



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

Quarterly Case Summaries

Investigative Activities

Fiscal Year 2019

Fourth Quarter

July 1, 2019 – September 30, 2019

Issued: October 2019

-- Caution --

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List of Acronyms

CFC	Combined Federal Campaign
CSRS	Civil Service Retirement System
DOJ	U.S. Department of Justice
FBI	Federal Bureau of Investigation
FDA	U.S. Food and Drug Administration
FEDVIP	Federal Employees Dental and Vision Insurance Programs
FEGLI	Federal Employees' Group Life Insurance Program
FEHBP	Federal Employees Health Benefits Program
FEI	The Federal Executive Institute
FERS	Federal Employee Retirement System
FFS	Fee-for-Service
HHS	U.S. Department of Health and Human Services
HMO	Health Maintenance Organization
NBIB	National Background Investigations Bureau
OCFO	OPM's Office of the Chief Financial Officer
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
OSC	U.S. Office of the Special Counsel
PCFO	Principal Combined Fund Organizations
RICO	Racketeer Influenced and Corrupt Organizations Act
ROI	Report of Investigation

In this report to the OPM Director, the U.S. Office of Personnel Management (OPM) Office of the Inspector General (OIG) presents summaries of noteworthy cases investigated by the Office of Investigations as we endeavor to curtail improper payments, stop patient harm, protect OPM programs, and provide independent and objective oversight of OPM operations. We have selected these cases to highlight the successes of our special agents and Investigative Support Operations group, as well as to describe the types of waste, fraud, abuse, and mismanagement that harm OPM, its programs, and Federal employees, retirees, and their dependents.

The cases below represent the period from July 1, 2019, through September 30, 2019.

Health Care Investigations

The “OPM Fiscal Year 2018 Agency Financial Report” states that in Fiscal Year 2018, the FEHBP made \$71.44 million in improper payments. These substantial, costly improper payments often derive from fraud, waste, and abuse throughout the FEHBP and negatively affect premium rates and the program as a whole. Moreover, fraudulent schemes that generate improper payments often also cause patient harm.

False Claims

- ❖ In June 2019, we received a referral from the FBI regarding a subject running a third-party medical billing company that sought extremely high reimbursements by submitting falsely billed claims on behalf of clients. Between January 2015 and July 2019, the FEHBP had \$243,424 in paid medical claims under specific procedure codes related to these false claims. In July 2019, a criminal complaint filed in the U.S. District Court for the Eastern District of New York charged the subject with health care fraud, wire fraud, and aggravated identity theft.
- ❖ We received a referral from a law enforcement partner regarding potential fraud that involved a provider submitting false claims for insurance reimbursement. The FEHBP exposure totaled \$27,222 based on specific procedural codes. In June 2019, a criminal information was filed in the U.S. District Court for the District of Maryland charging a subject with conspiracy to commit health care fraud and prohibited conflicts of interest. In July 2019, the subject pled guilty to both charges.

Improper Billing

- ❖ 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 and paying kickbacks to doctors for referrals. The FEHBP paid \$18,150,555 in claims related to this investigation. In November 2016, 21 defendants were indicted, with a superseding indictment filed against 17 of those defendants in August 2017. Between January and

August 2018, 10 defendants pled guilty in the U.S. District Court for the Northern District of Texas to conspiracy to pay and receive health care bribes and kickbacks or other crimes. Seven more individuals were convicted in April 2019. In July 2019, an additional individual pled guilty to conspiracy to misapply the property of a health care benefit program.

Pass-Through Billing Scheme

- ❖ In September 2016, we received a case referral from a carrier alleging that a behavioral health facility admitted ineligible beneficiaries and did not provide the necessary health services. Our investigation uncovered an elaborate pass-through billing scheme. The FEHBP paid the provider approximately \$3.1 million. In March 2019, criminal informations and indictments against more than 10 individuals, as well as against several business entities, were brought in the U.S. District Court for the Eastern District of Pennsylvania. In April and May 2019, three individuals pled guilty to conspiracy to commit health care fraud. Another individual pled guilty in August 2019 to conspiracy to commit health care fraud. In September 2019, one provider was sentenced to 3 years of imprisonment, 1 year of probation, and ordered to pay over \$2.4 million in restitution. The FEHBP will receive \$314,593 in a lump sum.
- ❖ A health carrier submitted a referral alleging a sober home treatment facility billed for services not rendered, used unlicensed facilities and staff, and double-billed for urinalysis testing. The FEHBP paid \$539,373 in the scheme. Four individuals were indicted in the U.S. District Court for the Southern District of Florida and arrested. Charges included violations of the Travel Act, health care fraud, and money laundering. In January 2019, one individual pled guilty to conspiracy to commit health care fraud. In June 2019, two individuals originally indicted pled guilty to conspiracy to commit health care fraud. In July 2019, another one of those originally indicted individuals pled guilty to the same.
- ❖ In August 2016, we received multiple case notifications alleging a provider submitted an unusual number of urinalysis tests. The investigation uncovered an expansive pass-through billing and rural hospital scheme with a global exposure of \$10,220,281. In July 2019, a criminal information was filed in the U.S. District Court for the Middle District of Florida against one target. The target pled guilty to conspiracy to commit money laundering and as part of the plea will forfeit all property traceable to the offense. In December 2018, an FEHBP carrier entered a settlement agreement with some entities involved in this scheme. Two more entities finalized similar carrier settlements in April 2019. In September 2019, we requested the carrier repay all FEHBP funds outstanding and documented in the settlement, a total of \$558,000.

Carrier Settlements

- ❖ We received a health carrier case notification that identified a provider as potentially upcoding charges. The loss to the FEHBP was \$6,747. In March 2019, we received notification of a potential settlement between the carrier and the provider. This settlement proposed including FEHBP funds, which we did not oppose. In

September 2019, we received final notice of the executed settlement that returns \$6,747 to the FEHBP.

- ❖ We received a case notification from a health carrier regarding a provider billing for services provided by unlicensed individuals. The FEHBP exposure was \$11,954. In July 2019, we received a signed settlement agreement that stated the FEHBP would receive \$2,052.
- ❖ In November 2017, we received a referral from a health carrier that alleged a provider submitted claims as emergency services that were in fact not emergencies. The carrier alleged the overpayment totaling \$152,821 based on the misrepresentation. In July 2019, we became involved at the request of the carrier after unproductive discussions between the carrier and the provider, which ultimately resulted in a settlement wherein the provider paid \$91,760, all of which will be returned to the OPM trust fund.
- ❖ A provider self-reported a failure to follow guidelines for billing a specific procedure, and an FEHBP provider found additional inappropriate billing. The FEHBP's total exposure related to the investigation was \$61,340. The carrier negotiated a settlement that returned \$30,458 to the FEHBP. In September 2019, we notified the carrier that we were not opposed to the settlement.
- ❖ We received a case notification regarding a provider billing for laboratory services that were actually performed by another provider. The FEHBP had financial exposure of \$40,400.74 from one carrier related to this case. We were notified of a proposed settlement agreement between that carrier and the provider that would return \$25,000 to the FEHBP, and in September 2019, we responded to the carrier that we were not opposed to the settlement.
- ❖ We received an August 2019 notification related to a settlement agreement between a carrier and a provider who allegedly billed for services not rendered, upcoded services, and used ineligible providers to perform services, among other issues. The FEHBP had \$330,233 in exposure related to the provider. The proposed settlement would return \$213,282 to the FEHBP. We notified the carrier that we were not opposed to the settlement.

Laboratory Fraud

- ❖ In March 2015, we received a case notification alleging that a pharmacy engaged in the submission of false or inflated claims. During our investigation, a number of pharmacies and labs were identified as part of the alleged fraud, which included false and fraudulent toxicology tests not legitimately prescribed, needed, and/or provided as billed, or which were the product of kickbacks. The FEHBP paid \$3,692,626 related to this scheme. In July 2017, criminal informations were filed in the U.S. District Court for the Northern District of Texas against four individuals for conspiracy to commit health care fraud. In December 2018, one individual was convicted and sentenced to prison for 35 months. In

September 2019, indictments charged seven additional individuals with conspiracy to commit health care fraud, as well as other crimes.

Compounded Medications

- ❖ We were contacted regarding a joint law enforcement investigation into several entities alleged to have engaged in a widespread compounding pharmacy scheme that involved kickbacks, forged signatures, product substitution, and a variety of other crimes. The global exposure was estimated to exceed \$1.5 billion. In January 2016, a major takedown operation on 50 entities seized over \$80 million in assets. Between July 2017 and February 2019, four individuals pled guilty and numerous additional indictments were filed for health care fraud, conspiracy to distribute controlled substances, money laundering, and racketeering charges, among others. In September 2019, a superseding indictment was filed against one individual who allegedly defrauded the United States, conspired to commit bribery and kickback schemes, and prescribed unnecessary compounded medications.
- ❖ In September 2016, we received a request for investigative assistance from the U.S. Attorney's Office for the Eastern District of Tennessee regarding a provider prescribing medications without a doctor-patient relationship. About the same time, we received an FEHBP health carrier notification alleging related fraud schemes by an associated entity. The investigation uncovered a scheme prescribing ineffective compounded medications; laundering money through "copay assistance programs" and pass-through or sham business arrangements; and other health care fraud schemes. The total loss to the FEHBP totaled \$1,526,420. In October 2018, four subjects were arrested related to the case. In July 2019, one provider entered into a civil settlement to pay the U.S. Government \$2.5 million. The FEHBP will receive \$326,564 from the settlement.
- ❖ We received a referral from a law enforcement partner alleging a provider was involved in a fraud and kickback scheme related to compounded medications. The FEHBP paid the provider approximately \$2,293,011 between 2013 and 2015. In September 2019, two individuals were indicted in the U.S. District Court for the Central District of California with conspiracy to commit mail fraud; wire fraud; health care fraud; aggravated identity theft; conspiracy to commit money laundering; and other crimes. Both individuals were arrested. One has pled guilty to illegal remunerations.

Pharmaceutical Fraud

- ❖ In February 2012, we received a referral alleging a pharmaceutical company marketed its product drug by providing bribes and consulting services as kickbacks to physicians. From January 2007 to November 2013, the FEHBP paid \$361,555,919.37 in claims to the pharmaceutical company. In September 2019, the DOJ entered into a \$15.4 million global civil settlement with the pharmaceutical company. As part of the global settlement, the FEHBP received \$609,160.

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 the Office of Investigations.

Treatment and Recovery

- ❖ In January 2017, we received a qui tam complaint referred by the U.S. Attorney’s Office for the Eastern District of Pennsylvania, wherein the relator alleged that a provider admitted certain substance-use disorder treatment patients at a higher tier of care without satisfying the medical necessity requirements to do so. The FEHBP paid the provider approximately \$39,726, of which \$431 met the established false claims criteria. The U.S. District Court for the Eastern District of Pennsylvania entered into a civil settlement with the provider in July 2019. The provider paid a total restitution of \$2.85 million, of which the FEHBP trust fund will recover \$431.

Opioid Manufacturers

- ❖ We received multiple qui tam complaints filed in the U.S. District Courts for the Western District of Virginia and the District of New Jersey alleging a drug manufacturer illegally promoted the use of an opioid-withdrawal suppressant for uses that were unsafe, ineffective, and medically unnecessary, and made false and misleading claims, among other allegations. In September 2012, the drug manufacturer submitted a claim to the FDA fraudulently claiming the medicine was discontinued due to safety concerns and took other steps to delay the entry of a generic-equivalent medication. Overall, we identified FEHBP claims totaling \$43,462,505 between January 2009 and March 2017. In April 2019, the drug manufacturer was indicted by a Federal grand jury in the U.S. District Court for the Western District of Virginia. In July 2019, the drug manufacturer entered into a civil settlement to pay \$700 million related to the allegations. The FEHBP received \$7.18 million.
- ❖ The DOJ referred to us a joint, nationwide investigation with the FBI, HHS OIG, and other Federal law enforcement partners regarding off-label marketing and health care fraud involving a Schedule II, fentanyl-based narcotic. The manufacturer illegally promoted the drug by offering financial inducements for providers and falsified or misrepresented information for prior authorizations. From April 2012 to September 2016, the FEHBP paid \$17,742,528. One former employee pled guilty to wire fraud conspiracy in June 2017, and a company vice president pled guilty to one count of racketeering conspiracy in November 2018. Six other subjects were found guilty in May 2019 in the U.S. District Court for the District of Massachusetts with crimes including RICO conspiracy. In July 2019, the U.S. District Court for the District of Massachusetts approved a settlement including global restitution of \$2 million in fines,

\$28 million in forfeiture, and \$195 million to settle allegations related to violations of the False Claims Act. A hearing for the restitution is scheduled for October 2019.

- ❖ 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 of its carriers related to one provider, which totaled \$63,420. In March 2018, all five providers were arrested and debarment referrals were submitted to the OIG's 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 Anti-Kickback Statute.
- ❖ In September 2013, we received a qui tam complaint alleging a pharmaceutical company conducted an off-label marketing campaign to induce prescriptions of a fentanyl-based opioid medication. Sales representatives marketed the drug for off-label uses and the company paid kickbacks to doctors in exchange for issuing prescriptions of the drug. The FEHBP exposure totaled \$9,562,098. In August 2019, the pharmaceutical company settled allegations related to the civil investigation. The FEHBP was awarded \$3.9 million, minus the 3-percent DOJ allocation.

Diversions

- ❖ We reviewed State prescription monitoring program data and in September 2017 presented allegations that an individual provided hundreds of fraudulent opioid prescriptions under different insurance cards and aliases. During the investigation, a provider admitted to defrauding health insurance carriers by billing for services not rendered. The FEHBP exposure was \$300,326. One individual was charged in the U.S. District Court for the Eastern District of Pennsylvania with distribution of a controlled substance and pled guilty. In September 2019, the provider pled guilty to conspiracy to commit wire fraud, illegal prescription of Schedule II controlled substances, and other charges.
- ❖ We received a case notification regarding a provider identified as a high prescriber alleged to prescribe controlled-substance medications without corresponding medical claims. The FEHBP had paid \$397 in medical claims from 2015 to 2017 to the provider. In September 2019, a grand jury in the U.S. District Court for the Western District of Pennsylvania indicted the provider for the distribution of Schedule II drugs and opioids.
- ❖ We joined an ongoing investigation with Federal and local law enforcement partners into the alleged off-label prescribing of medicine and kickbacks related to the prescription of fentanyl-based medications. The amount paid by the FEHBP to the provider for all Schedule II prescriptions totaled \$2,057,881. Interviews revealed that providers issued prescriptions for opioids and other drugs without legitimate medical need and beyond the bounds of acceptable medical practice. One provider also admitted to having sexual contact with patients in exchange for writing prescriptions. That provider was paid

\$115,575 from January 2012 to November 2017. In July 2019, the provider pled guilty in the U.S. District Court for the District of Maryland for conspiracy to distribute and dispense a controlled substance.

- ❖ We received a referral from a law enforcement partner regarding a provider allegedly engaged in several fraud schemes, including billing for services not rendered, falsifying patient records, using foreign and/or unapproved drugs on patients, billing for medically unnecessary services, allowing unsupervised and/or unlicensed individuals to administer drug injections, and providing Schedule II drugs to drug-seeking patients. In September 2019, a grand jury in the U.S. District Court for the Northern District of Illinois indicted the provider on a 19-count indictment.

Retirement Investigations

In Fiscal Year 2018, Retirement Services improperly paid \$284.08 million to retirees, survivors, representative payees, and families. One of the most common causes of improper payments is failure to verify the deaths of annuitants, which sometimes allows improper payments to continue for years and costs 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.

Disability Retirement

- ❖ In October 2018, we received notification of an ongoing investigation by a Federal law enforcement partner regarding a former Federal employee who submitted false documentation, such as falsified medical letters, to receive benefits from multiple Federal programs, including OPM Disability Retirement. An investigation quantified the loss to OPM at approximately \$30,000; however, the potential exposure was calculated at approximately \$717,000, based on a return to the OPM disability annuity at age 40 and living until 80 years old with annual 2-percent cost-of-living adjustments. In July 2019, the U.S. District Court for the Northern District of California sentenced the employee to 37 months of imprisonment and 3 years of supervised release, as well as \$632,368 in restitution to all affected Federal programs.

Identity Theft

- ❖ In May 2017, we received a referral from OPM's Retirement Services office alleging possible fraud involved in the overpayment of an annuity. An annuitant's death in February 2006 was not reported, and payment continued through August 2016. Retirement Services ultimately paid \$212,481 in improper payments. In July 2019, a criminal information was filed in the U.S. District Court for the Eastern District of Virginia for theft of Government property. In September 2019, the annuitant's son pled guilty.
- ❖ Our Investigative Support Operations group identified a deceased annuitant who had received \$566,547 in improper payments after his death. In August 2019, one individual

pled guilty in the U.S. District Court for the Eastern District of Michigan to one count of mail fraud and one count of aggravated identity theft.

Deceased Annuitant

- ❖ We received a referral in December 2018 from Retirement Services regarding the unreported July 2013 death of an annuitant. The associated improper payments totaled \$103,476. In September 2019, one individual pled guilty in the U.S. District Court of the Southern District of Ohio to two counts of theft of public money.
- ❖ We received a case referral from Retirement Services regarding the unreported April 1995 death of a CSRS annuitant. OPM had continued making monthly annuity payments through September 2017, for improper payments totaling \$107,383. In August 2019, one individual was indicted in the U.S. District Court for the Eastern District of Missouri for embezzlement of Government property.
- ❖ In May 2018, we received a referral from Retirement Services regarding the unreported April 1993 death of an annuitant. OPM continued to deposit payments through October 2017, resulting in an overpayment of \$326,091. In April 2019, the annuitant's daughter pled guilty to theft of Government property, and in August 2019, the daughter was sentenced to 36 months of probation, 18 months of home detention, and restitution of \$325,191 to the OPM retirement trust fund.
- ❖ In September 2016, we received a referral from Retirement Services regarding the unreported February 2012 death of a survivor annuitant. OPM deposited the annuity through October 2015, making \$86,209.01 in improper payments to the survivor annuitant's account. Through the reclamation process and the U.S. Department of the Treasury, OPM was able to recover \$8,778.60. In August 2018, the annuitant's daughter was indicted in the U.S. District Court for the District of Maryland on theft of Government property, aggravated identity theft, and aiding and abetting, and in May 2019, her husband was charged with aiding and abetting, theft of Government property, and conspiracy. In July 2019, the husband turned himself in on an unrelated warrant and was transported by U.S. Marshals to the U.S. District Court for the District of Maryland for appearance on Federal charges stemming from our investigation.
- ❖ In July 2017, we received a referral from OPM's Retirement Inspections office regarding the unreported death of annuitant. From June 2014 through October 2016, OPM paid \$71,701 in improper payments to the deceased annuitant. Our investigation determined that the annuitant's daughter diverted the annuity through forged AVLs and other communications with OPM. In July 2019, the subject was sentenced in the U.S. District Court for the District of Connecticut to 150 hours of community service and full restitution to the OPM retirement trust fund of the improper payment, plus a criminal fine of \$1,000.
- ❖ In July 2018, we received a notification from the U.S. Attorney's Office for the District of Maryland regarding suspected fraud involving a CSRS annuitant after we were

provided a death certificate confirming the November 2017 death of the annuitant. Payments had continued through January 2018 and amounted to more than \$47,000. In July 2019, one individual pled guilty in the U.S. District Court for the District of Maryland for theft of Government property.

Statute of Limitations Concerns

- ❖ In December 2018, we received a fraud referral from Retirement Services regarding retirement payments to an annuitant who was later confirmed to have died in December 2007. A total of \$60,333 was paid to the annuitant's account after their December 2007 death. OPM was able to recover nothing through the reclamation process with the U.S. Department of the Treasury. Because the last payment to the annuitant occurred in April 2010, the Federal statute of limitations expired. We took no further action and returned the case to the OPM Office of the Chief Financial Officer (OCFO).
- ❖ In May 2018, we received a fraud referral from Retirement Inspections regarding the unreported April 2006 death of an annuitant. Improper payments continued through June 2011, resulting in an overpayment of \$68,592. OPM was unable to recover any funds through the reclamation process, as the Notice of Reclamation was not issued until 2017 and the referral to the OIG was not submitted until the next year. In July 2018, we submitted an Inspector General subpoena to the financial institution hosting the annuitant's account. The financial institution, however, only maintained 7 years of records per its retention policy. The subpoena was unable to provide information to further our investigation. Therefore, we ended our investigation in July 2019.

Proactive Retirement Cases

- ❖ In April 2019, we proactively identified the obituary and death record for a Federal survivor annuitant whose death in January 2016 was not reported to OPM. The survivor annuitant had received annuity payments totaling \$72,340 and FEHBP premiums totaling \$27,799.83. Our Investigative Support Operations notified Retirement Services of the death. In July 2019, the OPM OCFO posted a recovery of the entire amount of the post-death annuity payments.
- ❖ In August 2019, Investigative Support Operations identified the obituary of a survivor annuitant showing that they died in February 2017. The annuitant received \$11,057 payments after death, and OPM paid health benefits premiums of \$21,905 during that time. We notified Retirement Services of our findings, and reclamation actions began. In September 2019, the OCFO posted a recovery of \$10,677.

National Security Investigations

OPM's National Background Investigations Bureau (NBIB) conducts background investigations of Federal job applicants, employees, members of the armed services, and contractor personnel for suitability and security purposes. Allowing the employment of or granting security clearances to potentially unsuitable persons through fraudulent, falsified, incomplete, or incorrect

background investigations creates vulnerabilities within the Federal workforce detrimental to Government operations. We provide external oversight of NBIB's background investigations to protect the integrity of these background investigations.

Falsifications of Background Investigations

- ❖ In May 2014, we received a referral from NBIB alleging that a contract background investigator submitted false and inaccurate Reports of Investigation (ROIs) between May 2013 and May 2014. The recovery cost to redo the background investigations affected totaled \$126,693. The contract background investigator was indicted in January 2019 on wire fraud and making false statements in the U.S. District Court for the District of Columbia. He pled guilty in April 2019. He was sentenced in July 2019 to 5 months of incarceration and 36 months of supervised release, as well as full restitution to OPM of the \$126,693.
- ❖ We received a referral from the NBIB Integrity Assurance office alleging the submission of false and inaccurate ROIs by a background investigator. The background investigator falsified 90 ROIs between September 2015 and October 2016, with an associated loss of \$212,407 to OPM in redoing the affected background investigations. In October 2016, the background investigator's Top Secret security clearance was suspended. In April 2019, a criminal information was filed in the U.S. District Court for the District of Columbia for false statements. He pled guilty in September 2019, and the court sentenced him to 36 months of supervised probation and 6 months of home confinement, as well as ordered full restitution to OPM of the \$212,407.

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.

Combined Federal Campaign Fraud

- ❖ In February 2015, we received information from the Combined Federal Campaign (CFC) regarding potential fraud against the program, with the financial exposure totaling \$36,256. Our investigation found that a Principal Combined Fund Organization (PCFO) in the CFC allegedly entered and potentially approved her own charity to the 2013 and 2014 CFC without the charity receiving approval from the Internal Revenue Service. Additionally, documentation may have been forged or altered and thousands of dollars disbursed to charities when no real donations were in fact made. In August 2019, the case was declined for prosecution by the U.S. Attorney's Office in the Western District of

Washington; however, in September 2019, we recovered \$21,012 related to the case and returned those funds to the CFC for disbursement.

Glossary

OPM Programs

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.

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 that are 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, postal, and military donors during the campaign season. These pledges support eligible nonprofit organizations.

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 inspection performed by the OIG. Reports to the OPM OIG hotline may be made online via <https://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/> or by telephone at 1-877-499-7295.

Health Care and Insurance

Carrier Letters are guidance that OPM Healthcare & Insurance provides to 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 health maintenance organizations (HMOs) and fee-for-service (FFS) health plans.

Compounded Medications are medications (often liquids or creams) made to fit the individual needs of a patient. The Food and Drug Administration (FDA) do 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, 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 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 best medical practice, 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.

Racketeer Influenced and Corrupt Organizations Act (RICO) is a Federal law with criminal penalties for anyone employed by or associated with a criminal enterprise. Specifically, RICO violations occur when: (1) an enterprise exists; (2) the enterprise affected interstate commerce; (3) the defendant was associated with or employed by the enterprise;

(4) the defendant engaged in a pattern of racketeering activity; and (5) the defendant conducted or participated in at least two acts of racketeering activity.

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

Retirement Programs

Address Verification Letters (AVLs) are sent to Federal retirees and survivor annuitants receiving CSRS/FERS benefits from OPM to verify whether annuitants are living and are living at the address currently on file with 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 Retirement Services attempts through the U.S. Department of the Treasury to recover money paid to Federal annuitants when a financial institution, such as a bank, holds the funds.

National Security

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

Integrity

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

Principal Combined Fund Organizations (PCFOs) were not-for-profit organizations hired to administer the CFC within a defined area. Under the supervision of a small group of Federal volunteers drawn from the same region, the PCFO performed various tasks such as processing local charity applications; holding events to publicize the campaign; collecting pledges; processing donations; reporting campaign results to charities and the Government. As of the 2017, PCFOs are no longer part of the CFC.