DECEMBER 2018 HIGHLIGHTS

Criminal Investigations Involving Health Care

Providence, Rhode Island, VA Medical Center Intensive Care Unit Nurse Pled Guilty to Drug Tampering

A Providence, Rhode Island, VA Medical Center (VAMC) Intensive Care Unit nurse pled guilty to charges of tampering with a consumer product and drug diversion after confessing to tampering with prepackaged fentanyl and hydromorphone syringes. An Office of Inspector General (OIG), VA Police Service, and Food and Drug Administration (FDA) investigation revealed the nurse would withdraw the narcotic, inject saline back into the carpuject (the device used for administering injectable fluid), and put the tampered drug back in the Pyxis automated medication dispensing machine for patient use.

Former Denver, Colorado, VA Medical Center Nurse Pled Guilty to Acquiring Controlled Substances by Deception or Subterfuge

A former Denver, Colorado, VAMC registered nurse pled guilty to acquiring controlled substances by deception or subterfuge. An OIG investigation revealed that after administering liquid medication to a patient, the defendant would use a syringe to draw the remaining portion from the dispensing container, which he diverted for his personal use. The defendant would then replace the liquid with saline and discard it in the presence of a witness. The defendant admitted that he had been diverting hydromorphone and sometimes fentanyl for approximately two years.

Former Memphis, Tennessee, VA Medical Center Nursing Assistant Sentenced for Assault

A former Memphis, Tennessee, VAMC nursing assistant was sentenced to 12 months' home detention and 12 months' supervised release after having pled guilty to "deprivation of rights under color of law" (using power given by a governmental agency to deprive another person of any right protected by law). An OIG, VA Police Service, and Memphis Police Department investigation revealed the defendant physically assaulted an inpatient inside the facility's locked mental health unit.

Criminal Investigations Involving Benefits

Former VA Vocational Rehabilitation and Employment Counselor Pled Guilty for Role in Fraud Scheme

A former VA Vocational Rehabilitation and Employment (VR&E) Counselor pled guilty to wire fraud, bribery, and falsification of documents. An OIG and Federal Bureau of Investigation (FBI) investigation revealed the defendant initiated kickback agreements with the owners of three educational institutions approved under the VR&E program. The defendant steered veterans to those three institutions without regard for the veterans' educational needs or preferences. In return, the school owners paid the defendant seven percent of all VR&E funds they received. The school owners fraudulently obtained

VR&E benefits by providing false information to VA concerning the number of hours of instruction and the manner and quality of the instruction provided to enrolled veterans whose tuition was paid by VA. It was discovered that enrolled veterans rarely, if ever, received instruction from school employees. Three additional individuals were convicted as a result of this investigation. The loss to VA is over $3 million.

Former Philadelphia, Pennsylvania, VA Regional Office Employee and Co-conspirators Sentenced for Roles in Theft Scheme

An OIG investigation revealed a former Philadelphia, Pennsylvania, VA Regional Office employee accessed the personally identifiable information of veterans and their spouses to manipulate previously submitted benefit claims and create fake claims to defraud VA of approximately $838,000. Prior to authorizing the fictitious claims, the former employee changed the direct deposit information to divert the stolen funds to his co-conspirators' accounts. After receiving the direct deposits from VA, his co-conspirators provided the former employee with a portion of the stolen funds as a kickback. The former VA employee was sentenced to 66 months' imprisonment, three years' supervised release, and restitution of $421,857. One co-conspirator was sentenced to 12 months' imprisonment and three years' supervised release, and two co-conspirators were each sentenced to three years' supervised release. These three co-conspirators were also ordered to pay combined restitution of $384,992. Eight additional individuals were convicted as a result of this investigation.

Veteran Indicted for Wire Fraud and Aggravated Identity Theft

A VA OIG, Social Security Administration (SSA) OIG, Office of Personnel Management (OPM) OIG, Department of Justice (DOJ) OIG, and Department of Labor (DOL) OIG investigation resulted in charges alleging the defendant repeatedly submitted false claims and information to VA and other federal agencies. Some of the false claims related to the defendant's military service, resulting in a VA disability rating of 100 percent and medical retirement from the Federal Bureau of Prisons at age 35. The total loss to the government is at least $575,000, which includes an approximate loss to VA of $230,500.

Veteran Pled Guilty to Theft of Government Funds and Social Security Disability Insurance Fraud

A VA OIG and SSA OIG investigation revealed that the defendant was witnessed driving a Harley-Davidson motorcycle while receiving Aid & Attendance compensation (financial help for in-home care) for the loss of the use of his hands and feet. Based on observations of his Compensation and Pension examination, the defendant was found to have misled the VA examiner about his ability to drive and walk. This investigation also yielded evidence that the defendant attempted to sell his electric wheelchair. The loss to VA is $617,360, and the loss to SSA is $212,701.

Veteran Indicted for Theft of Government Funds

An OIG investigation resulted in charges alleging the defendant worked as a plumber since 1999, yet intentionally withheld information about his employment and income from VA. As a result, he

continued to receive pension benefits. The defendant attempted to conceal his fraud by using the registered state license of another business as his own. The loss to VA is approximately $196,200.

Son of Deceased Veteran Pled Guilty to Theft of Government Funds

The son of a veteran pled guilty to theft of government funds. An OIG investigation revealed that between December 2005 and June 2015, the defendant negotiated (e.g., for cash or deposit) VA compensation benefit checks at two local check cashing institutions by forging his deceased father's signature. The total loss to VA is approximately $188,100

Criminal Investigations Involving Other Matters

Medical Device Manufacturer Agreed to Plead Guilty to Distributing an Adulterated Device

A medical device manufacturer agreed to plead guilty to a misdemeanor charge pertaining to the company's distribution of its neurovascular medical device in violation of the *Food, Drug and Cosmetic Act*. As part of the criminal resolution, the company will plead guilty to a misdemeanor offense (distributing an adulterated device), pay a criminal fine of $11.9 million, and forfeit $6 million. A VA OIG, Defense Criminal Investigative Service (DCIS), Health and Human Services (HHS) OIG, FBI, and FDA investigation revealed that the product, known as Onyx, was approved by the FDA for use inside the brain as a liquid embolization device that is surgically injected into blood vessels to block blood flow to arteriovenous malformations (abnormal connections between arteries and veins). Despite the FDA's limited approval, the manufacturer's sales representatives encouraged surgeons to use Onyx in large quantities for unproven and potentially dangerous surgical uses outside the brain even after FDA officials told company executives they had specific safety concerns regarding that type of use.

Former Pharmaceutical Executive Pled Guilty to Racketeering Conspiracy

The former Vice President of Sales of a pharmaceutical company pled guilty to racketeering conspiracy. A VA OIG, U.S. Postal Service (USPS) OIG, U.S. Postal Inspection Service (USPIS), Drug Enforcement Administration, OPM OIG, FBI, FDA, HHS OIG, DOL OIG, and DCIS investigation revealed that the defendant participated in a nationwide conspiracy to bribe medical practitioners to unnecessarily prescribe a fentanyl-based pain medication and to defraud healthcare insurers. To increase sales of the drug, the defendant used a paid speaker program as a vehicle to bribe doctors and other clinicians to prescribe the pain medication. The pharmaceutical company also hired the medical practitioners' employees, relatives, and individuals with whom they had close relationships to reward high-volume prescribers. The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) paid the pharmaceutical company approximately $3.3 million for this pain medication.

Eight Co-conspirators Arrested for Compounding Pharmacy Fraud

Eight co-conspirators were arrested after being indicted for their roles in a compounding pharmacy fraud scheme. A VA OIG, FBI, DCIS, OPM OIG, and HHS OIG investigation resulted in charges that allege these individuals helped bill TRICARE and CHAMPVA for over $75 million through multiple fraudulent practices. The scheme included kickbacks, the use of unapproved ingredients in medications, and filling unauthorized prescriptions. The loss to VA is approximately $3.3 million.

Two Medical Officer Administrators Indicted for Healthcare Fraud Conspiracy

A VA OIG, DOJ OIG, DOL OIG, USPS OIG, and Internal Revenue Service Criminal Investigation Division (IRS CID) investigation resulted in charges that allege the defendants submitted false claims to DOL's Office of Workers' Compensation Program (OWCP) on behalf of VA and other federal agencies. The defendants, who worked for a private healthcare provider, assigned inaccurate billing codes in an effort to increase the practice's OWCP reimbursement payments. Some of the medical procedures were medically unnecessary, while others were not performed. The investigation revealed that the two defendants conspired with others to perpetuate the fraud for approximately six years. The loss to VA is approximately $2.9 million.

Five Former Compounding Pharmacy Employees Convicted

Five former employees of a compounding pharmacy, including the pharmacy's part owner, were convicted of racketeering, conspiracy, and mail fraud after an eight-week trial. The compounding pharmacy was at the center of a 2012 nationwide fungal meningitis outbreak that killed 64 individuals and caused infections in 793 patients. A VA OIG, FDA, USPIS, DCIS, and FBI investigation revealed the defendants engaged in various schemes to defraud the government and patients. The schemes included authorizing the shipment of drugs before receiving test results confirming their sterility, not notifying customers of nonsterile results, and shipping compounded drugs with expired ingredients. Although no known VA patients died or became ill from the compounding pharmacy's product, VA purchased approximately $516,000 of products that were produced in unsanitary conditions and in an unsafe manner.

Private Physician Indicted for Role in Workers' Compensation Fraud

A physician was indicted for his involvement with a pharmacy that provided prescription medication to OWCP patients. A VA OIG, Department of Homeland Security OIG, USPS OIG, DOL OIG, and IRS CID investigation resulted in charges alleging that the defendant signed prescriptions for compounding medication for patients that he had not seen or evaluated and for patients who did not want or use the medication. The defendant was responsible for approximately $270,500 in prescriptions issued to VA's OWCP claimants and over $5.3 million in prescriptions issued to claimants from the impacted federal agencies.

Investigative Reports

Alleged Improper Contracting Practices within the Office of Product Effectiveness, Washington, DC

The OIG Administrative Investigations Division investigated an allegation that an employee in the Veterans Health Administration (VHA), Office of Quality, Safety and Value engineered the award of a contract valued in excess of $1 million to a company whose Chief Executive Officer was alleged to be a personal friend. The complainant claimed that an existing contracting vehicle was available to meet the requirement and should have been used to procure the services at issue, and that the employee instead improperly steered the contract to the company run by the employee's friend. The OIG did not substantiate the allegations.

Alleged Misuse of Overtime and Compensatory Time and Improper Telework at the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia

The OIG investigated an allegation that an employee of the Hunter Holmes McGuire VAMC in Richmond, Virginia, misused official time by recording more than 500 hours in overtime and 200 hours in compensatory time. Concurrent with the OIG investigation, the Veterans Integrated Service Network 6 (VISN 6) Financial Quality Assurance Manager audited the time worked by the employee and concluded that managers knew the extent of the employee's additional work hours, but documentation and internal controls governing the use of overtime were insufficient. VISN 6 recommended that the VAMC prioritize the hiring of an additional staff member in the employee's work group to reduce the need for overtime and that VAMC management establish and maintain proper internal controls for approving overtime and compensatory time. The OIG concurred with the findings and recommendations of the VISN 6 audit and made no additional recommendations.

Audits and Reviews

VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students

The OIG conducted this audit to determine if VA and State Approving Agencies (SAAs) were effectively reviewing and monitoring education and training programs that enrolled Post-9/11 GI bill students to ensure only eligible programs participated. Prior OIG reports noted financial risks for these programs. Based on its review, the OIG estimated that 86 percent of SAAs did not adequately oversee the education and training programs to make certain only eligible programs participated. The OIG estimated that, without correction, the Veterans Benefits Administration (VBA) could issue an estimated $2.3 billion in improper payments to ineligible programs over the next five years. Oversight deficiencies occurred, in part, because VBA maintained it has a limited role for oversight of SAAs. The OIG recommended clarifying requirements for approvals, requiring periodic re-approval of programs,

reporting schools with misleading advertising, strengthening compliance, revising program assessment standards, and confirming that SAA funding can support the recommended steps.

Inadequate Governance of the VA Police Program at Medical Facilities

The OIG audited the VA security and law enforcement program to determine whether there was an effective governance structure for reasonably assuring that the program was meeting its objectives, including protecting individuals at VA medical facilities. The OIG also examined whether the police workforce met staffing requirements and whether there was an adequate inspection program of its police units. The OIG found that VA did not have adequate governance over its police program to ensure effective management and oversight. Governance problems stemmed from confusion about police program roles and authority as well as the lack of a coordinated and centralized governance structure. The OIG made five recommendations for clarifying oversight responsibilities and evaluating the need for a centralized management entity, ensuring facility-appropriate police staffing models are implemented, addressing facilities' staffing challenges, providing resources for timely inspections of police units, and developing procedures for investigating medical facility leaders' alleged misconduct.

Delays in the Processing of Survivors' and Dependents' Educational Assistance Program Benefits Led to Duplicate Payments

The OIG conducted this audit to determine whether VBA adjusted compensation benefits in the Survivors' and Dependents' Educational Assistance (DEA) Program in a timely manner and accurately processed benefits payments. The DEA Program is VA's second-largest education program with more than $553 million in benefits paid in fiscal year 2017. The OIG found that delays in the processing of DEA benefit adjustments led to overpayments totaling approximately $4.5 million through February 1, 2018. Continued delays could result in an estimated $22.5 million in improper payments over a five-year period. The OIG recommended monitoring electronic mailboxes, ensuring receipt of benefit notifications by regional staff, developing system functionality to identify cases with potential duplication of benefits, processing benefit adjustments when ready, and taking prompt action to adjust benefits for cases in the OIG sample that VBA had not previously identified as requiring DEA-related compensation benefit adjustments.

Healthcare Inspections

Provider Assignment and Dermatology Consult Scheduling Delays at the Joint Ambulatory Care Center, Pensacola, Florida

An inspection was conducted to evaluate allegations related to a patient's care at the Joint Ambulatory Care Center in Pensacola, Florida—a clinic of the Gulf Coast Veterans Health Care System in Biloxi, Mississippi. The OIG found that the patient did not have an assigned primary care provider for nine months and experienced a delay in dermatology care. Although the patient did not experience an adverse clinical outcome, the risk of one was increased by the delay. Scheduling delays for 46 percent of fiscal year 2017 dermatology consults were also identified. For this cohort, the OIG team determined one

patient experienced an increased risk of an adverse clinical outcome and communications were entered in a patient's record that did not meet documentation requirements. The OIG made four recommendations related to primary care provider assignment, dermatology scheduling, reviewing staffing levels, and electronic health record documentation.

Delay in Care and Care Coordination at Cheyenne VA Medical Center, Wyoming, and Iowa City VA Health Care System

In response to confidential allegations, the OIG reviewed delays in a patient's renal cancer care and care coordination. The OIG substantiated that Cheyenne clinicians failed to provide timely and proper surveillance (follow-up) for the patient's renal cell carcinoma and left nephrectomy surgery. Additionally, an institutional disclosure and peer reviews were not initiated. The OIG did not substantiate that Iowa City providers failed to provide care and were unaware of the patient's cancer history. The OIG also reviewed patients' electronic health records to determine if Iowa City urology consults were timely and found that clinical care was provided and patients were not negatively impacted. However, Urology Clinic providers did not always complete e-consult documentation as required by VHA. The OIG made seven recommendations related to cancer surveillance, care coordination, provider communication, problem lists, institutional disclosure, and peer review.

Comprehensive Healthcare Inspection Program Reviews

Comprehensive Healthcare Inspection Program (CHIP) reviews are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year. The OIG's fiscal year 2019 areas of focus include

(1) Leadership and Organizational Risks;
(2) Quality, Safety, and Value;
(3) Credentialing and Privileging;
(4) Environment of Care;
(5) Medication Management;
(6) Mental Health;
(7) Long-Term Care;
(8) Women's Health; and
(9) High-Risk Processes.

The CHIP reports listed below may include topics that differ from those listed above if they were initiated in the prior fiscal year.

San Francisco VA Health Care System, California

West Palm Beach VA Medical Center, Florida

Marion VA Medical Center, Illinois

Iowa City VA Health Care System, Iowa

Robley Rex VA Medical Center, Louisville, Kentucky

G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi
VA Southern Nevada Healthcare System, North Las Vegas, Nevada
VA New Jersey Health Care System, East Orange, New Jersey
Durham VA Medical Center, North Carolina
VA Pittsburgh Healthcare System, Pennsylvania
Salem VA Medical Center, Virginia
Mann-Grandstaff VA Medical Center, Spokane, Washington
William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin

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