



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

Quarterly Case Summaries

Investigative Activities

Fiscal Year 2020

First Quarter

October 1, 2019 – December 31, 2019

-- Caution --

This report has been distributed to Federal officials who are responsible for the administration of the subject program. This non-public version may contain confidential and/or proprietary information, including information protected by the Trade Secrets Act, 18 U.S.C. § 1905, and the Privacy Act, 5 U.S.C. § 552a. Therefore, while a redacted version of this report is available under the Freedom of Information Act and made publicly available on the OIG webpage (<http://www.opm.gov/our-inspector-general>), this non-public version should not be further released unless authorized by the OIG.

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

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

The Federal Employees Health Benefits Program (FEHBP) provides health insurance to Federal employees, retirees, and their dependents. It is the largest employer-sponsored

health insurance program in the world and administers benefit payments within a universe of over 200 health plans, including health maintenance organizations (HMOs) and fee-for-service (FFS) health plans from a number of private health insurance carriers.

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

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

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

The cases below represent a period from October 1, 2019, through December 31, 2019.

Health care Investigations

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

Anti-Kickback Statute

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

- ❖ In December 2018, we received a *qui tam* complaint from the U.S. Attorney's Office for the District of New Hampshire regarding a medical center engaged in a kickback scheme with a medical device manufacturer. Between 2015 and 2018, the FEHBP paid the provider \$48,741,884. However, the U.S. Attorney's Office for the District of New Hampshire stated that the *qui tam* is focused only on violations of the AKS, which excludes the FEHBP. Because of this, we closed our investigation and no funds were returned to the FEHBP.

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

Improper Billing

- ❖ We received notification from the Federal Bureau of Investigation (FBI) that a provider improperly billed for medical equipment. The FEHBP paid the provider \$157,839. In August 2019, a criminal information filed in the U.S. District Court for the District of Oregon charged one individual with health care fraud. This individual was arrested on October 10, 2019. Judicial action continues in this case.
- ❖ We received a case referral in April 2012 related to an ongoing investigation of a medical center and its owners and providers. The alleged scheme involved waiving coinsurance

and patient financial responsibility for those with out-of-network benefits. Additionally, the provider paid kickbacks to doctors for referrals. The FEHBP paid \$18,150,555 in claims related to this investigation. Since November 2016, we have reported more than 20 indictments, 10 guilty pleas, and 7 convictions related to this scheme. On December 4, 2019, one individual was sentenced to 60 months of probation and ordered to pay \$27,855 in restitution. On December 19, 2019, another individual was sentenced to 60 months of imprisonment and 3 years of supervised release, as well as restitution for \$537,855 to OPM. Judicial action continues in this case.

- ❖ We received a November 2017 case notification identifying an outlying provider with high-dollar billing trends. The FEHBP had \$1,015,000 in exposure related to the provider. In March 2019, the provider was indicted on six counts of health care fraud and one count of making a false statement relating to health care matters. On December 6, 2019, the provider pled guilty in the U.S. District Court for the Northern District of California to one count of health care fraud and one count of making a false statement. Judicial action continues in this case.
- ❖ In June 2019, we received a referral from the FBI regarding a third-party medical billing provider that sought extremely high reimbursements by submitting false billing claims. The FEHBP had paid \$6,175,251 to the provider. In July 2019, a complaint filed in the U.S. District Court for the Eastern District of New York charged one individual with health care fraud, wire fraud, and aggravated identity theft. In August 2019, the individual was indicted on wire fraud and aggravated identity theft. On December 12, 2019, a superseding indictment filed in the U.S. District Court for the Eastern District of New York charged the individual with conspiracy to commit health care fraud, health care fraud, wire fraud, aggravated identity theft, and money laundering conspiracy. Judicial action continues in this case.
- ❖ In September 2013, we received a case referral regarding a provider billing for personal training and authorizing another individual to use his provider number to bill for unallowable activities. The FEHBP paid \$299,737 for all claims, but \$185,405 was specifically related to the fraud. One individual pled guilty in July 2018 and was sentenced to 5 years of imprisonment, 3 years of probation, and ordered to pay restitution of \$2.483 million, of which \$185,405 was returned to the FEHBP. In June 2019, a criminal information filed in the U.S. District Court for the Northern District of Texas charged a second individual who had used the provider's provider number with false statements relating to health care matters. In June 2019, this second individual pled guilty. On November 7, 2019, he was sentenced to 36 months of imprisonment and 36 months of supervised release.

Pass-Through Billing Scheme

- ❖ In August 2016, we received multiple case referrals regarding a potential pass-through billing scheme involving urinalysis at a rural hospital. The scheme also involved several other entities. The amount paid to the rural hospital provider totaled \$114 million. In September 2019, a criminal information against one individual was filed in the U.S.

District Court for the Western District of Missouri for conspiracy to commit health care fraud. The case was transferred to the U.S. District Court for the Middle District of Florida. On October 29, 2019, the individual pled guilty and as part of the plea agreement will forfeit \$5.1 million. Details regarding FEHBP restitution will be determined later. Judicial action continues in this case.

- ❖ In September 2014, we received a case referral from the FBI regarding a complaint alleging a provider attempted to bill thousands of dollars in unnecessary diagnostic tests to the patient's insurance. The FEHBP paid approximately \$86,000 to various providers associated with the scheme. We have reported several previous enforcement activities related to the case, including the FEHBP recovery of more than \$50,000 and multiple pleas and convictions. On November 14, 2019, one provider was sentenced in the U.S. District Court for the Southern District of Texas to 121 months in prison to be followed by 3 years of supervised release. Judicial action continues in this case.
- ❖ We received a referral alleging health care fraud and an inducement arrangement between a provider that allowed its pharmacists to substitute ingredients or medications based on insurance reimbursement rate and unrelated to medical necessity. Additionally, kickbacks were paid to providers, sponsors, sales representatives, and the provider group. The potential loss to the FEHBP was calculated as \$13,146,362. In July 2018, two individuals associated with the scheme were arrested for illegal distribution of marijuana across State lines. In September 2018, one of those individuals was indicted by criminal information in the U.S. District Court for the Northern District of Texas with conspiracy to commit money laundering. The individual subsequently pled guilty to the indictment, and on December 19, 2019, received a sentence of 66 months of incarceration, 3 years of supervised release, and restitution to all victims totaling \$3,042,716. The portion of restitution ordered to OPM has not been determined at this time.

Compounded Medications

- ❖ We received a referral from a law enforcement partner alleging that a pharmacist provider was involved in fraud and a kickback scheme related to compounded prescriptions. The FEHBP paid approximately \$2,293,011 between 2013 and 2015. In September 2019, the provider was indicted in the U.S. District Court for the Central District of California on conspiracy to commit mail fraud, wire fraud, health care fraud, illegal remuneration, aggravated identity theft, money laundering, aiding and abetting, and criminal forfeiture. On October 22, 2019, one individual pled guilty to illegal remuneration and forfeiture. Judicial action continues in this case.
- ❖ In June 2015, we participated in a joint investigation with Federal and State law enforcement partners into allegations that a variety of providers and associated entities and individuals conspired to defraud various health programs and insurances through a compounded medications scheme and illegal inducements. The FEHBP paid \$4.227 million in claims submitted by the entities targeted in this investigation. Six individuals were indicted in June 2018 in the U.S. District Court for the Central District of California for health care fraud, conspiracy to commit health care fraud, illegal remunerations in

connection with Federal health care programs, money laundering, criminal forfeiture, and aiding and abetting. On November 21, 2019, 4 additional individuals were indicted in a 48-count indictment. Judicial action continues in this case.

- ❖ In July 2016, we received a case referral from the FBI alleging a pharmacy paid multiple providers to solicit prescriptions to the pharmacy. Many of the providers received kickbacks in exchange for prescribing compounded medications, and our investigation found that several other entities were involved. The FEHBP exposure was approximately \$1,103,793. On December 18, 2019, two individuals were indicted in the U.S. District Court for the Western District of Texas for conspiracy to defraud the United States, as well paying and/or receiving health care kickbacks in violation of the AKS. Judicial action continues in this case.

Ineligible Dependents

- ❖ In April 2018, we received a case notification alleging an FEHBP enrollee submitted altered official court documents to remove his spouse from his FEHBP insurance in order to add his girlfriend. There was no financial loss to the FEHBP because the spouse was still rightfully covered and there were no insurance claims submitted by the enrollee's girlfriend. The enrollee was indicted in November 2018 on theft of Government funds, aggravated identity theft, and making false statements. He pled guilty in June 2019 to making false statements. On October 3, 2019, he was sentenced to 2 years of probation.
- ❖ We received a case notification regarding an ineligible dependent. The FEHBP paid \$8,934 for services related to the matter, all before October 2016. Documents from the Federal employing agency showed that there was confusion about removing the ineligible member, but the health insurance carrier did remove the ineligible member. It is unknown how much of the FEHBP payments fall outside the statute of limitations, but we closed our investigation based on the low improper payment amount. However, on November 12, 2019, we reopened the case for a review of improper payment reporting. We determined the FEHBP health insurance carrier failed to attempt recovery of the payments after we declined the case, which is required under FEHBP contract section 2.3(i). We notified the plan and the OPM Healthcare and Insurance program office of the improper payments for further action.

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.

Diversion

- ❖ In a case related to an opioid drug manufacturer, we were notified of an unsealed indictment related to five providers alleged to be participating in a kickback and bribery scheme that paid sham educational programs in exchange for prescribing millions of dollars of a fentanyl-based opioid. The FEHBP only received exposure information from one health insurance carrier related to one provider: \$63,420. In March 2018, all five providers were arrested and debarment referrals were submitted to the OIG FEHBP Administrative Sanctions Group. Between February 2019 and August 2019, four of the five providers pled guilty in the U.S. District Court for the Southern District of New York to violating the AKS. On October 28, 2019, one provider who pled guilty was sentenced to 2 years imprisonment and 2 years of supervised release, as well as forfeiture of \$127,100 and a \$100 special assessment. On December 5, 2019, a jury in the U.S. District Court for the Southern District of New York found one provider guilty on one count of conspiracy to violate the AKS, one count of violating the AKS and one count of conspiracy to commit honest services wire fraud. Judicial action continues in this case.
- ❖ In February 2018, we received a request from the FBI regarding a provider and related FEHBP exposure. It was alleged that the provider overprescribed opioids in order to receive kickbacks and possibly administered a non-Food and Drug Administration (FDA) approved drug. The FEHBP exposure totaled \$1,633,105. On October 25, 2019, the provider pled guilty in the U.S. District Court for the Eastern District of Pennsylvania to one count of health care fraud, one count of importation contrary to law, and two counts of distribution of a controlled substance. Judicial action continues in this case.
- ❖ In February 2018, we received a request for exposure from the FBI after allegations that a provider may have been overprescribing opioids in exchange for monetary kickbacks and administering a drug not approved by the FDA. An investigation found the provider defrauded insurance carriers by billing for services not rendered; selling controlled substance prescriptions and prescribing those medications without legitimate medical purpose; and ordering and administering a drug not approved by the FDA. On a criminal information charged that the provider committed health care fraud, importation contrary to law, and distribution of a controlled substance. On December 17, 2019, the provider pled guilty in the U.S. District Court for the Eastern District of Pennsylvania to the charges in the information. Judicial action continues in this case.

Improper Payments

- ❖ In September 2014, we received a case referral from the FBI regarding a provider billing for services not rendered. During the investigation, we found the provider was heavily under the influence of Schedule I narcotics while treating patients. In May 2016, one of the provider's business partners pled guilty to health care fraud; they were ordered to serve 21 months of imprisonment and to pay \$475,923 in restitution. In September 2017, the provider was charged in the U.S. District Court for the Central District of California with health care fraud. He fled to Iran and therefore was additionally charged with failure to appear in court. In August 2018, the provider attempted to reenter the United

States and was arrested by the U.S. Marshals. In October 2019, the provider was sentenced to 15 months of imprisonment and ordered to pay restitution in the amount of \$318,574 to all affected programs.

Retirement Investigations

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

Identity Theft

- ❖ Our Investigative Support Operations group proactively identified an annuitant whose death was unreported to the OPM Retirement Services program office. The improper payment to the annuitant totaled \$566,547. In May 2019, one person was indicted in the U.S. District Court for the Eastern District of Michigan for mail fraud and aggravated identity theft. In August, that person pled guilty to both counts. On December 3, 2019, they were sentenced to 24 months of imprisonment, 36 months of probation, as well as being ordered to pay \$566,547 in restitution to OPM, \$245,969 in restitution to another Federal benefit-paying agency, and a special assessment of \$200.
- ❖ We received a referral from the Retirement Services program office alleging that OPM had not received timely notification of an annuitant's December 2001 death. The Retirement Services program office continued to pay CSRS survivor annuity payments through September 2016 for a total improper payment of \$123,314. Reclamation actions through the Department of the Treasury recovered \$1,329, leaving an overpayment balance of \$121,985. Our investigation uncovered that the annuitant's daughter converted the annuity for her own use. In December 2018, in the U.S. District Court for the Central District of California, the daughter was indicted on eight counts of mail fraud, eight counts of theft of Government property, and one count of aggravated identity theft. In April 2019, she pled guilty to mail fraud. On December 9, 2019, the daughter was sentenced to 18 months in prison, 2 years of supervised release, and restitution of \$121,985 to OPM and \$155,079 to another Federal retirement program.

Deceased Annuitant

- ❖ We received a referral from the OPM Retirement Services program office regarding the death of an OPM annuitant that was concealed to steal annuity payments. The annuitant died in January 2002 and annuity payments continued through November 2013, totaling \$171,639. The annuitant's daughter was found to be the one converting the annuity for her own use, as well as using the account where the annuity was deposited to embezzle

funds from her employer. In January 2019, she was charged in the U.S. District Court for the Central District of California with one count of theft of Government property. She pled guilty in June 2019. On October 24, 2019, she was sentenced to 6 months of imprisonment and ordered to pay \$171,639 in restitution to OPM.

- ❖ In August 2015, we received a fraud referral from the Retirement Services program office regarding a deceased annuitant whose death in July 2011 was not reported to OPM. OPM had continued depositing the annuity through May 2015, resulting in an overpayment of \$107,239. Reclamation actions through the Department of the Treasury recovered \$3,750. Our investigation uncovered that the annuitant's daughter had forged OPM Address Verification Letters and taken the annuity for her personal use. In November 2018, the daughter was indicted in the U.S. District Court for the District of Maryland for theft of public money. On November 7, 2019, the daughter pled guilty to theft of public money; she was sentenced to 36 months of probation, including 10 months of home detention, and ordered to pay full restitution to OPM of \$107,239.
- ❖ In May 2018, we received a referral from a law enforcement partner alleging potential fraud involving a retiree receiving a CSRS annuity. The annuitant had died in January 2009, but her death had not been reported. OPM had continued payments through May 2018 for \$400,491 in improper payments. Our investigation revealed that the annuitant's son took the payments for his own use. In June 2018, OPM received a \$5,794 offset from Department of the Treasury related to the annuity. In July 2018, OPM was able to recover \$25,678 through the Department of the Treasury's reclamation process. In August 2019, the annuitant's son was indicted in the U.S. District Court for the District of Maryland for theft of public money. On October 22, 2019, he was arrested. Judicial action continues in this case.
- ❖ In March 2018, we received a case referral from the Retirement Services program office regarding the unreported December 2006 death of an annuitant. OPM continued to deposit the annuity and paid \$360,463 in overpayments. OPM recovered \$5,757 through the reclamation process, resulting in an outstanding improper payment of \$354,706. The annuitant's daughter admitted to using the annuity. On December 19, 2019, she was charged by information in the U.S. District Court for the District of Colorado with theft of Government funds, and she is scheduled to sign a plea agreement that will require full restitution to OPM. Judicial action continues in this case.
- ❖ In July 2018, we received a case referral from a law enforcement partner regarding a deceased annuitant whose death in September 2009 had been unreported to multiple Federal agencies, including OPM, and the alleged theft of the decedent's annuity. The overpayment totaled \$32,451. On October 23, 2019, the annuitant's daughter was charged in the U.S. District Court for the Eastern District of Michigan with theft of Government funds. Judicial action continues in this case.
- ❖ We received a case notification from the U.S. Attorney's Office for the District of Maryland regarding suspected fraud involving the OPM retirement program. A survivor annuitant had died in November 2012, but her death was not reported to OPM, and

payments continued and resulted in an overpayment of \$47,000. In January 2019, one individual was charged with theft of Government funds. In July 2019, that person pled guilty, and on October 4, 2019, they were sentenced to 6 months of incarceration and 36 months of probation, as well as being ordered to pay restitution of \$47,201 to OPM.

Statute of Limitations Concerns

- ❖ We received a fraud referral from the Retirement Services program office regarding the unreported death of an annuitant. The annuitant died in December 2010, but payment continued through August 2015, resulting in an overpayment of \$46,990. Retirement Services suspended payments in September 2015 because the annuitant was found in a death match with another Federal agency but failed to notify the OPM OIG at that time. In June 2018, as a part of our ongoing proactive searches, we requested information based on the prolonged suspended status of the retirement file. Based upon the information received from Retirement Services we began to conduct basic investigative actions; however, we elected to close the case in October 2019 due to insufficient time remaining within the statute of limitations to investigate and prosecute the case. OPM recovered \$1,531 through the Department of the Treasury's reclamation process.
- ❖ In September 2016, we received a fraud referral from the Retirement Services program office regarding the unreported death of a survivor annuitant. The annuitant's death occurred in January 1990, but monthly annuity payments continued through December 2013. The overpayment totaled \$156,079. Our Investigative Support Operations group was able to confirm that the reclamation payment was never received and had the financial institution reissue a reclamation amount of \$111,426. The outstanding \$77,412 had all been withdrawn prior to January 2010, outside of the civil and criminal statutes of limitations, and was therefore unrecoverable. Therefore, the total recovery to OPM was \$156,079.

Proactive Retirement Cases

The OIG performs proactive analyses to uncover improper payments. 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 Department of the Treasury's reclamation process in an effort to recover the improper payment funds.

Duration of Improper Payment	Improper Payment	Action
September 2019–November 2019	\$3,247	The Retirement Services program office initiated reclamation actions to recover the post-death annuity payments.
March 1991–June 2018	\$288,586	The financial institution where the improper payments were deposited only maintained records for

		7 years and was unable to provide bank records from before April 2012. In February 2019, our Investigative Support Operations group coordinated with Treasury to have the contents of the bank account (\$112,612) returned to OPM through reclamation actions. Because there were no withdrawals after April 2012, except bank fees, no suspect was identified. We closed our case on October 4, 2019, with the recovery of \$112,612 and the remaining improper payment total of \$175,814 referred to the OPM Office of the Chief Financial Officer for any further action.
September 2019–November 2019	\$5,860	On November 5, 2019, the Retirement Services program office initiated reclamation actions to recover the improper payments identified by our Investigative Support Operations group.
October 2019	\$1,951	On November 5, 2019, the Retirement Services program office initiated reclamation actions to recover the improper payments that our Investigative Support Operations group identified.
May 2011–November 2018	\$31,681	We notified the Retirement Services program office, who dropped the annuitant based on the death records. Investigation found that another individual had received the overpayments, but she was also deceased as of March 2016. We were unable to pursue the case further because the subject who allegedly fraudulently obtained the post-death annuity payments is deceased.
August 2013–November 2013	\$5,193	The Retirement Services program office had not dropped the annuitant for death or initiated reclamation actions to recover the improper payments. We provided the information regarding the death and requested the Retirement Services program office take appropriate action, which they did on December 3, 2019, by beginning reclamation actions and changing the annuitant's status.
September 2013–November 2013	\$5,746	The Retirement Services program office had not dropped the annuitant for death or initiated reclamation actions to recover the improper payments. We provided the information regarding the death and requested the Retirement Services program office take appropriate action, which they did on December 3, 2019, by beginning reclamation actions and changing the annuitant's status.
August 2013–November 2013	\$3,197 Annuity	The Retirement Services program office had not dropped the annuitant for death or initiated

	\$1,798 Health care premiums	reclamation actions to recover the improper payments. We provided the information regarding the death and requested the Retirement Services program office take appropriate action, which they did on December 3, 2019, by beginning reclamation actions and changing the annuitant's status
September 2013– November 2013	\$563 Annuity \$611 Health care premiums	The Retirement Services program office had not dropped the annuitant for death or initiated reclamation actions to recover the improper payments. We provided the information regarding the death and requested the Retirement Services program office take appropriate action, which they did on December 3, 2019, by beginning reclamation actions and changing the annuitant's status.
August 2013– November 2013	\$8,021 Annuity \$4,197 Health care premiums	The Retirement Services program office had not dropped the annuitant for death or initiated reclamation actions to recover the improper payments. We provided the information regarding the death and requested the Retirement Services program office take appropriate action, which they did on December 3, 2019, by beginning reclamation actions and changing the annuitant's status.
March 2017– December 2017	\$1,290	The Retirement Services program office had not dropped the annuitant for death or initiated reclamation actions to recover the improper payment. We provided the information regarding the death and requested the Retirement Services program office take appropriate action, which they did on December 3, 2019, by beginning reclamation actions and changing the annuitant's status.
September 2013– October 2013	\$2,190 Annuity \$1,245 Health care Premiums	The Retirement Services program office had not dropped the annuitant for death or initiated reclamation actions to recover the improper payments. We provided the information regarding the death and requested the Retirement Services program office take appropriate action, which they did on December 3, 2019, by beginning reclamation actions and changing the annuitant's status.
September 2013– November 2013	\$1,293 Annuity \$1,245 Health care Premium	The Retirement Services program office had not dropped the annuitant for death or initiated reclamation actions to recover the improper payment. We provided the information regarding the death and requested the Retirement Services program office take appropriate action, which they did on December 4, 2019, by beginning reclamation actions and changing the annuitant's status.

September 2013–November 2013	\$1,290	The Retirement Services program office had not dropped the annuitant for death or initiated reclamation actions to recover the improper payment. We provided the information regarding the death and requested the Retirement Services program office take appropriate action, which they did on December 9, 2019, by beginning reclamation actions and changing the annuitant's status.
May 2006–May 2018	\$77,231	Reclamation actions recovered \$21,440. The case was declined for prosecution in the U.S. District Court for the Eastern District of Michigan. However, the subject of the investigation contacted our investigator and requested information on reimbursing the improper payment. On December 5, 2019, the Retirement Services program office received a check for the remaining due balance of \$55,790.

National Security Investigations

The National Background Investigations Bureau (NBIB) of OPM conducted background investigations of Federal job applicants, employees, members of the armed services, and contractor personnel for suitability and security purposes. NBIB and its function were transferred to the Department of Defense on October 1, 2019 and became the Defense Counterintelligence and Security Agency. 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. We provided external oversight of NBIB's background investigations to protect the integrity of these background investigations.

Falsifications of Background Investigations

- ❖ In April 2018, we received a referral from the NBIB Integrity Assurance office regarding alleged falsifications made by an NBIB investigator in their background investigations. Specifically, NBIB discovered 43 falsified reports of investigation. In November 2018, a criminal information was filed in the U.S. District Court for the District of Columbia, and in April 2019, the NBIB investigator pled guilty to one count of making a false statement. On November 19, 2019, the NBIB investigator was sentenced to 1 year of probation, as well as a \$2,000 fine. The NBIB investigator paid \$40,000 for restitution to OPM.

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

The following are terms used in our case summaries.

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 FY 2019, OPM reported the Retirement Programs and the FEHBP combined to make more than \$339.36 million in improper payments.

Health care and Insurance

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

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

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

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

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

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

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

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

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

Telemedicine provides health care services to a patient by telecommunication, such as via webcam. While the practice increases convenience and care access, it is also a 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 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 mailed by OPM to Federal annuitants and survivor annuitants receiving CSRS/FERS benefits from OPM to verify whether annuitants are living and are living at the address currently on file with the Retirement Services program office. It is one of the surveys that the Retirement Services program office uses to confirm and census its annuitant population.

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

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

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