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

Quarterly Case Summaries

Investigative Activities

Fiscal Year 2019

First Quarter

October 2018 – December 2018

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-- Caution --

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List of Acronyms

CSRS	**Civil Service Retirement System**
DOJ	**U.S. Department of Justice**
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 Program**
FEHBP	**Federal Employees Health Benefits Program**
FEI	**The Federal Executive Institute**
FERS	**Federal Employees Retirement System**
FFS	**Fee-for-Service**
HHS	**U.S. Department of Health and Human Services**
HMO	**Health Maintenance Organization**
NBIB	**National Background Investigations Bureau**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
OSC	**U.S. Office of the Special Counsel**
ROI	**Report of Investigation**

In this report to the OPM Director, 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 the period from October 1, 2018, through December 31, 2018.

Health Care Investigations

The "OPM Fiscal Year 2018 Agency Financial Report" states that in fiscal year 2018, the FEHBP made $71.44 million in improper payments. These substantial, costly improper payments often derive from fraud, waste, and 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.

Pass-Through Billing

- We received a citizen complaint referral from the FBI alleging billing fraud related to the complainant's purchase of an alleged weight loss treatment from a coupon website. Our investigation found that health care providers performed unnecessary diagnostic tests, fraudulently billed tens of thousands of dollars to a health carrier, and operated a pass-through billing scheme to increase reimbursement. The OPM-administered Federal Employees Health Benefits Program (FEHBP) paid approximately $86,000 to the various entities involved. In December 2018, an associated provider pled guilty in the U.S. District Court for the Southern District of Texas to conspiracy to commit health care fraud and accepted responsibility for $1.5 million in improper claims. The provider will repay that amount over 5 years. The FEHBP has $51,100.62 in exposure related to this portion of the case that it intends to recoup via the settlement.

Unbundling

- We received a case referral from the U.S. Attorney's Office in the Eastern District of Pennsylvania alleging that a provider excessively billed the FEHBP in an unbundling scheme affecting thousands of claims. Additionally, interviews of former staff suggested that practitioners performed part of a procedure in a manner that was excessive or unnecessary, creating a patient-harm risk. In October 2018, we, along with the U.S. Department of Health and Human Services (HHS) OIG and other Federal law enforcement agencies, arrived at a settlement agreement with the provider. The provider will pay $11,250,000 in restitution, and its CEO will pay $1,250,000. The FEHBP will recover its entire damages of $269,258.12.

Medically Unnecessary Procedures

- We received a referral from a FEHBP health carrier alleging that a provider misstated fees related to sleep apnea testing and monitoring equipment. Further investigation found patients underwent medically unnecessary tests, employees falsified or altered referral forms and underwent tests of their own, and the provider entered into illegal inducement agreements. In December 2018, the U.S. District Court for the Eastern District of Virginia sentenced the providers to prison for conspiracy to commit health care and wire fraud, seven counts of health care fraud, conspiracy to defraud the United States, and filing a false tax return. One provider received 7 years' imprisonment; the other received 3 years' imprisonment. Both subjects are liable for restitution and the FEHBP's expected recoupment is $555,897.30.

- We received a case referral from a FEHBP health carrier alleging that a provider submitted false and inflated claims. Our investigation with the FBI and other Federal law enforcement partners found multiple fraud schemes involving medically unnecessary testing, services not provided as billed, and services generated as the product of inducements. The multiple fraud schemes in the case have a combined paid exposure for the FEHBP of $3,692,626.02. In December 2018, the U.S. District Court for the Northern District of Texas sentenced one individual to 35 months' imprisonment and 2 years of supervised release. The FEHBP did not have damages related to this individual: this marketer specifically recruited members from TRICARE.

Ineligible Dependents

- We received a referral from a health carrier alleging an FEHBP enrollee submitted altered official court documents to remove an ex-spouse from their FEHBP health insurance when adding a new spouse to their plan. Specifically, the document showed that the member purportedly divorced their ex-spouse in January 2017 when in fact they had divorced in April 1993. The FEHBP paid $154,102.42 in claims on behalf of the ex-spouse over the 14 years of ineligible coverage. The member was indicted in November 2018, in the U.S. District Court for the Northern District of Alabama on theft of Government funds, aggravated identity theft, and false statements. In December 2018, we arrested the member.

False Claims Act

- In March 2017, we received a referral from the U.S. Attorney's Office in the Eastern District of Pennsylvania regarding a qui tam lawsuit originally filed in September 2009. The lawsuit alleged a provider violated the Anti-Kickback Statute and the False Claims Act between 2006 and 2008 by providing inducements to physicians for brand-name prescriptions and marketing off-label indications not approved by the U.S. Food and Drug Administration (FDA). The FEHBP's exposure was calculated in excess of $34 million in fraudulent billing. Further analysis identified $566,375 in paid FEHBP claims that met all criteria under the specific allegations of the case. In October 2018, the

provider agreed to pay $25 million in a settlement with the United States Government. The FEHBP will recover its damages of $566,375.

- In April 2014, we received a referral for a qui tam complaint from the U.S. Attorney's Office for the District of Utah alleging that a provider telephonically marketed medical equipment and billed various Government health programs, including the FEHBP. The financial impact to the FEHBP was $59,660.30. A November 2018 civil settlement with the provider awarded the FEHBP a recovery of $17,021.87. Additionally, our civil investigation resulted in a settlement with one individual where the FEHBP received an additional recovery of $2,438.24.

Services Not Rendered

- In March 2017, we received a referral from a Federal agency that it was investigating a provider for billing for services not rendered and double billing studies. Our joint investigation determined the total loss to the FEHBP was approximately $98,082.62. Two individuals were indicted for health care fraud. In November 2018, they pled guilty in the U.S. District Court for the Central District of California.

Unauthorized Prescriptions – Compounded Drugs

- In March 2015, we received a case referral from a FEHBP health carrier that alleged a provider filled unauthorized prescriptions for compounded drugs. We investigated a telemedicine scheme where the provider overprescribed exorbitantly priced medications and prescribed drugs that were medically unnecessary in exchange for compensation from several telemedicine companies. These prescriptions were also prescribed outside the areas where the provider was licensed to practice. The FEHBP suffered $161,179.45 in exposure from 2014 to 2016. In November 2018, a criminal complaint was filed in the U.S. District Court for the District of New Jersey for conspiracy to commit health care fraud.

- In September 2016, we received a request for investigative assistance from the U.S. Attorney's Office in the Eastern District of Tennessee regarding a provider billing for expensive compounded medications without a doctor-patient relationship amid an elaborate telemedicine scheme. The case was investigated with Federal and State law enforcement partners. The FEHBP suffered $1,526,420.36 in losses related to the claim. In October 2018, the U.S. District Court for the Eastern District of Tennessee unsealed indictments against four individuals and seven companies.

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 costs associated with the crisis. Addressing opioid-related issues remains a priority for the Office of Investigations.

Unauthorized Prescriptions – Opioids

- The U.S. Department of Justice (DOJ) referred to us a joint, nationwide investigation with the FBI, HHS OIG, and other Federal law enforcement agencies regarding off-label marketing and health care fraud involving a Schedule II, fentanyl-based narcotic. The manufacturer illegally promoted the drug by offering financial inducements for providers and falsified or misrepresented information for prior authorizations via a "reimbursement center." From April 2012 to September 2016, the FEHBP paid $17,742,528.86 for 2,152 medical claims. One former employee pled guilty to wire fraud conspiracy in June 2017, and a company vice president pled guilty to one count of racketeering conspiracy in November 2018. Six other subjects were arrested in December 2018, and charged in the U.S. District Court for the District of Massachusetts with crimes including RICO charges, conspiracy to commit racketeering, and conspiracy to commit wire and mail fraud.

Retirement Investigations

In fiscal year 2018, OPM's Retirement Services office improperly paid $284.08 million to retirees, survivors, representative payees, and families. 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 hundreds 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.

Deceased Annuitant

- Our proactive review of retirement fraud cases in suspended status verified that a retired annuitant had died overseas in August 2014. OPM continued to make payments until our involvement, by which time the improper payments totaled $105,853.02. In October 2018, Retirement Services initiated reclamation proceedings from the U.S. Treasury Department and recovered $102,991.75.

- A State law enforcement agency notified us about possible fraud after a Federal annuitant suffering from severe starvation died. The nursing assistant working as a home health care provider had obtained power of attorney for the annuitant's financial and medical matters, including an OPM-administered annuity. The nursing assistant received $25,867.26 in payments from OPM's-administered Federal Employees' Group Life Insurance (FEGLI) program because of an altered beneficiary form and $64,385.10 in misdirected OPM monthly retirement payments intended for the annuitant. The loss amount by theft totaled $133,264.78. The North Carolina District Court for Hoke County issued an arrest warrant in December 2018 for obtaining property by false pretense and exploitation of a disabled/elderly person, both of which are felonies.

- We received a referral from OPM's Retirement Services office after a survivor annuitant's September 2004 death was not reported in a timely fashion, causing OPM to continue to deposit retirement annuity payments through February 2016. OPM initially stopped the annuity payments in December 2004; however, a person claiming to be the survivor annuitant contacted OPM and requested the payments be reinstated. OPM improperly paid a total of $152,445.28 after the survivor annuitant's death. Through the reclamation with the U.S. Department of the Treasury, OPM recovered $994.72, leaving a net overpayment of $151,450.56. The survivor annuitant's daughter was indicted in the U.S. District Court for the Central District of California in October 2018 on eight counts of bank fraud, six counts of theft of Government property, and one count of aggravated identity theft.

- We received a referral from a Federal law enforcement partner regarding a retired Federal annuitant who continued to receive payments after their death in December 2015. The annuity payments continued until July 2017, for an improper payment of $39,259.36. In August 2018, the Federal annuitant's daughter was indicted in the U.S. District Court for the District of Arizona on two counts of theft of Government money for collecting Social Security and OPM annuity benefits after the annuitant's death. In December 2018, she pled guilty to theft of Government money.

- We received a referral from OPM's Retirement Services office regarding the unreported July 2011 death of a retired annuitant. OPM continued making payments through May 2015, resulting in an improper payment totaling $107,239.03. OPM recovered $3,750.28 through the U.S. Department of the Treasury's reclamation process, leaving a balance of $103,488.75. The annuitant's daughter confessed to forging AVLs and taking the annuity payments. She was indicted in the U.S. District Court for the State of Maryland on charges of theft of Government money and arrested in November 2018.

- In November 2017, OPM's Retirement Services office suspended the annuity payments of a Federal retiree when they failed to respond to correspondence. We located an obituary for the retiree showing January 2007, as the date of death. The obituary was provided to Retirement Services. Retirement Services recovered the entire overpayment amount of $71,782.48 through the U.S. Department of Treasury's reclamation process. OPM also recovered the annuitant and Government shares of FEHBP premiums totaling $74,358.46.

- We received a referred retirement annuity file from OPM's Retirement Inspections office regarding the unreported December 2001 death of an annuitant. In total, OPM sent $123,314 in improper payments. The daughter of the deceased annuitant was indicted in the U.S. District Court for the Central District of California on eight counts of mail fraud, eight counts of theft of Government property, and one count of aggravated identity theft on December 2018.

Disability Fraud

- In October 2018, we received notification about an ongoing investigation by a Federal law enforcement partner regarding a former Federal employee who submitted false documentation, including falsified medical letters, to receive benefits from multiple Federal programs, including an OPM Disability Retirement. An investigation quantified the loss to OPM at approximately $30,000; however, the potential exposure was calculated at approximately $717,000, based on a return to the OPM disability annuity at age 40 and living until 80 years old, with annual 2-percent cost of living adjustments. The employee was arrested and indicted in the U.S. District Court for the Northern District of California on seven counts of wire fraud and one count of aggravated identity theft.

Retirement Services Error

- The OIG's Investigative Support Operations group reviewed an OPM retirement file and noted that OPM's Retirement Services office had used an incorrect rate to compute the retroactive annuity and the monthly survivorship amount after a Federal annuitant's death was not reported to OPM in a timely fashion. We referred the retirement file back to Retirement Services for corrective action. Retirement Services recomputed the amount of accrued survivor annuity applicable to its original $142,431.27 overpayment and calculated a due balance of $43,958.09, and a request for repayment was sent to the survivor annuitant.

National Security Investigations

OPM's National Background Investigations Bureau (NBIB) conducts 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 by the background investigators creates vulnerabilities within the Federal workforce detrimental to Government operations. We provide external oversight of NBIB's background investigations to protect the integrity of these background investigations.

Falsifications of Background Investigations

- We received a referral from the NBIB Integrity Assurance office regarding multiple inconsistencies in a background investigator's Reports of Investigation (ROIs). Case sampling found 37 falsifications between April 2014 and February 2015 by the background investigator, resulting in a background investigation recovery labor cost of over $189,000. The background investigator pled guilty in the U.S. District Court for the District of Columbia to making false statements. They were sentenced to 36 months of probation, 100 hours of community service, and full restitution to OPM of the $189,000 spent by OPM to re-investigate the falsified background investigations.

- We received a referral from the U.S. Attorney's Office for the Eastern District of Tennessee regarding a background investigator who submitted false and fraudulent documentation in order to secure employment with NBIB. OPM's exposure totaled $162,334. In July 2018, in the U.S. District Court for the Eastern District of Tennessee, the former NBIB background investigator was convicted of wire fraud, mail fraud, financial conflict of interest, theft of public money, and making false statements in matters within the jurisdiction of the United States. The investigator was sentenced in November 2018 to 96 months in Federal prison and ordered to pay $162,334 in restitution.

- We received a referral from the NBIB Integrity Assurance office regarding falsifications made by a background investigator. The investigation found 48 falsifications. In October 2018, the case was accepted for prosecution by the U.S. Attorney's Office for the District of Columbia. On November 2018, we received notification that the background investigator intends to plead guilty to making a false statement. Additionally, the background investigator will participate in a video interview about their falsifications that will be used for OPM training. He was also ordered to pay $40,000 in restitution.

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.

Prohibited Personnel Practices

- We received an in-person allegation from an OPM employee who alleged denial of a within-grade step increase because they rejected the inappropriate romantic advances of their supervisor. The complainant had also filed a complaint with OPM's Equal Employment Opportunity Office, which was accepted for investigation. Considering that office's involvement, our special agents provided resources on the U.S. Office of Special Counsel (OSC) for information on whistleblower retaliation and closed the complaint.

- We received an anonymous complaint alleging prohibited personnel practices by an OPM senior Government official at OPM's Federal Executive Institute (FEI). We referred this case to the United States Attorney's Office for the District of Columbia, which declined prosecution in August 2017, and January 2018, in lieu of administrative remedies available to OPM. Our investigation concluded that the subject senior Government official engaged in prohibited personnel practices. In December 2018, we referred the case to the then Acting Director of OPM and the OSC for appropriate action.

- We received anonymous allegations alleging prohibited personnel practices by two senior OPM officials in OPM's Office of the Chief Information Officer. These allegations related to the hiring and appointment of multiple employees, and the allegations were substantiated by our investigations. We referred the case to the U.S. Attorney's Office for the District of Columbia, which declined to prosecute in lieu of administrative remedies available to OPM. In December 2018, we referred the cases to the then Acting Director of OPM and the OSC for appropriate action.

Gross Mismanagement and Discrimination

- We received an allegation via the OIG Hotline regarding gross mismanagement that caused the accidental release of billions of dollars from an OPM-administered trust fund to the U.S. Department of Treasury, an incident caused by an employee error but which was corrected in a timely fashion and saw the responsible employee demoted. Additionally, the reporting party alleged that they were discriminated against because of their sexual orientation and religious beliefs. The case was referred to OPM's Equal Employment Opportunity Office, and we deferred to its investigation.

Glossary

OPM Programs

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.

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.

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 made online via https://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/ or by telephone at 1-877-499-7295.

Health Care and Insurance

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 health maintenance organizations (HMOs) and fee-for-service (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 U.S. Food and Drug Administration (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.

Off-Label Usage of medications is the usage of FDA-approved drugs for a use not specifically approved by the FDA. Doctors may prescribe or instruct a patient to use medications in this fashion in order to treat a disease or medical condition; however, companies cannot market medications according to off-label use or uses not approved by the FDA. Marketing or promoting drugs according to an off-label use is illegal.

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 a vulnerable to a variety of fraud schemes, including those involving opioids and compounded medications.

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

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.

Racketeer Influenced and Corrupt Organizations Act (RICO) is a Federal law with criminal penalties for anyone employed by or associated with a criminal enterprise. Specifically, RICO violations occur when: (1) an enterprise exists; (2) the enterprise affected interstate commerce; (3) the defendant was associated with or employed by the enterprise; (4) the defendant engaged in a pattern of racketeering activity; and (5) the defendant conducted or participated in at least two acts of racketeering activity.

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 OPM's Retirement Services office. It is one of the surveys that Retirement Services uses to confirm and census its annuitant population.

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

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

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.

Suspended Status is a temporary designation Retirement Services uses to categorize annuitants whose annuities are stopped pending some sort of other resolution to restore the annuity or place the annuitant in death or other removal status. Annuitants are commonly placed in suspended status because they fail to respond to an AVL or multiple consecutive payments are returned to the Treasury because of a closed or invalid bank account. The OIG, as part of its proactive efforts to stop improper payments, may investigate annuitants in suspended status to determine if their annuity should be resorted or if the annuitant has died.

National Security

The National Background Investigations Bureau (NBIB) conducts background investigations of Federal job applicants, employees, members of the armed services, and contractor personnel for suitability and security purposes. Background investigators submit their findings from interviews and other work in their **Reports of Investigation (ROIs).**

Integrity

The U.S. Office of Special Counsel (OSC) investigates and prosecutes prohibited personnel practices, whistleblower retaliation, and other violations that harm the civil service. We maintain concurrent jurisdiction with OSC in investigative prohibited personnel practices and other integrity investigations, and as an outcome of our integrity investigations involving OPM employees, we may refer cases to the OSC for further action.