Department of Veterans Affairs
Office of Inspector General
June 2012 Highlights

CONGRESSIONAL TESTIMONY

Office of Inspector General Updates House Veteran Affairs' Committee on Reviews of VA's Prime Pharmaceutical Vendor Contract

Linda A. Halliday, Assistant Inspector General (AIG) for Audits and Evaluations, and Maureen Regan, Counselor to the Inspector General, testified before the Committee on Veterans' Affairs, United States House of Representatives, on the results of a recent Office of Inspector General (OIG) report, *Review of the Controls for the Pharmaceutical Prime Vendor Fast Pay System*, and provided an update on ongoing work to review alleged contract violations. OIG found that VA implemented controls to provide timely and accurate payments for pharmaceutical items processed through VA's Fast Pay system and complied with applicable laws, regulations, and policies; however, quicker corrections of pricing differences is needed. OIG's review of open market purchases found that the open market purchases were significantly less than originally believed. OIG found that the PPV was doing a good job of adjusting prices through credits and rebillings to ensure that contract items are purchased at contract prices when VA provides data. Ms. Halliday was accompanied by Mr. Gary Abe, Director of the OIG's Seattle Office of Audits and Evaluations. Ms. Regan was accompanied by Mr. Michael Grivnovics, Director of the Federal Supply Schedule Division. [Click here to access testimony.]

Accuracy and Timeliness Continue to Challenge VBA in Processing Disability Claims for Veterans, AIG Tells House Committee on Veterans' Affairs

Ms. Halliday testified before the Committee on Veterans' Affairs, United States House of Representatives, on OIG reports related to the Veterans Benefits Administration's (VBA's) operations. These included a series of inspections of VA Regional Offices (VAROs), and OIG's reports on *Veterans Benefits Administration - Audit of 100 Percent Disability Evaluations; Audit of VA Regional Offices' Appeals Management Processes; Audit of VA's Internal Controls Over the Use of Disability Benefits Questionnaires*. OIG's inspections and audit work have consistently shown that VAROs do not always comply with VBA's national policy and struggle with implementing effective workload management plans and clear and consistent guidance to accomplish their benefits delivery mission. While VBA has made some incremental progress through its own initiatives and in response to OIG's prior report recommendations, more work remains to be done. Ms. Halliday was accompanied by Mr. Larry Reinkemeyer, Director of the OIG's Kansas City Office of Audits and Evaluations; Mr. Nick Dahl, Director of the OIG's Bedford Office of Audits and Evaluations; and Mr. Brent Arronte, Director of the OIG's Bay Pines Benefits Inspections Division. [Click here to access testimony.]

ADMINISTRATIVE INVESTIGATIONS

OIG issued two restricted reports this month, *Administrative Investigation, Falsification of Employment Record, Travel Irregularities, and Misuse of Position, VA Learning University, VA Central Office* (Report No. 11-04049-205, Issued 06-19-12) and

Administrative Investigation, Improper Locality Pay and Failure to Follow Federal Travel Regulations, Technology Transfer Program, VA Central Office
(Report No.11-03461-217, Issued 06-28-12). The Freedom of Information Act office may be contacted with questions regarding these restricted reports.

OIG REPORTS

Audit Shows Effective Planning, Use of National Cemetery Administration's Fiscal Years 2010/2011 Operations and Maintenance Budget

OIG determined the National Cemetery Administration (NCA) effectively budgeted and used operations and maintenance funds as intended. For Fiscal Years (FYs) 2010 and 2011, the budget authority increased 38 percent from the FY 2009 budget for operations and maintenance. NCA effectively planned its FY 2010 budgetary process using appropriated operations and maintenance funds. In addition, the controls over budget implementation were adequate. OIG identified minor conditions that needed correction to improve equipment accountability. However, these issues were not considered significant or systemic. OIG discussed these minor conditions with NCA's local management on a site-specific basis, and NCA took actions to address OIG's concerns. OIG made no recommendations in this report and did not require a written response. [Click here to access report.]

Nursing Care, Leadership Found Lacking at St. Louis Dialysis Unit

OIG conducted an inspection to determine the validity of allegations regarding the provision of nursing care in the hemodialysis (HD) unit of the John Cochran Division of the St. Louis VA Medical Center VA Medical Center (VAMC). Specifically, a complainant alleged that a licensed practical nurse (LPN) did not provide appropriate care to two HD patients, resulting in their subsequent need for emergency care, and that the HD unit had nursing leadership issues that affected patient care. OIG substantiated that the subject LPN did not recognize and report changes in the condition of Patient 1 during HD but did not substantiate the LPN provided less than standard care for Patient 2. OIG did not substantiate the allegation that the HD nurse manager favored the subject LPN or that nursing practice changes unfairly affected HD nursing staff. The HD unit had multiple problems that required improvement. The unit was lacking a strong leadership presence in the nurse manager and charge nurse roles. It was difficult to differentiate between the role of the Registered Nurses and the LPNs. There was no defined responsibility for the charge nurse and no policy for reporting events to the charge nurse or a physician. OIG made six recommendations. [Click here to access report.]

Review Supports Denial of Liver Transplant, But Policy Should Be Reconsidered

At the request of Congressman John Kline, OIG reviewed why a Veteran patient was "unable to receive a [liver] transplant through the VA system." The patient in question had chronic hepatitis C that had progressed to the point that without a liver transplant it would almost certainly be fatal. OIG found that the patient was indeed "unsuccessful in obtaining approval for a VA transplant." Two VA Transplant Centers (VATCs) did not accept the patient as a candidate for further evaluation, and on appeal, a third VATC also did not accept him as a candidate for further evaluation. Ultimately, the patient had

a liver transplant at a non-VA facility. OIG found that each of the three reviewing VATCs made a decision based upon the clinical data presented and in a manner consistent with Veterans Health Administration (VHA) policy. Nevertheless, OIG was concerned that while the VATC listed the presence of a cardiac stent (which this patient had) as an absolute contraindication to liver transplantation for the appeal, other VATCs do consider patients with cardiac stents. OIG concluded that when a patient has a condition regarded as an absolute contraindication at some but not all VATCs, the patient's case should be evaluated by VATCs that do not view that condition as an absolute contraindication. OIG recommended that VHA consider whether or not changes to their review process should be made to address facility specific absolute contraindications to transplants. In response, VHA reconsidered its policy but decided to continue its referral process as it is currently designed. [Click here to access report.]

OIG Makes Six Recommendations To Improve Management of Workplace Violence at VHA Facilities

OIG completed an evaluation of the management of workplace violence (WPV) in VHA facilities. The purpose of the evaluation was to determine the extent to which VHA facilities managed violent incidents. OIG conducted this review at 29 facilities during Combined Assessment Program reviews performed from April 1–September 30, 2011, and identified six areas where VHA needed to strengthen requirements and facilities needed to improve compliance. OIG recommended that VHA's comprehensive national guidance for managing WPV be formalized in a directive(s) or a handbook and that policy development include formalizing comprehensive national guidance for managing WPV that establishes procedures for managing disruptive or violent behavior by employees and others. OIG also recommended that facility managers monitor compliance with VHA policy related to WPV programs and management of disruptive behavior; that facilities periodically assess all work areas for risk of violence; and that facilities provide specialized WPV prevention training to all supervisors and to employees who work in high-risk areas, assess competence annually, and provide refresher training. [Click here to access report.]

Allegations of Poor Surgical Care Not Substantiated at the West Palm Beach VAMC, West Palm Beach, Florida

OIG conducted an inspection in response to an anonymous survey respondent's allegations of poor surgical care and inadequate follow-up of adverse outcomes at the West Palm Beach VAMC. OIG did not substantiate that three patients experienced adverse outcomes because an Ear, Nose, and Throat (ENT) surgeon did not possess the necessary qualifications or competence to care for otolaryngology patients. OIG also did not substantiate that the surgeon exercised poor judgment. The ENT surgeon met competency expectations, he was appropriately privileged to perform the surgeries in question, and his performance was periodically reviewed as part of the reprivileging process. OIG found that reporting and evaluation of adverse events needed improvement. Surgical staff did not appear to understand the requirement to report serious adverse events or to use the correct disclosure template. OIG made two recommendations related to staff training and disclosure of adverse events. [Click here to access report.]

Allegations of Quality of Care Issues and Lack of Management Responsiveness Not Substantiated at the VA Caribbean Healthcare System, San Juan, Puerto Rico
OIG reviewed allegations regarding quality of care issues and management responsiveness at the VA Caribbean Healthcare System, San Juan, PR. OIG did not substantiate that improper technique during a cystoscopy caused an infection. OIG also could neither confirm nor refute that the resident who performed the procedure ignored the patient's complaints of pain. OIG did not substantiate that management was unresponsive to the patient's concerns. While not one of the complainant's allegations, OIG found that the informed consent process was not completed according to policy regarding the change in practitioner prior to the procedure. OIG recommended the System Director implement measures to ensure the informed consent process complies with VHA requirements. [Click here to access report.]

Allegations Surrounding Surgical Care at Martinsburg, West Virginia, VAMC, Not Founded, but Improvements Needed in Management of Response Teams
OIG evaluated allegations regarding oversight and perioperative patient safety at the Martinsburg, WV, VAMC. OIG did not substantiate lack of facility action after observing discolored surgical instruments or intraoperative microfibers, a surgeon's responsibility for high or underreported blood loss, or facility failure to provide oversight of surgical events. Although OIG substantiated that a surgeon remained on duty following a sentinel event, no requirement was found for removal. OIG recommended conducting a risk assessment regarding temporary relief from duty. OIG did not substantiate delays in diagnosis or surgical mismanagement but did identify a lack of documentation and recommended that practitioners record treatment decision-making processes. OIG substantiated deficiencies in patient flow and recommended training for staff in perioperative locations on equipment and reporting near-miss patient safety incidents. OIG did not substantiate that the facility added surgery services without planning for support. While OIG substantiated canceled or delayed surgeries due to lack of beds, the facility acted to ensure bed availability. OIG also substantiated allegations of poorly managed Rapid Response Team (RRT) and Cardiac Arrest Team (CAT) activity, although lack of oversight of patient deaths was not confirmed. OIG recommended strengthening and monitoring adherence to local policies regarding response to changing clinical conditions, complying with VHA standards for Emergency Department physicians, and designating one committee with responsibility for reviewing CAT and RRT processes. [Click here to access report.]

Inspection Results for VA Clinics in Multiple VISNs
OIG reviewed four Community Based Outpatient Clinics (CBOCs) during the weeks of March 12, March 19, and March 26, 2012. CBOCs were reviewed in VISN 15 at Fort Dodge and Hutchinson, KS; O'Fallon (St. Charles), MO; and Emporia, KS. The purpose of the review was to assess whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care. The review covered the following focused topic areas: women's health, management of diabetes mellitus-lower limb peripheral vascular disease, heart failure follow-up, credentialing and privileging, and environment and emergency management. OIG noted opportunities for

improvement and made a total of 21 recommendations to the VISN and facility managers. [Click here to access report.]

In addition, four CBOCs were reviewed during the weeks of March 12 and 19, 2012. CBOCs were reviewed in VISN 11 at Yale, MI, and in VISN 12 at La Crosse, Wausau, and Wisconsin Rapids, WI. The purpose of the review was to assess whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care. The review covered the following focused topic areas: women's health, management of diabetes mellitus-lower limb peripheral vascular disease, heart failure follow-up, credentialing and privileging, environment and emergency management, and CBOC contracts. OIG noted opportunities for improvement and made a total of 14 recommendations to the VISN and facility managers. [Click here to access report.]

CRIMINAL INVESTIGATIONS

Medical Device Company Agrees to Pay U.S. Government $3.5 Million To Resolve Civil Allegations

The Department of Justice announced that a medical device company has agreed to pay the United States $3.65 million to resolve civil allegations under the *False Claims Act*. The allegations are that the company inflated the cost of replacement pacemakers and defibrillators purchased by VA and the Department of Defense (DoD) by knowingly failing to apply pricing credits for devices that were explanted while covered under a product warranty. The settlement resolved allegations that the company actively promoted the longevity of its pacemakers and defibrillators to physicians in an effort to convince them to implant the company's devices over those marketed by a competitor. The company reinforced these claims by touting the generous credits available should a device need to be replaced while covered under warranty. At the same time, the company allegedly knew that it failed to grant appropriate credits to the purchasers of devices in a large number of cases where a product failed while still under warranty. As a result, the United States contends the company submitted invoices to VAMCs and DoD military treatment facilities that overstated the cost for replacement pacemakers and defibrillators. The civil settlement totaled $3.65 million and VA was reimbursed $1.15 million in damages.

Federal Contractor Sentenced for Fraud

A Federal contractor was sentenced as a corporation to 3 years' probation and a $65,000 fine after pleading guilty to wire fraud relating to a $274,283 Historically Underutilized Business Zone (HUBZone) contract and making false statements relating to the Federal Surplus Property Program. An OIG investigation, conducted with eight other agencies, revealed that the contractor had been a part of a fraudulent scheme which involved $21,511,002 in Service-Disabled Veteran-Owned Small Business contracts, $1,657,231 in HUBZone contracts, $613,915 in minority 8(a) contracts, and $1,200,000 in fraudulently secured Federal surplus property.

Miami, Florida, VAMC Employee Sentenced for Identity Theft

A Miami, FL, VAMC employee was sentenced to 26 months' incarceration and 48 months' supervised release after pleading guilty to aggravated identity fraud and

access device fraud. An OIG, U.S. Secret Service, and U.S. Postal Inspection Service investigation revealed that the defendant sold 22 Veterans' identities in two separate undercover operations at the medical center. The defendant further admitted to selling 3,000 Veterans' identities over the past 5 years that were linked to a larger conspiracy to use stolen VA and non-VA identities in furtherance of a credit card fraud scheme.

Defendant Sentenced for Identity Theft Spanning 25 Years, $201,000 Restitution Ordered

A defendant was sentenced to 74 months' incarceration, 48 months' supervised release, and ordered to pay $201,295 in restitution after pleading guilty to aggravated identity theft and theft of Government funds. A VA OIG and Social Security Administration OIG investigation revealed that the defendant assumed the identity of an acquaintance and used this identity for approximately 25 years. This included the defendant fraudulently enlisting in the U.S. Army and subsequently obtaining VA and Social Security benefits using the false identity.

Non-Veteran Pleads Guilty to Identity Theft

A non-Veteran pled guilty to theft and aggravated identity theft after an OIG investigation determined that he assumed the identity of a Veteran in order to receive VA health care benefits. As a result, the defendant received $70,435 in VA medical benefits he was not eligible to receive.

Two Seattle, Washington, VAMC Travel Clerks and Five Veterans Arrested for $110,000 in Travel Benefit Fraud

Two Seattle, WA, VAMC travel clerks were arrested and five Veterans were charged with conspiracy to defraud the U.S. Government. An OIG investigation revealed that the two employees recruited Veterans to submit inflated and fictitious travel benefit vouchers. The VA employees processed the vouchers and then demanded kickbacks from the Veterans. During the past 18 months, each of the Veterans participating in the scheme received $15,000 to $30,000 in fraudulent travel benefits. The loss to VA is estimated to be $110,000. Other co-conspirators are expected to be charged in this case.

Former Fiduciary Pleads Guilty to Misappropriation

A former fiduciary pled guilty to misappropriation by a fiduciary. An OIG investigation determined that the defendant stole funds payable to a disabled Veteran and used the funds for his own personal use. The loss to the Veteran was $135,000.

Topeka, Kansas, VAMC Physician Arrested for Sexual Assault

A Topeka, KS, VAMC physician was arrested for aggravated sexual battery and sexual battery. An OIG, VA Police Service, and local police investigation revealed that the defendant sexually assaulted multiple patients while working at the medical center. The defendant was placed on administrative leave in September 2011 pending the outcome of the investigation.

Daytona Beach, Florida, Outpatient Clinic Social Worker Arrested for Sexual Misconduct
A Daytona Beach, FL, outpatient clinic licensed social worker was arrested for sexual misconduct by a psychotherapist. An OIG and VA Police Service investigation revealed that the defendant engaged in an inappropriate relationship with a patient that resulted in at least one instance of sexual contact during a therapy session.

Veteran Sentenced for Assault of VA Police Officer at Seattle, Washington, VAMC
A Veteran was sentenced to 5 years' probation and ordered to write a letter of apology to the victim after having previously pled guilty to assaulting a VA police officer at the Seattle, WA, VAMC. An OIG and VA Police Service investigation revealed that the defendant checked into the emergency room (ER) and informed an ER nurse that he was having suicidal thoughts to include "suicide by cop." When a VA police officer attempted to conduct a security screening, the defendant failed to comply with the officer's instructions and assaulted the officer. During the struggle, the defendant was able to obtain the officer's baton and attempted to take his weapon until subdued by the officer and other responders. The assault resulted in injuries to the officer.

Veteran Sentenced for Making Threat to VA Employees at Muskogee, Oklahoma, and Columbia, South Carolina, VAMCs
A Veteran was sentenced to 18 months' incarceration, 36 months' supervised probation, and ordered to attend mental health treatment programs after pleading guilty to influencing, impeding, or retaliating against a Federal official. An OIG investigation determined that the defendant telephoned the National Call Center in Muskogee, OK, angry about a benefits issue, and threatened VA employees working at the Columbia, SC, VARO. The defendant threatened to wait outside the facility and "bash in the face" of whoever was stealing his money and kill them. The defendant stated he was willing to go to jail for his actions.

Veteran Indicted for Making Threats to Spokane, Washington, VAMC
A Veteran was arrested and subsequently indicted for intentionally intimidating and impeding a Federal employee engaged in his official duties. An OIG and VA Police Service investigation revealed that the defendant threatened to return to the Spokane, WA, VAMC with a firearm after being denied an unscheduled refill of his narcotics. This was the third such incident in the past 2 years involving the defendant referencing firearms in an effort to intimidate VA staff. The defendant's criminal history included a previous arrest and conviction for bringing an assault rifle and two handguns onto the medical center property in 2005.

Former Northport, New York, VAMC Employee Arrested for Child Pornography
A former Northport, NY, VAMC employee was arrested after being indicted for making a false statement and accessing child pornography with intent to view. An OIG and local police investigation revealed that the defendant was viewing child pornography on his VA computer and lied to investigators about his activity. The defendant was arrested without incident following an appointment with his probation officer relating to a previous conviction for molesting a family member who was a minor.

Veteran Pleads Guilty to Possession of Child Pornography at Phoenix, Arizona VAMC
A Veteran pled guilty to possession of child pornography after an OIG investigation revealed that he was viewing child pornography on his personal computer at the Phoenix, AZ, VAMC. A search warrant and subsequent forensic examination of the defendant's laptop and related memory card devices identified approximately 110 digital images and 77 digital videos depicting child pornography. The defendant remains in custody pending sentencing.

Attorney and Client Charged with Fraud in Sham Marriage Scheme
An attorney and a female client were charged with wire fraud, harboring an alien, and marriage fraud. An OIG and Department of Homeland Security investigation revealed that the attorney, who was having an affair with the female client, developed a scheme for the female client to marry a disabled Veteran and avoid deportation. Subsequently, the attorney also convinced the disabled Veteran to apply for VA spousal benefits. Only days after the sham wedding, the defendants convinced the Veteran to sign a Power of Attorney for the attorney. Next, the attorney embezzled approximately $36,000 from the Veteran and used the stolen funds to pay for his female client's immigration fees, rent, utilities, living expenses, and upgrades to a property at which the Veteran did not reside.

Veteran Sentenced for Fraudulent PTSD Claim
A Veteran pled guilty to health care fraud and was sentenced to 24 months' incarceration and ordered to pay $144,885 in restitution to VA, which included $123,520 paid to the Veteran for a fraudulent post-traumatic stress disorder (PTSD) claim and additional funds paid to his daughter for education benefits that were not allowed by his subsequent 20 percent service-connected rating. An OIG investigation determined that the defendant fraudulently claimed to have PTSD and loss of the use of his extremities in order to receive additional VA benefits.

Veteran Charged with Making False Statements
A Veteran was charged with making false statements after a VA OIG and Department of Transportation OIG investigation revealed that while the defendant was receiving VA compensation benefits for chronic obstructive pulmonary disease (COPD), he had reported to the Federal Aviation Administration (FAA) that he was not diagnosed with a lung disease, had no other illness or disability, did not visit a health professional in the last 3 years, and did not receive medical disability benefits. The defendant's FAA license has been suspended and his VA compensation benefits for COPD were terminated. The loss to VA is $51,237.

Son of Deceased Beneficiary Sentenced for Theft of VA Benefits
The son of a deceased beneficiary was sentenced to 60 months' probation, 100 hours' community service, and ordered to pay VA $87,894 in restitution. An OIG investigation determined that the defendant stole VA funds from a joint account that were direct deposited after his mother's death in September 2005. The defendant admitted to using the VA benefits to pay for personal expenses.

Former Dallas, Texas, VAMC Employee Sentenced for Fraudulent Overtime Claims
A former Dallas, TX, VAMC employee was sentenced to 3 years' probation and ordered to pay VA restitution of $68,861. An OIG investigation revealed that from February 2007 to March 2010 the defendant submitted and was paid for numerous fraudulent overtime claims.

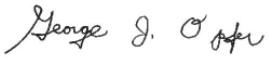
Defendant Pleads Guilty to False Statements
A defendant pled guilty to making a false statement relating to a credit application. A VA OIG and Department of Housing and Urban Development OIG investigation revealed that the defendant purchased homes under false pretenses and then sold them to individuals who were unaware of the existing mortgages. The loss to the Government is over $400,000, with approximately $48,000 in losses to VA.

Subjects Indicted for Drug Distribution at Richmond, Virginia, VAMC
An OIG, VA Police Service, and local police investigation resulted in the indictment of one VA employee, two Veterans, and two non-Veterans for the distribution of a controlled substance. To date, four of the five defendants have been arrested. The investigation revealed that the defendants were selling narcotics to other VA employees and Veterans in and around the Richmond, VA, VAMC. Also, one Veteran was allowing his nearby residence to be used to consume these drugs by employees and patients during working hours.

Subject Arrested for Drug Distribution at Bedford, Massachusetts, VAMC
A subject was arrested for distribution of heroin. During the course of an OIG, Drug Enforcement Administration, VA Police Service, and local police investigation, the defendant sold heroin to an OIG informant on five different occasions, with four of the sales occurring at the Bedford, MA, VAMC. During one undercover operation, the defendant sold approximately 7.5 grams of heroin.

Mountain Home, Tennessee, VAMC Employee Arrested for Diverting Narcotics
A Mountain Home, TN, VAMC nurse was arrested for acquiring a Schedule II substance by fraudulent means. VA medical staff suspected the defendant was diverting narcotics and notified OIG and VA Police Service. A subsequent investigation resulted in the defendant being caught attempting to remove morphine from a patient's IV.

Subject Arrested for Theft of VA Gravesite Markers
An OIG and State police investigation resulted in the arrest of a subject who stole bronze VA gravesite markers from his employer and then sold them to a scrap yard. The defendant was employed by a local funeral home and was not given permission by his employer to dispose of the markers. The markers were returned to the funeral home and properly placed at the appropriate Veteran gravesites in time for Memorial Day.



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