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**U.S. OFFICE OF PERSONNEL MANAGEMENT  
OFFICE OF THE INSPECTOR GENERAL  
OFFICE OF INVESTIGATIONS**

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# Quarterly Case Summaries

**Investigative Activities**

**Fiscal Year 2020**

**Second Quarter**

**January 1, 2020 – March 31, 2020**

**Issued: July 2020**

**-- Caution --**

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## List of Acronyms

<b>CSRS</b>	<b>Civil Service Retirement System</b>
<b>DOJ</b>	<b>U.S. Department of Justice</b>
<b>FBI</b>	<b>Federal Bureau of Investigation</b>
<b>FDA</b>	<b>U.S. Food and Drug Administration</b>
<b>FEDVIP</b>	<b>Federal Employees Dental and Vision Insurance Programs</b>
<b>FEGLI</b>	<b>Federal Employees' Group Life Insurance</b>
<b>FEHBP</b>	<b>Federal Employees Health Benefits Program</b>
<b>FEI</b>	<b>The Federal Executive Institute</b>
<b>FERS</b>	<b>Federal Employees Retirement System</b>
<b>FFS</b>	<b>Fee-for-Service</b>
<b>HHS</b>	<b>U.S. Department of Health and Human Services</b>
<b>HMO</b>	<b>Health Maintenance Organization</b>
<b>NBIB</b>	<b>National Background Investigations Bureau</b>
<b>OCFO</b>	<b>OPM Office of the Chief Financial Officer</b>
<b>OCIO</b>	<b>OPM Office of the Chief Information Officer</b>
<b>OIG</b>	<b>OPM Office of the Inspector General</b>
<b>OPM</b>	<b>U.S. Office of Personnel Management</b>
<b>OSC</b>	<b>U.S. Office of the Special Counsel</b>
<b>RICO</b>	<b>Racketeer Influenced and Corrupt Organizations Act</b>
<b>ROI</b>	<b>Report of Investigation</b>

## Overview of OPM Programs and Activities

**OPM-administered Federal Retirement Programs** include two primary Federal defined-benefit retirement plans: the **Civil Service Retirement System (CSRS)**, which covers employees hired by the Federal Government between 1920 and 1986, and the **Federal Employees Retirement System (FERS)**, which covers employees hired after 1987. These plans provide monthly annuities based on a Federal Government retiree's service. Additionally, **OPM Disability Retirement** allows for FERS-eligible Federal employees who become disabled to collect benefits.

**The Federal Employees Dental and Vision Insurance Programs (FEDVIP)** make supplemental dental and vision insurance available to Federal employees and retirees who are eligible for Federal employment benefits. FEDVIP operates on an enrollee-pay-all basis and creates a group pool that allows for competitive premiums and no preexisting condition limitations.

**The Federal Employees' Group Life Insurance (FEGLI)** program is the largest group life insurance program in the world, covering over 4 million Federal employees and retirees, as well as many of their family members. It provides a standard group term life insurance as well as elective coverage options.

**The Federal Employees Health Benefits Program (FEHBP)** provides health insurance to Federal employees, retirees, and their dependents. It is the largest employer-sponsored health insurance program in the world and administers benefit payments within a universe of over 200 health plans, including health maintenance organizations (HMOs) and fee-for-service (FFS) health plans from a number of private health insurance carriers.

**The Federal Executive Institute (FEI)** is part of OPM's Center for Leadership Development and offers learning and ongoing leadership development for senior leaders through classes and programs to improve the performance of Government agencies.

**The Combined Federal Campaign (CFC)** is the world's largest and most successful annual workplace charity campaign. It raises millions of dollars each year through pledges made by Federal current and retired civilian, postal, and military donors during the campaign season. These pledges support eligible nonprofit organizations.

**The National Background Investigations Bureau (NBIB)**, a former OPM bureau, conducted background investigations of Federal job applicants, employees, members of the armed services, and contractor personnel for suitability and security purposes. NBIB and its functions were transferred to the Department of Defense on October 1, 2019, and it is now the Defense Counterintelligence and Security Agency. Background investigators submitted their findings from interviews and other background work in **Reports of Investigation (ROIs)**.

**The OPM OIG Hotline** is mandated by the Inspector General Act of 1978, as amended, and helps ensure the proper and efficient use of taxpayer dollars for the American people. Government employees, contractors, or members of the public can report criminal activity, fraud, waste, abuse, and mismanagement of OPM programs via the Hotline. OIG Hotline staff review and process complaints, and complaints may result in an investigation, audit, or inspection performed by the OIG. Reports to the OPM OIG hotline may be submitted:

- By telephone (1-877-499-7295),
- By mail  
U.S. Office of Personnel Management, Office of the Inspector General  
Theodore Roosevelt Building  
1900 E Street NW  
Room 6400  
Washington, DC 20015-1100
- Online ([opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/](https://opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/)).

## **Director's Report**

In this report, the U.S. Office of Personnel Management (OPM) Office of the Inspector General (OIG) presents summaries of noteworthy cases investigated by the Office of Investigations as we endeavor to curtail improper payments, stop patient harm, protect OPM programs, and provide independent and objective oversight of OPM operations. We have selected these cases to highlight the successes of our special agents and Investigative Support Operations group, as well as to describe the types of waste, fraud, abuse, and mismanagement that harm OPM, its programs, and Federal employees, retirees, and their dependents.

The cases below represent a period from January 1, 2020, through March 31, 2020.

### **Health Care Investigations**

The OPM Fiscal Year 2019 Agency Financial Report states that in Fiscal Year (FY) 2019, the Federal Employees Health Benefits Program (FEHBP) made \$54.94 million in improper payments. These substantial, costly improper payments often derive from fraud, waste, or abuse throughout the FEHBP and negatively affect premium rates and the program as a whole. Moreover, fraudulent schemes that generate improper payments often also cause patient harm.

#### **Anti-Kickback Statute**

The FEHBP continues to be excluded from the Anti-Kickback Statute (AKS). We report the following cases closed this quarter that we were unable to pursue due to this exclusion:

- ❖ We received a *qui tam* complaint filed in the U.S. District Court for the Central District of California alleging a provider submitted false, fraudulent, or inflated claims for devices as part of a pass-through billing scheme and for services pursuant to a kickback arrangement. The FEHBP paid the provider \$4,178,157. However, the Assistant United States Attorney overseeing the case notified us that FEHBP claims were excluded due to the allegation being based on violations of the AKS. Because of the FEHBP's continued exclusion from the AKS, we closed our case.
- ❖ In November 2018, we were referred a *qui tam* complaint filed in the U.S. District Court for the District of Massachusetts regarding a provider that allegedly paid kickbacks to other providers or arranged kickbacks in exchange for an exclusive purchasing agreement for pharmaceutical products. After consultation with the U.S. Attorney's Office for the District of Massachusetts, the allegations were determined to be pursued for prosecution as kickbacks. The FEHBP is excluded from the AKS; therefore, we closed our case.
- ❖ In December 2019, we received a *qui tam* complaint referred by the U.S. Attorney's Office for the Western District of Michigan. The complaint alleged that a provider violated the Stark Law, which prohibits providers from referring patients for certain health services paid for by Medicare when the provider has a financial relationship such as an ownership or investment interest, and the AKS. Because of the nature of the

allegations (and the statutory exclusion of the FEHBP from the AKS) there was no nexus for us to investigate the cases as causing harm to the FEHBP.

Additionally, in other investigations summarized below, we were partially excluded from receiving full restitution from FEHBP losses because of our exclusion from the AKS.

## **Settlements**

- ❖ In April 2015, we received a health insurance carrier notification alleging that a provider had a pattern of improperly billing for multiple surgical procedures on the same patient on the same date of service. Between August 2011 and October 2014, the identified overpayment of FEHBP funds totaled \$13,725. The provider and the health insurance carrier reached a settlement in March 2018, and the health insurance carrier closed their case on February 15, 2020, after the provider paid reimbursement that included FEHBP funds totaling \$6,783.
- ❖ In January 2015, we received a *qui tam* complaint filed in the U.S. District Court for the Eastern District of Tennessee regarding a provider allegedly unbundling office visits and procedures. The FEHBP paid in total \$1,078,285 to the provider, of which \$92,351 related to the specific allegations. On January 27, 2020, the provider entered into a final settlement agreement in which the provider paid \$1.5 million and entered a corporate integrity agreement. The FEHBP will receive \$21,750 of the \$750,000 global restitution.
- ❖ We received a *qui tam* complaint alleging that a pharmacy provider and its subsidiaries engaged in a scheme to inaccurately fill prescriptions and submit false claims for reimbursement. The FEHBP suffered a potential loss of \$9,542,623 across all involved providers. Each provider will be handled in separate settlements. On March 26, 2020, one entity entered into a civil settlement. The FEHBP was awarded \$1,540. Judicial action continues for the other defendants in this case.
- ❖ In December 2019, we received notification from an FEHBP health insurance carrier that services billed by a provider were not supported by medical records. The FEHBP had paid \$675,488 to the provider since January 1, 2016. The provider entered a settlement on January 22, 2020, that will return FEHBP funds totaling \$107,449.

## **Ineligible Beneficiaries**

- ❖ In July 2017, we received a case referral from the U.S. Attorney's Office in the Northern District of Texas alleging that a Department of Justice (DOJ) employee added multiple ineligible beneficiaries to her FEHBP plan. The unauthorized beneficiaries included a friend and her four children. The FEHBP paid \$12,316 for claims related to the ineligible beneficiaries. The DOJ employee and her friend were indicted in the U.S. District Court for the Northern District of Texas in February 2018 on two counts of false statements relating to health care matters and aiding and abetting. In July 2018, the DOJ employee pled guilty to false statements related to health care matters, and in April 2018, she was sentenced to 3 years of probation and ordered by the court to pay OPM \$12,316 in

restitution. On February 25, 2020, the DOJ employee's friend entered into a plea agreement in which she agreed to plead guilty to one count of theft in connection with health care. On March 3, 2020, she was formally charged via criminal information. Judicial action continues in this case.

### **Pass-Through Billing**

- ❖ In September 2016, we received a case referral from an FEHBP health insurance carrier alleging that a behavioral health facility admitted ineligible beneficiaries and did not provide the necessary behavioral health services. Our investigation uncovered an elaborate pass-through billing scheme involving the behavioral health provider and kickbacks to multiple individuals. Overall, the FEHBP paid the provider approximately \$3.1 million. Since March 2019, multiple criminal informations and indictments have been filed against more than 10 individuals and several business entities; in previous months, several individuals pled guilty and were sentenced related to the scheme. On January 31, 2020, one defendant pled guilty in the U.S. District Court for the Eastern District of Pennsylvania to the charge. On February 27, 2020, an additional individual was arrested in violation of conspiracy to commit health care fraud. Judicial action continues in this case.
- ❖ We received a referral from the Federal Bureau of Investigation (FBI) alleging billing fraud related to a complainant's purchase of an alleged weight loss treatment from a coupon website. Our investigation found that providers performed unnecessary diagnostic tests, fraudulently billed tens of thousands of dollars to a carrier, and operated a pass-through scheme to increase reimbursement. The FEHBP paid approximately \$86,000 to the various entities involved in this scheme. We have since reported several previous enforcement activities related to the case, including the FEHBP recovery of more than \$50,000 and multiple pleas and convictions. On March 4, 2020, the cardiology provider was sentenced to 3 years of probation.

### **Compounded Medications**

- ❖ We received a referral from the FBI in July of 2015 regarding allegations that a provider of compounded medications induced physicians to sign blank prescriptions for medications and prescribe medications regardless of medical necessity in exchange for inducements. The FEHBP paid over \$1 million to one of the physicians involved in the scheme, but the exact amount paid to the provider has not been calculated, though it is estimated to be more than \$9 million across all harmed Federal health programs. In July 2017, one individual with the compounding pharmacy provider was charged with conspiracy to commit health care fraud, violations of the Travel Act, wire fraud, and violations of the AKS. In February 2019, the individual pled guilty in the U.S. District Court for the Western District of Texas to conspiracy to commit wire fraud, health care fraud, violations of the Texas commercial bribery statute, and paying health care bribes. On January 16, 2020, she was sentenced to 30 months of incarceration plus 3 years of supervised release, with restitution of \$1,746,222. The FEHBP will receive \$48,109.

## Improper Billing

- ❖ In June 2018, we coordinated with a law enforcement partner regarding potentially fraudulent claims submitted by a provider. The fraud consisted primarily of numerous treatments billed the same day and billing for services not rendered that cost the FEHBP \$74,110. On January 6, 2020, the provider was charged in the U.S. District Court for the Eastern District of Pennsylvania with health care fraud. Judicial action continues in this case.
- ❖ We received a referral from an FEHBP carrier in November 2017 regarding a provider who was a billing outlier with suspicious billing and coding patterns. The FEHBP had paid the provider more than \$1.015 million. In March 2019, the provider was indicted in the U.S. District Court for the Northern District of California on six counts of health care fraud and one count of making a false statement related to health care matters. In December 2019, the provider pled guilty to health care fraud and making a false statement. On March 23, 2020, he was sentenced to 12 months and 1 day in prison. He was also ordered to pay \$807,785 in restitution, of which \$594,915 will be paid to the FEHBP.
- ❖ In July 2017, we received a referral from the U.S. Department of Health and Human Services (HHS) OIG regarding foreign-sourced drugs and potential patient harm by a provider. The investigation uncovered foreign and unapproved drugs not approved by the U.S. Food and Drug Administration (FDA). The FEHBP exposure related to these drugs was \$33,976. On March 16, 2020, the provider agreed to a settlement in which they repaid \$425,000 to all Federal health programs. The FEHBP will receive \$22,427.
- ❖ We received a notification from a law enforcement partner about an ongoing investigation into a provider allegedly billing for services not rendered. The FEHBP's loss was \$98,082. In December 2017, two individuals were indicted in the U.S. District Court for the Central District of California for health care fraud and aiding and abetting. In November 2018, one individual pled guilty to health care fraud. On March 5, 2020, that individual was sentenced to 37 months in prison and 36 months of supervised probation. The court also ordered \$2.7 million in restitution, of which the FEHBP will receive \$98,082.
- ❖ In December 2016, we received a *qui tam* referral from the U.S. District Attorney's Office in the Eastern District of New York that alleged a provider submitted false and fraudulent billings to Government programs and provided services not medically necessary or fraudulently coded in order to increase reimbursement. The FEHBP had paid \$3,673,005 to the provider. However, the original allegation was unsubstantiated. Another allegation regarding this provider centered on adult care homes: it was alleged the FEHBP and other Government health care programs paid for services billed as performed by a physician when actually performed by another medical professional, as well medically unnecessary services. Additional allegations claimed the provider violated the AKS by paying patients to receive unnecessary testing. The FEHBP paid

\$4,760 between January 2012 and December 2016 to the provider and related to the at-issue care homes. In June 2019, the original *qui tam* was dismissed. In January 2020, the defendant entered a civil settlement to pay \$1.109 million, of which the FEHBP received \$2,720.

- ❖ In October 2016, we received a case referral from an FEHBP health insurance carrier regarding a provider whose alleged fraudulent schemes cost the FEHBP \$1,138,821. The allegations included billing for services not rendered, billing when the practice was closed or there was no provider onsite, upcoding, and creating false medical records to conceal the fraud. When one provider was removed by an FEHBP health insurance carrier, the practice allegedly submitted claims under other providers to continue receiving reimbursement. One subject fled the country. Another subject made plans to flee as well, but they were arrested in June 2019 on an arrest warrant issued by the U.S. District Court for the Northern District of Illinois. On January 15, 2020, that same individual was indicted for making false statements. Judicial action continues in this case.
- ❖ We received a *qui tam* complaint alleging a provider operating skilled nursing facilities engaged in a scheme to maximize its reimbursements by billing the most days possible for therapy. Our investigation found that the provider engaged in a scheme to defraud health insurance carriers by submitting claims for services not rendered and potentially upcoded procedures. The investigation also found the provider staffed at minimum levels and did not have adequate staff to care for patients. The FEHBP paid the provider approximately \$576,585. On February 11, 2020, the DOJ entered into a civil settlement with the provider in the U.S. District Court for the Eastern District of Pennsylvania. The provider paid \$15,466,278, of which OPM received a net payment of \$72,280.
- ❖ In June 2015, we received a case referral during a multiagency taskforce meeting held by the U.S. Attorney's Office for the Northern District of Illinois. It was alleged that a provider engaged in several fraud schemes involving multiple other providers. The total impact related to the allegations across all Federal health care programs was \$250,013; the FEHBP had \$751 in exposure. One individual was indicted in December 2018 in the U.S. District Court for the Northern District of Illinois on six counts of health care fraud. On February 10, 2020, the individual was convicted of all six counts in the indictment. Judicial action continues in this case.
- ❖ In January 2015, we received a *qui tam* complaint filed in the U.S. District Court for the Eastern District of Tennessee regarding a provider allegedly unbundling office visits and procedures. The FEHBP paid in total \$1,078,285 to the provider, of which \$92,351 was related to the specific allegations. On January 27, 2020, the provider entered into a final settlement agreement in which the provider paid \$1.5 million and entered a corporate integrity agreement. The FEHBP will receive \$21,750 in single damages of the \$750,000 restitution.



## **Special Topic: The Opioid Epidemic**

In his 2017 memorandum “Combatting the National Drug and Opioid Crisis,” President Donald J. Trump declared the opioid crisis a public health emergency and directed a multiagency response to combat the nationwide issue. The FEHBP faces substantial negative impacts from the opioid epidemic, as Federal employees and their families have not been spared from addiction, treatment, and other ancillary harms and costs associated with the crisis. Addressing opioid-related issues remains a priority for the Office of Investigations.

### **Pill Mill**

- ❖ We presented a case to the U.S. Attorney’s Office in the Eastern District of Pennsylvania regarding a provider potentially overly dispensing Schedule II drugs based on data from the Pennsylvania Prescription Monitoring Program. Specifically, a nurse was the target of a local law enforcement investigation for inappropriately dispensing the Schedule II drugs. The provider also admitted to defrauding other Federal health insurance carriers by billing for services not rendered via a coupon card program and creating fake prescriptions. The FEHBP had paid the provider \$300,326. In April 2019, the nurse was charged for filling fraudulent prescriptions, including those for opioids. She pled guilty in the U.S. District Court for the Eastern District of Pennsylvania in May 2019 to conspiring to distribute oxycodone. In September 2019, the provider entered a guilty plea in the U.S. District Court for the Eastern District of Pennsylvania for conspiracy to commit wire fraud, as well as 14 counts of prescribing medications outside the course of professional practice and not for legitimate medical purpose, including Schedule II controlled substances (including opioids). On March 12, 2020, the provider was sentenced to 36 months in prison and 24 months of supervised release. The court ordered \$300,000 in civil restitution, of which the FEHBP will receive \$45,373. Additionally, the court ordered criminal restitution for \$1.69 million to be paid to a defrauded pharmaceutical company.

### **Compounded Drugs**

- ❖ In April 2016, we received a referral from a Federal strike force regarding a provider allegedly billing patients for identical compounded drugs while running a pill mill. The FEHBP paid more than \$319,000. On January 24, 2020, the provider pled guilty in the U.S. District Court for the Eastern District of Pennsylvania to 19 counts of health care fraud and 23 counts of distribution of Schedule II and Schedule IV controlled substances. On March 17, 2020, the provider agreed to pay \$2.8 million in civil damages and penalties under the False Claims Act, the Controlled Substances Act, and in civil forfeiture. He will also be excluded from participating in Medicaid or Medicare for 20 years, and he was referred to the OIG Administrative Sanctions Group for debarment on March 3, 2020. Judicial action continues.

### **Improper Prescribing and Kickbacks**

- ❖ In a case related to an opioid drug manufacturer, we were notified of an unsealed indictment related to five providers alleged to be participating in a kickback and bribery scheme that paid sham educational programs in exchange for prescribing millions of dollars of a fentanyl-based opioid. The FEHBP only received exposure information from one FEHBP health insurance carrier related to one provider: \$63,420. In March 2018, all five providers were arrested and debarment referrals were submitted to the OIG FEHBP Administrative Sanctions Group. All five of the providers pled or were found guilty of various charges. One was sentenced to 2 years of imprisonment, 2 years of supervised release, and forfeiture of more than \$127,000. On January 27, 2020, one individual was sentenced to 57 months of imprisonment and 3 years of supervised release. Additionally, the court ordered forfeiture of \$68,400, with a restitution order pending. On March 2, 2020, another individual was sentenced to time served and 1 year of supervised release. Judicial action continues in this case.

## **Retirement Investigations**

In FY 2019, the Retirement Services program office improperly paid \$284.42 million to retirees, survivors, representative payees, and families, largely from the Civil Service Retirement System (CSRS) and the Federal Employees Retirement System (FERS) retirement programs. One of the most common causes of improper payments is failure to verify the deaths of annuitants, which sometimes allows improper payments to continue for years and costs tens of thousands of dollars. Fraud by forged documents, identity theft, and other schemes also highlight program vulnerabilities, and in some cases may stop Federal retirees or rightful annuitants from receiving their deserved benefits.

### **Restored Annuity**

- ❖ In November 2018, we received a fraud referral from the OPM Retirement Services program office regarding an annuitant who claimed he did not receive annuity payments between May 2017 and October 2018. Records show the potentially misdirected or stolen annuity amounted to \$32,573 and was directly deposited into a bank account for an individual the annuitant claimed he did not know. The U.S. Department of the Treasury's contacted financial institutions where the annuity was deposited and found that this unknown individual was listed as the account owner. Someone attempting to change details related to the annuitant's account also contacted the OPM Retirement Services program office. We issued a subpoena to the telecommunications providers for information about the numbers that had called the Retirement Services office, but the information did not generate sufficient leads and we closed our complaint. The annuitant now receives a hardcopy check and the Retirement Services office made additional changes to prevent future unauthorized activity.

### **Representative Payee Issues**

- ❖ A nursing home provider contacted OPM over a retired annuitant's failure to pay for care and alleged that the annuitant's brother diverted the OPM annuity for his own use. OPM records showed that the brother was the annuitant's Representative Payee. The annuitant

died in July of 2018. The annuitant's life insurance was denied to be paid to the brother after the life insurance company's investigation. No appeal was filed. Because the annuitant is deceased and no appeal was filed with the life insurance company, we closed our case. However, we note that because the Representative Payee Fraud Prevention Act of 2019 was not law during the timeframe when the misuse of the annuity was allowed to occur, we were unable to pursue further investigation.

### **Reclamation and Recovered Funds**

- ❖ An OPM annuitant whose October 2012 death was not reported to OPM continued to receive payments disbursed to his account through May 2018, resulting in an improper payment of \$130,958. OPM recovered more than \$25,000 through the Department of the Treasury's reclamation process. On December 2019, our Investigations Support Operations group sent documents to the Treasury supporting findings that the financial institution was liable based on its knowledge of the annuitant's death shortly after it occurred. The financial institution agreed in January 2020 that they were at fault, and on March 2, 2020, the OPM Office of the Chief Financial Officer posted a recovery of \$109,197.
- ❖ In June 2019, we received a referral from the Retirement Services program office regarding an annuitant's unreported May 1995 death. OPM paid \$71,939 after the annuitant's death, but recovered \$4,781 through the Department of the Treasury's reclamation process for a total outstanding amount of \$67,157. In January 2020, our Investigative Support Operations group obtained financial records showing that an individual who would have had survivor annuitant status after the original Federal annuitant's death received the payments. However, this survivor annuitant was deceased by the time the improper payment was discovered, and so we closed our case.

### **Remarried Survivor Annuitant**

- ❖ We received a case notification from an FEHBP health insurance carrier in March 2016 alleging an FEHBP enrollee filed health benefit claims even after losing eligibility to be covered by the FEHBP. The enrollee lost eligibility because she was a survivor annuitant who remarried after the death of her spouse. The FEHBP paid approximately \$41,890 in medical claims and \$2,670 in pharmacy claims for two ineligible persons related to this case. We requested the Retirement Services program office review the case file to determine the eligibility of the individuals for benefits and at what point the individuals became ineligible to receive benefits. The FEHBP health insurance carrier was able to recover \$41,890 from providers, to be returned to the FEHBP. The pharmacy benefits manager will offset \$2,645 in future claims as repayment.
- ❖ As part of our proactive review of survivor annuitant cases, we noted that a survivor annuitant's file had no documentation of her remarriage. A survivor annuitant who remarries prior to age 55 is ineligible to continue receiving an annuity unless they were married to the Federal annuitant for 30 years prior to the annuitant's death. In the time after her December 2017 remarriage, the survivor annuitant received \$2,121 in improper

annuity payments and health benefit premiums totaling \$1,389. OPM sent letters requesting repayment of the annuity, and the survivor annuitant repaid the \$2,121 debt in December 2019. On February 3, 2020, the Retirement Services program office took action to recover the health benefit premiums OPM paid after the survivor annuitant lost eligibility.

### **Disability Retirement Fraud**

- ❖ In September 2016, we received a referral from another Federal agency's program office regarding a former Federal special agent granted disability retirement. The former Federal special agent was allegedly observed doing physical activities that he claimed to be incapable of performing. The individual was charged in November 2019 by information in the U.S. District Court for the Southern District of California with making a false statement. He pled guilty. On March 27, 2020, he was sentenced to 5 years of probation, 8 months of home confinement, and was ordered by the court to pay \$197,517 in restitution to OPM.

### **Annuity Theft**

- ❖ In December 2018, we received a referral from the Retirement Services program office regarding an annuitant's unreported July 2013 death. In total, OPM improperly paid \$103,476 in retirement payments to the deceased annuitant. In September 2019, one individual pled guilty in the U.S. District Court for the Southern District of Ohio to two counts of theft of public money. He was sentenced on March 13, 2020, but the court is still determining the terms of the judgement and conviction.
- ❖ In July 2018, we received a case referral from a law enforcement partner regarding a deceased annuitant whose death in September 2009 was not reported to multiple Federal agencies and the alleged theft of the decedent's annuity. The overpayment totaled \$32,451. On October 23, 2019, the annuitant's daughter was charged in the U.S. District Court for the Eastern District of Michigan with theft of Government funds. On January 10, 2020, she pled guilty to the charge. As part of the plea agreement, she will pay full restitution to OPM and other affected Federal entities. Sentencing is scheduled for a future date.
- ❖ We received a case notification from the Retirement Services program office regarding a deceased annuitant whose April 1995 death was not reported to OPM. The improper payment totaled \$107,383. In August 2019, the annuitant's daughter was indicted in the U.S. District Court for the Eastern District of Missouri for theft of Government funds. On January 8, 2020, the daughter pled guilty. As part of the plea agreement, she will pay full restitution to OPM and other affected Federal entities. Sentencing is scheduled for a future date.
- ❖ In March 2018, we received a referral from the Retirement Services program office regarding an annuitant whose December 2006 death was not reported to OPM, resulting in an improper payment of \$360,463. OPM recovered \$5,757 through the reclamation

process, leaving a loss of \$354,706. Our investigation discovered that the annuitant's daughter used the funds for her own benefit after her father's death. In December 2019, she was charged in the U.S. District Court for the District of Colorado by information of theft of Government funds. On January 14, 2020, the daughter changed her plea to that of guilty to one count of theft of Government funds. Judicial action continues in this case.

- ❖ In May 2017, we received a fraud referral from the Retirement Services program office regarding an overpayment to an annuitant whose February 2006 death was unreported to OPM. OPM had received eight Address Verification Letters between 2009 and 2016, as well as a phone call, from the annuitant's son to restore payments after the program office suspended the annuity. The total overpayment totaled \$212,481. In July 2019, a criminal information charged the son with theft of Government property. In September 2019, he pled guilty to the charge in the U.S. District Court for the Eastern District of Virginia. On January 7, 2020, he was sentenced to 2 days in jail, 180 days of home confinement, and 3 years of supervised release. Additionally, he was ordered to pay full restitution of the \$212,481 to OPM.
- ❖ We received a referral from the Retirement Services program office alleging that OPM did not receive timely notification of a survivor annuitant's September 2004 death. OPM continued to deposit annuity payments through February 2016. The total improper payment amounted to \$152,455, and through the Department of the Treasury's reclamation process, OPM recovered \$994. The net overpayment was \$151,450. Our investigation determined the survivor annuitant's daughter converted the CSRS survivor annuity for her own use and forged checks after the survivor annuitant's death. In October 2018, the daughter was indicted in the U.S. District Court for the Central District of California on eight counts of bank fraud, six counts of theft of Government property and one count of aggravated identity theft. She pled guilty in July 2019. On January 27, 2020, she was sentenced to 1 day (time served), 24 months of probation, and ordered to pay restitution of \$151,450 to OPM.

## **National Security Investigations**

Prior to its transfer of duties to the Defense Counterintelligence and Security Agency on October 1, 2019, the National Background Investigations Bureau (NBIB) as an OPM bureau conducted background investigations of Federal job applicants, employees, members of the armed services, and contractor personnel for suitability and security purposes. Allowing the employment of or granting security clearances to potentially unsuitable persons through fraudulent, falsified, incomplete, or incorrect background investigations could create vulnerabilities within the Federal workforce detrimental to Government operations. We provided external oversight through the investigation of legacy cases (that is, cases begun prior to October 1, 2019) related to NBIB background investigations alleging falsifications.

We report no activities in any NBIB-related cases during this quarter.

## **Integrity Investigations**

In addition to conducting criminal and civil investigations, our office also conducts administrative investigations into fraud, waste, abuse, and mismanagement at OPM. We investigate cases involving OPM employees and contractors, including those referred through the OIG Hotline. Integrity investigations may involve whistleblowers and/or retaliation, and are an important part of the OIG's mission of providing independent oversight and reducing program vulnerabilities.

### **Alleged Whistleblower Retaliation**

- ❖ In August 2019, we received an allegation that an employee in the OPM Office of the Chief Information Officer (OCIO) retaliated against a former contract employee who alerted the OCIO employee to unlawful actions. Our interview and investigation found that we were not able to substantiate the allegation, and we found that the complainant's supervisor acted within the scope of the contract when removing the complainant from the contract.

## **Glossary**

The following terms were used in our Quarterly Case Summary.

**Improper Payments** are disbursements that should not have been made or were made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. The reduction of improper payments is a President's Management Agenda goal across all Executive Branch agencies. In fiscal year 2018, OPM reported Retirement Programs and the FEHBP combined to make more than \$355.5 million in improper payments.

### **Healthcare and Insurance Office**

**Carrier Letters** are guidance that OPM Healthcare & Insurance program office provides to health insurance carriers to specify how contracts with the FEHBP and other OPM-administered insurance programs are administered. Carrier letters are intended to be complied with in the same manner as carrier contracts, as they often serve as supplemental information to explain policy complexities.

**Carriers** are private insurance companies that contract with the FEHBP to provide health insurance benefits to Federal employees and retirees and their dependents. These insurance plans include HMO and FFS health plans.

**Compounded Medications** are medications (often liquids or creams) made to fit the individual needs of a patient. Compounded drugs are not approved by the FDA. A variety of health care fraud schemes involve compounded drugs: unscrupulous providers prescribing compounded medications without medical relationships with patients; prescribing medically unnecessary, ineffective, and/or exorbitantly priced compounded drugs; and prescribing compounded drugs in exchange for inducements or illegal compensation.

**The False Claims Act** allows for the prosecution of any person who knowingly submits false claims to the Government, including making a false record or statement to cause a false claim to be paid, or acting improperly to avoid paying the Government. It includes civil penalties for each false claim. Additionally, the False Claims Act allows for *qui tam* lawsuits wherein a member of the public files as a relator to sue on behalf of the Government. The relator may be compensated a percentage of the amount the Government recovers through the lawsuit.

**Ineligible Dependents** are persons who receive benefits from a Federal employee's benefits plan (most often from the FEHBP) but are not eligible to receive these benefits under statutory or regulatory guidelines. Former spouses, friends, self-sufficient children aged older than 26, and extended family (such as grandchildren) are common ineligible dependents. Any payment to an ineligible dependent is an improper payment.

**Medically Unnecessary Services** are items and services that are unreasonable or unnecessary for the diagnosis or treatment of an illness or injury. Medically unnecessary

services are often provided in exchange for inducements or as part of health care fraud schemes.

**Pass-Through Billing Schemes** involve unscrupulous providers paying a laboratory to perform tests but filing claims with an insurance company or Government program as if the provider or a related entity conducted the test. Pass-through billing schemes generate improper payments through inflated reimbursement or as part of an arrangement involving illegal inducements.

**Services Not Rendered** are procedures, tests, or appointments not performed by a provider but still billed as such, or billed inaccurately to misrepresent services as something eligible for a higher reimbursement than the services actually performed.

**Telemedicine** provides health care services to a patient by telecommunication, such as via webcam. While the practice increases convenience and care access, it is also vulnerable to a variety of fraud schemes, including those involving opioids and compounded medications.

**The Travel Act** provides for Federal-level criminalization of business activities that are illegal under certain State laws (e.g., bribery) if interstate commerce, travel, or mail was part of the illegal business activities. Recent use of the Travel Act is a pioneering enforcement strategy that allows us to pursue fraud schemes when relevant State laws have been broken.

**Unbundling** is a health care fraud scheme where a procedure or office visit is separated into multiple billing codes when the procedure or visit should be billed under a single “panel” or inclusive code. Unbundling creates improper payments through inflated reimbursement.

### **Special Topic: The Opioid Epidemic**

**Diversion** is the practice of transferring legally prescribed medications from the individual for whom it was prescribed to another person for illicit use.

**Opioids** are a class of pain medication labeled as **Schedule II drugs**, i.e., “drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence.” While largely safe when taken as prescribed by a doctor and according to medical best practices, opioids are often abused and can cause addiction, overdose, and death. Opioid drugs include **oxycodone**, one of the most common and most abused prescription drugs, and **fentanyl**, which has emerged as a dangerous additive to drugs such as heroin and can lead to overdoses in even small amounts.

**Pill Mills** are health care providers, facilities, or pharmacies that prescribe and/or dispense drugs without legitimate medical purpose.

**Sober Homes** aim to provide safe and drug-free residences for individuals suffering from addiction, but unscrupulous sober homes may submit patients to unnecessary, expensive, and excessive testing as part of a health care fraud scheme.



## Retirement Programs

**Address Verification Letters (AVLs)** are sent to Federal retirees and survivor annuitants receiving CSRS/FERS benefits from OPM to verify whether annuitants are living and are living at the address currently on file with the Retirement Services program office. It is one of the surveys that the Retirement Services program office uses to confirm and census its annuitant population.

**A Federal Annuitant** is a retiree or spouse of a retiree who receives an annuity from OPM.

**A Survivor Annuitant** is a surviving spouse or child entitled to receive OPM-administered benefits after the death of a Government employee receiving an annuity.

**Reclamation** is the process by which the Retirement Services program office attempts to recover money through the Department of Treasury reclamation process that is paid to Federal annuitants when a financial institution, such as a bank, holds the funds.