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

Quarterly Case Summaries

Investigative Activities
FY 2018
April 2018 – June 2018

Issued: September 2018

-- Caution --

ABBREVIATIONS

BCBSA	**BlueCross BlueShield Association**
CPT	**Current Procedural Terminology**
CSRS	**Civil Service Retirement System**
DCIS	**Defense Criminal Investigative Service**
DOJ	**U.S. Department of Justice**
DOL	**U.S. Department of Labor**
FBI	**Federal Bureau of Investigation**
FEHBP	**Federal Employees Health Benefits Program**
HHS	**U.S. Department of Health and Human Services**
IRS-CID	**Internal Revenue Service Criminal Investigation Division**
NBIB	**National Background Investigations Bureau**
OPM	**U.S. Office of Personnel Management**
OIG	**Office of the Inspector General**
RIB	**OPM Retirement Inspections Branch**
SSA	**U.S. Social Security Administration**
UDT	**Urinary Drug Testing**
USPS	**U.S. Postal Service**
VA	**U.S. Department of Veterans Affairs**

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I. HEALTH CARE FRAUD INVESTIGATIONS

Health care fraud cases are often time-consuming, complex, may involve several health care providers who are defrauding multiple health insurance plans and programs. The U.S. Office of Personnel Management (OPM) Office of the Inspector General (OIG) Office of Investigations' criminal and civil investigations are critical to protecting Federal employees, annuitants, and members of their families who are eligible to participate in the Federal Employees Health Benefits Program (FEHBP). Of particular concern are cases that involve harm to patients, pharmaceutical fraud, opioid abuse, and the growth of medical identity theft and organized crime in health care fraud, all of which have affected the FEHBP.

The following health care fraud case summaries represent some of our activities during third quarter of fiscal year 2018, between April 1, 2018, and June 1, 2018.

Case Summaries:

- In January 2015, our office was contacted by the U.S. Department of Labor (DOL) Office of Inspector General (OIG) concerning allegations that a day spa was billing health insurance programs for medical procedures while providing non-covered medical and cosmetic services (such as hair removal, massage, microdermabrasion, Botox injections, and facials) in order to receive insurance reimbursement. The day spa owner billed the FEHBP more than $200,000 for services not rendered. During our joint investigation, we found communications between the day spa owner and an employee of an FEHBP health insurance carrier who worked in the carrier's Special Investigations Unit, which identifies fraud and abuse. The communications suggested the employee of the carrier assisted the day spa owner to bill for the fraudulent services in exchange for cash payments. It was also alleged the employee worked to prevent the detection of the fraud by closing open investigations related to the day spa. On May 17, 2018, the owner of the day spa, three employees, and the FEHBP insurance carrier employee were indicted and arrested for conspiracy to commit health care fraud. The criminal investigation continues.

- In August 2017, we received a case referral from an FEHBP health insurance carrier alleging that a large hospital located in the San Francisco Bay, California, was billing for urinary drug testing (UDT) that it was not performing. The FEHBP carrier reported a significant increase in UDT claims submitted by the hospital compared to the previous 2 years. The carrier identified that the hospital had entered into an agreement with a third-party business affiliated with a network of physicians and several nonparticipating independent laboratories located throughout the United States. The relationship with the hospital allowed the independent laboratories and physicians to bypass billing health insurance carriers directly; instead, they used the hospital as a billing conduit to avoid insurance carrier scrutiny on the laboratory and physician claims. In addition, billing the UDTs through the hospital claim system would achieve higher reimbursement rates for the same UDT services. In March 2018, the FEHBP carrier independently entered into a settlement agreement with the hospital, but failed to notify and coordinate this action with our office as required by the OPM Carrier Letter 2017-13. We subsequently coordinated with the carrier, which resulted in a return of $6,291,931 to the FEHBP.

- In June 2015, we joined a multiagency Federal and State criminal investigation organized by the United States Attorney's Office (USAO) for the Central District of California with the Defense Criminal Investigative Service (DCIS), the Internal Revenue Service's Criminal Investigation Division (IRS CID), the Federal Bureau of Investigation (FBI), DOL's Employee Benefits Security Administration, the U.S. Department of Health and Human Services OIG (HHS OIG), the U.S. Department of Veterans Affairs OIG (VA OIG), Amtrak's OIG, and the California Department of Insurance. The targets of the investigation included physicians, marketers, marketing companies, pharmacists, and over a dozen compounding pharmacies who were alleged to have conspired to defraud the FEHBP, TRICARE, Medicare, and private insurance plans using compounded prescriptions based on services not rendered and illegal kickbacks.[1] The subjects conspired to defraud Government insurance programs by submitting claims for medically unnecessary compounded prescription medications, such as scar reduction and pains relieving creams. The FEHBP has paid $4,227,103.00 in claims submitted on behalf of the pharmacies connected in this investigation. In June 2018, six people were arrested and charged with conspiracy to commit health care fraud. The criminal investigation continues.

- In October 2017, we received a referral from the FBI's Houston-area Health Care Fraud Task Force. The referral alleged that a Houston-area pharmacy and associated businesses engaged in a compounding pharmacy fraud scheme. The allegations included financial kickbacks to physicians who referred patients through marketers to a specific compounding pharmacy. Large amounts of pain and scar creams were filled and distributed to patients that either did not need or did not qualify for the medications, and the patients' copays were waived. Because of the referral, we contacted FEHBP carriers to obtain exposure information related to paid claims. Review of data revealed that FEHBP carriers paid approximately $2,313,848 in medical claims. In June 2018, five subjects were arrested and charged with multiple counts of health care fraud. The criminal investigation continues.

- In March 2015, we joined a multiagency joint task force created by the Jackson, Mississippi, Division of the FBI. The task force also included DCIS, IRS CID, DOL OIG, HHS OIG, the U.S. Food and Drug Administration Office of Criminal Investigations, Mississippi Bureau of Narcotics, and additional State regulators. The joint task force had received allegations about a large-scale health care fraud and kickback scheme involving retail and mail order compounding pharmacies located in Mississippi. Allegations included billing for prescriptions and refills that were never ordered; forged doctor's signatures on prescriptions; paying kickbacks; and/or offering incentives to patients in exchange for their health insurance information. The total exposure to all private and public payers was estimated at over $1.5 billion. The total amount of FEHBP claims paid to the conspirators is approximately $2.7 million. To date, the investigation has resulted in the seizures of approximately $80 million in cash and liquid assets. In June 2018, four subjects were arrested and charged with multiple counts of health care fraud. The criminal investigation continues.

[1] TRICARE provides civilian health benefits for U.S Armed Forces military personnel, military retirees, and their dependents, including some members of the Reserve Component.

- In April 2016, we received a case referral from DCIS and the USAO for the Central District of California involving a compounding pharmacy located in Southern California. The pharmacy allegedly fraudulently billed for compounded prescriptions that were not prescribed by a patient's physician. The investigation focused on two podiatrists receiving kickbacks for prescribing compounded medications that were not medically necessary and were prescribed without the patients' knowledge, and a marketer, who was being paid commissions for facilitating referrals for unnecessary compounded prescription medications. Our investigation found that from 2012 to 2015, the FEHBP paid the compounding pharmacy $800,142 for alleged unnecessary compounded prescriptions. In May 2018, three subjects were arrested and charged with conspiracy. The criminal investigation continues.

- In April 2015, we joined a multiagency investigation with DCIS, the FBI, and the U.S. Postal Service OIG. The allegations included a southern California compounding pharmacy that had engaged in a kickback scheme with health care providers in order to prescribe unnecessary compounded medications. The pharmacy operated primarily as a multi-State mail order pharmacy. The vast majority of its revenue derived from filling, refilling, and dispensing by mail prescriptions for compounded pain cream medications throughout the country. Between September 2011 and June 2015, this single pharmacy collected nearly $64 million from Federal health care programs and private health insurers. The vast majority of the payments (95 percent) were for compounded pain and scar creams. We determined that FEHBP carriers paid this pharmacy $1,849,213 during the period of the alleged fraud scheme. In April 2018, two of the six subjects of this investigation pled guilty to conspiracy charges. Sentencing will occur later this year. The criminal investigation continues.

- In September 2014, we opened a case in response to a citizen complaint made to the FBI's Houston Division regarding alleged billing fraud after the complainant purchased weight loss injections off a consumer coupon website. The complainant reported that when the complainant went to the clinic for the injections, unnecessary diagnostic tests were attempted and tens of thousands of dollars were billed to their health insurance plan. We determined FEHBP carriers had paid approximately $86,000 related to a medical clinic and hospital associated with the complaint. In the scheme, the clinic sold their claims to the hospital for a flat fee in order for the hospital to bill the claim as an "out of network" hospital service instead of "in network" professional services. In May 2018, one of the subjects under investigation was charged with conspiracy. The criminal investigation continues.

- In September 2011, we received a qui tam referral from the U.S. Department of Justice (DOJ) concerning violations of the False Claims Act by a global pharmaceutical company.[2] The complaint alleged that the pharmaceutical company illegally promoted osteoporosis medications with false claims of their superiority over a competitor's drugs and illegally promoted a drug as improving patient compliance despite the lack of clinical

[2] A qui tam lawsuit may be filed on behalf of the Federal Government if an individual has knowledge of a person or company filing false claims against the Government.

evidence. Further, it was alleged that a kickback scheme was used where Medical Education Events ("Med Eds") would pay for expensive dinners and speaking fees, and provide employee billing assistance to induce physicians to increase the number of prescriptions.

The alleged False Claims Act violations took place from approximately October 2009 through February 2012. In October 2015, as part of a global settlement, the pharmaceutical company agreed to resolve its criminal and civil liability arising from the company's illegal marketing practices. The FEHBP received a net payment of $1,071,375. After the civil portion of the case was completed, investigators and prosecutors opened a criminal case focusing on a physician obstructing a health care fraud case. In April 2018, a jury found the physician guilty of obstruction of a health care investigation. Sentencing has not been scheduled.

- In May 2015, we received a qui tam complaint from DOJ regarding a New York-based wellness clinic alleged to have billed for healthcare services that were never provided. The investigation uncovered that the wellness clinic was routinely reimbursed for fraudulent claims: the clinic submitted claims to the FEHBP for annual wellness patient services, well woman examinations, and sonogram services, but the medical documentation did not support the billings. In July 2018, a civil settlement agreement was achieved and the FEHBP was awarded $80,865. The case is now closed.

- In November 2014, we received a case notification from an FEHBP carrier regarding allegations that a Maryland physician was upcoding services and billing for services never performed.[3] The FEHBP paid the provider more than $480,000 for allergy tests that were never performed. In April 2018, the physician was arrested and charged with health care fraud. The criminal investigation continues.

- On December 8, 2010, we received an allegation from the USAO for the District of Maryland alleging a medical device and drug manufacturer paid illegal kickbacks to health care providers to market and distribute one of its products, as well as intentionally failing to inform doctors, patients, and the U.S. Food and Drug Administration that the product had a design defect. The investigation determined that the manufacturer knowingly advertised, marketed, and distributed a gastric banding device and product for use in procedures that were not reasonable and necessary for the diagnosis or treatment of any illness or injury. In order to market and distribute the product, the manufacturer paid illegal kickbacks to health care providers in connection with their participation regarding educational events, surgeon workshops, advisory boards, and training events in which the aforementioned uses were discussed or demonstrated. In April 2018, the manufacturer entered into a civil settlement. The FEHBP was awarded restitution totaling $393,438.

- In 2003, we initiated an investigation based on a referral from the Texas Department of Insurance's Fraud Unit. The referral alleged that a Houston-area physician was upcoding services, unbundling medication packages, and billing for services not provided to

[3] "Upcoding" is when a provider is billing for services under an incorrect (higher-paying) Current Procedural Terminology code to increase reimbursement.

Hepatitis C patients.[4] We participated in a joint investigation that resulted in the physician being found guilty and sentenced to 135 months of incarceration, 36 months of probation, and ordered to pay restitution in the amount of $646,309 to the FEHBP. In addition, the physician had to forfeit $10 million and pay a fine of $4,440. On June 22, 2018, OPM finally received the court ordered restitution in the amount of $649,309 resulting from a civil forfeiture order.

[4] "Unbundling" is the practice of using several CPT codes for a service to increase reimbursement when one inclusive code is available.

II. RETIREMENT ANNUITY FRAUD INVESTIGATIONS

The Office of Investigations uses a variety of approaches to identify potential fraud cases affecting the Civil Service Retirement System (CSRS) and the Federal Employees Retirement System (FERS). We coordinate closely with OPM's Retirement Services office to identify and address program vulnerabilities. We also coordinate with the U.S. Department of the Treasury's Bureau of the Fiscal Service to obtain payment information. Other referrals come from Federal, State, and local agencies, as well as private citizens. The OPM OIG also works proactively to identify retirement annuity fraud.

The following retirement annuity fraud cases represent some of our activities during this quarter.

Case Summaries:

- We received a retirement fraud referral in April 2015 from OPM's Retirement Inspection Branch regarding the potential theft of CSRS annuity benefit payments after the annuitant had died. According to the referral, the annuitant lived near San Diego, California, and died on December 8, 1997, but the death was not reported to OPM. As a result, OPM continued to deposit monthly annuity payments directly into the deceased annuitant's checking account through December 2014, resulting in an overpayment of $396,134.58. OPM recovered $3,232.26 through the Department of the Treasury's reclamation process leaving a balance due of $392,902.32. Our investigation identified that the deceased annuitant's step-granddaughter accessed the annuitant's bank account and wrote checks to herself by forging the annuitant's signature. In August 2017, the subject was indicted and arrested in the Southern District of California for identity theft. In May 2018, the step-granddaughter was sentenced to 5 years of probation and ordered to pay restitution to OPM in the amount of $392,902.32.

- We received a referral in July of 2016 from OPM's Retirement Inspections Branch alleging that the son of a deceased survivor annuitant fraudulently obtained CSRS retirement annuity payments after her death. It was determined that the survivor annuitant died on January 17, 2001, and OPM was not notified of the death. As a result, June 2015. The failure to notify OPM of the survivor annuitant's death led to an overpayment of $338,313.55 in retirement annuity benefits. OPM was not able to recover any monies from the bank account through the Department of the Treasury's reclamation process. There was no evidence that anyone attempted to notify OPM of the survivor annuitant's death. However, OPM OIG investigators determined through bank record analysis that the deceased survivor annuitant's son had access to and withdrew the funds from a joint checking account. The case was presented to and accepted by the Camden County Prosecutor's Office in New Jersey. In March 2017, a complaint-summons was filed charging the subject with theft. In April 2018, the son pled guilty; he was accepted into the Pre-Trial Intervention program. As part of the program, he was ordered to pay restitution to OPM in the amount of $338,313.55.

- In July 2017, we received a request for assistance from the U.S. Social Security Administration (SSA) OIG regarding an investigation of a CSRS survivor annuitant who died on March 1, 1999. SSA OIG identified the deceased annuitant through their

Medicare Non-Usage Project, (the project looks at elderly recipients receiving Medicare benefits but who have not recently used those benefits). They determined that the deceased had also been receiving $416 per month in OPM CSRS benefits. According to the SSA OIG, the deceased annuitant's son allegedly continued to withdraw money from the joint bank account he held with his mother after her death. After learning of annuitant's death, OPM's Retirement Services Branch stopped the annuity payments. The overpayment at that time was $79,401.00. The Retirement Services Branch was able to recover $2.02 through the Department of the Treasury's reclamation process, leaving a net overpayment balance of $79,398.98. The investigation found that the son of the deceased annuitant stole a combined total of $150,000 from SSA, the VA, and OPM between March 1999 and July 2017. In March 2018, the son was indicted and arrested on charges of theft of Government funds. In April 2018, the son pled guilty and was ordered pay OPM restitution in the amount of $79,401.00 and was placed on probation for 1 year.

III. ADMINISTRATIVE INVESTIGATIONS

In addition to conducting criminal and civil investigations, our office also conducts administrative investigations of OPM employees and contractors for fraud, waste, abuse, or mismanagement at OPM.

The following represents our activities during the reporting period.

Case Summary:

There were no reportable activities during this period.

IV. NATIONAL BACKGROUND INVESTIGATIONS BUREAU

The Office of Investigations investigates allegations of fraud within OPM's Revolving Fund programs, including the background investigations program and human resources products and services program.

Prior to the establishment of the National Background Investigations Bureau (NBIB) effective October 1, 2016, OPM's Federal Investigative Services (known as FIS) conducted background investigations on Federal job applicants, employees, military members, and contractor personnel for suitability and security purposes. The violations investigated by our criminal investigators include contract violations, as well as fabrications by OPM background investigators (i.e., the submission of work products purported to represent investigative work that was not in fact performed). We consider such cases to be a serious national security and public trust issue. If a background investigation contains incorrect, incomplete, or fraudulent information, a qualified candidate may be wrongfully denied employment or an unsuitable person may be cleared and allowed access to Federal facilities and/or classified information.

OPM's Human Resources Solutions (HRS) provides on a reimbursable basis other Federal agencies with human resources products and services to help agencies develop leaders, attract and build a high-quality workforce, and transform into high-performing organizations. For example, HRS operates the Federal Executive Institute, a residential training facility dedicated to developing career leaders for the Federal Government. Cases related to HRS investigated by our criminal investigators include employee misconduct, regulatory violations, and contract irregularities.

The following represents our activities during the reporting period.

Case summary:

- On December 8, 2017, we received a request from DOJ to open an investigation into an NBIB background investigator. The DOJ Assistant United States Attorney assigned to the case as part of another unrelated investigation concluded that in 2016 the background investigator likely submitted false and fraudulent documentation so that he could secure employment with NBIB and receive a favorably adjudicated background investigation for a Top Secret security clearance. Our investigation determined that the NBIB background investigator engaged in providing false statements on various OPM employment and background investigation forms, submitted documentation of a fraudulent undergraduate degree, and provided false information during his background investigation interview. In December 2017, he was indicted in the Eastern District of Tennessee on a number of charges, including wire and mail fraud and making false statements to the Government. On July 25, 2018, the subject was found guilty on all counts listed in the indictment. A sentencing date has not been scheduled.

- On August 13, 2013, we received a case referral from NBIB regarding allegations that a former background investigator who worked for a background investigation contractor falsified several background reports of investigations. Our investigation found that the subject had falsified 55 source interviews, which resulted in a background investigation

recovery cost to NBIB of $77,649.33 for costs associated with reconducting background investigations on the falsified interviews. In July 2017, the subject was arrested in the District of Columbia and charged with making false statements to the Government. In June 2018, the subject pled guilty to the charges. On August 20, 2018, the subject was sentenced to 1 month of incarceration followed by 24 months of supervised release, as well as ordered to pay full restitution in the amount of $77,649.33 to OPM.

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:

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