



HIGHLIGHTS March 2010

CONGRESSIONAL TESTIMONY

AIG for Audits and Evaluations Testifies on VA's Systematic Technical Accuracy Review Program

Assistant Inspector General for Audits and Evaluations Belinda Finn testified before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, U.S. House of Representatives, on Office of Inspector General (OIG) findings related to Veterans Benefits Administration's (VBA) quality assurance processes. OIG projected VBA's accuracy rate for Systematic Technical Accuracy Review (STAR) reviewed claims was only 78 percent, 10 percentage points lower than VBA's reported error rate. She also told the Subcommittee that staff shortages affected VBA's ability to complete consistency reviews in claims with the same diagnostic codes in fiscal year 2009, and that an inadequate infrastructure and management strategy impeded another VBA quality assurance program, the Compensation & Pension (C&P) Service's Site Visit program, from accomplishing its mission and goals. Ms. Finn was accompanied by Larry Reinkemeyer, Director, Kansas City Office of Audits and Evaluations.

OIG REPORTS

Compensation & Pension Exams Need Greater Oversight To Improve Timeliness

At the request of Senator Daniel Akaka, Chairman of the Senate Committee on Veterans' Affairs, OIG conducted an audit to determine if VA commits sufficient resources to provide Veterans with timely C&P medical examinations. OIG determined that VA management has not given the C&P exam program the attention needed to ensure it is managed effectively. The audit found limited VA Central Office oversight regarding resource allocation, utilization, and productivity of the program. Furthermore, collaboration between the Veterans Health Administration (VHA) and VBA on issues affecting the timely delivery of exams is not adequate. VA currently lacks a performance standard that enables management to adequately measure whether exam requests are completed in a timely manner. As a result, many Veterans do not receive timely exams which can delay the delivery of disability benefits. OIG made 10 recommendations to help VA improve oversight and timeliness. [\[Click for Report.\]](#)

Improper Reprocessing of Reusable Medical Equipment Found at San Juan Health Care System

OIG conducted a healthcare inspection to determine the merit of allegations made against the Mayaguez and Ponce Outpatient Clinics (OPCs), within the VA Caribbean

Health Care System (HCS), San Juan, Puerto Rico. OIG substantiated that endovaginal transducers were not properly disinfected; leak testing was not being performed in the Ponce OPC, or on colonoscopes or laryngoscopes in the Mayaguez OPC; the system inaccurately certified compliance on three occasions; and senior managers were aware of these issues and took no action to assess the risk to patients. OIG also learned that laryngoscopes were not properly pre-cleaned and one unit contained a leak. The Veterans Integrated Service Network (VISN) Director chartered an Administrative Investigation Board (AIB) to investigate and address management responsiveness. OIG recommended that a risk assessment be performed and that the VISN Director take appropriate administrative action on the recommendations from the AIB. [\[Click for Report.\]](#)

VBA Fiduciary Program Needs Management Infrastructure Improvements

OIG's audit of VBA's Fiduciary Program found that VBA lacks reasonable assurance that VA-derived income and estates of incompetent beneficiaries are used solely for their care, support, welfare, and needs. The Fiduciary Program does not consistently pursue delinquent fiduciary accountings and follow up on potential misuse of beneficiary funds. VBA lacks elements of an effective management infrastructure to monitor program performance, effectively utilize staff, and oversee fiduciary activities. As a result, VA Regional Offices (VAROs) are not consistently taking timely or effective actions to ensure VA-derived income and estates of incompetent beneficiaries are protected. VBA needs to improve the management infrastructure to direct the Fiduciary Program nationwide more effectively. In addition, VBA needs to develop and disseminate policies and procedures to improve the effectiveness of analyzing annual accountings filed by fiduciaries and investigating and reporting allegations of misuse of beneficiary funds. [\[Click for Report.\]](#)

Patient Safety, Resource Management Issues Confirmed at Northern Indiana HCS

OIG reviewed allegations regarding mismanagement of resources and patient safety issues at the Northern Indiana HCS in Fort Wayne and Marion, IN. OIG substantiated five of the allegations and identified other environment and maintenance issues at the Fort Wayne campus that required management attention. OIG recommended that actions be taken to correct the findings. [\[Click for Report.\]](#)

Rate of Duplicate Payments Lower Than Average at VA Pacific Islands HCS

Also at the request of Chairman Akaka, OIG conducted a review of the VA Pacific Islands HCS (PIHCS) to determine the extent and causes of improper payments for PIHCS' outpatient fee care program. OIG found that PIHCS improperly made duplicate payments for 13 percent of outpatient fee claims, which resulted in overpayments of \$49,571 (or less than 1 percent of total outpatient fee expenditures). The error rate at PIHCS was significantly lower than the national error rate identified in a previous OIG audit. Since June 2008, PIHCS managers have provided training for fee staff on avoiding duplicate payments and notified local providers of proper billing requirements. OIG recommended that PIHCS management initiate recovery of the duplicate overpayments identified. [\[Click for Report.\]](#)

Increased Documentation of Elderly Veteran Cognitive Assessments Needed

OIG evaluated the extent to which VHA clinicians conduct assessments of elderly patients during hospitalization and ensure post-discharge follow-up care. Reviewers evaluated records for the presence of functional and cognitive assessments that are widely accepted as a basic level of care for vulnerable elders. OIG found that assessments of functional status were completed for more than 97 percent of hospitalized elders and that 94 percent of them had some evidence of care within 6 weeks of hospital discharge. In contrast, less than 40 percent of patients had evidence of any cognitive assessment during their hospitalization or in the 6 months prior to admission. OIG recommended that the Under Secretary for Health develop and implement a plan to ensure that vulnerable elderly Veterans admitted to VA hospitals have a documented assessment of cognitive functioning. [\[Click for Report.\]](#)

Strengthened Oversight Needed for Recovery Act Contract Award Monitoring

OIG reviewed the effectiveness of the VHA American Recovery and Reinvestment Act of 2009 (ARRA) non-recurring maintenance (NRM) contract award monitoring processes. OIG found that improved ARRA NRM oversight would ensure that VHA contract awards met the ARRA's requirements and accountability, efficiency, and transparency objectives. During the initial implementation of the ARRA, contracting officers did not properly publicize and prepare NRM contract solicitations and awards. OIG made four recommendations to strengthen oversight for ARRA NRM contract awards. [\[Click for Report.\]](#)

Review Finds Mental Health Safety Issues, Credentialing and Privileging Irregularities at Pineville, Louisiana, VAMC

OIG conducted a review to determine the validity of allegations regarding mental health (MH) safety issues and credentialing and privileging irregularities at the Alexandria VA Medical Center (VAMC) in Pineville, LA. OIG substantiated that MH inpatients were put at risk because staff did not comply with requirements for suicide risk assessments, suicide safety plans, an interim life safety plan, and MH environmental hazards inspections and training; there was insufficient follow up for high risk MH outpatients because of deficiencies with policies and suicide-related issue brief corrective action plans; blank Professional Standards Board (PSB) action forms were given to Service chiefs for signature prior to PSB action; and some renewed licenses were attached to previous license sections in VetPro. These findings resulted in recommendations to the VISN and VAMC Directors. [\[Click for Report.\]](#)

Improved Oversight, Controls Needed at Philadelphia and Togus VAROs

OIG conducted an onsite inspection at the Philadelphia, PA, VARO to review disability compensation claims processing and Veterans Service Center operations. OIG determined management needs to provide additional oversight and training of personnel processing benefits claims for temporary 100 percent disability evaluations, traumatic brain injury, and disabilities related to herbicide exposure. Additionally, management needs to improve controls over the safeguarding of Veterans' personally identifiable

information (PII) and processing adjustments for fiduciary claims related to incompetent Veterans. [\[Click for Report.\]](#)

OIG conducted a similar onsite inspection at the Togus, ME, VARO. OIG determined the VARO needs to improve the accuracy of disability claims processing and provide additional oversight of personnel responsible for claims identified as temporary 100 percent disability evaluations, post-traumatic stress disorder, and disabilities related to herbicide exposure. Management also needs to improve controls over correcting errors identified by VBA's STAR program, safeguarding of Veterans' PII, handling of claims-related mail, and processing adjustments for incompetent Veterans' fiduciary claims correctly. [\[Click for Report.\]](#)

Reviews Conducted of Seven Community Based Outpatient Clinics in VISN 16

OIG reviewed seven Community Based Outpatient Clinics (CBOCs) throughout VISN 16, visiting Kosciusko and Meridian, MS; Tulsa, Konawa, and Lawton, OK; Texarkana, AR; and Longview, TX. 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 22 recommendations. [\[Click for Report.\]](#)

CRIMINAL INVESTIGATIONS

Veteran Pleads Guilty To Fraudulently Obtaining VA Benefits

After 2 days of trial, a Veteran pled guilty to conspiring with a former Disabled American Veterans (DAV) service officer and a former VA employee to fraudulently obtain VA benefits. The defendant also pled guilty to structuring financial transactions to avoid reporting requirements in order to conceal the conspiracy. An investigation by OIG and the Federal Bureau of Investigation revealed that the Veteran, a pilot for a commercial airline carrier, enlisted the assistance of a DAV service officer and a VA employee to receive a disability rating of 100 percent service connection by inserting fabricated medical examination into his claims file and removing all hearing exams from military service to ensure his claim for hearing loss was approved. In exchange for getting the claim approved, the Veteran paid the DAV service officer and the VA employee each one-third of his \$93,240 retroactive benefit check. Both the DAV officer and VA employee have pled guilty to their part of the scheme and are awaiting sentencing.

Atlanta VAMC Physician Indicted for Abusive Sexual Contact and Assault

An Atlanta, GA, VAMC physician was indicted for abusive sexual contact, assault, and false statements. An OIG investigation revealed that a female patient was examined at the VAMC without another staff member in the room and was sexually assaulted by the physician. The investigation also revealed that a VAMC nurse was asked by the defendant to provide false statements to reflect that the nurse was present in the room during the examination.

Former Postal Employee Arrested for Drug Theft

A multi-agency investigation resulted in the arrest of a former postal employee suspected of diverting more than 2,000 tablets of VA medication from the mail. The

defendant subsequently admitted to selling the stolen VA medication. The defendant was charged with trafficking opium/heroin, maintaining a dwelling house for the keeping or selling of controlled substances, and 153 other criminal violations. The defendant was held under a \$1,615,000 secured bond.

Brockton, Massachusetts, VAMC Employee Arrested for Drug Theft

A Brockton, MA, VAMC employee was arrested for possession with intent to distribute oxycodone. An OIG, VA Police, Drug Enforcement Administration, and local police investigation determined that since January 2010, the defendant, who was a VA mail courier, had taken approximately 1,300 oxycodone pills from outgoing packages being mailed to VAMC patients. The defendant opened the prescription bottles while they remained sealed in shipping envelopes, emptied a portion of the pills, replaced the cap on the bottle, and tore a small hole in the envelope from which the pills were removed. In most instances, when the envelopes arrived the patients were unaware they were missing narcotics. At the time of his arrest, the defendant had stolen narcotics in his possession, confessed to being addicted to pain medications, and to distributing a portion of the narcotics off VA property.

Tampa Nurse Arrested for Drug Diversion

A Tampa, FL, VAMC registered nurse was arrested for unauthorized possession of controlled substances and petit theft. An OIG and VA Police investigation revealed that the defendant diverted several pharmaceutical drugs, mainly hydromorphone and Percocet, by removing the drug from syringes located in a Pyxis machine or by giving patients only a portion of the drugs prescribed to them.

Fiduciary Sentenced for Embezzlement

A fiduciary was sentenced to 55 months' incarceration after pleading guilty to making a false statement to VA in an effort to conceal her embezzlement of Veterans' funds. A joint Federal and state investigation determined that the defendant had embezzled nearly \$1 million from 33 disabled Veterans while acting as their appointed fiduciary. The defendant admitted to taking funds from the Veterans' bank accounts to support her gambling habit as well as to submitting false accountings to VA. The defendant agreed to make restitution to VA, the Social Security Administration (SSA), and a bonding company that reimbursed the Veterans for their losses.

Veteran Arrested for Making Threats to VA

A Veteran was arrested at the Houma, LA, VA OPC after an OIG and local sheriff's office investigation determined that the Veteran made telephonic and electronic threats to VA employees at the New Orleans VARO and the Houma OPC. The Veteran has a history of making threats and was involuntarily committed in May 2009 as a result of threats he made to the VARO, OIG, and a local sheriff's office.

Former Fort Harrison, Montana, VA Employee Sentenced for Child Pornography

A former Fort Harrison, MT, VA employee was sentenced to 24 months' incarceration and 10 years' probation after pleading guilty to possession of child pornography. An

OIG investigation disclosed that the defendant used his computer at the VAMC to download pornographic images from the internet and transfer them to his iPod.

Veteran Sentenced for Theft of Government Benefits

A Veteran was sentenced to 3 years' probation and ordered to pay restitution of \$105,528 after pleading guilty to making fraudulent statements to agencies of the United States. The defendant received disability benefits from VA and SSA based on his claim of being unable to walk. An OIG and SSA OIG investigation revealed that the defendant was a licensed commercial truck driver, having passed Department of Transportation physicals requiring full mobility, during the same time period he was in receipt of disability benefits. While working, the defendant used his son's name and social security number to hide his income.

Veteran's Daughter Sentenced for Theft of VA Benefits

The daughter of a Veteran was sentenced to 180 days' incarceration, 3 years' probation, and ordered to pay restitution of \$70,695. The defendant admitted that she spent her father's VA disability benefits on alcohol, hotel rooms, and other personal items. The Veteran, a double leg amputee, was in the process of being evicted from his nursing home for not paying his rent.

Veteran Pleads Guilty to Theft of Benefits

A Veteran pled guilty to theft of Government funds after an OIG investigation revealed that he fraudulently received over \$50,470 in VA disability pension benefits from September 2003 to September 2007. The Veteran failed to report that he had returned to work as a truck driver and did not accurately report his income and earnings to VA.

Veteran and Co-Defendants Arrested for Theft of Government Benefits

A Veteran, his wife, and his employer were arrested in connection with VA unemployability compensation and social security fraud. The Veteran and his wife were both charged with theft of Government funds, while the employer was charged with false statements. The Veteran was rated with a 70 percent service-connected disability, but was collecting at the 100 percent rate due to his claim of being unemployable as a result of his service-connected disability. An OIG, SSA OIG, and U.S. Secret Service investigation determined that the defendant submitted false certifications concerning his employment to both VA and SSA. The defendant's wife previously provided false information to VA OIG agents so that her husband could continue to receive VA and SSA benefits. The wife arranged for her husband's wages to be paid using her social security number in order to conceal his wages from VA and SSA. The Veteran's employer submitted false documentation stating he did not employ the Veteran and fraudulently paid wages to the Veteran using the wife's social security number. The loss to VA is approximately \$82,000 and the loss to SSA is approximately \$48,000.

Fayetteville, North Carolina, VA Employee Arrested for Identity Theft

A VA Office of Information and Technology employee, working in Fayetteville, NC, was indicted and arrested for filing false and fraudulent tax returns, wire fraud, and aggravated identity theft. An OIG and Internal Revenue Service Criminal Investigations

Division investigation disclosed that the employee utilized the PII of at least four Veterans without their knowledge to prepare fraudulent tax documents. The defendant used his position to access the Veterans' information.

Veteran Sentenced for Identity Theft

A Veteran was sentenced to 30 months' incarceration, 36 months' probation, and ordered to pay restitution of \$43,835 after pleading guilty to theft of Government property and additional charges. An OIG and U.S. Postal Inspection Service investigation revealed that the defendant, who had been dishonorably discharged from the military, assumed the identity of an honorably discharged Veteran and fraudulently received VA medical treatment and benefits in both Tennessee and Washington. The loss to VA is \$23,574.

Son of Deceased Beneficiary Pleads Guilty to Forgery

The son of a deceased VA beneficiary pled guilty to forgery. An OIG investigation revealed that the defendant failed to report his mother's death to VA, forged his mother's signature on two VA Marital Questionnaire documents, and stole, forged, and negotiated 221 VA benefit checks over a period of approximately 19 years. The loss to VA is \$191,669.

Former Providence, Rhode Island, VAMC Employee Indicted for Theft

A former Providence, RI, VAMC employee was indicted for aiding and abetting and theft of Government property. An OIG and VA Police investigation determined that the defendant and an unknown accomplice stole two computers and flat screen monitors from the medical center.

Fugitive Veteran Arrested With Assistance of OIG

A Veteran was arrested by OIG and the U.S. Marshals Service for violating his parole after being convicted of robbery and failure to register as a sex offender. The Veteran was held pending extradition to California.

(original signed by:)
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Inspector General