



Department of Veterans Affairs

Office of Inspector General

September 2013 Highlights

OIG REPORTS

Noncompliance with Safe Medication Management Cited in Review of Unexpected Death at Lyons, New Jersey, VA Medical Center

The Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) conducted an inspection in response to a request by OIG's Office of Investigations to review the care of a patient who died unexpectedly while residing at the Mental Health Residential Rehabilitation Treatment Program (MH RRTP) at the VA New Jersey Health Care System (HCS), Lyons, NJ. The Office of the State of New Jersey Medical Examiner's autopsy report listed "Acute intoxication due to the combined effects of cyclobenzaprine, tramadol, gabapentin, sertraline, hydroxyzine, and amlodipine" as the cause of death. The manner of death (suicide, homicide, accidental) was listed as undetermined and final diagnoses included hypertensive and atherosclerotic cardiovascular disease. OIG found that program staff did not comply with Veterans Health Administration (VHA) and facility requirements for an effective, safe medication management program or document the resident's care sufficiently or timely. OIG also found that leadership did not provide sufficient professional support for a MH RRTP advanced practice registered nurse (mid-level provider). OIG recommended that the HCS Director ensures that the facility complies with MH RRTP safe medication management requirements, completes required electronic health record (EHR) documentation, and provides appropriate follow-up to requests for professional support by MH RRTP mid-level providers. [\[Click here to access report.\]](#)

Review Substantiates Missed Cancer Diagnosis Allegation at Erie, Pennsylvania, VA Medical Center

OIG conducted an inspection to evaluate the care and services a patient received at the Erie VA Medical Center (VAMC), Erie, PA; the Warren Community Based Outpatient Clinic (CBOC), Warren, PA; and the VA Pittsburgh HCS, University Drive Campus, Pittsburgh, PA. OIG substantiated the allegations that VA providers missed the patient's cancer diagnosis, did not manage his pain appropriately, and that there were scheduling delays in the patient's referrals and follow-up care. OIG could not confirm the allegation that an outpatient specialty care provider was rude to the patient and family during the patient's care visit. OIG found factors that contributed to the missed diagnosis as well as opportunities for improvement in system processes that affected this patient's care. The oversight of the patient's care continuum was lacking, and there was inadequate communication between primary and specialty care providers and VA and community health care facilities. OIG recommended that the Network Director initiate a root cause analysis to evaluate system issues outlined in this report and evaluate the care of the patient discussed in this report with Regional Counsel for possible disclosure to the surviving family member(s) of the patient. The Network Director concurred with OIG's recommendations and provided an acceptable action plan. [\[Click here to access report.\]](#)

Continued Vigilance Needed To Ensure Gastroenterology Consult Backlog in Columbia, South Carolina, VA Facility Does Not Recur

OIG conducted a review at the William Jennings Bryan Dorn VAMC in Columbia, SC, to determine whether deficient practices contributed to or caused delays in care, and whether facility leaders appropriately addressed clinical managers' concerns. OIG substantiated the allegations and found additional factors that contributed to the events. In July 2011, Veterans Integrated Service Network (VISN) and facility leaders became aware of the gastroenterology (GI) consult backlog involving 2,500 delayed consults, 700 "critical." The VISN awarded the facility \$1.02M for fee colonoscopies in September 2011. Because facility leaders did not ensure a structure for tracking and accountability by December 2011, the backlog stood at 3,800. The facility developed an action plan in January 2012, but had difficulty making progress in reducing the backlog. An adverse event in May 2012 prompted facility, VISN, and VHA leaders to re-evaluate the GI situation and essentially eliminate the backlog by late October 2012. During the review "look-back," 280 patients were diagnosed with GI malignancies; 52 of these were associated with a delay in diagnosis and treatment. Several factors contributed to the GI backlog and hampered efforts to improve the condition. Specifically, the facility's Planning Council did not have a supportive structure; Nursing Service did not include GI nurses on their priority hiring list; Fee Basis care had been reduced; low-risk patients were being referred for screening colonoscopies, thus increasing demand; staff members did not consistently and correctly use the consult management reporting and tracking systems; critical VISN and facility leadership positions were filled by a series of managers who often had collateral duties and differing priorities; and Quality Management was not included in discussions about the GI backlogs.

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

VBA Pension Management Centers Need To Improve Timeliness of Payments to Low Income Veterans

OIG conducted this audit to determine if the Pension Management Centers (PMCs) processed pension payments accurately. VA paid nearly \$5 billion in fiscal year (FY) 2012 for pension benefits to over 500,000 low income Veterans or their beneficiaries. Delayed or incorrect payments have the potential to affect the economic status of eligible Veterans and beneficiaries. Veterans Benefits Administration (VBA) can improve the timeliness, and therefore the accuracy, of pension payment processing. During a 1-year period, an estimated 93,000, or 18 percent of 514,000 Veterans and beneficiaries, experienced an average 15-month delay in receiving their new pension award or adjustments to their current payment. Delays resulted in \$308 million in underpayments and \$194 million in overpayments. This included retroactive adjustments as early as 2006. Once PMC staff processed the claims, they correctly calculated pension payments for new awards and adjustments 96 percent of the time. The delays occurred for two primary reasons. First, PMCs did not process new awards and adjustments timely because of an increased workload and a lack of clear communication of priorities. Second, PMCs did not receive timely notification of changes that affected current pension benefits, and did not have an effective plan to reduce the time to collect income, expense, or dependency changes. In addition, VBA systems contained a small rate of duplicate pension records. VBA was aware of the

potential for creating duplicate records and began taking action to control them. To reduce notification delays, the Under Secretary for Benefits (USB) should ensure Pension and Fiduciary Service implement a plan to reduce under and overpayments due to changes in income and dependency, and establish and implement matching agreements. To reduce processing delays, the USB should ensure Pension and Fiduciary Service implement new triage and processing procedures at the PMCs. The USB should implement additional controls to identify and correct duplicate records. The USB concurred with OIG recommendations and provided plans for corrective actions. [\[Click here to access report.\]](#)

VHA Could Pay Ineligible Agencies \$893.5M, Make \$13.2M in Improper Payments for In-home Care for Veterans

OIG assessed whether VHA effectively managed non-institutional purchased home care services to ensure eligible Veterans receive entitled services. OIG audited these services because of their expected growth, budgeted to increase to \$798 million in FY 2013. VHA's Non-Institutional Care program allows Veterans to receive VA and contractor-provided services in the least restrictive environment possible. Under purchased home care, contract agencies provide Veterans with home health aide or other skilled care services in their homes. OIG estimated VHA's waiting lists did not include at least 49,000 Veterans who had purchased home care needs in FY 2012. OIG projected that 114 VA medical facilities limited access to purchased home care services through the use of more restrictive eligibility criteria than VHA policy required, applying nonstandard review processes, and relying on inaccurate and nonstandard eligibility information. OIG found VA facilities added requirements to limit Veterans' access and did not always use required waiting lists to track eligible Veterans. This occurred because VA medical facility officials limited the costs of services paid through fee service, relied on inaccurate eligibility information for skilled care services, and redirected funds towards higher priorities. VHA redistributed \$76 million; VA medical facilities spent \$99 million less than VA had budgeted for these services; and VHA did not meet its target to increase the average daily census for these services in FY 2012. VA medical facilities' staff also did not identify 31 ineligible agencies and did not properly manage 19 high-risk agencies which were providing care to these Veterans. Fee staff did not always verify billings before paying for services, resulting in \$67,000 in improper payments. Without actions to strengthen controls, VHA could pay ineligible agencies about \$893.5 million and make just over \$13.2 million in improper payments over the next 5 years. OIG recommended the Under Secretary for Health (USH) standardize the application of eligibility reviews and criteria and strengthen controls to ensure eligible patients receive purchased home care services. OIG also recommended that VHA adequately review and monitor agencies, properly document orders, and review orders to verify payments. The USH concurred with OIG's recommendations and provided responsive action plans, but had concerns about OIG's sampling methodology and statistical analysis. [\[Click here to access report.\]](#)

VA's Technology Acquisition Center Could Save \$108.7M By Competing Task Orders and Contracts for IT Services

The Technology Acquisition Center (TAC) awarded approximately 1,200 Information Technology (IT) services contracts, valued at approximately \$5.2 billion, from October 2010 through June 2012. OIG conducted this audit to determine whether the TAC awards and administers IT services contracts in accordance with the Federal Acquisition Regulation (FAR) and VA policy. OIG found no significant issues with 61 of 79 statistically selected IT services contracts. However, the TAC awarded 18 contracts that did not meet the FAR competition requirements. This occurred because the TAC did not adequately justify using an exception to the FAR competition requirements to award four of six task orders under two Indefinite Delivery/Indefinite Quantity (IDIQ) contracts valued at approximately \$143.1 million. OIG extended its review procedures to include an additional 72 task orders processed under these contracts. The TAC used the same FAR exception for 16 of the 72 task orders valued at approximately \$146.6 million. In addition, by not demonstrating IT services could not be obtained as conveniently or economically by contracting directly with a commercial source the TAC did not follow FAR requirements before awarding 14 Interagency Acquisitions valued at approximately \$254 million. This occurred because VA's Integrated Oversight Process (IOP) reviews did not identify or prevent the TAC's noncompliance with the FAR requirements concerning competing task orders and using Interagency Acquisitions. OIG projects the TAC missed an opportunity to save approximately \$57.9 million in acquisition costs by not competing IDIQ task orders. OIG also projects the TAC could have saved approximately \$50.8 million by competing contracts among commercial sources instead of awarding Interagency Acquisitions. OIG made three recommendations to the Principal Executive Director for the Office of Acquisition, Logistics, and Construction (OALC) to ensure that IDIQ task order awards and Interagency Acquisitions comply with FAR competition requirements. The Principal Executive Director for OALC concurred with the recommendations and provided an acceptable action plan. [\[Click here to access report.\]](#)

VA Incurred \$13M Developing New System Functionality, Duplicating Existing Contract Management System

OIG conducted this review to assess the merits of an anonymous Hotline allegation that the Virtual Office of Acquisition (VOA) software development project was not managed under VA's Project Management Accountability System (PMAS) control and oversight. The complainant also alleged the VOA project was unnecessary because VA already owned a system that met 95 percent of VOA's requirements. OIG substantiated the allegation that the VOA software development project was not managed under PMAS. TAC officials believed that because the OALC was managing VOA development, the project did not need PMAS oversight provided by VA's Office of Information and Technology (OIT). As such, the software development project was not centrally evaluated to ensure it would support the best mix of projects to minimize duplication and maximize VA's investment in IT. OIG partially substantiated the allegation that VOA development was unnecessary. OIG found VA owned the Electronic Contract Management System (eCMS), OALC's mandatory contract management system, which VOA functionality partially duplicated. The TAC did not develop a business case, as

required under PMAS. Submitting a business case under PMAS could have minimized duplication and maximized VA's investment. By developing duplicative eCMS functionality, VA potentially incurred unnecessary costs of approximately \$13 million. OIG recommended the Principal Executive Director for OALC implement controls to ensure that all future software developments fall under PMAS control. OIG further recommended the TAC be required to submit a business case justifying how the costs associated with duplicative system requirements and future system maintenance will be managed moving forward. The Principal Executive Director for OALC concurred with OIG recommendations and provided acceptable corrective action plans.

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

OIG Questions Nearly \$2M Spent on Separately Priced Items for Conferences, Recommends Discontinuing Agreements with OPM

VA reported spending approximately \$15.5 million on three financial management training conferences in 2010 and 2011, using an Interagency Agreement (IA) with the Office of Personnel Management (OPM). Of the \$15.5 million VA reported spending on these conferences, about \$6.7 million was spent on Separately Priced Item (SPI) purchases and related service fees. OIG conducted this review to assess VA's oversight of SPI purchases. Our review of three conferences found VA paid about \$5.3 million of \$6.7 million for goods and services the prime vendor should not have purchased as SPIs. Instead, VA and OPM should have identified essential goods and services and required the prime vendor to deliver them as firm-fixed-price tasks rather than as SPIs. VA and OPM did not approve all SPI purchases in advance, and VA paid the prime vendor for SPIs and service fees without adequate supporting documentation. VA paid the prime vendor about \$697,000 in inappropriate service fees. Additionally, VA paid OPM about \$132,000 in service fees associated with inappropriate SPI purchases. VA placed its trust and reliance on OPM to manage and administer the IA without establishing adequate oversight. This resulted in VA relinquishing its responsibility and accountability to sufficiently monitor and review conference-related expenditures. OIG questioned about \$1.1 million in SPI purchases that could have been saved through competitive contracting. OIG also questioned \$697,000 in prohibited service fees paid to the prime vendor and \$132,000 in service fees paid to OPM associated with inadequate oversight. OIG recommended the Assistant Secretary for Human Resources and Administration consider discontinuing the use of assisted acquisition IAs with OPM for training conferences and establish controls to improve oversight of SPIs purchased through existing assisted acquisition IAs with OPM. OIG recommended the Principal Executive Director for OALC update its policy to ensure a qualified individual with appropriate training in contracting is assigned to all IAs and take action to recover service fees paid to the prime vendor and OPM that were inappropriate or associated with inadequate oversight. The Assistant Secretary for Human Resources and Administration and the Principal Executive Director for OALC concurred with OIG's recommendations and provided plans for corrective actions.

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

Weak Administration Could Cost VA \$12M for Veterans Not Meeting Full-Time Attendance Required for Retraining Program

OIG performed this audit to determine whether VBA's Veterans Retraining Assistance Program (VRAP) was administered to maximize Veterans' use of the program. Congress passed the Veterans Opportunity to Work to Hire Heroes Act authorizing VRAP in November 2011. As implemented by VA, VRAP offers training assistance to unemployed Veterans who are not eligible for any other VA education benefits program. Enrollment for this program expires in March 2014. Early in OIG's audit, OIG issued an interim report stating that VRAP would not achieve the participant levels authorized by Congress. The USB agreed with OIG recommendations to accept applications until VBA reached the enrollment limit for this program. This report identifies additional issues since the interim report. OIG found weak administration of the program allowed Veterans to enroll without complying with the program's full-time attendance requirements, and over half of those Veterans inaccurately certified their status as full-time students. OIG also identified situations where some school officials did not adequately monitor Veterans' academic progress or accurately report enrollment information. In addition, VBA could have better described the penalties for false certifications. VBA also approved one of the schools that did not have appropriate procedures as a training institution. OIG projected that VBA paid about \$12 million to just over 2,300 Veterans who were not complying with VRAP attendance requirements. Without increased oversight and controls, VBA risks continuing inappropriate payments to Veterans who do not meet full-time attendance requirements. OIG recommended the USB reinforce the schools' requirement to monitor Veterans' progress and accurately report enrollments, clarify and establish procedures to manage VRAP, and warn Veterans of the penalty for incorrect certifications. If extended beyond March 2014, VBA needs stronger controls to ensure the long-term integrity of the program. The USB concurred with OIG recommendations and provided plans for corrective actions.

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

NCA Needs To Enforce Use of Competition Requirements and Make Full Use of Electronic Contracting System

The National Cemetery Administration (NCA) transferred contract responsibilities from VHA to NCA's Office of Management Contracting Service in February 2008 to improve its acquisition process. NCA administered 574 contracts during calendar year 2012 with an estimated contract value of about \$382 million. OIG conducted this audit to assess the adequacy of contract development, award, administration, and oversight processes of the NCA Office of Management Contracting Services. OIG found that NCA did not have effective internal controls, or existing controls were not followed, to ensure adequate development, award, and administration of contracts. In a statistical sample of 50 competitive contracts and all 32 noncompetitive contracts, OIG found one or more contract deficiencies in each of the 82 contracts reviewed. Contract files did not always have sufficient evidence of acquisition planning, market research, and vendor past performance. NCA improperly awarded 16 of the 32 noncompetitive contracts, as opposed to competitively bid small business set-asides. Contracting officers did not consistently provide a complete history of contract actions in VA's mandatory eCMS. Additionally, NCA did not conduct IOP reviews of 25 of the 36 competitive contracts and

24 of the 29 noncompetitive contracts that were required to be reviewed under this mandatory process. These deficiencies occurred because NCA did not have sufficient management staff in place to lead and manage the newly established organization. Without sufficient management oversight, NCA could not ensure internal controls were working properly or as planned when developing and awarding contracts. As a result, NCA cannot ensure awarded contracts consistently met the FAR and VA policies. OIG recommended NCA strengthen contracting processes and controls by enforcing the proper use of competition requirements, make full use of eCMS, and fully implement IOP reviews. The Under Secretary for Memorial Affairs agreed with OIG's recommendations and provided an appropriate action plan.

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

OIG Recommends VHA Procurement & Logistics Office Conduct Annual Reviews of Duty Stations To Ensure Correct Salaries

OIG conducted this review to determine the merits of four allegations claiming VHA's Procurement and Logistics Office (P&LO) mismanaged travel, duty stations assignments, salaries, and funds. OIG substantiated two of the four allegations: P&LO did pay some employees the incorrect salaries for their duty station locations, and P&LO did improperly use the VA Supply Fund to pay for travel. However, OIG did not substantiate that P&LO authorized excessive, unnecessary travel or that employees were virtually stationed away from where they needed to work. OIG determined P&LO needed to strengthen internal procedures for approving travel. P&LO needs to ensure authorizing officials have direct knowledge of employee travel plans and only authorize travel after validating the necessity of the travel. P&LO paid three employees incorrect salaries due to inaccurate duty station assignments in FY 2010. Prior to OIG's review, P&LO identified the errors for two of the three employees, and corrected the salaries and recouped related overpayments. The third employee was overpaid about \$18,000 into FY 2013 because P&LO did not have standard procedures in place to ensure accurate duty station assignments. Finally, P&LO improperly augmented FY 2010 appropriations by using the VA Supply Fund to pay travel costs for an employee whose salary was funded through appropriations. P&LO did not have procedures in place to ensure appropriate use of the VA Supply Fund. OIG recommended the Chief Procurement and Logistics Officer implement controls to strengthen employee travel review and authorization. P&LO should initiate a periodic review of all employee duty station assignments to correct assignment errors and recoup incorrect payments as appropriate. While the USH concurred, the Principal Executive Director for OALC generally concurred with OIG's report recommendations. [\[Click here to access report.\]](#)

Laboratory Delays and Alleged Staff Training Issues at Memphis VAMC, Memphis, Tennessee

OIG conducted a health care inspection to determine the merit of allegations related to laboratory delays impacting patient care and a lack of staff training in the Pathology and Laboratory Medicine Service (PLMS) at the Memphis VAMC, Memphis, TN. OIG substantiated that urgent laboratory tests were not processed in a timely manner and that a patient experienced a lengthy delay in treatment while waiting for laboratory test results. OIG did not substantiate that there were delays in reporting test results with

critical values to ordering providers. OIG also did not substantiate that PLMS staff were not trained on vital laboratory equipment and processes. The VISN and Facility Directors concurred with OIG recommendations to ensure that processes be strengthened to ensure that laboratory turnaround times adhere to facility and VISN expectations, and to ensure that policies and processes are put in place to establish consistent and appropriate methods for data collection and analysis of laboratory test processing times. [\[Click here to access report.\]](#)

Alleged Sterile Processing Service Deficiencies at VA Puget Sound Health Care System, Seattle, Washington

OIG's OHI conducted an inspection to assess allegations regarding operations within the Sterile Processing Service (SPS) at VA Puget Sound HCS Seattle, WA. OIG substantiated that instruments were processed in a pan that was not approved for the sterilizer in use; however, OIG did not substantiate that this caused the instruments involved to be unsterile. OIG did not substantiate that leadership knowingly covered-up and failed to disclose processing problems associated with equipment. OIG did not substantiate that the HCS reused single-use devices; however, OIG did find that the HCS resterilized single-use devices that had not yet been used. OIG did not substantiate that standard operating procedures and staff competency folders are not accurate and current or that SPS had not provided sufficient staff training. However, OIG did find deficiencies in the manner in which the files were organized. OIG concluded that the HCS generally complied with clinical and administrative processes within SPS. OIG found areas needing improvement in the management of single-use devices and the maintenance and tracking of SPS staff competency files.

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

Inadequate Staffing, Poor Patient Flow Found in the Emergency Department of VA Maryland Health Care System

OIG evaluated allegations regarding staffing and poor patient flow in the Emergency Department (ED) at the VA Maryland HCS, Baltimore, MD. A complainant alleged that patients were left unmonitored for extended periods of time and experienced prolonged ED stays due to severe bed and staff shortages. The complainant also described poor patient flow and problematic administrative processes. OIG substantiated that there were times when patients' monitoring was interrupted due to lack of specialty (telemetry and isolation) beds; however, the facility had already initiated plans to expand specialized bed capacity. OIG also found there were staff shortages and that the facility did not have contingency plans for ED staffing in times of increased patient care demand. OIG found problems with patient flow from the ED to inpatient areas, and noted that data used by the facility to address flow issues was inaccurate. OIG made five recommendations to improve specialty bed access, contingency staffing, and processes for patient flow. [\[Click here to access report.\]](#)

OIG Identifies Five Areas for Improvement in VHA Polytrauma Care

OIG completed an evaluation of polytrauma care in VHA facilities. The purpose of the evaluation was to determine whether VHA facilities complied with selected requirements related to screening, evaluation, and coordination of care for patients affected by

polytrauma. OIG evaluated polytrauma care at 57 facilities during reviews conducted from October 1, 2011, through September 30, 2012. Fifty-four facilities had Combined Assessment Program reviews, and separate visits were made to three facilities. OIG identified five areas where VHA facilities needed to improve compliance. OIG recommended that: (1) VHA perform a detailed analysis of workload and resource use to determine whether there is continued need for the numbers of sites at the current levels and whether changes in the requirements for dedicated polytrauma resources are needed; (2) Level IV sites performing comprehensive traumatic brain injury (TBI) evaluations have approved alternate plans; (3) clinicians consistently complete TBI evaluations within 30 days of positive screens; (4) the case management process meets requirements; and (5) staff caring for polytrauma patients have the documented competencies required for caring for these patients. [\[Click here to access report.\]](#)

OIG's Review of 92 VA Clinics Results in 10 Recommendations for Improvement

The purpose of OIG's evaluation was to assess if CBOCs provide Veterans with consistent, safe, and high-quality health care. OIG performed this review with inspections of 92 VHA CBOCs during FY 2012. These inspected CBOCs are a statistical sample of all VHA CBOCs with more than 500 patients aligned under selected parent VA facilities. OIG's review focused on four components: (1) FY 2012 CBOC-specific information gathering and review; (2) EHR reviews of care performed in FY 2011 for determining compliance with VHA policies; (3) on-site environment of care and emergency management inspections during FY 2012; and (4) CBOC contract reviews of quarter 3 of FY 2011. OIG recommended that: (1) CBOC clinicians document foot care education provided to diabetic patients in the EHR; (2) perform risk assessments and document risk levels for diabetic patients in the EHR; (3) document referrals for preventative foot care, including foot wear, as clinically indicated, for patients with diabetes in the EHR; (4) CBOC managers establish a process to consistently link breast imaging and mammography results to the appropriate radiology mammogram or breast study order for all fee basis and contract patients; (5) establish a process to notify patients of normal mammogram results within the allotted timeframe and that notification is documented in the EHR; (6) service chiefs' documentation in VetPro reflects documents reviewed and the rationale for privileging or re-privileging CBOC providers; (7) facility Directors grant privileges consistent with the services provided at the CBOCs; (8) adequate resources and controls are in place to address deficiencies in the invoice validation process and to reduce the risk of overpayments; (9) the oversight of the contract acquisition process is compliant with VA Directives, including a thorough pre-award review and interim contract authority prior to contract approval; and (10) all new CBOCs undergo the required contract approval processes prior to initiating operations. [\[Click here to access report.\]](#)

Inspection Results for Clinics in Multiple VAMCs

OIG reviewed the VA Maryland HCS's five CBOCs during the week of July 15, 2013. 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 Loch Raven CBOC,

Baltimore, MD, for a site visit and evaluated credentialing and privileging, environment of care, and emergency management processes. OIG noted opportunities for improvement and made a total of two recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG also conducted several CBOC reviews covering the same health care topics at the following locations:

OIG reviewed the Fargo VA HCS's CBOCs during the week of July 22, 2013. OIG noted opportunities for improvement and made a total of six recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the Sheridan VA HCS's five CBOCs during the week of July 22, 2013. OIG noted opportunities for improvement and made a total of six recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the James A. Haley Veterans' Hospital's four CBOCs during the week of July 22, 2013. OIG noted opportunities for improvement and made a total of five recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the Chalmers P. Wylie Ambulatory Care Center's four CBOCs during the week of August 12, 2013. OIG noted opportunities for improvement and made a total of four recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

Benefits Inspection Results for VA Regional Office Muskogee, Oklahoma

OIG evaluated the Muskogee VA Regional Office (VARO) to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 25 (42 percent) of 60 disability claims OIG reviewed. OIG sampled claims it considers to be at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Specifically, 12 of 30 temporary 100 percent disability evaluations OIG reviewed were inaccurate; however, OIG identified no systemic trend associated with these processing errors. Additionally, staff misinterpreted VBA policy and inaccurately processed 13 of 30 TBI claims. VARO management ensured Systematic Analyses of Operations (SAOs) were complete and timely, but did not ensure staff properly addressed Gulf War Veterans' entitlement to MH treatment. VARO staff provided adequate outreach to homeless Veterans; however, OIG could not fully assess the effectiveness of VBA's outreach activities because VBA needs performance measures for its homeless Veterans outreach program. OIG recommended the VARO Director develop a plan to review the 304 temporary 100 percent disability evaluations remaining from OIG's inspection universe of related claims. The Director should provide and monitor the effectiveness of training on processing TBI claims. The Director should implement a plan to ensure accurate second-signature reviews of TBI claims. The Director should also ensure staff addresses Gulf War Veterans' entitlement to MH treatment. The Director concurred with OIG recommendations, although VARO staff did not agree with 6 of 13 TBI claims processing errors OIG identified. [\[Click here to access report.\]](#)

Benefits Inspection Results for VARO in St. Paul, Minnesota

OIG evaluated the St. Paul VARO to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 14 (23 percent) of 60 disability claims reviewed. OIG sampled claims it considers at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Specifically, 5 of 30 temporary 100 percent disability evaluations OIG reviewed were inaccurate. These errors generally occurred because VARO staff did not establish controls to request future medical reexaminations. Further, VARO staff incorrectly processed 9 of 30 TBI claims. These errors occurred primarily due to ineffective training on processing complex TBI claims. Management generally ensured SAOs were complete and timely. However, VARO staff did not always properly grant Gulf War Veterans entitlement to MH treatment. VARO staff provided adequate outreach to homeless Veterans. Due to a lack of performance measures, OIG could not fully assess the effectiveness of the VARO's homeless Veterans outreach program. OIG recommended the VARO Director develop and implement a plan to review the 299 temporary 100 percent disability evaluations remaining from our inspection universe of related claims and take appropriate action. The Director should also provide refresher training on processing TBI claims and monitor the effectiveness of that training. The VARO Director concurred with OIG recommendations.

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

Benefits Inspection Results for VARO in Togus, Maine

OIG evaluated the Togus VARO to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 4 of 39 disability claims reviewed. OIG sampled claims it considered at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Generally, VARO staff processed temporary 100 percent disability evaluations correctly. However, staff incorrectly processed 2 of 9 TBI claims. These errors occurred because staff used insufficient medical examination reports and misinterpreted VBA policy when rating the claims. SAOs were incomplete and untimely. VARO managers lacked adequate measures to ensure staff addressed all required elements and submitted the annual analyses by the due date. Staff accurately addressed Gulf War Veterans' entitlement to MH treatment and provided adequate outreach to homeless Veterans in the VARO's area of jurisdiction. However, OIG could not fully assess the effectiveness of these outreach activities because VBA lacked performance metrics for its Homeless Veterans Outreach Program. [\[Click here to access report.\]](#)

CRIMINAL INVESTIGATIONS**East Orange, New Jersey, VAMC Former Supervisory Engineer Pleads Guilty to Fraud**

A former supervisory engineer at the East Orange, NJ, VAMC pled guilty to a criminal information containing a variety of fraud charges. An OIG, Federal Bureau of Investigation (FBI), and Internal Revenue Service (IRS) Criminal Investigation Division (CID) investigation revealed that the defendant accepted kickback payments in connection with VA contracts awarded to companies he had relationships with and engaged in a scheme to defraud VA by falsely claiming one of the companies was

owned by a service-disabled Veteran. The defendant also conspired with a partner to set up three companies that could be used to obtain VA contracts and then directed more than \$6 million worth of VA construction projects to those companies, of which, more than \$3 million was paid to the falsely claimed service-disabled veteran-owned small business. The defendant admitted to accepting approximately \$1,275,000 in kickbacks in exchange for his official action and influence between 2007 and 2012.

Augusta, Georgia, VAMC Nurse Arrested for Assault

An Augusta, GA, VAMC nurse was arrested for assault. An OIG and VA Police Service investigation revealed that the defendant entered a patient's room, while two other staff members attempted to treat the patient, and punched the patient causing fractured ribs.

Three Former New Orleans, Louisiana, VAMC Employees Sentenced for Health Care Fraud

Three former New Orleans, LA, VAMC employees were sentenced after pleading guilty to health care fraud for their role in a fraud scheme involving the billing of the medical center for services not rendered. The first defendant was sentenced to 24 months' incarceration and 3 years' supervised release. The second defendant was sentenced to 15½ months' incarceration and 3 years' supervised release. The third defendant was sentenced to 17 months' incarceration and 3 years' supervised release. All of the defendants were ordered to pay VA varying amounts of restitution totaling \$563,986.

Former Biloxi, Mississippi, VAMC Nurse Sentenced for Prescription Forgery

A former Biloxi, MS, VAMC nurse was sentenced to 3 years' probation and fined \$1,300 after pleading guilty to prescription forgery. An OIG and state law enforcement investigation revealed that the defendant used the names and personal identifying information (PII) of two Veterans from the medical center in order to fraudulently obtain narcotics from retail pharmacies.

Philadelphia, Pennsylvania, VAMC Nursing Home Employee and Accomplice Sentenced After Pleading Guilty to Theft by Deception

A Philadelphia, PA, VAMC nursing home employee and her accomplice were sentenced after pleading guilty to theft by deception. The former employee was sentenced to 11½ to 23 months' house arrest and 5 years' probation. Additionally, the former employee's license as a Certified Nursing Assistant was ordered revoked. The co-defendant was sentenced to 4 years' probation. An OIG and local police investigation revealed that the perpetrators stole a Veteran's credit card, fraudulently charged purchases and attempted to make an additional \$5,000 of charges to the card. Additionally, the former VA employee admitted to stealing cash from various Veterans while being employed at the VA nursing home.

Atlanta, Georgia, VAMC Pharmacist Arrested for Theft

An Atlanta, GA, VAMC pharmacist was arrested on theft charges. An OIG investigation revealed that the defendant stole pills from the VA pharmacy and attempted to conceal them in her personal bag. The defendant subsequently admitted that the drugs were stolen.

Former Cleveland, Ohio, VAMC Nurse Sentenced for Theft of Dangerous Drugs

A former Cleveland, OH, VAMC nurse pled guilty to theft of dangerous drugs and was subsequently sentenced to 18 months' probation. An OIG and VA Police Service investigation revealed that the defendant stole vials of fentanyl, midazolam, and lidocaine, as well as syringes and needles from the medical center.

Former Chicago, Illinois, VARO Employee Sentenced for Theft

A former Chicago, IL, VARO employee, who was a union official, was sentenced to 24 months' probation and ordered to pay restitution of \$18,662 after pleading guilty to theft. The defendant resigned prior to being terminated. An OIG and Department of Labor investigation revealed that the defendant withdrew funds from a union account for personal use, forged the signatures of other union officials to checks written to himself, and purchased two computers for personal use with a union debit card.

Veteran Indicted for Terroristic Threats at the Atlanta, Georgia, VAMC

A Veteran was indicted for terroristic threats made towards the medical staff at the Atlanta, GA, VAMC. An OIG investigation revealed the Veteran threatened to kill the medical staff by shooting them in the head if he didn't receive his 100 percent disability pension.

Veteran Arrested for Threats to Nashville, Tennessee, VAMC Employees

A Veteran was arrested and involuntarily committed for a psychological evaluation after making telephonic threats to VA employees. An OIG and local police investigation revealed that the defendant repeatedly called the Nashville, TN, VAMC and told staff members that he was going to kill everyone at the facility.

Veteran Arrested for Aggravated Harassment

A Veteran was arrested for aggravated harassment. An OIG and State Police investigation revealed that the Veteran made numerous telephonic threats to several employees at a VA call center relating to his attempts to obtain various medications, including methadone, from VA.

Veteran Pleads Guilty to Threatening National Guard General

A Veteran pled guilty to threatening to murder a Federal official. An OIG and FBI investigation revealed that during a VA compensation and pension appointment the defendant discussed his plan to execute a General with the Mississippi Army National Guard in Jackson, MS.

Veteran's Daughter Sentenced for Assault of VA Police Officers at Bronx, New York, VAMC

The daughter of a Veteran was sentenced to 12 months' probation and ordered to receive psychological counseling after assaulting a VA police officer at the Bronx, NY, VAMC. An OIG and VA Police Service investigation revealed that the defendant and her brother assaulted VA police officers in the medical center's emergency room. One officer required medical attention. The defendant's brother was previously sentenced in this case.

VA Appointed Fiduciary Indicted for Misappropriation

A VA appointed fiduciary was indicted for theft of Government funds, misappropriation by a fiduciary, and false statements after an OIG investigation revealed he misused funds intended for his Veteran brother. As a result of his actions, the Veteran sustained a loss of approximately \$50,000.

VA Fiduciary Indicted for Misappropriation by a Fiduciary

A VA fiduciary was indicted for misappropriation by a fiduciary. An OIG investigation revealed that the defendant, who is the Veteran's sister, used the Veteran's VA funds for personal expenses and for approximately 2 years failed to pay the Veteran's mortgage payments. The Veteran's home subsequently entered into foreclosure status as a result of the defendant's actions.

Two Non-Veterans Arrested for Identity Theft

Two non-Veterans were arrested for aggravated identity theft, access device fraud, theft of Government funds, and conspiracy to defraud the United States. An OIG, IRS CID, and local police investigation revealed that one defendant, a former Tampa, FL, VAMC volunteer, stole patients' PII from the Tampa, FL, VAMC and traded the information with a second defendant for crack cocaine. The second defendant subsequently used the VA PII and additional PII to file approximately \$550,000 in fraudulent tax returns.

Veteran Sentenced for Identity Theft

A Veteran was sentenced to 140 months' incarceration, lifetime supervision, and ordered to pay \$53,935 in restitution, \$12,027 of this amount to be paid to VA. The defendant previously pled guilty to possession of child pornography, failure to register as a sex offender, health care fraud, and possession of firearms as a convicted felon. An OIG investigation revealed that for 7 years the defendant, who resided in Vermont, assumed a North Carolina Veteran's identity and used the false identity to obtain a U.S. Passport, purchase firearms, vote, obtain employment, and obtain VA medical care through the VA fee basis program. A computer analysis conducted by OIG's Computer Forensics Laboratory also linked the defendant to child pornography.

Veteran Indicted for Theft of Government Funds and Aggravated Identity Theft

A Veteran was indicted for theft of Government funds and aggravated identity theft. A VA OIG and Social Security Administration (SSA) OIG investigation determined that the Veteran received VA individual unemployability benefits since 1997 while working as a golf professional, car salesman, Pentecostal preacher, mortgage loan specialist, and in a variety of other jobs. In an effort to hide earned income, the defendant used other individuals' Social Security Numbers (SSN) for employment. The Veteran also used these SSN's to obtain automobile loans. The loss to VA is approximately \$350,000, and the loss to the SSA is approximately \$407,000.

Three Former Veteran Caretakers Sentenced for Conspiracy and Theft of Government Funds

Three former Veteran caretakers were sentenced after pleading guilty to conspiracy and theft of Government funds. The first defendant was sentenced to 24 months'

incarceration, and the other two defendants were sentenced to 16 months' incarceration. Additionally, all defendants were ordered to serve 3 years' supervised release. An OIG and U.S. Postal Inspection Service investigation revealed that the defendants applied for and received VA pension benefits without the knowledge of the Veteran, while he resided in their personal care home. The defendants used a post office box to receive all of the Veteran's VA benefit checks from August 2003 to October 2010. The approximate loss to VA is \$123,000.

Widow Sentenced for Theft of VA Benefits

The widow of a Veteran was sentenced to 15 months' incarceration, 3 years' supervised release, and ordered to pay VA restitution of \$308,040. An OIG investigation revealed that the defendant repeatedly made false reports to VA by failing to report her April 1978 remarriage. The defendant filed the false reports in order to continue to receive Dependency and Indemnity Compensation benefits.

Physician's Assistant Sentenced for Health Care Fraud

A physician's assistant was sentenced to 8 months' home confinement, 2 years' supervised probation, and ordered to pay VA restitution of \$154,872 after pleading guilty to health care fraud and conspiracy to commit health care fraud. The defendant's wife was sentenced to 18 months' probation after entering into a Pre-Trial Diversion (PTD) agreement as a co-conspirator to the health care fraud. An OIG investigation revealed that the defendant, his wife, and their medical director, who is a physician, were contracted to conduct disability rating examinations of Veterans in northern Mississippi. The contract with VA stipulated that the physician perform all disability rating examinations. The investigation determined that the defendant conducted 337 of the 347 exams performed at the clinic between September 2005 and August 2008. The defendant forged the doctor's signature on all of the reports and then submitted the reports and false claims to VA for payment.

Veteran Indicted for Theft of Government Funds and Illegally Possessing Weapons, Wife Indicted for Theft of Government Funds

A Veteran and his wife were indicted for theft of Government funds after an OIG investigation revealed that he fraudulently received more than \$7,000 per month in VA compensation benefits by claiming the loss of use of both legs. Surveillance video showed the Veteran ambulating freely on several occasions, driving an automobile unattended, moving hay bales, and driving a riding lawnmower. After the initial indictment, the defendant failed to register as a sex offender after moving back to North Carolina and was subsequently indicted for that as well. Police reports filed by the defendant in 2011 claimed firearms were stolen from his home. Subsequent investigation revealed the defendant's mother and stepfather had purchased over 23 firearms for him in 2011. As a result, a second superseding indictment was filed charging the defendant with being a convicted felon in possession of firearms and conspiracy. The defendant's mother and stepfather were also indicted for conspiracy and making material false statements intended to deceive Federal licensed firearms dealers.

Daughter of Deceased Beneficiary Pleads Guilty to Theft of Government Funds

The daughter of a deceased beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited into her mother's bank account after her mother's death in May 2005. The loss to VA is \$103,557.

Veteran Sentenced for VA Travel Benefit Fraud

A Veteran was sentenced to 4 months' home detention, 5 years' probation, and ordered to pay \$15,878 in restitution. An OIG investigation revealed that the Veteran filed multiple false travel claims for daily travel from Tallahassee, FL, to the Gainesville, FL, VAMC. The defendant actually drove to Gainesville at the beginning of the week, slept in a vehicle or at a motel each night, and then returned to Tallahassee at the end of the week.

Non-Veteran Arrested for Access Device Fraud and Theft of Government Funds

A non-Veteran was arrested for access device fraud and theft of Government funds. During an OIG, IRS CID, and local police investigation, the defendant used PII, supplied by an undercover officer, to file \$126,793 in fraudulent tax returns. Also, during the investigation, the defendant sold illicit drugs and stolen firearms to an undercover officer. Illicit drugs, PII, a ballistic vest, and firearms were found during a search of the defendant's residence.

Defendants Sentenced for Drug Violations

A Veteran entered into an 18 month PTD program after being charged with the sale of schedule III substances. A non-Veteran pled guilty to attempted trafficking in oxycodone and was sentenced to 18 months' incarceration. A VA employee was sentenced to 6 months' incarceration, 5 years' probation, and 500 hours' community service after being convicted at trial for the sale of oxycodone. Operation Tango Vax, a 7-month multi-agency diversion task force operation, focused on combating the sale and distribution of illicit and controlled prescription pharmaceutical drugs at the West Palm Beach, FL, VAMC and the surrounding community by VA employees, Veterans, and their associates. The investigation identified that the majority of all criminal activity occurred at the medical center and resulted in the seizure of over 3,000 oxycodone pills, two vehicles, and \$180,920.

Veteran Indicted for Theft of Government Funds and Making False Statements

A Veteran was indicted for theft of Government funds and making false statements. An OIG investigation revealed that the defendant submitted an altered DD-214, which reflected service in Vietnam, a Purple Heart, and a Bronze Star, and then made false statements during a compensation and pension examination claiming that he had been an assassin in Vietnam. The investigation further disclosed that the defendant never served in combat and was never awarded a Bronze Star or Purple Heart. The loss to VA is \$114,208.

Veteran Arrested for Theft and Fraud

A Veteran was indicted and subsequently arrested for theft of Government funds, wire fraud, false statements, false claims, and failure to file a tax return. An OIG and IRS CID investigation revealed that the defendant received VA unemployability benefits while operating a Ponzi scheme that defrauded investors of over \$3.5 million. The loss to VA is approximately \$250,000.

Veteran Sentenced for Theft of Government Funds

A Veteran was sentenced to 3 years' probation and fined \$2,500 after pleading guilty to theft of Government funds. An OIG and FBI investigation revealed that the Veteran fraudulently claimed the loss of use of both feet, which entitled him to Special Monthly Compensation. Prior to sentencing, the Veteran made full restitution of \$61,686 to the VA Debt Management Center.

Nephew of a Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds

The nephew of a deceased VA beneficiary was arrested and subsequently pled guilty to theft of Government funds. An OIG and U.S. Secret Service investigation revealed that the defendant stole VA benefit payments issued after his aunt's death in January 2010. The loss to VA is \$124,994.

Veteran Sentenced for Travel Benefit Fraud

A Veteran was sentenced to 4 months' incarceration, 36 months' probation, and ordered to pay VA \$30,448 in restitution after pleading guilty to theft of Government funds. An OIG investigation determined that the defendant submitted approximately 150 fraudulent travel claims reporting 500 miles of round trip travel from Yuma, AZ, to the Tucson, AZ, VAMC. The defendant resided within a few blocks of the Tucson, AZ, VAMC.

Home Health Aide of Disabled Veteran Sentenced for Theft

The home health aide of a service-connected disabled Veteran was sentenced to 15 years' incarceration, with the first 3 years to be served in confinement, and the remainder to be served on probation. The defendant was also ordered to pay \$17,500 in restitution, a \$2,550 fine, and perform 40 hours' community service after pleading guilty to identity theft, exploitation of the elderly or disabled, felony theft by taking, and transaction card theft. An OIG investigation revealed that the defendant stole the Veteran's personal and financial information while acting as a caregiver for the Veteran. The defendant subsequently contacted VA and re-directed the Veteran's VA compensation benefit payments. To further the scheme, the defendant applied for and received several prepaid debit cards in the Veteran's name and used the prepaid debit cards for his personal use. The loss to the Veteran was \$17,908.

Non-Veteran Sentenced for Theft of VA Benefits

A non-Veteran, falsely claiming to be a Vietnam Veteran, was sentenced to 6 months' incarceration and ordered to pay \$51,868 in restitution. An OIG and Defense Criminal

Investigative Service investigation revealed that the defendant submitted a fraudulent DD-214 to VA and subsequently obtained VA health care and pension benefits.

Former U.S. Postal Service Employee Sentenced for Drug Theft

A former U.S. Postal Service (USPS) employee was sentenced to 4 years' probation after pleading guilty to theft of mail by an employee. An OIG and USPS OIG investigation revealed that between January 2010 and May 2012 the defendant stole approximately 52 VA narcotic packages from the mail. The defendant admitted to stealing the controlled substances for personal use.

Former USPS Employee Pleads Guilty to Mail Theft

A former USPS employee pled guilty to theft of mail by an employee. A VA OIG and USPS OIG investigation determined that between September 2012 and February 2013 the defendant stole approximately 85 VA drug packages from a USPS distribution facility. The defendant admitted to stealing the controlled substances for personal use.

Former United Parcel Service Employee Arrested for Theft of VA Narcotics

A former United Parcel Service (UPS) employee was arrested after being charged with theft of Government property and possession of a controlled substance. The defendant was caught with a stolen VA narcotic package by OIG and UPS investigators and admitted to stealing VA narcotics from the Flagstaff, AZ, UPS for personal use.

Fugitive Veteran Wanted for Child Molestation Arrested with Assistance of OIG

A Veteran was arrested at the Atlanta, GA, VAMC on outstanding warrants for aggravated child molestation, aggravated sodomy, child molestation, aggravated sexual battery, and incest. A U.S. Marshals Fugitive Task Force and local law enforcement arrested the fugitive with the assistance of OIG and the VA Police Service.



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

GEORGE J. OPFER
Inspector General