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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

**Investigative Activities**

**Fiscal Year 2020**

**Fourth Quarter**

**July 1, 2020 - September 30, 2020**

**-- Caution --**

This report has been distributed to Federal officials who are responsible for the administration of the subject program. This non-public version may contain confidential and/or proprietary information, including information protected by the Trade Secrets Act, 18 U.S.C. § 1905, and the Privacy Act, 5 U.S.C. § 552a. Therefore, while a redacted version of this report is available under the Freedom of Information Act and made publicly available on the OIG webpage (<http://www.opm.gov/our-inspector-general>), this non-public version should not be further released unless authorized by the OIG.

## List of Acronyms

<b>AKS</b>	<b>Anti-Kickback Statute</b>
<b>CSRS</b>	<b>Civil Service Retirement System</b>
<b>FBI</b>	<b>Federal Bureau of Investigation</b>
<b>FDA</b>	<b>U.S. Food and Drug Administration</b>
<b>FEDVIP</b>	<b>Federal Employees Dental and Vision Insurance Program</b>
<b>FEGLI</b>	<b>Federal Employees' Group Life Insurance</b>
<b>FEHBP</b>	<b>Federal Employees Health Benefits Program</b>
<b>FEI</b>	<b>Federal Executive Institute</b>
<b>FERS</b>	<b>Federal Employees Retirement System</b>
<b>FFS</b>	<b>Fee-for-Service</b>
<b>FY</b>	<b>Fiscal Year</b>
<b>HHS</b>	<b>U.S. Department of Health and Human Services</b>
<b>HMO</b>	<b>Health Maintenance Organization</b>
<b>NBIB</b>	<b>National Background Investigations Bureau</b>
<b>OIG</b>	<b>OPM Office of the Inspector General</b>
<b>OPM</b>	<b>U.S. Office of Personnel Management</b>
<b>OSC</b>	<b>U.S. Office of the Special Counsel</b>
<b>ROI</b>	<b>Report of Investigation</b>

## Overview of 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 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 training center 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 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 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 may 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/](https://opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/)).

**On page 14 of this document, we have included an additional glossary of terms 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 its Office of Investigations as we endeavor to curtail improper payments, stop patient harm, protect OPM programs, and provide independent and objective oversight of OPM programs and operations. We have selected these cases to highlight the successes of our criminal investigators and Investigative Support Operations group, as well as to describe the types of waste, fraud, abuse, and mismanagement that harm OPM, its programs and operations, and Federal employees, retirees, and their eligible dependents.

The cases below represent a period from July 1, 2020, through September 30, 2020. This period was severely affected by the ongoing novel coronavirus (COVID-19) pandemic throughout the Nation, from changing investigative priorities to limiting 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 and most Federal employees were under maximum telework.

## **Health Care Investigations**

The OPM Fiscal Year 2019 Agency Financial Report states that in Fiscal Year (FY) 2019, the Federal Employees Health Benefits Program (FEHBP) made \$54.94 million in improper payments. 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 FEHBP continues to be excluded from the Federal Anti-Kickback Statute (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 \$65.2 million, closed this quarter that we were unable to pursue due to this exclusion:

- ❖ We received an August 2019 *qui tam* filed in the U.S. District Court for the Western District of Washington State regarding a provider who allegedly paid kickbacks to other practitioners to refer patients for surgical procedures. We identified more than \$1.3 million paid by the FEHBP to this provider. On July 2, 2020, the U.S. Attorney's Office informed us that prosecution of the case focuses on violations of the AKS. Because of our exclusion from the AKS, we were unable to take further action and closed our investigation.
  
- ❖ In October 2019, we received a case referral from an FEHBP health insurance carrier regarding a provider unbundling and improperly billing for a medical device. We were additionally notified that individuals associated with the provider had been indicted by a Federal grand jury in June 2018 on charges of conspiracy and violations of the AKS.

Between 2016 and 2019, the FEHBP had paid the provider \$326,933. On July 23, 2020, we referred the provider to the OPM OIG Administrative Sanctions Group for possible debarment.

- ❖ In October 2019, we received a *qui tam* complaint filed in the U.S. District Court for the Southern District of New York alleging that a pharmaceutical company paid kickbacks (disguised as speaker fees) to induce doctors to prescribe certain medicines. The FEHBP's exposure related to the drugs in question exceeded \$61.7 million. Because the FEHBP is excluded from the AKS, we closed our complaint without any recovery.
- ❖ On July 13, 2020, we received a self-disclosure notification from a provider stating that it had engaged in behavior that may have violated the AKS by accepting software free of charge while other providers, who purchased the software at the disclosing provider's recommendation, were charged fees. Because the alleged violations apply specifically to the AKS, we were unable to participate in the case and closed our investigation.
- ❖ In March 2020, we received a referral from the U.S. Attorney's Office in the Southern District of New York regarding a provider who allegedly marketed and misbranded a medication and paid kickbacks to physicians to increase prescriptions of the medication. Between 2014 and 2019, the FEHBP paid more than \$1.89 million in claims related to the at-issue medication. On September 1, 2020, the Civil Chief for the U.S. Attorney's Office in the Southern District of New York notified us that the only claims being investigated relate to the AKS. Because of our exclusion from the AKS, we closed our case.

Additionally, other investigations summarized below may include instances where we were partially excluded from receiving full restitution of FEHBP losses because of our exclusion from the AKS.

#### **FEHBP Health Insurance Administrative Recoveries**

- ❖ In June 2020, we received a case notification from an FEHBP health insurance carrier regarding a provider alleged to be upcoding and billing excessive charges for services. The FEHBP loss totaled \$56,283. On July 7, 2020, the FEHBP carrier who submitted the case notification notified the OIG it entered into a settlement with the provider. Under the settlement, the FEHBP will recover \$8,533.
- ❖ In September 2018, we received an FEHBP carrier notification from an FEHBP carrier alleging that a provider engaged in a urine drug testing and pass-through billing scheme. The loss to the FEHBP was \$43,706. On August 17, 2020, the provider and the FEHBP carrier entered wherein the FEHBP received \$25,017.
- ❖ In April 2015, we received a referral from an FEHBP health insurance carrier regarding a provider alleged to have improperly submitted claims as a non-participating provider, which resulted in higher reimbursement. The identified loss to the FEHBP was \$31,511.

On September 2, 2020, the FEHBP health insurance carrier executed a settlement with the provider that returned \$3,333 to the FEHBP.

- ❖ In June 2019, we received a referral from an FEHBP health insurance carrier regarding a provider alleged to have used a drug not approved by the U.S. Food and Drug Administration (FDA). The total FEHBP exposure related to the referral was \$80,952. On July 14, 2020, the FEHBP health insurance carrier and the provider executed a settlement agreement. The FEHBP will receive \$32,524.
- ❖ In July 29, 2019, we received a case referral from a FEHBP health insurance carrier regarding a provider allegedly billing for services not medically necessary. The health insurance carrier conducted an audit and found documentation that did not support treatments as medically necessary or were not eligible for reimbursement according to the plan. The identified FEHBP loss was \$50,225. On June 30, 2020, the health insurance carrier entered into a settlement agreement with the provider. Under the settlement, the provider will return \$34,324 to the FEHBP.
- ❖ In July 2020, we received a case referral from an FEHBP health insurance carrier regarding a provider allegedly billing multiple therapies rather than one-on-one therapy as required by the health insurance carrier's guidelines. The identified loss to the FEHBP was \$49,327. On September 22, 2020, the provider entered a settlement and will repay the FEHBP \$49,327.

## **False Claims**

- ❖ 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 from actions by the provider and its subsidiaries was \$9,542,623. Subsidiaries have entered into separate settlements to resolve the allegations. On July 2, 2020, one provider entered into a settlement that awarded a net recovery of \$54,670 to the FEHBP. On July 20, 2020, a different provider entered into a settlement that awarded a net recovery of \$17,925 to the FEHBP. These settlements are among multiple settlements related to this investigation, and further judicial action is anticipated in this matter.
- ❖ In March 2015, we received a whistleblower complaint from the Department of Justice (DOJ) that alleged a provider submitted claims for services not medically needed and created false documentation to obtain preauthorization for procedures. The provider also allegedly engaged in a kickback scheme involving the payment of inflated rent and other inducements to medical providers in return for patient referrals. The FEHBP paid \$210,896 to this provider between January 2010 and December 2017. The provider was previously sentenced in August 2018 to 34 months of incarceration, 3 years of supervised release, 100 hours of community service, and restitution of \$217,364. The FEHBP received \$17,024 in restitution at that time. On August 7, 2020, the provider entered into a civil settlement to resolve the False Claims Act allegations and agreed to pay \$2 million. The FEHBP will receive a net recovery of \$75,971.

- ❖ In December 2016, we received a *qui tam* from DOJ. The *qui tam* was filed in the U.S. District Court for the Western District of Washington State and alleged a manufacturer marketed a medicine for off-label use. Between January 2010 and October 2018, the FEHBP's exposure was more than \$15 million. Under a settlement agreement entered on August 26, 2020, to resolve False Claims Act allegations, the drug manufacturer will pay \$20,750,000. The FEHBP will receive \$587,225.
- ❖ In May 2018, we received a notice from the U.S. Attorney's Office in the Northern District for Texas about an open investigation of a provider for false claims, with a request for FEHBP claims data related to the at-issue provider. Between 2017 and 2019, the FEHBP paid \$200,626 to the provider. On September 8, 2020, the provider entered into a settlement agreement wherein they will pay the FEHBP \$149,147 in restitution.

### **Durable Medical Equipment Schemes**

- ❖ In April 2017, we received information from the U.S. Department of Health and Human Services (HHS) OIG regarding a provider alleged to be supplying durable medical equipment; specifically, the provider billed and delivered supplies not prescribed by physicians or requested by patients. The FEHBP had paid the provider \$305,850. The HHS OIG-referred investigation found a separate, ongoing investigation into the provider by the U.S. Attorney's Office in the Central District of California, which subsequently merged with an investigation ongoing in the U.S. Attorney's Office in the District of Maryland. On September 28, 2020, one individual was charged in the U.S. District Court for the Central District of California with violating conspiracy to solicit and receive illegal remunerations for health care referrals. Further judicial action is expected in this case.

### **Compounded Medications**

- ❖ We received a referral from a law enforcement partner alleging a pharmacist provider was involved in fraud and a kickback scheme related to compounded prescriptions. The FEHBP paid approximately \$2,293,011 between 2013 and 2015. Numerous judicial actions were previously reported related to this case. On July 20, 2020, another individual was convicted of conspiracy in the U.S. District Court for the Central District of California. Further judicial action is anticipated in this matter.
- ❖ In June 2015, we joined a joint Federal and State criminal investigation involving several law enforcement partners. It was alleged a group of providers that included pharmacists, doctors, and marketers worked together to defraud Government health programs, including the FEHBP. More than \$40 million in false claims were submitted. These involved compounded medications prescribed based on services not rendered and illegal kickbacks. The FEHBP paid more than \$4.2 million related to this scheme. In June 2018, six defendants were charged in the U.S. District Court for the Central District of California with health care fraud, conspiracy to commit health care fraud, and other crimes. On August 26, 2020, one individual was sentenced to 34 months in prison and

ordered to pay \$28 million in restitution. On August 31, 2020, the court sentenced a second individual to 1 day in prison and 21 months of home detention, as well as ordered the individual to pay \$3.1 million in restitution. A third individual was sentenced to 1 day in prison and 18 months of home detention, as well as ordered to pay \$1.425 million in restitution. The FEHBP will receive its exact restitution in upcoming sentencing. Therefore, further judicial action is anticipated in this case.

### **Miscoded, Medically Unnecessary, or Ineligible Services or Services Not Rendered**

- ❖ We received a referral from the U.S. Attorney's Office in the Southern District of California regarding an allegation that a provider miscoded medical services in order to increase Federal reimbursements. This fraud scheme allegedly lasted from April 2013 to March 2016. The FEHBP paid more than \$2.032 million during this timeframe, with additional lost investment income of \$300,913. The FEHBP total loss was \$2,333,170. On July 21, 2020, the U.S. Attorney's Office entered into a civil settlement with the provider to resolve the allegations. The provider agreed to reimburse the Government \$16.4 million. The FEHBP was awarded single damages of \$2,032,257 and remuneration for the lost investment income of \$300,913. The net recovery for the FEHBP is \$2,333,170.
- ❖ In June 2018, we coordinated with a Federal law enforcement partner to investigate claims submitted by a provider alleged to be overbilling the number of treatments in a day. Our investigation found the provider engaged in a scheme billing for services not rendered. The FEHBP had paid the provider \$74,110. In January 2020, the provider was charged with health care fraud via criminal information in the U.S. District Court for the Eastern District of Pennsylvania. On July 15, 2020, the provider pled guilty to the charge. Sentencing is scheduled for November 2020. Further judicial action is anticipated in this case.
- ❖ In March 2019, we opened an investigation of a provider based on multiple *qui tam* complaints that alleged the provider defrauded the Government by providing treatment beyond what was medically necessary. According to the allegations, patients covered by Government third party payors (e.g., FEHBP carriers) were specifically targeted. Between January 2006 and December 2018, the FEHBP paid more than \$1.67 million. On July 15, 2020, the DOJ entered into a civil settlement with the provider. The provider will pay \$117 million to resolve its civil liability. The FEHBP received \$923,205 in restitution.
- ❖ In May 2018, we received a referral alleging a provider billed significant services to one FEHBP beneficiary. The provider was married to that FEHBP enrollee. The FEHBP's exposure was \$247,195. In April 2019, the provider owner was indicted in the U.S. District Court for the Eastern District of California with one count of mail fraud. On June 23, 2020, the provider owner pled guilty to one count of mail fraud. Sentencing is not yet scheduled, and further judicial action is anticipated in this case.

- ❖ In January 2014, we received a case notification from an FEHBP carrier that alleged a provider intentionally upcoded services for 10 years. The overpayment calculation estimated that 51 percent of paid claims were upcoded. The FEHBP's exposure was estimated at \$522,433. On August 11, 2020, the U.S. Attorney's Office in the Southern District of Iowa informed the OIG that a civil settlement was reached. The FEHBP's net recovery is \$122,450.
- ❖ We received a case referral in April 2012 related to an 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. Additionally, the provider paid kickbacks to doctors for referrals. The FEHBP paid \$18,150,555 in claims related to this investigation. In previous Quarterly Summaries, we reported more than 20 indictments, eventually resulting in 17 guilty pleas 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. Several of these individuals were previously sentenced during other quarters. On August 14, 2020, one individual was sentenced to 66 months of imprisonment and ordered to pay restitution of \$82,960,866. The FEHBP will receive \$840,005 in restitution. Further judicial action is anticipated in this case.
- ❖ In December 2016, we received a *qui tam* complaint alleging that a provider fraudulently billed for services not rendered. The provider also waived copays and improperly backdated forms to receive payment for treatments given after the authorization date. The FEHBP had \$171,356 in exposure related to this provider. In September 2020, the provider entered into a civil settlement wherein they agreed to pay \$4 million. The FEHBP was awarded \$168,000 in restitution, \$31,087 in investigative costs, and \$32,367 in lost investment income. Therefore, we recovered a total of \$231,455 for the FEHBP trust fund.
- ❖ In October 2016, we received a case referral from an FEHBP health insurance carrier regarding a provider that allegedly billed for high-dollar reimbursement medications from two manufacturers in a way that suggested an improper relationship between the provider and the manufacturers. Between November 2015 and September 2016, the FEHBP paid over \$670,000 for the at-issue medications. On September 29 and 30, 2020, three individuals were charged by criminal information with conspiracy to offer and pay health care kickbacks. The three individuals appeared in the U.S. District Court for the Eastern District of Virginia and pled guilty to the charges. Further judicial action is anticipated in this case.

### **Ineligible Beneficiaries**

- ❖ In July 2017, we received a case referral from the U.S. Attorney's Office in the Northern District of Texas alleging that a DOJ employee added multiple ineligible individuals to her FEHBP health insurance plan. This included one adult and four children. The FEHBP paid \$12,316 for services provided to the ineligible individuals. The DOJ employee was charged and subsequently sentenced in 2018, which was reported previously. On September 30, 2020, the ineligible adult was sentenced to 2 years of

probation and 50 hours of community service following a guilty plea to theft in connection with health care.

## **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 our Office of Investigations.

### **Improper Payments**

- ❖ We presented a case to the U.S. Attorney’s Office in the Eastern District of Pennsylvania regarding a provider potentially overly dispensing Schedule II drugs based on data from the Pennsylvania Prescription Monitoring Program. Specifically, a nurse working for the provider was the target of a local law enforcement investigation for inappropriately dispensing the Schedule II drugs. The provider also admitted to defrauding health insurance carriers by billing for services not rendered via a coupon card program and creating fake prescriptions. The FEHBP paid the provider \$300,326. We reported in previous Quarterly Summaries that the nurse pled guilty in the U.S. District Court for the Eastern District of Pennsylvania to conspiring to distribute oxycodone and pled guilty. We also previously reported about the provider’s guilty plea, sentencing and restitution, and settlement. On June 30, 2020, the nurse was sentenced to 1 day in prison and 36 months of supervised release.
- ❖ In September 2016, we received a case notification from a health insurance carrier alleging that a provider admitted ineligible beneficiaries and did not provide the necessary behavioral health services. The provider also illegally placed patients in company-owned housing to maximize patient treatment plans to continue billing insurance carriers. A kickback scheme involving the provider sent thousands of unnecessary urine drug tests to various Florida-based laboratories as an additional facet of the widespread fraud scheme. Overall, the FEHBP paid the provider approximately \$3.1 million. In previous Quarterly Summaries, we reported indictments of approximately 10 individuals and subsequent guilty pleas in the U.S. District Court for the Eastern District of Pennsylvania. On July 10, 2020, two defendants were sentenced. One received 48 months of probation, and the other received 24 months of probation. On August 17, 2020, an individual was sentenced to 36 months of imprisonment and 3 years of supervised release. This individual was also ordered by the court to pay \$9,338,607 in restitution. The FEHBP will receive \$327,990. Further judicial action is expected in this case.
- ❖ In September 2018, we received a *qui tam* complaint alleging a pharmaceutical company misbranded a drug used to treat opioid addiction. Allegedly, the promotion of the drug violated a specific Risk Evaluation and Mitigation Strategy. Therefore, each claim

submitted to the Government for reimbursement involving the drug constituted an illegal promotional activity and False Claims Act violation. The FEHBP had paid more than \$43 million between January 2009 and March 2017 in claims for at-issue medication. On July 24, 2020, the pharmaceutical company entered into a settlement with the Federal Government to pay \$300 million to resolve civil allegations. The total single damages for the settlement exceed \$130 million. The single damages attributable to the FEHBP are \$2.7 million. Further judicial action is expected in this case.

- ❖ In February 2018, we received an FBI request for FEHBP exposure related to a provider allegedly overprescribing opioids in exchange for monetary kickbacks and administering drugs not approved by the FDA to patients. The investigation found the provider billed for services not rendered, sold prescriptions for controlled substances (including opioids) without legitimate medical purpose and outside the usual course of professional practice, and ordered and administered drugs not approved by the FDA. The FEHBP paid the provider \$1.6 million. We previously reported that the provider pled guilty in the U.S. District Court for the Eastern District of Pennsylvania to the commission of health care fraud, the importation of medicines contrary to law, and distribution of controlled substances. On September 15, 2020, the provider was sentenced to 1 day in prison and 12 months of probation. The court ordered the provider pay \$1.2 in restitution, of which OPM will receive \$24,835. On September 23, 2020, the U.S. Attorney's Office for the Eastern District of Pennsylvania entered into a civil settlement with the provider. The provider will pay \$1.2 million, of which the FEHBP will receive \$41,460.
- ❖ In May 2017, we received a referral from a law enforcement partner regarding an investigation into a provider allegedly prescribing large quantities of prescription narcotics, including Subsys, which contains fentanyl. The investigation found a scheme in which the provider prescribed the drug to patients who did not meet the medically necessary requirements. The provider received kickbacks for these prescriptions. The FEHBP paid the provider approximately \$639,981 for these prescriptions. On September 15, 2020, the provider was indicted for health care fraud. Further judicial action in this case is pending.
- ❖ In 2009, we received a complaint alleging two individuals ran a pill mill that sold hydrocodone and other controlled substances for cash and operated a practice that billed for services not rendered. In 2011, two providers were ordered to pay FEHBP \$973,623 in restitution. On September 16, 2020, we were notified the FEHBP was ordered to receive an additional \$66,030 in restitution from the liquidation of assets.

## **Retirement Annuity Investigations**

In FY 2019, the Retirement Services program office improperly paid \$284.42 million in annuities 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 a Representative Payee alleged to be stealing funds from a Federal annuitant. The total amount involved was \$32,225. On July 7, 2020, the Representative Payee was charged by information filed in the U.S. District Court for the District of Minnesota and pled guilty to wire fraud. Further judicial action is anticipated in this matter.

### **Deceased Annuitant**

- ❖ In March 2018, we received a case referral from Retirement Services program office regarding the unreported death of an annuitant. The annuitant died in December 2006, but payments continued and resulted in an overpayment of \$360,463. The U.S. Department of the Treasury (Treasury) reclamation actions recovered \$5,757 from the account where the payments were deposited, leaving a remaining overpayment of \$354,706. Our investigation found that the annuitant's daughter illegally used the annuity payments. In January 2020, the daughter pled guilty to theft of Government funds. On July 16, 2020, she was sentenced to 8 months of imprisonment and 36 months of supervised release. Additionally, the court ordered payment of restitution totaling \$429,454, with \$354,706 to be returned to OPM.
- ❖ We received a case referral from the Retirement Services program office in August 2019 regarding a survivor annuitant whose August 2012 death went unreported to OPM. We received this referral based on our proactive discovery of an obituary for the survivor annuitant, which we supplied to the Retirement Services program office. OPM had continued to send monthly survivor annuity payments through March 2019, resulting in an annuity overpayment of \$35,401, as well as \$52,950 paid in health benefit premiums. The improper payment totaled \$88,351. On July 13, 2020, the annuitant's son pled guilty U.S. District Court for the Southern District of Ohio to two counts of theft of Government funds. Further judicial action is expected in this case.
- ❖ In August 2018, we received a fraud referral from the Retirement Services program office regarding the unreported February 2008 death of an annuitant. Monthly annuity payments continued through May 2018, resulting in an overpayment of \$236,555. No money was recovered through the Treasury's reclamation process. In June 2019, the annuitant's granddaughter admitted to OIG investigators that she used money from the deceased annuitant's account. Additionally, four other individuals conspired for financial gain from the deceased annuitant's account. In August 2019, the case was declined for prosecution both Federally and locally. In January 2020, we discussed the case with the OPM Office of General Counsel because the case involved a court-appointed estate attorney who sold the deceased annuitant's estate. This court-appointed estate attorney requested a judgment order from OPM against the deceased annuitant's heirs in order to return the funds. In April 2020, we referred this case back to the Retirement Services

program office and the OCFO for action. In July 29, 2020, OPM confirmed that the agency would coordinate to recover the money owed to OPM. We closed our case.

- ❖ In September 2016, we received a fraud referral from the Retirement Services program office regarding the unreported February 2012 death of an OPM survivor annuitant. Monthly annuity payments continued through October 2015, resulting in an overpayment of \$86,209. The Treasury reclamation process recovered \$8,778. As previously reported, both the survivor annuitant's daughter and husband were indicted in the U.S. District Court for the District of Maryland for various charges relating to the fraud. On September 8, 2020, the husband pled guilty to theft of Government property. Further judicial action is expected in this case.
- ❖ In March 2019, we proactively identified a survivor annuitant who died in March 2014 and continued to receive monthly annuity payments from OPM. The improper payments spanned March 2014 through February 2019 and totaled \$202,206. FEHBP premiums totaling \$40,841 were also paid during this period, for a total loss of \$243,047. Retirement Services initiated the Treasury reclamation process to recover the post-death annuity payments and health benefit premiums. On September 17, 2020, a criminal information was filed in the U.S. District Court in the Southern District of Ohio charging an individual with two counts of theft of public money. Further judicial action is anticipated in this case.

### **Disability Retirement Benefits**

- ❖ In September 2018, we received a referral from a Federal law enforcement partner regarding an employee for a Federal agency who received disability benefits. The employee applied for OPM benefits in 2012 but also returned to work that same year. The Federal employee received \$136,186 in disability retirement benefits. In July 2019, the Retirement Services program office stopped monthly annuity payments. In a February 2020 meeting between the OIG and the Retirement Services program office, the program office disclosed the Federal employee had filed an Equal Employment Opportunity complaint contesting her separation in 2012, which the employee won. While the employee was separated from her employing Federal agency, she applied for OPM retirement disability. OPM-issued payments continued even after she returned to work. In 2018, the employee left Federal service. Because of the resignation, the Retirement Services program office would have to attempt to recover the \$136,186 overpayment as an administrative recovery; however, this action is only legally possible if the employing Federal agency changed the personnel actions to show the 2012 separation as erroneous and the August 2018 action as a retirement, not a resignation. The employing Federal agency has declined to take this action. Therefore, there is insufficient evidence to support criminal violations, and the overpayment cannot be recovered. No further payments will be made, and we closed our case.

## **National Security Investigations**

As an 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. Current allegations are investigated by the Defense Criminal Investigative Service.

- ❖ No NBIB-related investigations reached reporting milestones during this quarter.

## **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.

- ❖ No integrity investigations reached reporting milestones during this quarter.

## 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.

### **Healthcare and Insurance Programs**

**Carrier Letters** are guidance that OPM Healthcare & Insurance 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 FFS 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 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, and/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 the Retirement Services program office. It is one of the surveys that the Retirement Services program office uses to confirm and census its annuitant population.

**A Federal Annuitant** is a retiree or a spouse of a deceased 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 when a financial institution, such as a bank, continues to hold the funds.