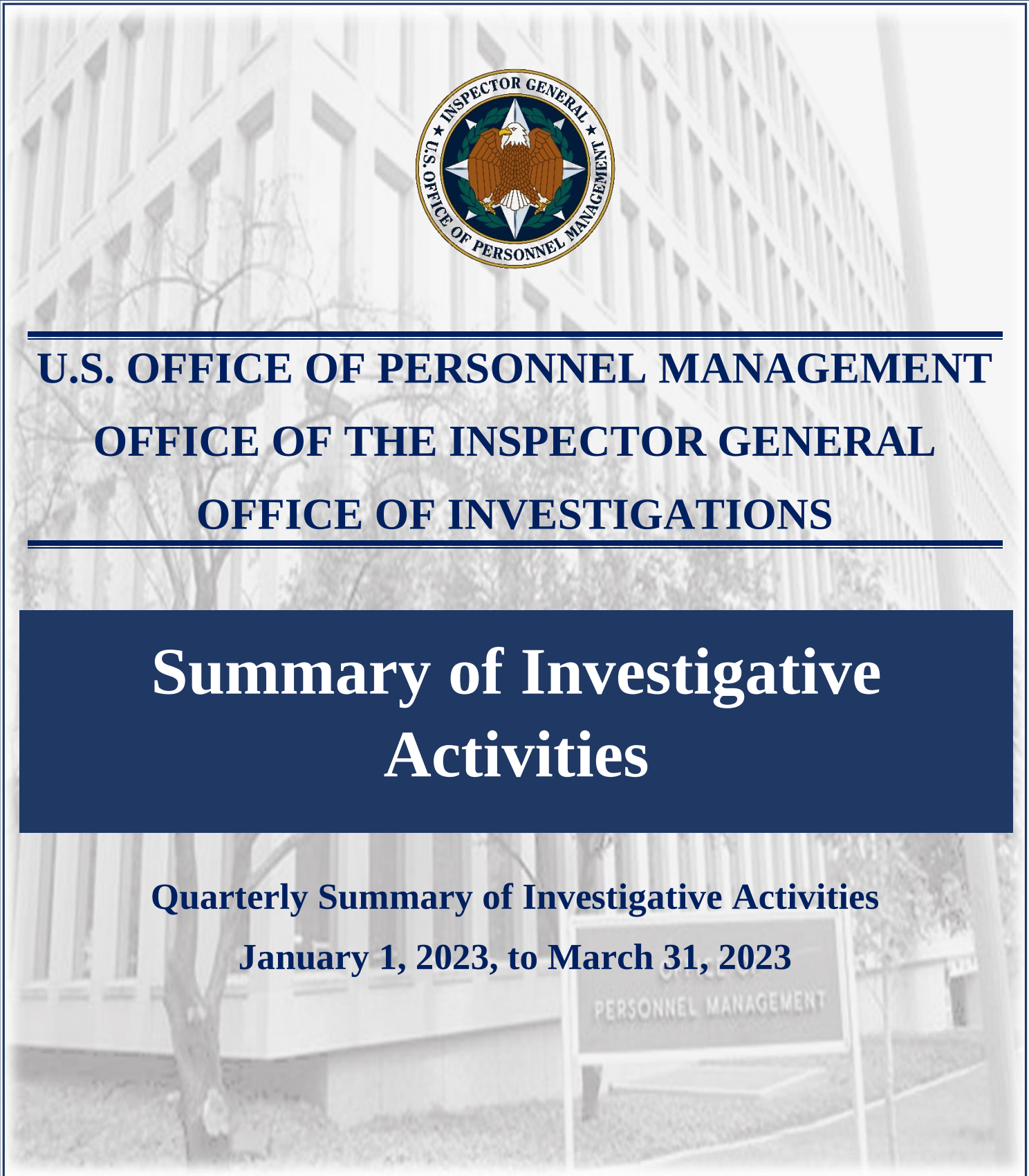

U.S. OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL
OFFICE OF INVESTIGATIONS

Summary of Investigative Activities

Quarterly Summary of Investigative Activities
January 1, 2023, to March 31, 2023

Executive Summary

Summaries 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. Our efforts are to curtail improper payments, stop patient harm, protect the integrity of OPM programs, and 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 OIG oversight; and describe the fraud, abuse, waste, and mismanagement that harms OPM, its programs and operations, and Federal employees, retirees, and their eligible dependents.

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),
- the Federal Employee 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 Executive Institute (FEI),
- the Combined Federal Campaign (CFC), and
- other OPM programs and operations.

These investigations are essential to the oversight of OPM programs and operations and ensuring OPM maintains the trust of the public and the Federal employees, annuitants, and eligible dependents that it serves.

An indictment is merely an allegation. Defendants referenced in these case summaries are presumed innocent unless and until proven guilty beyond a reasonable doubt in a court of law.

Abbreviations

OPM	**U.S. Office of Personnel Management**
OIG	**Office of the Inspector General**
CFC	**Combined Federal Campaign**
CSRS	**Civil Service Retirement System**
FEDVIP	**Federal Employee Dental and Vision Insurance Program**
FEGLI	**Federal Employees' Group Life Insurance**
FEHBP	**Federal Employees Health Benefits Program**
FEI	**Federal Executive Institute**
FERS	**Federal Employees Retirement System**

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Health Care Investigations

Health Care Investigations

U.S. Office of Personnel Management (OPM) health benefits programs—the Federal Employees Health Benefits Program (FEHBP) and the Federal Employee Dental and Vision Insurance Program (FEDVIP)—cumulatively pay tens of millions of dollars annually in improper payments that are caused in part by fraud, waste, and abuse. Common health care fraud allegations that the OPM Office of the Inspector General (OIG) investigates include medical providers overbilling, billing for services not covered or performed, falsifying diagnoses, and performing unnecessary tests or procedures. Ineligible beneficiaries who receive FEHBP benefits also cause improper payments.

We prioritize investigating allegations of patient harm or substantial monetary loss to these health care programs as well as cases that involve health care priorities such as the opioid epidemic or the COVID-19 pandemic.

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 March 2022, we received a referral from a Federal law enforcement partner regarding a medical provider entity that allegedly improperly used health care claims modifiers, which provide additional information about a health care claim, related to COVID-19 to increase reimbursement. FEHBP health insurance carriers paid the medical provider entity $1.46 million between January 2020 and January 2022. The owner of the medical provider entity was previously indicted in the U.S. District Court for the District of Maryland on three counts of health care fraud. On January 11, 2023, a superseding indictment charged the individual with five additional counts of health care fraud. Further judicial action is anticipated in this case.

- In October 2020, we received a *qui tam*, which is a lawsuit filed by a private individual on behalf of the Government, filed in the U.S. District Court for the Eastern District of Virginia alleging that medical providers at a practice billed for services that were medically unnecessary or never provided, among other allegations. Between January 2015 and November 2020, FEHBP health insurance carriers paid $4.64 million for all claims associated with this provider. On January 3, 2023, a settlement was reached between the Government and the medical practice. The medical provider practice paid $185,000 to the Government, of which the FEHBP received $29,765.

- In July 2018, we received a *qui tam* filed in the U.S. District Court for the Northern District of Texas regarding a medical provider entity that allegedly billed for services when the practicing physician was not present, used unlicensed medical assistants to complete and dispense patient prescriptions, and upcoded services. FEHBP health insurance carriers had paid this provider $84,534 for claims. On January 27, 2023, an executed settlement repaid the FEHBP $12,459.

- In December 2018, we received a *qui tam* filed in the U.S. District Court in the Middle District of Florida that alleged a medical practice had violated the False Claims Act, specifically by performing an excessive number of procedures or procedures that were medically unnecessary. FEHBP carriers paid $3.89 million in total claims to the providers between January 2009 and May 2019. In January 2023, the medical provider practice and the U.S. Department of Justice entered into a $2 million settlement regarding claims submitted to Government health care programs (including the FEHBP) that received payment when the providers were not in the United States on the days the services were rendered. The FEHBP was awarded $25,264.

- In February 2022, we received a complaint from the U.S. Department of Justice regarding a pharmacy alleged to have violated the False Claims Act and the Controlled Substances Act. The allegations included that pharmacy employees regularly used the code "Bill But Don't Fill," or BBDF, when billing insurance companies for drugs that were not dispensed to beneficiaries. FEHBP carriers had paid $576,966 in claims to the pharmacy. Specifically, $4,987 in claims payments were associated with the BBDF code. In August 2022, the pharmacy agreed to pay $2.9 million across all affected Federal health care programs to resolve their civil liability for the allegations. The FEHBP received $4,838, as well as an additional $599 in lost investment income. On February 10, 2023, a pharmacy technician associated with the scheme was required to pay $10,000 in civil restitution. The FEHBP's losses were covered in the August 2022 settlement.

- In January 2021, we received a case referral from an FEHBP health insurance carrier alleging that a medical doctor billed for "travel claims" (services billed when the doctor was actually out of State) and "ghost patient visits" (submitting claims as if multiple procedures were performed on different days when the procedures were actually performed on a single day of service). Per a criminal information filed in the U.S. District Court in the Northern District of Illinois, some procedures were also medically unnecessary. The FEHBP improperly paid the provider $42,919. On March 2, 2023, the doctor pleaded guilty to one count of health care fraud. Further judicial action is anticipated in this case.

FEHBP Health Insurance Carrier Settlements

The OPM OIG annually receives hundreds of allegations of fraud, waste, and abuse from FEHBP health insurance carriers. We decline to investigate some allegations because of a lack

of investigative resources, small FEHBP loss amounts, legal or statutory difficulties, or other concerns. FEHBP health insurance carriers sometimes negotiate settlements with providers to recover FEHBP improper payments in settlements that can simultaneously recover money for their private lines of business. The FEHBP often recovers only some of its total loss in these settlements.

In this quarter, we do not report any FEHBP Health Insurance Carrier Settlements.

The Opioid Crisis and the FEHBP

In October 2017, the opioid crisis was declared a public health emergency. All Executive agencies were directed to use their available means to combat the consequences of the epidemic. We continue to prioritize opioid-related investigations during this public health emergency. Opioid investigations by our office may involve the manufacturing or marketing of opioids; the prescribing practices of medical providers; or fraud, waste, or abuse by sober homes and substance abuse recovery facilities.

Opioid-Related Case Summaries

- In July 2019, we received a referral from a U.S. Attorney's Office strike force about a medical provider who was an outlier for an injectable procedure. The medical provider also allegedly allowed unlicensed individuals to treat patients and overprescribed opioids. We previously reported our investigative efforts related to this case, including that our investigation found FEHBP carriers paid approximately $303,737 in claims related to this expansive scheme to defraud health benefit programs. Our investigation had previously resulted in multiple indictments. On December 6, 2022, four individuals were charged with a superseding indictment in the U.S. District Court for the Eastern District of Pennsylvania with health care fraud, conspiracy to commit health care fraud and wire fraud, money laundering, unlawful monetary transactions, conspiracy to distribute controlled substances, and aiding and abetting. Further judicial action is anticipated in this case.

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

The Anti-Kickback Statute (Title 42 U.S. Code § 1320a–7b) makes it illegal for health care providers to knowingly and willfully solicit or 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. Additionally, if health care providers are tempted to profit off referrals for treatments or procedures that are not medically necessary, FEHBP members can suffer harm.

The FEHBP's exclusion from the Anti-Kickback Statute can interfere with our ability to protect the FEHBP and its members from improper conduct that, when committed against any other Federally funded health care program, constitutes a Federal crime. Improperly paid FEHBP dollars can go unrecovered because of our exclusion.

Typically, our investigations are complicated by the FEHBP's Anti-Kickback Act exclusion when either of the following findings occur:

1. Our investigation finds alleged wrongdoing by a medical provider 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 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 based on the Anti-Kickback Statute's exclusion.

Anti-Kickback Statute-Related Case Summaries

- In November 2022, we received a *qui tam* filed in the U.S. District Court for the Middle District of Tennessee that alleged that a medical equipment company overbilled for durable medical equipment and falsified, forged, or inappropriately authored patient documents. FEHBP health insurance carriers had paid $545,201 for claims related to this medical equipment company. Per information from the U.S. Attorney's Office, settlement negotiations were ongoing, but the allegations involved in the case were violations of the Anti-Kickback Statute. Because of the FEHBP's exclusion from the Anti-Kickback Statute, we closed our investigation.

- In October 2022, we received a *qui tam* filed in the U.S. District Court for the District for the Northern District of Texas about a company that billed Government health care programs, including the FEHBP, for nonreimbursable experimental diagnostic tests as part of alleged violations of the Anti-Kickback Statute. FEHBP health insurance carriers had paid approximately $1.79 million for the procedure codes identified in the alleged scheme. We were informed by the U.S. Attorney's Office that the investigation will focus solely on kickbacks. Because of the FEHBP's exclusion from the Anti-Kickback Statute, we closed our investigation.

- We previously reported a joint Federal and State, multiagency criminal investigation regarding dozens of medical providers, marketers, and compounding pharmacies that submitted more than $40 million in false claims for medically unnecessary compounded

medication prescriptions and a system of illegal kickbacks. FEHBP health insurance carriers had paid more than $1.86 million to the providers involved in this scheme. There have been more than 28 indictments and 12 convictions in this case previously. In March 2023, an additional individual—a pharmacy's director of operations—was convicted and sentenced; however, the allegations involved paying kickbacks to marketers, and the FEHBP's exclusion from the Anti-Kickback Statute meant that there were no recoveries attributable to this individual outcome.

Retirement Investigations

Retirement Investigations

OPM reported $325.81 million in improper payments for its retirement programs in fiscal year 2022. These improper payments often are from fraud, waste, or abuse in the Civil Service Retirement System (CSRS) and the Federal Employees Retirement System (FERS) retirement programs.

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 payments continue for years and cost tens of thousands of dollars before discovery.

Fraud by forged documents (such as OPM's Address Verification Letters), identity theft, and other schemes are common harms that the OPM OIG investigates. We also investigate allegations of elder abuse 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 OPM 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 from our Investigative Support Operations that we refer to OPM can also help the agency recover money through administrative actions such as payment agreements or the U.S. Department of the Treasury (Treasury) reclamation process.

OPM Retirement Fraud Case Summaries

- We received a fraud referral in October 2021 from the Retirement Services program office about an annuitant whose April 2018 death was discovered via agency matching with the Social Security Administration's Death Master File. OPM had made overpayments totaling $58,420. Through Treasury reclamation actions, OPM recovered $13,187, leaving a net overpayment of $45,232. On January 24, 2023, one individual was charged by criminal information in the U.S. District Court for the Southern District of Illinois with theft of Government funds. Further judicial action is expected in this case.

- In May 2021, we received information from the Retirement Services program office about an annuitant's unreported November 2008 death. Between then and May 2019, OPM paid $143,296. OPM recovered $9,950 through Treasury reclamation actions, leaving a net overpayment of $133,345. On January 25, 2023, a criminal information

was filed in the U.S. District Court for the Northern District of Alabama charging one individual with theft of Government funds. Further judicial action is expected in this case.

Proactive Retirement Investigations

Our investigative efforts in proactive discovery of improper payments can lead to financial recoveries when OPM recoups lost funds through administrative methods available to the agency such as Treasury reclamation actions. We develop these cases through data analysis, ongoing investigative and demographic projects, and other methods. In some cases, instead of finding overpayments, we find information about annuities owed to annuitants or survivor annuitants and can provide information to OPM so the agency can pay these annuities owed to OPM beneficiaries. The chart below describes our actions during the reporting period.

Predication	OPM Loss	OIG Action and OPM Resolution
Our proactive retirement investigations found that a disabled survivor annuitant was receiving two survivor annuity payments. One annuity was in suspended status; the other was active. The program office was able to review both annuities and determined that both should be active based on the information available.	None	The Retirement Services program office was able to establish a new representative payee to oversee the disabled survivor annuitant's payments, authorized a payment of $1,268 for the period when one of the annuities was in suspended status, and then authorized a second payment of $6,057 for the same reason. The disabled survivor annuitant in total received $7,325.
Our proactive investigative efforts located an obituary for a retired annuitant who had died in October 2013. OPM had suspended retirement annuity payments in February 2021, but it had not closed the case or initiated reclamation actions.	$143,364 ($84,431 in post-death annuity payments and $58,933 in health benefit premiums)	The case was closed in June 2022 based on the information we provided about the annuitant's death. In December 2022, we received a fraud referral related to this case. On February 15, 2023, we informed the agency that we had declined to intervene in this case because the potential investigative subject had made $2,500 in payments towards the improper payment amount. We closed our case for OPM to continue with its efforts to recover the debt administratively.

Predication	OPM Loss	OIG Action and OPM Resolution
Our proactive investigations discovered that an OPM annuitant with both a survivor annuity and a retirement annuity had one annuity—the survivor annuity—active, while the retirement annuity was in suspended status. We learned of open investigations by Adult Protective Services regarding the annuitant's representative payee. The nursing home where the annuitant lived had applied to be named as the new representative payee. However, according to the Retirement Services program office's answers to multiple inquiries by the OPM OIG between August 2022 and March 2023, the nursing home had not filed or returned necessary documents to OPM.	None	We contacted the nursing home and were able to verify that the annuitant was still living, and we also provided updated contact information from the nursing home to the Retirement Services program office to facilitate changing the representative payee. Any further action based on our current knowledge of this case will be between the nursing home and the Retirement Services program office, so we closed our case.
Our proactive investigations found a November 2007 death record for an OPM annuitant whose death was not reported to OPM. The Retirement Services program office had suspended annuity payments in October 2018, but it had not initiated reclamation actions to recover the post-death annuity payments.	$164,594 ($87,147 in post-death annuity payments and $77,446 in health benefit premiums)	We provided the information we located to the Retirement Services program office. The recovery from the Treasury reclamation process was $39,135 for post-death annuity payments and the full amount of the health benefit premiums paid after death ($77,446), for a total recovery of $116,581.

Integrity Investigations

Integrity Investigations

We conduct 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 civil servants 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

- In November 2022, the OPM OIG Hotline received allegations about nepotistic practices within one of OPM's Retirement Services program office units. Our investigation found that there were no specifically known instances of supervisor–subordinate relationships under the definition of nepotism. We also found no known examples of family members (1) serving on a hiring panel of, (2) recommending applicants to, (3) acting as supervisor of, or (4) in the chain of command of another family member. According to our interview with one deputy associate director, because of the small geographic area with a limited employment population, applicants could be related, and relatives were employed at the unit, but the office took steps to ensure relatives did not work with or for each other. Based on our investigation, we determined the allegations were unsubstantiated, but we informed the reporting individual that they could pursue action via the U.S. Office of Special Counsel, which receives and investigates claims of prohibited personnel practices.

About OPM Programs

- **Federal Employees Health Benefits Program (FEHBP):** The FEHBP is the largest employer-sponsored health insurance program in the world, covering more than 8.2 million Federal employees, annuitants, family members, and other eligible individuals. 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.

- **Federal Employee Dental and Vision Insurance Program (FEDVIP):** FEDVIP makes supplemental dental and vision insurance available to Federal employees and retirees who are eligible for Federal employment benefits.

- **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 survivors of deceased OPM annuitants. OPM paid billions in defined benefits to retirees, survivors, representative payees, and families 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 family members. It provides standard group term life insurance and elective coverage options.

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

- **Combined Federal Campaign (CFC):** CFC is the largest and most successful annual workplace charity campaign in the world, raising millions of dollars each year through pledges made by Federal civilian and retiree, postal, and military employee donors during the campaign season. These pledges support eligible nonprofit organizations.

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