



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

Quarterly Case Summaries

**Investigations Resolved
During the Period January 1, 2017 through March 31, 2017**

Issued September 2017

REPORT FRAUD, WASTE, AND MISMANAGEMENT

INTRODUCTION

Our investigative workload involves crimes affecting U.S. Office of Personnel Management (OPM) programs. Provided below are summaries of the Office of the Inspector General's (OIG) investigations resolved during the period January 1, 2017 through March 31, 2017.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Health Care Fraud:

- I 2010 00539: In March 2010, our office received an allegation from the Federal Bureau of Investigations (FBI) that a Northern Virginia dermatologist and surgery center owner were committing healthcare fraud. The dermatologist was alleged to have intentionally misdiagnosed patients with skin cancer and performed unnecessary surgery on patients' benign skin tissue. It was also alleged that the doctor submitted claims to Federal healthcare programs on the basis of fraudulent skin cancer diagnoses codes and false certifications that the procedures had been medically necessary for the health of the patients. Further, the doctor allegedly billed healthcare programs for procedures that he did not perform. He directed his unlicensed and unqualified medical assistants to perform procedures on patients while he was seeing patients at other office locations and then fraudulently billed healthcare programs as if he had performed or personally supervised the procedures. The dermatologist and surgery center owner entered into a civil settlement agreement with the United States Attorney's Office for the Eastern District of Virginia in which he agreed to pay the United States \$190,000. OPM's Federal Employees Health Benefits Program (FEHBP). The FEHBP received \$64,706.79.
- I-15-00434: A Plantation, Florida otolaryngologist in February 2017, entered into a civil settlement agreement with the Federal Government agreeing to pay a total of \$750,000 to resolve disputed claims for surgeries that allegedly were not necessary or were not provided. The investigation found that the otolaryngologist routinely performed diagnostic endoscopies on patients, but billed these diagnostic procedures as more expensive and intrusive surgical debridement. Surgical debridement is a specialized procedure frequently performed following sinus surgery involving the trans-nasal insertion of an endoscope and parallel insertion of various instruments to remove postsurgical crusting, bone or tissue deposits. It may also be used to remove crusts and debris in patients with longstanding chronic sinusitis who have undergone surgery in the past. The FEHBP will receive \$25,258.80 as a result of the settlement. Our office worked jointly on this *qui tam* case with the FBI and the Department of Health and Human Services (HHS) OIG.
- 2011 00782: In 2015, a *qui tam* lawsuit was filed in the U.S. District Court for Utah alleging that sales representatives of a Durable Medical Equipment (DME) provider were altering medical records in order to get their claims for power wheelchairs and accessories paid. The civil lawsuit resulted in a total settlement of \$7.5 million of which the FEHBP received

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\$55,290. We learned in February 2017 that the owner of the DME supply company was convicted in the criminal case and agreed to pay restitution totaling \$4,000,000. No FEHBP claims were included in the criminal restitution ordered; however, as part of the settlement, the \$4,000,000 criminal judgment was to be applied to the civil case for which the owner was a co-defendant. The FEHBP's share of this new settlement totaled \$29,488 for a total settlement of \$84,778 for the FEHBP for this case.

- I-12-00342: In April 2012, the U.S. Attorney's Office in the Northern District of Texas notified our office that the principal owner of a major physician-owned hospital chain with multiple locations in Texas, had allegedly signed medical documentation as the supervising anesthesiologist for procedures that were actually performed by unsupervised Certified Registered Nurse Anesthetists. The subject of the investigation was an anesthesiologist who also owned a secondary business which provided anesthesia services exclusively to the Texas hospital chain where he was also the principal owner. It was further alleged that at his direction his employees padded the anesthesia times on surgical procedures in order to boost revenue. The subject owner was found guilty of Health Care Fraud and on March 20, 2017 was sentenced in the U.S. District Court for the Northern District of Texas to 41 months incarceration, 12 months of probation, and ordered to pay restitution in the amount of \$7,365,481.40. The FEHBP's portion of the restitution was \$392,604.40.
- I-12-00381: An FEHBP health insurance carrier's Special Investigations Unit (SIU) notified our office in April 2012 that they had identified some abnormal billing patterns of a podiatrist located in Havertown, Pennsylvania. Specifically, the carrier alleged the podiatrist was billing for services not rendered and/or for services that were not medically necessary. The billing pattern revealed that he performed an excessive number of procedures per day, submitted an excessive number of claims per patient, and billed an excessive paid amount per patient. Our investigation revealed that the podiatrist had submitted fraudulent claims to Federal healthcare programs for procedures that were not performed, or were not medically necessary. In addition, he provided "pill seeking" patients with prescriptions for oxycodone in exchange for allowing him to perform medically unnecessary podiatry procedures and submit fraudulent claims to their insurance providers. The podiatrist was found guilty of Health Care Fraud and on February 7, 2017 was sentenced in the U.S. District Court for the Eastern District of Pennsylvania to 97 months in jail, three years of probation, and ordered to pay \$4,960,295.95 in restitution and a \$100 assessment fee. The FEHBP's portion of the recovery was \$1,215,272.51. We worked jointly on this case with the FBI, HHS OIG, the Drug Enforcement Agency, and the Railroad Retirement Board OIG.
- I-14-00891: In May 2014, an anesthesia practice self-reported an overbilling issue related to time and units on anesthesia claims to an FEHBP health insurance carrier. The practice prepared an audit and determined that they were overpaid nearly \$336,137 on health insurance claims that they submitted to the carrier. We reviewed the matter and discussed the company's disclosure with the United States Attorney's Office in the Eastern District of Virginia. On March 1, 2017, the company entered into a civil settlement agreement in which they agreed to pay the FEHBP \$336,137.52. In addition, the settlement agreement required the company to return an additional \$33,579 in wrongfully collected co-payments to the FEHBP.

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- I-15-00156: A FEHBP health insurance carrier informed us in November 2014 of a former Department of Defense (DOD) civilian employee who submitted false claims to the FEHBP for services he did not receive. The former DOD employee, stationed in Germany, submitted 66 invoices representing over 1,300 health claims totaling over \$150,000 for visits with a German physical therapist for treatment to his back and legs that never occurred. Our joint investigation with the DOD OIG determined that the employee used DOD fax and computer equipment to submit these fraudulent claims to an FEHBP health insurance carrier. We coordinated with the health plan, DOD OIG and the U.S. Department of Veterans Affairs and were able to prove that these claims were fictitious. In November 2016, the former employee entered a guilty plea to one-count of Healthcare Fraud. In February 2017, he was sentenced to 60 months of probation, 180 days of home detention, and ordered to pay restitution in the amount of \$143,111 to the FEHBP.
- I-17-00076: In April 2014, a whistleblower filed a *qui tam* lawsuit in the U.S. District Court for the Eastern District of California alleging that three associated Orthopedic surgical clinics located throughout Northern California violated the False Claims Act by billing Federal and State healthcare programs for reimported osteoarthritis medications, known as viscosupplements. The viscosupplements are reimbursed in the United States at a set rate based on the Average Sales Price (ASP) of the domestic product. It is alleged that the clinics purchased heavily discounted viscosupplements that were reimported from foreign countries, then billed state and Federal healthcare programs at the U.S. ASP in order to obtain higher profit from the healthcare insurance reimbursement system, even though these foreign obtained and reimported viscosupplements were not FDA-approved and therefore not reimbursable by those programs. All three clinics entered into settlement agreements to resolve these allegations. In total, the civil settlement obtained \$2,390,032 from all three clinics. The FEHBP's portion of the recovery was \$8,863.75.
- I-16-00780: A former physician at a large multi-state hospital chain headquartered in Illinois filed a *qui tam* lawsuit in September 2009, in the U.S. District Court for the Northern District of Illinois (NDIL) alleging that the multi-state hospital chain violated the False Claims Act by billing Federal healthcare programs for higher and more expensive levels of general medical service than were actually performed. The OPM OIG joined the investigation with the U.S. Attorney's Office NDIL in September 2016. It was alleged that the multi-state hospital chain's management encouraged false billings by its medical professionals, especially those with billing levels lower than their peers. To resolve these allegations, the hospital chain entered into a civil settlement agreement on February 6, 2017 in which they agreed to pay the United States \$60,000,000. The FEHBP's portion of the settlement was \$470,450.
- I-16-00447: In December 2015, a whistleblower filed a *qui tam* lawsuit in the U.S. District Court for the Western District of Tennessee alleging that the owner of a podiatry clinic submitted false and fraudulent claims to Federal healthcare programs. The owner allegedly billed for foot care services that did not meet the medical criteria to be eligible for coverage, diagnostic tests that were not medically necessary, and for podiatry services that were not provided. To resolve these allegations, the owner entered into a civil settlement agreement in

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February 2017 in which he agreed to pay the United States \$124,000. The FEHBP's portion of the settlement was \$16,871.63.

- I-13-00745: We were notified in May 2013 by an FEHBP health insurance carrier's Special Investigations Unit that a pain management physician operating under an umbrella company in Georgia and Kentucky was providing Intra-Operative Monitoring (IOM) services by unlicensed or unqualified staff, and billing for services he did not perform and/or were medically unnecessary. Two lawsuits filed by three whistleblowers under the *qui tam* provisions of the False Claims Act were resolved on January 20, 2017 after the physician agreed to pay the United States \$20,000,000 to resolve allegations that he violated the False Claims Act. The physician was sentenced to 38 months in prison, three years of probation, and ordered to pay \$138,277.38 to the FEHBP.

Fraudulent Medical License:

- I-15-00194: In November 2014, the OIG at the U.S. Department of Health and Human Services notified our office of an allegation that someone claiming to be an obstetrician-gynecologist was performing medical services in Maryland using a fraudulent medical license. Due to the allegations and potential for patient harm and safety, our office opened an investigation into the individual's medical background and immigration status. As a result, it was revealed that the individual was using an alias and had obtained fraudulent Social Security numbers using other names and false identifying information. He used the false information to obtain a medical license and to get into residency programs in the United States. He also used false Social Security numbers to fraudulently apply for Federal education loans for his children. A search of his residence recovered a false Social Security card, a false passport, a false U.S. visa, and fraudulent documents related to immigration, medical diplomas, medical transcripts, letters of recommendation and birth certificates. In the U.S. District Court for the District of Maryland, the individual pled guilty to misusing a Social Security account number to fraudulently obtain a medical license. On February 27, 2017 he was sentenced to six months in jail, followed by six months of home detention as part of three years of probation. He was also ordered to pay a special assessment of \$100.

FEHBP Suspension and Debarment:

- During the period January 1, 2017 through March 31, 2017, our Office of Investigations referred 16 healthcare providers to the OIG debarment official to consider for debarment from participation in the FEHBP, and recommended two suspensions.

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RETIREMENT PROGRAMS

(Civil Service Retirement System and Federal Employees Retirement System)

Deceased Annuitant Fraud:

- I-13-00542: A proactive project conducted by our office revealed that the October 23, 2009 death of an annuitant had not been reported to OPM. As a result, OPM continued to issue monthly retirement annuity payments through March 2013, resulting in an overpayment of \$63,769.09. OPM recovered \$11,721.88 through the reclamation process with the deceased's financial institution, leaving a balance due of \$52,047.21. Our investigation revealed that after the annuitant died, her son continued to receive the annuity payments and used them for his own benefit. We coordinated with OPM's Office of the Chief Financial Officer (OCFO) and the son's attorney in an attempt to get the son to repay the Government funds. Attempts to finalize an agreement were unsuccessful. Therefore, on March 22, 2017, the OCFO's Funds Management Section submitted a debt referral to the U.S. Department of the Treasury for collection of \$52,136.80, which includes interest added to the principal amount owed.
- I-15-00634: In 2015, through the proactive efforts of the OPM OIG Investigations Support Group, we identified a potential overpayment of an OPM annuitant's retirement and survivor annuity payments that continued after death. The annuitant's August 2012 death was not reported to OPM and benefit payments continued through August 2014, resulting in an overpayment of \$83,865 for the retirement annuity and \$103,282 on the survivor annuity. Our investigation discovered that the annuitant's daughter maintained a joint account with the annuitant where the annuity benefit payments were electronically deposited. Our special agents interviewed the daughter who admitted that she converted the annuity payments to her own personal use after her mother's death. The daughter confessed that she received correspondence from OPM inquiring as to the vital status of her mother, but she ignored this correspondence, knowing that the benefits would be discontinued if she informed OPM of her mother's death. After the Department of the Treasury's reclamation process, the net balance due for the entire overpayment was \$138,047. The U.S. Attorney's Office in the Eastern District of Virginia initiated a civil action to recover the overpayment. In January 2017, the defendant settled this matter with the Government agreeing to repay \$112,714 via one lump sum payment of \$100,000 and 36 subsequent payments in monthly installments to settle her debt.

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FEDERAL EMPLOYEES' GROUP LIFE INSURANCE

Fraudulent Claims:

- I-17-00105: In December 2016, we received notification from the contracted carrier for the Federal Employees' Group Life Insurance (FEGLI) program that someone had fraudulently obtained \$312,964.03 in FEGLI benefits to which he/she was not entitled. The investigation revealed that a Civil Service retiree designated that his FEGLI death benefits be paid to his son. Following the retiree's death, the niece of the deceased submitted a forged claim form to the carrier and received the \$312,964.03 in life insurance benefits that was intended for the son. Further review of the claims filed determined that the son received \$64,487.27 of the \$312,964.03, but was still due the balance of \$248,476.76. On November 9, 2016, in the Court of Common Pleas of Montgomery County, Pennsylvania, the niece pled guilty to the charges of Information for False Impressions, Theft by Failure to Make Required Disposition of Funds Received, and Misapplication of Entrusted Property and Property of Government or Financial Institution. On February 28, 2017, she was convicted and sentenced to eight to twenty-three months of incarceration, eighty-four months of probation, and ordered to pay \$248,476.76 in restitution to the son.

OPM

False Statements:

- I-12-00647: OPM hired a contract employee in April 2012 to work as a full time systems administrator and required him to perform his duties on-site. In May 2012, unbeknownst to OPM, the National Security Agency (NSA) hired the employee as a subcontractor to work on computer systems where he was also required to work full-time and on-site. From May through August of 2012, he worked at both OPM and NSA, but neither agency was aware that he was working for the other. A review of OPM building access reports revealed that OPM paid the contractor for 323.75 hours in which he was not actually present at his work site. He was subsequently terminated by OPM. OPM learned of his employment at NSA after his termination. A review of NSA building records revealed that he was paid for 269.5 hours in which he did not work and was not present on-site. He pled guilty to the charge of making a False Statement and on February 17, 2017 was sentenced in the U.S. District Court for the District of Columbia to five years of probation, three months of which will be home detention. He was also ordered to perform 360 hours of community service and to pay \$70,646.25 in restitution and a \$100 assessment fee. OPM's portion of the restitution was \$43,706.

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NATIONAL BACKGROUND INVESTIGATIONS BUREAU (NBIB)

Debarment and Suspension of Background Investigators:

- During the period January 1, 2017 through March 31, 2017, the OPM OIG referred five background investigators to OPM for debarment and nine for suspension. The background investigators were referred for these administrative sanctions for falsifying their work products, specifically reports of investigations they provided Federal agencies regarding the background investigations they conducted for them. During this time, OPM issued Notices of Proposed Debarment to one background investigator.



Report Fraud, Waste, and Mismanagement

Fraud, waste, 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: <http://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse>

By Phone: Toll Free Number: (877) 499-7295
Washington Metro Area: (202) 606-2423

By Mail: Office of the Inspector General
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