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

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# Quarterly Case Summaries

**Investigations Resolved  
During the Period July 1, 2015 through September 30, 2015**

**Issued January 2016**

OFFICE OF  
PERSONNEL MANAGEMENT

# QUARTERLY CASE SUMMARIES

## **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 July 1, 2015 through September 30, 2015.

## **FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP)**

### **False Claims**

- I 2011 00148: The Chief Executive Officer of Kentwood Pharmacy, Grand Rapids, Michigan, pled guilty to a conspiracy to commit health care fraud based on billing Medicare Part D Plans, Medicaid, and private insurance plans, including the FEHBP, for misbranded and adulterated drugs. This case involved a drug substitution scheme whereby the co-conspirators returned, restocked and re-dispensed drugs that were previously dispensed in adult foster care and nursing homes. On August 28, 2015, the Chief Executive Officer was sentenced in the U.S. District Court for the Western District of Michigan to a ten year prison term, three years of probation and ordered to pay a \$7,500 fine and a \$100 assessment fee. As a result of this investigation, 18 employees at Kentwood Pharmacy were convicted of criminal offenses stemming from the practices at Kentwood Pharmacy, including the felony convictions of six licensed pharmacists. Kentwood Pharmacy's Vice President of Sales was sentenced to 14 years in prison, five years of probation and ordered to pay a \$2,500 fine and a \$100 assessment fee for his involvement in the health care fraud conspiracy and a separate charge of possession of child pornography. The Chief Pharmacist was sentenced to six years imprisonment, three years of probation and ordered to pay a \$5,000 fine and a \$100 assessment fee for his role in the conspiracy. Restitution has not yet been ordered due to the vast number of victims; however, the FEHBP is expected to receive over \$400,000.
- I-12-00445: A receptionist at the East Islip Family Care (EIFC), New York, filed a complaint in the Eastern District of New York claiming that physicians at the EIFC submitted claims to Federal health care programs for procedures that were not medically necessary. An investigation ensued and confirmed that physicians had billed Medicare and the FEHBP for nerve conduction studies that were not medically necessary. In July 2015, two physicians at the EIFC entered into civil settlement agreements in which they agreed to collectively pay the United States a total of over \$1.1 million to resolve the allegations. The FEHBP's portion of the total recovery was \$18,766.18.
- I-12-00548: The U.S. Attorney's Office in the District of North Dakota and the OIG for the Department of Health and Human Services (HHS) notified OPM's OIG that representatives of Medcenter One (MCO) wished to disclose billing issues in connection with MedEquip One, LLC (MedEquip), a corporate subsidiary of MCO. MedEquip is a

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durable medical equipment supplier located in Bismarck, North Dakota. Counsel for MCO revealed that internal audits beginning in 2011 identified that MedEquip had submitted claims to Federal health care programs that lacked supporting documentation. Our investigation confirmed that MedEquip submitted claims that did not satisfy all elements necessary for reimbursement. In August 2015, MedEquip entered into a civil settlement agreement in which they agreed to pay the United States \$1.25 million. The FEHBP's portion of the total recovery was \$44,054.20.

- I-13-00980: On July 9, 2015, a Detroit area hematologist-oncologist was sentenced to serve 45 years in prison and ordered to forfeit over \$17.6 million for his role in a health care fraud scheme that included administering a variety of cancer and hematology treatments to patients who did not need them. A multi-agency investigation initiated by the HHS OIG in conjunction with the Federal Bureau of Investigation concluded that this doctor deliberately misdiagnosed patients as having cancer, in order to justify unnecessary cancer treatment, and also administered unnecessary chemotherapy to patients in remission. The doctor also solicited kickbacks from a hospice and a home health care service in exchange for his referral of patients to those facilities. Medically unnecessary infusions or injections were given to 553 individual patients and resulted in approximately \$34 million in fraudulent claims to Medicare, the FEHBP, and private insurance companies. Restitution has not yet been ordered due to the vast number of victims, but we have determined that FEHBP insurance carriers issued over \$1.2 million in benefits to this doctor. Our office also debarred the doctor from participation in the FEHBP.
- I-14-00547: The Special Investigations Unit at Highmark Blue Cross Blue Shield of West Virginia notified OPM's OIG of irregular billing made by The Kuzbari Clinic (Clinic). An audit discovered that when billing for office visits and physician services, the Clinic used certain billing codes significantly more frequently than did similar clinics. OPM's OIG and the Department of Justice conducted an investigation into alleged upcoding, which is billing for a higher level of service than was actually provided. This resulted in the Clinic entering into a civil settlement agreement in September 2015, which required them to pay the United States \$440,232.00. The FEHBP's portion of the total recovery was \$79,659.31.
- I-14-00840: Express Scripts Pharmacy Benefit Management's (PBM) Program Integrity conducted an investigation after receiving a tip on their Fraud Tip Hotline alleging fraudulent activity at LCRX, an Arizona corporation that operated a compounding pharmacy under the trade name of Alpha Direct Compounding. The investigation found that the pharmacy allegedly submitted claims for prescriptions that were not dispensed to beneficiaries, waived co-payments, and dispensed drugs that were not in compliance with state and Federal requirements. To resolve these allegations, in September 2015, LCRX entered into a civil settlement agreement that required them to pay the United States \$48,952.60. The FEHBP's portion of the total recovery was \$15,427.60.

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- I-14-01014: In June 2015, a Federal jury convicted two Southern California residents in connection with a scheme to defraud union and private health insurance programs by submitting bills for more than \$71 million – and receiving over \$50 million in payments – for medically unnecessary procedures performed on insurance beneficiaries who received free or discounted cosmetic surgeries in exchange. The evidence presented by an OPM OIG special agent during the trial showed that members of the scheme lured insured “patients” to a surgery center with promises that they could use their union or Preferred Provider Organization (PPO) health insurance plans to pay for cosmetic surgeries, which are generally not covered by insurance.

Marketers referred “patients” to the surgery center, where they were told they could receive free or discounted cosmetic surgeries if they underwent multiple, medically unnecessary procedures that would be billed to their union or PPO health care benefit program. A consultant at the surgery center scheduled procedures after telling the “patients” about the free cosmetic procedures they could receive and coaching them to fabricate or exaggerate symptoms so that their medical procedures would be covered by their insurance.

The two defendants sentenced were the consultant, who was sentenced to 41 months in Federal prison and ordered to pay over \$2.6 million in restitution; and the marketer, who was sentenced to 5 months in prison and ordered to pay restitution of \$85,000.00. As a result of the convictions, the FEHBP will receive \$73,362.13.

- I-15-00482: In July 2015, a Staten Island, New York, physician accused of improperly billing Medicare and other Government health programs for millions of dollars in diagnostic tests and treatments agreed to pay \$8 million as part of a civil settlement agreement. The board certified obstetrician and gynecologist with offices in Staten Island and Brooklyn, was accused of billing for diagnostic procedures and physical therapy performed by unsupervised and unlicensed staff while he was out of the office. As a result of the settlement, the FEHBP received \$63,669.21.

## **Kickbacks**

- I-13-00147: A former sales representative at medical device manufacturer NuVasive, Inc. (NuVasive) filed a *qui-tam* whistleblower lawsuit in the U.S. District Court for the District of Maryland regarding NuVasive’s marketing of their CoRoent System. After a multi-agency investigation, in August 2015, NuVasive agreed to pay the Government \$13.5 million to resolve allegations that between 2008 and 2013, NuVasive promoted the use of the CoRoent System for surgical uses that were not approved or cleared by the Food and Drug Administration (FDA), including for use in treating two complex spine deformities, severe scoliosis and severe spondylolisthesis. As a result of this conduct, the Government alleged that NuVasive caused physicians and hospitals to submit false claims to Federal health care programs for certain spine surgeries that were not eligible

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for reimbursement. For programs other than the FEHBP, the settlement further resolves allegations that NuVasive paid kickbacks to induce physicians to use the company's

CoRoent System. The FEHBP recovered no damages relative to the kickback allegations, due to the exclusion of the FEHBP from the Anti-Kickback Statute. Nevertheless, the FEHBP was affected by the payment of kickbacks, which consisted of promotional speaker fees, honoraria and expenses relating to physicians' attendance at events sponsored by a group known as the Society of Lateral Access Surgery (SOLAS). SOLAS was allegedly created, funded and operated solely by NuVasive, despite its outward appearance of independence.

As a result of the settlement with NuVasive, the FEHBP will receive \$467,483. If the FEHBP were not excluded from the Federal Anti-Kickback Statute, we estimate the FEHBP may have recovered an additional \$121,600 from this settlement to compensate for damage caused to the FEHBP by NuVasive's alleged payment of kickbacks.

The Federal Anti-Kickback Statute made it illegal for health care providers to knowingly and willfully accept bribes or other forms of remuneration in return for generating "Federal health care program business," with the notable exception of the FEHBP, which was excluded. As a result, the FEHBP lacks a statute which renders kickbacks illegal. It is our position that legislative change is required to protect FEHBP beneficiaries from the harm they may suffer from health care providers whose medical decision making is tainted by bribery.

## Off-Label Promotion

- I 2011 00165: Relators filed a *qui tam* lawsuit in the U.S. District Court for the Southern District of New York alleging that Inspire Pharmaceuticals, Inc. (Inspire) violated state and Federal False Claims Act laws by illegally marketing the drug Azasite for off-label uses not approved by the FDA. The FDA approved Azasite for the treatment of bacterial conjunctivitis (pink eye), but not blepharitis, which is an infection of the eyelid. Nevertheless, Inspire allegedly actively marketed the drug for the treatment of blepharitis. While physicians are permitted to prescribe drugs for conditions other than those for which the drugs have been approved by the FDA, pharmaceutical companies are prohibited from marketing drugs to physicians for such off-label conditions. In June 2015, the United States reached a settlement with Inspire in which Inspire agreed to pay the Federal and state Medicaid programs \$4,938,573.77, which includes civil restitution for damages to the state Medicaid programs and other Federal healthcare programs. The FEHBP's portion of the total civil recovery was \$584,531.21.

## Management Advisory Report

- P-12-00165: In September 2015, the OIG's Office of Investigations issued a Management Advisory Report to OPM concerning "Recommendations to Prevent Foreign Claims Fraud in the Foreign Service Benefit Plan." The recommendations for program

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improvement arose as a result of observations made during a previously reported investigation of foreign claims fraud which resulted in the criminal conviction of a Foreign Service Benefit Plan enrollee.

## **RETIREMENT PROGRAMS (CSRS and FERS)**

### **Deceased Annuitant Fraud**

- I-14-00369: OPM's Retirement Inspections Branch notified OPM's OIG that the May 30, 2006 death of an annuitant had not been reported to OPM. As a result, OPM continued making annuity payments through May 2013, resulting in an overpayment of \$90,859.93. OPM recovered \$1,955.12 through the reclamation process with the deceased's financial institution, leaving a balance due of \$88,904.81. An investigation revealed that one month before the annuitant died, he married his caregiver, and she continued to receive and spend his annuity after he died. Subsequent to the OPM OIG's investigation, the defendant entered into a Pre-Trial Diversion Program with the U.S. District Court for the District of Nevada in which she is required to pay \$88,904.81 in restitution to OPM.
- I-15-00225: The OIG at the Social Security Administration (SSA) notified us that the June 22, 2001 death of an annuitant had not been reported to SSA or to OPM. As a result, OPM continued making annuity payments through December 2012, resulting in an overpayment of \$49,118.00. OPM recovered \$22,650.64 through reclamation from the deceased's financial institution, leaving a balance due of \$26,467.36. SSA paid \$15,677.36 in benefits after the annuitant's death. A joint investigation revealed that after the annuitant died, her daughter withdrew funds from her bank account on a monthly basis for her own personal benefit. The daughter pled guilty to the charge of Failure to Disclose an Event with Intent to Fraudulently Secure Payment When No Payment is Authorized. On July 8, 2015, she was sentenced in the U.S. District Court for the Eastern District of Virginia to 36 months of probation, ten months of home detention, and she was ordered to pay \$42,144.72 in restitution (\$26,467.36 to OPM and \$15,677.36 to SSA), as well as a \$100 assessment fee.
- I-15-00546: OPM's Retirement Inspections notified OPM's OIG that the August 23, 2004 death of an annuitant had not been reported to OPM, resulting in an overpayment of \$199,915.16. OPM recovered \$2,902.83 through the reclamation process, leaving a balance due of \$197,012.23. An investigation revealed that the annuitant's son continued receiving his father's Federal annuity payments after his death and used them for his own benefit. In June 2015, the son pled guilty to Theft from the Government and in September 2015 was sentenced to 48 months of probation, four months of home detention and ordered to pay \$197,012.23 in restitution to OPM and a \$100 assessment fee.

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- C-15-01052: The daughter of a Federal annuitant repeatedly attempted to contact OPM to repay the retirement annuity that OPM paid her mother after her mother's death. Her mother died on April 23, 2009, but OPM continued making annuity payments through May 2014, resulting in an overpayment of \$44,154.22. OPM recovered \$1,437.88 through the reclamation process, leaving a balance due of \$42,716.34. The daughter was unable to resolve the issue with OPM until contacted by special agents from OPM's OIG. OIG special agents were able to recover \$37,000 from the daughter and deferred the \$5,716.34 balance of the overpayment to OPM's Debt Management branch for collection.

## **FEDERAL INVESTIGATIVE SERVICES (FIS)**

### **Contractual Offset**

- I 2011 00172: In April 2013, our office received an allegation from the FIS Integrity Assurance office regarding misconduct and false statements made by an OPM contract background investigator employed by U.S. Investigations Services Inc. (USIS). From March 2010 through October 2010, the contract background investigator indicated that he had interviewed a source or reviewed a record relating to the subject of the background investigation, when in fact, he had not conducted the interview or obtained the record. These reports were utilized and relied upon by Federal agencies requesting the background investigations to determine whether these subjects were suitable for positions having access to classified information, for positions impacting national security and public trust, or for receiving or retaining security clearances. These false representations required FIS to reopen and reinvestigate numerous background investigations assigned to the background investigator. Our criminal investigators reviewed numerous case reports, records, and contacted sources to confirm that the contract background investigator did not conduct interviews as indicated in his reports of investigation. The contract background investigator was also interviewed, but denied intentionally falsifying source interviews and/or records of interest. In March 2015, the case was declined for criminal prosecution by the Department of Justice. In May 2015, the FIS Integrity Assurance office proceeded with an administrative contractual offset of \$183,233.78 against USIS.

I 2011 00780: In September 2015, USIS and its parent company, Altegrity, Inc., agreed to settle allegations that USIS violated the False Claims Act for conduct involving a contract for background investigations that USIS held with OPM. The companies have agreed to forgo their right to collect payments that they claim were owed by OPM, valued at least at \$30 million, in exchange for a release of liability under the False Claims Act.

From its privatization in 1996 until September 2014, USIS provided background investigations services for OPM under various fieldwork contracts. The Government alleged that beginning in at least March 2008 and continuing through at least September 2012, USIS deliberately circumvented contractually required quality reviews of completed background investigations in order to increase the company's revenues and

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profits. Specifically, USIS allegedly devised a practice referred to internally as “dumping” or “flushing,” which involved releasing cases to OPM and representing them as complete when, in fact, not all the reports of investigations comprising those cases had received a contractually-required pre-submission quality review. The Government contended that, relying upon USIS’ false representations, OPM issued payments and contract incentives to USIS that it would not otherwise have issued had OPM been aware that the background investigations had not gone through the contractually required pre-submission quality review process.

The settlement was the result of a coordinated effort by the DOJ’s Civil Division’s Commercial Litigation Branch, the U.S. Attorney’s Office for the District of Columbia, the U.S. Attorney’s Office for the Middle District of Alabama, OPM, and our office.

## **Debarment of Background Investigators**

- During the period July 2015 through September 2015, the OIG referred seven background investigators to OPM for debarment. The background investigators were referred for debarment for falsifying their work products, specifically reports regarding the background investigations they conducted. OPM issued Notices of Proposed Debarment to eight background investigators during this time period.



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**By Mail:** Office of the Inspector General  
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