



Department of Veterans Affairs

Office of Inspector General

July 2014 Highlights

CONGRESSIONAL TESTIMONY

Assistant Inspector General for Audits and Evaluations Testifies That Decrease in Veterans Benefits Administration Backlog Adversely Affected Accuracy and Other Workloads

Linda A. Halliday, Assistant Inspector General for Audits and Evaluations, testified before the Committee on Veterans' Affairs, United States House of Representatives, on the Office of Inspector General's (OIG) work on the progress of the Veterans Benefits Administration's (VBA) efforts to address the claims backlog. Ms. Halliday discussed the results of recent OIG reports, including *Review of VBA's Special Initiative To Process Rating Claims Pending Over 2 Years*, which estimated that VBA removed over 7,000 provisionally rated claims from the inventory even though they still awaited final decisions. This process misrepresented VBA's actual workload of pending claims and its progress toward eliminating the overall claims backlog. Because VBA did not ensure existing controls were functioning as needed to effectively identify and manage provisionally rated claims, some veterans may never have received final rating decisions if not for OIG's review. She also discussed concerns about other VBA workload areas that have experienced delays and/or an increase in volume due to the focus on claims processing. These areas include: appeals, benefit reductions, education benefits, other eligibility determinations, and dependency changes. Ms. Halliday was accompanied by Mr. Brent Arronte, Director, OIG's San Diego Benefits Inspections Division. [\[Click here to access testimony.\]](#)

ADMINISTRATIVE INVESTIGATION

Former Under Secretary for Memorial Affairs Promoted Friend and Gave Preferential Treatment to National Cemetery Administration Contractor

The former Under Secretary for Memorial Affairs engaged in a prohibited personnel practice when he created a position and preselected an employee for that position. He also engaged in preferential treatment of a National Cemetery Administration (NCA) contractor when he developed a less-than-arm's-length relationship with the contractor. Further, NCA improperly gave the contractor sole-source contracts to provide one-to-one employee development services to select NCA employees.

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

OIG REPORTS

VBA's Provisional Ratings for Older Claims Less Effective Than Existing Process, Led To Misrepresentation of Workload

On April 19, 2013, VBA began a Special Initiative to process all claims pending over 2 years. VA Regional Office (VARO) staff were to issue provisional ratings for cases awaiting required evidence and complete these older claims within 60 days. OIG's review focused on whether (1) provisional ratings resulted in veterans receiving benefits more quickly and helped eliminate the backlog, and (2) older claims were accurately processed under the Special Initiative. The Special Initiative rating process was less

effective than VBA's existing rating process in providing benefits to veterans quickly. Further, VBA removed all provisional claims from its pending inventory, despite more work being needed to complete them. This process misrepresented VBA's actual workload of pending claims and its progress toward eliminating the overall claims backlog. At the end of June 2013 following completion of the Special Initiative, VBA reported 516,922 rating claims pending in its backlog but only 1,258 rating claims pending over 2 years. OIG estimated 7,823 provisionally rated claims had been removed from the inventory though they still awaited final decisions. These claims represented less than 2 percent of VBA's reported backlog but about 12 percent of claims completed under the Initiative. VAROs did not prioritize finalization of the provisionally rated claims once they were issued. OIG estimated 6,860 provisional ratings were still waiting for final decisions as of January 2014, 6 months after the Initiative had ended. Because VBA did not ensure existing controls were functioning as needed to effectively identify and manage provisionally rated claims, some veterans may never have received final rating decisions if not for OIG's review. Additionally, VBA did not accurately process 77 (32 percent) of 240 rating decisions OIG reviewed under this Initiative. Generally, these errors occurred because VAROs felt pressured to complete these claims within VBA's 60-day deadline. OIG estimated VARO staff inaccurately processed 17,600 of 56,500 claims, resulting in \$40.4 million in improper payments during the Initiative period. OIG recommended the Under Secretary for Benefits (USB) establish controls for all provisionally-rated claims, reflect these claims in VBA's pending workload statistics, expedite finalization of provisional ratings, and review for accuracy all claims that received provisional ratings under the Special Initiative. The USB concurred with OIG's recommendations. Management's planned actions are responsive and OIG will follow up as required on all actions. [\[Click here to access report.\]](#)

Lapses in Management Controls at Baltimore VARO Result in Mail Mismanagement and Claim Processing Delays

On June 19, 2014, the Acting Director of the Baltimore VARO alerted OIG that approximately 8,000 documents and claims folders for 80 veterans were inappropriately stored in a supervisor's office. Desk audits of staff office space performed by VARO management revealed approximately 1,500 additional documents containing Personally Identifiable Information (PII) were inappropriately stored in employees' individual workspaces. OIG initiated this review to assess the allegations of a lack of accountability for mail management and benefits claims processing at the VARO. OIG dispatched a team of benefits inspectors to the Baltimore VARO from June 21 to 27, 2014, and substantiated the conditions reported. OIG determined a supervisor had inappropriately stockpiled approximately 8,000 documents in an office. Most of the documents reviewed contained PII and consisted of processed and unprocessed claims-related mail with the potential to affect benefits payments. Some veterans' claims, found in the supervisor's office, required additional processing actions to finalize rating decisions or award benefits payments. Generally, these conditions occurred because the VARO did not use available controls to identify claims folders stored at one location for a lengthy period or adequately monitor cycle-time performance reports for its non-rating related claims inventory. Further, VARO

management did not perform quarterly desk audits of staff workspace as required. As a result, more than 9,500 documents and 80 claims folders lacked the oversight necessary to ensure timely claims processing and the protection of veteran and employee PII. A proactive approach to addressing these management issues is needed to rebuild trust with veterans and other VA stakeholders. OIG recommended the USB implement a plan to ensure proper control of documents and claims folders, staff training on mail handling and workload management, quarterly desk audits, and mail mismanagement impact assessments at the Baltimore VARO. The USB concurred with OIG's recommendations, provided an acceptable corrective action plan, and quickly responded to ensure this mail was processed. Further, the USB directed a 100 percent regional office wide, facility, and desk audit for mail or documents across the country. [\[Click here to access report.\]](#)

To Improve Access to Burial Options, NCA Needs Better Methodology To Identify Unserved Rural Veterans

In accordance with Public Law 113-6, *Consolidated and Further Continuing Appropriations Act of 2013*, which requires NCA to address congressional concerns that NCA does not adequately serve the Nation's rural veterans, OIG conducted this audit to evaluate whether NCA's Rural Veterans Burial Initiative (Rural Initiative) identifies the number and percentage of unserved veterans in rural areas. NCA's Rural Initiative does not adequately identify the number and percentage of veterans residing in rural areas who do not have reasonable access to a burial option. OIG determined that prior to the planned Rural Initiative National Veterans Burial Grounds, NCA was not providing reasonable access to a burial option for approximately 302,000 (34 percent) of roughly 888,000 rural veterans in the initiative's 8 targeted states. When completed, NCA's Rural Initiative is expected to decrease the total number of unserved rural veterans by nearly 120,000 (40 percent) to roughly 182,000 in these 8 states. NCA could not adequately identify the number and percentage of unserved veterans who reside in rural areas because it uses a methodology that identifies veterans residing within a 75-mile radius of a National, VA-funded State or tribal organization veterans' cemetery and does not classify veterans as rural, urban, or any other designation. In addition, NCA lacked a specific performance measurement that evaluated NCA's progress towards increasing service to rural veterans. As a result, NCA cannot evaluate the level of service provided to veterans and their families residing in rural areas throughout the eight targeted states and the entire Nation. Without this veteran population information, NCA cannot adequately report to Congress, and other stakeholders, its performance on serving rural veterans. OIG recommended the Under Secretary for Memorial Affairs establish a methodology to identify the number and percentage of served and unserved rural veterans, publish a national map showing the areas and number of served and unserved rural veterans, and establish performance goals for the percentage of rural and urban veterans served. The Under Secretary concurred with the recommendations and submitted acceptable corrective action plans. OIG will follow up on implementation of the corrective actions. [\[Click here to access report.\]](#)

Opportunities Exist for Veterans Health Administration To Reduce Workers' Compensation Program Costs by \$95.2 Million with Improved Claims Management

OIG determined whether the Veterans Health Administration (VHA) improved Workers' Compensation Program (WCP) case management to better control costs in chargeback year 2012, which represented the most current audit data available at the time OIG began work on this project. OIG identified issues with claims initiation and monitoring similar to those disclosed in our 2004 and 2011 audit reports. Specifically, WCP case files lacked initial or sufficient medical evidence to support connections between claimed injuries and medical diagnoses. OIG estimated VHA inaccurately initiated approximately 56 (7 percent) of 793 WCP claims. WCP claims also were not consistently monitored to timely return employees to work. VHA WCP specialists did not make job offers or take actions to detect fraud. OIG projected 489 (61.7 percent) of 793 active claims were inadequately monitored. These issues occurred because VHA still lacked standard guidance and a clear chain of command to ensure compliance with WCP statutory requirements and VA policy. VHA also lacked a fraud detection process. Overall, OIG estimated VHA can reduce WCP costs over the next 5 chargeback years by \$11.9 million through improved claims initiation and \$83.3 million by increasing efforts to return medically able staff to work. In total, opportunities exist for VHA to reduce WCP costs by roughly \$95.2 million with improved claims management. OIG also identified \$2.3 million in unrecoverable payments due to VHA's lack of oversight to return medically able employees to work. OIG recommended the Acting Under Secretary for Health (USH) ensure clear oversight, standard guidance, adequate staffing, and fraud detection procedures to improve VHA's WCP case management. The Acting USH concurred with OIG's findings and recommendations and plans to complete all corrective actions by May 29, 2015. [\[Click here to access report.\]](#)

Audit Finds \$60 Million in Payment Delays, \$41 Million in Inaccurate Payments for Veterans Receiving G.I. Bill Housing and Book Stipends

OIG evaluated VBA's management of Post-9/11 G.I. Bill monthly housing allowance and book stipend payments. OIG performed this audit due to the size of the program and the financial risks associated with benefits delivery. During calendar year 2013, VBA paid roughly \$5.4 billion in housing allowances and book stipends to approximately 789,000 students. OIG's review of 200 students found that 92 (46 percent) experienced processing delays in the approval of their original claims, and 35 (18 percent) students experienced payment processing delays in their housing allowance and book stipends. Fifteen of the 35 students received approximately \$32,000 in payments an average of 73 days after the start of their school terms. In addition, 39 (20 percent) students received 125 improper payments valued at approximately \$128,000 and 8 students received roughly \$2,400 in book stipends that were not recovered after the students withdrew from courses. Thus, OIG estimated students annually experience approximately \$60.8 million in payment processing delays and receive roughly \$41 million in improper or inaccurate payments. Over the next 5 years, OIG estimated that students could experience roughly \$205 million in inaccurate payments if Post-9/11 G.I. Bill claims processing controls are not strengthened. OIG recommended the USB provide veterans additional information on educational benefits and the requirement to

relinquish other education benefits before the submission of applications and establish a timeliness standard for the submission of enrollment certifications. OIG also recommended the USB reinforce the need for training and monitoring of school certifying officials, improve monitoring of VBA claims processing staff, address automated claims processing programming issues, reconcile book stipend collection procedures, and collect outstanding improper payments. The USB concurred with OIG's recommendations and provided plans to complete corrective actions by December 31, 2014. OIG considers the actions acceptable and will follow up on their implementation. [\[Click here to access report.\]](#)

Connecticut Healthcare System, West Haven, Connecticut Took Appropriate Steps To Address Patients' Exposure to Creutzfeldt-Jakob Disease

OIG conducted an oversight review regarding potential exposure of two veteran patients to Creutzfeldt-Jakob Disease (CJD) at the VA Connecticut Healthcare System (facility), West Haven, CT. OIG reviewed the facility's procedures for reprocessing of neurosurgical instruments, handling and tracking of loaner instrument trays, and responding to potential exposures and the follow-up actions taken post-exposure. In addition, OIG reviewed VHA reprocessing requirements for neurosurgical instruments. OIG concluded that the facility took appropriate steps to address potential patient exposure to CJD. Managers were proactive in seeking counsel from subject matter experts within the VA and other Government agencies to ensure that proper patient follow-up and notification occurred in a timely manner. Facility providers notified and met with the involved patients and/or their family members to discuss the potential exposure to CJD, the risks of CJD transmission, and answer questions or concerns. Providers documented clinical disclosures in the patients' EHRs. Although the facility met the recommended manufacturer's minimum requirement for sterilization of surgical instruments, the facility amended its process by increasing sterilization time from 4 to 18 minutes for neurosurgical instruments. Additionally, managers implemented a process for tracking all loaner instruments from receipt to return. OIG concluded that VHA had appropriate policies and procedures for reprocessing neurosurgical instruments. OIG made no recommendations. [\[Click here to access report.\]](#)

OIG's Unannounced Inspection at Atlanta VA Medical Center Confirms Ongoing Problems with Medication Carts

OIG conducted an inspection to evaluate allegations of medication cart deficiencies, unsafe medication administration practices, and insufficient leadership response to these problems at the Atlanta VA Medical Center (VAMC), Decatur, GA. During an unannounced site visit, OIG found that four of the five carts used in the Community Living Center for medication pass had to remain plugged-in due to insufficient battery power and some of the medication drawers on two of the carts did not lock. Of the 14 carts in service on the 7th and 10th medical floors, 5 had to remain plugged-in due to short battery life and 6 had unsecurable medication drawers. The computers and scanners were functional on all 19 medication carts observed, but OIG noted that some computers were slow to operate or required multiple reboots. OIG found that due to inadequate and/or non-functional medication carts, nurses have had to administer medications late and that nurses did not consistently document the reason for late

medication administration. OIG did not substantiate the allegations that due to inadequate and/or non-functional medication carts, nurses had to engage in workarounds; in fact, an approved alternate method was available for nursing staff to follow when administering medications. OIG substantiated that if nurses did not follow medication administration policy, they could be at risk professionally. While OIG confirmed ongoing problems with medication carts, we did not substantiate the allegation that leadership has not responded to complaints about the issue. OIG made three recommendations. [\[Click here to access report.\]](#)

Allegations Regarding Mismanagement of Patient Care Assessed at the Carl Vinson VAMC, Dublin, Georgia

OIG conducted an inspection in response to allegations about mismanagement of patient care at the Carl Vinson VAMC (facility), Dublin, GA. OIG did not substantiate that a patient with systemic lupus erythematosus was not promptly treated for a urinary tract infection and that the infection contributed to her premature death. The patient did not have test results consistent with a urinary tract infection. OIG does not know the precise cause of death, but the patient had laboratory evidence consistent with increased lupus activity in the month preceding her death. While facility and contract community based outpatient clinic (CBOC) providers were aware of the patient's lupus diagnosis, neither acknowledged this significant clinical finding in their progress notes nor consulted a rheumatologist for follow-up. OIG could not substantiate that the patient was told that the facility would not pay for further care with a private-sector rheumatologist. OIG was unable to interview the Albany CBOC providers or their supervisors, but the patient's electronic health record (EHR) in the 9 months prior to her death did not reflect discussion of the need for reauthorizing Non-VA care. Therefore, OIG could not say specifically what the patient was told about future Non-VA care. Based on medical record documentation, it did not appear that either of the Albany CBOC physician assistants who cared for the patient in 2011–2012 ensured that she received appropriate continuity of rheumatology care. Responsible facility clinicians and managers did not comply with guidelines for completing peer reviews, and as a result, the peer review of this case did not address the full scope of quality issues contributing to the patient's outcome. OIG made four recommendations.

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

IG Makes Nine Recommendations To Improve Patient Care and Staff Safety at Huntsville, Alabama, Outpatient Clinic

OIG conducted an inspection to assess the merit of allegations concerning the quality of care provided by a primary care provider (PCP) and staff safety at the CBOC located in Huntsville, AL. OIG substantiated the PCP did not consistently document opioid medication management, did not consistently document and respond to patients' abnormal test results, and on one occasion, entered a derogatory comment in the EHR. OIG did not substantiate that the PCP had made multiple medication errors, failed to respond to health care concerns appropriately, failed to refer a homicidal/suicidal patient, forced patients to receive vaccinations, and treated patients preferentially causing them to request a transfer of care to another PCP. OIG did not substantiate that the PCP inappropriately instructed staff to shred patients' non-VA medical

documents; however, OIG found that staff did not consistently follow facility policy for the management of non-VA medical records. OIG did not substantiate that the PCP yelled and became upset when CBOC staff cautioned the PCP to not perform a procedure that was not approved for the CBOC setting. However, OIG found that the PCP had performed other CBOC-setting approved procedures for which he/she was not privileged to perform. OIG did not substantiate that the facility did not respond to staff concerns about quality of care or safety. OIG substantiated that the CBOC did not initially have a mental health (MH) emergency standard operating procedure, and once developed, it did not include all actions staff might take when addressing an MH emergency. OIG substantiated that the CBOC had non-functioning panic alarms. During OIG's inspection, we noted that the facility did not have a pain management policy as required and did not complete mandatory EHR quarterly quality reviews for outpatient programs. OIG made nine recommendations. [\[Click here to access report.\]](#)

Allegations Regarding Mismanagement of Catheterization Laboratory Patient Emergencies and Staffing Reviewed at the Baltimore, Maryland, VAMC

OIG conducted an inspection in response to allegations regarding mismanagement of cardiac catheterization laboratory (CCL) patient emergencies and CCL staffing at the Baltimore VAMC, Baltimore, MD. OIG did not substantiate allegations that a patient died because CCL staffing was insufficient to perform an urgent case and leadership delayed transferring the patient to the University of Maryland medical center. OIG also did not substantiate allegations that the CCL nurse manager, intensive care unit nurses, and Anesthesia Service ignored CCL staff requests for help during a cardiac emergency. OIG did substantiate that CCL staff were correctly told not to call the rapid response team for help because the CCL is considered an outpatient clinic and the rapid response team is limited to responding to inpatient situations only. OIG did not substantiate that the facility did not follow "standard of care requirements" since there are no definitive national or VHA standards for minimal staffing of the CCL. However, OIG found that the facility did not consistently meet national and local policy requirements for staffing during CCL procedures involving moderate sedation. Changes implemented at the facility in April 2013 required two RNs be present for all CCL procedures. The facility acknowledged ongoing efforts to evaluate the cost-benefit of CCL in-house operations due to low volume of procedures performed in the CCL. Incidental to OIG's inspection, we found that staff were unclear about the roles of the code blue and rapid response teams, as well as the process for obtaining anesthesiologist assistance in the event of an emergency in the CCL. OIG made three recommendations. [\[Click here to access report.\]](#)

Allegations Regarding Surgical Service Not Substantiated at the Malcolm Randall VAMC, Gainesville, Florida

OIG conducted an inspection in response to allegations concerning the Surgical Service at the Malcolm Randall VAMC (the facility), Gainesville, FL. The facility is part of the North Florida/South Georgia VA Healthcare System (HCS) in Veterans Integrated Service Network (VISN) 8. OIG did not substantiate that a cardiopulmonary resuscitation event in the operating room was not handled appropriately. OIG did not substantiate that surgeons were not allowed to perform a certain procedure in the

operating room so that surgical mortality data would be lower. OIG also did not substantiate that patients deemed at high risk of mortality were sent to a local hospital so that if these patients died, the deaths would not count against the facility's surgical mortality data. OIG noted that a team from VISN 8 completed a site visit to the facility in 2013 and made recommendations to strengthen the facility's surgical program. The facility developed and completed action plans based on these recommendations. OIG made no recommendations. [\[Click here to access report.\]](#)

Allegations of Patient Neglect Not Substantiated at the Central Alabama Veterans HCS, Tuskegee, Alabama.

OIG conducted an inspection to evaluate reporting of suspected patient neglect at the Central Alabama Veterans HCS, Tuskegee, AL. OIG did not substantiate that a registered nurse (RN) failed to report a case of suspected neglect to Adult Protective Services or that the RN failed to triage the patient to determine the need for intervention. OIG found that the RN's actions were clinically appropriate. Documentation reflected that the RN attended to the caregiver's concerns and initiated processes to secure respite care and in-home nursing services to support both the patient and caregiver. OIG did not substantiate that a social work supervisor improperly restricted a social worker's ability to report cases of abuse and neglect. Facility practice is for social workers to discuss cases of suspected abuse and neglect with their supervisors before reporting whenever possible. OIG made no recommendations. [\[Click here to access report.\]](#)

Results for Benefits Inspection of VARO, New Orleans, Louisiana

OIG evaluated the New Orleans VARO to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 42 (47 percent) of 90 disability claims reviewed. OIG sampled claims we considered at higher risk of processing errors, thus these results do not represent overall disability claims processing accuracy at this VARO. Specifically, 15 of 30 temporary 100 percent disability evaluations were inaccurate, generally because management did not prioritize processing of claims requiring reduced evaluations. VARO staff processed 10 of 30 traumatic brain injury (TBI) claims incorrectly due to ineffective training on processing such complex cases. VARO staff also incorrectly processed 17 of 30 special monthly compensation (SMC) and ancillary benefits claims due to a lack of training and emphasis on addressing all ancillary issues. Nine of 11 Systematic Analyses of Operations (SAOs) were incomplete due to inadequate oversight. VARO staff also did not timely or accurately complete 12 of 30 benefit reduction cases due to a lack of training and priority on addressing this workload. OIG recommended the VARO Director develop and implement a plan to ensure staff timely process benefit reductions, review the 329 temporary 100 percent disability evaluations remaining from OIG's inspection universe and take appropriate action, and monitor the effectiveness of training on processing TBI claims and SMC and ancillary benefits. The Director should implement a plan to ensure SAOs contain all required elements, including timeframes for implementing the recommendations. The Director should also ensure staff receive training on how to properly complete SAOs and process proposed benefit reductions. The VARO Director concurred with all recommendations. [\[Click here to access report.\]](#)

Results for Benefits Inspection of VARO, St. Louis, Missouri

OIG evaluated the St. Louis VARO to see how well it accomplishes its mission. OIG found VARO staff did not accurately process 31 (34 percent) of 90 disability claims reviewed. OIG sampled claims we considered at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Claims processing that lacks compliance with VBA procedures can result in the risk of paying inaccurate and unnecessary financial benefits. Nineteen of 30 temporary 100 percent disability evaluations OIG reviewed were inaccurate, generally because VARO staff delayed ordering medical reexaminations on average for 9 months after receiving reminder notifications. VARO staff incorrectly processed 4 of 30 TBI claims. Staff also incorrectly processed 8 of 30 claims related to SMC and ancillary benefits. Generally, the errors in TBI and SMC and ancillary benefits processing were due to lack of oversight to ensure these complex claims were completed and reviewed by designated staff. VARO managers ensured SAOs were complete and timely. However, staff delayed completion of 7 of the 30 rating reduction claims OIG reviewed because management placed a higher priority on other work. OIG recommended the VARO Director implement the plans needed to ensure timely and appropriate action on reminder notifications for medical reexaminations, appropriate action on the 559 temporary 100 percent disability evaluations remaining from our inspection universe, staff is assigned to a specialized team to process TBI and SMC claims, clarification of local policy by clearly defining which SMC claims require processing by a specialized team, staff comply with local policy requiring Decision Review Officers to conduct second-signature reviews of SMC claims, and prioritization of benefits reduction actions in order to minimize improper payments to veterans. The VARO Director concurred with all recommendations and the planned corrective actions are generally responsive. However, OIG remains concerned that potential delays in addressing issues related to temporary 100 percent disability evaluations and benefit reductions will result in continued improper payments. OIG will follow up on all actions. [\[Click here to access report.\]](#)

Combined Assessment Program Reviews

In July 2014, OIG published three Combined Assessment Program (CAP) reviews containing OIG findings for the facilities listed below. The purpose of the CAP reviews was to evaluate selected health care facility operations. Topics reviewed may vary due to differences in services provided at each facility, the need to follow up on previous CAP findings, or the rotation of CAP review topics over time. The reviews covered the following seven activities: (1) medication management, (2) coordination of care, (3) community living center resident independence and dignity, (4) magnetic resonance imaging safety, (5) quality management, (6) environment of care, and (7) acute ischemic stroke care.

[South Texas Veterans HCS, San Antonio, Texas](#)
[VA Black Hills HCS, Fort Meade, South Dakota](#)
[New Mexico VA HCS, Albuquerque, New Mexico](#)

CBOC Reviews

In July 2014, OIG published eight CBOC reviews containing OIG's findings at select CBOCs and primary care clinics that fall under the oversight of the parent facilities listed below. The purpose of the CBOC reviews was to evaluate three operational activities: (1) alcohol use disorder, (2) medication management, and (3) designated women's health provider.

[VA Black Hills HCS, Fort Meade, South Dakota](#)

[James J. Peters VAMC, Bronx, New York](#)

[Jonathan M. Wainwright Memorial VAMC, Walla Walla, Washington](#)

[Robert J. Dole VAMC, Wichita, Kansas](#)

[Grand Junction VAMC, Grand Junction, Colorado](#)

[John D. Dingell VAMC, Detroit, Michigan](#)

[West Texas VA HCS, Big Spring, Texas](#)

[Washington DC VAMC, Washington, DC](#)

CRIMINAL INVESTIGATIONS

Veteran's Widow Arrested for Murder

A veteran's widow was arrested for first degree murder and conspiracy to commit first degree murder. A VA OIG, Social Security Administration (SSA) OIG, Tennessee Bureau of Investigation, and District Attorney's Office investigation revealed that the defendant and her current spouse conspired to murder her previous husband, a combat veteran and VA beneficiary, by forcing him to overdose on prescription drugs and then staging a crime scene to make it appear that he committed suicide. The defendant later applied for Dependency and Indemnity Compensation (DIC) benefits and falsely claimed that her husband's drug overdose was related to his service-connected post-traumatic stress disorder. The defendant's current spouse has pled guilty to conspiracy to commit first degree murder and has agreed to fully cooperate with the prosecution against his wife in exchange for a reduced sentence. The loss to VA is over \$100,000.

Training Center Owners Arrested for Theft

Two owners of a training center were arrested for grand theft, organized scheme to defraud, and conspiracy. An OIG investigation revealed that the defendants owned and operated a school that billed VA between \$5,750 and \$7,750 for courses taken by veterans as part of their Post-9/11 G.I. Bill benefits, while charging non-veterans between \$249 and \$645 for the same courses. The loss to VA is \$635,465.

Augusta, Georgia, VAMC Nurse Pleads Guilty to Assault

An Augusta, GA, VAMC nurse pled guilty to assault and agreed to surrender his nursing license. 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 serious bodily injury.

Veteran Convicted of Assault of Miami, Florida, VA Physician

A veteran was convicted at trial of assault on a VA physician. An OIG investigation revealed that the defendant became angry at how long he had to wait for his appointment for pain medication and subsequently assaulted his Miami, FL, VAMC physician.

Veteran Sentenced for Making Bomb Threats to VA

A veteran was sentenced to 3 years' probation and ordered to attend special counseling pertaining to education, employment, and self-help after pleading guilty to aggravated harassment. An OIG investigation revealed that the defendant made bomb threats against a VAMC because of a reduction in benefits and a wage garnishment letter he received in the mail.

Veteran Arrested for Making Threats to VA

A veteran who threatened to blow up VA, put his guns to use, and also threatened the Postal Service was arrested after fleeing for 10 days from his residence in Delaware. The veteran was located and arrested in another state and is awaiting extradition.

Fiduciary Sentenced for Misappropriation

The fiduciary of a 100 percent service-connected incompetent veteran pled guilty to theft, misappropriation by fiduciaries, and Social Security representative fraud. A VA OIG and SSA OIG investigation revealed that the fiduciary failed to provide fiduciary accountings as required and misappropriated \$321,512 in VA and Social Security funds.

Former Fiduciary Pleads Guilty to Misappropriation

A former VA fiduciary pled guilty to misappropriation by a fiduciary. An OIG investigation determined that the fiduciary stole \$28,305 in VA funds that should have been paid to a nursing home on behalf of the veteran. The defendant embezzled the funds for use in a failed construction business.

Las Vegas, Nevada, VAMC Employee Convicted of Seeking Sexual Relationship with Young Girl

A Las Vegas, NV, VAMC employee was convicted at trial of coercion and enticement. An OIG and local police investigation revealed that the defendant used VA computers to post ads on Craig's List stating that he was seeking a sexual relationship with a young girl. The employee corresponded with an undercover officer, who he believed was a 14-year-old girl, and was subsequently arrested when he arrived at a meeting location.

West Palm Beach, Florida, VAMC Employee and Husband Sentenced for Drug Trafficking

A West Palm Beach, FL, VAMC employee and her husband were sentenced to a combined 71 months' incarceration and assessed \$160,292 in fines and court fees after pleading guilty to trafficking oxycodone and the sale of marijuana. These sentences stemmed from a 7-month OIG and local drug diversion task force investigation. Operation Tango Vax 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. 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 in cash.

VAMC Employees Arrested for Drug Diversion

A Mountain Home, TN, VAMC nurse was indicted and arrested for theft of a controlled substance. An OIG and VA Police Service investigation revealed that on numerous occasions the defendant diverted oxycodone tablets from a psychiatric patient. The defendant subsequently confessed to stealing the veteran's narcotics. Administrative action is also pending against the defendant. In addition, a Gainesville, FL, VAMC RN was arrested for fraudulently acquiring controlled substances. An OIG investigation revealed that on multiple occasions the defendant removed hydromorphone from medical center Pyxis machines for her own use. Finally, an Atlanta, GA, VAMC pharmacist was charged with theft by taking after 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 to the theft of the drugs.

Former Bath, New York, VAMC Nurse Sentenced for Drug Diversion

A former Bath, NY, VAMC licensed practical nurse was sentenced to 5 years' probation after pleading guilty to possession of oxycodone. An OIG and VA Police Service investigation revealed that the defendant diverted medications intended for patients for personal use.

Medical Equipment Company Reaches Civil Settlement with Federal Government

A medical equipment company reached a civil settlement of \$6 million with the Federal Government. The agreement resulted from a joint VA OIG, Health and Human Services OIG, Department of Labor (DOL) OIG, and Department Of Defense (DoD) OIG investigation into allegations that the medical equipment company entered into a kickback scheme by creating personal service agreements with staff members of physician offices to promote the use of the company's bone growth stimulators. The bone growth stimulators are medical devices used to repair bone fractures that are slow to heal. The company also refurbished used bone growth stimulators and billed the Government for the price of new bone growth stimulators. VA will receive \$66,488 of the settlement.

Veteran Sentenced for Credit Card Fraud

A veteran was sentenced to 366 days' incarceration after pleading guilty to a variety of credit card fraud charges after an OIG and VA Police Service investigation revealed that the defendant stole a VA physician's purse while receiving treatment at the West Palm Beach, FL, VAMC and used the physician's credit cards to make fraudulent transactions.

Non-Veteran Arrested for Identity Theft

A non-veteran pled guilty to access device fraud and aggravated identity theft. An OIG, Internal Revenue Service Criminal Investigation Division (IRS CID), and local sheriff's office investigation revealed that during an undercover operation the defendant

purchased what he believed to be a Tampa, FL, VAMC patient's PII. The defendant subsequently used the "controlled" PII, in conjunction with a deceased individual's PII, to file \$307,721 in fraudulent tax returns.

Defendant Pleads Guilty to Fraud

An individual pled guilty to a variety of identity theft fraud charges after an OIG and VA Police Service investigation revealed that the defendant, along with a Palo Alto, CA, VAMC employee and two other defendants, conspired to steal the PII of a VAMC employee and used the information to create unauthorized credit card accounts and counterfeit checks. Criminal charges have also been filed against the VA employee and the other two subjects. The defendants used the credit card accounts and counterfeit checks to make purchases at various retail stores. The purchased items were then either sold or traded for narcotics.

Veteran Sentenced for VA Compensation Fraud

A veteran was sentenced to 24 months' incarceration, 3 years' supervised release, and ordered to pay restitution of \$108,489 after pleading guilty to theft of Government funds and conspiracy to make false statements to Federally-licensed firearms dealers. An OIG investigation revealed that the defendant obtained VA compensation benefits by claiming the loss of the use of both legs. The veteran was observed ambulating freely, driving a vehicle, mowing grass, and feeding horses. The veteran's wife was placed into a pre-trial diversion program and ordered to pay restitution of \$18,000 for her part of the scheme. Additionally, the veteran's mother was sentenced to 1 year of probation and the veteran's stepfather was sentenced to 3 years' probation, to include 6 months' home detention, after pleading guilty to conspiracy in making false statements to Federally-licensed firearms dealers. The mother and stepfather purchased over 25 firearms for the defendant, who is a registered sex offender and is prohibited from possessing firearms due to a prior felony conviction for committing a lewd act with a minor. The loss to VA is \$159,297.

Veteran Sentenced for Theft of Government Funds

A veteran was sentenced to 24 months' probation, 6 months' home detention, 100 hours' community service, and ordered to pay VA \$116,233 (constituting the remaining balance of the original \$122,993 loss to the Government) in restitution after pleading guilty to theft of Government funds. A VA OIG, IRS CID, and DOL OIG investigation revealed that the defendant was employed as a building contractor while fraudulently receiving Individual Unemployability benefits.

Veteran Sentenced for VA Pension Fraud

A veteran was sentenced to 3 years' incarceration after pleading guilty to theft. An OIG investigation revealed that the defendant falsified his income in order to qualify for VA pension benefits.

Daughter of Deceased DIC Beneficiary Ordered to Repay VA

The daughter of a deceased DIC beneficiary, who was previously charged in a civil complaint, agreed to the stipulation of a civil judgment in favor of VA that ordered the

defendant to pay \$162,954. An OIG investigation revealed that the defendant, a joint account holder on her deceased mother's bank account, failed to report her mother's May 2006 death to VA and then used the VA funds deposited after her mother's death for personal expenses and to repair her deceased mother's residence.

Veteran Sentenced for Wire Fraud

A former U.S. Marine Corps Captain was sentenced to 4 months' incarceration, 1 year of home confinement, and ordered to pay \$90,602 in restitution after pleading guilty to wire fraud. An OIG and Naval Criminal Investigative Service investigation revealed that the defendant failed to inform VA that he returned to active duty and continued to receive VA disability benefits that he was not entitled to receive. The defendant also falsely claimed military housing reimbursement for rent he never paid. Also, while on active duty the defendant tried to increase the amount of his improper disability payments. The loss to VA is \$41,862 and the loss to DoD is \$48,740.

Home Care Owner Indicted for Wire Fraud Involving Deceased Veteran

A defendant was indicted for wire fraud after a VA OIG and SSA OIG investigation revealed that the defendant owned and operated a personal care home where a veteran beneficiary resided. After the veteran's death in November 1997, the defendant stole VA and SSA benefits that were direct deposited to a joint account. The approximate loss to VA is \$258,000.

Veterans Indicted for Doctor Shopping for Controlled Medication

A total of 25 veterans were indicted for obtaining prescription medication by fraud, deceit, or subterfuge and theft of Government property. To date, 23 of the defendants have been located and arraigned on these charges after an OIG, State, and local investigation revealed numerous veterans were simultaneously obtaining controlled medication from VA and outside sources. Each veteran and their respective VA physicians were interviewed and provided information in furtherance of the cases. The U.S. Attorney for the District of South Carolina worked in conjunction with the local coordinator of the VA's Veterans Justice Outreach Program to pursue appropriate judicial avenues.

Veteran Pleads Guilty to Drug and Weapon Violations

A veteran pled guilty to a variety of drug charges and knowingly possessing and transferring a machine gun. As part of the plea, the defendant agreed to forfeit a number of long guns, handguns, and ammunition confiscated during the arrest and execution of a search warrant at his residence. An OIG, Bureau of Alcohol, Tobacco, Firearms and Explosives, Defense Criminal Investigative Service, and local police investigation revealed that the defendant participated in a plan with at least two other veterans in the theft and transport of at least two machine guns allegedly supplied from Fort Bragg. Controlled buys of the guns were conducted, and the other veterans were arrested based on those purchases. This defendant continued his illicit activity to include selling a shotgun, ammunition, a bullet proof vest, and his VA prescription medications to one of the previously arrested veterans.

Veteran Arrested for Travel Benefit Fraud

A veteran was arrested for grand larceny relating to beneficiary travel fraud. A VA OIG, NY State Medicaid OIG, and NY District Attorney's Office investigation revealed that on 513 occasions the defendant claimed and received Medicaid-paid transportation to and from the Montrose, NY, VAMC while also being reimbursed for travel by VA. The loss to VA is \$19,733.



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