Department of Veterans Affairs
Office of Inspector General
August 2011 Highlights

OIG REPORTS

Misinterpretation of Reporting Guidance Results in Unreported Overpayments

As required by Executive Order 13520 on reducing improper payments, the Office of Inspector General (OIG) reviewed VA's fiscal year (FY) 2010 First Quarter High-Dollar Overpayments Report to determine if it was complete and the process to identify susceptible programs was adequate. OIG found that the report was incomplete primarily because the Veterans Benefits Administration (VBA) misinterpreted guidance and did not report 143 high-dollar overpayments totaling $623,434. VBA also did not adequately consider including an additional 39,208 potential high-dollar overpayments totaling $213 million. VBA made adjustments after the first quarter to improve compliance, but VBA's process still did not fully follow guidance for identifying the high-dollar overpayments. OIG also found Veterans Health Administration's (VHA) FY 2009 risk assessment did not adequately assess the level of risk associated with their programs. OIG recommended the Under Secretary for Benefits report prior period overpayments and administrative errors as required; and the Under Secretary for Health implement planned improvements to risk assessments. [Click here to access report.]

More Work Needed To Fully Execute IT Project Management Accountability System

At the request of the Chief Information Officer (CIO), OIG evaluated the effectiveness of Project Management Accountability System (PMAS) planning and implementation. VA has a history of problems managing its information technology (IT) development projects. VA launched PMAS in 2009 to improve its IT development success rate. OIG found the Office of Information and Technology (OIT) has made progress establishing PMAS. It published a PMAS Guide, developed a prototype system for monitoring project status, and used the oversight approach to better meet incremental deliverable due dates for all active IT development projects. However, OIT created and instituted the PMAS concept without a roadmap, adequate leadership, and staffing to effectively implement and manage this new methodology. OIG made six recommendations that the CIO agreed to implement. [Click here to access report.]

Allegations of Clinical and Administrative Issues Not Substantiated at Pineville, Louisiana, VA Medical Center

OIG performed an inspection at the Alexandria VA Medical Center (VAMC), Pineville, LA, to determine the validity of allegations regarding clinical and administrative issues in the Suicide Prevention Program. The complainant alleged that there were more than 600 patients on the "high risk for suicide" list who were not being monitored as required; that confidentiality and privacy were being breached in several program areas; and that Social Work Service leaders were not providing adequate oversight of programs, were not responsive to complaints, and were not appropriately addressing peer review findings. OIG found that at one point, there were over 400 patients on the "high risk for suicide" list; however, this condition no longer existed at the time of OIG's site visit and

OIG found that the revised monitoring system meets VHA requirements. OIG did not substantiate breaches in confidentiality or privacy, lack of management oversight, or inadequate follow-up of peer reviews findings. OIG made no recommendations. [Click here to access report.]

Deficiencies Noted in Prescribing Practices at Tyler VA Primary Care Clinic, Tyler, Texas

OIG's Office of Healthcare Inspections conducted an evaluation to determine the validity of allegations regarding inadequate medical and mental health care for a patient at the Tyler VA Primary Care Clinic in Tyler,TX. The complainant further alleged that the patient had dementia and facility providers disregarded her concerns. OIG substantiated the allegation that facility providers improperly prescribed opioids and alprazolam to the patient. Specifically, the following deficiencies were identified in prescribing practices: (a) inconsistent documentation of pain assessments, (b) absence of a written opioid treatment agreement or urine drug tests, (c) no consideration of non-pharmalogical approaches for pain management, and (d) absence of evaluations of opioid therapy effectiveness. However, OIG could neither substantiate nor refute the allegation that prescribing practices contributed to his overdose and death. OIG found no evidence to support the allegation that the patient had dementia or otherwise lacked decision-making capacity. OIG recommended that the System Director ensures that providers document pain assessments for patients on opioid therapy and monitor and evaluate these patients in accordance with VHA policies. [Click here to access report.]

OIG Reviews VA Regional Offices in Columbia, South Carolina, and Buffalo, New York

The Benefits Inspection Division conducted an onsite inspection of the Columbia, SC, VA Regional Office (VARO) to review disability compensation claims processing and Veterans Service Center operations. OIG found staff followed VBA's policy for establishing dates of claim, processing incoming mail, completing Systematic Analyses of Operations (SAOs), and correcting errors identified through the Systematic Technical Accuracy Review (STAR) program. VARO performance was generally effective in processing post-traumatic stress disorder (PTSD) claims and handling mail. The VARO lacked effective controls and accuracy in processing some disability claims. Inaccuracies processing temporary 100 percent disability evaluations occurred because staff did not schedule future medical reexaminations as required. Inaccuracies related to traumatic brain injury (TBI) claims and herbicide exposure-related claims resulted from inadequate quality assurance. Overall, VARO staff did not accurately process 33 (32 percent) of the 104 disability claims reviewed. OIG also noted the VARO did not meet the 7-day standard in recording Notices of Disagreement (NODs) for appealed claims. However, the VARO's processing timeliness for NODs was 73 days less than the national average. OIG recommended VARO management implement controls to improve its quality review process for TBI and herbicide exposure-related claims processing. The VARO Director concurred with our recommendations. [Click here to access report.]

In a similar review of the Buffalo, NY, VARO, OIG found staff correctly established dates of claim in the electronic record and were generally effective in processing PTSD claims and correcting errors identified by VBA's STAR program staff. However, they lacked accuracy in processing temporary 100 percent disability evaluations, which resulted when future medical reexaminations were not scheduled. Staff incorrectly interpreted policy, using insufficient medical examinations to process TBI claims. Inadequate training and oversight lead to errors in herbicide exposure-related disability claims. Overall, VARO staff did not correctly process 32 (32 percent) of the 101 disability claims reviewed. VARO management did not ensure staff completed SAOs, properly processed mail, and immediately completed final competency determinations. OIG recommended the VARO Director follow policy on timely processing of temporary disability reevaluations, implement a plan to review adequacy of training on processing herbicide exposure-related claims, and provide refresher training and return inadequate medical examination reports to hospitals for correction to support proper processing of TBI claims. Management also needs to ensure oversight and control of mail handling and completion of SAOs. The VARO Director concurred with our recommendations. [Click here to access report.]

CRIMINAL INVESTIGATIONS

Former VA Field Examiner and Fiduciary Plead Guilty to Embezzling $900,000

A former VA Field Examiner and a court appointed fiduciary pled guilty to a criminal information that charged both defendants with theft of Government funds and conspiracy. An OIG and Federal Bureau of Investigation (FBI) investigation revealed that for approximately 10 years the defendants stole nearly $900,000 from 12 Veterans' bank accounts. The defendants lost large sums of the embezzled money gambling in casinos. The OIG Office of Audit and Evaluations provided significant assistance with this case.

Columbia, South Carolina, Nurse's Aide Indicted for Sexual Assault

A Columbia, SC, VAMC nurse's aide was indicted for criminal sexual conduct, sexual battery of a physically helpless adult, and false statements. The employee gave a sworn statement denying the charges, but following an OIG polygraph exam, he confessed to touching the patient's genitals. The Veteran patient was an amputee and a resident of the VAMC's nursing home.

Subject Arrested for Sexual Assault at Perry Point, Maryland, VAMC

An AmeriCorps member, residing in leased housing at the Perry Point, MD, VAMC, was arrested after being indicted on various charges related to committing a sexual assault. An OIG and State police investigation revealed that the defendant sexually assaulted a female AmeriCorps member at her residence, located on the grounds of the VAMC. The defendant remains in custody pending trial.

Multiple Arrests Made in Major Palm Beach, Florida, Drug Distribution Investigation

A 7-month OIG and Palm Beach County, FL, multi-agency diversion task force undercover investigation resulted in the arrests of 7 VA employees, 3 Veterans, and

10 associates for numerous felony drug charges. This operation focused on combating the sale and distribution of illicit and controlled pharmaceutical drugs at the West Palm Beach, FL, VAMC and the surrounding community. The investigation resulted in the recovery of 6,000 oxycodone pills and $180,920.

Veteran Indicted for Arson at Chicago, Illinois, VAMC
A Veteran was indicted for aggravated arson after setting fire to his room at the Chicago, IL, VAMC. The fire caused damage to the room and extensive smoke and water damage throughout the ward. The investigation further revealed that the defendant tampered with the ceiling-mounted fire suppression sprinkler heads, causing them to malfunction during the fire.

Subject Arrested for Robbery of Veteran at Fayetteville, North Carolina, VAMC
A subject was arrested for robbery after an OIG and local law enforcement investigation revealed that he assaulted and robbed a Veteran on the grounds of the Fayetteville, NC, VAMC. The Veteran sustained a broken nose and several lacerations and contusions to his face. The defendant has an extensive criminal record to include assault with a deadly weapon with intent to kill and narcotic-related offenses.

Buffalo, New York, VAMC Employee Pleads Guilty to Bribery
A Buffalo, NY, VAMC employee pled guilty to bribery after an OIG investigation revealed that, from approximately 1992 to 2008, he received gift certificates, gift cards, and cash totaling $46,075 from a vendor's sales agents in exchange for making purchases from that vendor.

Son-in-Law of Incompetent Veteran Sentenced for Elder Abuse
The son-in-law of an incompetent and disabled Veteran was sentenced to 19 to 23 months' incarceration and ordered to participate in a substance abuse program after pleading guilty to the exploitation of a disabled or elderly adult. An OIG, Social Security Administration OIG, local law enforcement, and social services investigation revealed that the defendant and his wife stole $213,662 from the Veteran and that they physically and mentally abused the Veteran for several years. Collaborative efforts resulted in the Veteran being placed in a safe environment with a fiduciary.

Veteran Sentenced to Incarceration for Travel Fraud
A Veteran was sentenced to 6 months' incarceration, 3 years' supervised release, and ordered to pay $20,464 in restitution after pleading guilty to making a false claim. An OIG investigation determined that for approximately 1 year the defendant filed 202 false travel vouchers at the Spokane, WA, VAMC, claiming that he resided in Omak, WA, with a resulting commute to the medical center of approximately 182 miles. The Veteran actually resided less than 2 miles from the medical center.

Veteran Sentenced for Theft of Travel Benefits
A Veteran was sentenced to 5 years' probation and ordered to pay restitution of $28,655 after pleading guilty to theft of Government funds. An OIG investigation revealed that the Veteran filed 336 fraudulent travel claims at the VAMC's in Gainesville

and Lake City, FL. The Veteran falsely claimed that he was traveling from Tallahassee, FL, to the VAMC.

Former Durham, North Carolina, VAMC Employee Arrested for Purchase Card Fraud
A former Durham, NC, VAMC employee was arrested on fraud charges after an OIG investigation revealed that she purchased $7,200 worth of home furnishings using her VA purchase card. All of the purchased items were discovered during a search of the defendant's home. The defendant's VA employment was terminated following a pattern of misconduct.

Fee Basis Dentist Charged with Wire Fraud
A VA fee basis dentist was charged with wire fraud after an OIG and FBI investigation revealed that she fraudulently billed VA for dental treatments on homeless Veterans that were never performed. The dental treatments were offered to Veterans as part of the VA Palo Alto Health Care System's Homeless Veteran Rehabilitation Program (HVRP). Fifteen Veterans participating in the VA's HVRP were authorized treatment from the defendant, and 12 of the 15 Veterans never received any treatment. The investigation also revealed that the defendant had a conscious sedation permit and was diverting controlled substances from her dental practice to support her personal addiction. The loss to VA is $27,898.

Physician's Assistant and Wife Arrested for Defrauding VA
A physician's assistant and his wife were arrested for conspiracy to commit health care fraud, false claims, and aiding and abetting after an OIG investigation revealed that the two defendants were fraudulently conducting disability rating examinations of Veterans. The company's contract with VA required that a physician perform all disability rating examinations conducted at the clinic. However, the investigation determined that the defendants conducted 337 of the 347 exams performed at the clinic between September 2005 and August 2008 and forged the signature of the company's medical director, who is a physician, on all of the reports. The defendants then submitted the reports and claims to VA for payment. The loss to VA is $154,219.

Daughter of Deceased Beneficiary Indicted for Theft of Government Funds
The daughter of a deceased beneficiary was indicted for theft of Government funds after an OIG investigation determined that she withdrew VA funds from a bank account after her mother's death in December 2001. The defendant contacted VA posing as her deceased mother in order to continue to obtain VA benefits. The loss to VA is $104,000.

Veteran Indicted for Education Fraud
A Veteran was indicted for identity fraud and false statements after an OIG investigation revealed that he submitted a fraudulent DD-214 to VA in support of an application for education benefits under the Montgomery GI Bill.

Former VA OIT Employee Sentenced for Identity Theft
A former VA OIT employee was sentenced to 11 years' incarceration, 3 years' supervised release, and ordered to pay $464,599 in restitution. An OIG and Internal Revenue Service Criminal Investigation Division investigation revealed that the defendant, while employed by VA, stole the personal identifiable information of at least 160 Veterans to create fraudulent tax documents without the Veterans' knowledge.

Three Arrested for Identity Theft
Three individuals were arrested for attempting to obtain a controlled substance by fraud. In addition, one of the defendants pled guilty and was sentenced to 12 months in a drug treatment program. An OIG, VA Police, and local police investigation revealed that the defendants conspired with an employee of the American Lake Division of the VA Puget Sound Health Care System in Tacoma, WA, to steal patient information in order to obtain narcotics, to include oxycodone. As part of the scheme, the VA employee and the other defendants obtained veteran information from VA patient records and from a local Veterans of Foreign War facility. The VA employee then used the veteran information on fraudulent VA prescriptions sent to local pharmacies. The employee previously pled guilty to her part of the scheme and resigned from VA employment.

Former Leavenworth, Kansas, VAMC Canteen Employee Pleads Guilty to Theft
A former Leavenworth, KS, VAMC canteen employee pled guilty to theft of Government funds after an OIG and Department of Labor (DOL) OIG investigation revealed that between 2003 and 2008 the defendant concealed approximately $577,000 in earnings from VA and DOL while managing a subcontracting business and receiving workers' compensation benefits. The defendant also stole, forged, and negotiated approximately $27,000 in Office of Workers' Compensation benefit checks intended for her deceased brother, a former Postal Service employee and service-connected Veteran. The loss to VA is approximately $175,000.

Veteran Arrested for "Doctor Shopping" to Obtain Oxycodone
A Veteran, who is also a local sheriff's deputy, was arrested for withholding information from a practitioner and prescription fraud. An OIG and local task force investigation revealed that the defendant simultaneously acquired oxycodone and other scheduled drugs from VA and multiple non-VA providers. The defendant violated her pain management contract with VA by not informing VA that she received oxycodone from non-VA providers.

Former Nashville, Tennessee, VAMC Nurse Sentenced for Drug Diversion
A former Nashville, TN, VAMC registered nurse was sentenced to 2 years' incarceration (suspended) and 2 years' supervised probation after pleading guilty to obtaining a controlled substance by fraud. An OIG investigation revealed that for 6 months the defendant stole approximately 5 tablets of hydrocodone and/or oxycodone every week from the Nashville, TN, VAMC.

Company Manager Sentenced for Perjury and Forgery
A regional accounts receivables manager of a company that provided nursing home services was sentenced to 10 months' incarceration after pleading guilty to perjury and forgery. The state judge ordered the defendant to serve the sentence concurrently with an earlier sentence of 18 months' incarceration. A Federal and State investigation revealed that the defendant provided false documents concerning a resident receiving nursing home care and lying about the matter in civil court.

Ambulance Service Company Enters into $2.7 Million Settlement Agreement with Government
An ambulance company that provided services to and received payment from various Federal programs to include VA entered into a settlement agreement, agreeing to pay over $2.7 million in damages. The settlement was the result of a VA OIG, Health and Human Services OIG, FBI, Office of Personnel Management OIG, and United States Postal Inspection Service investigation that revealed the ambulance company engaged in questionable billing practices by up-coding transactions to include billing for advanced life support transport when only a basic life support transport occurred or transporting patients by ambulance when other forms of transportation were more appropriate and less expensive. VA received $11,327 as a result of this investigation.

Former West Los Angeles, California, VAMC Chief Financial Officer Indicted for Possession of Child Pornography
A former West Los Angeles, CA, VAMC Chief Financial Officer was indicted for possession of child pornography. During an OIG and Internet Crimes Against Children Task Force investigation, numerous DVDs, CDs, and a computer hard drive containing images of child pornography were found in the defendant's residence, which was located on VA property.

Fugitive Veteran Arrested with Assistance of OIG
The OIG, working with a United States Marshals Fugitive Apprehension Strike Team, arrested a Veteran wanted for the sexual abuse of a child. The Veteran had previously been convicted of murder and manslaughter.

(original signed by Richard J. Griffin,
Deputy Inspector General for:)
GEORGE J. OPFER
Inspector General