



Department of Veterans Affairs

Office of Inspector General

February 2013 Highlights

CONGRESSIONAL TESTIMONY

Assistant Inspector General for Audits and Evaluations Tells Congress VA's Efforts to Fix Errors in Temporary 100 Percent Disability Ratings Are Not Aggressive Enough

Linda A. Halliday, Assistant Inspector General for Audits and Evaluations, testified before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, United States House of Representatives, on issues related to the Veterans Benefits Administration's (VBA) effectiveness in processing temporary 100 percent disability ratings. She discussed the results of a January 2011 audit on the issue as well as recent results from the Office of Inspector General's (OIG) inspections of VA Regional Offices (VAROs) where OIG continues to find a consistently high error rate for processing temporary 100 percent disability ratings. VBA has not been aggressive, timely, or thorough in completing its national review of the issue and they have continued to rely on electronic fixes but done little to address the issue of staff error. The long delay in taking action places VA at risk of underpaying some Veterans and repeatedly overpaying others without proper support, thereby diverting millions of dollars from other important programs for America's Veterans today and into the future. Ms. Halliday was accompanied by Mr. Larry Reinkemeyer, Director of OIG's Kansas City Office of Audits and Evaluations, and Mr. Brent Arronte, Director of OIG's San Diego Benefits Inspections Division. [\[Click here to access testimony.\]](#)

OIG REWARD

Reward for Report of Fraud in Government Contracts Meant for Veterans

In January 2013, OIG presented a reward to a confidential informant. The source of the information reported an apparent fraud of the VA Service-Disabled Veteran-Owned Small Business (SDVOSB) program. This information launched an investigation by OIG that subsequently proved that the defendant fraudulently claimed SDVOSB status in order to obtain Federal government set-aside contracts. Such contracts are specifically set aside for small businesses which are owned by veterans with disabilities. Sentences in such cases have included time in prison, supervised release, fines, restitution, and forfeiture of property.

OIG REPORTS

National Cemetery Administration Identifies More Misplaced Headstones After IG Recommended Revisions to Gravesite Review Procedures

The Committee on Veterans' Affairs requested OIG conduct this audit to determine if the National Cemetery Administration (NCA) adequately addressed issues found during its Phase One review of headstones and markers at VA national cemeteries. OIG found NCA did not have an independent review procedure to identify misplaced headstones and unmarked gravesites, did not provide sufficient resources to conduct a review of this magnitude, and Memorial Service Networks did not provide cemetery directors with updated gravesite layout maps. In July 2012, OIG issued NCA recommendations to

revise its procedures for completing gravesite reviews. NCA subsequently conducted its Phase One follow-up and identified 146 additional errors at 4 cemeteries. OIG recommended the Under Secretary for Memorial Affairs ensure an improved process for internal reviews with proper resources and follow-up to correct errors, as well as implementing controls to ensure gravesite maps are accurate. The Under Secretary for Memorial Affairs agreed with the recommendations and provided action plans.

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

VA Needs Plan To Resolve Performance Issues with Paperless Claims Processing System To Eliminate Backlog By 2015

In May 2012, the House Appropriations Committee directed OIG to evaluate the Veterans Benefits Management System (VBMS) to determine whether VA has performed sufficient systems testing. OIG's review included assessing whether VBA is positioned to meet its goal of eliminating the claims backlog and increasing the accuracy rate of processing claims to 98 percent by 2015. OIG also evaluated the effectiveness of VBA's efforts to scan and digitize Veterans' claims to support paperless claims processing. OIG found, as of September 2012, in the early stages of VBMS system development, VA had not fully tested VBMS. The system had not been fully developed to the extent that its capabilities could be sufficiently evaluated and the partial deployment to date has experienced system performance issues. VA officials stated they have taken action to improve digitization of Veterans' claims including better organization of electronic claims folders. [\[Click here to access report.\]](#)

IG Criticizes Washington, DC, VA Medical Center for Delays in Management of Staph Infection and Failure To Conduct Quality Review

OIG conducted a review to determine the validity of allegations regarding a patient's quality of care and communication between professional staff and a patient's family at the Washington, DC, VA Medical Center (VAMC). The complainant alleged that treatment of the patient's urinary tract infection was delayed; that the facility did not tell the family the patient had a Methicillin-Resistant Staphylococcus Aureus (MRSA) infection; that the patient was released from outpatient care despite the MRSA infection; and that communication with the family about all of the patient's conditions was poor. OIG substantiated that management of the MRSA urinary tract infection was not timely instituted. OIG found that the facility did not conduct a Quality Review for the outpatient MRSA management issue. OIG substantiated that the patient and family were not timely notified of the patient's MRSA infection while he was an outpatient. OIG did not substantiate the allegation that the facility lacked professionalism in relating to the patient's family. OIG recommended that the facility Director, in accordance with Veterans Health Administration (VHA) Handbook 1004.08, consult with Regional Counsel regarding institutional disclosure to the patient's family; ensure that a quality of care review is conducted with specific attention to deficiencies identified in this report; and monitor providers' documentation to ensure compliance with VHA policies on information management and health records. [\[Click here to access report.\]](#)

VHA Needs To Reconcile Travel Expense Claims with Disbursed Payments To Improve Beneficiary Travel Program and Reduce Risk of Fraud

OIG found VHA lacks assurances that program costs are accurate and paid only to eligible Veterans and that its liabilities, expenditures, and full costs of the Beneficiary Travel Program (BTP) are accurately recorded, monitored, and reported. OIG evaluated VHA's management and oversight of VA's BTP, which has experienced dramatic growth in costs, to ensure reimbursements for Veterans' travel was in compliance with requirements. In 2010, VHA began a series of initiatives to improve program oversight. During this audit, VHA had not fully implemented all changes. VHA has not developed a process to reconcile travel expense claims with disbursed payments. OIG identified differences in mileage reimbursements paid compared with approved mileage reimbursements. OIG recommended the Under Secretary for Health strengthen authorization, payment, and oversight controls for the BTP. The Under Secretary for Health concurred with OIG's findings and recommendations and provided an action plan. [\[Click here to access report.\]](#)

Allegations of Issues Regarding Mid-Level Provider Patient Care Substantiated at the George E. Wahlen VAMC, Salt Lake City, Utah

OIG conducted an inspection to assess the merits of allegations concerning the quality of mid-level provider patient care in an Intensive Care Unit (ICU) and the failure of leadership to take action when complaints were reported at the George E. Wahlen VAMC, Salt Lake City, UT. OIG substantiated that mid-level providers restarted a patient's home medications without necessary adjustments; inappropriately administered hydralazine to a patient resulting in cardiogenic shock; and failed to timely notify attending physicians when a patient experienced prolonged bradycardia. OIG did not substantiate allegations that facility leadership failed to take any action regarding these complaints. OIG identified issues concerning Physician Assistant (PA) supervision and scope of practice reviews, lack of a process equivalent to credentialing and privileging of physicians for the PAs and nurse practitioners, and confusion regarding the reporting of adverse events. OIG recommended that the Facility Director establish a process for mid-level provider scope of practice reviews that is equivalent to the Focused Professional Practice Evaluations and Ongoing Professional Practice Evaluations processes; ensure that mid-level Professional Standards Boards forward their recommendations for the granting of scopes of practice to the Medical Executive Committee for review; provide adverse event reporting training for all ICU staff and attending physicians; and strengthen ICU near miss and adverse event reporting procedures. [\[Click here to access report.\]](#)

Allegations of Issues Regarding Dental Patient Care Substantiated at a Veterans Integrated Service Network 9 Dental Clinic

OIG conducted an inspection to assess the merit of allegations regarding dental care provided at a Veterans Integrated Service Network (VISN) 9 dental clinic. OIG conducted an Employee Assessment Review survey, a short confidential survey that invites all system employees to share general observations about the quality of care and safety provided within the system. The Employee Assessment Review survey results included 15 allegations regarding dental patient care provided at a VISN 9 dental

clinic. OIG divided the allegations into four categories: dental vacuum system; dentists practice issues; eligibility, scheduling, and productivity; and work environment and leadership. Based on OIG's interviews with leadership and staff, VISN Dental Consultant interviews and reports, electronic health record reviews, patient schedules, dental productivity reports, and onsite physical inspections, OIG substantiated three of the allegations. OIG recommended that leadership ensure that dental clinic staff have adequate knowledge regarding periodontal disease; ensure treatment plans are developed, revised, followed, and documented; and develop and implement a plan to improve communication and professional interaction among dental clinic staff. The VISN and Facility Directors concurred with OIG's recommendations and provided an acceptable action plan. OIG will follow up on the planned actions until they are completed. [\[Click here to access report.\]](#)

Allegations of Laboratory Processing Delays and Environmental Safety Concerns Not Substantiated at the VA North Texas Health Care System, Dallas, Texas

OIG conducted an inspection to determine the validity of allegations regarding laboratory processing delays and environmental safety concerns at the VA North Texas Health Care System (HCS), Dallas, TX. A complainant alleged that specimen containers have unreadable labels that cannot be matched to the paperwork received; a patient went to a private provider for a Papanicolaou (Pap) test because of delays receiving results through the VA, and the test was positive for cancer; service leadership took no action when the Pap test delays were reported; the ventilation system in the Histology laboratory is not adequate; chemicals and explanted pacemakers are not appropriately stored and disposed of; and food and drinks are stored in refrigerators meant for laboratory items. OIG did not substantiate any of the allegations and found proper procedures in place for specimen labeling, processing, and documentation of records. OIG made no recommendations.

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

Results for Benefits Inspection of Cheyenne Veterans Service Center

OIG conducted this inspection to evaluate how well the Cheyenne Veterans Service Center (VSC) accomplishes the VBA mission. OIG found VSC staff did not accurately process 20 of the 30 disability claims OIG reviewed. However, these results do not represent the overall accuracy of disability claims processing at this VSC as OIG samples selected types of claims at higher risk of processing error. Specifically, 79 percent of the 24 temporary 100 percent disability evaluations OIG reviewed were inaccurate because staff did not take action to schedule follow-up medical examinations after receiving system-generated reminder notifications. An error in processing one of six Traumatic Brain Injury claims OIG reviewed occurred because staff used an insufficient exam report as a basis for the rating decision. Management did not ensure staff accurately completed Systematic Analyses of Operations or addressed Gulf War Veterans' entitlement to mental health treatment. VSC staff did provide adequate outreach to homeless Veterans. [\[Click here to access report.\]](#)

Inspection Results for Clinics in Multiple VAMCs

OIG reviewed the Durham VAMC's three Community Based Outpatient Clinics (CBOCs) during the week of November 5, 2012. The purpose of the review was to assess whether the CBOCs provide Veterans with consistent and safe high-quality health care. The review covered the clinical care components of women's health cervical cancer screening and tetanus and pneumococcal vaccinations. OIG also randomly selected the Greenville, NC, CBOC for a site visit and evaluated credentialing and privileging, environment of care, and emergency management processes. OIG noted opportunities for improvement and made three recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the Alaska VA HCS's three CBOCs during the week of November 5, 2012. OIG noted opportunities for improvement and made three recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the Charles George VAMC's two CBOCs during the week of November 5, 2012. OIG noted an opportunity for improvement and made one recommendation to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the Spokane VAMC's two CBOCs during the week of November 5, 2012. OIG noted opportunities for improvement and made seven recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the John J. Pershing VAMC's six CBOCs during the week of November 5, 2012. OIG noted opportunities for improvement and made 10 recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the Marion VAMC's eight CBOCs during the week of November 5, 2012. OIG noted opportunities for improvement and made four recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the Salem VAMC's five CBOCs during the week of November 12, 2012. OIG noted opportunities for improvement and made three recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the Iowa City VA HCS's seven CBOCs during the week of December 3, 2012. OIG noted opportunities for improvement and made four recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the William S. Middleton Memorial Veterans Hospital's five CBOCs during the week of December 3, 2012. OIG noted opportunities for improvement and made three recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

CRIMINAL INVESTIGATIONS**Three Former New Orleans, Louisiana, VAMC Employees Plead Guilty to Conspiracy to Commit Health Care Fraud**

Three former New Orleans, LA, VAMC employees pled guilty to a criminal information charging them with conspiracy to commit health care fraud. An OIG investigation revealed that between January 2001 and December 2008 the defendants devised a scheme to defraud VA by creating false companies and billing patient files using the identities of Veterans registered with the VAMC. The health care services were never provided to the Veterans. The payments associated with the fraudulently submitted bills were then split among the defendants. The loss to VA is approximately \$563,000.

Former American Federation of Government Employees Union President Pleads Guilty to Theft of Union Funds

A former American Federation of Government Employees union president pled guilty to theft of union funds. An OIG and Department of Labor (DOL), Office of Labor Management Standards investigation revealed that the defendant, while serving as the president of the VA Hospital Workers Union at the New York, NY, VAMC, wrote approximately 187 checks to himself for \$112,477 from the union's checking account.

Veteran Arrested for Sexually Assaulting Manchester, New Hampshire, VAMC Employee

A Veteran was arrested for sexually assaulting a VA employee at the Manchester, NH, VAMC. An OIG, VA Police Service, and local police investigation revealed that the defendant grabbed the employee in the groin area while at the employee's desk. The victim was subsequently absent from work because she felt frightened by the incident.

Veteran Arrested for Assaulting Northampton, Massachusetts, VAMC Employee

An inpatient at the Northampton, MA, VAMC was arrested for assaulting a VA employee. An OIG and VA Police Service investigation revealed that the defendant punched the victim in the head several times and bit the employee on the side of the neck. The employee required medical treatment.

Veteran Pleads Guilty to Assault of Lyons, New Jersey, VAMC Police Officer

A Veteran pled guilty to the assault of a Lyons, NJ, VAMC police officer. An OIG investigation revealed that the Veteran, while an inpatient at the VAMC, assaulted VA police officers on multiple occasions while officers were responding to several different medical assistance calls. The defendant was held without bail since his arrest in July 2012 due to his assaultive behavior towards the judge, prosecutor, and U.S. Marshals during his initial appearance. The defendant was remanded to the custody of State officials for parole violations while he awaits sentencing.

Veteran Sentenced for SDVOSB Fraud

A Veteran was sentenced to 100 hours' community service at a Veterans' service organization, 5 years' probation, and fined \$206,844 after pleading guilty to making false statements for representing his company as an SDVOSB. An OIG investigation revealed that the defendant submitted claims to VBA for a service-connected disability

in 1969 and 2009 and was denied service connection for each of his claims. The defendant fraudulently certified his company as an SDVOSB, and VA awarded approximately \$5,849,000 in SDVOSB set-aside contracts to the company between August 2009 and March 2011. Approximately \$3,571,000 of the contract awards were funded with *American Reinvestment and Recovery Act of 2009* funds.

Former Roseburg, Oregon, VAMC Pharmacy Technician Sentenced for Drug Theft

A former Roseburg, OR, VAMC pharmacy technician was sentenced to 24 months' incarceration and ordered to pay \$23,475 in restitution. An OIG and Drug Enforcement Administration investigation revealed that for approximately 18 months the defendant stole over 6,000 tablets of controlled narcotics from the VAMC pharmacy by posting false drug orders in the VistA database. As part of the scheme, the defendant manipulated VistA by placing disbursement orders to make it appear narcotics were being replenished in narcotic dispensing machines located throughout the VAMC. In particular, the technician selected dispensing machines that did not normally stock a narcotic and so avoided inventory contradictions, automated replenishment orders, and oversight controls. The loss to VA was approximately \$23,500.

Former Tucson, Arizona, VAMC Nurse Indicted for Drug Theft

A former Tucson, AZ, VAMC nurse was indicted for fraudulent schemes and acquisition of a narcotic drug. An OIG investigation revealed that for 6 months the defendant stole over 1,700 controlled substance medications to include morphine, oxycodone, and hydromorphone. The defendant tested positive for hydromorphone and morphine use after completing a drug screen.

Former Martinsburg, West Virginia, VAMC Registered Nurse Pleads Guilty to Drug Diversion

A former Martinsburg, WV, VAMC registered nurse pled guilty to acquiring and obtaining a controlled substance by misrepresentation, fraud, forgery, deception, and subterfuge. An OIG and VA Police Service investigation revealed that on approximately 78 occasions, the defendant retrieved controlled medication from the facility's automated Pyxis medication dispensers using the names of VA patients whose electronic medical records indicated that they did not receive the medication.

Biloxi, Mississippi, VAMC Nurse Charged with Prescription Forgery

A former Biloxi, Mississippi, VAMC nurse was charged with prescription forgery. An OIG and State investigation revealed that the defendant used the names and personal identifying information of two Veterans from the VAMC to commit the fraud.

Former Togus, Maine, VAMC Canteen Service Cashier Sentenced for Theft

A former Togus, ME, VAMC Canteen Service cashier was sentenced to 12 months' deferred prosecution, 40 hours' community service, a \$300 fee, and ordered to pay \$344 in restitution. An OIG and VA Police Service investigation, which included the use of a polygraph, determined that the defendant stole cash from the Canteen Service's retail store. The defendant subsequently resigned from VA.

Prescott, Arizona, VAMC Employee Indicted for Fraudulent Schemes

A Prescott, AZ, VAMC employee was indicted for fraudulent schemes and theft by converting services or property. An OIG investigation revealed that the defendant intentionally allowed time sensitive laboratory reagents to expire and then destroyed them because she did not want to complete the work involved in validating newly purchased lab equipment with these reagents. The loss to VA is approximately \$50,000.

Lyons, New Jersey, VAMC Employee Arrested for Theft

A Lyons, NJ, VAMC employee was arrested for theft after a VA OIG, General Services Administration (GSA) OIG, and local prosecutor's office investigation determined that he was using the GSA Fleet card to purchase fuel for his personally owned vehicle. The investigation further determined that the defendant fueled his vehicle twice a week from June 2012 to February 2013. The loss to VA is approximately \$7,500.

Former VA Fiduciary Sentenced for Theft

A former VA fiduciary was sentenced to 5 years' probation and ordered to pay VA \$68,358 in restitution after pleading guilty to theft of Government funds. An OIG investigation determined that the defendant continued to receive and negotiate VA benefit checks as the VA appointed fiduciary for a Veteran who died in October 2009.

Non-Veteran Arrested for Theft of Government Funds

A non-Veteran was arrested for theft of Government funds after an OIG investigation revealed that he fraudulently received VA health care. The investigation determined that the defendant never served in the U.S. Marine Corps and was previously un-enrolled from the Naval Reserve Officer Training Corps. The defendant admitted to lying about being a combat Veteran and receiving injuries from an improvised explosive device while in Afghanistan in order to receive VA medical benefits. The defendant fraudulently received approximately \$100,000 in VA medical care.

Veteran Convicted of Fraud

A Veteran was found guilty at trial of mail fraud, wire fraud, false statements, and workers' compensation fraud against VA and the U.S. Navy. An OIG and Naval Criminal Investigative Service investigation revealed that since 2005 the Veteran received over \$400,000 in fraudulent VA individual unemployability benefits and DOL workers' compensation benefits by claiming dual compensation for an on-the-job injury and by failing to disclose to VA that he was in receipt of Office of Workers' Compensation Program benefits. Additionally, while receiving both benefits the Veteran was managing a successful landscaping business. The loss to VA is over \$143,000.

Veteran Indicted for Theft of Government Services

A Veteran, who was ineligible to receive VA benefits, was indicted for theft of Government services. An OIG investigation revealed that the defendant submitted a fraudulent DD-214 to VA and that from April 2009 to August 2012 he received extensive VA medical care and medication from various VAMCs. The loss to VA is approximately \$307,000.

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 revealed that for several years the defendant concealed his income from VA. Due to his alleged severe disabilities, the defendant received Aid and Attendance and his wife was appointed as his VA fiduciary. The defendant was rated as permanently and totally disabled and having no income. In actuality, the defendant was employed as a pastor at different churches, worked as a handyman, and drove a race car in a stock car race. The loss to VA is approximately \$254,000.

Veteran Indicted for Theft of Government Funds

A Veteran was indicted and arrested for theft of Government funds, workers' compensation fraud, and false statements. The VA rated the defendant as 100 percent service disabled for post-traumatic stress disorder (PTSD), fibromyalgia, and back issues after reporting that he was socially isolated, could not tolerate crowded areas, lift heavy objects, and was unable to function in society. A VA OIG, U.S. Postal Service OIG, and DOL OIG investigation revealed that during this time the defendant coached youth sports, participated in events, bred and sold dogs for profit, and lifted heavy objects. The loss to VA is approximately \$51,000 and the loss to the U.S. Postal Service is in excess of \$288,000.

Veteran Indicted on Multiple Charges

A Veteran was indicted and arrested for interstate threats against VA employees, theft of Government funds, false impersonation of an officer or employee of the United States, and smuggling night vision goggles from the United States. The defendant was rated 100 percent service-disabled for PTSD, back and neck issues, and chronic obstructive pulmonary disease. An OIG, Defense Criminal Investigative Service, and Immigration and Customs Enforcement investigation revealed that the defendant submitted a fraudulent DD-214 to VA, misrepresented his true level of functioning, impersonated military personnel, participated in civilian contracted military exercises, taught martial arts, and illegally bought and sold military-grade lasers overseas. The loss to VA is approximately \$120,000.

Veteran Indicted for Travel Benefit Fraud

A Veteran was arrested after being indicted for false statements and false claims. An OIG investigation revealed that for 16 months the defendant submitted fraudulent beneficiary travel claims to the White River Junction, VT, VAMC. The loss to VA is approximately \$26,000.

Veteran Pleads Guilty to Travel Benefit Fraud

A Veteran pled guilty to theft of Government property after an OIG investigation revealed that from May 2005 to June 2011 he filed 126 fraudulent travel vouchers at the Boise, ID, VAMC. The defendant claimed VA beneficiary travel from multiple states, when in actuality he resided less than three miles from the VAMC. The loss to VA is \$10,641.

Veteran Indicted for Possession of Child Pornography at Dayton, Ohio, VAMC

A Veteran was arrested after being indicted for possession of child pornography. An OIG investigation determined that the defendant viewed sexually explicit images of minor children while a patient at the Dayton, OH, VAMC. The defendant had the material on a removable computer storage device and viewed the images in a computer room available to patients at the VAMC. The defendant was previously convicted of possessing child pornography in 2003.

Daughter of Deceased Beneficiary Arrested for Theft of Government Funds

The daughter of a deceased beneficiary was arrested after being indicted for theft of Government funds. A VA OIG and Social Security Administration (SSA) OIG investigation determined that the defendant stole \$68,086 in VA benefits and \$120,332 in SSA benefits that were direct deposited into her mother's account after her mother's death in April 2003. The defendant admitted to using the stolen funds for personal use.



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