



**U.S. Office of Personnel Management
Office of the Inspector General
Office of Investigations**

Quarterly Case Summaries

Investigative Activities

Fiscal Year 2021 Fourth Quarter

July 1, 2021 — September 30, 2021

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-- Caution --

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List of Acronyms

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

Overview of U.S. Office of Personnel Management (OPM) Programs and Activities

OPM-administered Federal Retirement Programs include two primary Federal defined-benefit retirement plans: the **Civil Service Retirement System (CSRS)**, which covers employees hired by the Federal Government between 1920 and 1986, and the **Federal Employees Retirement System (FERS)**, which covers employees hired after 1987. These plans provide monthly annuities based on a Federal Government retiree's service. Additionally, **OPM Disability Retirement** allows for FERS-eligible Federal employees who become disabled to collect benefits.

The Federal Employee Dental and Vision Insurance Program (FEDVIP) makes supplemental dental and vision insurance available to Federal employees and retirees who are eligible for Federal employment benefits. FEDVIP operates on an enrollee-pay-all basis and creates a group pool that allows for competitive premiums and no preexisting condition limitations.

The Federal Employees' Group Life Insurance (FEGLI) program is the largest group life insurance program in the world, covering over 4 million Federal employees and retirees, as well as many of their family members. It provides a standard group term life insurance and elective coverage options.

The Federal Employees Health Benefits Program (FEHBP) provides health insurance to Federal employees, retirees, and their eligible 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 health plans from a number of private health insurance carriers.

The Federal Executive Institute (FEI) is part of OPM's Center for Leadership Development and training center offers learning and ongoing leadership development for Federal senior leaders through classes and programs to improve the performance of Government agencies.

The Combined Federal Campaign (CFC) is the world's largest and most successful annual workplace charity campaign. It raises millions of dollars each year through pledges made by Federal civilian and retiree, postal, and military donors during the campaign season. These pledges support eligible nonprofit organizations.

The National Background Investigations Bureau (NBIB), a former OPM bureau, conducted background investigations of Federal job applicants, employees, members of the armed services, and contractor personnel for suitability and security purposes. NBIB and its functions were transferred to the Department of Defense (DoD) on October 1, 2019, and it is now the Defense Counterintelligence and Security Agency (DCSA). Background investigators submitted their findings from interviews and other background work in **Reports of Investigation (ROIs)**.

The OPM Office of the Inspector General (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 can be submitted:

- ❖ By telephone (1-877-499-7295);
- ❖ By mail
U.S. Office of Personnel Management, Office of the Inspector General
Theodore Roosevelt Building
1900 E Street NW
Room 6400
Washington, DC 20015-1100; or
- ❖ Online (<https://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/>).

At the end of this document, we include an additional glossary related to the types of investigations we conduct in our oversight mission to protect OPM programs from fraud, waste, and abuse.

Director's Report

In this quarterly report to the Director, the U.S. Office of Personnel Management (OPM) Office of the Inspector General (OIG) presents summaries of noteworthy cases investigated by the OPM OIG Office of Investigations as we endeavor to curtail improper payments, stop patient harm, protect OPM programs, and provide independent and objective oversight of OPM programs and operations. We have selected these cases to highlight the successes of our Office of Investigations' special agents and investigative support staff, 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.

Health Care Investigations

According to OPM, in Fiscal Year (FY) 2020, the FEHBP across all of its health insurance carriers paid \$25.18 million in improper payments. These substantial, costly improper payments often derive from fraud, waste, or abuse throughout the FEHBP and negatively affect premium rates and the program as a whole. Moreover, fraudulent schemes that generate improper payments often also cause patient harm.

Health Care Fraud

- ❖ In May 2017, we received a *qui tam* referral from the Department of Justice (DOJ) regarding a medical device company that allegedly manufactured and sold cardiac devices with a life-threatening defect and continued to sell the devices even after becoming aware of the defect. Data analysis of FEHBP claims found that between 2011 and 2016, the FEHBP paid the device company \$954,011 associated with implantable device codes. Subsequent data analysis requested by DOJ identified that between November 2014 and October 2016, the FEHBP had paid \$4,189. On July 7, 2021, the medical device company agreed to pay \$27 million to Government health care programs to settle False Claims Act allegations related to devices implanted between November 2014 and October 2016. OPM recovered \$22,155 for damages and investigative costs.
- ❖ In January 2016, we received a referral from the DOJ regarding a medical provider that hired a medical professional excluded (i.e., debarred) from participating in Government health care programs such as the FEHBP. Additionally, the owner of the medical provider practice engaged in a scheme that involved moving Schedule II narcotics from one pharmacy to another and dispensing expired medications. The FEHBP had paid the medical provider \$676,082. On July 27, 2021, the U.S. Attorney's Office for the Eastern District of Pennsylvania entered into a civil settlement with both the medical provider and the excluded medical professional. Under the settlement, each will pay \$250,000 to Government health care programs. The FEHBP will receive \$12,367 in total.
- ❖ In September 2016, we received a *qui tam* filed in the U.S. District Court for the Middle District of Florida that alleged a medical provider performed unnecessary medical procedures and misrepresented patient medical records to justify procedures. The

FEHBP’s exposure was \$721,840. On September 15, 2021, the medical provider entered into a settlement with the U.S. Government. Per the settlement, the medical provider will pay \$6.7 million to Government health care programs resolve allegations of violating the False Claims Act. The FEHBP will receive \$250,000 from the settlement.

- ❖ A medical provider allegedly created false prescriptions of an intravenous treatment between December 2017 and March 2019. On September 24, 2021, the medical provider pled guilty in the U.S. District Court for the Central District of California to health care fraud, bank fraud, aggravated identity theft, and subscription to a false tax return. The FEHBP did not have any exposure related to this provider; however, this case action is related to a larger, ongoing investigation involving the FEHBP. Further judicial action is expected in this case.

- ❖ In July 2017, we received a case referral from a Federal law enforcement partner detailing allegations that a medical provider group submitted false claims to Government health care programs, including to the FEHBP. The loss related to the allegations was calculated as \$27,222. We previously reported that several individuals were charged and pled guilty in the U.S. District Court for the District of Maryland with crimes including conspiracy to commit health care fraud and acceptance of gratuities by a public official. On September 9, 2021, one individual was sentenced to 8 months of imprisonment and 1 year of supervised release, with 4 months of that to be served in home confinement. The court also ordered this individual to pay \$50,000 in fines and restitution of \$27,890. On September 30, 2021, a second individual was sentenced to 8 months of imprisonment and 1 year of supervised release, with 4 months of that to be served in home confinement. The court also ordered this second individual to pay \$7,890 in restitution. The FEHBP is expected to receive \$27,222 in restitution across all defendants. Further judicial action is anticipated in this case.

FEHBP Health Carrier and Provider Settlements

Predication	OPM Loss	Settlement
In January 2020, we received a carrier notification from an FEHBP health insurance carrier regarding a provider group that billed for services not rendered or inaccurately billed.	\$136,801	On August 4, 2021, we received an update that the FEHBP health insurance carrier had agreed to a settlement with the provider group. The FEHBP will recover \$3,220.
In June 2021, we received a carrier notification from an FEHBP health insurance carrier regarding a medical provider who billed while misrepresenting the servicing provider or billed using insufficient documentation.	\$19,782	On July 8, 2021, we received an update that the FEHBP health insurance carrier entered into a settlement wherein the provider will return \$205,558 across all lines of business. Of that, \$9,591 will be returned to the FEHBP.

Predication	OPM Loss	Settlement
In March 2021, we received a carrier notification from an FEHBP health insurance carrier purporting inappropriate claims for services provided by one medical provider but billed as being performed by another.	\$30,331	On July 2, 2021, we received an update that the FEHBP carrier and the medical provider had entered into a settlement wherein the medical provider agreed to pay \$150,000 across all lines of business to settle the allegations. The FEHBP recovered \$23,554.
In April 2021, we received a carrier notification from an FEHBP health insurance carrier alleging that a medical provider double-billed certain medical claims.	\$9,380	On July 14, 2021, we received an update that the FEHBP health insurance carrier had entered into a settlement wherein the provider will pay \$151,470 across all lines of business, including \$7,205 to be returned to the FEHBP.
In April 2021, we received a carrier notification from an FEHBP health insurance carrier regarding a medical provider who double-billed medical claims.	\$7,563	On July 15, 2021, we received notification that the carrier entered into a settlement with the provider. The provider will pay \$194,921 total, with \$5,473 to be returned to the FEHBP.
In July 2021, we received a carrier notification alleging that a provider inflated billing by performing repeated drug screenings under certain procedure codes.	\$64,968	On September 22, 2021, the provider and the FEHBP health insurance carrier entered into a settlement wherein the provider will repay 100 percent of the calculated improper payment, as calculated by the FEHBP health insurance carrier, over 3 years.
In June 2021, we received a carrier notification from an FEHBP carrier regarding a provider who billed for services not rendered or services misrepresented.	\$120,009	On August 31, 2021, a settlement was executed between the FEHBP health insurance carrier and the provider. The settlement requires the provider to pay the health insurance carrier \$200,000 for all lines of business. Of that, the FEHBP will receive \$23,058.

Special Topic: The Opioid Epidemic

In the 2017 Presidential memorandum “Combating the National Drug and Opioid Crisis,” the opioid crisis was declared a public health emergency. The memorandum 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.

Opioid-Related Health Care Fraud

- ❖ In March 2018, we received information from the DOJ related to an unsealed indictment that charged five medical providers with participating in a scheme to receive bribes and kickbacks through sham educational programs in exchange for prescribing a fentanyl-based medication. The FEHBP had paid \$63,420 to the medical providers. We previously reported that the five medical providers had pled guilty in the District Court for the Southern District of New York. On July 8, 2021, one of the medical providers was sentenced to 121 months in prison and 3 years of supervised release, as well as ordered by the court to forfeit \$308,600 and to pay a fine of \$75,000. Further judicial action is anticipated in this case.
- ❖ In October 2016, we received a case referral alleging that a provider group improperly dispensed medications, including one containing naloxone. The FEHBP paid \$670,000 in claims between November 2015 and September 2016 for the at-issue medications. We previously reported that multiple individuals were indicted, pled guilty, and were sentenced in the U.S. District Court for the Eastern District of Virginia. On September 24, 2021, charges were filed against a seventh individual in this case. This individual was charged in the U.S. District Court for the Eastern District of Virginia with health care fraud and pled guilty. Further judicial action is anticipated in this case.

Retirement Investigations

In FY 2020, OPM reported that they paid \$299.04 million in improper payments related to its retirement programs to retirees, survivors, representative payees, and families, largely from the Civil Service Retirement System (CSRS) and the Federal Employees Retirement System (FERS) retirement programs. One of the most common causes of improper payments is failure to verify the deaths of annuitants, which sometimes allows improper payments to continue for years and costs tens of thousands of dollars. Fraud by forged documents, identity theft, and other schemes also highlight program vulnerabilities, and in some cases may stop Federal retirees or rightful annuitants from receiving their deserved benefits. Based on our investigations, OPM can potentially use Department of the Treasury (Treasury) reclamation actions or other measures to recover improper payments.

Unreported Annuitant Death Cases

- ❖ In January 2020, we received a referral from the OPM Retirement Services program office alleging that an individual fraudulently obtained annuity payments after a survivor annuitant died in September 2013. OPM paid \$50,950 in overpayments, but it was able to recover \$7,763. Therefore, the total overpayment was \$43,186. We previously reported that an individual was charged in the U.S. District Court for the Middle District of Florida with theft of Government property. On August 11, 2021, the individual pled guilty to the charge. Further judicial action is anticipated in this case.

- ❖ In February 2021, we received a referral from another Federal agency regarding potential overpayment to an OPM annuitant who died in October 2018. The improper payment was discovered to be \$29,830. The financial institution where the OPM retirement payments were deposited was held liable for the amount because it did not respond to an OPM Notice of Reclamation within 60 days or notify OPM of the annuitant's death. Our investigation ultimately resulted in OPM requesting the reclamation action; the re-credit is complete, and as of July 1, 2021, we closed our case.

Administrative and Reclamation Actions Referred to OPM's Retirement Services Program Office

Predication	OPM Loss	OIG Actions	OPM Actions
We proactively located a death record for a survivor annuitant who had died in January 2011. The Retirement Services program office had suspended the survivor annuity payments in April 2017, but the case was never dropped for death.	\$15,707 in post-death annuity payments \$45,004 in health benefits premiums \$60,712 total post-death loss	On July 6, 2021, we provided the death record we located to the Retirement Services program office.	The Retirement Services program office dropped the case for death on July 7, 2021, and initiated Treasury reclamation actions on July 13, 2021.
We proactively located a death record for a survivor annuitant who died in June 2020. The Retirement Services program office had not dropped the case for death or initiated Treasury reclamation actions.	\$893 in post-death annuity payments	On August 12, 2021, we provided the death record to the Retirement Services program office.	On August 13, 2021, the Retirement Services program office dropped the case for death and initiated Treasury reclamation actions to recover the post-death annuity payments.

Predication	OPM Loss	OIG Actions	OPM Actions
<p>We proactively located an obituary for a survivor annuitant who died in February 2020. The Retirement Services program office had suspended the annuity payments but had not dropped the case for death or initiated Treasury reclamation actions.</p>	<p>\$904 in post-death annuity payments</p> <p>\$4,584 in post-death health benefits premiums</p> <p>\$5,489 total post-death loss</p>	<p>On August 23, 2021, we provided the death record to the Retirement Services program office.</p>	<p>The Retirement Services program office initiated Treasury reclamation actions to recover the post-death annuity payments and health benefit premiums.</p>
<p>We proactively located a death record for a retired annuitant who died in March 2020. The Retirement Services program office had not dropped the case for death or initiated Treasury reclamation actions.</p>	<p>\$1,297 in post-death annuity payments</p>	<p>On September 10, 2021, we provided the death record to the Retirement Services program office.</p>	<p>Between September 13–15, 2021, the Retirement Services program office dropped the case for death and initiated Treasury reclamation actions. Dropping the case for death will allow the deceased annuitant’s spouse to apply to receive monthly survivor annuity payments.</p>
<p>We identified the April 2019 death record of a retired annuitant whose retirement case was not dropped for death by the Retirement Services program office. The Retirement Services program office had also not initiated Treasury reclamation actions.</p>	<p>\$34,026 in post-death annuity payments</p> <p>\$7,066 in post-death health benefits premiums</p> <p>\$41,093 total loss</p>	<p>On September 24, 2021, we provided a copy of the death record to the Retirement Services program office.</p>	<p>Between September 27–29, 2021, the Retirement Services program office dropped the case for death and initiated Treasury reclamation actions to recover the post-death annuity payments and health benefits premiums.</p>

Cases Affected by Statute of Limitations Concerns

In the following cases, we received fraud referrals related to deceased annuitants or survivor annuitants whose financial accounts continued to receive payments from OPM Retirement Programs for years after their death. However, in these cases, a portion of the funds improperly paid could not be considered as a prosecutable loss because of the statute of limitations. Because only a portion of the improper payment was prosecutable, these cases were declined for prosecution or we closed our investigation.

- ❖ In December 2019, we received a fraud referral from the Retirement Services program office regarding a deceased survivor annuitant whose May 1991 death was not reported to OPM. Monthly annuity payments continued through May 2019, resulting in an overpayment of \$249,366. OPM recovered \$50,593 through the reclamation process, leaving a balance of \$198,772. However, only \$81,160 was supported by bank records and fell within the statute of limitations. This is below the threshold for the U.S. Attorney's Office in the Northern District of California to accept for prosecution. We referred the case back to the Office of the Chief Financial Officer (OCFO) for administrative action.
- ❖ In November 2020, we received a fraud referral regarding a deceased retired annuitant whose November 2007 death was not reported to OPM. Retirement annuity payments continued through May 2019, resulting in an overpayment of \$328,888. OPM recovered \$4,453 through the Treasury reclamation process. However, the financial institution did not have records far enough back to corroborate most of this loss, and only a \$31,166 loss was prosecutable under the statute of limitations. This is under the established threshold for prosecution by the U.S. Attorney's Office for the Central District of California. We referred the case back to the OCFO for administrative action.
- ❖ A survivor annuitant's March 2001 death was not reported to OPM in a timely manner. OPM paid \$255,722 after the annuitant's death. The agency recovered \$1,448 through the Treasury reclamation process, leaving a total outstanding loss of \$254,273. However, our investigation was only able to subpoena bank transactions and financial records to support a loss of \$121,590. Furthermore, only \$53,567 of that fell within the statute of limitations, which is under the established threshold for prosecution by the U.S. Attorney's Office for the Central District of California. We referred the case back to the OCFO for administrative action.
- ❖ In June 2019, we received a referral from the Retirement Services program office regarding an annuitant's death that was not reported to OPM in a timely manner. The annuitant had died in January 1992, but payments continued until December 2012, resulting in \$377,231 in post-death annuity payments. OPM was unable to recover any funds through the Treasury reclamation process. We provided the results of our investigation to OPM, including findings that \$270,458 was escheated by the State of Illinois. Escheatment returns money to a government after a person without heirs dies. In July 2021, when the OPM OCFO contacted the Illinois State Treasurer, only \$82 remained from the escheatment. The OCFO decided not to file a claim to recover the

funds, and because the last payment to the decedent was in February 2013, the statute of limitations was expired. We closed our investigation on July 27, 2021.

- ❖ In March 2020, we received a referral from the Retirement Services program office regarding a deceased annuitant who had died in August 2002. OPM had overpaid \$164,233 in post-death annuity payments. While \$33,880 was recovered through Treasury reclamation actions, the remaining improper payment balance was \$130,353. Our investigation found the last activity related to this money was in May 2016. We closed our investigation due to statute of limitations concerns.
- ❖ In October 2020, we received a referral from the Retirement Services program office regarding a survivor annuitant who died in January 2003 whose death was not reported to OPM. Annuity payments continued through May 2019, resulting in an overpayment of \$101,828. OPM recovered \$1,105 through Treasury reclamation actions. However, our investigation was only able to establish a prosecutable loss of \$39,557 based on information from the annuitant's financial institution. When contacted by investigators, the subject of the investigation expressed willingness to repay the funds to satisfy the debt. The loss threshold falls below guidelines for a criminal investigation by the applicable U.S. Attorney's Office, so we referred the case back to the OCFO for administrative recovery of the debt.

Earlier detection and referral of these cases to the Office of Investigations is an important factor in the recovery of the improper payments and, as necessary, the prosecution of individuals who steal Government funds.

National Security Investigations

As a former OPM bureau, the National Background Investigations Bureau (NBIB) conducted background investigations of Federal job applicants, employees, members of the armed services, and contractor personnel for suitability and security purposes. Allowing the employment of or granting security clearances to potentially unsuitable persons through fraudulent, falsified, incomplete, or incorrect background investigations creates vulnerabilities within the Federal workforce detrimental to Government operations. Though the Government's background investigative function is no longer an OPM-administered program as of October 1, 2019, we continue to provide external oversight of some legacy background investigations begun before the October 1, 2019, transfer of the former bureau to the Department of Defense.

Falsified Reports of Investigation

- ❖ In October 2017, we received a referral from the NBIB Integrity Assurance office alleging that a contract background investigator submitted false Reports of Investigation (ROIs). Our investigation found 26 falsified ROIs. The loss and associated recovery effort to the Government totaled \$105,186. We previously reported that the contract background investigator pled guilty in the U.S. District Court for the District of Columbia to making a false statement. On July 19, 2021, the contract background investigator was

sentenced to 24 months of probation and 200 hours of community service and was ordered by the court to pay \$86,562 in restitution and a \$4,000 fine.

Integrity Investigations

In addition to conducting criminal and civil investigations, our office also conducts administrative investigations into fraud, waste, abuse, and mismanagement at OPM. We investigate cases involving OPM employees and contractors, including those referred through the OIG Hotline. Integrity investigations may involve whistleblowers and/or retaliation, and are an important part of the OIG's mission of providing independent oversight and reducing program vulnerabilities.

We do not report any integrity investigations this quarter.

Glossary

Improper Payments are disbursements that should not have been made or were made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. The reduction of improper payments is a President's Management Agenda goal across all Executive Branch agencies. In fiscal year 2018, OPM reported Retirement Programs and the FEHBP combined to make more than \$355.5 million in improper payments.

Health Care and Insurance Programs

Carrier Letters are guidance that the OPM Healthcare & Insurance program office provides to health insurance carriers to specify how contracts with the FEHBP and other OPM-administered insurance programs are administered. Carrier letters are intended to be complied with in the same manner as carrier contracts, as they often serve as supplemental information to explain policy complexities.

Carriers are private insurance companies that contract with the FEHBP to provide health insurance benefits to Federal employees and retirees and their dependents. These insurance plans include HMO and fee-for-service health plans.

Compounded Medications are medications (often liquids or creams) made to fit the individual needs of a patient. The U.S. Food and Drug Administration (FDA) does not approve compounded drugs. A variety of health care fraud schemes involve compounded drugs: unscrupulous providers prescribing compounded medications without medical relationships with patients; prescribing medically unnecessary, ineffective, or exorbitantly priced compounded drugs; and prescribing compounded drugs in exchange for inducements or illegal compensation.

The False Claims Act allows for the Federal prosecution of any person who knowingly submits false claims to the Government, including making a false record or statement to cause a false claim to be paid, or acting improperly to avoid paying the Government. It includes civil penalties for each false claim. Additionally, the False Claims Act allows for *qui tam* lawsuits, wherein a member of the public files as a relator to sue on behalf of the Government. The relator may be compensated a percentage of the amount the Government recovers through the lawsuit.

Ineligible Dependents are persons who receive benefits from a Federal employee's benefits plan (most often from the FEHBP) but are not eligible to receive these benefits under statutory or regulatory guidelines. Former spouses, friends, self-sufficient children aged older than 26, and extended family (such as grandchildren) are common ineligible dependents. Any payment to an ineligible dependent is an improper payment.

Medically Unnecessary Services are items and services that are unreasonable or unnecessary for the diagnosis or treatment of an illness or injury. Medically unnecessary

services are often provided in exchange for inducements or as part of health care fraud schemes.

Pass-Through Billing Schemes involve unscrupulous providers paying a laboratory to perform tests but filing claims with an insurance company or Government program as if the provider or a related entity conducted the test. Pass-through billing schemes generate improper payments through inflated reimbursement or as part of an arrangement involving illegal inducements.

Services Not Rendered are procedures, tests, or appointments not performed by a provider but still billed as such, or billed inaccurately to misrepresent services as something eligible for a higher reimbursement than the services actually performed.

Telemedicine provides health care services to a patient by telecommunication, such as via webcam. While the practice increases convenience and care access, it is also vulnerable to a variety of fraud schemes, including those involving opioids and compounded medications.

The Travel Act provides for Federal-level criminalization of business activities that are illegal under certain State laws (e.g., bribery) if interstate commerce, travel, or mail was part of the illegal business activities. Recent use of the Travel Act is a pioneering enforcement strategy that allows us to pursue fraud schemes when relevant State laws have been broken.

Unbundling is a health care fraud scheme where a procedure or office visit is separated into multiple billing codes when the procedure or visit should be billed under a single “panel” or inclusive code. Unbundling creates improper payments through inflated reimbursement.

Special Topic: The Opioid Epidemic

Diversion is the practice of transferring legally prescribed medications from the individual for whom it was prescribed to another person for illicit use.

Opioids are a class of pain medication labeled as **Schedule II drugs**, i.e., “drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence.” While largely safe when taken as prescribed by a doctor and according to medical best practices, opioids are often abused and can cause addiction, overdose, and death. Opioid drugs include **oxycodone**, one of the most common and most abused prescription drugs, and **fentanyl**, which has emerged as a dangerous additive to drugs such as heroin and can lead to overdoses in even small amounts.

Pill Mills are health care providers, facilities, or pharmacies that prescribe and/or dispense drugs without legitimate medical purpose.

Sober Homes aim to provide safe and drug-free residences for individuals suffering from addiction, but unscrupulous sober homes may submit patients to unnecessary, expensive, and excessive testing as part of a health care fraud scheme.

Retirement Programs

Address Verification Letters (AVLs) are sent to Federal retirees and survivor annuitants receiving CSRS/FERS benefits from OPM to verify whether annuitants are living and are living at the address currently on file with 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.

A **Survivor Annuitant** is a surviving spouse or child entitled to receive OPM-administered benefits after the death of a Government employee receiving an annuity.

Reclamation is the process by which the Retirement Services program office attempts to recover funds through the Department of the Treasury for money paid as an annuity to deceased Federal annuitants through a financial institution, such as a bank.

National Security

The **National Background Investigations Bureau (NBIB)** was previously a part of OPM that conducted 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 **Reports of Investigation (ROIs)**.

Integrity

The **Office of Special Counsel (OSC)** investigates and prosecutes prohibited personnel practices, whistleblower retaliation, and other violations that harm the civil service. As an outcome of our integrity investigations involving OPM employees, we may refer cases to the OSC for further action.