



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

FEBRUARY 2021 HIGHLIGHTS

Investigations Involving Health Care

Six Defendants Charged in Civil Complaint in Connection with Compounding Pharmacy Scheme

The owners of a compounding pharmacy, two physicians, and two third-party marketers were charged through a civil complaint in the District of Nevada with violations of the False Claims Act. An investigation conducted by the VA Office of Inspector General (OIG), Federal Bureau of Investigation (FBI), Defense Criminal Investigative Service, and Air Force Office of Special Investigations resulted in charges alleging the defendants submitted false claims for compounded prescriptions to the Department of Defense's healthcare program TRICARE and VA's Civilian Health and Medical Program (CHAMPVA). It is alleged that the owners of the compounding pharmacy paid substantial kickbacks to third-party marketers in exchange for the referral of prescriptions for compounded drugs. The compounded prescriptions were fraudulently dispensed by doctors who were geographically located in different states than the patients, and for whom no doctor-patient relationship existed. The overall loss to the government is approximately \$5,650,000. Of this amount, the loss to VA is approximately \$1,900,000.

Former VA Supply Supervisor and Medical Supply Company President Indicted in Connection with Fraud Scheme

A former central supply department supervisor at the Jesse Brown VA Medical Center in Chicago, Illinois, and a medical supply company president were indicted for wire fraud. A VA OIG investigation resulted in charges alleging that the former employee received monetary kickbacks in exchange for initiating VA orders from the medical supply company for medical products, many of which were never delivered to VA. The former employee was also indicted on additional counts of wire fraud, attempted witness tampering, and obstruction. The defendants are accused of defrauding VA of approximately \$1,700,000. The defendants were indicted in the Northern District of Illinois.

Defendant Pleads Guilty in Connection with Durable Medical Equipment Fraud Scheme

A business owner who established numerous durable medical equipment companies pleaded guilty in the Middle District of Florida to conspiracy to commit healthcare fraud and filing a false tax return. A VA OIG, Internal Revenue Service Criminal Investigation, Department of Health and Human Services OIG, and FBI investigation resulted in charges alleging the defendant placed the companies in the names of straw owners, which led to the submission of over \$400 million in fraudulent durable medical equipment claims to Medicare and CHAMPVA. The defendant and her coconspirators allegedly purchased thousands of doctors' orders for braces from marketers who bribed doctors to sign under the guise of telemedicine. The defendant admitted to using the fraud proceeds to purchase numerous personal items. The total loss to VA is approximately \$500,000.

Seven Defendants Indicted in Connection with Compounding Pharmacy Scheme

Seven defendants were indicted in the Southern District of Florida for conspiracy to commit wire fraud, mail fraud, conspiracy to pay healthcare kickbacks, and payment of healthcare kickbacks. A VA OIG, Food and Drug Administration Office of Criminal Investigations, Army Criminal Investigation Command, Department of Labor Employee Benefits Security Administration, and Defense Criminal Investigative Service investigation resulted in charges alleging that the defendants submitted false claims for compounded prescriptions totaling over \$110.8 million to TRICARE, CHAMPVA, and private insurance companies. It is alleged that the compounded prescriptions were fraudulently dispensed by doctors who were geographically located in different states than the patients, and for whom no doctor-patient relationship existed. It is further alleged that the compounded prescriptions were fraudulently dispensed by unlicensed pharmacies; dispensed without a physician's authorization; dispensed to TRICARE, CHAMPVA, and privately insured recipients without approval; or were billed for but never provided. The overall estimated loss to the government and private insurance is approximately \$29.3 million. Of this amount, the loss to VA is approximately \$450,000.

Former VA Hospice Nurse Sentenced for Drug Diversion

A former hospice unit nurse at the VA Bedford Healthcare System in Massachusetts was sentenced to 40 months' incarceration and three years' supervised release after previously pleading guilty to tampering with a consumer product and obtaining a controlled substance by misrepresentation, fraud, deception, and subterfuge. A VA OIG investigation revealed the defendant used tap water to dilute liquid morphine and subsequently administered the diluted substance to hospice patients. The defendant then ingested the diluted amount of the remaining drug. To conceal her drug diversion, the defendant falsified medical records by reporting that the patients had received more pain medication than they did. The defendant was sentenced in the District of Massachusetts.

Investigations Involving Benefits

Defendant Indicted for Bank Fraud

A nonveteran was indicted in the Northern District of Illinois for bank fraud. A VA OIG and Department of Housing and Urban Development (HUD) OIG investigation resulted in charges alleging that between January 2012 and December 2013, the defendant recruited 14 buyers to obtain mortgage loans through fraudulent pretenses. It is alleged that the defendant, who served as the loan officer for four of these properties, fraudulently caused lenders to issue mortgage loans by making false representations regarding loan applications, gift donors, and HUD-1 settlement statements. The false representations pertained to various items, such as the buyers' marital statuses, assets, sources of down payments, and intentions to occupy the properties purchased as primary residences. Thirteen of the real estate transactions were mortgage loans insured by the Federal Housing Administration that totaled \$2,475,143, and one was a VA guaranteed mortgage for \$175,787. The loss to HUD is \$1,770,175 and the loss to VA is \$78,406.

Investigations Involving Other Matters

Virginia Businessman Pleads Guilty in Connection with Multiple Fraud Schemes

The chief executive officer of a government service provider pleaded guilty in the Eastern District of Virginia to false statements, wire fraud, and theft of government funds. A VA OIG, Department of Homeland Security OIG, and FBI investigation revealed that the defendant made false statements to both VA and the Federal Emergency Management Agency to obtain contracts, which were valued at approximately \$38 million, to provide personal protective equipment (PPE). The defendant falsely claimed to VA and the Federal Emergency Management Agency that he possessed large quantities of PPE, to include N95 masks. The defendant also electronically submitted applications containing false information for Paycheck Protection Program and Emergency Injury Disaster Loans, which resulted in his receipt of approximately \$1 million in loans. The investigation also revealed that the defendant submitted a fraudulent DD Form 214 (certifying release or discharge from active duty) to VA, which falsely reflected that he served in the U.S. Marine Corps. As a result, the defendant fraudulently received VA compensation benefits. The loss to the Small Business Administration is approximately \$261,000 and the loss to VA is approximately \$74,000.

Audits and Reviews

Insufficient Oversight for Issuing Prosthetic Supplies and Devices

The OIG assessed the Veterans Health Administration's (VHA) oversight of prosthetic supplies and devices (including artificial limbs and devices that support or replace a body part or function, as well as sensory aids for hearing, vision, mobility, or speech and communication) issued to veterans. VA's Prosthetic and Sensory Aids Service costs have increased from over \$2.9 billion in fiscal year 2016 to nearly \$3.5 billion in fiscal year 2019. The OIG found oversight weaknesses that contributed to Prosthetic and Sensory Aids Service staff cloning (copying) consults improperly. Consequently, VHA improperly issued an estimated \$15.8 million in prosthetic supplies in 2017—also affecting the tracking of fulfillment times. Only six percent of transactions for supplies related to deceased veterans were improper and there was no evidence of fraud. VHA also adequately oversaw duplicate supply issuance. VHA concurred with the OIG's four recommendations to improve oversight of the clone consult function to prevent improper issuance of prosthetic supplies.

VA Needs Better Internal Communication and Data Sharing to Strengthen the Administration of Spina Bifida Benefits

The OIG reviewed VA's spina bifida program to assess concerns that eligible individuals may not be receiving all their benefits. Children born with spina bifida may receive VA benefits if a biological parent is a veteran presumed to have been exposed to herbicides during the Vietnam War. The Veterans Benefits Administration (VBA) determines benefit eligibility and issues monthly payments, while VHA covers all medically necessary health care. The OIG found VBA staff generally decided spina bifida

benefits claims accurately. However, VBA and VHA program offices did not adequately communicate or share data, contributing to improper payments, payments made after deaths, and delays in health care enrollments. VA also did not consistently reach out to eligible individuals or accurately provide benefits information. The OIG recommended improving coordination between VBA and VHA, ensuring beneficiaries are promptly enrolled in health care and consistently provided accurate and comprehensive information, and engaging beneficiaries unaware of or not using services.

Reporting and Monitoring Personal Protective Equipment Inventory during the Pandemic

The OIG received allegations that VHA medical facilities lacked enough PPE to keep pace with the escalating needs to protect personnel and patients as COVID-19 spread. In response, a review team assessed how VHA reported and monitored its PPE supply levels during the pandemic. Based on interviews with 22 people involved in logistics operations for 42 facilities, none reported running out of PPE items. The OIG found VHA took swift steps to work around known limitations in its inventory management system, to use near real-time data to shift and order supplies, and to help ensure facilities did not exhaust PPE supplies. VHA could, however, improve the accuracy and consistency of information collected about PPE supplies to guide decisions. The OIG recommended providing guidance for reporting usable expired items and effectively verifying PPE information. VHA was also urged to report any data limitations until corrections can be made.

Biologic Implant Purchasing, Inventory Management, and Tracking Need Improvement

The OIG determined that VHA lacked effective procedures for purchasing, inventorying, and tracking biologic implants such as skin substitutes and corneal or dental implants. The audit team's visits to four medical facilities revealed purchasing agents did not always record implants properly or use the appropriate funds. The facilities also had an inaccurate and incomplete inventory of biologic implants and did not review the inventory on hand. For example, the audit team could not locate 714 biologic implants in facility inventories, valued at almost \$1.1 million. Finally, facilities failed to track (for possible recall notifications) at least 45 percent of implants reportedly used from October 2017 through March 2019. VHA did not designate responsibility for oversight of tracking, develop a national policy on facility biologic implant tracking processes, or have a standard tracking system for facilities that meets accreditation requirements. VHA concurred with the OIG's 11 recommendations.

Healthcare Inspections

Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi

This inspection addressed allegations regarding inappropriate conduct toward women veterans by a gynecological provider; a nurse chaperone's failure to provide patient support; and three additional concerns related to patient complaint processes, leaders' response to the provider's misconduct, and state licensing board(s) and National Practitioner Data Bank reporting. The provider's conduct was

unprofessional and insensitive, and the nurse chaperone did not provide support to the patients. VHA has not incorporated trauma-informed care and sensitive examination policies into training and practice, and VHA policies did not outline the role and training of chaperones. In addition, patient complaints data was incomplete, limiting the accuracy and value of identified trends, and facility leaders failed to effectively address the provider's misconduct for years and did not report the provider to state licensing board(s) or the National Practitioner Data Bank, although the conduct may have met the reporting standards. The OIG made six recommendations.

Communication of Test Results and Oncology Scheduling Concerns at the Beckley VA Medical Center in West Virginia

Conducted at the request of Representative Carol Miller (West Virginia), this inspection assessed allegations that a patient received untimely and poor quality of care in the emergency department and oncology service. The OIG did not substantiate that the patient received untimely or poor quality of care in the facility's emergency department. On two occasions, there was no documentation that a primary care provider communicated test results with the patient. The OIG found deficits in an oncologist's use of scheduling orders and adherence to the Primary Care and Oncology Service Agreement wait times. The OIG was unable to determine whether compliance with the Return to Clinic policy would have altered the patient's course. Facility leaders performed comprehensive reviews of the patient's care. The OIG made two recommendations to communicate and document laboratory results and comply with clinic scheduling and ordering policies.

VHA's Response following Cardiac Catheterization Lab Closure at the Samuel S. Stratton VA Medical Center in Albany, New York

The OIG conducted this healthcare inspection after it did not receive a response from Veterans Integrated Service Network (VISN) 2 staff following an inquiry to assess an allegation that the cardiac catheterization lab (CCL) was closed due to concerns of risk to patients. A facility fact-finding review identified concerns with communication and team dynamics and suspended CCL procedures. VISN and facility leaders arranged for a National Cardiology Program Office review. The National Cardiology Program Office made recommendations addressing the CCL cardiologists' clinical judgement and technical skills. Facility leaders convened an administrative investigation board and initiated management reviews. VISN and facility leaders decided that the CCL should remain closed indefinitely. The OIG made three recommendations: two recommendations to the under secretary for health regarding the designation of a VHA specialty leader in interventional cardiology and one recommendation to the VISN director about the failure to respond to an OIG inquiry.

Mammography Program Deficiencies and Patient Results Communication at the Washington DC VA Medical Center

Pursuant to a congressional request, the OIG conducted an inspection at the Washington DC VA Medical Center to review patients who did not receive mammography exam results. After the discovery of unsent mammography result letters, the facility completed reviews and four patients with breast

cancer were identified. Though the four patients did not receive letters, they received timely notification from the ordering provider and follow-up. Ordering providers did not consistently document patient notification of abnormal mammography results. Due to staffing, the facility did not have a mammography program and had not fully implemented National Radiology Program Office recommendations. The National Radiology Program Office did not identify a lack of a program standard operating procedure manual. The OIG made seven recommendations related to documentation and notification processes, action plans, standard operating procedures, staff training, and National Radiology Program Office reviews and requirements.

Comprehensive Healthcare Inspections

Comprehensive Healthcare Inspection Program (CHIP) reports are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year. The following are OIG's current areas of focus:

- (1) Leadership and organizational risks
- (2) COVID-19 pandemic readiness and response
- (3) Quality, safety, and value
- (4) Registered nurse credentialing
- (5) Medication management
- (6) Mental health care
- (7) Care coordination
- (8) High-risk processes

Recently published CHIP report:

Dayton VA Medical Center in Ohio

To listen to the podcast on the February 2021 highlights, go to www.va.gov/oig/podcasts.