBP for Unnecessary Surgical Procedures

In June 2003, our office became involved in a joint investigation with the Federal Bureau of Investigation (FBI) of an outpatient surgical facility located in southern California. The



INVESTIGATIVE ACTIVITIES

allegations, first reported by the FEHBP's Mail Handlers Benefits Plan, claimed that the facility solicited patients to have unnecessary diagnostic and invasive surgical procedures in exchange for cash or cosmetic procedures.

The two-year investigation determined that the owner and at least three employees of the facility recruited patients with cash payments of up to \$1,000 and free cosmetic surgeries. In exchange, the patients agreed to undergo multiple unnecessary procedures. The facility billed the patient's health insurance in amounts up to ten times the usual and customary fee.

Employees of Outpatient Surgical Center Indicted for Health Care Fraud

In October 2004, a federal grand jury in the Central District of California returned a 16 count indictment, charging the owner and three employees of the facility with fraud, conspiracy, and perjury. Based on the charges in the indictment, the OIG debaring official suspended these individuals, as well as the facility itself, from participating in the FEHBP.

We will track the progress of this case in future reports.

Retired Federal Employee Pleads Guilty to Defrauding the FEHBP

In June 2003, our office received a complaint from the BlueCross BlueShield Association's (BCBSA) anti-fraud unit. The allegations suggested that a retired federal employee in Los Angeles, California had received up to 50 times the FDA approved dosage of a steroidal medication known as Serostim from 1999 to 2001. Serostim is usually prescribed to patients with an HIV related illness, but has recently become popular with body builders. However, its use for such purposes is illegal. In

addition, BCBSA alleged that many of the prescriptions may have been forged by the retired federal employee.

Our joint investigation with the FBI determined that the retired Federal employee had fraudulently obtained or forged several prescriptions for Serostim as well as other medications. These actions cost the FEHBP over \$350,000 in improper payments. We also found that the subject of our investigation had fraudulently obtained medical benefits from California's Medicaid program, and subsequently received approximately \$50,000 in reimbursements for the same medications through his FEHBP prescription drug benefit.

In February 2005, the subject agreed to plead guilty to two counts of health care fraud.

This case is being prosecuted in the federal Central District of California. We will track the progress of this case in future semiannual report.

Retired Federal Employee Admits to Prescription Drug Fraud Costing the FEHBP over \$350,000

Neurologist and Wife Guilty of Health Care Fraud

As previously noted in the Administrative Sanctions section of this report, in September 2003, a federal grand jury in Alexandria, Virginia, indicted a neurologist, who owned two northern Virginia clinics, along with his wife, who worked as the office manager. They were each charged with one count of conspiracy to commit health care fraud and 61 counts of health care fraud, in a scheme involving inflated invoices and claims for services not rendered.

In November 2004, the doctor and his wife were found guilty of conspiracy and health care fraud. In February 2005, they were



sentenced to 41 months incarceration and ordered to pay approximately \$500,000 in restitution.

The OIG debaring official suspended the physician and his wife from the FEHBP at the time of their indictment, and debarred them for eight years on the basis of their conviction.

Physician and Wife Sentenced to 41 Months Imprisonment and \$500,000 in Restitution

As we noted in a prior edition of our semiannual report, this case was a joint investigation with the FBI, the Department of Health and Human

Services Office of Inspector General, the Defense Criminal Investigative Service, and the Postal Inspection Service.

RETIREMENT FRAUD

We proactively identify retirement fraud by reviewing annuity records to discover payments to individuals who have greatly exceeded normal life expectancy. Using automated data systems available to law enforcement agencies, we screen the list of older annuitants to identify persons that may be deceased but to whom annuity benefits are continuing to be paid. We confirm the accuracy of the information through follow-up inquiries. When we determine that someone other than the intended recipient has used the annuity funds, we initiate a full investigation.

We also receive information from our agency's Center for Retirement and Insurance Services through the computer matches it performs using OPM's annuity rolls and the Social Security Administration's death records to identify payments to deceased federal annuitants. These computer matches have proven very helpful to OPM since many annuitants or those receiving survivor benefits may also be eligible for Social Security benefits.

Annuitant's Daughter Sentenced for Retirement Fraud

In a previous semiannual report, we noted that the daughter of a deceased annuitant was indicted by a federal grand jury in Los Angeles, California for retirement fraud. She had failed to report her mother's death in 1993 and diverted the annuity payments to her own use. In January 2005, she was sentenced to five years probation, 100 hours of community service, and ordered to make full restitution in the amount of \$100,766.

Court Orders Five Years Probation and Restitution of Over \$100,000

Daughter Pleads Guilty in Retirement Fraud Case

In December 2004, the daughter of a Civil Service Retirement System annuitant pleaded guilty to embezzlement in the U.S. District Court for the Southern District of Alabama. She failed to report her mother's death in 1985 and continued to collect her mother's civil service and veteran's benefits. In March 2005, the daughter was sentenced to 33 months imprisonment, 3 years supervised probation, \$200 special assessment (\$100 per count), and restitution of \$124,881 to the OPM retirement annuity trust fund. This case was jointly investigated by the U.S. Department of Veterans' Affairs OIG and our office.

Daughter Sentenced to 33 Months Imprisonment and Restitution of \$125,000



INVESTIGATIVE ACTIVITIES

OPM EMPLOYEE INTEGRITY

Annuitant Pleads Guilty to Retirement Fraud

We previously reported on a joint investigation with the FBI, which found that two OPM retirement benefits specialists had conspired with a number of federal annuitants to misappropriate money from OPM's retirement trust fund. The six year scheme involved the payment of almost \$4 million in fraudulent federal retirement benefits.

In March 2003, an annuitant who was the seventeenth and final person involved in the scheme pleaded guilty in the U.S. District Court in Maryland in connection with

her receipt of over \$430,000 in survivor annuity payments from the Civil Service Retirement Fund. She was charged with conspiracy to defraud the United States, receiving stolen

Annuitant Admits to Theft of More Than \$430,000 from Retirement Trust Fund

government funds, and payment of bribes to government employees. Sentencing is scheduled for May 2005.

OIG HOTLINES AND COMPLAINT ACTIVITY

OIG's health care fraud hotline, retirement and special investigations hotline, and mailed-in complaints also contribute to identifying fraud and abuse. We received 507 formal complaints and calls on these hotlines during the reporting period. Additional information, including specific activity breakdowns for each hotline, can be found in Table 2 on page 26.

The information we receive on our OIG hotlines is generally concerned with FEHBP

health care fraud, retirement fraud and other complaints that may warrant special investigations. Our office receives inquiries from the general public, OPM employees, contractors and others interested in reporting waste, fraud and abuse within OPM and the programs it administers.

In addition to hotline callers, we receive information from individuals who report through the mail or have direct contact with our investigators. Those who report information can do so openly, anonymously and confidentially without fear of reprisal.

Retirement Fraud and Special Investigations Hotline

The Retirement and Special Investigations hotline provides a channel for reporting waste, fraud and abuse within the agency and its programs. During this reporting period, this hotline received a total of 154 contacts, including telephone calls, letters, and referrals from other agencies.

Health Care Fraud Hotline

The primary reason for establishing an OIG hotline was to handle complaints from subscribers in the Federal Employees Health Benefits Program. The hotline number is listed in the brochures for all the health insurance plans associated with the FEHBP, as well as on our OIG Web site at www.opm.gov/oig.

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



The Health Care Fraud hotline received 353 complaints during this reporting period, including both telephone calls and letters.

OIG-INITIATED COMPLAINTS

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

An example of a complaint that our office will initiate involves retirement fraud. When

information generated by OPM's automated annuity roll systems reflect irregularities such as questionable payments to annuitants, we determine whether there are sufficient grounds to justify an investigation. At that point, we may initiate personal contact with the annuitant to determine if further investigative activity is warranted.

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



INVESTIGATIVE ACTIVITIES

TABLE 2: INVESTIGATIVE ACTIVITY

Judicial Actions:

Arrests.....	9
Indictments.....	10
Convictions.....	6

Judicial Recoveries:

Fines, Penalties, Restitutions and Settlements	\$1,616,989
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Retirement and Special Investigations Hotline and Complaint Activity:

Retained for Further Inquiry.....	15
Referred to:	
OIG Office of Audits	0
OPM Program Offices.....	87
Other Federal Agencies	52
Total	154

Health Care Fraud Hotline and Complaint Activity:

Retained for Further Inquiry.....	94
Referred to:	
OPM Program Offices.....	62
Other Federal/State Agencies	65
FEHBP Insurance Carriers or Providers.....	132
Total	353

Total Hotline Contacts and Complaint Activity	507
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STATUTORY AND REGULATORY REVIEW

SEMIANNUAL REPORT TO CONGRESS

October 1, 2004 – March 31, 2005

Our office monitors and reviews legislative and regulatory proposals for their impact on the Office of the Inspector General and the Office of Personnel Management's programs and operations. Our reviews focus on the impact of these proposals in encouraging economy and efficiency and preventing fraud, waste, and mismanagement. We also monitor legal issues that have a broad effect on the Inspector General community governmentwide and, through testimony and other communications, inform Congress of our interests and concerns.

As part of our legislative review responsibilities, we work closely with OPM's Office of Congressional Relations, which refers legislation and congressional requests for comments directed to the agency to our office. In such instances, we may either ask for the agency to include our perspective within its comments or, more frequently, we send separate comments. We also participate in consideration of legislative matters through the President's Council

on Integrity and Efficiency, particularly through its Legislation Committee.

Although OPM's Office of Congressional Relations and the PCIE Legislative Committee referred several legislative matters to our office for review during this reporting period, we determined that none of them had a direct impact on inspectors general or impact on our operations as to warrant comment.



INDEX OF REPORTING REQUIREMENTS

(Inspector General Act of 1978, As Amended)

Section 4 (a) (2):	Review of legislation and regulations	No Activity
Section 5 (a) (1):	Significant problems, abuses, and deficiencies.....	2-24
Section 5 (a) (2):	Recommendations regarding significant problems, abuses, and deficiencies	7-19
Section 5 (a) (3):	Recommendations described in previous semiannual reports on which corrective action has not been completed	17
Section 5 (a) (4):	Matters referred to prosecutive authorities.....	21-24
Section 5 (a) (5):	Summary of instances where information was refused during this reporting period.....	No Activity
Section 5 (a) (6):	Listing of audit reports issued during this reporting period.....	30-33
Section 5 (a) (7):	Summary of particularly significant reports.....	7-24
Section 5 (a) (8):	Audit reports containing questioned costs.....	29-31
Section 5 (a) (9):	Audit reports containing recommendations for better use of funds	No Activity
Section 5 (a) (10):	Summary of unresolved audit reports issued prior to the beginning of this reporting period	29
Section 5 (a) (11):	Significant revised management decisions during this reporting period	No Activity
Section 5 (a) (12):	Significant management decisions with which OIG disagreed during this reporting period	No Activity



APPENDICES

SEMIANNUAL REPORT TO CONGRESS
October 1, 2004 – March 31, 2005

APPENDIX I FINAL REPORTS ISSUED WITH QUESTIONED COSTS October 1, 2004 to March 31, 2005

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	14	\$32,389,058
B. Reports issued during the reporting period with findings	21	32,368,006
Subtotals (A+B)	35	64,757,064
C. Reports for which a management decision was made during the reporting period:	19	43,218,344
1. Disallowed costs		41,178,719
2. Costs not disallowed		2,039,625
D. Reports for which no management decision has been made by the end of the reporting period	16	21,538,720
Reports for which no management decision has been made within 6 months of issuance		

APPENDIX II FINAL REPORTS ISSUED WITH RECOMMENDATIONS FOR BETTER USE OF FUNDS October 1, 2004 to March 31, 2005

No activity during this reporting period



APPENDICES

APPENDIX III INSURANCE AUDIT REPORTS ISSUED October 1, 2004 to March 31, 2005

Report Number	Standard Audits	Issue Date	Questioned Costs
1C-X8-00-03-024	HealthKeepers, Inc. in Richmond, Virginia	October 8, 2004	\$109,260
1A-10-70-04-021	Premera BlueCross in Mountlake Terrace, Washington	October 19, 2004	1,963,887
1C-2G-00-03-007	CareFirst Blue Choice, Inc. in Owings Mills, Maryland	November 4, 2004	3,180,882
1A-10-00-03-102	Global Coordination of Benefits (Tier 2) for BlueCross and BlueShield Plans in Washington, D.C.	November 9, 2004	11,805,906
1C-Q8-00-04-008	Univera HealthCare in Buffalo, New York	November 15, 2004	437,049
1A-10-45-03-012	Anthem BlueCross BlueShield of Kentucky in Mason, Ohio and Indianapolis, Indiana	November 17, 2004	2,970,719
1A-10-06-03-033	CareFirst BlueCross BlueShield of Maryland in Owings Mills, Maryland	December 1, 2004	1,918,379
1C-KR-00-04-005	BlueCare Network of Michigan in Southfield, Michigan	December 3, 2004	517,225
1A-10-55-04-010	Independence BlueCross in Philadelphia, Pennsylvania	December 15, 2004	1,171,851
1D-FX-00-04-001	Health Alliance Medical Plans, Inc. in Urbana, Illinois	December 20, 2004	105,119
1C-GA-00-04-004	MVP Health Plan of the Eastern Region in Schenectady, New York	December 21, 2004	690,797
1C-K9-00-04-006	PacifiCare of Nevada in Phoenix, Arizona	December 23, 2004	143,403
1C-NQ-00-03-057	HealthGuard of Lancaster, Inc. in Lancaster, Pennsylvania	December 23, 2004	3,249,147



APPENDIX III
INSURANCE AUDIT REPORTS ISSUED
October 1, 2004 to March 31, 2005

(Continued)

Report Number	Standard Audits	Issue Date	Questioned Costs
1A-10-62-04-003	Anthem BlueCross BlueShield of Virginia in Richmond, Virginia	January 4, 2005	\$828,279
1C-F8-00-04-057	Kaiser Foundation Health Plan of Georgia, Inc. in Atlanta, Georgia	January 5, 2005	
1C-KA-00-04-095	OmniCare Health Plan in Detroit, Michigan	January 12, 2005	866,098
1C-WJ-00-04-014	Group Health Cooperative of South Central Wisconsin in Madison, Wisconsin	February 2, 2005	914,779
1C-9T-00-04-017	CIGNA HealthCare of California, Inc. in Santa Ana, California	February 22, 2005	
1C-UR-00-04-083	Humana Health Care of Texas in Louisville, Kentucky	February 23, 2005	
1C-27-00-03-010	Health Net of Pennsylvania, Inc. in Woodland Hills, California	February 23, 2005	377,456
1A-10-82-04-028	BlueCross BlueShield of Kansas in Topeka, Kansas	March 1, 2005	270,687
1C-ED-00-04-016	Keystone Health Plan East in Philadelphia, Pennsylvania	March 15, 2005	
1C-6U-00-04-035	FIRSTCARE – Central Texas in Austin, Texas	March 29, 2005	770,435
1C-CK-00-04-034	FIRSTCARE – West Texas in Austin, Texas	March 29, 2005	20,204
1C-DP-00-03-009	Health Net of Connecticut, Inc. in Shelton, Connecticut	March 31, 2005	56,444
1C-SG-00-05-007	Capital District Physician's Health Plan, Inc. in Albany, New York	March 31, 2005	
TOTALS			\$32,368,006



APPENDICES

APPENDIX IV INTERNAL AUDIT REPORTS ISSUED October 1, 2004 to March 31, 2005

Report Number	Subject	Issue Date
4A-CF-00-03-113	Office of Personnel Management's Fiscal Year 2003 Annual Performance Data	October 5, 2004
4A-RI-00-02-071	Internal Controls over Non-Recurring Payment Actions in the Retirement Services Program	November 2, 2004
4A-CF-00-04-030	Office of Personnel Management's Fiscal Year 2004 Consolidated Financial Statements	November 15, 2004

APPENDIX V INFORMATION SYSTEMS AUDIT REPORTS ISSUED October 1, 2004 to March 31, 2005

Report Number	Subject	Issue Date
1A-99-00-04-015	Information Systems General and Application Controls at Health Care Service Corporation in Chicago, Illinois, and Abilene and Richardson, Texas	January 19, 2005



APPENDIX VI
COMBINED FEDERAL CAMPAIGN AUDIT REPORTS ISSUED
October 1, 2004 to March 31, 2005

Report Number	Subject	Issue Date
3A-CF-00-03-054	The 2001 and 2002 Combined Federal Campaign Activities for the United Way of America, in Alexandria, Virginia	November 9, 2004
3A-CF-00-04-037	The 2001 and 2002 Combined Federal Campaigns for Lake County, Illinois in Gurnee, Illinois	November 22, 2004
3A-CF-00-03-051	The 2000 and 2001 Combined Federal Campaigns for South Hampton Roads in Norfolk, Virginia	December 29, 2004
3A-CF-00-03-083	The 2000 and 2001 Combined Federal Campaigns for the Heart of Alabama in Montgomery, Alabama	January 7, 2005
3A-CF-00-04-040	The 2001 and 2002 Combined Federal Campaigns for Maricopa County in Phoenix, Arizona	January 11, 2005
3A-CF-00-03-046	The 2000 and 2001 Combined Federal Campaigns for the Central Virginia Area in Richmond, Virginia	January 31, 2005
3A-CF-00-04-046	The 2002 Combined Federal Campaign for King County in Seattle, Washington	February 23, 2005
3A-CF-00-04-036	The 2001 and 2002 Combined Federal Campaigns for Okaloosa-Walton Counties in Walton Beach, Florida	March 1, 2005

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