



Department of Veterans Affairs

Office of Inspector General

October 2016 Highlights

OIG REPORTS

Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System

The Office of Inspector General (OIG) initiated this review to look into allegations made in 2015 by a confidential complainant and reported to OIG by the House Committee on Veterans' Affairs. OIG's review substantiated that the Phoenix VA Health Care System (PVAHCS) inappropriately discontinued consults for patients. In August 2014, the OIG previously reported on numerous allegations regarding patient deaths, patient wait times, and scheduling practices at PVAHCS. That report recommended that the VA Secretary ensure PVAHCS follow VA consult guidance and appropriately review consults before closing them to ensure veterans receive necessary medical care. Although the Veterans Health Administration (VHA) made efforts to improve the care provided at PVAHCS, OIG found that consult management issues continue at PVAHCS. The current review determined that because consults were inappropriately discontinued, some patients did not receive the care requested or they experienced delays in receiving care. The review found that during calendar year 2015, PVAHCS staff inappropriately discontinued and canceled consults and were generally unclear about following specific consult management procedures. Procedures and consult management responsibilities varied in different specialties throughout the system, which further led to staff confusion and, in some cases, canceled consults. OIG's recommendations focused on improving the consult procedures at PVAHCS to ensure veterans receive the necessary follow-up medical care. [\[Click here to access report.\]](#)

Nurse Staffing and Patient Safety Reporting Concerns, VA Roseburg Healthcare System, Roseburg, Oregon

OIG conducted an inspection at the request of Congressman Peter A. DeFazio in response to allegations about inadequate nurse staffing in the Community Living Center (CLC) and patient safety reporting at the VA Roseburg Healthcare System (system), Roseburg, OR. OIG did not substantiate the allegation that the system's CLC nurse staffing was inadequate and not in compliance with VHA policy. System leadership implemented VHA's staffing methodology. OIG did not substantiate the allegation that failure to correctly staff the CLC units resulted in patient falls or employee injuries. The system, including the CLC, had a comprehensive approach to identifying high risk patients and managing fall prevention, although staffing levels were not consistently analyzed after a fall occurred. OIG did not substantiate the allegation that the CLC had no working alarms. Nurse call and elopement prevention system alarms functioned as required. OIG did not substantiate the allegation that patient safety concerns were not reported. Patient safety issues were communicated to leadership and incident reports completed. OIG repeatedly heard complaints of low staff morale; however, OIG determined leadership at both the system and Veterans Integrated Service Network (VISN) level continued to take action regarding improving workplace culture. [\[Click here to access report.\]](#)

Review of an Alleged Radiology Exam Backlog at the W.G. (Bill) Hefner VAMC in Salisbury, North Carolina

The VA Secretary forwarded to OIG allegations received from the Office of Special Counsel regarding access to care at the W.G. (Bill) Hefner VA Medical Center (VAMC), Salisbury, NC. The complainant made six allegations related to the existence of a large backlog of radiology exams at the VAMC. These allegations are in addition to the allegations investigated and published October 4, 2016, in the Administrative Summary of Investigation in *Response to Allegations Regarding Patient Wait Times—VA Medical Center in Salisbury, North Carolina*, by OIG's Office of Investigations. OIG substantiated the allegation that the VAMC had a backlog of about 3,300 pending orders for radiology exams, but did not substantiate the other five allegations. OIG confirmed the existence of a backlog of over 3,000 pending orders for radiology exams at a specific point in time in 2014 near the date identified by the complainant. However, Salisbury VAMC Imaging Service decreased the over 3,000 pending exams and the number of pending orders. The facility averaged 1,358 pending orders from January 1, 2014 through March 31, 2016, but was unable to eliminate the backlog. Furthermore, OIG review found the Imaging Service was not effectively managing its pending radiology exam workload to ensure patients received timely exams. Some patients experienced significant delays in the completion of ordered exams. OIG reviewed the records of 15 patients who died before the completion of a total of 16 ordered exams, but did not determine that any of the deaths or adverse clinical outcomes resulted from the delays. OIG recommended the VAMC Director require staff review all unscheduled radiology exam orders that are 30 days past the clinically indicated date and either cancel the orders if the exams are not needed or ensure the exams are scheduled. OIG also recommended the Director make unscheduled urgent and STAT orders a priority in the staff's review of unscheduled radiology orders and identify whether potential harm has occurred to patients due to delays in care. Finally, OIG recommended the VA Mid-Atlantic Health Care Network Director ensure the VAMC develops a plan to address existing demand for radiology exams and ensure future patients receive access to exams in accordance with VHA policy. The VA Mid-Atlantic Health Care Network Director and the VAMC Salisbury Director concurred with OIG findings and recommendations and provided an appropriate corrective action plan.

[\[Click here to access report.\]](#)

Teleradiology Concerns, VA Roseburg Healthcare System, Roseburg, Oregon

OIG conducted an inspection to assess the merit of allegations made by a confidential complainant regarding radiology services at the VA Roseburg Healthcare System (system), Roseburg, OR, and teleradiology services with the Alaska VA Healthcare System, Anchorage, AK, and the Jonathan M. Wainwright Memorial, VAMC, Walla Walla, WA. OIG substantiated the allegation that the reading of teleradiology studies for Anchorage patients by system radiologists occurred prior to both sites signing a Memorandum of Understanding. OIG found no evidence of delays in radiologic interpretation, misinterpretation of studies, or reports of patient harm. OIG did not substantiate that delays in radiologic readings occurred for Roseburg patients as a result of providing teleradiology services to Anchorage and Walla Walla. OIG substantiated that the system lacked an integrated peer review process for radiology.

The system's Radiology Service level peer review program was not an integrated part of the system's overall peer review program for Quality Management. This could hinder the system's ability to detect misinterpretations of radiologic studies if they occurred. OIG did not substantiate that the system improperly credentialed and privileged teleradiology providers. All four of the system's staff radiologists providing teleradiology services were appropriately credentialed and privileged. [\[Click here to access report.\]](#)

CRIMINAL INVESTIGATIONS

Former Augusta, Georgia VAMC Chief of Fee Basis Sentenced for Making False Statements

A former Augusta, GA VAMC Chief of Fee Basis was sentenced to 27 months' incarceration, 3 years' supervised release, and was ordered to pay a \$5,100 special assessment and a \$1,500 fine after being found guilty at trial of making false statements in relation to health care and making a false statement to a Federal agent. An OIG investigation revealed that the defendant instructed four subordinate employees to improperly close approximately 2,700 non-VA care coordination consults at the medical center. Specifically, the defendant directed his subordinates to falsely document "services provided or patient refused services" in the patients' VA electronic medical records even though employees had not reviewed the records or contacted the patients. OHI conducted a review of approximately 2,700 patient records and determined that over 450 patients never received care and/or refused services.

Ten Non-Veterans Indicted for Redirecting Veterans' Benefits

Ten non-veterans were indicted and eight were subsequently arrested for conspiracy to commit wire fraud, wire fraud, and aggravated identity theft. One defendant resides in Jamaica and another is a fugitive; both are actively being sought by law enforcement. A VA OIG, Department of Homeland Security (DHS) OIG investigation, and United States Postal Service (USPS) Inspection Service investigation resulted in the discovery of the defendants in Jamaica redirecting the monthly benefit payments of veterans and social security recipients. Subsequently, cards containing the benefit payments were mailed to co-defendants in the U.S. (Miami) where the funds were removed, a portion kept, and the remainder sent back to Jamaica. Additionally, the investigation also identified that the co-defendants were allegedly involved in lottery scams, which target elderly, vulnerable victims. Seven of eight defendants confessed to their roles in the scheme and the eighth later agreed to cooperate. The total loss to VA, Social Security Administration, and the lottery scam victims is approximately \$3 million. This investigation began as a proactive, nationwide effort to combat the growing problem of veterans' benefits redirections.

Three Defendants Found Guilty of Workers' Compensation Fraud

Three defendants were found guilty at trial of conspiracy, health care fraud, wire fraud, and money laundering relating to their ownership and operation of multiple workers' compensation clinics throughout the United States. A VA OIG, USPS Inspection Service, Department Of Labor OIG, DHS OIG, and Internal Revenue Service (IRS) Criminal Investigator investigation resulted in the defendant being charged with conspiring since January 2011 to unlawfully bill multiple Federal agencies for false and

fraudulent claims and for services not rendered. The investigation also revealed that in July 2013, shortly after the execution of a Federal search warrant on the business, two of the defendants “laundered” \$700,000 in an attempt to conceal the money’s location from law enforcement. The loss to the Government is approximately \$9 million.

Husband and Wife Sentenced for Service-Disabled Veteran-Owned Small Business Fraud

A husband and wife were sentenced to 48 months’ and 30 months’ incarceration respectively, and 36 months’ supervised release after previously being convicted at trial of major fraud against the Government, wire fraud, and conspiracy to commit wire fraud. The defendants also forfeited over \$170,000 in cash and five rental properties that were acquired using proceeds from the fraudulently obtained Government contracts. A VA OIG, Department Of Interior OIG, and Small Business Administration (SBA) OIG investigation revealed that the defendants used a “pass-through” scheme to create a Service-Disabled Veteran-Owned Small Business in order to qualify for and obtain set-aside construction contracts in multiple states. The defendants used a service-disabled veteran who was a full-time truck driver and had no construction experience or equipment to establish a construction business and provided fraudulent references to VA and other Government agencies in order to obtain the work. The defendants also created another business to obtain SBA 8(a) set-aside contracts with the two businesses sharing employees, financial assets, and then subcontracting out the work on most projects. The \$4 million VA loss includes American Recovery and Reinvestment Act funds. The total loss to the Government is \$15 million.

Two Nursing Home Operators Agreed to Pay \$4.7 Million

The Department of Justice announced that two nursing home operators agreed to pay \$4.7 million to resolve allegations concerning inflated therapy claims by their contracted rehabilitation therapy company. This civil settlement was the result of a VA OIG, Health and Human Services OIG, and Federal Bureau of Investigation (FBI) investigation into allegations that the company utilized numerous schemes to inflate the amount of therapy that they actually provided to patients, including veterans placed by VA at these nursing homes. A criminal investigation regarding the company is still ongoing.

Three Former Pharmaceutical Company Managers Sentenced for Health Care Fraud

The former district manager of a pharmaceutical company was sentenced to 8 months’ probation with home confinement, 128 hours’ community service, and was ordered to pay \$21,500 in asset forfeiture after previously pleading guilty to conspiracy to commit health care fraud. A second former district manager, who had previously pled guilty to conspiracy to commit health care fraud, was sentenced to 8 months’ probation with home confinement and was ordered to pay a \$10,000 criminal fine and \$28,237 in asset forfeiture. A third former district manager, who had previously pled guilty to wrongful disclosure of identifiable health information, was sentenced to 12 months’ probation and a \$10,000 criminal fine. All of these sentences were part of a larger multi-agency investigation into allegations of kickbacks, off-label marketing, and the submission of false claims in the form of prior authorizations.

Veteran Sentenced for Unlawful Sexual Contact with a Minor

A veteran participating in compensated work therapy at the Chillicothe, OH VAMC was sentenced to 3 years' incarceration after pleading guilty to unlawful sexual contact with a minor and gross sexual imposition. The veteran was also adjudicated a Tier 2 Sex Offender/Child Victim Offender Registrant. An OIG and local police investigation resulted in the defendant being charged with the sexual contact of a 14-year-old disabled daughter of a VA volunteer on VA property.

Veteran Pleads Guilty to Mail Fraud and Structuring Currency Transactions

A veteran pled guilty to mail fraud and structuring currency transactions. A VA OIG and IRS Criminal Investigator investigation resulted in the defendant being charged after he was alleged to have defrauded at least 15 veterans by representing that, in exchange for money, he could assist them in obtaining increased benefits from VA. The defendant represented that the money the veterans provided to him would be used to pay for the services of an attorney or other expenses. The defendant did not initiate any claims for the veterans; he kept the money for personal use and subsequently defrauded his victims of approximately \$525,000. As part of the scheme, the defendant also structured approximately \$36,000 in bank deposits.

Former VA Fiduciary Arrested for Misappropriation

A former VA fiduciary was indicted and arrested for theft of Government funds and misappropriation by a fiduciary. An OIG investigation resulted in the defendant being charged with making numerous cash withdrawals and purchases from a veteran's bank account from October 2014 to July 2015. The veteran had recently received a large sum of back pay from VA. The defendant allegedly misappropriated approximately \$37,197 in VA benefits.

Subject Arrested for Identity Theft

A subject was arrested for fraud and related activity in connection with access devices. A VA OIG and Federal Housing Finance Agency OIG investigation resulted in the defendant being charged with fraudulently receiving VA and Freddie Mac employees' personally identifiable information. The stolen identities were then used to open credit card accounts and to receive non-VA medical care.

Veteran Sentenced for the Fraudulent Receipt of VA Compensation Benefits

A veteran was sentenced to 24 months' incarceration, 3 years' supervised release, and was ordered to pay VA \$789,472 in restitution after being found guilty at trial of health care fraud. An OIG and FBI investigation revealed that from March 1995 through June 2013 the defendant misrepresented his vision loss to VA. The defendant was granted a 100 percent service connection for vision loss, special monthly compensation, and other program benefits to which he was not entitled. The defendant was observed walking without assistance and driving. The defendant also maintained a valid driver's license and received a speeding ticket. In addition to receiving approximately \$700,000 in VA compensation benefits, the defendant also received a \$10,000 VA grant to purchase an automobile (intended for another person to drive the defendant), and an \$11,000 VA grant towards the installation of an in-ground swimming pool at his residence. The

defendant also received over \$75,000 in VA health care benefits to which he was not entitled, to include Civilian Health and Medical Program of the VA, dental services, beneficiary travel pay, blind rehabilitation training, and prosthetics equipment and devices.

Veteran Sentenced for Theft of Government Funds

A veteran was sentenced to 5 years' probation and was ordered to pay \$313,276 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that in 1998 the defendant provided VA with a medical report from a non-VA ophthalmologist reporting that his visual acuity was "hand motion only," his vision would not get better, and that his vision could not be corrected by surgery. Based on this information, the defendant was rated 100 percent service connection for blindness. The investigation further revealed that the defendant possessed a valid driver's license, rode a motorcycle, and worked for 6 years as a mail clerk at a private business. A VA ophthalmologist examined the defendant and determined that he was not and could never have been blind. The loss to VA is \$518,486, with \$205,210 being recovered administratively.

Veteran Pleads Guilty to Making a False Statement to VA

A veteran pled guilty to making a false statement and agreed to pay VA \$148,000 in restitution. An OIG investigation revealed that the defendant falsely claimed to suffer from symptoms of narcolepsy and received a medical discharge from the Navy in 1997. The defendant subsequently applied for and received VA compensation benefits for service-connected narcolepsy, claiming the condition rendered him homebound and unable to work. The defendant later became a Federal employee for the U.S. Army Corps of Engineers and utilized his Federal employee health benefits to obtain treatment and medication for the fraudulently claimed condition in furtherance of his scheme to defraud VA. The defendant also provided material false statements to investigators, a VA physician, and a rating veterans service representative about his condition and symptoms. The loss to VA is over \$270,000.

Veteran Charged with Stolen Valor

A veteran was charged with wire fraud and stolen valor. The veteran alleged that while serving in the United States Marine Corps he was awarded a Combat Action Ribbon along with two Purple Heart medals. The veteran claimed to have been injured by an improvised explosive device (IED) while serving in Iraq. As a result of his claims, the veteran fraudulently obtained VA compensation benefits, in addition to receiving a mortgage-free house from the Military Warrior Support Foundation. An OIG and FBI investigation resulted in the defendant being charged with falsely claiming the Combat Action Ribbon and Purple Heart medals. The investigation also revealed that the veteran was not injured by an IED and did not engage in combat. The loss to VA is \$243,436.

Veteran Sentenced for Theft of VA Compensation Benefits

A veteran was sentenced to 6 months' incarceration, 6 months' home confinement, 2 years' supervised release, and was ordered to pay VA restitution of \$150,164 after

previously pleading guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with claiming false post-traumatic stress disorder (PTSD) stressors in order to fraudulently collect VA compensation benefits for approximately 10 years. Examples of stressors the veteran fraudulently claimed included his participation in a "dead body detail" during Operation Desert Storm and his involvement in an incident in which a fellow soldier's Humvee was fired upon causing the vehicle to crash and kill the soldier. The investigation determined that from July 1991 to January 1992 the veteran served as an administrative clerk in Saudi Arabia and Kuwait and did not serve in a combat role during his tour of duty overseas. Additionally, the defendant was not involved in a Humvee accident or "dead body detail." The defendant was previously convicted in 1996 as the result of an OIG investigation involving the VA Home Loan Program.

Veteran Sentenced for Theft of Government Funds

A veteran was sentenced to 3 years' probation, 250 hours' community service, and was ordered to pay VA restitution of \$56,740 after pleading guilty to theft of Government funds. An OIG investigation revealed that from 2012 to 2015 the defendant received individual unemployment benefits while employed by a local district attorney's office and the Oregon Department of Justice.

Relative of Deceased VA Beneficiary Sentenced for Theft of Government Funds

A relative of a deceased VA beneficiary was sentenced to 3 years' probation, 300 hours' community service, and was ordered to attend mental health and alcohol treatment programs and to pay \$109,292 in restitution after previously pleading guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA Dependency and Indemnity Compensation (DIC) benefits that were direct deposited after the beneficiary's death in November 2009. The defendant admitted to using the stolen funds for personal use.

Son of Deceased VA Beneficiary Sentenced for Theft of Government Funds

The son of a deceased VA beneficiary was sentenced to 11 months' incarceration, 3 years' supervised release, and was ordered to pay restitution of \$86,516 after pleading guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA DIC benefits that were direct deposited into a joint account after his mother's death in December 2005. The defendant admitted to using the stolen funds for personal use.

Daughter of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds

The daughter of a deceased beneficiary was sentenced to 3 years' probation and was ordered to pay \$77,184 in restitution after previously pleading guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with the theft of VA DIC benefits that were direct deposited after the beneficiary's death in July 2009. The defendant admitted to using the stolen funds for personal use.

Veteran Sentenced for Weapons Violation

A veteran was sentenced to 4 years' incarceration and 3 years' probation after pleading guilty to unlawfully converting a firearm into a machine gun and then selling the weapon. During an OIG and VA Police Service investigation involving illicit drug sales at the Long Beach, CA VAMC, the defendant sold a fully automatic SKS rifle, two 20-round magazines, and ammunition to an undercover VA police officer.

Long Beach, California VAMC Employee Sentenced for Criminal Threats

A Long Beach, CA VAMC employee was sentenced to 6 days in jail and 3 years' probation after pleading guilty to criminal threats. An OIG and VA Police Service investigation resulted in the defendant being charged after texting pictures of his genitals to a subordinate employee. The defendant was also accused of sexually assaulting another employee. During the investigation, the employee allegedly threatened to kill a witness.

Veteran Sentenced for Making Threat to VA

A veteran was sentenced to 6 months' incarceration and 3 years' supervised release after pleading guilty to an interstate communication of a threat to injure another. An OIG investigation revealed that the defendant called the VA National Suicide Hotline and communicated a plan to purchase a firearm once he received his Social Security check and travel to a VA regional office and "kill as many people as possible," before committing suicide. During a subsequent interview, the defendant admitted to making the threat because he was extremely agitated due to VA's repeated denials of his benefits for PTSD.

Former Livermore, California VAMC Employee Sentenced for Drug Theft

A former Livermore, CA VAMC employee was sentenced to 3 years' probation, time served (1 day), and was ordered to attend and successfully complete a 4-month drug treatment program after pleading "no contest" to possession of a controlled substance. During an OIG and VA Police Service investigation involving the theft of prescription medication packages, the defendant was observed at his work desk smashing pills into a powder form that he subsequently inhaled. The defendant admitted to stealing narcotics from the USPS packages.

Wilkes-Barre, Pennsylvania VAMC Nurse Charged with Acquiring Narcotics by Fraud

A Wilkes-Barre, PA VAMC CLC nurse was charged with acquiring narcotics by fraud or misrepresentation. An OIG and VA Police Service investigation resulted in the defendant being charged after she allegedly diverted morphine and hydromorphone for approximately 9 months by reporting in the Omnicell automated medication dispensing system that she had disposed of the narcotics. The defendant is further alleged to have stolen the drugs for personal use.

Former St. Joseph, Missouri Community Based Outpatient Clinic Physician Arrested for Fraudulently Attempting to Obtain a Controlled Substance

A former St. Joseph, MO Community Based Outpatient Clinic physician was arrested for fraudulently attempting to obtain a controlled substance. An OIG and local police investigation resulted in the defendant being charged after he allegedly wrote VA prescriptions for a non-veteran. The physician allegedly wrote the fraudulent prescriptions from August 2015 to April 2016 in order to obtain the controlled substances for his personal use.

Portland, Oregon VAMC Fee-Based Physician Enters into a Pretrial Diversion Agreement

A Portland, OR VAMC fee-based physician entered into a Pretrial Diversion agreement with the Government. A VA OIG and Office of Personnel Management OIG investigation revealed that the fee-based physician prescribed controlled substances for her husband, who was a full-time VA surgeon at the same facility, and then diverted the controlled substances for her own use. The two physicians did not share the same last name, and the husband was unaware of the diversion. The physician's employment was terminated by the facility.

Veteran Pleads Guilty to Possession With Intent to Deliver Narcotics

A veteran pled guilty to possession with intent to deliver narcotics. An OIG, state police, and VA Police Service investigation was initiated in 2013 when a patient seeking drug addiction treatment reported being approached on several occasions to buy narcotics from individuals at the Philadelphia, PA VAMC. Through several undercover operations, 12 other subjects were identified as selling narcotics at the medical center and have also been charged as part of this investigation.

Son of a Deceased Veteran Indicted for Unlawful Possession of Oxycodone and Identity Theft

The son of a deceased veteran was indicted for unlawful possession of oxycodone and identity theft. An OIG investigation resulted in the defendant being charged with posing as his deceased father and contacting VA to refill his father's oxycodone prescription. For over 9 months, VA shipped 4,500 oxycodone tablets to the son's home.

ADMINISTRATIVE SUMMARIES OF INVESTIGATION

OIG conducted extensive work related to allegations of wait time manipulation after the allegations at the Phoenix VA Health Care System in April 2014. Since that event and through FY 2015, OIG received numerous allegations related to wait time manipulation at VA facilities nationwide from veterans, VA employees, and Members of Congress that were investigated by OIG criminal investigators.

At this time, OIG has completed more than 80 criminal investigations related to wait times and provided information to VA's Office of Accountability Review for appropriate action. It has always been our intention to release information regarding the findings of these investigations at a time when doing so would not impede any planned prosecutive

or administrative action. As other administrative summaries of investigation are completed, we intend to post them to our website so that veterans and Congress have a complete picture of the work conducted in their state.

You may view and download these administrative summaries of investigation by clicking on the link to our webpage at www.va.gov/oig/publications/administrative-summaries-of-investigation.asp and selecting the appropriate state.

Administrative Summary of Investigation (October 2016)	
Summary Number	Location
14-02890-255	Salisbury, North Carolina, VA Medical Center



MICHAEL J. MISSAL
Inspector General