# II. OTHER SIGNIFICANT OIG ACTIVITIES

In addition to its operational audit, investigative, contract review, and healthcare inspection roles, the OIG is responsible for a wide range of other significant activities that contribute to fulfilling the OIG's overall mission objective. A description of these activities follows.

## HOTLINE

The Hotline staff operates a toll-free telephone service 24 hours a day, 7 days a week or individuals can send their concerns in writing (address on back cover). In addition, the OIG Hotline has a Homepage (http://www.va.gov/oig/hotline/hotline.htm) on the Internet and E-mail access. Calls, letters, and E-mail are received from employees, veterans, the general public, the Congress, GAO, and other Federal agencies reporting issues of fraud, waste, and abuse. Due consideration is given to all complaints and allegations received, with each addressed by OIG or other Departmental staff and a response provided to the reporting individual.

### 1. HOTLINE CASES PROCESSED

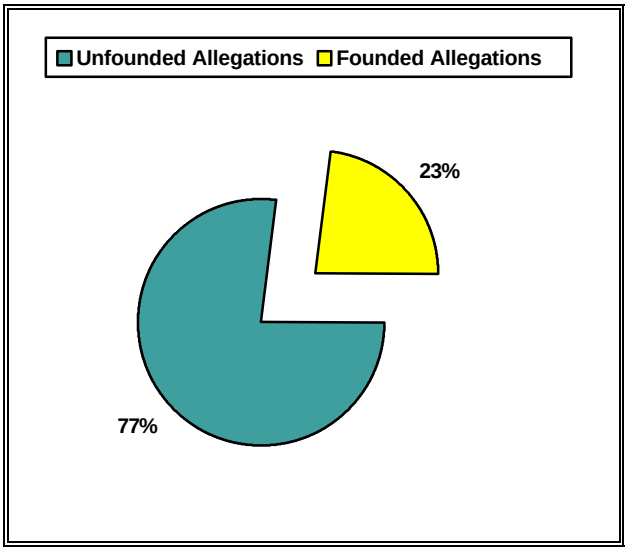
During the period, the Hotline Section received 9,745 contacts, with 357 cases opened and referred, and 311 cases closed, as follows:

| HOTLINE WORKLOAD | |
|---|---|
| **Total Contacts** | **9,745** |
| **Cases opened and referred*** | **357** |
| OIG Audit | 2 |
| OIG Investigations | 18 |
| OIG Hotline and Special Inquiries | 24 |
| OIG Healthcare Inspections | 12 |
| Other OIG | 1 |
| VA Program Managers | 304 |
| **Cases closed** | **311** |

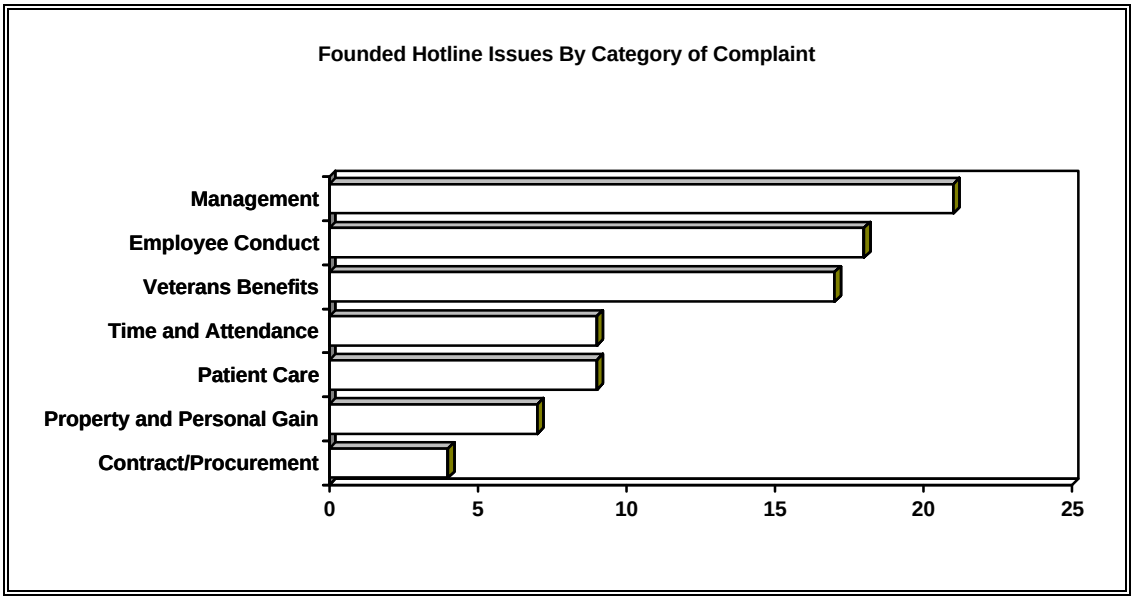
* Some cases referred to more than one office.

## 2. FOUNDED ALLEGATIONS

Of the 311 cases closed during this period, 70 cases contained founded allegations. The following graph illustrates the percentage of cases warranting corrective actions.




The majority of the issues associated with the founded allegations concerned management, employee conduct, veterans benefits, time and attendance, patient care, property and personal gain, and contract/ procurement irregularities. The following table illustrates the number of complaints by category for the founded allegations.



As a result of these reviews, VHA managers imposed 28 administrative sanctions (e.g. counselings, admonishments, reassignments, and terminations) against employees during this reporting period. A total of $370,000 in potential recoveries was also identified. Following are examples of allegations that were founded for each of the categories listed on the preceding table.

**Management**

- A VHA review substantiated allegations of illegal personnel actions, unauthorized mileage payments, and an administrative error concerning a date on an employee's resignation action at a VAMC. Bills of collection in the amounts of $3,623 and $2,077 were issued to recoup excessive salaries paid. A bill for $2,581 was also issued to an employee for mileage payments that should not have been authorized. A senior official was admonished for authorizing the two illegal personnel actions. Corrective action was also taken concerning an incorrect date on an employee's resignation action.

**Employee Misconduct**

- A VHA review revealed that a former agent cashier at a VAMC was granted relief from a $1,400 liability, while a lead cashier confessed to the FBI that he was responsible for the shortage. The lead cashier was terminated from VA employment, and is making payments for the liability. The former finance section chief was reassigned and cashiers were given detailed instructions and training.

- The VHA reviewed allegations of mismanagement and employee misconduct at a VAMC and found that VAMC employees were conducting personal business on government property and during working hours. The VAMC issued 3 written counselings, 2 verbal counselings and 1 admonishment in connection with employee wrongdoing. In addition, a 14-day suspension and reassignment were proposed concerning an employee soliciting and transacting personal business on government property during scheduled work hours.

**Veterans Benefits**

- The VBA conducted a review to determine if a claimant was receiving payment for dependents under false pretenses. The claimant did not reply to a request for information concerning her dependents. Therefore, the VA reduced her award by removing entitlement for the children creating a debt of $6,842.

- A VBA review substantiated allegations that a claimant was engaged in conduct warranting the inference of remarriage and was no longer entitled to a Dependency and Indemnity Compensation award.

The claimant was advised of the termination of benefits and the resulting debt of $131,161.

**Time and Attendance**

- A VHA review addressed numerous allegations involving a VA police officer. The review disclosed that, in several incidents, the validity of the officer's entries in a daily journal of activities performed conflicted with records of his personal medical center appointments, for which he should have taken leave. The employee was counseled and issued a letter of reprimand for the falsification of official records and time and leave abuse.

**Patient Care**

- A VHA review substantiated that a medication error occurred and that it was not clearly communicated that the veteran should have discontinued taking the medication. It was also noted that the veteran's chart was not immediately available to the pharmacist. The process of returning charts to the file room was corrected and charts are now being returned in a timely manner. In addition, pharmacists were reminded to continue to utilize every opportunity to educate veterans and their families regarding their roles in medication administration.

- A VHA review substantiated allegations that a veteran was given a controlled substance prescription that had the wrong physician's name on the bottle. The review disclosed that the prescription was processed accurately with the exception that the pharmacist entered the wrong physician name in the computer system. Policies and procedures were reviewed with the responsible pharmacist to ensure that data entry requirements for prescriptions are met.

**Property and Personal Gain**

- A VHA review substantiated that a team leader at a vet center falsely identified his facility as a radio station, improperly received recordings from approximately 10 record distributors or companies over a 7-year period, and utilized promotional items he received for personal use. The employee was directed to discontinue any reference to the facility as a radio station and may not receive any promotional and related items from record distributors and companies. In addition, the employee received a 5-day suspension.

**Contract/Procurement**

- An OIG review substantiated allegations of improper contract procedures at a VAMC. The former Contracting Officer's Technical Representative for the VAMC was sentenced to a term of 12 months probation with a special condition to perform 150 hours of community service. In addition, he was to pay a $1,000 fine, a

monthly probation fee of $195 for the term of his probation, and a special assessment fee to the court of $50.

## FORENSIC DOCUMENT LABORATORY

The OIG operates a nationwide forensic laboratory service for fraud detection which can be utilized by all elements of VA. The types of requests routinely submitted to the laboratory include handwriting analysis, typewriting, inks, paper, photocopied documents, and suspected alteration of official documents. During this reporting period, the forensic laboratory received 513 documents from various non-OIG sources which required 1,448 laboratory examinations. The laboratory received 502 additional pieces of evidence in 8 OIG criminal investigations, which required 1,618 laboratory examinations. There were a total of 38 laboratory reports issued during the period covered by this report.

| LABORATORY CASES FOR THE PERIOD | |
|---|---|
| **REQUESTER** | **CASES COMPLETED** |
| OIG Office of Investigations | 8 |
| Regional Offices | 24 |
| Medical Centers | 2 |
| OIG U.S. Small Business Administration | 1 |
| VA Top Management | 3 |
| **TOTAL** | **38** |

The following are examples of the fraudulent activities that were involved and the laboratory work that was completed:

- The Board of Veterans Appeals requested forensic laboratory examinations concerning a veteran who submitted medical records in support of his claim for service-connection for a psychiatric disorder. Laboratory examinations identified the veteran as the author of fraudulent handwritten entries on four medical records.

- Court testimony was requested in a VA OIG investigation of a VA veterans benefits counselor. The counselor solicited and accepted bribes from widows of deceased veterans in order to expedite and process their claims. Two laboratory reports were issued in this case which identified the veterans benefits counselor as the author of handwritten entries on documents used in the bribery scheme. The counselor pleaded guilty to three counts of soliciting bribes by a public official, and one count of tampering with a Federal witness.

- Court testimony was requested in a VA OIG investigation of a former VA food service foreman and his wife, the VA chief of labor

relations at a VAMC. Forensic laboratory examinations identified the husband and wife as the author of handwritten false statements which they conspired to use in order to secure workers' compensation payments. Both individuals pleaded guilty to making false statements in connection with the husband's claim for compensation.

- Eight requests were received from the VA regional office Manila, Philippines, for handwriting, fingerprint, paper, ink, photocopy, and typewriter laboratory examinations in eight different cases. The documents examined will be used by the office to determine the eligibility of veterans or their widows for VA benefits. The documents consisted of military service and medical records. Laboratory examinations of documents in the eight cases determined that the questioned documents were fraudulent. In addition, laboratory examinations determined that the same individuals authored fraudulent signatures in several different cases. It also was determined that a single typewriter was used to create fraudulent documents in several different cases.

## REVIEW OF LEGISLATION AND REGULATIONS

The OIG reviews existing and proposed legislation and regulations relating to Department programs and operations. The OIG makes appropriate comments and recommendations concerning the impact of the legislation and regulations on economy and efficiency in the administration of programs and operations or the prevention and detection of fraud and abuse.

During this period, 25 legislative and 68 regulatory proposals were reviewed and commented on, as appropriate. We are concerned with the impact of acquisition reform legislation as explained below.

**Acquisition Reform Legislation**

The process of federal procurement reform has resulted in the passage of the Federal Acquisition Streamlining Act of 1994 (FASA), P.L. 103-355, and the Federal Acquisition Reform Act of 1996 (FARA), P.L. 104-106. We are concerned about the impact of this legislation on postaward audits involving VA's $10 billion Multiple Awards Schedule (MAS) contracting program for health care products. Presently, the General Services Administration (GSA) is preparing to issue a final rule which will address the commercial item acquisition provisions of FASA and FARA through reform of GSA's and VA's MAS program. A major issue is whether postaward audit rights will be retained in the final rule. The Department of Justice, and VA and GSA Inspectors General continue to argue for retention of these rights to protect the Government and ultimately the American taxpayer from paying inflated prices on its contracts due to inaccurate or fraudulent pricing disclosures.

Historically these contractual rights have allowed the VA OIG to review the contractor's pricing records to ensure that awarded contract prices were based on the contractor providing the VA contracting officer with accurate and complete pricing information during negotiations. An estimated 85 percent of the OIG postaward reviews of FSS contracts resulted in significant monetary recoveries to VA for contract overcharges. Since October 1993, these recoveries have amounted to approximately $53 million. The annual costs of doing these reviews is about $1 million. We believe the postaward audit program is entirely commensurate with VA's efforts to deliver the best health care products at the best prices to the veteran population.

## OIG MANAGEMENT PRESENTATIONS

**Participation in Financial Statement Audit Task Force**

During this reporting period, OIG financial audit staff continued its participation in the "Governmentwide Financial Statement Audit Task Force" subgroup on credit reform accounting and auditing issues. The subgroup consists of GAO, OMB, CFO and OIG participants. They are focusing on key accounting and auditing issues facing the audit of the FY 1997 government-wide financial statements. VA OIG staff also participated in the Federal Audit Executive Counsel subgroup on financial statement audits.

**National Academy of Public Administration Presentation**

Office of Inspector General staff met with staff of the National Academy of Public Administration to brief them on major issues facing VBA and the Board of Veterans Appeals. We discussed action taken or planned to correct long-standing deficiencies, and impediments to timely and accurate delivery of benefits and services to veterans and other beneficiaries.

## OIG CONGRESSIONAL TESTIMONY

On March 18, 1997, the Deputy Inspector General testified before the United States House of Representatives, Committee on Government Reform and Oversight, Subcommittee on Human Resources, at a hearing on "Department Oversight - Mission, Management and Performance." The testimony addressed management and programmatic issues facing VA.

## FREEDOM OF INFORMATION/PRIVACY ACT/OTHER DISCLOSURE ACTIVITIES

During this reporting period, we processed 124 requests under the Freedom of Information and Privacy Acts and released 233 audit, investigative and other OIG reports. We totally denied five requests under the appropriate exemptions of the Acts. Information was partially withheld in 98 requests because release would have

constituted an unwarranted invasion of personal privacy, interfered with enforcement proceedings, disclosed the identity of confidential sources, disclosed internal Department matters, or was specifically exempted from disclosure by statute.

## OBTAINING REQUIRED INFORMATION OR ASSISTANCE

Sections 5(a)(5) and 6(b)(2) of the Inspector General Act of 1978 require the Inspector General to report instances where access to records or assistance requested was unreasonably refused, thus hindering the ability to conduct audits or investigations. During this 6-month period, there were no reportable instances under these sections of the Act.

Under P.L. 95-452, the IG has authority ". . . to require by subpoena the production of all information, documents, reports, answers, records, accounts, papers, and other data and documentary evidence necessary . . . ." The use of IG subpoena authority has proven valuable in our efforts, especially in cases dealing with third parties. During this reporting period, 33 subpoenas were issued in conjunction with various OIG investigations and audits.