UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

March 25, 2016

MEMORANDUM FOR BETH F. COBERT
Acting Director

FROM: NORBERT E. VINT
Acting Inspector General

SUBJECT: Summaries of Recent OIG Investigations

The purpose of this memorandum is to share with you the results of investigations recently conducted by the Office of the Inspector General (OIG). We routinely share with you the results of our oversight efforts of U.S. Office of Personnel Management (OPM) programs and operations, including reports on internal employee misconduct investigations. The majority of our investigative workload involves crimes affecting the OPM programs committed by external parties. Attached are summaries of our investigations resolved during the period October 1, 2015 through December 31, 2015.

Please feel free to contact me if you have any questions, or you may have someone from your staff contact Assistant Inspector General for Investigations Michelle B. Schmitz, at (757) 595-3968.

Attachment

cc: Kiran A. Ahuja, Chief of Staff
Dennis F. Coleman, Chief Financial Officer
Kathleen M. McGettigan, Chief Management Officer
Mark D. Reinhold, Associate Director, Employee Services
Kenneth J. Zawodny, Jr., Associate Director, Retirement Services
Mark W. Lambert, Associate Director, Merit System Accountability & Compliance
John O'Brien, Director, Healthcare and Insurance
Alan Spielman, Senior Advisor, Healthcare and Insurance
Merton W. Miller, Associate Director, Federal Investigative Services
Joseph S. Kennedy, Associate Director, Human Resources Solutions
Robin E. Jacobsohn, General Counsel
Dean S. Hunter, Director, Facilities, Security and Contracting

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

Quarterly Case Summaries

Investigations Resolved
During the Period October 1, 2015 through
December 31, 2015

Issued March 2016

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 (OIGs) investigations resolved during the period October 1, 2015 through December 31, 2015.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP)

Compounding Pharmacy Fraud: The Middle District of Florida has taken the lead in a nationwide effort to pursue recovery under the False Claims Act against compounding pharmacies that have engaged in systemic fraud against Federal health care programs. Compound drugs require a prescription and are custom prepared to meet an individual patient's needs. Sometimes, this is medically appropriate, such as when a patient's unique health needs cannot be met by an existing prescription medication approved by Food and Drug Administration. In such cases, a compounding pharmacy may combine, mix, or alter the ingredients of a drug to create a custom medication designed and prescribed specifically for an individual. However, fraud schemes have emerged in which compound drugs are used and/or billed inappropriately. As the cases below illustrate, the payment of kickbacks is often a feature of the overall fraud scheme. This highlights once again the FEHBP's need for an Anti-Kickback statute. Other Federal health care programs are protected by an Anti-Kickback statute, while the FEHBP is not.

- I-15-01546: Med Match Pharmacy (Med Match), a compounding pharmacy based in Jacksonville, Florida, agreed to pay the United States $4,736,133.63 to resolve allegations that it paid kickbacks to marketers; filled prescriptions it knew, or should have known, were not legitimate; and sent prescriptions to states in which it did not have a valid license. The United States contended that Med Match's incentive compensation structure provided improper payments for referrals, or for the generation of Federal health care program business. Med Match received a large number of prescriptions from a physician in Jacksonville, Florida, an amount far greater than any other provider. In addition, the prescriptions were for the same compounded prescription substance, regardless of the patient's age, condition, or health record. Based on these facts, Med Match should have known that these prescriptions were not legitimate. Med Match was also found to have mailed various prescriptions to beneficiaries in Alabama. The United States contended that these prescriptions were not reimbursable since Med Match did not have a license to ship prescriptions to Alabama. The FEHBP's portion of the recovery was $39,233.34.

- I-15-01549: Durbin Pharmacy (Durbin), a compounding pharmacy based in Jacksonville, Florida, began submitting compounded prescriptions to Federal health care programs in 2013. Durbin's compounded prescriptions insurance claims were $1.8 million in 2013 and $1.7 million in 2014, but spiked to more than $1.1 million in just the first three

months of 2015. This significant increase prompted an investigation which lead to allegations that Durbin knowingly billed Federal health care programs for prescriptions that were not reimbursable. A review of Durbin's reimbursements revealed that their top two providers wrote prescriptions in the absence of a bona fide patient-physician relationship. Patients of one provider confirmed that they never met with the physician and only had brief phone conversations with members of his office. One provider admitted that he did not see the patients for whom he wrote prescriptions and that he received $100 in cash from his marketing representative for each prescription he wrote. To resolve the allegations, Durbin entered into a settlement agreement and agreed to pay the United States $3,700,000. The FEHBP's portion of the recovery was $4,528.59.

- I-15-01551: An investigation into WELLHealth, a compounding pharmacy in Jacksonville, Florida, began after this pharmacy was identified as a top biller of compounded prescription drugs. WELLHealth was alleged to have knowingly filled prescriptions that were written by referral sources that had a financial interest in the prescriptions. These referring physicians were supposedly participating in a research study related to compounded prescriptions. The Government contended that the research study was a sham and that the compensation far exceeded fair market value. In order for the treating physicians to actually receive a percentage of the prescription reimbursement, they agreed to call themselves research study "consultants." After issuance of a Civil Investigative Demand, WELLHealth self-disclosed that the vast majority of their prescriptions were potentially tainted by Anti-Kickback Statute violations. On October 28, 2015, WELLHealth entered into a settlement agreement agreeing to pay $3,781,566.00. The FEHBP's portion of the recovery was $195,452.26.

- I-15-01552: A huge increase in compounded prescription claims in the first four months of 2015, coupled with the fact that more than one third of all of the prescriptions came from a provider more than 1,000 miles away, prompted an investigation of North Beaches Pharmacy (North Beaches) in Jacksonville, Florida. In 2014, North Beaches created an Advisory Board of physicians purportedly to discuss product development and target applications related to compounded prescriptions. It was determined that the creation of the Advisory Board was an attempt to skirt around the Anti-Kickback statute. By signing up doctors to serve on this Advisory Board, North Beaches found a way to compensate physicians for their role in referring business. Evidence showed that North Beaches accepted prescriptions without a doctor's signature and even recommended prescriptions to doctors. On November 13, 2015, North Beaches entered into a settlement agreement agreeing to pay $10,000 plus fifty percent of net profits for the next five years. The FEHBP portion of the recovery was $128.88.

Other False Claims and Kickbacks Cases:

- I-12-00291: Relators filed a qui tam lawsuit in the U.S. District Court of Massachusetts alleging that Millennium Laboratories (Millennium) billed Federal health care programs for medically unnecessary tests and paid kickbacks to medical providers in exchange for

patient referrals. An investigation revealed that Millennium systematically billed Federal health care programs for excessive and unnecessary drug testing and genetic testing. Testing was routinely conducted without an individualized assessment of need. Millennium also provided physicians with free drug test cups on the express condition that the physicians return the specimens to Millennium for additional testing. Millennium agreed to pay $227,000,000 to resolve these allegations. The exact amount of the FEHBP's portion of the recovery will not be known until approximately March 2016. It is estimated to be around $4,950,000.

- I-13-00596: Blue Cross Blue Shield of Texas (BCBSTX) notified the OPM OIG that a licensed acupuncturist continued to bill for evaluation and management services after BCBSTX advised him that these services were outside the scope of practice and therefore not reimbursable. The OPM OIG and the Texas Department of Insurance conducted an investigation into the allegations. The acupuncturist entered into a plea deal in which he agreed to pay the FEHBP $100,000.00 in restitution. He was later convicted on a charge of Insurance Fraud in the 89th District Court of Wichita County, Texas and was sentenced to two years of probation and ordered to pay an additional $37,893.00 in restitution to the FEHBP and a $304 assessment fee.

- I-14-00325: BCBSTX notified the OPM OIG of allegations that Rabon Communications Enhancement (RCE), a speech therapy clinic in Sugarland, Texas, was submitting false and fraudulent claims for payment to Tricare and BCBSTX for services that they did not provide. An investigation confirmed that the owner and office manager at RCE submitted claims for patients, as well as for themselves and three other RCE employees, for speech therapy, swallowing therapy treatments, evaluations and other services that RCE did not provide. The owner of RCE, a licensed speech therapist, was sentenced in the U.S. District Court for the Southern District of Texas to 151 months in jail, three years of probation and ordered to pay a $600 assessment fee. The company's office manager was sentenced to 51 months in jail, three years of probation and ordered to pay a $500 assessment fee. The two defendants were also ordered to jointly pay $1,297,644.71 in restitution to the United States. The FEHBP's portion of the total recovery has not yet been determined.

- I-15-00196: A physician practicing in Centreville, Virginia who specializes in obstetrics and gynecology allegedly purchased discounted versions of Mirena intrauterine devices (IUDs) from a foreign distributor. The foreign distributor sold a version of Mirena that was intended for use in a foreign market and was manufactured in establishments that were not registered with the U.S. Food and Drug Administration (FDA). As such, the IUDs and associated services were not covered for reimbursement by insurance carriers. The physician provided the foreign, non-FDA approved IUDs to Virginia Medicaid, FEHBP, and Tricare beneficiaries and then sought payment from the respective insurance carriers for the device and administration of the IUDs. The investigation of the physician resulted in a civil settlement where the physician agreed to pay $26,374.20 to the United States and the Commonwealth of Virginia. The FEHBP's portion of the recovery was $1,640.11.

Use of Banned Pharmacists

- I-15-01544: The Kroger Company (Kroger), a supermarket chain headquartered in Cincinnati, Ohio, self-disclosed to the Department of Health and Human Services (HHS) OIG that they employed and utilized pharmacists in their pharmacies that were banned from participation in Federal health care programs by the HHS OIG. Kroger discovered that they had employed banned pharmacists through internal reviews of their company. An investigation confirmed that Kroger employed 14 employees that were debarred from participating in the FEHBP. Insurance claims for items or services furnished by, or at the medical direction or on the prescription of, the debarred individuals are not reimbursable. Kroger agreed in a civil settlement to pay Federal health care programs $21,523,047 in restitution and penalties. The FEHBP's portion of the recovery was $943,064.99; $628,709.99 in restitution and $314,355.00 in penalties.

Suspension and Debarment

- During the period October 2015 through December 2015, the Office of Investigations referred one health care provider to the OIG debarring official to consider for debarment from participation in the FEHBP for committing insurance fraud.

RETIREMENT PROGRAMS (CSRS and FERS)

Disability Retirement Fraud

- I 2011 00238: The OIG at the United States Postal Service (USPS) contacted OPM's OIG regarding their investigation into an individual's eligibility to receive benefits from the Office of Workers' Compensation Programs (OWCP). The individual had also been approved by OPM to receive disability retirement benefits and was illegally receiving both benefits at the same time. The USPS OIG conducted surveillance of the individual and observed her exceeding her medical restrictions on multiple occasions. She was charged in an eleven count Federal indictment that included five counts of Mail Fraud, three counts of False or Fraudulent Statements regarding Workers' Compensation Benefits, two counts of Conversion of Government Funds and one count of False Statement. A jury found her guilty on ten of the counts (one count was withdrawn by the Government). On November 18, 2015 the individual was sentenced in the U.S. District Court for the Eastern District of Pennsylvania to 36 months in jail, three years of probation, and ordered to pay $164,428.20 to the U.S. Department of Labor, $30,057.47 to OPM and a $1,000 assessment fee.

Deceased Annuitant Fraud

- I-13-00319: The U.S. Secret Service notified the OPM OIG that the June 24, 2001 death of an annuitant had gone unreported. As a result, OPM continued making annuity payments through February 2013, resulting in an overpayment of $110,328.00. On

October 13, 2015, the United States reached a settlement agreement with the granddaughter of the annuitant, who was acting as the annuitant's Power of Attorney at the time of her death. The granddaughter agreed to pay the United States $110,328.00. OPM received the entire amount of the recovery.

- I-14-00816: The OIG at the Social Security Administration (SSA) notified the OPM OIG that the March 27, 2007 death of an annuitant had not been reported to SSA or to OPM. As a result, OPM continued making annuity payments through December 2010, resulting in an overpayment of $89,368.07. OPM recovered $6,088.68 through reclamation from the deceased's financial institution, leaving a balance due of $83,279.39. SSA paid $138,667.48 in benefits after the annuitant's death. A joint investigation revealed that after the annuitant died, her son fraudulently received the annuity payments and used the funds for his own personal benefit. The son pled guilty to committing fraud and on November 13, 2015, he was sentenced in the U.S. District Court for the Southern District of Indiana to three years of probation and was ordered to pay $221,946.87 in restitution ($83,279.39 to OPM and $138,667.48 to SSA), as well as a $100 assessment fee.

FEDERAL INVESTIGATIVE SERVICES (FIS)

Debarment of Background Investigators

- During the period October 2015 through December 2015, the OIG referred fifteen 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 one background investigator during this time period.

Misuse of Government Vehicle and Fuel Card

- I-15-00785: The OPM OIG received a referral from FIS alleging that one of their background investigators, a Federal employee, misused an assigned Government-Owned Vehicle (GOV) and Government Fuel Card (GFC). A FIS review of the background investigator's mileage reports and GFC records revealed abnormal activity. The background investigator admitted to using the assigned GOV for personal use on a daily basis. FIS terminated the employment of the 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
U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, DC 20415-1100

--CAUTION--