



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

Quarterly Case Summaries

Investigative Activities

Fiscal Year 2020

Third Quarter

April 1, 2019 - June 30, 2019

-- Caution --

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List of Acronyms

AKS	Anti-Kickback Statute
CSRS	Civil Service Retirement System
FBI	Federal Bureau of Investigation
FDA	U.S. Food and Drug Administration
FEDVIP	Federal Employees Dental and Vision Insurance Program
FEGLI	Federal Employees' Group Life Insurance
FEHBP	Federal Employees Health Benefits Program
FEI	Federal Executive Institute
FERS	Federal Employees Retirement System
FFS	Fee-for-Service
FY	Fiscal Year
HHS	U.S. Department of Health and Human Services
HMO	Health Maintenance Organization
NBIB	National Background Investigations Bureau
OIG	OPM Office of the Inspector General
OPM	U.S. Office of Personnel Management
OSC	U.S. Office of the Special Counsel
ROI	Report of Investigation

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 Program (FEDVIP) makes 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 civilian and retiree, 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 evaluation 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/).

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 programs and operations. We have selected these cases to highlight the successes of our criminal investigators and Investigative Support Operations group, as well as to describe the types of waste, fraud, abuse, and mismanagement that harm OPM, its programs and operations, and Federal employees, retirees, and their dependents.

The cases below represent a period from April 1, 2020, through June 30, 2020. This period was severely affected by the ongoing novel coronavirus (COVID-19) pandemic throughout the Nation, from changing investigative priorities to limiting criminal investigators' ability to travel, conduct interviews, and interact with our law enforcement and Department of Justice (DOJ) partners whose offices closed or transitioned to socially distanced-only operations and most Federal employees were under maximum telework.

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 Federal Anti-Kickback Statute (AKS). We report the following cases closed this quarter that we were unable to pursue due to this exclusion:

- ❖ In June 2019, we received a *qui tam* referral from the DOJ regarding a provider waiving copay obligations for out-of-network claims. The FEHBP paid \$10.9 million between 2014 and 2019. This case is being pursued by the U.S. Attorney's Office in the Northern District of Illinois under the AKS. Because the FEHBP is excluded from the AKS, we were unable to pursue further action and closed our case in April 2020.
- ❖ In March 2020, we received a *qui tam* complaint filed with the U.S. Attorney's Office for the Southern District of California regarding a laboratory provider alleged to be providing kickbacks to physicians and hospitals. The scheme primarily affected Medicare, Medicaid, and TRICARE. The U.S. Attorney's Office also confirmed that the allegations were predicated on violations of the AKS. Because the FEHBP is excluded from the AKS, we closed our case in April 2020.

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

Carrier Settlements

- ❖ In July 2018, we received a case referral from an FEHBP health insurance carrier regarding its audit of a provider. As part of the audit, the carrier conducted patient interviews that revealed allergy testing performed by medical assistants or technicians. Such practice is not allowed in the State of New Jersey, where the provider was located. The FEHBP had paid \$37,325 to the provider between June 2012 and May 2017. On June 8, 2020, the provider entered into a settlement agreement that returned \$37,325 to the FEHBP.
- ❖ In January 2020, we received a case notification from an FEHBP health insurance carrier regarding its audit of a provider who improperly pre-billed for durable medical equipment (DME). From September 2017 through September 2019, the provider billed the FEHBP \$71,341, of which the FEHBP paid \$57,715. The health insurance carrier reached a settlement with the provider on April 3, 2020. From that settlement, \$41,683 will be returned to the FEHBP.
- ❖ In April 2018, we received a case referral from an FEHBP health insurance carrier regarding a provider allegedly billing for more services than could be provided per day. Claims analyses identified overpayments. Between August 2015 and September 2018, the FEHBP paid \$157,961 to the provider. The carrier who referred the case reached a settlement with the provider on June 1, 2020. According to the settlement, the provider will return \$22,897 to the FEHBP.

False Claims

- ❖ In April 2015, we received a *qui tam* referral alleging a pharmacy and its subsidiaries engaged in a scheme to inaccurately fill prescriptions and submit false claims for reimbursement. The potential loss to the FEHBP, based on claims data from the pharmacy and its subsidiaries, was more than \$9.5 million. Over the course of this quarter, settlements with eight entities were finalized. From those eight settlements, the FEHBP will recover more than \$662,000. Additional settlements with other associated entities are anticipated.

Durable Medical Equipment Schemes

- ❖ In January 2018, we received a case referral from an FEHBP health insurance carrier regarding a DME provider allegedly charging excessive amounts under two Healthcare Common Procedural Codes System (HCPCS) codes. Instead of the health care carrier paying its stated policy of 85 percent of the Manufacturer's Suggested Retail Price (MSRP), the DME provider charged up to 65 percent over MSRP. The initial medical claims identified for the relevant HCPCS code was \$717,750 for the period from September 2014 to September 2017. In June 2020, the FEHBP health insurance carrier reached a settlement agreement for \$267,000 related to one of the relevant HCPCS code. From that settlement, the FEHBP will receive \$195,892.

Compounded Medications

- ❖ In December 2016, we received a *qui tam* complaint from the United States Attorney's Office for the Southern District of New York regarding a provider who allegedly sold compounded pain medications paid for by Government funds, as well as paid kickbacks to encourage customers to purchase the provider's medications. The FEHBP paid more than \$299,000 between January 2010 and July 2017. In April 2020, the provider entered into a civil settlement wherein it paid \$426,000 to the Federal Government. The FEHBP will receive \$15,803, as well as investigative costs of \$4,602, for a total of \$20,405.

Miscoded, Medically Unnecessary, or Ineligible Services or Services Not Rendered

- ❖ We received a case referral from an FEHBP carrier in October 2018 alleging a provider submitted claims for services not rendered. The services were provided to a patient whom the provider had a personal relationship with, as well as the patient's minor children. Between August 2015 and August 2018, more than 160 claims were submitted to the FEHBP. The provider billed the FEHBP \$9,000, of which a total of \$2,850 was paid. The provider did not cooperate with an investigation by a State agency, and his chiropractic license was revoked in January 2020. On June 6, 2020, the provider was debarred from the FEHBP. That debarment will remain in effect for an indefinite period.
- ❖ We received a *qui tam* complaint in November 2017 regarding allegations that a provider billed for services not rendered, upcoded or miscoded claims, made false claims and diagnoses, and made claims for services that were not medically necessary. Between January 2012 and April 2017, the FEHBP paid more than \$36,250. On May 1, 2020, in the U.S. District Court for the Eastern District of Kentucky, the provider agreed to a civil settlement with the Government. Per the settlement, the provider paid \$750,000, of which \$362,382 is restitution. The FEHBP will receive \$13,774 in single damages and lost investment income.
- ❖ In August 2018, we received a referral from the U.S. Attorney's Office in the Middle District of Florida regarding suspicious prescribing behavior by a provider. The investigation found that the provider billed for use of a single vial of an injectable medication without having adequate stock to provide such an amount. The FEHBP paid the provider \$552,123 in total claims, with \$346,895 specifically related to the injectable medication. On May 22, 2020, the provider agreed to pay \$4.8 million to the Government to resolve allegations of health care fraud. From that agreement, the FEHBP will receive \$346,895.
- ❖ We received a referral for a *qui tam* case filed in the U.S. District Court for the Western District of North Carolina regarding a provider who allegedly miscoded services in order to maximize reimbursement, billed for unnecessary tests, and billed for tests without regard for coverage guidelines. The provider allegedly also paid kickbacks and other financial inducements. The FEHBP paid the provider more than \$4.3 million on more than 175,000 claims, with \$2.4 million specifically included in the suspected fraudulent

claims activity. The United States Attorney's Office handling the case established the need for alternative settlement options based on the provider's ability to pay. Under an April 24, 2020, settlement, the provider will pay approximately \$17 million through the surrender of claim funds held in suspension by Medicare and TRICARE. Additionally, the provider may pay up to an additional \$26 million depending on future financial contingencies. FEHBP funds will be recovered from the contingency settlement monies if paid in the future.

- ❖ In September 2018, we received a *qui tam* complaint filed in the U.S. District Court for the District of Alaska that alleged a provider engaged in multiple fraudulent medical billing schemes between 2013 and 2017. Specifically, the provider unbundled medical codes to increase billing, billed for massage therapy under incorrect codes, and misused modifiers and manipulated dates of service to have claims paid at higher rates. The scheme was identified globally to cost \$1.4 million. The FEHBP specifically had \$534,744 in exposure from improper payments and lost investment income related to the scheme. On June 5, 2020, a settlement agreement with the provider and the Government was fully executed. Under the settlement terms, the provider paid \$2 million. The FEHBP received a total recovery of \$518,702.

Ineligible Beneficiaries

- ❖ We received a complaint via the OPM OIG hotline alleging that a Federal retiree improperly added multiple ineligible beneficiaries to his FEHBP insurance. We requested claims data from 2017 through 2020 for the potential ineligible beneficiaries and found \$73 in claims related to one ineligible beneficiary. The other potential ineligible beneficiaries did not have any paid claims. We contacted the FEHBP health insurance carrier who covered the Federal retiree; the carrier responded that it had initiated a claim payment recovery for the amount paid on behalf of the ineligible beneficiary. Claims related to the other potential ineligible beneficiaries were placed into a pending status and a marriage certificate for proof of eligibility was requested. As of the end of the quarter, the health insurance carrier has not received that information. Because of the health insurance carrier's measures, we closed our case in June 2020 without further action.
- ❖ In October 2018, we received an OIG hotline complaint alleging a Federal employee at the U.S. Department of Transportation fraudulently enrolled two ineligible beneficiaries for health insurance coverage on his FEHBP plan. These ineligible beneficiaries were added as a spouse and child when in fact they were a sister and niece who resided in a different State. The ineligible beneficiaries were added in January 2005 and coverage continued until January 2017. The FEHBP paid medical claims of \$108,411 on behalf of the ineligible members, as well as a portion of premiums on Family coverage instead of Self-Only coverage, which resulted in an additional loss of \$43,248. The total loss to the FEHBP was \$151,660. On May 18, 2020, the Federal employee was charged via criminal information in the U.S. District Court for the Southern District of West Virginia with health care fraud. On June 10, 2020, the Federal employee pled guilty to the charge. Sentencing is currently pending.

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 multi-agency 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 our Office of Investigations.

Pass-Through Billing Scheme

- ❖ In August 2016, we received multiple case notifications regarding a rural hospital group billing an unusually high number of urine drug screens. This hospital group arranged on a massive scale for urinary drug tests and blood tests to be performed outside of the hospitals on behalf of individuals who had no connection to the hospitals, which is a pattern characteristic of pass-through billing schemes. Many of the tests were medically unnecessary. Marketers solicited samples from substance abuse treatment centers, sober living homes, and other sources in exchange for a portion of insurance reimbursements. More than \$1.4 billion in false and fraudulent claims were submitted to the FEHBP and private insurers. OPM’s exposure amounted to more than \$3 million. On June 17, 2020, 10 individuals were indicted in the U.S. District Court for the Middle District of Florida with health care fraud, money laundering, aiding and abetting, and related charges. Judicial action continues.

- ❖ In September 2016, we received a case notification from an FEHBP health insurance carrier alleging that a provider admitted ineligible beneficiaries and did not provide the necessary behavioral health services. The provider also illegally placed patients in company-owned housing to maximize patient treatment plans to continue billing insurance carriers. A kickback scheme involving the provider sent thousands of unnecessary urine drug tests to various Florida-based laboratories as an additional facet of the widespread fraud scheme. Overall, the FEHBP paid the provider approximately \$3.1 million. In previous Quarterly Summaries, we reported indictments of approximately 10 individuals and subsequent numerous guilty pleas in the U.S. District Court for the Eastern District of Pennsylvania related to this case. On April 24, 2020, one individual was sentenced to 15 months and 1 day of imprisonment and 3 years of supervised release for conspiracy to commit health care fraud. He was ordered to pay \$3.4 million in restitution, of which the FEHBP will receive \$13,399. On May 22, 2020, a second individual was sentenced on one count of conspiracy to commit health care fraud to 37 months of imprisonment and 3 years of supervised release, and the court ordered this individual to pay restitution of \$3.07 million to an affected health insurance provider. On June 25, 2020, a third individual was sentenced on one count of conspiracy to commit health care fraud to 14 days of incarceration, 11 months of home confinement, and 50 hours of community service. This third individual was ordered to pay \$3.4 million in restitution, of which the FEHBP will receive \$13,399.

Improper Payments

- ❖ In May 2014, we received a referral from an FEHBP health insurance carrier alleging a provider submitted false claims related to residential and nonresidential substance abuse treatment facilities. The FEHBP paid the provider more than \$6.2 million, of which \$3.1 million was improperly paid. On June 8, 2020, a settlement agreement between the Government and the provider was fully executed. The FEHBP was awarded a net recovery of \$121,250.
- ❖ In October 2016, we received a *qui tam* complaint filed in the U.S. District Court for the Eastern District of Pennsylvania alleging a provider used a variety of schemes that caused physicians to order excessive urine drug testing for patients. Our investigation found numerous related schemes that submitted numerous false or unnecessary claims to Federal health care programs. From 2010 to 2017, the FEHBP paid more than \$1.02 million. On April 15, 2020, the provider entities and two former executives agreed to a settlement of \$41 million in civil restitution for violations of the False Claims Act. The FEHBP will receive \$788,324. Additionally, the laboratory provider agreed to enter into a Corporate Integrity Agreement for 3 years.

Retirement Annuity Investigations

In FY 2019, the Retirement Services program office improperly paid \$284.42 million in annuities 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.

Representative Payee Fraud

- ❖ In December 2018, we received a fraud referral from a law enforcement partner regarding representative payee fraud. While reviewing bank records, the law enforcement partner found checks for an OPM annuitant. The misappropriated amount was \$32,225. On May 26, 2020, an information filed in the U.S. District of Minnesota charged one individual with a violation of mail fraud, as well as criminal forfeiture. Judicial action continues.

Deceased Annuitant

- ❖ In May 2018, we received a referral from a law enforcement partner regarding potential fraud related to a CSRS annuitant. We received information that an annuitant died in January 2009, but the death was not reported to OPM. Monthly annuity payments continued through May 2018, resulting in an overpayment of \$400,491. Our investigation identified the deceased annuitant's son as the person converting the annuity for his illegal use. In June 2018, OPM received a treasury offset for \$5,794 of debt

collection payments, and in July 2018, OPM recovered \$25,678 through the Treasury reclamation process. In August 2019, the annuitant's son was indicted in the U.S. District Court for the District of Maryland with theft of Government funds. He was arrested in October 2019. In June 2020, he pled guilty to the charge of one count of theft of public money. Sentencing is currently pending.

Proactive Retirement Cases

The OIG performs proactive analyses to uncover improper payments in both the CSRS and FERS programs. In particular, we have identified retirement cases where program vulnerabilities, weak controls, or other circumstances allowed years of improper payments. We report these cases to the Retirement Services program office for action, who in turn can initiate the Treasury reclamation process in an effort to recover funds.

Date of Death	Date Annuity Stopped or Suspended	Total Improper Payment	Date OIG Referred to Retirement Services	Action Taken
November 2007	April 2010	\$31,416	April 7, 2020	Retirement Services requested Treasury initiate reclamation actions to recover the post-death annuity payments.
October 2010	January 2011	\$10,293	April 7, 2020	Retirement Services requested Treasury initiate reclamation actions to recover the post-death annuity payments.
January 2011	February 2011	\$1,417	April 7, 2020	Retirement Services requested Treasury initiate reclamation actions to recover the post-death annuity payments.
October 2012	December 2012	\$244	April 7, 2020	Retirement Services requested Treasury initiate reclamation actions to recover the post-death annuity payments.
September 2012	November 2012	\$518	April 7, 2020	Retirement Services requested Treasury initiate reclamation actions to recover the post-death annuity payments.

National Security Investigations

The National Background Investigations Bureau (NBIB) 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 creates vulnerabilities within the Federal workforce detrimental to Government operations. Though the Government's background investigative function is no longer an OPM-administered program as of October 1, 2019, we continue to provide external oversight of legacy NBIB background investigations begun before October 1, 2019.

- ❖ No NBIB-related investigations reached reporting milestones 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.

- ❖ No integrity investigations reached reporting milestones during this quarter.

Glossary

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 Programs

Carrier Letters are guidance that OPM Healthcare & Insurance 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. The U.S. Food and Drug Administration does not approve compounded drugs. 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 Federal 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 funds through the Department of the Treasury for money paid as an annuity to deceased Federal annuitants when a financial institution, such as a bank, continues to hold the funds.