



Department of Veterans Affairs

Office of Inspector General

November 2012 Highlights

OIG REPORTS

More Mental Health Workers Needed To Meet Workload Demands at Loma Linda, California, Healthcare System

The VA Office of Inspector General (OIG) conducted an evaluation to determine the validity of allegations related to Behavioral Medicine Service (BMS) staffing, workload management, patient evaluations, and supervision at the VA Loma Linda Healthcare System (HCS) in Loma Linda, CA. OIG substantiated that the facility needed more psychiatrists, psychologists, and social workers to meet the increased mental health (MH) workload demands. OIG did not substantiate that patient evaluations were inadequate or that the social workers' schedules were not kept full. OIG could not confirm or refute that workload rules were not applied fairly. OIG determined that supervision for the social work staff was adequate and that unlicensed social work staff had appropriate supervision. OIG found that MH patients did not consistently receive timely evaluations. OIG concluded that the Chief, BMS, provided adequate supervision and oversight. However, OIG determined that the facility needs to establish a MH Executive Council (MHEC). OIG recommended that MH patients receive timely care and that a MHEC be established as required by the Veterans Health Administration (VHA). [\[Click here to access report.\]](#)

Clinical Allegations Involving Surgical Service at Carl Vinson VAMC, Dublin, GA, Not Substantiated, But Provider Reprivileging Needs Improvement

OIG conducted an evaluation to determine the validity of allegations related to inadequate communication and delayed interfacility patient transfers between the Carl Vinson VA Medical Center (VAMC), Dublin, GA, and the Charlie Norwood VAMC, Augusta, GA. OIG did not substantiate the allegation that facility providers gave inaccurate patient information to the Charlie Norwood VAMC prior to a patient's transfer for neurosurgical evaluation. OIG found documentation in the patient's electronic health record (EHR) to support that appropriate information was communicated to the Charlie Norwood VAMC. OIG did not substantiate the implication that a patient's colon perforation was the result of the physician's non Board-certified status. OIG could not confirm or refute that delay and transfer issues resulted in a patient's death. During the course of our review, OIG identified opportunities to improve the facility's provider reprivileging processes, as well as the collection and analysis of aggregated surgical complication data. OIG recommended that provider reprivileging processes be conducted in accordance with VHA guidelines. OIG also recommended that the Operative and Other Procedures Review Committee collect and analyze aggregate surgical complication data to identify trends and patterns, and take appropriate corrective action when indicated. [\[Click here to access report.\]](#)

IG Finds Alleged Patient Rights Violations Did Not Occur at Carl Vinson VAMC

OIG conducted an inspection in response to allegations that a patient's rights were violated, that the patient's Durable Power of Attorney for Health Care (DPAHC) may not

have been valid, and that facility leaders were not responsive to staff and family concerns about this case. OIG did not substantiate that a patient with dementia, who was deemed to have decision making capacity regarding where he wanted to live, was held against his will for an extended period of time. The Interdisciplinary Treatment Team made efforts to address the complicated medical, ethical, and legal considerations that delayed the patient's discharge to a Florida assisted care facility. OIG could neither confirm nor refute the validity of the patient's DPAHC. Due to a lack of medical record documentation, a Regional Counsel attorney was unable to determine whether the document was legally executed. However, during most of the patient's nearly 3-year stay at the facility, the son was the patient's recognized health care agent by both facility staff and other family members. OIG confirmed that facility leaders did not appear to respond to clinicians' requests for assistance. OIG discussed these issues with facility leadership and were assured that complicated cases will continue to be discussed at the daily executive clinical meeting. OIG made no recommendations. [\[Click here to access report.\]](#)

Allegations of Misdiagnosed Stroke at Atlanta VAMC, Atlanta, GA, Are Unfounded

OIG conducted an inspection in response to allegations of misdiagnosis and other care issues at the Atlanta, GA, VAMC and two community based outpatient clinics (CBOCs) in Veterans Integrated Service Network (VISN) 7. The purpose of this inspection was to determine the validity of the allegations. OIG did not substantiate that a facility emergency department (ED) physician misdiagnosed a stroke as vertigo (a feeling of motion while one is stationary) in September 2010. OIG determined that the facility ED physician's evaluation and management of the patient's complaints and hyperglycemia were appropriate. OIG did not substantiate that the patient received deficient care or that facility and CBOC providers failed to appropriately meet the patient's vision, hearing, and stroke rehabilitation needs. Although OIG found VA transportation failed to provide scheduled transportation on two occasions, OIG did not find these failures affected the patient's ability to receive health care or indicated a systematic transportation problem. OIG did not substantiate that patient advocate services were not accessible to the patient. OIG did not substantiate a lapse in civility by a CBOC provider. OIG made no recommendations. [\[Click here to access report.\]](#)

Pancreatic Cancer Misdiagnosis at Hudson Valley HCS, Castle Point, NY, Not Substantiated

OIG evaluated allegations regarding alleged misdiagnosis at the Hudson Valley HCS, Castle Point, NY. Specifically, the complainant alleged a patient initially told by staff he had pancreatic cancer was later advised that he did not due to a mix-up with the laboratory results. In addition, the complainant alleged another patient was never informed of positive pancreatic cancer test results. OIG did not substantiate the allegation that a patient was misdiagnosed with pancreatic cancer or that a patient was diagnosed with pancreatic cancer and not notified. OIG reviewed the EHR of the identified patient and found no mention of pancreatic cancer or reports of emotional distress related to such. The facility had no new cases of pancreatic cancer diagnosed during the relevant timeframe and OIG found no documentation suggestive of a missed

or delayed pancreatic cancer diagnosis. It appears unlikely that a laboratory “mix-up” occurred. OIG made no recommendations. [\[Click here to access report.\]](#)

Inspection Results for Clinics in Nevada, California, New York, and Pennsylvania

OIG reviewed four CBOCs during the week of July 16, 2012. CBOCs were reviewed in VISN 21 at Minden, NV, and Auburn, CA, and in VISN 22 at Chula Vista and Escondido, CA. The purpose of the review was to assess whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care. The review covered the following focused topic areas: women’s health, management of diabetes mellitus-lower limb peripheral vascular disease, heart failure follow-up, credentialing and privileging, environment and emergency management, and CBOC contracts. OIG noted opportunities for improvement and made a total of 20 recommendations to the VISN. [\[Click here to access report.\]](#)

OIG reviewed three CBOCs during the week of July 16, 2012. CBOCs were reviewed in VISN 3 at Brooklyn (Chapel Street) and Sunnyside (Queens), NY, and in VISN 4 at Franklin (Venango), PA. OIG noted opportunities for improvement and made a total of 10 recommendations to the VISN and facility managers.

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

CRIMINAL INVESTIGATIONS

Phony War Hero Gets 7 Years in Prison for Scheme To Get Government Contracts Meant for Veterans

A Veteran was sentenced to 87 months’ incarceration and a personal forfeiture of \$6,836,278 after pleading guilty to conspiracy to commit fraud against the United States, major program fraud, wire fraud, money laundering, conspiracy, and false statements. The Veteran, who owns a construction company, falsely claimed to be a service-disabled and highly decorated war Veteran in order to qualify for contracts set-aside for businesses owned by service-disabled Veterans. A VA OIG, General Services Administration OIG, Small Business Administration OIG, and Department of Defense (DoD) investigation revealed that the defendant received over \$6.7 million in contracts from VA and over \$748,000 in contracts from DoD awarded under the Service-Disabled Veteran-Owned Small Business program. The defendant claimed service in Vietnam and that he was awarded three Silver Stars, three Purple Heart Medals, and numerous other citations. Federal and state records report that the defendant served in the National Guard from 1963 to 1968, with 6 months’ service on active duty and that he never left the State of Missouri. Three co-defendants are awaiting trial.

Three New Orleans, Louisiana, VAMC Employees Charged with Conspiracy To Commit Health Care Fraud

Three New Orleans, LA, VAMC employees were charged in a criminal information with conspiracy to commit health care fraud. An OIG investigation disclosed that, between January 2001 and December 2008, the defendants devised a scheme to defraud VA by creating false companies and then billing VA for fraudulent patient care services. One defendant used his position with the medical center to obtain the identities of the

Veterans used in the scheme. The defendants submitted and received approximately \$563,000 in fraudulent health care claims from VA.

Former Cleveland, Ohio, VAMC Purchasing Agent Pleads Guilty to Conspiracy To Commit Health Care Fraud

A former VA purchasing agent in the Prosthetics Department of the Cleveland, OH, VAMC pled guilty to conspiracy to commit health care fraud. The owner of a durable medical equipment provider previously pled guilty to the same charge and awaits sentencing. The former VA employee used her position to provide competitors' bid information to the medical equipment provider and allowed for inflated payments for services provided. Also, in some instances the equipment was not installed by the provider, either because the Veteran refused delivery or because the Veteran died prior to delivery. The provider then charged VA as if the equipment had been installed. The loss to VA is \$110,581.

Physician's Assistant Pleads Guilty to Health Care Fraud

A physician's assistant pled guilty to health care fraud. An OIG investigation revealed that a physician's assistant, his wife, and a physician serving as the medical director were contracted to conduct disability rating examinations of Veterans. The contract with VA stipulated that the physician was to perform all disability rating examinations conducted at the clinic. The investigation disclosed that the physician's assistant conducted 337 of the 347 exams performed at the clinic between September 2005 and August 2008. The physician's assistant forged the doctor's signature on all of the reports and then submitted the reports and false claims to VA for payment. This investigation originated under the *qui tam* provisions of the *False Claims Act*, and civil action is still pending. The loss to VA is \$154,872.

Veteran Pleads Guilty to Making False Statements

A Veteran pled guilty to a criminal information for willfully making false statements relating to his VA benefits. The defendant, who received more than \$7,000 per month in VA compensation benefits, reported to VA that he had no use of his upper or lower extremities, required assistance with daily activities, and required prosthetic aids. An OIG investigation determined that the defendant could walk and drive a vehicle without any assistance and only used his VA-issued electric scooter while attending VA medical appointments. The loss to VA is approximately \$510,000.

Veteran Indicted for Theft of Government Funds and False Statements

A Veteran was indicted for theft of Government funds and false statements. An OIG investigation determined that for approximately 3 years the defendant, who is also homeless, assumed the identity of a deceased Veteran in order to obtain medical treatment at four different VAMCs. In addition to obtaining medical care, the defendant also applied for and received VA pension benefits under the assumed identity. The defendant admitted to assuming the identity of the deceased Veteran and also stated that he would not be eligible to obtain medical care from VA under his own name because he had an outstanding felony warrant. The loss to VA is in excess of \$125,000.

Judge Gives New York Man 2 Years' Probation for Altering DD-214 and Falsely Claiming Purple Heart in Attempt To Get VA Benefits

A former Canandaigua, NY, VAMC employee was sentenced to 24 months' probation. An OIG investigation revealed that the defendant submitted a fraudulent Purple Heart certificate and altered medical notes, military documents, and a discharge certificate in order to fraudulently increase his VA compensation benefits.

Veteran Indicted for VA Compensation Fraud

A Veteran receiving VA disability compensation was indicted for theft after an investigation by OIG and Federal Bureau of Investigation (FBI) revealed that he received a special monthly compensation by fraudulently claiming the loss of the use of his feet. The loss to VA is \$61,686.

Daughter of Deceased Beneficiary Indicted for Theft of Benefits

The daughter of a deceased VA and Social Security beneficiary was indicted for conspiracy, theft, false statements, and aggravated identity theft. A VA OIG and Social Security Administration (SSA) OIG investigation revealed that the defendant received, forged, and negotiated VA and Social Security benefit checks that were issued after her mother's death in July 2002. The loss to VA is approximately \$120,500 and the loss to SSA is approximately \$57,400.

Nephew of Dependency and Indemnity Compensation Beneficiary Forges and Negotiates Erroneously Issued VA Benefit Check

The nephew of a deceased Dependency and Indemnity Compensation (DIC) beneficiary was indicted for theft of Government funds. An OIG and U.S. Secret Service investigation revealed that the defendant received, forged, and negotiated three VA benefit checks that were issued after the beneficiary's death in January 2010 and converted the funds for his own personal use. The largest of the checks was for \$122,636 and was issued in error by VA. The total loss to VA is \$124,994.

Widow Pleads Guilty to Theft of Government Funds

A widow receiving DIC benefits waived indictment and pled guilty to theft of Government funds. An OIG investigation revealed that the defendant remarried 19 years ago and failed to notify VA of her remarriage. The loss to VA is \$191,000.

Former Estate Manager Charged with Embezzlement

The former estate manager of a non-profit corporation, who was also a VA fiduciary, was charged in a criminal information with embezzling approximately \$52,000 from disabled Veterans and Social Security beneficiaries. A VA OIG and SSA OIG investigation revealed that the defendant embezzled funds from 23 victims, to include 3 disabled Veterans, by creating a payee code that issued checks to the defendant and by purchasing gift cards at retail stores. After discovering discrepancies, the non-profit corporation took prompt action to terminate the employee, notify authorities, and refund the victims' accounts.

Former Legal Assistant Pleads Guilty to Theft of Government Funds

A former legal assistant working at a law firm pled guilty to theft of Government funds. An OIG investigation revealed that the defendant embezzled funds from 19 Veteran fiduciary accounts. In an effort to conceal the embezzlement from VA, the defendant submitted falsified accountings to her fiduciary firm. The loss to VA is \$25,377.

Fiduciary Indicted for Misappropriation

A VA-appointed fiduciary was indicted for misappropriation by a fiduciary. An OIG investigation revealed the defendant misappropriated \$35,000 in VA benefits intended for the Veteran and used the funds for personal expenses.

Mortgage Broker Sentenced for Loan Guaranty Fraud

A mortgage broker was sentenced to 10 years' incarceration after pleading guilty to engaging in organized criminal activity. An OIG and local investigation revealed that the defendant conspired with a loan officer and a realtor to defraud the VA Home Loan Guaranty Program on the purchase of a residential property valued at \$416,772. The realtor, who is also a Veteran, previously pled guilty to a charge of false statements and received a 10-year suspended sentence in return for his cooperation and testimony against the mortgage broker. The loan officer involved in this investigation was indicted on other unrelated charges.

Grand Jury Indicts Nine Veterans for Filing False Mileage Claims with Dayton, Ohio, Medical Center

Nine Veterans were charged with theft and tampering with records. An OIG and VA Police Service investigation revealed that the defendants filed fraudulent travel vouchers at the Dayton, OH, VAMC in order to obtain travel benefits they were not entitled to receive. The loss to VA is approximately \$56,000.

Former Boston, Massachusetts, VAMC Employee Sentenced for Possession of Controlled Substances

A former Boston, MA, VAMC employee was sentenced to 12 months' probation after pleading guilty to possession of controlled substances. An OIG and VA Police Service investigation determined that the defendant illegally used controlled substances while on duty at the VAMC. The employee resigned from VA as a result of the investigation.

Roseburg, Oregon, VAMC Pharmacy Technician Pleads Guilty to Drug Theft

A Roseburg, OR, VAMC pharmacy technician pled guilty to theft of Government property. An OIG investigation revealed that for over 18 months the defendant diverted over 6,000 tablets of Schedule II narcotics from the pharmacy. As part of the scheme, the defendant used her position and access to a VA computer to remove Schedule II narcotics from the pharmacy inventory and avoided audit detection by designating that the narcotics were being transferred to an automated drug dispenser located elsewhere in the VAMC. The loss to VA is approximately \$26,000.

Former Mountain Home, Tennessee, VAMC Nurse Sentenced for Drug Theft

A former Mountain Home, TN, VAMC nurse previously charged with obtaining controlled substances by fraud, deception, and subterfuge was sentenced to 36 months' probation and 50 hours' community service. An OIG and VA Police Service investigation determined that the defendant removed Dilaudid from a patient's intravenous solution.

Manchester, New Hampshire, VAMC Physician Pleads Guilty to Obtaining a Controlled Substance by Fraud

A Manchester, NH, VAMC physician signed a plea agreement after being charged in a criminal information with obtaining a controlled substance by fraud. An OIG investigation disclosed that, from June 2010 through approximately January 2011, the defendant issued prescriptions to a Veteran for approximately 68,760 milligrams of OxyContin and oxycodone that were filled outside VA. The prescriptions were written on VA prescription forms and not documented in the patient's VA medical record. During the same time period, the patient received 82,800 milligrams of OxyContin and oxycodone from VA that were documented in the patient's VA medical record. The investigation determined that the patient was also a VA employee and associated with the physician outside of work. The investigation further revealed that the physician received a portion of narcotics from the patient. The physician has been out of work since November 2010 pursuant to an unrelated workers' compensation claim.

Veteran Sentenced for Possession of Child Pornography

A Veteran was sentenced to 204 months' incarceration, 10 years' supervised release, and a \$1,200 fine after pleading guilty to possession of child pornography. An OIG and Immigration and Customs Enforcement investigation revealed that the Veteran was storing and sending child pornography through the Internet using VA computers.

Former Pittsburgh, Pennsylvania, VAMC Agent Cashier Indicted for Theft

A former Pittsburgh, PA, VAMC agent cashier was indicted for theft of Government funds. An OIG investigation revealed that the defendant stole \$4,298 from her agent cashier drawer for personal use.

Non-Veteran Arrested for Identity Theft

A non-Veteran was indicted and subsequently arrested for aggravated identity theft, wire fraud, filing false claims, and theft of Government funds. An OIG, Internal Revenue Service Criminal Investigation Division, and local police investigation revealed that the defendant used Veterans' personal identifying information obtained from stolen VA medical records and other individuals' information to file fraudulent tax returns. The defendant received approximately \$160,000 in fraudulent refunds and attempted to file approximately \$350,000 in additional fraudulent returns. The defendant in this investigation is also the subject of an unrelated statewide shoplifting ring. During a consent search, a significant amount of stolen property was recovered. Racketeering charges are now being considered.

Miami, Florida, VAMC Employee Pleads Guilty to Credit Card Fraud

A Miami, FL, VAMC employee pled guilty to the use or attempted use of an unauthorized access device and aggravated identity theft. An OIG and U.S. Secret Service investigation revealed that the defendant used fraudulently obtained credit card numbers and stolen identities to make over \$9,000 in online purchases from various retailers utilizing the VA network and computers.

Veteran Arrested for Making Threat To Kill National Guard Major General

A Veteran was arrested by OIG and the FBI after threatening to kill a Major General of the U.S. Army National Guard. During a compensation and pension appointment with a VAMC psychologist, the defendant discussed a detailed plan to assassinate the Major General at a retirement ceremony. The Veteran is currently being held without bond pending trial.

Veteran Arrested For Threatening To Shoot Montgomery, Alabama, Vocational Rehabilitation Counselor

A Veteran was arrested for making threats after an OIG, Federal Protective Service (FPS), and local police investigation revealed that he threatened to shoot a vocational rehabilitation counselor at the Montgomery, AL, VA Regional Office (VARO). The defendant made the threat after being told that the counselor needed to review his file and that he needed a "Plan of Service" before the counselor could authorize a computer software purchase.

Veteran Indicted for Threat To Kill a Montgomery, Alabama, VAMC Physician

A Veteran was arrested and subsequently indicted for intimidating a Federal employee engaged in his official duties. An OIG and local sheriff's office investigation revealed that the defendant threatened to return to the Montgomery, AL, VAMC and kill a VA physician and everyone else who entered the medical center. During a search incident, OIG agents and the local officers seized a rifle, shotgun, and two handguns.

Veteran Arrested for Threat To Kill Dothan, Alabama, CBOC Employee and Others

A Veteran was arrested after an OIG and local police investigation determined that during a telephone conversation with a Dothan, AL, CBOC employee, the Veteran threatened to use his handgun to kill the employee along with 42 other people. The initial law enforcement contact with the Veteran resulted in a 2-hour standoff as the Veteran barricaded himself in his residence with a firearm. The defendant was subsequently subdued and arrested without incident after he attempted to flee from officers. He is currently being held without bond pending judicial action.

Veteran Arrested for Threats to New York, New York, Vocational Rehabilitation Counselor

A Veteran was arrested for aggravated harassment after an OIG, FPS, and local police investigation determined that she threatened to cause bodily harm to a New York, NY, vocational rehabilitation counselor. On a voicemail recording to the victim and during a

subsequent conversation with a service organization officer, the defendant stated that she was going to harm the counselor at the VARO or outside of the facility.

A handwritten signature in black ink, appearing to read "Richard J. Griffin". The signature is written in a cursive style with a large initial "R" and "G".

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

GEORGE J. OPFER
Inspector General