



Department of Veterans Affairs

Office of Inspector General

October 2014 Highlights

CONGRESSIONAL TESTIMONY

Assistant Inspector General for Audits and Evaluations Testifies at House Committee on Veterans' Affairs Subcommittee Field Hearing on the Operations of the Philadelphia, Pennsylvania, VA Regional Office

Linda A. Halliday, Assistant Inspector General for Audits and Evaluations, testified at a field hearing of the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, United States House of Representatives, on October 3, 2014. The hearing was held at the Pemberton, NJ, campus of Burlington County College and focused on the operations of the Philadelphia, PA, VA Regional Office (VARO). Ms. Halliday discussed the initial results of the Office of Inspector General's (OIG) unannounced visit to the VARO in June 2014 and advised that OIG's work continues on the issues raised during the visit. These issues include allegations that mail was not scanned timely into Virtual VA—the electronic claims repository; staff were hiding mail or shredding mail; staff were cherry-picking claims to process; and the VARO improperly implemented Fast Letter 13-10, which was rescinded based on the OIG's June 2014 management advisory memorandum to the Under Secretary for Benefits. The OIG will issue a final report when our work is completed. Ms. Halliday was accompanied by Ms. Nora Stokes, Director, Bay Pines Benefits Inspection Division; Mr. Al Tate, Audit Manager, Atlanta Office of Audits and Evaluations; and Mr. Jeffrey Myers, Benefits Inspector, San Diego Benefits Inspection Division.

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

OIG REPORTS

Ten Percent of Patients Seeking Emergency Care at Leavenworth, Kansas, VA Medical Center Did Not Receive Required Medical Screening

OIG conducted an inspection to assess the validity of an allegation concerning the Dwight D. Eisenhower VA Medical Center (VAMC) Emergency Department (ED), Leavenworth, KS, part of the Eastern Kansas Health Care System (HCS), Topeka, KS. OIG substantiated the allegation that 10 percent of patients who sought care at the Leavenworth VAMC ED did not receive a required medical screening examination to determine whether an emergency medical condition existed. OIG also determined Leavenworth VAMC ED registered nurse (RN) triage staff did not always use required ED documentation templates, and ED and Primary Care Clinic nursing staff did not consistently document required assessments. OIG recommended that the Eastern Kansas HCS Director ensure all patients who present to the Leavenworth VAMC ED requesting an examination or treatment receive a medical screening examination, that Leavenworth VAMC ED and Primary Care Clinic nursing staff document required assessments, and that compliance be monitored. [\[Click here to access report.\]](#)

OIG Finds High Quality Medical Care at Iowa City, Iowa, VA HCS, More Work Needed To Sustain Progress in Workplace Culture

OIG conducted an inspection at the request of Senator Charles E. Grassley to follow up on a prior inspection at the Iowa City VA HCS, Iowa City, IA. OIG previously evaluated the overall quality of care, management, and operations, as well as an allegation that concerns expressed by staff “have been largely ignored,” and published *Review of Quality of Care, Management, and Operations, Iowa City VA Health Care System, Iowa City, Iowa* (Report No. 12-02263-269, August 29, 2012). For the current inspection, OIG assessed the implementation and progress of the action plans developed in response to Office of Healthcare Inspections recommendations from the 2012 report and evaluated a new allegation that “nothing had changed in Iowa City.” OIG noted overall improvements and did not substantiate the allegation that “nothing had changed.” OIG found that high quality medical care had been maintained. While some concerns remain in limited areas regarding blame, fear of retaliation, and reactionary leadership, system leadership is working to create a culture and environment that feels safe and non-retaliatory and acknowledges the need for continued progress in these areas. OIG made no recommendations. [\[Click here to access report.\]](#)

Results for Benefits Inspection of VARO Portland, Oregon

OIG evaluated the Portland VARO to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 24 (29 percent) of 84 disability claims reviewed. OIG sampled claims considered at higher risk of processing errors, thus these results do not represent this VARO’s overall disability claims processing accuracy rate. Specifically, 10 of 30 temporary 100 percent disability evaluations reviewed were inaccurate, generally, because management did not prioritize processing of such cases requiring reduced evaluations. VARO staff incorrectly processed 3 of 30 traumatic brain injury (TBI) claims; however, these inaccuracies did not constitute a systemic issue. VARO staff also incorrectly processed 11 of 24 special monthly compensation (SMC) claims due to a lack of training and no second-level review policy. All 11 Systematic Analyses of Operations (SAOs) were incomplete because management did not provide adequate oversight to ensure staff completed the SAOs correctly. VARO staff did not timely process 10 of 30 proposed benefits reduction cases that averaged 5-month delays and resulted in overpayment of benefits to veterans. The processing delays occurred because management did not provide oversight and prioritize this workload. OIG recommended the VARO Director develop and implement a plan to ensure staff timely process temporary 100 percent disability evaluation cases requiring reductions, and review the 364 temporary 100 percent disability evaluations remaining from the inspection universe and take appropriate action. The Director should assess the effectiveness of SMC training, ensure SAOs are complete, and implement a plan to ensure management oversight and prioritization of benefits reduction cases. OIG recommended the Under Secretary for Benefits (USB) implement a national plan for an additional level of review of SMC and ancillary benefits claims. The USB and VARO Director concurred with all recommendations. [\[Click here to access report.\]](#)

Results for Benefits Inspection of VARO Salt Lake City, Utah

OIG evaluated the Salt Lake City, UT, VARO to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 15 of 68 disability claims reviewed. OIG sampled claims considered at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Of the three types of disability claims reviewed, OIG found VARO staff should improve processing actions related to temporary 100 percent disability evaluations. In the 2014 inspection, 12 of the 30 temporary 100 percent disability evaluations were inaccurate, primarily because staff delayed ordering medical reexaminations on average for 5 months after receiving reminder notifications. Comparatively, 16 of the 30 cases reviewed during the 2011 benefits inspection contained errors. Most of the errors from the 2011 inspection occurred when VARO staff did not enter suspense diaries in the electronic record. Generally, VARO staff processed TBI claims correctly—a significant improvement from the 40 percent inaccuracy rate identified during the 2011 inspection. However, two of the eight SMC and ancillary benefits claims completed by VARO staff during calendar year 2013 contained errors. The errors were unrelated and did not constitute a systemic processing weakness. For two consecutive benefits inspections, VARO managers ensured SAOs were complete and timely. However, staff delayed completing 4 of 30 rating reduction claims because management prioritized other rating-related work. OIG recommended the VARO Director implement plans needed to ensure timely action on reminder notifications for medical reexaminations and take appropriate action on the 135 temporary 100 percent disability evaluations remaining from the inspection universe. The Director should also develop a plan to prioritize actions on benefits reductions to minimize improper payments to veterans and ensure the VARO's timeliness standards for processing benefits reduction cases are consistent with Veterans Benefits Administration policy. The VARO Director concurred with all recommendations. [\[Click here to access report.\]](#)

Combined Assessment Program Reviews

In October 2014, OIG published five 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 activities covered in each review are listed below.

[VA Eastern Kansas HCS, Topeka, Kansas](#)

This review covered the following seven activities: (1) quality management (QM), (2) environment of care (EOC), (3) medication management (MM), (4) coordination of care, (5) acute ischemic stroke care, (6) community living center (CLC) resident independence and dignity, and (7) magnetic resonance imaging (MRI) safety.

[VA Long Beach HCS, Long Beach, California](#)

This review covered the following eight activities: (1) QM, (2) EOC, (3) MM, (4) coordination of care, (5) acute ischemic stroke care, (6) CLC resident independence and dignity, (7) MRI safety, and (8) construction safety.

Tennessee Valley HCS, Nashville, Tennessee

This review covered the following seven activities: (1) QM, (2) EOC, (3) MM, (4) coordination of care, (5) acute ischemic stroke care, (6) CLC resident independence and dignity, and (7) MRI safety.

Alexandria VA HCS, Pineville, Louisiana

This review covered the following seven activities: (1) QM, (2) EOC, (3) MM, (4) coordination of care, (5) acute ischemic stroke care, (6) CLC resident independence and dignity, and (7) MRI safety.

Huntington VAMC, Huntington, West Virginia

This review covered the following six activities: (1) QM, (2) EOC, (3) MM, (4) coordination of care, (5) acute ischemic stroke care, and (6) MRI safety.

Community Based Outpatient Clinic Reviews

In October 2014, OIG published one Community Based Outpatient Clinic (CBOC) review 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 review was to evaluate four operational activities: (1) EOC, (2) alcohol use disorder, (3) MM, and (4) designated women's health provider proficiency.

Wilkes-Barre VAMC, Wilkes-Barre, Pennsylvania

CRIMINAL INVESTIGATIONS

West Palm Beach, Florida, VAMC Chief of Prosthetics Arrested for Conspiracy To Commit Healthcare Fraud

The West Palm Beach, FL, VAMC Chief of Prosthetics was arrested for conspiracy to commit healthcare fraud. An OIG investigation revealed that the defendant solicited and accepted over \$71,000 in kickbacks from a Durable Medical Equipment (DME) vendor and conspired with that vendor to create fraudulent DME orders that were never provided to veterans. Over a 4-year period, the defendant created an environment within the Prosthetics Service that steered over \$2.2 million DME orders to the vendor. Additionally, the defendant conspired with the vendor to create an orthotic shoe fitting business in which they agreed to split the profits. The loss to VA is approximately \$143,000 for the fraudulent DME orders and \$671,730 in overcharges for DME.

Five Defendants Sentenced for Service-Disabled Veteran-Owned Small Business Fraud

Five defendants involved in a Service-Disabled Veteran-Owned Small Business (SDVOSB) scheme were sentenced to terms of between 27 to 56 months' incarceration, home confinement, fines, assessments, and joint restitution of \$267,697. Debarment of the defendants and the company involved in this case is pending. A VA OIG, Department of Labor (DOL) OIG, Defense Criminal Investigative Service (DCIS), Department of Homeland Security OIG, and Department of Housing and Urban Development OIG investigation determined that the company's owner was not a

service-disabled veteran and had obtained various Federal contracts under a set-aside SDVOSB solicitation. The VA contract involved was valued at \$50,000.

Son of Disabled Veteran Indicted for Theft of Government Funds and Aggravated Identity Theft Relating to SDVOSB Fraud

The son of a disabled veteran was indicted for theft of Government funds and aggravated identity theft. A VA OIG, Army Criminal Investigation Command, DCIS, General Services Administration OIG, Social Security Administration (SSA) OIG, and Small Business Administration OIG investigation revealed that the defendant, using two separate businesses, obtained 15 SDVOSB contracts by using his father's identity and military records without his father's knowledge or consent. As a result, the defendant was awarded 5 VA contracts and 10 U.S. Army and Air Force contracts totaling \$2.7 million.

Former Dublin, Georgia, VAMC Nurse Sentenced for Fraud

A former Dublin, GA, VAMC nurse was sentenced to 60 months' incarceration, 36 months' supervised release, and ordered to pay restitution of \$454,740 after pleading guilty to mail fraud. A VA OIG and DOL OIG investigation revealed that the defendant made over 200 false claims for mileage and medical cost reimbursements associated with a workers' compensation claim.

Veteran Indicted for Abusive Sexual Contact

A veteran was indicted for abusive sexual contact. An OIG investigation determined that while the veteran was an inpatient at the Portland, OR, VAMC, he groped a VA certified nursing assistant (CNA) while she was performing her duties. The defendant, a registered sex offender, admitted that he had previously assaulted other nurses in a similar manner.

Las Vegas, Nevada, VAMC Employee Sentenced for Coercion and Enticement

A Las Vegas, NV, VAMC employee was sentenced to 120 months' incarceration and lifetime supervised release after being convicted at trial of coercion and enticement. An OIG and local police investigation revealed that the defendant used VA computers to post advertisements on Craigslist seeking a sexual relationship with a young girl. The employee corresponded with an undercover officer whom he believed was a 14-year-old girl and was subsequently arrested when he arrived at a prearranged location for a meeting with the girl.

Former Augusta, Georgia, Nurse Sentenced for Assault

A former Augusta, GA, VAMC nurse was sentenced to 12 months' probation and a \$1,000 fine. The defendant also 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.

Former Northport, New York, VAMC Information Technology Specialist Pleads Guilty to Illicit Salary Supplementation

A former Northport, NY, VAMC information technology specialist pled guilty to illicit salary supplementation. An OIG investigation revealed that the defendant unlawfully accepted over \$40,000 in gifts, to include expense-paid vacations, dinners, golf outings, and concert tickets from sales representatives working for a telecommunications firm contracted by the VAMC. The gifts were paid to the defendant because of a longstanding relationship he developed with the contractor and not for any specific act. The employee retired from VA as a result of this investigation.

Philadelphia, Pennsylvania, CNA Charged with Theft of Government Funds

A CNA, who had worked for a contractor providing services to the Philadelphia, PA, VAMC, was charged with theft of Government funds. An OIG investigation revealed that the defendant billed the contractor for hours in which services were not performed. The loss to VA is \$64,377.

Gainesville, Florida, VAMC RN Enters into Pre-Trial Agreement

A Gainesville, FL, VAMC RN entered into a pre-trial intervention agreement after fraudulently acquiring controlled substances. The agreement included 18 months' probation and 50 hours' community service. An OIG investigation revealed that on multiple occasions the defendant removed hydromorphone from the medical center's Pyxis machines and diverted the narcotics for personal use.

Husband of Portland, Oregon, VAMC Employee Arrested for Assault

The husband of a Portland, OR, VAMC employee was arrested for assault. An OIG and VA Police Service investigation revealed that the defendant assaulted his wife in the VAMC parking lot. The employee was hospitalized as a result of her injuries.

VA-Appointed Fiduciary Pleads Guilty to Theft of Government Funds

A VA-appointed fiduciary for an incompetent veteran pled guilty to theft of Government funds. An OIG investigation determined that the fiduciary misappropriated over \$89,636 in VA funds.

Former VA Contractor Arrested for Burglary and Possession of Controlled Substance Paraphernalia

A former VA contractor was arrested for burglary and possession of controlled substance paraphernalia. An OIG and VA Police Service investigation revealed that the defendant stole sharps containers that held used syringes and mostly empty narcotic vials from the Palo Alto, CA, VAMC. The defendant used his position as an exterminator to gain access to a biohazard-holding cage that contained sharps containers ready for disposal. A search of the defendant's work vehicle revealed approximately 20 gallons of used syringes and empty narcotic vials. During an interview, the defendant admitted that he used syringes from the stolen sharps containers to inject himself with morphine and dilaudid.

Veteran Sentenced for Firing a Weapon at the VA Lubbock, Texas, Outpatient Clinic

A veteran was sentenced to 18 months' incarceration (suspended), 5 years' probation, 120 hours' community service, and ordered to pay VA restitution of \$3,352 after pleading guilty to criminal mischief. Also, the veteran is now classified as a convicted felon and is prohibited from possessing firearms. An OIG and local police investigation revealed that the defendant discharged a firearm into the VA Lubbock, TX, Outpatient Clinic and then fired again once inside the clinic causing additional damage to the property.

Seven Veterans Indicted for VA Beneficiary Travel Fraud at the West Palm Beach, Florida, VAMC

Seven veterans were indicted for false statements related to the VA beneficiary travel program. An OIG investigation revealed that the defendants submitted false travel vouchers to the West Palm Beach, FL, VAMC in order to receive increased reimbursement for travel to and from their VA appointments. The loss to VA is approximately \$157,753.

Personal Care Home Owner Pleads Guilty to Theft

The owner of a personal care home pled guilty to theft. 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 into a joint account. The approximate loss to VA is \$258,000.

Daughter of Deceased VA Beneficiary Sentenced for Theft of Government Funds

The daughter of a deceased Dependency and Indemnity Compensation beneficiary was sentenced to 5 months' incarceration, 2 years' supervised release, and ordered to pay VA \$90,600 in restitution after pleading guilty to theft of Government funds. The defendant was also ordered to participate in a substance abuse treatment program. An OIG investigation revealed that the defendant failed to notify VA of her mother's death in December 2007 and then stole VA benefits that were direct deposited to a joint account.

Business Owner Arrested for Fraud Involving Deceased VA Beneficiary

A business owner was arrested for mail fraud, bank fraud, passing a forged endorsement on a Treasury check, theft of Government property, and aggravated identity theft. An OIG investigation revealed that before her death a widow beneficiary had her VA benefits mailed to a private mailbox business operated by the defendant. The defendant then stole, forged, and negotiated VA benefit checks that were issued after the beneficiary's death in February 2001. The loss to VA is \$116,598.

Veteran Sentenced for Making False Statements

A veteran was sentenced to 180 days' home confinement, 2 years' probation (including mental health treatment), and ordered to pay restitution of \$63,041 to VA and \$83,188 to the SSA after pleading guilty to making a false statement. A VA OIG and SSA OIG

investigation revealed that the defendant falsely claimed to VA and SSA that he was not employed when in actuality he was working full-time earning substantial income.

Former Palo Alto, California, VAMC Employee Sentenced for Conspiracy and Fraud

A defendant was sentenced to 24 months' incarceration, 5 years' probation, and ordered to pay over \$3,000 in restitution after pleading guilty to conspiracy and fraud in connection with identification information. An OIG and VA Police Service investigation revealed that a Palo Alto, CA, VAMC employee and three other defendants conspired to steal personal identification of another VAMC employee and use that information to create unauthorized credit card accounts and counterfeit checks. The defendants then used the credit card accounts and checks to make purchases at various retail stores. The items purchased at the stores were either sold or traded for narcotics.

Former Bank Manager Pleads Guilty to Theft by a Bank Officer

A former bank manager pled guilty to theft by a bank officer. An OIG investigation revealed that while the defendant was employed by a bank he became aware that a veteran had died in the Dominican Republic. VA was unaware of the veteran's death and continued depositing VA benefits into the veteran's account. The defendant then embezzled the VA funds and the funds of another bank customer to support a gambling habit. The loss to VA is \$37,830.

United States Postal Service Carrier Pleads Guilty to Mail Theft

A United States Postal Service (USPS) carrier pled guilty to mail theft. A VA OIG and USPS OIG investigation revealed that for over a year the defendant stole at least 20 VA-issued narcotic parcels from a mail sorting facility.

Veteran Arrested for "Doctor Shopping"

A veteran was arrested for obtaining a controlled substance by the concealment of a material fact. An OIG investigation revealed that for over 2 years the defendant obtained 16,335 methadone tablets from both VA and outside sources.



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