



HIGHLIGHTS
September 2009

CONGRESSIONAL TESTIMONY

Counselor to IG Testifies on VA's Interagency Agreement with Navy's Space and Warfare Systems Center

Counselor to the Inspector General, Maureen Regan, testified before the U.S. House of Representatives' Committee on Veterans' Affairs Subcommittee on Economic Opportunity on an Office of Inspector General (OIG) review of the VA's interagency agreement (IAA) with Navy's Space and Warfare Systems Center (SPAWAR). This review was requested by the VA Secretary and the Ranking Member of the House Veteran's Affairs Committee. Ms. Regan told the Subcommittee that OIG concluded that neither VA nor SPAWAR has complied with the terms and conditions of the IAA, and that VA had relinquished its oversight role of financial performance and work performed under the IAA to SPAWAR. Ms. Regan also discussed the OIG report on the failure of the Replacement Scheduling Application development program. Ms. Regan was accompanied by Michael Grivnovics, Director, OIG Office of Contract Review.

[\[Click for Testimony.\]](#)

AIG for Audits and Evaluations Testifies on VA's Inventory of Non-Controlled Drugs

Assistant Inspector General (AIG) for Audits and Evaluations, Belinda Finn, testified before the U.S. House of Representatives' Committee on Veterans' Affairs Subcommittee on Health on two recent OIG reports, *Audit of VA Consolidated Mail Outpatient Pharmacy (CMOP) Inventory Accountability* and *Audit of Veterans Health Administration's (VHA) Management of Non-Controlled Drugs*. She told the Subcommittee that while VA spent \$3.7 billion on pharmaceuticals in fiscal year 2008, VHA medical facilities and CMOPs could not accurately account for non-controlled drug inventories because of inadequate inventory management practices, record keeping, and inaccurate pharmacy data. Without improved controls, VHA cannot ensure its non-controlled drug inventories are appropriately safeguarded, nor can VHA accurately account for these expensive inventories. Ms. Finn was accompanied by Irene Barnett, Ph.D., Audit Manager, OIG Bedford Audit Operations Division. [\[Click for Testimony.\]](#)

AIG for Investigations Testifies on Administrative Investigations of VA's Office of Information and Technology

AIG for Investigations, James O'Neill, testified before the U.S. House of Representatives' Committee on Veterans' Affairs Subcommittee on Oversight and Investigations on two recent OIG reports, *Administrative Investigation – Misuse of Position, Abuse of Authority, and Prohibited Personnel Practices Office of Information & Technology (OI&T), Washington, DC*, and *Administrative Investigation – Nepotism, Abuse of Authority, Misuse of Position, Improper Hiring, and Improperly Administered Awards, OI&T, Washington, DC*. Mr. O'Neill discussed issues related to the hiring practices within OI&T and other administrative matters, including nepotism, misuse of position, prohibited personnel practices, misuse of hiring authorities, improper funding of academic degrees, and improper administration of awards. Mr. O'Neill was accompanied by Joseph Sullivan, Deputy AIG for Investigations, and Michael Bennett, Attorney Advisor. [\[Click for Testimony.\]](#)

OIG REPORTS

Audit Recommends Improved Controls over Handling of Veterans' Claims Folders

OIG determined that the Veterans Benefits Administration (VBA) does not have effective controls in place to manage Veterans' claims folders adequately. At the time of the review, VBA had assigned about 4.2 million claims folders to regional offices for benefit claims processing and safeguarding. Approximately 7 percent of these claims folders were misplaced and an additional 3 percent were lost. Misplaced and lost claims folders ultimately cause unnecessary claim processing delays and place additional burdens on Veterans. OIG made recommendations to ensure that management track the number of lost or rebuilt folders, consistently enforce Control of Veterans Records System policies, and establish effective search procedures for missing claims folders. [\[Click for Report.\]](#)

VBA Needs to Improve Mailroom Management

OIG conducted an audit to evaluate whether VA Regional Offices (VAROs) effectively managed mailroom operations and controlled the timely and accurate processing of claim-related mail. In fiscal year 2008, VBA processed about 33 million pieces of incoming and outgoing mail. Both the significant number of claim-related documents handled by VARO mailrooms and the potential processing effect of Veterans claims if documents are inappropriately handled or destroyed make this a high-risk area for VBA. OIG determined that VARO mailrooms needed improvements in the handling, processing, and protection of claims-related documents as well as in meeting mailroom security and other operational requirements. [\[Click for Report.\]](#)

Unannounced Inspections Find Improved Reprocessing Compliance

In August 2009, OIG performed unannounced follow-up inspections of all VHA facilities that perform colonoscopy reprocessing. Among the 129 facilities inspected, all were in compliance with standard operating procedures. With one exception, all facilities had adequate documentation of demonstrated competence for reprocessing staff. VHA is still in the process of implementing recommendations made in OIG's initial report,

issued June 16, 2009, on the use and reprocessing of flexible fiberoptic endoscopes at VAMCs. [\[Click for Report.\]](#)

OIG Identifies Opportunities to Improve Rating Claims Processing Timeliness

OIG conducted an audit of VARO rating claims processing in order to identify opportunities to improve timeliness and minimize the number of claims with processing times exceeding 365 days. OIG determined that inefficient VARO workload management and/or claims processing activities performed by entities outside VARO control caused avoidable processing delays for almost all of the claims pending more than 365 days. OIG made four recommendations to improve rating claims processing timeliness and minimize the number of rating claims with processing times exceeding 365 days. [\[Click for Report.\]](#)

Improved Oversight of IT Investments Needed in OI&T

An OIG audit found management control deficiencies in OI&T use of the System Development Life Cycle process, which manages major VA information technology (IT) investments totaling approximately \$3.4 billion. OIG determined that OI&T needs to communicate and enforce guidance to ensure major investments are effectively managed. Moreover, OI&T should take immediate action to implement management controls to ensure centralized oversight of VA's IT investments. These deficiencies prevent OI&T from ensuring effective and efficient management, leaving VA's IT investment portfolio at risk of cost and schedule overruns, which could ultimately lead to costly, unproductive, or failed programs and projects. OIG made four recommendations to facilitate the implementation of management controls, ensure centralized management of VA's IT investments, improve risk management, and improve the overall governance of VA's IT investments. [\[Click for Report.\]](#)

VA Needs to Apply Lessons Learned to Technology Program

An OIG audit determined that VA needs to increase management controls over the development of the Financial and Logistics Integrated Technology Enterprise (FLITE) program. The FLITE program is experiencing repeat issues that arose during the implementation of the Core Financial and Logistics System: critical program functions were not fully staffed, non-FLITE expenditures were funded through the FLITE program, and contract awards did not comply with competition requirements. VA has already implemented 7 of the 11 recommendations made by OIG to correct these issues. [\[Click for Report.\]](#)

OIG Audits Recovery Act Funds for State Housing Grants

An OIG audit determined that VHA needs to acquire additional staff to accommodate the increased workload within State Home Construction Grant Program. The American Recovery and Reinvestment Act provided \$150 million for VHA to provide grants for the construction of State extended care facilities. [\[Click for Report.\]](#)

OIG's Benefits Inspection Program Visits Wilmington and Nashville VAROs

The Benefits Inspection Program conducted an on-site inspection at the Wilmington, DE, VARO to review disability compensation claims processing and Veteran Service

Center operations. The Wilmington VARO met the requirements for processing benefit claims involving traumatic brain injury, systematic analysis of operations, correcting Systematic Technical Accuracy Review errors, date stamp accountability, implementation of the Claims Process Improvement model, handling claims-related mail, and responding to electronic inquiries. However, OIG noted several opportunities for improvement and recommended providing refresher training on claims-processing and improving management oversight and controls over operations. The Director concurred with all recommendations but offered qualifications and commentary on some issues. [\[Click for Wilmington Report.\]](#)

The Benefits Inspection Program also reviewed disability compensation claims processing and Veteran Service Center operations during an on-site inspection at the Nashville, TN, VARO. The Nashville VARO met the requirements for processing benefit claims involving diabetes, tracking claims folders, systematic analysis of operations, date stamp accountability, and accurately and timely handling congressional inquiries. OIG identified several areas for improvement and recommended providing refresher training on claims-processing and improving management oversight and controls over operations in both cases. The Director of the Nashville VARO concurred with all recommendations except for training Legal Instrument Examiners. [\[Click for Nashville Report.\]](#)

Review of 13 Community Based Outpatient Clinics Conducted

OIG reviewed seven Community Based Outpatient Clinics (CBOCs) throughout Veterans Integrated Service Networks (VISNs) 2, 4, and 9, visiting Lockport and Olean, NY; Monaca, Washington, Berwick, and Sayre, PA; and Somerset KY. The review covered five areas: quality of care measures, credentialing and privileging, environment of care and emergency management, patient satisfaction, and CBOC contracts. OIG noted several opportunities for improvement and made a total of 18 recommendations. [\[Click for Report.\]](#)

Additionally, OIG conducted another set of CBOC reviews throughout VISNs 5 and 6, visiting Cambridge, Fort Howard, and Greenbelt, MD; Alexandria, VA; and Wilmington and Jacksonville, NC. OIG reviewed quality of care measures, credentialing and privileging, environment of care and emergency management, patient satisfaction, and CBOC contracts. OIG made 15 recommendations to ensure the CBOCs operate in a manner that provides Veterans with consistent, safe, high-quality health care. [\[Click for Report.\]](#)

OIG Finds VHA Suicide Prevention Programs Generally Compliant

OIG evaluated the extent to which 24 VHA facilities implemented suicide prevention programs in compliance with VHA requirements. All 24 facilities implemented suicide prevention programs that generally met the VHA requirements. To strengthen the programs, OIG recommended that VHA ensure: documentation of collaboration between suicide prevention coordinators (SPCs) and mental health (MH) providers, MH providers develop comprehensive and timely safety plans, and full-time SPCs are appointed at very large CBOCs. [\[Click for Report.\]](#)

OIG Reviews Allegations Against VA North Texas Health Care System

An OIG review determined that allegations regarding widespread false documentation of resident supervision and unfulfilled contractual obligations by attending physicians from the University of Texas Southwestern Medical Center at Dallas were not valid. The complainant also alleged that an attending physician was not present at the facility during a Code Blue (cardiorespiratory arrest) event. OIG confirmed that although the physician was absent during the Code Blue, there is no requirement to be physically present in the unit to fulfill supervision responsibilities, and the patient was managed appropriately by other physicians. OIG further determined that the system needed to comply with VHA discharge summary documentation requirements and noted that the facility had already implemented corrective actions. [\[Click for Report.\]](#)

Review of Allegations Finds Issues with Fee Basis Consults at Prescott VAMC

OIG evaluated allegations related to quality of care in several services and the rating change of a peer review at the Bob Stump VAMC in Prescott, AZ. Although the allegations were not substantiated, the inspection revealed that the VAMC lacked a mechanism for tracking their large number of fee basis consults. Additionally, a VAMC provider failed to inform leadership about an unacknowledged abnormal chest x-ray from the Southern Arizona VA Health Care System, Tucson, AZ. [\[Click for Report.\]](#)

OIG Inspects Allegations Against Hampton, Virginia, VAMC

OIG made four recommendations to address the substantiated allegations against the Emergency Department (ED) at the Hampton VAMC in Hampton, VA. OIG substantiated that the treating physician did not conduct an adequate work-up of a patient's stroke symptoms, the ED physician violated VHA guidelines and erroneously copied and pasted another patient's laboratory results into the medical record of the complainant, and that staff did not promptly respond to the patient's concerns. OIG could not confirm that the patient's blood pressure was inaccurately recorded or that the physician was discourteous. [\[Click for Report.\]](#)

CRIMINAL INVESTIGATIONS

Pharmaceutical Manufacturer Settles with Government

A major pharmaceutical manufacturer and its subsidiary have agreed to pay \$2.3 billion, the largest health care fraud settlement in the history of the Department of Justice, to resolve criminal and civil liability arising from the illegal promotion of certain pharmaceutical products. The subsidiary has agreed to plead guilty to a felony violation of the Food, Drug, and Cosmetic Act for misbranding a drug with the intent to defraud or mislead. A joint investigation was conducted by OIG, Federal Bureau of Investigation (FBI), Health and Human Services OIG, Food and Drug Administration (FDA) Office of Criminal Investigations, Defense Criminal Investigative Service, and U.S. Postal Service OIG. The investigation determined that the company promoted the sale of the drug for several uses and dosages that the FDA specifically declined to approve due to safety concerns. The company will pay a criminal fine of \$1.195 billion, the largest criminal fine ever imposed in the United States. The subsidiary will also forfeit \$105 million for a total criminal resolution of \$1.3 billion.

In addition, the company has agreed to pay \$1 billion to resolve allegations under the civil False Claims Act. The allegations include that the company illegally promoted four drugs and caused false claims to be submitted to Government health care programs for uses that were not medically accepted indications and therefore not covered by those programs. The civil settlement also resolves allegations that the company paid kickbacks to health care providers to induce them to prescribe these and other drugs. The Federal share of the civil settlement is \$668,514,830, of which \$11.3 million will be returned directly to VA. The state Medicaid share of the civil settlement is \$331,485,170. This is the largest civil fraud settlement against a pharmaceutical company.

Previously, as a result of this investigation, a former district manager was found guilty at trial of obstruction of justice and sentenced to 6 months' home confinement and 3 years' probation. A former regional manager was sentenced to 24 months' probation and a \$75,000 fine after pleading guilty to distribution of a misbranded drug.

Former Louisville, Kentucky VA Employee and DAV Service Officer Plead Guilty

A former Louisville, KY, VARO employee and a former Disabled American Veterans (DAV) service officer pled guilty to conspiracy to defraud the United States, bribery of a public official, and theft of Government funds. In November 2008, the two defendants were indicted, along with 12 others, for filing fraudulent claims with VA. These claims were backdated approximately 18 to 24 months by the VARO employee and the DAV service officer causing a large retroactive back payment to be generated to the Veterans. In addition, the two defendants altered or counterfeited medical documents to ensure the fraudulent claims were approved with a 100% service-connection disability. Once the retroactive disability payments were received by the Veterans, the two defendants would generally receive two-thirds of the retroactive checks, with the Veterans keeping the monthly VA disability payment. To date, twelve of the indicted defendants have entered guilty pleas. Two additional defendants are pending judicial action. The loss to VA is approximately \$2 million.

Veteran's Wife Arrested for Poisoning

A Veteran's wife was arrested for poisoning her husband while an inpatient at the Temple, TX, VAMC. The Veteran survived the poisoning. A joint OIG, FBI, and VA Police investigation revealed that the defendant introduced various toxic substances (currently believed to be insecticides and household cleaning liquids) into her husband's beverages over a period of approximately 5 weeks, causing him to repeatedly lose consciousness and require multiple hospital admissions. Video surveillance of the Veteran's hospital room revealed that the defendant continued to poison her husband even after he was admitted to the facility for treatment of previous poisonings committed outside the facility.

Fiduciary Pleads Guilty to Embezzlement

A fiduciary pled guilty to making a false statement after an OIG and Social Security Administration OIG investigation determined that she embezzled approximately \$1.3 million dollars belonging to 33 Veterans for whom she provided fiduciary services.

Beneficiary Pleads Guilty to Wire Fraud

The widow of a Veteran pled guilty to wire fraud after an OIG investigation revealed that she failed to report to VA that she had remarried and fraudulently received \$125,732 in VA benefits.

Daughter of Deceased Beneficiary Pleads Guilty to Theft

The daughter of a deceased VA Dependency and Indemnity Compensation (DIC) beneficiary pled guilty to a criminal information charging her with theft of Government funds. An OIG investigation revealed that the defendant failed to notify VA of her mother's death, pretended to be her mother in her contacts with VA, and stole VA funds that were deposited into her mother's account. The loss to VA is \$112,443.

Veteran Sentenced for Fraudulent Receipt of VA Benefits

A Veteran was sentenced to 30 months' probation and ordered to pay \$57,435 in restitution after being convicted of fraudulently receiving VA benefits. An OIG investigation revealed that the Veteran, who was in receipt of Individual Unemployability benefits due to an alleged service-connected back condition, failed to accurately report the level of his disability during a VA Compensation and Pension examination. Specifically, he denied participating in any sports or hobbies, when in fact he was a member of a bowling association and bowled in multiple leagues.

Oklahoma City VAMC Nurse Indicted for Assault

An Oklahoma City, OK, VAMC nurse was indicted for assault and concealment of a material fact after an OIG investigation determined that he assaulted an 82 year-old VAMC patient suffering from dementia. When interviewed by OIG agents the defendant initially denied assaulting the patient, who suffered a fractured right humerus bone and severe bruising and swelling in his right arm and hand.

Veteran's Brother Indicted for Identity Theft and Health Care Fraud

The brother of a Veteran was indicted for health care fraud, theft of public money, identity theft, and aggravated identity theft. An OIG investigation revealed that the defendant assumed the identity of his brother and fraudulently received VA medical care for over 8 years. The defendant also filed fraudulent applications for medical benefits and documents that contained false income information so he could continue receiving the care at no cost. The loss to VA is \$378,542.

Veteran Arrested for Education Benefits Fraud

A Veteran was arrested for theft of Government funds and false claims after an OIG investigation determined that he fraudulently received VA education benefits from

March 2004 to July 2007. The investigation determined that the defendant submitted VA Monthly Certifications falsely reporting that he was attending school. The loss to VA is \$20,920.

Daughter of Deceased Beneficiary Charged with Theft

A criminal information was filed charging the daughter of a deceased DIC beneficiary with theft of Government funds. An OIG investigation revealed that the defendant failed to notify VA of her mother's death and subsequently stole, forged, and negotiated VA benefit checks issued after her mother's death in March 1994. The loss to VA is \$136,885.

Defendant Arrested for Theft of Government Funds

A non-Veteran was arrested for theft of Government funds after an OIG investigation revealed he stole the identity of a Veteran and redirected the Veteran's VA compensation benefits and military retirement to his own bank account. The defendant also used the Veteran's personal information to obtain VA health care and to apply for an increase in VA benefits. The defendant attended a Compensation and Pension examination, posing as the Veteran, and was subsequently granted an increase in compensation benefits. The defendant also fraudulently received several credit cards using the Veteran's personal information. The total loss is approximately \$150,000.

Albuquerque VAMC Nurse Indicted for Drug Diversion

An Albuquerque, NM, VAMC nurse was indicted for drug diversion by deception after an OIG investigation disclosed she used the medical center's Acudose system to steal oxycodone and other controlled substances for personal use. The defendant attempted to conceal the diversion activity by associating the oxycodone with certain patients, many of them having no order from a physician for the medication.

(original signed by:)
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