



Department of Veterans Affairs

Office of Inspector General

May 2010 Highlights

CONGRESSIONAL TESTIMONY

Assistant Inspector General for Audits & Evaluations Testifies on VA's Information Security Program

Assistant Inspector General for Audits & Evaluations Belinda Finn testified before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives, on Office of Inspector General's (OIG) audit of VA's implementation of the *Federal Information Security Management Act of 2002* (FISMA), which requires that VA develop, document, and implement an agency-wide information security program. Ms. Finn told the Subcommittee that while VA has made progress, its highly decentralized and complex system infrastructure poses significant challenges for implementing effective access controls, system interconnection controls, configuration management controls, and contingency planning practices to protect mission critical systems from unauthorized access, alteration, or destruction. Ms. Finn was accompanied by Michael Bowman, Director, Information Technology and Security Audits. [\[Click here for testimony.\]](#)

OIG REPORTS

Quality Management Lapses Cited in Review of Brachytherapy Treatment

At the request of the VA Secretary and Members of Congress, OIG performed a comprehensive review of prostate brachytherapy performed at the Philadelphia, PA, VA Medical Center (VAMC) and elsewhere in the Veterans Health Administration (VHA). OIG found that an incident at the Philadelphia VAMC involving a prostate cancer patient being inadvertently implanted with radioactive seeds of the wrong strength was an isolated occurrence; however, there were numerous process deficiencies at the VAMC in quality management, information technology, and contracting with the University of Pennsylvania. The VAMC also had numerous Nuclear Regulatory Commission compliance issues. Despite these issues, recurrence and disease-relapse rates of VAMC prostate brachytherapy patients appear within the norm and complication and adverse event rates were not excessive. OIG made five recommendations to correct these deficiencies. [\[Click here for report.\]](#)

VA Could Save \$92 Million in Patient Transportation Contracts

An OIG audit determined that Veterans Integrated Service Network (VISN) contract managers did not effectively provide the oversight needed to develop, administer, award, and monitor VHA patient transportation contracts. Additionally, Contracting Officer's Technical Representatives did not adequately review invoices before certifying payments. VHA missed opportunities to provide full and open competition in soliciting offers and awarding patient transportation contracts. Because Contracting Officers did not always award transportation services competitively, and instead extended or awarded sole-source contracts, VA cannot be assured of obtaining the best price for the services. OIG made eight recommendations to improve VHA's oversight of patient

transportation contracts that could save VA \$92 million over 5 years if implemented. [\[Click here for report.\]](#)

OIG Finds Progress, Barriers in Implementation of VHA Mental Health Handbook

OIG conducted a review of VA's progress in implementing VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* (the Handbook), as directed in House of Representatives Report 111-188 to accompany H.R. 3082, the Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2010. The review also assessed the metrics developed by VA to ensure implementation of Handbook requirements, the system developed to track use of evidence-based post-traumatic stress disorder (PTSD) therapies, whether VA has sufficient inpatient capability available for substance use treatment, and the identification of any barriers to full implementation. OIG made five recommendations to the Under Secretary for Health to achieve full implementation of the Handbook. [\[Click here for report.\]](#)

VBA Call Centers Can Do Better Job Providing Veterans with Timely, Accurate Information

OIG audited the Veterans Benefits Administration's (VBA's) call centers and internet-based Inquiry Routing and Information System (IRIS) to determine whether Veterans are provided with timely and adequate information. For fiscal year (FY) 2009, OIG concluded that any one call placed by a unique caller had only a 49 percent chance of reaching an agent and getting the correct information. This occurred because VBA did not have a central entity to provide leadership and guidance, establish sufficient performance standards to evaluate timeliness and accuracy, provide adequate training, and implement an efficient call-routing system. VBA initiated some corrective measures and plans to implement a new process in FY 2011 to route calls more efficiently. After modifying procedures and providing refresher training, call center and IRIS staff compliance with safeguard personal information increased to 96 and 93 percent, respectively. [\[Click here for report.\]](#)

Muskogee VARO Cited for Best Practices, Faster Claims Processing

The Muskogee, OK, VA Regional Office (VARO) properly established the correct dates of claim in the electronic record and accurately and timely completed all Systematic Analysis of SAOs. Further, management developed a best practice process to ensure staff promptly corrected errors identified by VBA's STAR staff and an extensive training program that improved Triage Team routing of incoming mail. As of December 2009, the VARO took an average of 115.4 days to complete compensation-rating claims—approximately 42.7 days better than the national target of 158.1 days. VARO management needs to improve the control and accuracy of disability claims processing for temporary 100 percent disability evaluations and improve accuracy for processing claims involving TBI. VARO staff did not accurately process disability claims for 23 percent of claims OIG reviewed. Management also needs to strengthen controls over establishing NODs for appealed claims and processing incompetency determinations. OIG made three recommendations to address findings. [\[Click here for report.\]](#)

Albuquerque VARO Needs To Reduce Claims Processing Error Rate

OIG's review of the Albuquerque, NM, VARO determined management needs to improve the accuracy of disability claims processing for temporary 100 percent disability evaluations, PTSD, and traumatic brain injury (TBI) claims. VARO staff did not accurately process disability claims for 36 percent of claims reviewed. OIG believes lengthy vacancies for the VARO Director's position as well as the Veterans Service Center Manager position were a contributing factor to the high error rates for the claims OIG reviewed. Management also needs to improve controls over establishing timely Notices of Disagreement (NODs) for appealed claims, completing Systematic Analysis of Operations (SAOs) accurately and timely, correcting errors identified by VBA's Systematic Technical Accuracy Review (STAR), and handling mail appropriately. OIG made seven recommendations to address these findings. [\[Click here for report.\]](#)

OIG Confirms Incorrect Administration of Medication to Battle Creek, Michigan, VAMC Employee

OIG performed an inspection at the Battle Creek, MI, VAMC to determine the validity of allegations regarding quality of care and privacy violations. OIG substantiated that an employee had an allergic reaction and that epinephrine was administered incorrectly. Five of the complainant's allegations resulted in recommendations to the VISN and Medical Center Directors. [\[Click here for report.\]](#)

ICU Alarm Turned Off at Lexington, Kentucky, VAMC

OIG reviewed allegations that poor post-operative nursing care in the intensive care unit (ICU) led to complications resulting in a patient's death at the Lexington, KY, VAMC. OIG concluded the nursing care provided in the intensive care unit was appropriate. OIG substantiated the allegation that the pulse oximeter alarm was turned off during a nursing shift. In addition, OIG found that nursing care flow sheets and progress notes in the medical record were difficult to navigate. OIG recommended that alarm systems in the ICU remain activated and functional at all times, and that processes be established to improve medical record documentation of nursing care in the intensive care unit. [\[Click here for report.\]](#)

Abuse Allegations Not Substantiated Against Cleveland, Ohio, VAMC

OIG reviewed allegations related to patient abuse and quality of care at the Louis Stokes VAMC in Cleveland, OH. The complainant provided limited information related to the alleged abuse; however, we found no evidence of abuse based on our review of relevant documents and staff interviews. Further, while the patient's death did result from a perforated bowel during hernia repair surgery, this is an unfortunate but known potential complication of the procedure. When the perforated bowel and subsequent sepsis were discovered, clinical staff aggressively treated the patient's multiple and complex medical issues. OIG did not make any recommendations. [\[Click here for report.\]](#)

QUI TAM AND CIVIL FRAUD**\$520 Million Settlement Reached between Government and Pharmaceutical Company**

The Department of Justice entered into an agreement with AstraZeneca to settle allegations that the company engaged in illegal conduct in the marketing of the drug Seroquel for unapproved uses. AstraZeneca agreed to pay the Government and the Medicaid Participating States \$520 million to settle the claims. VA will be reimbursed approximately \$15.8 million.

CRIMINAL INVESTIGATIONS**Pharmaceutical Subsidiaries Agree to \$81 Million Settlement**

Two subsidiaries of a major pharmaceutical company, Ortho-McNeil, agreed to an \$81 million global settlement to resolve criminal and civil liability arising from the illegal promotion of its epilepsy drug. One of the subsidiaries agreed to plead guilty to a misdemeanor and pay a \$6.14 million criminal fine for the misbranding of Topamax, an anti-epileptic drug approved for the treatment of partial onset seizures, but not for psychiatric use. In addition to the criminal fine, the second subsidiary will pay \$75.37 million to resolve civil allegations that it illegally promoted the drug and caused false claims to be submitted to Government health care programs, to include VA, for a variety of psychiatric uses that were not medically accepted indications. VA will receive approximately \$2.9 million of the civil settlement.

Pharmaceutical Company Settles in Off-Label Promotion Case for \$72.5 Million

A major pharmaceutical company, Novartis, agreed to pay \$72.5 million to resolve a civil false claims act allegation that it illegally promoted the drug Tobi, an inhaled antibiotic used for the treatment of certain cystic fibrosis patients. The company marketed the drug for unapproved uses in patients that did not meet the parameters of the FDA approved indicators. VA will receive \$989,893 as part of the settlement.

Executive Arrested for Fraud in Veteran Owned Set Aside Contracts

The Chief Executive Officer of a construction management and general contracting company that received VA and Department of the Army construction contracts set aside for Service Disabled Veteran Owned Small Businesses (SDVOSB) and Veteran Owned Small Businesses (VOSB) was arrested for defrauding the Government. An OIG, Small Business Administration OIG, and Army Criminal Investigation Division investigation revealed that the defendant falsely self-certified that his company was an eligible SDVOSB and VOSB when he bid on several Government contracts that he was later awarded. The company presently has over \$16 million in contracts with work ongoing at various VA facilities.

Former Corporate Recruiter Pleads Guilty to Defrauding Government

A former recruiter for a corporation providing home health care services to VA pled guilty to knowingly and willfully defrauding a health care program. A multiagency investigation revealed that the defendant misrepresented dates and hours on corporation time sheets for services not rendered and forged signatures on timecards

for a health care provider who never actually worked for the corporation. The time sheets were ultimately used to bill various health care programs.

Veteran Sentenced for Making Threat to Jackson, Mississippi, VAMC

A Veteran was sentenced to 18 months' incarceration and 3 years' supervised release after being convicted of conveying threatening communications by telephone to the Jackson, MS, VAMC. An OIG investigation disclosed that the defendant told VA employees that he was going to use plastic explosives to blow up the facility. He provided specific locations where he was going to place the explosives, including elevator shafts and the radiology department. During a subsequent interview, the defendant described how to make homemade explosive devices and detonators.

Veteran and Wife Plead Guilty to Fraud Charges for Feigned Paralysis

A Veteran and his wife pled guilty to conspiracy, false statements, and fraud charges. An OIG and Social Security Administration (SSA) OIG investigation determined that the Veteran was receiving both VA and Social Security benefits for paralysis caused by a 2004 automobile accident occurring while the Veteran was in the military. During the investigation, it was determined that the Veteran could walk with no apparent difficulties and, along with the assistance of his wife, had been feigning paralysis in order to fraudulently collect VA and Social Security benefits. The loss to the Government is approximately \$175,000.

Veteran Sentenced for Compensation Fraud

A Veteran was sentenced to 27 months' incarceration, 3 years' supervised release, and ordered to pay restitution of \$280,161 after being convicted of wire fraud, mail fraud, false statements, and Social Security fraud. An OIG and SSA OIG investigation revealed that the defendant fraudulently claimed to have suffered from PTSD after alleging that he witnessed a fellow sailor being badly burned in 1984. The defendant was able to convince VA staff that he was so traumatized by the event that he was rated 100 percent service-connected with individual unemployability, along with Social Security disability benefits. The investigation revealed that the defendant did not disclose to VA or SSA his activities as a volunteer firefighter, his membership on the county dive team, his memberships in various organizations, or that he was the owner and operator of a local tavern. The defendant also falsely claimed to associates that he was a Navy Seal and to VHA personnel that he saw combat in Grenada, Panama, and Lebanon. He subsequently recanted that he was ever a Navy Seal or in combat. The loss to VA is \$166,116.

Son of Deceased Beneficiary Sentenced for Theft

The son of a deceased VA beneficiary was sentenced to 3 years' probation and ordered to pay \$204,032 in restitution after pleading guilty to theft. An OIG investigation revealed that the defendant submitted fraudulent documents to VA in order to continue to receive the VA benefits for his own personal use after his mother's death in April 1987.

Former Wife of Deceased Veteran Pleads Guilty to Theft

The former wife of a deceased Veteran pled guilty to theft of public money and was subsequently sentenced to 1 day of incarceration, 3 years' probation, and ordered to pay VA restitution of \$102,860. An OIG investigation determined that the defendant submitted a fraudulent claim for death pension benefits and an altered death certificate indicating that she was married to the Veteran at the time of his death. The defendant also submitted a fraudulent claim for a dependent child. The Veteran's claim file contained no record indicating that the child was his dependent.

Two West Los Angeles VAMC Employees Charged with Theft involving Time and Attendance Fraud

Two West Los Angeles, CA, VAMC respiratory therapists were arraigned on charges of grand theft for activities related to time and attendance fraud. An OIG investigation revealed that the defendants were working at outside employment during their scheduled working hours. The combined loss to VA is approximately \$55,000.

Former Sepulveda, California, VAMC Employee Sentenced for False Overtime Claim

A former Sepulveda, CA, VAMC employee was sentenced to 3 years' probation and ordered to pay restitution of \$20,000 after pleading guilty to Grand Theft. An OIG and VA Police investigation determined that the defendant fraudulently claimed overtime hours she did not work.

Former Montgomery, Alabama, VARO Employee Charged with Theft

A former Montgomery, AL, VARO employee was charged with theft of Government property after an OIG, Internal Revenue Service Criminal Investigation Division, and local police investigation disclosed that the former employee stole the names, social security numbers, and dates of birth of six Veterans from VARO files in order to file fraudulent tax returns. The fraudulently obtained refunds were then deposited into various bank accounts.

St. Louis, Missouri, VAMC Employee Pleads Guilty to Theft of VA Property

A St. Louis, MO, VAMC employee pled guilty to theft charges after admitting to stealing computers, monitors, and other VA property to pawn or trade for drugs and money. None of the computers contained personally identifiable information. The approximate loss to VA is \$122,000.

Man Convicted of Theft for Using Brother's Identity

The brother of a Veteran was convicted of theft of Government funds after an OIG and SSA OIG investigation determined that the defendant utilized the Veteran's identity to obtain medical care from two VAMCs, as well as VA pension benefits and SSA identification cards in the name of the Veteran. The loss to the Government is \$120,063.

Veteran Arrested for Assaulting Philadelphia VAMC Employee

A Veteran inpatient was arrested at the Philadelphia, PA, VAMC for assault after an OIG and VA Police investigation revealed that the Veteran assaulted a VA employee while she was providing care to the Veteran.

Former Sacramento VAMC Employee Charged with Drug Theft

A former Sacramento, CA, VAMC employee was charged with obtaining controlled substances by misrepresentation or fraud. The defendant, a registered nurse, admitted to OIG agents that he had been diverting fentanyl, morphine, hydromorphone, and methadone for several months and ingesting the controlled substances while working.

Dallas VAMC Employee Arrested for Possession of Child Pornography

A Dallas, TX, VAMC employee was arrested for possession of child pornography after an OIG investigation revealed that the defendant used his VA computer to access and view child pornography while at the VAMC.

Veteran Arrested for Weapon Possession at Phoenix VAMC

A Veteran was arrested for possession of a stolen firearm while at the Phoenix, AZ, VAMC. An OIG, VA Police, and Bureau of Alcohol, Tobacco, Firearms and Explosives investigation determined that the defendant, a recent Iraq war Veteran, made statements to VAMC staff that if he “did something crazy to be on television maybe that would help the next guy to get his benefits.” A search of the defendant’s car by VA Police revealed a loaded M-4 carbine that was reported stolen from the U.S. Army and a combat Kevlar ballistic vest.

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

GEORGE J. OPFER
Inspector General