MAY 2020 HIGHLIGHTS

Criminal Investigations Involving Health Care

Defendant Pleads Guilty to Defrauding VA's Civilian Health and Medical Program

A deceased veteran's widow pleaded guilty in the Southern District of Texas to false statements relating to healthcare matters. A VA Office of Inspector General (OIG) investigation revealed that over a period of five years, the defendant fabricated fictitious pharmacy receipts and submitted them to VA's Civilian Health and Medical Program for reimbursement. The loss to VA is approximately $648,100.

Two Defendants Sentenced and Three Defendants Plead Guilty in Connection with Bribery Scheme

A vendor was sentenced in the Southern District of Florida to an 18-month term of confinement (consisting of one year of home confinement followed by six months' imprisonment due to the COVID-19 pandemic), three months' supervised release, and restitution of $850,000. In addition, a suspended employee of the Bruce W. Carter VA Medical Center in Miami, Florida, was sentenced to six months' home confinement, three years' supervised release, and restitution of $8,596. Finally, two suspended employees and one former employee of the medical center each pleaded guilty to bribery. A VA OIG investigation that was based on a hotline complaint resulted in charges that these defendants and 11 other individuals engaged in a bribery and kickback scheme involving multiple vendors and employees of the VA medical centers in West Palm Beach and Miami, Florida. The charges allege that VA employees placed supply orders in exchange for cash bribes and kickbacks from the vendors. In many instances, the prices of supplies were grossly inflated, or the orders were only partially fulfilled or not fulfilled at all. Since 2009, the vendors received millions of dollars from numerous VA medical centers throughout the country through purchase card orders and service and construction contracts.

Former Beckley, West Virginia, VA Medical Center Doctor Indicted for Civil Rights Offense and Abusive Sexual Contact

A former Beckley, West Virginia, VA medical center doctor specializing in Osteopathic Manipulation Therapy was indicted in the Southern District of West Virginia on charges of deprivation of rights under the color of law (civil rights) and abusive sexual contact. A VA OIG, Federal Bureau of Investigation (FBI), and VA Police Service investigation resulted in charges alleging the defendant sexually molested six patients during examinations at the facility.

Criminal Investigations Involving Benefits

Two Veterans Indicted for Life Insurance Fraud Scheme

Two veterans were indicted in the Southern District of California for wire fraud, conspiracy to commit wire fraud, and making a false claim. A VA OIG, Naval Criminal Investigative Service, and FBI investigation resulted in charges alleging these two veterans and at least 16 others submitted numerous

policy claims for Servicemembers' Group Life Insurance Traumatic Injury Protection (TSGLI) that reflected fraudulent narratives of catastrophic injuries and exaggerated the loss of activities of daily living, generating payouts of $25,000 to $100,000 per claim. VA supervises the administration of the TSGLI program. Three additional veterans were previously indicted in connection with this investigation in October 2019. One of the previously indicted veterans allegedly recruited a Navy command medical doctor and a Navy nurse to create false medical records and sign the claims. The loss to the TSGLI program is approximately $2 million.

Three Defendants Charged in Connection with Fraud Scheme

Three defendants were charged with racketeering, obtaining funds under false pretenses, and forgery (two in the 18th District Court of Michigan and one in the 27th District). A VA OIG and Michigan Attorney General investigation resulted in charges alleging that the defendants used aliases to obtain or create fraudulent documents, including vital records such as birth certificates, to make it appear as if they were surviving spouses of deceased veterans. These documents were then allegedly used to fraudulently obtain VA Dependency and Indemnity Compensation benefits, VA Survivors Pension benefits, and unclaimed funds from the state of Michigan. The total loss is approximately $470,000, of which the loss to VA is approximately $430,000.

Criminal Investigations Involving Other Matters

Construction Company, Majority Owner, and Former Service-Disabled Veteran-Owned Small Business Affiliate Agree to Pay $4.35 Million to Resolve Civil Fraud Allegations

A large construction company, its majority owner, and a former service-disabled veteran-owned small business (SDVOSB) affiliate agreed to pay $4.35 million to the government as part of a civil settlement with the U.S. Attorney's Office for the Northern District of New York to resolve allegations surrounding their involvement in an alleged scheme to defraud various limited-competition government contracting programs. The SDVOSB was allegedly established so that the large construction company could obtain SDVOSB, Historically Underutilized Business Zone, and small business set-aside contracts for which it was ineligible. This settlement follows a separate and related settlement for $100,000 with the bonding agent for both companies, who was allegedly complicit in the scheme. The total value of the VA contracts was approximately $32.6 million. This case was investigated by the VA OIG, Army Criminal Investigation Command, Defense Criminal Investigative Service, Department of Transportation OIG, and Small Business Administration OIG.

Audits and Reviews

VA's Compliance with the Improper Payments Elimination and Recovery Act for Fiscal Year 2019

The OIG reviewed whether VA complied with Improper Payments Elimination and Recovery Act of 2010 requirements for fiscal year (FY) 2019. VA did not comply because it did not satisfy two of the six requirements. VA did not meet annual reduction targets for a program considered at risk for improper payments and did not report a gross improper payment rate of less than 10 percent for six programs and activities. The OIG also determined the Veterans Health Administration (VHA) understated a program estimate because of insufficient documentation that services were received, and recommended VHA implement appropriate testing procedures. Four programs and activities were noncompliant for five consecutive fiscal years and two activities were noncompliant for three years. VA must submit compliance plans to Congress for them. VA satisfied the additional reporting requirements for two high-priority programs and another program with a monetary loss of more than $100 million as reported in FY 2018.

Healthcare Inspections

Radiology Concerns at the VA Illiana Health Care System in Danville, Illinois

This inspection assessed facility leaders' response to a radiologist's four alleged errors. The OIG determined that care for one of the four patients met institutional disclosure criteria. Facility leaders conducted two expanded reviews of the radiologist with Veterans Integrated Service Network and National Teleradiology Program assistance. The OIG concluded the Radiology Service lacked early detection and identification processes for radiologic errors, and the radiology service chief inadequately assessed the radiologist's performance. The OIG made six recommendations: one to the under secretary for health regarding radiologists' professional practice evaluation guidelines; one to the Veterans Integrated Service Network director regarding continued oversight of the facility's response to National Teleradiology Program findings; and four to the facility director regarding disclosures to patients or families, Radiology Service improvements in quality assurance and performance plans, radiologist competency reviews based on VA's National Guidelines for Radiology Professional Competency, and further evaluation of National Teleradiology Program final findings.

Critical Care Unit Staffing and Quality of Care Deficiencies at the Charlie Norwood VA Medical Center in Augusta, Georgia

The OIG assessed allegations that inadequate nurse staffing resulted in the development of pressure ulcers, inadequate cardiac and respiratory care, and medication management failures. Lack of consistent documentation prevented the OIG from determining whether nurse staffing contributed to many of the alleged conditions. Noncompliant practices and other deficits were identified that contributed to care management challenges and increased risk for poor clinical outcomes. Facility and tele-intensive care

unit (ICU) staff did not immediately recognize and respond to a life-threatening arrhythmia, which may have contributed to a patient's death. Other OIG-identified deficits related to the facility's pressure injury program, respiratory care, and medication management. Recommendations were made related to compliance with VHA and local requirements for pressure injury prevention and management including nursing documentation. Other recommendations focused on tele-ICU and cardiac monitoring, the respiratory care for a specific patient, processes for securing sitters, and nursing staff assignment practices.

Delays in Diagnosis and Treatment and Concerns of Medical Management and Transfer of Patients at the Fayetteville VA Medical Center in North Carolina

The OIG assessed the diagnostic delay and treatment of one patient's (Patient A) leukemia, a second patient's (Patient B) admission, inter-facility transfer processes, and facility responses to both patients' deaths. A primary care provider failed to act on Patient A's abnormal laboratory results and pathologists' recommendations. The OIG was unable to determine whether a delay in diagnosing and treating Patient A's leukemia occurred. A hospitalist failed to initiate the emergency transfer protocol, which delayed the transfer. Staff response to an emergency medical service's call delayed Patient B's inter-facility transfer. Patient B died, but the OIG was unable to determine whether the delay was a factor. The facility's policy did not reflect available treatment capabilities. Leaders did not conduct comprehensive analyses of the deaths. The OIG made 12 recommendations regarding abnormal laboratory results, community care processes, emergency patient treatment and transfer policy updates, facility responses to the events, and providers' evaluations.

Death of a Patient, Deficiencies in Domiciliary Safety and Security, and Inadequate Contractual Agreement at the VA Northeast Ohio Healthcare System in Cleveland

This healthcare inspection of the facility's domiciliary assessed alleged deficiencies in the care of a patient who died. The team also examined safety and security measures and nurse staffing. In response to a congressional request, the OIG evaluated whether Volunteers of America (VOA) met contractual requirements for providing nonclinical staffing and food and cleaning services. The OIG did not substantiate that emergency department staff failed to properly assess the patient; however, no provider ordered an electrocardiogram as recommended by VHA prior to initiating methadone. VOA staff were found to have improperly completed health and safety sheets. The OIG determined nurse staffing was not unsafe and core clinical staffing met or exceeded requirements. VOA substantially met its contractual obligations. Two recommendations were made to the VA Office of Asset Enterprise Management director related to contract modifications, and three were made to the facility director related to electrocardiograms, institutional disclosure, and safety rounds.

To listen to the podcast on the OIG's May 2020 activity highlights, go to www.va.gov/oig/podcasts.