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

Quarterly Case Summaries

Investigative Activities

Fiscal Year 2019

Third Quarter

April 2019 – June 2019

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-- Caution --

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List of Acronyms

CSRS	**Civil Service Retirement System**
DOJ	**U.S. Department of Justice**
FBI	**Federal Bureau of Investigation**
FDA	**U.S. Food and Drug Administration**
FEDVIP	**Federal Employees Dental and Vision Insurance Programs**
FEGLI	**Federal Employees' Group Life Insurance Program**
FEHBP	**Federal Employees Health Benefits Program**
FEI	**The Federal Executive Institute**
FERS	**Federal Employee Retirement System**
FFS	**Fee-for-Service**
HHS	**U.S. Department of Health and Human Services**
HMO	**Health Maintenance Organization**
NBIB	**National Background Investigations Bureau**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
OCFO	**OPM's Office of the Chief Financial Officer**
OCIO	**OPM's Office of the Chief Information Officer**
RICO	**Racketeer Influenced and Corrupt Organizations Act**
ROI	**Report of Investigation**

In this report to the OPM Director, the U.S. Office of Personnel Management (OPM) Office of the Inspector General (OIG) presents summaries of noteworthy cases investigated by our Office of Investigations as we endeavor to stop patient harm, curtail improper payments, protect OPM programs, and provide independent and objective oversight of OPM operations. We selected cases to highlight the successes of our special agents and Investigative Support Operations group, as well as to describe the types of waste, fraud, abuse, and mismanagement that harm OPM, its programs, and Federal employees, retirees, and their dependents.

The cases below represent the period from April 1, 2019, through June 30, 2019.

Health Care Investigations

The "OPM Fiscal Year 2018 Agency Financial Report" states that in fiscal year 2018, the Federal Employees Health Benefits Program (FEHBP) made $71.44 million in improper payments. These substantial, costly improper payments often derive from fraud, waste, and 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.

Improper Billing

- The Civil Division of the U.S. Attorney's Office in the District of Maryland notified us of its review of billing practices at several hospitals. One hospital provider allegedly engaged in improper billing practices and unbundling. As a result, the FEHBP suffered $96,308 in exposure related to the practices. In June 2019, the Government reached a civil settlement with the hospital provider for $3.154 million. Of that, the FEHBP will receive $108,538.53, including lost investment income.

Ineligible Dependents

- We received a referral from the U.S. Attorney's Office in the Northern District of Texas alleging that a U.S. Department of Justice (DOJ) employee added multiple ineligible members to an FEHBP health insurance plan. The FEHBP paid $12,316 for services provided to these ineligible dependents. In February 2018, the DOJ employee and a codefendant were indicted for making false statements relating to health care matters, as well as aiding and abetting the same. In July 2018, the DOJ employee pled guilty, and in April 2019, she was sentenced by the U.S. District Court for the Northern District of Texas to 3 years of probation and ordered to pay $12,316 in restitution.

- We received a referral from a health carrier alleging an FEHBP enrollee submitted altered official court documents to remove an ex-spouse from their FEHBP insurance when adding a new spouse to their plan. Specifically, the document showed that the member purportedly divorced their ex-spouse in January 2017 when in fact they had divorced in April 1993. The FEHBP paid $154,102.42 in claims on behalf of the ex-

spouse over the 14 years of ineligible coverage. In June 2019, the member pled guilty in the U.S. District Court for the Northern District of Alabama to making false statements.

Unauthorized Prescriptions

- During a 2015 law enforcement operation, our Federal law enforcement partners identified a provider receiving and dispensing drugs not approved for use in the United States. We were contacted regarding the FEHBP's exposure from this provider, which totaled $2,723.85. The provider settled with the U.S. Attorney's Office for the Middle District of Alabama in May 2019 for $50,000, of which $2,133.36 will be returned to the FEHBP.

False Claims Act

- We received a qui tam complaint from DOJ alleging that a national pharmacy chain submitted false claims to Federal and State health care programs for excessive quantities of insulin and automatically refilled prescriptions ahead of the use schedule. The FEHBP's exposure totaled $374,064,655.81 over 13 years. In January 2019, in the U.S. District Court for the Southern District of New York, the provider entered a civil settlement for $209.2 million. Due to an oversight, the FEHBP was not included in the original settlement, but by cooperation between OPM, DOJ, and our office, corrected the oversight. In May 2019, the FEHBP was awarded $531,569.70 in reimbursement.

Services Not Rendered

- We received a referral from a health carrier that alleged a provider billed a significant amount of services to a single FEHBP enrollee. This enrollee happened to be the spouse of the provider. The FEHBP's total exposure equaled $247,195. In interviews with our special agents, the provider admitted that all of the services submitted for his spouse were fraudulent. In April 2019, a grand jury indicted the provider in the U.S. District Court for the Eastern District of California.

- In September 2017, we received a health carrier referral alleging an FEHBP enrollee submitted fraudulent claims for services never received from a nonparticipating provider. These claims generated payments to the enrollee. From June 2013 to May 2017, the loss to the FEHBP totaled to $207,506.40. In March 2019, the enrollee pled guilty in the U.S. District Court for the Southern District of New York to one count of health care fraud. The enrollee was sentenced in June 2016 to 27 months of incarceration, 3 years of supervised release, and $502,980.01 in restitution. Of that, $207,506.40 will be returned to the FEHBP.

- In September 2013, we received a health carrier referral alleging that an FEHBP provider allowed an associate to bill under his provider number, and both the provider and associate misrepresented services. The FEHBP improper payment related to the scheme totaled $185,405.35. A criminal information filed in the U.S. District Court for the Northern District of Texas in March 2018 charged that the provider made false

statements relating to health care matters. The provider pled guilty and was sentenced to 60 months of imprisonment and 3 years of supervised release, as well as ordered to pay $2,483,273.00 in restitution. From that amount, the FEHBP will recover its entire damages. In June 2019, the associate pled guilty in the U.S. District Court for the Northern District of Texas with one count of making false statements relating to health care matters.

- In October 2016, we received a case referral regarding multiple individuals and providers. The alleged frauds included billing for services not rendered, waiving out-of-pocket expenses, altering medical records to obscure health care fraud, and operating a pass-through billing scheme using another entity's provider and tax information. The FEHBP suffered $1,138,821.80 in exposure. One individual fled the country after a search warrant conducted with Federal law enforcement partners. In June 2019, another individual appeared to make plans to flee the country as well, but they were arrested and a criminal complaint for making false statements was filed in the U.S. District Court for the Northern District of Illinois.

Unreported Restitution

- In June 2018, we identified a conviction of a provider in the U.S. District Court for the District of Hawaii that was not sufficiently reported to our office. OPM's exposure was $5,577.65. The U.S. Attorney's Office associated with the case declined to assist with our attempts to receive restitution. We provided guidance to the health carrier regarding proper notification in order to prevent future noncompliance with the applicable FEHBP Carrier Letter regarding reporting case notifications and restitution to the OPM OIG. In May 2019, the provider was sentenced to 42 months of imprisonment, 3 years of supervised release, and $3,796,207 in restitution. The FEHBP-related portion of $5,577.65 will be credited back to the carrier and to their letter of credit account.

Medically Unnecessary Treatment

- In June 2015, we received a case referral during a law enforcement task force meeting regarding a provider group allegedly falsifying documentation to order medically unnecessary treatments for patients. The FEHBP suffered $258,613 in exposure. One provider was charged with health care fraud, making false statements, and money laundering; in June 2019, the provider pled guilty in the U.S. District Court for the Northern District of Illinois to health care fraud.

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.

Unauthorized Prescriptions

- The DOJ referred to us a joint, nationwide investigation with the FBI, HHS OIG, and other Federal law enforcement agencies regarding off-label marketing and health care fraud involving a Schedule II, fentanyl-based narcotic. The manufacturer illegally promoted the drug by offering financial inducements for providers and falsified or misrepresented information for prior authorizations via a "reimbursement center." From April 2012 to September 2016, the FEHBP paid $17,742,528.86 for 2,152 medical claims. One former employee pled guilty to wire fraud conspiracy in June 2017, and a company vice president pled guilty to one count of racketeering conspiracy in November 2018. Six other subjects were found guilty in May 2019 in the U.S. District Court for the District of Massachusetts with crimes including RICO conspiracy. In June 2019, the manufacturer agreed to global restitution of $2 million in fines and $28 million in forfeiture, and $195 million to settle allegations related to violations of the False Claims Act. The manufacturer's subsidiary also pled guilty to five counts of mail fraud.

Diversion

- Based on referral from a State drug-monitoring program and cooperative efforts with local law enforcement, we investigated a pharmacy for overly dispensing Schedule II drugs, including opioids. Local police had already revealed a drug diversion scheme by an employee at the pharmacy to create opioid prescriptions, but our investigation also found that the owner defrauded FEHBP carriers by billing for services not rendered. In May 2019, the employee pled guilty to conspiring to distribute oxycodone.

Retirement Investigations

In Fiscal Year 2018, OPM's Retirement Services office (Retirement Services) improperly paid $284.08 million to Federal retirees, survivors, representative payees, and families. One of the most common causes of improper payments is the failure to verify the deaths of Federal annuitants, which sometimes allows improper payments to continue for years and costs hundreds 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.

Restored Annuity

- As part of a proactive project, our Investigative Support Operations office reviewed an annuity suspended by Retirement Services after the survivor annuitant failed to respond to an OPM Address Verification Letter (AVL). The retirement file contained a December 2017 AVL, but it was not notarized, and therefore the annuity was not restored at the time; however, the survivor annuitant also sent a notarized AVL in January 2018. We referred this information, along with other errors in the survivor annuitant's file, to Retirement Services. After requesting and receiving another notarized AVL, Retirement Services resumed the annuity in April 2019.

Proactive Retirement Cases

- In December 2017, Retirement Services suspended a survivor annuity after attempting payment to a closed account on five consecutive occasions. The Investigative Support Operations located records confirming the death of the survivor annuitant in spring of 2018. The provider in charge of the annuitant's care had changed financial institutions, which led to the attempted payments into the closed account. There were no successful payments after the annuitant's death. Retirement Services changed the status of the annuitant to "drop for death" based our Investigative Support Operations' proactive work.

- Investigative Support Operations identified an obituary for a Federal annuitant who died in January 2018, but continued to receive monthly annuity payments from OPM. OPM paid improper payments of $23,663.33 for the annuity and $11,128.35 towards FEHBP premiums. Investigative Support Operations notified Retirement Services in April 2019. OPM ended its payments to the deceased annuitant and the OCFO will take reclamation actions.

- In March 2019, Investigative Support Operations identified an obituary and death record for a Federal annuitant who died in January 2016. OPM made improper annuity payments of $33,120.10, plus additional improper payments totaling $27,057.94 for FEHBP premiums. Investigative Support Operations submitted evidence of the death to Retirement Services; it removed the annuitant from the rolls and initiated reclamation to recover the improperly paid annuity and premiums.

- Investigative Support Operations identified an October 2013 death record for a retired annuitant and matched the record to hospital discharge codes stating that the annuitant was deceased. OPM paid $2,774.41 in annuity payments and $599.63 in FEHBP premiums after the annuitant's death. Investigative Support Operations sent the discovered records to Retirement Services, and in April 2019, the annuitant's status was changed and reclamation actions began.

- Investigative Support Operations identified a retired annuitant death record dated November 2017. Corresponding health benefit claim records supported this finding. Until April 2019, OPM made improper payments totaling $33,494.06 for the retirement annuity and $13,290.10 for FEHBP premiums. We referred the discovered records to Retirement Services to initiate reclamation actions. In June 2019, the OPM's Office of Chief Financial Officer (OCFO) posted a recovery of all posthumous annuity payments ($33,464.06).

- Investigative Support Operations identified a death record for a retirement annuitant who died in January 2013 but continued to receive OPM annuity payments until February 2014. The annuity payments totaled $23,343.60. Investigative Support Operations provided this information to Retirement Services; it confirmed the death via death certificate and began reclamation actions.

- In March 2019, Investigative Support Operations proactively identified a deceased annuitant receiving both a retirement annuity and survivor annuity after her September 2017 death. The annuitant continued to receive payments until February 2019. The post-death retirement annuity totaled $36,573.77, the post-death survivor annuity totaled $20,134.52, and FEHBP premiums totaled $13,226.18. OPM ultimately paid $69,974.47 in improper payments after the annuitant's death. Through the reclamation process, Retirement Services recovered the entire amount.

Deceased Annuitant

- We received a referral from Retirement Inspections in August 2016 regarding the unreported death of a survivor annuitant in September 2007. Improper payments had continued through March 2016 and totaled $112,636.07. OPM recovered $18,257.75 by the reclamation process. Our investigation revealed that the deceased annuitant's son withdrew the funds. The subject pled guilty in the U.S. District Court for the Southern District of Ohio to theft of public money. In April 2019, he was sentenced to 3 years of probation, 6 months of home detention, and ordered to pay restitution of $94,378.32.

- We received a referral from Retirement Services regarding the unreported April 1993 death of an annuitant. OPM continued to deposit monthly retiree annuity payments until October 2017, resulting in an improper payment of $326,091. While the deceased annuitant's daughter agreed to a repayment plan to correct the improper payment and did pay $900 total, our special agents found the daughter forged signatures on two OPM forms in order to allow the payments to continue after the annuitant's death. In April 2019, she pled guilty to one count of theft of Government property in the U.S. District Court for the District of Maryland.

- We received a referral from Retirement Services regarding the unreported death of an annuitant in February 2012. OPM continued to deposit the annuity until October 2015. The improper payment totaled $86,209.01, of which $8,778.60 was recovered through the reclamation process. Our investigation found the annuitant's daughter had diverted the remaining funds for her own use. In August 2018, the annuitant's daughter was arrested after being indicted in the U.S. District Court for the District of Maryland on one count each of theft of Government property, aggravated identity theft, and aiding and abetting. In May 2019, the daughter's husband was indicted on theft of Government property, aiding and abetting, and conspiracy.

- We received a referral from Retirement Services regarding the unreported death of a retirement annuitant in November 2012. The annuity continued until May 2018, and the improper payment totaled $81,587. OPM recovered $6,060 through the reclamation process to reduce the outstanding amount to $75,527. The widow of the annuitant acknowledged that she continued to use the full retirement payment that she was not entitled to; however, as a survivor annuitant, she would have received a smaller annuity. Retirement Services calculated the improper payment to total $12,366.30. By agreement, the widow will pay $300 per month from her survivor annuity to resolve the debt.

- ❖ We received a referral from Retirement Services regarding the unreported death of an annuitant who died in January 2002 and continued to receive CSRS retirement payments totaling $268,369.63 through November 2013. Additionally, OPM paid $88,811.23 in FEHBP premiums. Some funds were recovered through the reclamation process, but the loss to the Government was $352,568.35. The annuitant's daughter admitted to converting the CSRS annuity for her own use. In January 2018, she was indicted in the U.S. District Court for the Central District of California on one count of theft of Government property; she pled guilty to the charge in June 2019.

National Security Investigations

OPM's National Background Investigations Bureau (NBIB) conducts 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. We provide external oversight of NBIB's background investigations to protect the integrity of these background investigations.

Falsifications of Background Investigations

- ❖ In October 2016, we received a referral from the NBIB Integrity Assurance office regarding possible falsifications in an NBIB background investigator's submitted Reports of Investigations (ROIs). An investigative review found approximately 90 falsified ROIs between September 2015 and October 2016. The associated loss to OPM totaled $213,407.03. The background investigator's Top Secret security clearance was suspended and he was ultimately removed from his position with NBIB. In May 2019, the background investigator pled guilty in the U.S. District Court for the District of Columbia to making a false statement. Sentencing was scheduled for September 2019.

- ❖ In December 2017, the OPM OIG received notification from the NBIB Integrity Assurance office regarding a contract background investigator who allegedly submitted false and inaccurate ROIs. In total, seven falsifications were found. The background investigator was removed from the OPM contract, and in April 2019, NBIB requested a contractual offset for processing that amounted to the cost associated with its recovery effort to redo the background investigations: $136,775.65. We referred the complaint back to NBIB Integrity Assurance to take appropriate action, including a referral to the OPM Suspension and Debarment Committee.

- ❖ We received a referral from NBIB Integrity Assurance that a background investigator submitted false and inaccurate ROIs. NBIB Integrity Assurance discovered 35 falsified ROIs and calculated recovery costs of redoing those background investigations amounting to $126,693.17. The background investigator was indicted on four counts of wire fraud and four counts of making false statements. In April 2019, the background investigator pled guilty in the U.S. District Court for the District of Columbia to making false statements.

- ❖ We received a referral from NBIB Integrity Assurance regarding falsifications discovered during a quality review. The investigation found the background investigator falsified 43 ROIs. In April 2019, the background investigator pled guilty to one count of making a false statement. Additionally, the background investigator will discuss their falsifications in a video interview to be used for NBIB training and paid $40,000 in restitution.

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 our 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.

- ❖ In July 2018, we received notification alleging a U.S. Government agency conducted unauthorized testing of OPM IT systems. As a further consequence of this testing, we also investigated the failure of OPM's Office of the Chief Information Officer (OCIO) to report the IT incident to the OIG in an immediate fashion as required. In the course of our investigation, a senior employee in the OCIO made false statements to OIG special agents. In January 2019, the DOJ declined any action related to the unauthorized testing, and the U.S. Attorney's Office for the District of Columbia declined to pursue criminal prosecution for the false statement in lieu of administrative remedies available to OPM. The OIG provided information to the OCIO, and the final program coordination for this matter occurred in July 2019, as well as DOJ's statement about the administrative remedies available to OPM for their action.

Glossary

OPM Programs

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 that are 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 Programs (FEDVIP) make 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.

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.

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 made online via https://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/ or by telephone at 1-877-499-7295.

Health Care and Insurance

Carriers are private health insurance companies that contract with the FEHBP to provide health insurance benefits to Federal employees and retirees and their dependents. These insurance plans include HMOs and FFS health plans.

Carrier Letters are guidance that OPM's Healthcare & Insurance office provides to FEHBP health 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.

The False Claims Act allows for the 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.

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.

Racketeer Influenced and Corrupt Organizations Act (RICO) is a Federal law with criminal penalties for anyone employed by or associated with a criminal enterprise. Specifically, RICO violations occur when: (1) an enterprise exists; (2) the enterprise affected interstate commerce; (3) the defendant was associated with or employed by the enterprise; (4) the defendant engaged in a pattern of racketeering activity; and (5) the defendant conducted or participated in at least two acts of racketeering activity.

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 Retirement Services. It is one of the surveys that Retirement Services uses to confirm and census its annuitant population.

A Federal Annuitant is a retiree or spouse of a retiree who receives an annuity from OPM.

Reclamation is the process by which Retirement Services through the U.S. Department of the Treasury attempts to recover money paid to Federal annuitants when a financial institution, such as a bank, holds the funds.

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.

National Security

The National Background Investigations Bureau (NBIB) conducts background investigations of Federal job applicants, employees, members of the armed services, and contractor personnel for suitability and security purposes. Background investigators submit their findings from interviews and other work in their **Reports of Investigation (ROIs).**