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

Quarterly Case Summaries

Investigative Activities
Fiscal Year 2018
October 2017 - December 2017

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ABBREVIATIONS

AFGE	**American Federation of Government Employees**
CFC	**Combined Federal Campaign**
DOD	**U.S. Department of Defense**
DOJ	**U.S. Department of Justice**
eOPF	**Electronic Official Personnel Folder**
FBI	**Federal Bureau of Investigation**
FDA	**U.S. Food and Drug Administration**
FEHBP	**Federal Employees Health Benefits Program**
HHS	**U.S. Department of Health and Human Services**
ISG	**OPM-OIG's Investigative Support Group**
NBIB	**National Background Investigations Bureau**
OI	**OPM-OIG's Office of Investigations**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PII	**Personally Identifiable Information**
RRB	**U.S. Railroad Retirement Board**
SSA	**Social Security Administration**
USAO	**U.S. Attorney's Office**
USPS	**U.S. Postal Service**
VA	**U.S. Department of Veterans Affairs**
VRA	**Voluntary Repayment Agreement**

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I. Health Care Fraud Investigations

In the first quarter of fiscal year (FY) 2018, between October 1, 2017, and December 31, 2017, the U.S. Office of Personnel Management (OPM) Office of the Inspector General (OIG) resolved 10 health care fraud investigations, resulting in the recovery of approximately $584,000 to OPM's Federal Employees Health Benefits Program (FEHBP). Summaries of these cases are below.

Also during this time period, our Office of Investigations referred three health care providers to the OIG debarring official to consider for debarment or suspension from participation in the FEHBP.

Case Summaries:

- We were contacted by the U.S. Attorney's Office (USAO) for the Northern District of New York regarding a settlement. A private health insurance company alleged that an anesthesiology group located in Syracuse, New York, billed Current Procedural Terminology (CPT) code 99144 for moderate (conscious) sedation services performed by a physician who also performed a medical or surgical procedure. After conducting an audit, the insurance company discovered that the anesthesiology group did not follow and document Medicare's so-called "16 Minute Rule," which states that Medicare will pay for the procedure only if the physician spends 16 minutes or more meeting face-to-face with the patient while providing the service. In October 2017, the USAO in Syracuse, New York, reached a settlement with the anesthesiology group; as a result, the FEHBP received $24,435.61.

- In February 2014, the U.S. Department of Justice (DOJ) notified the OPM OIG of a case involving a Palm Beach, Florida, dermatologist allegedly committing health care fraud. After our years-long investigation, the dermatologist pled guilty on December 13, 2017, to Federal charges of health care fraud and obstruction of a criminal health care fraud investigation in connection with his operation of clinics in Port St. Lucie and Okeechobee, Florida. A civil investigation was conducted parallel to the criminal investigation. The provider admitted to billing for services not rendered and ordering staff to insert false documents into patient's medical files. He faces a maximum 15-year prison term and $500,000 fine in connection with a scheme to defraud Government insurers out of between $250,000 and $550,000. As part of the plea deal, he agreed to give up his medical license. He was sentenced on February 22, 2018, to 36 months imprisonment followed by 1 year of supervised released and mandatory mental health and substance abuse treatment; he was also ordered to pay a fine of $200,000. No restitution was ordered in the criminal case because of the settlement of the related civil case. We worked this case with the Federal Bureau of Investigation (FBI), the U.S. Department of Health and Human Services (HHS) OIG, the U.S. Department of Defense (DoD) OIG, and the U.S. Railroad Retirement Board (RRB) OIG.

- In January 2015, DoD OIG notified our office of a Pompano Beach, Florida, pharmacy under investigation for possible health care fraud. The pharmacist and his right-hand man at the pharmacy entered into a vast conspiracy with marketers who paid physicians to write prescriptions for expensive topical medications that cost up to $17,000 per bottle.

The pharmacist and the coconspirators agreed to refill the prescriptions automatically, sending numerous refills to patients who did not request them; they did this while not charging a copay in hopes that the patients would not bother to return the medications. On September 5, 2017, after a trial lasting 1 month, a Miami, Florida, jury found the pharmacist guilty of health care fraud and other related charges. Through the conspiracy, the pharmacy billed over $37 million to TRICARE (DoD's military health system) and the FEHBP, leading to $30 million in false and fraudulent claims and the FEHBP paying over $220,000. The pharmacist was sentenced on March 9, 2018, to 17 years imprisonment followed by 3 years of supervised release and ordered to pay restitution of $31,259,252. We worked this case with DoD OIG, U.S. Postal Service (USPS) OIG, the Food and Drug Administration (FDA) Office of Criminal Investigations (OCI), and U.S. Department of Veterans Affairs (VA) OIG.

- In March 2015, we received a case notification from an FEHBP carrier's pharmacy benefit manager that a provider, a pharmacy, and a laboratory engaged in the submission of false or inflated claims. Our investigation found that the laboratories submitted false and fraudulent claims for toxicology and DNA cancer screening tests that were not legitimately prescribed, not needed, not provided as billed, or were the product of kickbacks. The defendants induced patients with gift cards to provide urine and saliva specimens. The specimens were mailed to the laboratories for unnecessary toxicology and DNA cancer screening tests. On July 12, 2017, a criminal information was filed in the USAO for the Northern District of Texas, which charged four defendants each with one count of conspiracy to commit health care fraud. One of the four defendants has signed a plea agreement; however, the judge deferred acceptance of the plea pending the completion of the pre-sentence investigation. The total estimated loss to the FEHBP is $4,000,000. We worked jointly in this case with the HHS OIG, VA OIG, DoD OIG, and the FBI.

- On June 29, 2017, we received information from the USAO in Portland, Oregon, that a dental provider used non-FDA approved injectable drugs obtained from a mail-order pharmacy in Canada in his orthopedic practice. Since foreign-sourced drugs bypass safety protocols implemented by the FDA, their use could place FEHBP enrollees' health and safety at risk. The provider agreed to resolve the issue through a civil settlement. The FEHBP portion of the settlement amounts to approximately $10,000.

- The FBI referred this case to an FEHBP insurance carrier, who then forwarded the allegations to our office in January 2016. The notification involved allegations that a chiropractor billed for services not rendered. Based upon the work performed by our criminal investigators, on March 16, 2017, a Federal grand jury issued an 18-count indictment against the chiropractor. The indictment charged him with committing health care fraud on 18 separate dates during from 2013 to 2015 when he was not in the country or the patient billed for the service was deceased. The provider pled not guilty and went to trial. On October 27, 2017, a jury in the Northern District of Illinois convicted him on all 18 counts of health care fraud. He was sentenced on February 13, 2018, to 5 years imprisonment followed by 1 year of supervised released and ordered to pay $4,087,735 in restitution. Restitution to the FEHBP was included in the amount payable to one of the

affected insurance carriers that, in total, received $2,256,651. The investigation determined that the total loss to the FEHBP is approximately $100,000.

- In August 2016, our office received a referral from an FEHBP carrier indicating that a physician was billing the carrier for services rendered after her medical license was suspended in 2013 by the State of Missouri for failure to pay State income taxes. On July 12, 2017, a Federal grand jury indicted the provider in the Eastern District of Missouri for three counts of billing for office visits in 2016 when she did not have a valid medical license. On November 13, 2017, she entered a plea of guilty for false statements relating to health care matters. Additional charges of the same crime were dropped at sentencing on February 21, 2018. The provider was sentenced to 5 years of probation and ordered to pay $304,844 in restitution. Additional restitution of $14,669 was ordered to be paid to two insurance carriers. The loss to the FEHBP is $72,743.65.

- In July 2009, we received a case referral from an FEHBP carrier stating that a sleep diagnostic center was misstating fees relating to sleep apnea testing, apnea monitoring equipment, and treatment at clinics located throughout Northern Virginia and Maryland. An additional complaint was received in July 2012 from another FEHBP carrier stating that this sleep diagnostic center was providing a new continuous positive airways pressure (CPAP) machine every year to 18 months to patients, despite the fact that a new CPAP machine was not medically necessary, and the patients were not required to pay an insurance copayment. In October 2017, the owners of the sleep diagnostic center were indicted in the U.S. District Court for the Eastern District of Virginia for health care fraud and various other counts related to false and fraudulent statements. In December 2017, one of the owners pled guilty. They are scheduled for sentencing in September 2018. The other owner is scheduled for trial in July 2018. According to court documents, the loss attributable to their conduct is between $4.5 and $25 million, and the loss to the FEHBP is more than $1 million.

- In June 2012, our office received notification from an FEHBP carrier that an Internal Revenue Service retiree was using his FEHBP medical benefits to obtain a synthetic opioid, Nalbuphine (Nubain), at numerous emergency rooms in multiple States from 2002 through 2012. His frequent emergency room visits resulted in more than $824,000 being paid by the FEHBP for services rendered at those facilities. In May 2016, a Federal indictment was filed in the U.S. District Court for the Western District of Virginia charging that the retiree knowingly and willfully made false statements relating to health care matters and devised a scheme and artifice to defraud the FEHBP. In November 2017, he was sentenced to 20 months incarceration followed by 36 months of supervised release. In addition, he was ordered to pay $549,607.43 in restitution to the FEHBP.

- In September 2011, we received a referral from the HHS OIG, alleging that two physicians operating a pain management practice were involved in an illegal kickback scheme and committing health care fraud. As part of the pain management operation, patients were routinely required to provide a urine sample to determine what drugs (if any) were present in the patient's bloodstream, and the urine sample was sent to a drug

screening laboratory for testing. One of the physicians entered into an unlawful agreement with a urine testing laboratory in New Jersey in which the physician agreed to send all of their urine specimens to that laboratory in exchange for a kickback fee. In total, the providers received $1.37 million in unlawful remunerations. One of the providers also committed health care fraud relating to anesthesia services provided at the practice. He billed as if two physicians were present when there was actually only one physician present and providing both surgical and anesthesia services. One of providers committed suicide in September 2016, shortly after being indicted. In October 2017, following a 13-day trial, a Federal jury in the U.S. District Court for the District of Maryland (Baltimore) convicted the second provider on 26 felony counts including health care fraud, violating the Anti-Kickback Act and the Travel Act, and making false entries in patients' medical records. His sentencing is scheduled for May 2018. He also faces additional charges related to tax fraud. A criminal trial related to these charges was scheduled for February 2018 but has been rescheduled. The provider was arrested in trying to flee the country.

II. RETIREMENT FRAUD INVESTIGATIONS

During this reporting period, the OIG resolved nine retirement cases that resulted in the return of approximately $706,000 to the OPM retirement programs.

Case Summaries:

- We received a referral in August 2016 from the Social Security Administration (SSA) OIG alleging that the granddaughter of a Federal survivor annuitant received and converted for her own use the benefits issued to her deceased grandmother by both SSA and OPM. When the granddaughter was interviewed, she admitted that she was aware that what she was doing was wrong but stated she depended on the money to support herself. The loss to the U.S. Government totaled $75,271.72. On July 19, 2017, the granddaughter was indicted in the Middle District of Florida for theft of public money, property, or records. On September 5, 2017, she pled guilty, and on November 29, 2017, she was sentenced to 24 months of probation and ordered to pay restitution in the amount of $75,271.72 to the Government, with OPM receiving $30,456.62 and SSA receiving $44,815.10.

- In November 2016, our office received a fraud referral from the OPM's Retirement Inspections Branch regarding the retirement annuity of a deceased annuitant. The Federal annuitant's February 2005 death was never reported to OPM, and so the agency had continued to deposit her monthly retirement annuity payments into her checking account through June 2015, resulting in an overpayment of $81,291.93. OPM recovered $28,499.61 through the reclamation process with the U.S. Treasury Department, leaving a balance due of $53,422.32. In August 2017, the annuitant's son was interviewed, and he admitted to accessing the funds deposited into his deceased mother's bank account. The USAO in the Middle District of Pennsylvania declined to prosecute the case in October 2017 because the annuitant's son repaid OPM the entire overpayment of $53,422.32.

- In June 2017, we received a request for assistance from the SSA OIG regarding an investigation of an OPM survivor annuitant who died in 2005. The investigation determined that the survivor annuitant's daughter failed to report her mother's death to OPM and instead continued to collect the annuity. In September 2017, a criminal complaint was filed against the daughter in the U.S. District Court for the Southern District of Ohio for theft of public funds. In November 2017, the daughter signed a plea agreement admitting to the theft of SSA and OPM funds designated for her mother and agreeing to pay restitution in the amount of $24,458 to SSA and $96,516 to OPM. The total restitution is $120,974. She further agreed to a term of probation of 36 months, with the first 10 months to be served in home detention.

- On August 27, 2014, our Investigative Support Group's proactive work identified a survivor annuitant who died on January 31, 2001, but, due to OPM not being notified of her death, continued to receive monthly annuity payments deposited into her bank account through May 2013. On June 22, 2016, the daughter of the deceased annuitant admitted to our investigators to having the bank statements sent to her address, ordering a new debit card, and withdrawing money from the annuitant's account for her own personal use. On July 19, 2017, the daughter was indicted on one count of theft of

Government funds and five counts of aggravated identity theft. On October 26, 2017, she plead guilty to theft of Government funds. The fraudulent behavior resulted in an overpayment of $85,550. OPM recovered $992 through the reclamation process with the U.S. Department of the Treasury, leaving a balance due of $84,558. The daughter was sentenced on February 20, 2018 to 3 years of probation with the first 6 months in home detention and ordered to pay $84,558 in restitution to OPM.

- On May 6, 2015, our office received a fraud referral from OPM's Retirement Inspections Branch regarding a survivor annuitant whose death in 1997 was not reported to the agency. OPM continued directly depositing her monthly annuity payments into a savings account through March 2015. An anonymous tipster informed the Retirement Inspections Branch that the annuitant's daughter was collecting the annuity now that her mother was dead. On June 21, 2017, the daughter was indicted in the Territory of Guam for theft of Government money. She pled guilty before a magistrate judge in the Territory of Guam on August 21, 2017, with no written plea agreement. The total overpayment in this case was $297,170.27. OPM recovered $1,755.87 through the reclamation process with the U.S. Department of the Treasury, leaving a balance due of $295,414.40. The daughter was sentenced on January 9, 2018, in the U.S. District Court for the District of Guam to 18 months of incarceration and 3 years of supervised release, and she was ordered to pay $295,414.40 in restitution to OPM.

- The SSA OIG referred a case to us on June 12, 2014. It was discovered because of SSA's centenarian project wherein SSA reviewed records of individuals who are a certain age and attempted to locate them to confirm those individuals are still alive. The investigation identified a recipient of post-death benefits from the SSA, VA, and OPM. The retiree's nephew was identified as the subject who received the benefits and converted them to his personal use. On February 17, 2017, he was indicted on 15 counts of theft of Government property and 1 count of Social Security fraud by concealment. He pled guilty to all charges on December 19, 2017. The OPM loss is identified as $109,497. Total loss to all Government programs is $363,924. He was sentenced on March 5, 2018, to 3 years of probation with 1 year of home detention and ordered to pay restitution of $363,960. OPM will receive $109,497 of the restitution.

- In April 2016, our hotline received an allegation from OPM's Retirement Inspections Branch of potential retirement fraud perpetrated by the son of two OPM annuitants. The father died in March 1993. His survivor annuity was paid to his wife, who had also retired from Federal service in early 1984 and later died in June 2012. The son did not report his mother's death, so OPM continued to pay both her annuity and her deceased husband's survivor annuity into her bank account through March 1, 2016. In August 2016 in the U.S. District Court for the District of Maryland in Greenbelt, a grand jury returned an indictment against the son on three counts of aggravated identity theft and three counts of theft of Government property. In March 2017, the son pled guilty to each of the three counts of theft of Government property while the USAO agreed to abandon the three counts of aggravated identity theft in the original indictment. In October 2017, the son was sentenced to pay restitution in the amount of $142,490.96 to OPM, serve 3 months of home detention, and 48 months' probation.

- On February 10, 2017, our Investigative Support Group identified a survivor annuitant whose annuity was not terminated when she remarried under the age of 55. A survivor annuitant who remarries prior to turning age 55 becomes ineligible to continue receiving the survivor annuity unless they were married to the deceased annuitant for 30 years or longer. The annuitant was under age 55 when she remarried on October 13, 1997. This marriage ended in divorce on November 9, 1999. OPM continued her survivor annuity payments through February 1999, resulting in an overpayment of $10,163. In addition, the annuitant married again on January 12, 2008. This marriage ended in divorce on March 11, 2009. OPM did not terminate her survivor annuity during the period of this remarriage either, resulting in an additional $11,111.67 overpayment. The annuitant notified OPM of both of her remarriages and divorces. The Investigative Support Group notified Retirement Services of the errors made on this case and asked them to take appropriate corrective action. On October 3, 2017, Retirement Services sent the annuitant a letter regarding the $21,274.67 overpayment. OPM will collect the debt from the annuitant's monthly annuity payments in 85 monthly installments, beginning with the January 1, 2018, payment.

- On March 10, 2016, we received a fraud referral from OPM's Retirement Inspections Branch regarding an annuitant who died on March 3, 2005, but whose death was not reported to the agency. As a result, OPM continued to deposit his monthly annuity payments directly into his checking account through June 2015. This resulted in an overpayment of $209,211.52. OPM recovered $3,082.42 through the reclamation process with the Department of the Treasury, leaving a balance due of $206,129.10. According to the referral, the annuitant elected to provide survivor annuity benefits to his spouse; however, the spouse did not complete the necessary application to receive the survivor annuity benefit. The daughter of the deceased annuitant and survivor spouse stated she was unaware that her mother had to apply for the survivor benefit but thought that her father's annuity would automatically convert to the survivor annuity.

  Retirement Services decided not to pay the spouse the survivor annuity retroactive to March 4, 2005. Instead, it applied the $139,673.84 due to the spouse from March 4, 2005, through September 30, 2015, to the $206,129.10 balance due on the overpayment to the annuitant. Retirement Services then began paying the annuitant's spouse a survivor annuity effective October 1, 2015 and were not attempting to collect the remaining $66,455.26 debt from her monthly survivor annuity payments. However, our investigation showed that the survivor spouse's daughter had access to the account and had been withdrawing funds for her own personal use. On November 28, 2017, the OPM OIG was notified by the OPM that the daughter signed a Voluntary Repayment Agreement (VRA). According to the VRA, the daughter agreed to repay the overpayment amount of $66,455.26 to OPM, in 265 monthly installments of $250 per month.

III. DEBARRMENT REFERRALS

We referred three background investigators to OPM for debarment actions: one for full debarment and two for suspension. This was based on our findings that each falsified their work products. Background investigators who are debarred are unable to work on Federal contracts. Background investigators are most commonly referred for debarment based on the falsification of background investigation reports of investigation.

IV. COMBINED FEDERAL CAMPAIGN INVESTIGATIONS

During the reporting period, the OIG was pleased to successfully resolve a 3-year investigation involving fraud committed by an individual against charities that participate in OPM's Combined Federal Campaign (CFC) program, which is the world's largest annual workplace charity campaign.

Case Summary:

- In November 2012, we received a case referral from OPM's CFC office related to allegations that a former executive director of a charitable organization that was a consortium of independent charities misappropriated funds that should have been distributed to the member-charities. Specifically, the consortium received donations from the CFC itself and functioned as a pass-through for donations to its member charities. The OIG's investigation found that the former executive fraudulently diverted the funds by writing checks from the consortium's bank account to his personal bank accounts. In December 2016, in the U.S. District Court for the District of Columbia, the executive pled guilty to one count of interstate transportation of stolen property and one count of aiding and abetting and causing an act to be done. In December 2017, he was sentenced to 18 months of incarceration, 3 years of supervised release, and was ordered to pay $385,564 in restitution to the affected former member-charities. The total amount owed to the Government by way of the forfeiture monetary judgment is $443,996.

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