Department of Veterans Affairs
Office of Inspector General
January 2013 Highlights

OIG REPORTS

IG Finds 66 Percent Compliance Rate for Diabetic Patients' Annual Required Foot Care

The VA Office of Inspector General (OIG) assessed whether patients with diabetes mellitus and additional risk factors for lower extremity amputation received annual foot care in accordance with Veterans Health Administration (VHA) requirements. The study population consisted of patients with a diagnosis of diabetes mellitus and one or more of the following risk factors for amputation during July 1, 2009–February 28, 2010: peripheral vascular disease, peripheral neuropathy, and Charcot joint disease with foot deformity. OIG used a two-stage approach to evaluate the annual rate of patient encounters with VA or fee-basis foot care specialists. OIG first examined administrative data for evidence of specialized foot care and then conducted a focused electronic health records (EHRs) review of a randomly selected sample of patients for whom there was no evidence of annual care in administrative data. OIG estimated the VHA compliance rate for annual foot care in this population at increased risk to be 66.2 percent, and OIG is 95 percent confident that the actual compliance rate is between 64.95 and 67.49 percent. OIG recommended and the Under Secretary for Health agreed to implement a plan to ensure compliance with VHA's requirement that patients who are at increased risk for amputation be examined by a foot care specialist at least once each year. [Click here to access report.]

VA Heart of Texas Network Will Establish Special Units and Upgrade Training To Improve Non-VA Fee Care Processing

OIG substantiated the allegation the South Texas Veterans Health Care System (STVHCS) authorized several million dollars in fee care during fiscal years (FY) 2009 and 2010 although it did not have sufficient funds obligated and available to pay for the services the Veterans received. STVHCS did not ensure clinical and fee staff complied with required steps for authorizing fee care and fee staff also did not timely process fee care payments. STVHCS clinical and fee staff lacked defined roles and responsibilities, sufficient training, and adequate supervision. Management in neither STVHCS nor Veterans Integrated Service Network (VISN) 17 had effective oversight mechanisms in place to ensure sufficient funds were available to pay for the fee care received by Veterans. STVHCS lacked visibility over these unpaid claims when vendors' invoices were received until fee staff researched, summarized, and processed this information dating back to FY 2009. STVHCS incurred avoidable interest penalties for untimely payments. [Click here to access report.]

OIG Substantiated the VA San Diego Healthcare System, San Diego, California, Patient Call Center Failed to Follow Procedures Resulting in Delays

OIG conducted an inspection to determine the validity of allegations regarding scheduling primary care appointments at the Patient Call Center (PCC), VA San Diego Healthcare System (HCS), San Diego, CA. The complainant alleged that a PCC agent

refused to schedule a follow-up appointment and an urgent appointment. The complainant also alleged that he was forced to seek medical treatment at a community hospital emergency department (ED) for an infection in his finger, and that he was at risk for amputation of his finger due to lack of medical attention at the HCS. OIG found that the PCC agent did not follow procedures for managing calls and that the PCC agent's failure to follow PCC procedure caused delays. While the HCS failed to provide timely follow-up, OIG determined that the complainant was not denied access to care. OIG recommended that the HCS Director ensure that PCC agents follow standard operating procedures for scheduling follow-up appointments and managing non-urgent symptomatic calls, and ensure that timeframes for the primary care teams to follow up with patients be established. [Click here to access report.]

Denial of Inpatient Care Allegation, Unsubstantiated at the VA North Texas Health Care System, Dallas, Texas

OIG conducted an inspection to determine the validity of an allegation related to a patient being denied inpatient mental health (MH) treatment at the VA North Texas HCS in Dallas, TX. Specifically, the complainant alleged that a patient presented to the ED with suicidal ideation and had to wait in the triage holding area for over 4.5 hours prior to being seen by a psychiatrist. The psychiatrist told the patient that admission was not indicated. The patient had a panic attack, and the police were called to escort the patient out of the facility as the patient was upsetting the staff. OIG did not substantiate that a suicidal patient was denied admission for inpatient treatment. OIG interviewed staff, reviewed the patient's EHR, and reviewed facility policies. Although the patient's EHR documented the patient was hopeless and depressed, it also documented that the patient denied suicidal ideation. OIG determined that there was no facility policy or standard operating procedure written to describe the process for patient evaluations in the ED; therefore, there was no training on such a policy or procedure for anyone working in the ED. This may have contributed to the long ED visit for the patient and influenced the patient's decision to leave against medical advice. OIG also reviewed the patient's ED Integration Software (EDIS) tracking sheet that is used to monitor a patient's real-time movement through the ED. The tracking sheet did not match the patient's EHR. ED administrative and clinical staff do not consistently update EDIS as required. In addition, social workers on call for the ED after hours did not assist homeless patients to find a shelter or direct them to the Healthcare for Homeless Veterans program as required. OIG recommended that the Facility Director ensure that the facility develops a written policy for ED patient evaluation and provide orientation to all ED staff and on-call personnel; EDIS is used as required; and social work services are provided in the ED as required. The VISN and Facility Directors agreed with our findings and recommendations and provided acceptable improvement plans.
[Click here to access report.]

Inspection Results for Anchorage, Alaska, VA Regional Office

OIG conducted this inspection to evaluate how well the Anchorage VA Regional Office (VARO) accomplishes its mission of providing Veterans with access to high-quality benefits and services. OIG found VARO staff inaccurately processed 50 percent of the temporary 100 percent disability evaluations OIG reviewed due to lack of effective

controls. However, VARO managers generally ensured staff accurately reported to Veterans Benefits Administration (VBA) actions taken on temporary 100 disability claims to address our prior audit report recommendations. Errors in processing of traumatic brain injury (TBI) claims were also identified. Although our results show VARO staff did not accurately process 18 of the 38 disability claims, these results do not represent the overall accuracy of disability claims processing at this VARO as OIG sample selected types of claims at higher risk of processing error. VARO staff provided adequate outreach to homeless Veterans but did not address Gulf War Veterans' entitlement to MH treatment. The VARO Director concurred with our recommendations.
[Click here to access report.]

Results for Benefits Inspection of Detroit VA Regional Office
OIG conducted this inspection to evaluate how well the Detroit VARO accomplishes its mission of providing Veterans with access to high-quality benefits and services. VARO staff did not accurately process 31 (52 percent) of 60 disability claims reviewed. OIG sampled and reviewed claims OIG considered at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Specifically, 60 percent of the 30 temporary 100 percent disability evaluations reviewed were inaccurate because of a lack of training and controls related to future medical reexaminations. Errors in processing 43 percent of 30 TBI claims occurred because staff used insufficient medical examination reports. Managers did not ensure staff fully completed Systematic Analysis of Operations or addressed Gulf War Veterans' entitlement to MH treatment. Staff provided adequate outreach to homeless Veterans; however, VBA needs a measure to assess its homeless outreach program.
[Click here to access report.]

CRIMINAL INVESTIGATIONS

Former Richmond, Virginia, VAMC Housekeeping Aid Sentenced for Homicide
A former Richmond, VA, VA Medical Center (VAMC) housekeeping aid was sentenced to life imprisonment after pleading guilty to the use of a firearm in relation to a crime of violence that caused the death of another. An OIG and Federal Bureau of Investigation (FBI) investigation determined that the defendant, after engaging in a brief verbal confrontation with two individuals in the medical center parking lot, shot one of the individuals in the shoulder with a .38 caliber revolver. Upon seeing the victim fall to the ground, the defendant followed the second individual a short distance and then returned to the victim, shooting him a second time.

Veteran Arrested for Sexual Battery of a Topeka, Kansas, VAMC Contract Employee
A Veteran was arrested for sexual battery of a Topeka, KS, VAMC contract employee. An OIG and local police investigation revealed that the defendant sexually assaulted the female employee during a medical appointment. The defendant confessed to touching the employee without her consent.

Veteran Sentenced for Making Threats to Phoenix, Arizona, VA Call Center
A Veteran was sentenced to 4 months' home confinement, 5 years' probation, and a $2,000 fine. The Veteran was convicted at trial of making terroristic threats to a call taker at the Phoenix, AZ, VA Call Center. An OIG and local police investigation revealed that the defendant told the call taker that he was going to the Atlanta VARO and shoot the first 3,000 people he saw if he did not receive a permanent rating decision within 5 business days.

Former Los Angeles, California, VAMC Chief Accountant Sentenced for Embezzlement
A former Los Angeles, CA, VAMC chief accountant was sentenced to 1 year of incarceration, 3 years' supervised release, and ordered to pay VA restitution of $229,191. An OIG investigation revealed that the defendant embezzled $681,087 of VA funds. To date, VA has recovered $451,896 of the embezzled funds. The defendant stole checks sent to VA for various purposes to include prescription rebates, restitution from U.S. District Court, and insurance payments. The defendant then deposited the checks into the VA agent cashier's account at a commercial bank, later withdrawing the funds in a combination of cash and cashier checks. The defendant also embezzled funds from the State of California and non-profits working on the medical center campus. The OIG has provided VHA a Management Implication Notification Report on the details of this crime to allow VHA to determine if stronger controls could be implemented.

Manchester, New Hampshire, VAMC Physician Pleads Guilty to Fraudulently Obtaining Controlled Substances
A Manchester, NH, VAMC physician pled guilty to fraudulently obtaining controlled substances. A VA OIG, Drug Enforcement Administration (DEA), and Office of Personnel Management OIG investigation disclosed that from June 2010 to January 2011 the defendant wrote approximately 17 prescriptions (68,760 total milligrams) for oxycodone and Oxycontin that were not documented in the medical records of one of his patients. Some of these prescriptions were written for the patient after the defendant went out on workers' compensation leave. This was in addition to 82,800 mg of oxycodone and Oxycontin that the patient received from VA during the same time period. The patient admitted that he provided some of his narcotics to the defendant. As part of his plea agreement, the defendant agreed to surrender his DEA registration and to never apply for another one.

Alexandria, Louisiana, VAMC Nurse Arrested for Drug Diversion
An Alexandria, LA, VAMC registered nurse was arrested for obtaining prescriptions by fraud, identity theft, computer fraud, and forgery. An OIG and state police investigation revealed that the defendant ordered fraudulent controlled substance prescriptions in the Computerized Patient Record System for Veterans assigned to her care. The defendant then retrieved the controlled medication from the medical center pharmacy by misrepresenting herself as a family member of the Veterans and forged their names on the electronic signature pad. This resulted in the diversion of approximately 780

controlled substance tablets. The defendant was also charged with felony doctor shopping by the state police for an unrelated investigation.

Former VA Community Residential Care Home Employee Arrested for Drug Diversion
A former VA community residential care home employee was arrested for diversion of a controlled substance. An OIG investigation revealed that the defendant illicitly obtained clonazepam from several Veterans living at the home and that she attempted to conceal the theft by replacing the stolen clonazepam with over-the-counter pills. This case was initiated when it was discovered that several Veterans were going to be short on their monthly VA prescription medication supply.

Miami, Florida, VAMC Employee Sentenced for Credit Card Fraud
A Miami, FL, VAMC employee was sentenced to 24 months' and 1 day of incarceration. An OIG and U.S. Secret Service investigation revealed that the defendant used stolen credit card numbers and identities to make over $9,000 in online purchases from various retailers utilizing VA networks and computers.

Fiduciary Sentenced for Theft
An attorney was sentenced to 46 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $2,352,107 to VA and $282,112 to the Internal Revenue Service. An OIG investigation revealed that the attorney, who served as a court appointed guardian and Federal fiduciary for 54 Veterans, conspired with his wife to steal from the Veterans' bank accounts and failed to report the income on their Federal tax returns. The defendant's wife previously received the same sentence for her involvement in the conspiracy.

Former Legal Assistant Sentenced for Embezzlement
A former legal assistant working at a law firm was sentenced to 4 months' incarceration, 8 months' home confinement, 60 months' probation, and ordered to pay $20,377 in restitution. An OIG investigation revealed that the defendant embezzled funds from 19 Veteran fiduciary accounts. In an effort to conceal the embezzlement from VA the defendant submitted falsified accountings to her fiduciary firm. The loss to VA is $25,377.

Former Fiduciary Pleads Guilty to Theft of Government Funds
A former VA court appointed fiduciary pled guilty to a criminal information charging him with theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant embezzled $460,679 of VA benefits and $176,246 of SSA benefits from an incompetent Veteran. The defendant admitted to submitting fraudulent accountings to both VA and the court by creating fake certificates of deposit.

Former Fiduciary Sentenced for Theft of Government Benefits
A former VA fiduciary was sentenced to a minimum 6 months' court supervised sobriety program and ordered to pay $83,652 in restitution after pleading guilty to theft of Government funds. A VA OIG and SSA OIG investigation determined that from

April 2005 to September 2009 the defendant, who was acting as his brother's fiduciary, embezzled VA and SSA benefits for his personal use.

Medical Equipment Provider Sentenced for Fraud
The owner of a durable medical equipment provider was sentenced to 3 months' incarceration, 6 months' home confinement, 2 years' supervised release, and ordered to pay $110,581 in restitution. The defendant previously pled guilty to conspiracy to commit health care fraud. A former Cleveland, OH, VAMC purchasing agent working in the prosthetics department pled guilty to the same charge. The former VA employee used her position to provide competitors' bid information to the medical equipment provider and approved inflated payments for services provided. Also, in some instances the equipment was not installed by the provider, either because the Veteran refused delivery or because the Veteran died prior to delivery. The provider then charged VA as if the equipment had been installed.

Veteran Pleads Guilty to Theft of Government Funds
A Veteran pled guilty to theft of Government funds after an OIG investigation disclosed that he made false statements in order to fraudulently obtain VA disability benefits. From 2000 to 2012 the defendant received VA compensation payments for panic disorder with agoraphobia, a back injury, and aid and attendance. The defendant admitted that he defrauded VA by exaggerating his disabilities and lying about his ability to work. The loss to VA is approximately $329,000.

Veteran and Spouse Plead Guilty to Theft of Government Funds
A Veteran and his spouse pled guilty to conspiracy, false statements, theft of Government funds, and Social Security Administration (SSA) fraud and were subsequently sentenced to 30 months' and 20 months' incarceration, respectively. The defendants were also ordered to pay $326,390 in restitution to VA and SSA and were required to forfeit $78,804 in funds that were previously seized from their bank account. A VA OIG, SSA OIG, FBI, and U.S. Air Force investigation revealed that the defendants conspired to fraudulently obtain benefits from VA and SSA by providing numerous false statements and forged documents which reflected that the Veteran had participated in Special Operations combat duty in Vietnam and Iran while he was a member of the U.S. Air Force.

Veteran Sentenced for Travel Benefit Fraud
A Veteran was sentenced to 21 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $14,333. An OIG investigation revealed that the defendant, who resided in Gainesville, FL, filed false travel claims for travel from St. Augustine, FL, to the Gainesville, FL, VAMC.

Veteran Indicted for Identity Theft
A superseding indictment was filed charging a Veteran with possession of child pornography, failure to register as a sex offender, false statements in order to acquire a firearm, health care fraud, and aggravated identity theft, in addition to the original charges of fraudulently obtaining a U.S. passport and possessing firearms as a

convicted felon. An OIG investigation revealed that the defendant, who resided in Vermont, assumed a North Carolina Veteran's identity for the past 7 years and used the false identity to obtain a U.S. passport, purchase firearms, vote, obtain employment, and obtain VA-funded medical care through the VA fee basis program. A computer analysis conducted by OIG's Computer Forensics Laboratory identified child pornography linked to the defendant. The defendant continues to be detained.

Non-Veteran Arrested for Identity Theft
A non–Veteran was arrested for the criminal use of a personal identification, fraudulently obtaining goods or services from a healthcare provider, and organized scheme to defraud. An OIG, VA Police Service, and local police investigation revealed that the defendant stole a Veteran's identity in order to fraudulently receive approximately $19,000 in VA medical care and services.

Veteran Sentenced for Drug Distribution
The last of six Veterans was sentenced to 15 months' incarceration after previously pleading guilty to distributing and conspiring to distribute controlled substances at the Bedford, MA, VAMC. These sentences followed an extensive 6 month OIG, VA Police Service, and DEA investigation into drug distribution at the medical center, a facility that has multiple services for substance abuse and addiction rehabilitation.

Veteran Pleads Guilty to Mail Fraud
A Veteran pled guilty to mail fraud after fraudulently receiving advanced VA education payments under the GI Bill. An OIG investigation revealed that the defendant, while on active duty, obtained a personnel roster that contained personally identifiable information of other service members. After being discharged from the service, the defendant used the identities of six Veterans to request advanced VA education payments. The Veteran had the checks, in the names of other Veterans, mailed to her address and created false powers of attorney in order to negotiate the checks. The loss to VA is $18,000.

Veteran Sentenced for VA Pension Beneficiary Fraud
A Veteran was sentenced to 5 years' probation and ordered to pay VA $177,108 in restitution. An OIG investigation revealed that the defendant and his live-in girlfriend structured their business in the girlfriend's name to hide the defendant's income in order to qualify for VA pension benefits. Accordingly, the Veteran and his girlfriend operated the business for over 8 years while the Veteran received VA pension benefits and co-pay exempt VA healthcare. The defendant is also being charged in a separate case with delivery of a controlled substance for selling his VA prescribed morphine tablets.

Veteran's Widow Sentenced for Theft of VA Benefits
A widow receiving Dependency and Indemnity Compensation was sentenced to 4 years' probation, with the first 10 months to be served in home confinement, and ordered to pay $188,546 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant failed to notify VA that she remarried 19 years ago.

Daughter of Deceased Beneficiary Pleads Guilty to Theft of Benefits
The daughter of a deceased VA and SSA beneficiary pled guilty to conspiracy, theft of Government property, and false statements. A VA OIG and SSA OIG investigation revealed that the defendant received, forged, and negotiated approximately $177,900 in VA and Social Security benefit checks issued after her mother's death in July 2002. The defendant also provided false statements to VA and the SSA purporting to be the beneficiary, causing the reissuance of checks and the continued issuance of benefits. The loss to VA is approximately $120,500.

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