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

Summary of Investigative Activities

Quarterly Summary of Investigative Activities

April 1, 2025, to June 30, 2025

Executive Summary

Summary of Investigative Activities

In this report, the U.S. Office of Personnel Management (OPM) Office of the Inspector General (OIG) summarizes recent cases investigated by the OPM OIG Office of Investigations as part of our mission to provide independent and objective oversight of OPM programs and operations.

These cases highlight the successes of our criminal investigators and investigative analysts; present challenges and risks to OPM programs and OPM OIG oversight; and describe fraud, waste, abuse, and mismanagement that harms OPM, its programs and operations, and federal employees, retirees, and their eligible dependents.

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Drew M. Grimm
Assistant Inspector General for Investigations

About OPM OIG Investigations

The OPM OIG Office of Investigations investigates allegations of wrongdoing related to OPM employees and contractors and allegations of fraud, waste, abuse, or mismanagement involving or affecting OPM programs and operations, including the following:

- the Federal Employees Health Benefits Program (FEHBP), including the Postal Service Health Benefits Program (PSHBP);
- the Federal Employees Dental and Vision Insurance Program (FEDVIP);
- the Federal Employees' Group Life Insurance program (FEGLI);
- OPM retirement programs, including the Civil Service Retirement System (CSRS) and the Federal Employees Retirement System (FERS);
- the Federal Long Term Care Insurance Program (FLTCIP);
- the Combined Federal Campaign (CFC); and
- other OPM programs and operations.

These investigations are essential to the OPM OIG's oversight of OPM programs and operations and ensuring OPM maintains the trust of the public and the federal employees, annuitants, and eligible dependents whom the agency serves.

An indictment is merely an allegation. Defendants referenced in these case summaries who have not pleaded guilty or been convicted are presumed innocent unless and until proven guilty beyond a reasonable doubt in a court of law.

Abbreviations

CFC	**Combined Federal Campaign**
CFR	**Code of Federal Regulations**
CSRS	**Civil Service Retirement System**
FEDVIP	**Federal Employees Dental and Vision Insurance Program**
FEGLI	**Federal Employees' Group Life Insurance**
FEHBP	**Federal Employees Health Benefits Program**
FERS	**Federal Employees Retirement System**
FLTCIP	**Federal Long Term Care Insurance Program**
FSAFEDS	**Federal Flexible Spending Account Program**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PSHBP	**Postal Service Health Benefits Program**
U.S.C.	**U.S. Code**

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Quarterly Investigative Productivity

- **Dollars referred for judicial or administrative action.....$4,803,997**

  This is the amount the U.S. Office of Personnel Management (OPM) Office of the Inspector General (OIG) referred for judicial or administrative action based on the casework of the OIG Office of Investigations during this quarter. Our investigative activities identified that this money is associated with allegations of waste, fraud, or abuse and/or improper payments issued by the agency.

- **Restitution orders, settlements, and other recoveries.....$199,190**

  This is the amount of court-ordered or otherwise promised monetary recoveries through judicial orders (restitution or settlements) or administrative agreements during this quarter. This money may be returned in this quarter or future quarters based on settlement structures, payment plans, or other factors.

- **Actual dollars returned to the OPM trust funds $596,034**

  This is the amount of money that OPM reported to the OIG as received and returned to the retirement or Federal Employees Health Benefits Program (FEHBP) trust funds during the quarter for actions associated with OIG investigative activities (e.g., settlements, restitution payments, or administrative payments). The payment may be based on case outcomes from earlier quarters.

- **OPM OIG Hotline contacts received.....904**

  This is the number of contacts that the OIG Hotline received during the quarter. The OIG Hotline is a statutorily mandated component of the OIG that receives allegations of fraud, waste, or abuse and whistleblower complaints.

Health Care Investigations

About OPM OIG Health Care Investigations

The FEHBP pays tens of millions of dollars annually in improper payments caused in part by fraud, waste, and abuse. Common health care fraud allegations that the OIG investigates include medical providers overbilling, billing for services not covered or performed, falsifying diagnoses, and performing unnecessary tests or procedures. Ineligible members who receive health benefits also cause improper payments.

The OIG Office of Investigations prioritizes investigating allegations of patient harm, substantial monetary loss to OPM health care programs, program vulnerabilities, or cases that involve health care priorities such as the opioid epidemic.

In cases where fraud, waste, or abuse affects programs or entities beyond OPM programs, we work closely with our law enforcement partners in the U.S. Department of Justice, the U.S. Department of Health and Human Services OIG, and other federal and state law enforcement agencies.

Health Care Fraud Case Summaries

- In April 2018, we received information from a law enforcement partner about alleged offerings of free custom hearing protection for members of an FEHBP insurance plan. Our investigation into these billed "digital hearing aids" found that the provider submitted claims for custom ear protection—specifically, hearing protection sold at gun shows—to FEHBP members based on falsified diagnoses of sensorineural hearing loss, despite no audiology testing and no evidence of medical necessity. Our investigative analysis found $834,154 in improper payments. Claims also increased substantially to coincide with an area gun show. Three individuals were indicted in the U.S. District Court for the District of Utah on conspiracy to commit health care fraud. On June 11, 2025, those three individuals were arrested by OPM OIG special agents in a law enforcement operation. Future investigative activity is expected in this case.

- In 2024, we received a case referral alleging that two individuals submitted incorrect or falsified Federal Long Term Care Insurance Program (FLTCIP) claims. One insured individual billed for care every day of the week during business hours, beginning on her benefit eligibility date, with no breaks in service—a highly suspicious billing pattern. This person was also potentially still working for the U.S. Army Corps of Engineers at the time. The second individual began submitting claims that listed the same caregiver as the first individual, and our investigation identified that this second individual had participated in—and pleaded guilty to conspiracy to commit racketeering as part of—a highly publicized fraud scheme involving college admissions. These two individuals received $381,930 from fraudulent claims submitted to FLTCIP providers. OPM OIG law enforcement conducted various law enforcement activities, including a search

warrant, during this quarter. Additionally, we served financial forfeiture warrants that resulted in the recovery of $230,000.

- We previously reported our investigation into a federal employee who submitted fictitious medical claims on behalf of his dependent children as part of a scheme to receive reimbursement for services that were inflated or never happened. Our investigation also identified a co-conspirator who submitted false claims. The first individual previously pleaded guilty to health care fraud and was sentenced in June 2024. On May 6, 2025, the co-conspirator charged with health care fraud changed his plea to guilty. Further judicial action related to sentencing is expected in this case.

- In April 2024, we received a qui tam complaint filed in the U.S. District Court for the Northern District of New York about multiple pain management centers that allegedly maximized profits by performing as many interventional pain procedures on as many patients as possible.[1] Clinicians were allegedly encouraged to order as many billable treatments as possible (including unnecessary or harmful procedures such as injections, excessive steroids, and x rays). FEHBP health insurance carriers paid $143,802 related to the allegations. On April 29, 2025, OPM OIG criminal investigators and other law enforcement partners conducted a search warrant at multiple locations.

- We received a qui tam complaint that alleged that a laboratory and its owner double-billed for COVID-19 laboratory tests by billing both the state of Illinois and FEHBP members' insurers. The lawsuit also alleged that the laboratory billed for testing pathology interpretations that were never performed. FEHBP health insurers paid $364,321 related to the allegations. The owner of the laboratory was indicted in the U.S. District Court for the Central District of Illinois on six charges of health care fraud, one count of mail fraud, and three counts of wire fraud. On April 23, 2025, the owner pleaded guilty to one count of health care fraud and one count of wire fraud. Further judicial action related to sentencing is expected in this case.

- In September 2022, we received a referral from a law enforcement partner alleging that a medical entity billed for COVID-19 testing services and other medical services that were never provided. According to the allegation, when health insurers requested proof to support the claims, the owner had staff develop a program to automatically generate fabricated medical records. FEHBP health insurance carriers paid $775,883 for claims related to these allegations. On June 23, 2025, the owner was indicted by a grand jury in the U.S. District Court for the Southern District of New York on multiple charges, including health care fraud. Further judicial action is expected in this case.

- In January 2021, we received a referral from an FEHBP health insurance carrier alleging that a provider billed for hyperbaric oxygen therapy without rendering those services, billed excessively for services provided to the provider's employees or family members, and billed for services provided by nonqualified personnel. FEHBP health insurance carriers had paid the provider $533,943 in claims related to this scheme. On June 24,

[1] The False Claims Act allows private citizens to file suits on behalf of the United States against those who have defrauded the government. These suits are called "qui tam" suits. Private citizens who successfully bring qui tam actions may receive a portion of the government's recovery.

2025, a criminal information filed in the U.S. District Court for the Eastern District of Virginia charged one individual with health care fraud. Further judicial action is anticipated in this case.

- In August 2021, we received a qui tam complaint filed in the U.S. District Court for the Eastern District of Pennsylvania alleging that a plastic surgeon submitted false or fraudulent claims. The plastic surgeon had treated the minor child of an FEHBP member and submitted claims exceeding the services provided. Our investigative staff presented the case to the Assistant U.S. Attorney's Office in the Eastern District of Pennsylvania. Initially, this case was closed because of lack of investigative resources. However, the case was reopened when the relator and the subject agreed to a settlement. On April 24, 2025, the settlement was finalized and OPM received a net recovery of $60,532, including OPM OIG investigative costs.

- In July 2023, we received a referral from an FEHBP health insurance carrier alleging that its audit found a company was forging doctors' signatures for referrals related to durable medical equipment. Our investigation identified more than 70 durable medical equipment and laboratory providers associated with a call center in Pakistan and other international entities allegedly participating in the fraud scheme. FEHBP health insurance carriers had paid $1.08 million in claims related to the allegations. We identified several individuals who resided outside of the United States as participants in the scheme. On June 6, 2025, these individuals were indicted for health care fraud and money laundering. Because the defendants are currently located in Pakistan and beyond our jurisdictional reach, we closed our investigation.

- In December 2023, we received a case notification from an FEHBP health insurance carrier alleging that a group of medical entities billed the FEHBP for COVID-19 laboratory tests that never happened. FEHBP health insurance carriers paid $866,212 for claims related to the allegations. Two individuals were charged on June 13, 2025, by a criminal complaint filed in the U.S. District Court for the Northern District of Illinois. One individual was charged with money laundering, and one individual was charged with health care fraud. Our law enforcement agents arrested the individuals at the airport before they boarded one-way international flights. Further judicial action is expected in this case.

- In July 2018, we received a qui tam complaint involving a drug company that worked with a network of pharmacies to illegally maximize the number of prescriptions for the drug. We previously reported that case outcome: the drug manufacturer agreed to pay $12.7 million as part of a November 2021 civil settlement. In a spin-off case, a pharmacy allegedly provided false statements to obtain favorable preauthorization and coverage determinations for the drug at issue in the original case as well as multiple other medications. FEHBP health insurance carriers paid $2.49 million to this pharmacy for the medications identified as part of the fraud scheme. On April 10, 2025, the pharmacy pleaded guilty to one count of health care fraud. As part of the plea agreement, it agreed to pay $82,000 in restitution and $1.01 million to resolve the allegations of violating the False Claims Act. The amount OPM will receive is yet to be determined because of the pharmacy's inability to pay.

- We received information from a law enforcement partner that FEHBP members may have been affected by a company billing for services not rendered as part of a durable medical equipment fraud scheme involving wound dressings, glucose monitors, and orthotic braces. Our investigative analysts identified $288,479 in paid FEHBP claims related to the allegations. On June 4, 2025, a criminal complaint filed in the U.S. District Court for the Southern District of Florida charged the owner of the company with money laundering. OPM OIG special agents participated in the arrest of the owner on June 10, 2025. Further investigative activity is expected in this case.

OPM OIG Investigations Involving the Postal Service Health Benefits Program

The Postal Service Health Benefits Program (PSHBP) is a separate health benefits program under the FEHBP. The PSHBP covers U.S. Postal Service employees, annuitants, and their eligible family members, with its first coverage year beginning on January 1, 2025. The OPM OIG investigates health care fraud cases involving the PSHBP as part of our efforts to protect the FEHBP and OPM programs.

- We have no reportable actions in PSHBP-related investigations during this quarter.

OPM OIG Investigations Involving the Opioid Crisis

In 2017, the U.S. Department of Health and Human Services declared the opioid crisis a public health emergency. The OIG Office of Investigations continues to prioritize opioid-related investigations during this ongoing public health emergency. Opioid investigations by our office may involve the manufacturing or marketing of opioids; inappropriate or medically unnecessary prescribing practices; or fraud, waste, or abuse by sober homes and substance abuse recovery facilities.

Opioid-Related Case Summaries

- We previously reported we received a case referral from a federal law enforcement partner alleging that two doctors specializing in pain management were billing excessively and billing for services not rendered. Patients were billed for injections they did not receive. Patients also received “goody bags” that included prescription medications prescribed without medical need. The medical practice inappropriately dispensed opioids and other Schedule II controlled substances. On April 15, 2025, a jury in the U.S. District Court for the Eastern District of Pennsylvania found the doctor who owned the practice guilty on three counts of health care fraud, one count of conspiracy to commit health care fraud, one count of money laundering, one count of unlawful monetary transactions, one count of conspiracy to distribute controlled substances, and two counts of aiding and abetting. Further judicial action related to sentencing is expected in this case.

- Between 2018 and 2023, we received multiple qui tam complaints alleging that a national pharmacy chain knowingly caused the submission of false claims to government programs, violating the Controlled Substances Act and the False Claims Act. The national pharmacy chain dispensed opioid medications and controlled substances in scenarios where it should have refused to fill the prescriptions. This included

prescriptions for U.S. Food and Drug Administration Schedule II medications with high morphine milligram equivalent doses, poly-pharmacy combinations, and early and often refills. The national pharmacy chain allegedly pressured pharmacists to ignore the dangers of these prescriptions, which put FEHBP members at risk of harm. FEHBP health insurers paid approximately $8.2 million to this national pharmacy chain for claims identified as relevant to our investigation. On April 21, 2025, the U.S. DOJ and the national pharmacy chain agreed to a $300 million civil settlement agreement. OPM will receive $4.9 million to be returned to the FEHBP trust fund as its portion of the settlement.

- We previously reported that in November 2022, the OIG, as part of its work with the FBI Health Care Fraud Task Force, opened an investigation into a management consulting firm that provided consulting services to a pharmaceutical company. The management consulting firm allegedly advised the pharmaceutical company to intensify marketing of its opioid medication to certain health care providers, including some known to prescribe large quantities of opioids. This caused false or fraudulent FEHBP claims for opioid medications. In addition to a previously reported settlement, one individual was charged by criminal information in the U.S. District Court for the Western District of Virginia with the destruction, alteration, or falsification of records in a federal investigation and pleaded guilty to the charge in January 2025. On May 23, 2025, this former senior partner was sentenced to 6 months in prison, 2 years of supervised release, 1,000 hours of community service, and a $40,000 fine.

The FEHBP's Exclusion from the Anti-Kickback Statute: A Barrier to Recovering FEHBP Improper Payments

The Anti-Kickback Statute (title 42 U.S.C. sections 1320a–7b) makes it illegal for health care providers to knowingly and willfully accept bribes or other forms of remuneration in return for activities such as patient referrals. The FEHBP is excluded from pursuing cases under the Anti-Kickback Statute. Kickbacks can increase FEHBP costs and patients can suffer harm if health care providers profit from referrals for treatments or procedures that are not medically necessary.

The FEHBP's exclusion from the Anti-Kickback Statute has interfered with our ability to fully protect the FEHBP and its members from improper conduct that would constitute a federal crime when committed against any other federally funded health care program. Improperly paid FEHBP dollars can go unrecovered because of the program's exclusion.

Typically, our investigations are complicated by the FEHBP's Anti-Kickback Statute exclusion if one of the following findings occur:

1. Our investigation finds alleged wrongdoing by a medical provider that involves Anti-Kickback Statute violations as well as other wrongdoing. In these cases, we often continue our investigation. However, if there is a settlement or restitution, the FEHBP may be unable to recover losses considered Anti-Kickback Statute violations. The FEHBP may recover a smaller part of its improper payments compared to other federal programs.

2. Our investigation finds alleged wrongdoing by a medical provider that involves primarily or exclusively Anti-Kickback Statute violations. When the Department of Justice prosecutes these cases, other federal health care programs are identified as victims—but the FEHBP is not, regardless of dollars lost. We typically close these cases after a prosecutorial determination excludes the FEHBP.

Anti-Kickback Statute–Related Case Summaries

- In January 2025, we received a case notification from an FEHBP health insurance carrier and a request for information from the U.S. DOJ about a hospital group as part of an ongoing investigation. The FEHBP had paid $16.14 million to this entity, though this was the overall paid amount and not specific to the allegations. U.S. DOJ staff informed the OIG that the allegation is being investigated as violations of the Anti-Kickback Statute. Because of the FEHBP's exclusion, we closed our investigation.

Retirement Investigations

About OPM OIG Retirement Investigations

OPM reported $243.7 million in overpayments under the Retirement Services program in fiscal year 2024. These improper payments often are from fraud, waste, or abuse in the OPM-administered Civil Service Retirement System (CSRS) and the Federal Employees Retirement System (FERS).

The most common causes of improper payments are related to annuitant deaths that are unreported or unknown to OPM. These unreported deaths may allow payments to continue because of program vulnerabilities or intentional fraud on the part of bad actors. Sometimes, CSRS or FERS improper annuity payments continue for years and amount to tens of thousands of dollars before discovery.

Fraud by forged documents (such as OPM's Address Verification Letters to annuitants), identity theft, and other schemes are common harms that the OIG investigates. We also investigate allegations of financial elder abuse to OPM annuitants that may relate to OPM programs and mismanagement of funds by representative payees who violate their duty to act on behalf of an OPM annuitant or survivor annuitant.

As part of our investigative work, our Investigative Support Operations group performs proactive searches of death records and other data analysis to find annuitants and survivor annuitants who died but to whom OPM continues to send annuity payments. These proactive investigations are a vital process for finding and stopping improper payments. In some cases, our proactive analysis generates leads for criminal investigations. Information our investigative analysts and special agents refer to OPM can also help the agency recover improper payments through administrative actions such as payment agreements or the U.S. Department of the Treasury reclamation process.

OPM Retirement Fraud Case Summaries

- We received a fraud referral from the Retirement Services Fraud Unit in October 2024 after OPM sent a Centenarian Project letter to the address in the survivor annuitant's file. OPM received a copy of a death certificate in response. Based on the information from the death certificate, OPM had paid $142,878 after the survivor annuitant's death. OPM recovered $12,789 through Treasury reclamation actions. Our investigation found that the decedent's bank knew of the death and did not notify the government as required by title 31 CFR 210.10(a). Therefore, the bank was liable for returning the remaining amount to OPM, which it did on June 16, 2025. Based on our actions, OPM recovered $130,088.

Integrity Investigations

About OPM OIG Integrity Investigations

The Office of Investigations conducts investigations into allegations of fraud, waste, abuse, or mismanagement involving OPM employees and contractors. These integrity investigations may involve whistleblowers or allegations of retaliation.

Integrity investigations are essential to maintaining public confidence in OPM, which includes the trust of the current and retired civil servants and eligible family members who rely on OPM programs to operate efficiently and effectively.

Our efforts in these investigations are an important part of the OIG's mission to provide independent and objective oversight of OPM programs and operations.

Integrity Investigations Case Summaries

- We have no reportable actions in integrity-related investigations during this quarter.

About OPM Programs

- **Federal Employees Health Benefits Program (FEHBP):** The FEHBP is the largest employer-sponsored health insurance program in the world, covering millions of federal employees, annuitants, and eligible family members. The FEHBP provides quality, affordable, and comprehensive health benefits with national and local plan choices. It is a vital part of the federal government's benefits package.

  Postal Service Health Benefits Program (PSHBP): The PSHBP is a separate health benefits program under the FEHBP that covers U.S. Postal Service employees, annuitants, and their eligible family members. The PSHBP's first plan year began January 1, 2025.

- **Federal Employees Dental and Vision Insurance Program (FEDVIP):** FEDVIP makes supplemental dental and vision insurance available to federal employees and retirees and their eligible family members as well as certain TRICARE (a health care program of the U.S. Department of Defense Military Health System) members.

- **Federal Flexible Spending Account Program (FSAFEDS):** FSAFEDS allows eligible federal employees to save money for health care expenses with a Health Care or Limited Expense Health Care FSA. Money in an FSA is deducted automatically from an employee's paycheck before taxes are taken out. These pre-tax dollars can be used to pay for eligible health care or dependent care expenses.

- **OPM Retirement Programs, including the Civil Service Retirement System (CSRS) and the Federal Employees Retirement System (FERS):** OPM Retirement Programs pay monthly annuities to retired civil servants and the eligible survivors of deceased OPM annuitants. OPM paid billions of dollars in defined benefits to retirees, survivors, representative payees, and eligible family members during the previous fiscal year.

- **Federal Employees' Group Life Insurance program (FEGLI):** FEGLI is the largest group life insurance program in the world, covering enrolled federal employees, retirees, and their eligible family members. It provides standard group term life insurance and elective coverage options. FEGLI disburses millions of dollars in benefits annually.

- **Federal Long Term Care Insurance Program (FLTCIP):** FLTCIP provides supplemental long term care insurance to help pay for costs of care when enrollees need help with daily activities or have severe cognitive impairment. The program is currently suspended for new applications until December 2026.

- **Combined Federal Campaign (CFC):** The CFC offers the federal community an opportunity to donate to thousands of eligible charities. As the largest and most successful annual workplace charity campaign in the world, the CFC raises millions of dollars each year through pledges made by civilian, postal, and military employees and retirees.

Report Fraud, Waste, Abuse, and Mismanagement

Fraud, waste, abuse, and mismanagement in government concerns everyone: Office of the Inspector General staff, agency employees, and the general public. We actively solicit allegations of any inefficient and wasteful practices, fraud, and mismanagement related to OPM programs and operations. You can report allegations to us in several ways:

By Internet: https://oig.opm.gov/contact/hotline

By Phone: Toll Free Number: 877-499-7295

By Mail: Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street NW
Room 6400
Washington, DC 20415-1100