



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

Quarterly Case Summaries

Investigative Activities

Fiscal Year 2021

Quarter

October 2020 - December 2020

Issued: February 2021

-- Caution --

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List of Acronyms

AKS	Anti-Kickback Statute
CSRS	Civil Service Retirement System
DOJ	Department of Justice
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FEDVIP	Federal Employees Dental and Vision Insurance Program
FEGLI	Federal Employees' Group Life Insurance
FEHBP	Federal Employees Health Benefits Program
FEI	The Federal Executive Institute
FERS	Federal Employee 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
OCFO	Office of the Chief Financial Officer
OCIO	Office of the Chief Information Officer
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

Overview of U.S. Office of Personnel Management (OPM) Programs and Activities

OPM-administered Federal Retirement Programs include two primary Federal defined-benefit retirement plans: the **Civil Service Retirement System (CSRS)**, which covers employees hired by the Federal Government between 1920 and 1986, and the **Federal Employees Retirement System (FERS)**, which covers employees hired after 1987. These plans provide monthly annuities based on a Federal Government retiree's service. Additionally, **OPM Disability Retirement** allows for FERS-eligible Federal employees who become disabled to collect benefits.

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

The Federal Employees' Group Life Insurance (FEGLI) program is the largest group life insurance program in the world, covering over 4 million Federal employees and retirees, as

well as many of their family members. It provides a standard group term life insurance and elective coverage options.

The Federal Employees Health Benefits Program (FEHBP) provides health insurance to Federal employees, retirees, and their eligible 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 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 training center offers learning and ongoing leadership development for Federal senior leaders through classes and programs to improve the performance of Government agencies.

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

The National Background Investigations Bureau (NBIB), a former OPM bureau, conducted background investigations of Federal job applicants, employees, members of the armed services, and contractor personnel for suitability and security purposes. NBIB and its functions were transferred to the Department of Defense on October 1, 2019, and it is now the Defense Counterintelligence and Security Agency. Background investigators submitted their findings from interviews and other background work in **Reports of Investigation (ROIs)**.

The OPM Office of the Inspector General (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 can 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; or
- ❖ Online (opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/).

At the end of this document, we include an additional glossary related to the types of investigations we conduct in our oversight mission to protect OPM programs from fraud, waste, and abuse.

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 OPM OIG 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, 2020, through December 31, 2020.

This period was affected by the ongoing novel coronavirus (COVID-19) pandemic throughout the Nation, which includes changing investigative priorities and impact to criminal investigators' ability to travel, conduct interviews, and interact with our law enforcement and Department of Justice (DOJ) partners whose offices closed or transitioned to socially distanced-only operations. Most OPM OIG Federal employees are operating under a maximum telework posture. We are part of the Pandemic Response Accountability Committee and the DOJ's Proactive Data Group as part of our work to investigate fraud, waste, abuse, and mismanagement related to the FEHBP and other OPM programs.

Health Care Fraud Investigations

According to OPM, in Fiscal Year (FY) 2020, the Federal Employees Health Benefits Program (FEHBP) across all health care carriers paid more than \$25.18 million in improper payments, for an improper payment rate of 0.05 percent. 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 Federal Anti-Kickback Statute (AKS) is one of the best-known Federal fraud and abuse statutes. The AKS is a criminal statute that prohibits transactions intended to induce or reward referrals for items or services reimbursed by Federal health care programs. It has a significant effect on business relationships in the health care, pharmaceutical, and medical device sectors.

The FEHBP continues to be excluded from the AKS.

We have previously discussed issues arising from this exclusion at length in several Semiannual Reports to Congress, and we will continue to work with Congress to address this gross injustice. We report the following cases, which include FEHBP losses exceeding \$1.097 million in addition to undetermined losses, closed this quarter that we were unable to pursue due to this exclusion:

- ❖ In September 2020, we received a complaint filed in the U.S. District Court for the Northern District of Maryland alleging several providers collectively purchased medical devices for implantation in a master purchasing agreement without regard for contraindication or patient safety. However, on October 22, 2020, we were notified that the allegations in the complaint focused specifically on violations of the AKS. Because of the continued exclusion of the FEHBP, we closed our case.
- ❖ In June 2019, we received a case notification from an FEHBP health insurance carrier regarding a provider allegedly perpetrating an overbilling scheme by fraudulently stacking procedural codes when billing for its services. The provider was subject of a *qui tam* filed in November 2017. In November 2019, the provider entered into a settlement agreement with the DOJ to resolve False Claims Act violations and patient referrals in violation of the AKS and the Stark Law. FEHBP claims were not considered in this settlement because of our exclusion from the AKS, and the exact amount of FEHBP exposure was undetermined.
- ❖ We received a *qui tam* complaint filed in the U.S. District Court for the District of South Carolina regarding a provider allegedly submitting false claims and upcoding. The FEHBP paid \$266,291 related to the allegations. However, the Assistant U.S. Attorney's Office notified us that the case is focused on violations of the AKS. Because of our exclusion from the AKS, we closed our case.
- ❖ In October 2020, we received a *qui tam* complaint filed in the U.S. District Court for the Northern District of Indiana alleging that a provider engaged in schemes to create false records and submit false claims for reimbursement from Government health programs. The scheme involved kickbacks and illegal self-referrals, as well as billing for services not rendered, performed without appropriate supervision, or billed improperly to increase reimbursement. The FEHBP paid \$831,032 to the provider between 2015 and 2020. However, because the allegations involve violations of the AKS, we were unable to pursue the investigation.

Health Care Fraud Investigations Affected by the COVID-19 Pandemic

During this quarter, we had several cases affected by the COVID-19 pandemic.

- ❖ In January 2019, we received a *qui tam* complaint filed in the U.S. District Court for the Eastern District of New York alleging that a provider violated the False Claims Act by admitting patients known not to meet inpatient criteria. The FEHBP improper payments related to the allegations totaled \$676,457. In March 2020, the U.S. Attorney's Office cancelled interviews due to the COVID-19 pandemic. As of this time, interviews cannot be resumed due to the health situation and no further action has been taken by the U.S. Attorney's Office. Because of this, we closed our investigation. We plan to reopen the case when we can operate safely and our investigation can proceed unhindered by the health environment.

- ❖ In April 2019, we received a *qui tam* complaint from the U.S. Attorney's Office for the Eastern District in New York against a provider alleged to have violated the False Claims Act by admitting patients to emergency departments who should have been discharged to home or admitting patients who should have been placed in observation, among other allegations. The FEHBP exposure was approximately \$51 million. Because of the COVID-19 pandemic, subjects (including emergency physicians) were not available to be interviewed. As of this time, interviews cannot be resumed due to the health situation and no further action has been taken by the U.S. Attorney's Office. Because of this, we closed our investigation. We plan to reopen the case when we can operate safely and our investigation can proceed unhindered by the health environment.
- ❖ In January 2019, we received a *qui tam* complaint from the U.S. Attorney's Office for the Eastern District of New York regarding a medical provider alleged to be violating the False Claims Act. Specifically, between 2012 and 2020, it was alleged that the provider knowingly submitted false reimbursement claims and upcoded medical records to admit patients for inpatient care with inaccurate diagnosis codes to increase reimbursement. The FEHBP paid \$549,144 related to these allegations. Because of the COVID-19 pandemic, subjects (including emergency physicians) were not available to be interviewed. As of this time, interviews cannot be resumed due to the health situation and no further action has been taken by the U.S. Attorney's Office. Because of this, we closed our investigation. We plan to reopen the case when we can operate safely and our investigation can proceed unhindered by the health environment.

Conspiracy

- ❖ In October 2016, we received a referral from an FEHBP-contracted health carrier regarding a pharmacy provider alleged to have an improper relationship with drug manufactures of medications that receive high-dollar reimbursements. Between November 2015 and September 2016, the FEHBP paid over \$670,000 for claims related to the at-issue medications. We previously reported that in September 2020, three individuals were charged and pled guilty to various charges, including conspiracy to pay health care kickbacks, in the U.S. District Court for the Eastern District for Virginia. On October 20, 2020, a fourth individual was charged and pled guilty in the U.S. District Court for the Eastern District of Virginia to conspiracy to commit health care fraud. Further judicial action is expected in this case.

Ineligible Beneficiaries

- ❖ In October 2018, we received a hotline complaint alleging an employee at the U.S. Federal Highway Administration fraudulently enrolled two individuals purported to be their wife and stepchild in the FEHBP. The beneficiaries were actually ineligible and remained on FEHBP health insurance between January 2005 and January 2017. The FEHBP paid claims totaling \$108,411 on behalf of the ineligible beneficiaries. We previously reported that the FHWA employee was charged in the U.S. District Court for the Southern District of West Virginia with healthcare fraud and pled guilty. On October 20, 2020, the FHWA employee was sentenced to 24 months of supervised release,

including 6 months of home confinement via electronic monitoring. The court also ordered the FHWA employee pay restitution of \$108,411 to the FEHBP for the fraudulent healthcare claims, a fine of \$10,000, and \$100 special assessment fee. The restitution, fine, and special assessment fee were paid at sentencing. Restitution of \$43,248 for FEHBP premiums paid for the ineligible members was not included by the court.

False Claims Investigations

- ❖ In April 2015, we received a *qui tam* referral alleging a provider and its subsidiaries engaged in a scheme to inaccurately fill prescriptions and submit false claims for reimbursement. The potential total loss to the FEHBP was \$9,542,623. Subsidiaries entered into separate settlements to resolve the allegations. We previously reported many of these settlements in earlier quarterly summary reports. In this quarter, we entered additional settlements that returned funds to the FEHBP: On October 2, 2020, we entered into three settlements that returned a total of \$98,866 to the FEHBP.
- ❖ In July 2017, we received a referral from a law enforcement partner regarding potential fraud by a health care provider alleged to have submitted false claims to health insurance companies, including those that participate in the FEHBP. Our review of claims between March 2009 and September 2017 found that the FEHBP paid the provider \$536,547. This included an identified loss of \$27,222 related to the specific allegations. In 2019, one individual was charged and pled guilty in the U.S. District Court for the District of Maryland with conspiracy to commit health care fraud and prohibited conflict of interest; a second person, who previously worked at Walter Reed National Military Medical Center, was charged with accepting financial benefits and failing to report them on Confidential Financial Disclosure Forms. On October 20, 2020, this second individual pled guilty to acceptance of gratuities by a public official. Further judicial action is expected in this case.
- ❖ In November 2018, we received a request from the U.S. Attorney's Office for the Eastern District of Pennsylvania for information regarding FEHBP exposure related to a specific medical device alleged to have been inappropriately billed. The investigation found a provider engaged in a scheme to defraud health insurance carriers by submitting claims for inappropriate payments related to the aforementioned medical device. On November 9, 2020, the U.S. Attorney's Office for the Eastern District of Pennsylvania entered into a civil settlement with the provider to resolve liability under the False Claims Act for the alleged improper billing allegations. The FEHBP received a net payment of \$6,400 as part of the settlement.
- ❖ In April 2012, we received a complaint from DOJ regarding a company that sold combined drug and medical device systems and allegedly marketed these systems for off-label uses, including marketing it for unapproved use in pediatric patients. On November 19, 2020, the U.S. Attorney's Office in the Eastern District of Pennsylvania entered into a civil settlement with the company. Under the terms of the settlement to resolve its liability under the False Claims Act, the company agreed to pay \$10 million,

as well as \$1.5 million to resolve allegations that the company continued its improper sales and promotion practices after the company was acquired by another in 2012. The FEHBP received a net payment of \$119,502.

- ❖ In January 2019, we received a referral from DOJ regarding a provider who supplied durable medical equipment. The provider allegedly submitted false claims to Federal health programs, including the FEHBP, for reimbursement of devices that were not medically necessary or involved the improper waiving of patient coinsurance payments. In December 2020, a settlement was reached wherein the provider will pay \$40.5 million to resolve the allegations. The FEHBP's paid exposure was \$4.9 million. There was also \$44,277 in investigative expenses and \$222,083 in lost investment income. The Assistant U.S. Attorney's Office for the Southern District of New York calculated the restitution due to OPM to be \$207,428.

Compounded Medication Fraud

- ❖ In November 2015, we received a case referral from an FEHBP subcontractor alleging that a nutritional supplement was being billed at exceptionally higher cost than other sources as part of a compounded drugs scheme. The FEHBP paid \$3.2 million, of which \$1.13 million was suspected fraud paid for the at-issue drug. In July, one individual was indicted in the U.S. District Court for the Central District of California for conspiracy to solicit and receive illegal remunerations and solicitation and receipt of illegal remunerations. On December 2, 2020, we were notified that the charged individual fled the United States and is now believed to be residing in Russia. Because of this issue, as well as statute of limitations concerns, we ended our investigation.

Unbundling, Miscoding, or Other Healthcare Fraud

- ❖ In August 2020, we received a referral from an FEHBP health insurance carrier alleging that a provider misused, unbundled, or overbilled for certain procedural codes. The FEHBP's identified loss totaled \$25,310. On October 23, 2020, the provider and the FEHBP health insurance carrier agreed to an administrative recovery that will return \$12,772 to the FEHBP.
- ❖ In July 2019, we received a case notification from an FEHBP health insurance carrier regarding a provider who allegedly misrepresented rendered services. The total loss to the FEHBP was \$40,329. On October 24, 2020, the provider and the health insurance carrier entered into a settlement that returned an administrative recovery of \$10,424 to the FEHBP.
- ❖ In May 2018, we received a referral from an FEHBP health insurance carrier regarding a provider who billed significant services to a single FEHBP enrollee revealed to be married to the owner of the provider. The FEHBP exposure was \$247,195. We previously reported that the owner was indicted and pled guilty. On November 20, 2020, the provider was sentenced in the U.S. District Court for the Eastern District of California

on one count of mail fraud to serve 5 years of probation, 6 months of house arrest, 150 hours of community service, and ordered to pay restitution of \$500,268, of which the FEHBP will receive \$247,195.

- ❖ In April 2013, we received a referral from an FEHBP health insurance carrier alleging that providers created non-participating entities to maximize revenue and billed for services not rendered, as well as engaged in a scheme that paid for patient referrals. The FEHBP suffered \$175,304 in identified loss. Over the course of calendar year 2020, the FEHBP carrier reached three separate settlements with the providers, and from those settlements the FEHBP will recover an administrative recovery of \$16,072.
- ❖ On August 5, 2020, we received a case notification from an FEHBP health insurance carrier regarding a provider who allegedly had suspicious usage of certain procedural codes. The FEHBP paid \$56,062 in improper payments. On October 8, 2020, the health insurance carrier notified us that it had entered into a settlement agreement with the provider wherein the FEHBP will receive an administrative recovery of \$56,062 in repayment.
- ❖ In January 2019, we received a case notification from an FEHBP health insurance carrier alleging that a provider improperly applied a procedural code that resulted in overbilling. The loss to the FEHBP was calculated at \$22,999. On October 6, 2020, the health insurance carrier and the provider agreed to a settlement that will return an administrative recovery of \$5,636 to the FEHBP.
- ❖ In August 2019, we received a case notification from an FEHBP health insurance carrier related to a case settlement between the health insurance carrier and a provider alleged to have submitted false claims for services not rendered, upcoding, and a billing error rate higher than 80 percent. The improper payments related to the FEHBP totaled \$330,233. On December 4, 2020, we received notification that the health insurance carrier had executed a settlement with the provider that returned an administrative recovery of \$239,261 to the FEHBP.
- ❖ In June 2020, we received a case notification from an FEHBP health insurance carrier regarding a provider who billed a large amount of one medication to an FEHBP member. The cost to the FEHBP associated with the medication and treatment was \$13,061. We were updated on December 8, 2020, that the carrier was not pursuing a settlement with the provider because they stopped performing the treatment and entered into a corrective action plan, which included recovering the FEHBP's overpayment of \$1,046.
- ❖ In October 2019, we received a case notification from an FEHBP health insurance subcontractor regarding a provider billing for services not rendered. The subcontractor performed a desk audit for dates ranging between July 2016 and July 2019 and found a 100 percent error rate. The total overpayment for the FEHBP was \$1,447. The subcontractor finished recovering the overpayment amount on December 1, 2020.

- ❖ In June 2015, we received a case referral from an FEHBP health insurance carrier regarding a provider submitting incorrect place of service information to enhance reimbursement, as well as potentially unbundling procedures. Further investigation found a potential issue with how the FEHBP health insurance carrier contracted with the provider as an ambulatory surgery center. Specifically, the provider did not meet requirements for the State it operated in and should not have been reimbursed for services of an ambulatory surgery center. We referred this matter to our Office of Audits in February 2018. On December 7, 2020, we were informed that the health insurance carrier agreed to a settlement with the provider that will return an administrative recovery of \$1,395,989 to the FEHBP.

Special Topic: The Opioid Epidemic

In his 2017 memorandum “Combatting the National Drug and Opioid Crisis,” former 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.

Health Care Fraud Conspiracy

- ❖ In October 2016, we received a case referral from an FEHBP health insurance carrier regarding a provider who allegedly billed high-dollar reimbursement medications from two manufacturers in a way that suggested an improper relationship between the provider and manufacturers. One of these medications was specifically an opioid antagonist used to counter the effects of opioid overdose. Between November 2015 and September 2016, the FEHBP paid more than \$670,000 for the at-issue medications. We previously reported that multiple individuals were charged in the U.S. District Court for the Eastern District of Virginia. On October 20, 2020, an additional defendant was charged and pled guilty to conspiracy to commit healthcare fraud. On November 10, 2020, another individual was charged and pled guilty to conspiracy to commit healthcare fraud. Additional judicial action is anticipated in this case.

Recovery and Treatment Fraud

- ❖ We received a case notification from an FEHBP health insurance carrier regarding a drug treatment facility with suspicious billing patterns. The allegations were not related to patient harm, and the actual loss to the FEHBP was \$5,076. On October 31, 2020, the FEHBP health insurance carrier and the drug treatment facility agreed to a settlement that returned \$3,054 to the FEHBP.
- ❖ In September 28, 2020, we received a case referral from an FEHBP health insurance carrier regarding a substance abuse facility alleged to be billing physician rates for services provided by midlevel practitioners. The cost to the FEHBP was \$5,214. On

December 4, 2020, the health insurance carrier and the provider entered into a settlement that returned \$1,121 to the FEHBP.

Retirement Investigations

In FY 2020, OPM paid more than \$299.04 million in improper payments related to its retirement programs to retirees, survivors, representative payees, and families, largely from the Civil Service Retirement System (CSRS) and the Federal Employees Retirement System (FERS) retirement programs. One of the most common causes of improper payments is failure to verify the deaths of annuitants, which sometimes allows improper payments to continue for years and costs tens of thousands of dollars. Fraud by forged documents, identity theft, and other schemes also highlight program vulnerabilities, and in some cases may stop Federal retirees or rightful annuitants from receiving their deserved benefits.

Representative Payee Fraud

- ❖ In December 2018, we received a fraud referral from a Federal law enforcement partner regarding allegations of Representative Payee fraud. The amount misappropriated by the Representative Payee was \$32,225. In July 2020, the subject of the investigation pled guilty to wire fraud. On November 10, 2020, they were sentenced to 28 months of incarceration and ordered by the court to pay restitution of \$365,374 and a fine of \$7,000. This case was made possible because of the bipartisan Representative Payee Fraud Prevention Act of 2019, signed March 18, 2020, which closed a loophole that inhibited prosecution of some Representative Payees who unlawfully used or stole annuity payments from Federal retirees or survivor annuitants.

Survivor Annuity Benefits

- ❖ In January 2016, the OPM Retirement Services program office suspended a survivor annuitant's payments due to remarriage. However, there was no documentation that the program office verified the date of the remarriage, computed the overpayment, or sent an overpayment notice. The overpayment between November 2015 and December 2015 was \$1,716. In 2018, our Investigative Support Operations group requested more information from the Retirement Services program office. In March 2020, our investigators obtained a marriage certificate for the survivor annuitant that confirmed a marriage made them no longer eligible to receive survivor annuity benefits. We supplied this information to the Retirement Services program office. On October 7, 2020, Retirement Services sent a debt letter to the survivor annuitant requesting repayment of the \$1,716 overpayment.

Elder Abuse

- ❖ In February 2018, we received a request for information from a Federal law enforcement partner regarding a retired annuitant. This OPM annuitant was part of an investigation involving exploitation of the elderly. We previously reported in quarterly summaries that the caretaker of this annuitant received \$25,867 in FEGLI payments and \$64,385 in

misdirected OPM retirement benefits, and the caretaker was charged with obtaining property by false pretense and one count of exploitation of an elderly person in 2018 in Hoke County, North Carolina. In October 20, 2020, the case was transferred to the U.S. District Court for the Eastern District of North Carolina and indicted on a 27-count indictment for a scheme to defraud and wire fraud charges. Further judicial action is anticipated in the case.

- ❖ In August 2020, we received a case notification from an FEHBP health insurance carrier after an FEHBP enrollee was found deceased in June 2016. The coroner's toxicology report showed the deceased died of an opioid overdose. The case was investigated as a homicide by the local police department. The FEHBP had paid \$3,861 in medical claims related to the prescription opioids involved in the death, as well as \$26,461 in post-death payments the decedent received from an OPM annuity. We provided this information to the Riverside County District Attorney's Office investigating the case, who informed us that the information was relevant to the case because of a potential financial motive to the homicide. On November 19, 2020, the caretaker of the decedent was found guilty of homicide, as well as elder abuse, identity theft, perjury, making false statements, and aggravated white collar crime. On December 21, 2020, the caretaker was sentenced to 30 years of imprisonment for the murder of the Federal annuitant and the conversion of the annuitant's finances for their own use.
- ❖ In August 2019, we received a request for information regarding an OPM annuitant regarding potentially the victim of elder abuse. However, we were unsuccessful in locating the subject of our investigation allegedly perpetrating the abuse because the subject is homeless and of unknown whereabouts. On December 15, 2020, a criminal complaint was filed in the Placer County Superior Court of California and an arrest warrant was issued. The subject of our investigation was declared a fugitive by the State Attorney General. We have closed our investigation pending the fugitive's arrest.

Unreported Annuitant Death

- ❖ In May 2018, we received a referral from a law enforcement partner regarding potential fraud involving a CSRS annuitant. That law enforcement partner provided a death certificate confirming the annuitant died in January 2009, but their death had not been reported to OPM. Monthly annuity payments continued until May of 2018. The total overpayment was \$400,491. Treasury was able to recover \$5,794 through debt collections, as well as \$25,678 via their reclamation process from the financial institution paying the Federal Government checks. In previous summaries, we reported that the annuitant's son pled guilty in the U.S. District Court for the District of Maryland to one count of theft of public money. On October 13, 2020, he was sentenced to 18 months of incarceration, 36 months of supervised release, and ordered to pay restitution totaling \$409,421, of which \$369,018 will be returned to OPM.
- ❖ In March 2019, our Investigative Support Operations group identified an obituary for a deceased person receiving a survivor annuity. This annuitant had died in March 2014, but OPM paid \$199,032 in improper payments after her death, as well as \$40,841 in

FEHBP premiums. In September 2020, a criminal information was filed in the U.S. District Court in the Southern District of Ohio, and on November 2, 2020, an individual related to the deceased annuitant pled guilty to two counts of theft of public money. As part of the plea agreement, this individual will pay restitution of \$257,547, which includes restitution of \$58,515 to the Department of Defense and \$199,032 to be returned to OPM.

- ❖ In September 2016, we received a fraud referral from the OPM Retirement Services program office regarding an OPM annuitant who died in February 2012. The annuitant's death was not reported to OPM and improper payments continued until October 2015, resulting in an overpayment of \$86,209. OPM recovered \$8,778 through the Treasury reclamation process. We have previously reported that two individuals were charged in the U.S. District Court for the District of Maryland with crimes related to the theft of the annuity. On November 10, 2020, one of the individuals was sentenced to 14 months of incarceration and 3 years of supervised release, as well as ordered by the court to pay \$78,201 in restitution to OPM. On November 17, 2020, a second individual was sentenced to 12 months of home detention and 5 years of probation, as well as ordered to pay \$78,201 in restitution to OPM.
- ❖ We received a case referral from the Retirement Services program office regarding a CSRS annuitant who died in April 1995 but whose death was not reported to OPM. The Retirement Services program office continued to make annuity payments through September 2017 for \$107,383 in improper payments. We previously reported that an individual was indicted and pled guilty to theft of Government funds in the U.S. District Court for the Eastern District of Missouri. On December 10, 2020, the individual was sentenced to 60 months of probation and ordered by the court to pay \$107,383 in restitution to OPM.
- ❖ In June 2019, we received information from a member of the public regarding an OPM survivor annuitant who was allegedly deceased and whose benefits were being illegally used by another individual. According to the complaint, the survivor annuitant moved to Colombia in July 2015, but there had been no contact between her and the complainant in 4 years. Our Investigative Support Operations group requested the OPM program office suspend the annuity in June 2019, pending our investigation. Beginning in November 2019 and up to December 2020, we contacted Interpol and the Colombian Embassy for assistance locating the potentially deceased survivor annuitant. However, no investigative information was obtained. We also requested information from the Retirement Services program office regarding the cancellation of the survivor annuitant's FEHBP health benefits in 2015, but there was no record for that transaction. Therefore, we closed our investigation.

Administrative and Reclamation Actions Referred to the OPM's Retirement Services Program Office

Date of Death	Date Annuity Stopped or Suspended	Total Improper Payment	Date the OPM OIG Referred Annuitant File to Retirement Services	OIG Action Taken
August 2020	October 15, 2020	\$2,882	October 14, 2020	The Retirement Services program office initiated Treasury reclamation action to recover the post-death annuity payments.
April 2017	-	\$13,790	-	<p>In November 2019, we received an inquiry from a local law enforcement partner in Pennsylvania regarding an investigation where a deceased annuitant's niece spent OPM monthly annuity payments after the annuitant died.</p> <p>On October 13, 2020, the OPM CFO confirmed that all of the post-death annuity payments were recovered via Treasury reclamation actions.</p>
August 2020	August 2020	\$6,287	October 23, 2020	Retirement Services had suspended payments to the deceased annuitant but not dropped the case for death. After our notification, the Retirement Services program office dropped the case for death initiated Treasury Reclamation actions to recover the overpayment.
June 2017	October 2020	\$2,945	October 30, 2020.	<p>The Retirement Services program office had suspended payments to the deceased annuitant but not dropped the case for death.</p> <p>After receiving the information we located, the Retirement Services program office dropped the case for death and initiated Treasury reclamation actions to recover the overpayment.</p>
January 2018	January 2018	\$0	December 1, 2020	We notified the Retirement Services program office that although annuity payments were stopped, the case was not dropped for death. On December 7,

				2020, the Retirement Services program office dropped the case for death.
November 2017	November 2017	\$0	December 1, 2020	We notified the Retirement Services program office that although annuity payments were stopped, the case was not dropped for death. On December 7, 2020, the Retirement Services program office dropped the case for death.
November 2017	November 2017	\$0	December 1, 2020	We notified the Retirement Services program office that although annuity payments were stopped, the case was not dropped for death. On December 7, 2020, the Retirement Services program office dropped the case for death.
October 2017	October 2017	\$2,368	December 9, 2020	We sent the Retirement Services program office the October 2017 death record of a survivor annuitant. On December 9, 2020, the program office initiated Treasury reclamation actions to recover the improper payment.
March 2017	-	\$17,371	December 10, 2020	<p>Our Investigative Support Operations group located a death record for a survivor annuitant. While the Retirement Services program office had stopped the payments for the annuity, the case was not dropped for death and Treasury reclamation actions had not been initiated.</p> <p>On December 15, 2020, we also located records indicating the survivor annuitant received a retirement annuity from OPM as well. That annuity had also not been dropped for death.</p> <p>We notified the Retirement Services program office, and it initiated Treasury reclamation actions.</p>
February 2016	December 2020	\$15,207	December 28, 2020	We informed the Retirement Services program office of an OPM survivor annuitant's death record. The Retirement Services program office dropped the case for death and initiated Treasury reclamation actions to recover the post-death annuity payments.

National Security Investigations

As a former OPM bureau, the National Background Investigations Bureau (NBIB) conducted background investigations of Federal job applicants, employees, members of the armed services, and contractor personnel for suitability and security purposes. Allowing the employment of or granting security clearances to potentially unsuitable persons through fraudulent, falsified, incomplete, or incorrect background investigations creates vulnerabilities within the Federal workforce detrimental to Government operations. Though the Government's background investigative function is no longer an OPM-administered program as of October 1, 2019, we continue to provide external oversight of legacy background investigations begun before October 1, 2019. Most commonly, allegations involve falsified Reports of Investigation (ROIs) by background investigators.

Falsified Reports of Investigation

- ❖ In April 2019, we received a referral from DoD's Defense Counterintelligence and Security Agency (DCSA), formerly NBIB, regarding possible falsifications by a Federal background investigator. The loss to the Government to determine the depth and scope of the falsified background investigations between February 2018 and April 2019 were \$101,344. On October 27, 2020, the background investigator was indicted in the U.S. District Court for the District of Columbia on 11 counts of wire fraud and 10 counts of making false statements. Further judicial action is anticipated in this case.
- ❖ In December 2017, we received a referral from NBIB's Integrity Assurance office that alleged a contract background investigator submitted false and inaccurate ROIs. Preliminary investigations revealed the contract background investigator falsified 20 ROIs. However, because of the COVID-19 pandemic, information from DCSA could not be obtained. Therefore, no joint interviews between OPM OIG and DCSA investigators could be conducted. On October 1, 2020, the funding the OPM OIG had to investigate cases with DCSA ended. Therefore, we closed our investigation.
- ❖ In July 2016, we received a referral from the NBIB Integrity Assurance group alleging that a contract background investigator had falsified ROIs. The loss to OPM from the falsifications was \$254,555 (\$214,302 in labor costs and \$40,253 for travel costs). On November 23, 2020, the contract background investigator pled guilty in the U.S. District Court for the District of Columbia to one count of making a false statement. Further judicial action is expected in this case.

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.

Personnel Investigations

- ❖ In August 2020, we received information that the FBI arrested an OPM employee for possession of child pornography. We obtained further information regarding the case, including that the employee admitted to possession of child pornography and having contact with a minor. However, on October 23, 2020, the FBI notified us that the OPM employee died by suicide. Therefore, we closed our investigation.

Glossary

Improper Payments are disbursements that should not have been made or were made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. The reduction of improper payments is a President's Management Agenda goal across all Executive Branch agencies. In fiscal year 2018, OPM reported Retirement Programs and the FEHBP combined to make more than \$355.5 million in improper payments.

Health Care and Insurance Programs

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

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

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

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

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

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

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

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

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

Telemedicine provides health care services to a patient by telecommunication, such as via webcam. While the practice increases convenience and care access, it is also vulnerable to a variety of fraud schemes, including those involving opioids and compounded medications.

The Travel Act provides for Federal-level criminalization of business activities that are illegal under certain State laws (e.g., bribery) if interstate commerce, travel, or mail was part of the illegal business activities. Recent use of the Travel Act is a pioneering enforcement strategy that allows us to pursue fraud schemes when relevant State laws have been broken.

Unbundling is a health care fraud scheme where a procedure or office visit is separated into multiple billing codes when the procedure or visit should be billed under a single “panel” or inclusive code. Unbundling creates improper payments through inflated reimbursement.

Special Topic: The Opioid Epidemic

Diversion is the practice of transferring legally prescribed medications from the individual for whom it was prescribed to another person for illicit use.

Opioids are a class of pain medication labeled as **Schedule II drugs**, i.e., “drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence.” While largely safe when taken as prescribed by a doctor and according to medical best practices, opioids are often abused and can cause addiction, overdose, and death. Opioid drugs include **oxycodone**, one of the most common and most abused prescription drugs, and **fentanyl**, which has emerged as a dangerous additive to drugs such as heroin and can lead to overdoses in even small amounts.

Pill Mills are health care providers, facilities, or pharmacies that prescribe and/or dispense drugs without legitimate medical purpose.

Sober Homes aim to provide safe and drug-free residences for individuals suffering from addiction, but unscrupulous sober homes may submit patients to unnecessary, expensive, and excessive testing as part of a health care fraud scheme.

Retirement Programs

Address Verification Letters (AVLs) are sent to Federal retirees and survivor annuitants receiving CSRS/FERS benefits from OPM to verify whether annuitants are living and are living at the address currently on file with Retirement Services. It is one of the surveys that Retirement Services uses to confirm and census its annuitant population.

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

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

Reclamation is the process by which the Retirement Services program office attempts to recover funds through the Department of the Treasury for money paid as an annuity to deceased Federal annuitants through a financial institution, such as a bank.

National Security

The National Background Investigations Bureau (NBIB) was previously a part of OPM that conducted 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)**.

Integrity

The Office of Special Counsel (OSC) investigates and prosecutes prohibited personnel practices, whistleblower retaliation, and other violations that harm the civil service. As an outcome of our integrity investigations involving OPM employees, we may refer cases to the OSC for further action.