Department of Veterans Affairs
Office of Inspector General
February 2015 Highlights

OIG REPORTS

Informal Claims Not Properly Controlled at Oakland, California, VA Regional Office, 21 Percent of Claims Reviewed Not Processed, Some as Old as 2002

On July 10, 2014, the Office of Inspector General (OIG) received a request for assistance from the Under Secretary for Benefits (USB) to review allegations that the VA Regional Office (VARO) in Oakland, CA, had not processed nearly 14,000 informal requests. The allegation indicated some claims dated back to the mid-1990s. The same allegation was forwarded to OIG by Representative Doug LaMalfa, who also requested an OIG review. In addition, another complainant alleged that "informal claims" were being improperly stored. OIG immediately initiated an unannounced, onsite review at VARO Oakland and its Sacramento satellite office. OIG substantiated the allegations that VARO staff had not processed informal claims. OIG confirmed that staff had not properly controlled these claims documents, which were accidently found in a filing cabinet, during a construction project. OIG did not identify any current storage or control issues during their site visit. VARO management advised that a team assisting the Oakland Veterans Service Center had located approximately 14,000 informal claims, some of which dated back to the mid-1990s. VA considers an informal claim as any type of communication or action, indicating the intent to apply for one or more benefits, in accordance with existing laws. Management stated it counted the documents and actually identified 13,184 informal claims. Of these 13,184 informal claims, 2,155 required review or action by VARO staff. VARO management told OIG they had created a "special project team" to process the 2,155 informal claims and thought the task had been completed. However, in April through May 2014, VARO staff again "discovered" additional claims, some of which the VARO's "special project team" had annotated as reviewed. After 2 months, VARO management created a tracking spreadsheet to determine which claims needed to be processed. VARO management determined staff (assigned to the special project team) had not processed 537 informal claims. At the time of their onsite review, OIG could not confirm the existence of the 13,184 informal claims, or which of them were the 2,155 claims needing review or action. OIG reviewed 34 of these newly "discovered" claims and found 7 (21 percent) remained unprocessed. While no claims in their sample dated back to the mid-1990s, some were as old as July 2002. OIG also found VARO staff had repeatedly reviewed these seven informal claims from December 2012 through June 2014 for various reasons, but took no additional action on them, as required. VARO staff did not maintain adequate records or provide proper supervision to ensure informal claims received timely processing. As a result, veterans did not receive consideration for benefits to which they may have been entitled. During their inspection, no current issues related to the lack of control and improper storage of informal claims documents came to their attention. OIG recommended the VARO Director complete and certify the review of the 537 informal claims, take appropriate action, and provide documentation to certify these actions are complete. Also, the Director should better enforce

compliance with existing Veterans Benefits Administration (VBA) and VARO policies pertaining to the processing of informal claims. [Click here to access report.]

Allegations Not Substantiated That Radiology Procedures Were Performed by Poorly Trained Staff at Salem, Virginia, VA Medical Center

OIG conducted an inspection at the request of Senator Tim Kaine in response to allegations that interventional radiology procedures at the Salem VA Medical Center (VAMC) (facility), in Salem, VA, were being performed by a radiologist with inadequate training, that the facility lacked adequate medical and surgical support for patients who might develop complications after certain interventional radiology procedures, and that the facility has no formal training and competency program for interventional radiology nurses and technicians. The purpose of the review was to determine whether the allegations had merit. OIG did not substantiate the allegation that radiology procedures at the facility were being performed by a radiologist with inadequate training. OIG found that facility credentialing staff properly verified all educational, training, and licensure credentials for the subject radiologist who was then granted initial privileges to perform procedures, including the two procedures named in the allegation. OIG did not substantiate the allegation that the facility lacked adequate medical and surgical support for patients who might develop complications after certain interventional radiology procedures. The facility has a vascular surgeon and gastroenterologists who are onsite during interventional procedures and available should a patient undergoing an interventional radiology procedure need further care. In addition, the facility has a fully equipped Post Anesthesia Care Unit and Intensive Care Unit. OIG did not substantiate that the facility has no formal training and competency program for interventional radiology nurses and technicians. The facility requires all interventional radiology nurse and technician staff to undergo an annual competency assessment, which is completed by direct observation of the technician while performing his or her duties. OIG made no recommendations. [Click here to access report.]

OIG Makes Five Recommendations To Improve Scheduling Procedures at Phoenix Health Care System Radiology Department

OIG conducted an inspection in response to allegations regarding appointment scheduling, staffing, and other administrative issues in the Radiology Department of the Phoenix VA Health Care System (HCS) (facility), in Phoenix, AZ. OIG substantiated the allegations that a Microsoft Outlook software calendar was used to supplement radiology scheduling, that radiology appointments were not reflected on the patients' clinic appointment reminder lists, and that radiology clerks had no access to the facility-wide scheduling system. OIG also substantiated that films and files had been stored in the basement and were not easily accessible to staff for a limited time and that the Radiology Department had insufficient clerical staff. OIG recommended that the Interim Facility Director ensure that the Radiology Department uses software that is consistent with VA policy to schedule appointments. OIG also recommended that Radiology Department managers explore the use of the scheduling system by radiology clerks, develop and implement a scheduling policy and a formal training program for clerks, monitor clerical needs to ensure all radiology areas are staffed, and implement the

facility's plan for centralized radiology scheduling and procedures to ensure a timely response to phone calls or messages.
[Click here to access report.]

No Conclusive Findings of Inappropriate Prescription Practices at Tomah, VAMC, Tomah, Wisconsin

This inspection was originally administratively closed in March 2014 because OIG could make no conclusive finding of inappropriate prescription practices. OIG previously released the report pursuant to the Freedom of Information Act. Because of continuing public interest, OIG is now publishing the report. OIG conducted a review to assess the validity of multiple allegations of misprescribing and diversion of opioid drugs and a physician's abuse of administrative and clinical authority at the Tomah VAMC, in Tomah, WI (facility). OIG did not substantiate the majority of allegations made in the various complaints that OIG received. Although the allegations dealing with general overuse of narcotics at the facility may have had some merit, they do not constitute proof of wrongdoing. OIG did not find any conclusive evidence affirming criminal activity, gross clinical incompetence or negligence, or administrative practices that were illegal or violated personnel policies. OIG briefed the Facility and Veterans Integrated Service Network Director and brought several suggestions to their attention to improve communication between staff and clinicians concerning opioid prescription practices, assist with the treatment of patients who have complex pain management issues, and evaluate and monitor facility and provider opioid prescribing practices.
[Click here to access report.]

VBA Guidance on Date of Claim Made Claims Difficult To Track and Misrepresented Processing Time at Little Rock VARO

On July 11, 2014, the OIG received an anonymous allegation that staff at the Little Rock VARO inappropriately applied the VBA's Fast Letter 13-10, "Guidance on Date of Claim Issues," dated May 20, 2013. The complainant alleged that adjusting the dates of claims was done to give the appearance that VBA was making more progress than it actually had in eliminating its backlog of disability claims. On June 27, 2014, the USB suspended use of Fast Letter 13-10 after OIG determined staff were misapplying the guidance at another VARO. OIG had previously reported to the USB that the guidance was used inappropriately to adjust dates of claims for unadjudicated claims discovered in the files. Changes to veterans' claims were made to process old mail instead of unadjudicated claims information found in the files. OIG substantiated the allegation that Little Rock VARO staff adjusted dates of claims for unadjudicated claims discovered in the files; however, staff did so in compliance with VBA Fast Letter guidance in effect at that time. OIG reviewed documentation on 48 unadjudicated claims that VARO staff located in claims folders from May 22, 2013, through June 20, 2014. Staff adjusted the dates of claim for all 48 cases OIG reviewed, resulting in the claims having more current dates than the dates they were initially received within VA. OIG interviewed staff who raised concerns that the use of this guidance led to providing veterans with incorrect information on claims processing timeliness. The application of this guidance was also considered inconsistent with VBA standard policy requiring use of the earliest date that a document is stamped as received at a VA facility as the date

of claim. Staff typically process claims in their workloads by claim type and age, generally working the oldest claims first. This VARO maintained records of the changes made to veterans' claims per the requirements in the guidance. To mitigate the potentially adverse effect the date adjustments would have on veterans' benefits, Little Rock VARO staff took the initiative to develop a spreadsheet to track all unadjudicated claims found in the claims folders where dates of claims were changed. This action provided VARO managers with assurance that staff could easily identify the claims and initiate required development actions. Based on OIG's review, OIG concluded that adjusting the dates of aging claims to more recent "discovered" dates resulted in a lack of assurance that staff would expedite processing of the discovered unadjudicated claims, further delaying benefits decisions for veterans. Adjusting the dates of claims also misrepresented the time required for VARO staff to process the claims, potentially making performance look better than it actually was. In order to minimize confusion or misinterpretation of guidance for future claims processing, OIG recommended that VBA maintain a standard, universal policy for establishing dates of claims. In a memo, received January 8, 2015, the USB concurred with OIG's recommendation and reported VBA terminated the use of Fast Letter 13-10, effective June 27, 2014. The memo also indicated all VARO staff had been instructed to immediately follow the permanent procedural guidance found in VBA's governing directives for all claims, to include "found" claims. However, as outlined in this report, OIG concluded that VBA did not take action to terminate Fast Letter 13-10 until January 22, 2015. Further, OIG remains concerned that VBA's permanent guidance related to dates of claims continues to provide for an exception that allows VARO staff to use a later date of claim, despite having evidence that an earlier date of claim exists. [Click here to access report.]

OIG Makes Four Recommendations To Improve Staffing and Reduce Falls in the Medical Intensive Care Unit, West Palm Beach, Florida, VAMC

OIG conducted an inspection in response to complaints about staffing and patient care issues in the medical intensive care unit (MICU) at the West Palm Beach VAMC (facility), in West Palm Beach, FL. OIG substantiated the allegation that nursing management had an inappropriate understanding of the staffing methodology in the MICU. OIG did not substantiate that insufficient staffing in the MICU caused orders to be missed or delays in blood transfusions. OIG substantiated that understaffing in the MICU contributed to an increase in patient falls. OIG did not substantiate that two falls resulted in patient injury. OIG substantiated that frequent floating of the MICU staff contributed to the departure of several experienced registered nurses (RN) and that frequent floating and assignment changes of MICU staff occurred. OIG substantiated the allegation that nursing staff were sent to areas where they did not feel competent. OIG did not substantiate the allegation that, to prevent the use of overtime, a staff member who was still being oriented was required to sit with suicidal patients. OIG did not substantiate that insufficient staffing caused difficulty in covering additional duties of MICU RN staff. OIG did not substantiate that the step down unit was frequently closed. OIG substantiated that one RN was left alone in the step down unit on four occasions. OIG did not substantiate that the RN had to leave the patients unattended. OIG found that the facility's process for reporting incidents was not set up to ensure that incidents

were reported as required. OIG also found that the facility policy for prevention of falls was not being followed. OIG made four recommendations.
[Click here to access report.]

OIG Finds No Evidence To Question Accuracy of Information Presented in the Deputy Secretary's Official Biography

On December 3, 2014, OIG received an allegation that the official biography of Mr. Sloan Gibson, Deputy Secretary for the U.S. Department of Veterans Affairs does not present accurate and transparent information. The allegation focused on the information available on VA's Web site relating to Mr. Gibson's accomplishments during the period 2008–2013, when he held a leadership role at the United Service Organizations, Inc. (USO). Specifically, the complainant questioned the methodology used to calculate net fundraising, which in turn questioned the source of funds enabling dramatic growth in USO programs and facilities. Using USO's publically available audited financial statements and program lists from 2008 through 2013, OIG did not substantiate the allegation. OIG does not have oversight authority over the USO. Although congressionally chartered, the USO is a nonprofit, private organization, and not a Government agency. Without access to USO internal financial documents, OIG could not test the reliability, accuracy, or completeness of the documents received from the complainant. OIG focused their review specifically on the accuracy of the statement, in the Deputy Secretary's official biography that "During his five years at the USO, net fundraising grew 90 percent, enabling dramatic growth in programs and facilities supporting their forward-deployed men and women, military families, as well as their wounded, ill, and injured Service members, their families, and the families of the fallen." The official biography is included at Appendix A of this report. Based on their review of the publicly available financial statements, OIG calculated reasonable, comparable percentages as contained within the official biography. Additionally, OIG identified a dramatic increase in programs from 2008–2013. In conclusion, OIG found no physical or testimonial evidence to question the accuracy of the statements made in the VA Deputy Secretary's official biography. Thus, OIG is not making a recommendation to change the information in the Deputy Secretary's official biography.
[Click here to access report.]

Alleged Consult Management Issues and Improper Conduct, W.G. (Bill) Hefner VAMC, Salisbury, North Carolina

OIG conducted an inspection in response to allegations that a physician improperly closed Non-VA Care Coordination (NVCC) consults and inappropriate comments were made about a patient at the W.G. (Bill) Hefner VAMC in Salisbury, NC. OIG did not substantiate the allegation that a physician improperly cancelled or discontinued NVCC consults, thus denying patients needed care. Record reviews of 214 consults revealed that the reasons for cancellation or discontinuation were logical, met Veterans Health Administration (VHA) and/or local guidelines, and were appropriately documented. While OIG substantiated the allegation that a physician made an inappropriate comment about a patient, OIG found that the facility took appropriate action, and the physician apologized for the statement. OIG made no recommendations.
[Click here to access report.]

Results for Benefits Inspection of VARO Boston, Massachusetts
OIG evaluated the Boston VARO to see how well its staff processes disability claims and provides a range of services to veterans. OIG also interviewed VARO staff to gain a better understanding of how a VARO implemented Fast Letter 13-10 "Guidance on Date of Claims Issues." Overall, VARO staff did not accurately process 21 (23 percent) of 90 disability claims OIG reviewed. OIG sampled claims they considered at increased risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. For the disability claims and processing actions reviewed: (1) Ten of 30 temporary 100 percent evaluations were inaccurate, primarily because staff did not take timely action on reminders for medical reexaminations. In contrast, in February 2011, OIG reported errors in 25 of 30 cases, mainly due to staff not taking action to input suspense diaries in the electronic record. (2) Five of 30 traumatic brain injury (TBI) claims were inaccurate, primarily because oversight was lacking to ensure staff complied with VBA's second-signature policy. This area improved since OIG's February 2011 report where 11 of 30 TBI cases had errors due to a lack of training. (3) Six of 30 special monthly compensation and ancillary claims were inaccurate due to insufficient refresher training. (4) Lacking authority to deviate from VBA's policy requiring Systematic Analysis of Operations (SAO), the Director suspended SAOs in 2013 due to VBA's emphasis on production requirements. (5) Staff delayed completing 6 of 30 benefits reductions cases because management prioritized other work higher. While conducting research related to the implementation of Fast Letter 13-10, OIG determined one Boston VARO employee misapplied the guidance by adjusting the dates of claims that were 2 weeks or older. The employee indicated the 2-week standard was his own interpretation and not provided by management. The Boston VARO Director needs to implement plans to ensure timely action on reminders for medical reexaminations; take appropriate action on the 189 temporary 100 percent disability evaluations remaining from OIG's inspection universe; ensure secondary reviews and conduct training on processing TBI and special monthly compensation claims; improve management of SAOs; and prioritize actions related to benefit reduction cases. The Director of the Boston VARO concurred with all recommendations. Management's planned actions are responsive, and OIG will follow up as required. [Click here to access report.]

Combined Assessment Program Reviews
In February 2015, OIG published eight Combined Assessment Program (CAP) reviews and one summary report 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 activities: (1) quality management, (2) environment of care, (3) medication management, (4) coordination of care, (5) magnetic resonance imaging (MRI) safety, (6) acute ischemic stroke care, (7) surgical complexity, (8) emergency airway management, (9) mental health residential rehabilitation treatment program, and (10) pressure ulcer prevention.

VA Illiana HCS, Danville, Illinois

VA Ann Arbor HCS, Ann Arbor, Michigan
VA Hudson Valley HCS, Montrose, New York
Cincinnati VAMC, Cincinnati, Ohio
Erie VAMC, Erie, Pennsylvania
VA North Texas HCS, Dallas, Texas
Beckley VAMC, Beckley, West Virginia
Tomah VAMC, Tomah, Wisconsin
CAP Summary – Evaluation of Pressure Ulcer Prevention and Management at VHA Facilities

Community Based Outpatient Clinic Reviews

In February 2015, OIG published four Community Based Outpatient Clinic (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 four operational activities: (1) environment of care, (2) alcohol use disorder, (3) human immunodeficiency virus (HIV) screening, and (4) outpatient documentation.

VA Hudson Valley HCS, Montrose, New York
Cincinnati VAMC, Cincinnati, Ohio
Erie VAMC, Erie, Pennsylvania
VA North Texas HCS, Dallas, Texas

CRIMINAL INVESTIGATIONS

Veteran Convicted of Service-Disabled Veteran-Owned Small Business Fraud

A veteran, who is not service-disabled, was convicted at trial of wire fraud for circumventing the procurement set-aside rules used to award a patient transportation contract as a Service-Disabled Veteran-Owned Small Business (SDVOSB). As a result, the company fraudulently received more than $3.2 million from VA. An OIG investigation determined that the defendant obtained the contract by falsely claiming that another veteran, who is service-disabled, was the majority owner/operator of the company instead of the defendant. Additionally, due to the poor execution of the contract, patients were endangered; in fact, one was seriously injured.

OIG SDVOSB Fraud Investigation Leads to Prison Time for San Antonio, Texas, Businessman

A veteran was sentenced to 366 days' incarceration, 3 years' supervised release, and ordered to pay restitution of $1,494,000 after pleading guilty to wire fraud. A VA OIG and Small Business Administration OIG investigation revealed that the defendant fraudulently claimed to be the owner of a SDVOSB in order to qualify for and obtain VA SDVOSB set-aside contracts for architectural and engineering services. The defendant did not have a service-connected disability and had previously been denied VA benefits. Additionally, the defendant submitted documents containing false information regarding employees and past projects. The defendant, his wife, and 20 of their affiliated companies have been suspended and debarment has been proposed.

$1.3 Million Civil Settlement Between U.S. Department of Justice and Construction Company That Claimed SDVSOB Status
A civil settlement was reached between a U.S. Attorney's Office and Veteran Construction Associates concerning allegations of SDVOSB fraud. The $1.3 million settlement represented fraudulently obtained profits and additional civil-imposed penalties. An OIG investigation revealed a "rent-a-vet" scheme in which the veteran was a full-time state employee during much of the time he and his co-conspirators claimed the veteran to be the full-time owner of the SDVOSB.

West Palm Beach, Florida, VAMC Chief of Prosthetics Pleads Guilty to Conspiracy To Commit Healthcare Fraud
The Chief of Prosthetics at the West Palm Beach, FL, VAMC pled guilty to conspiracy to commit health care fraud related to VA prosthetics procurement. An OIG investigation revealed that the defendant solicited and accepted over $71,000 in kickbacks from a durable medical equipment (DME) vendor to create fraudulent DME orders, which were never provided to veterans. For approximately 4 years, the defendant used his position at VA to steer over $2.2 million in 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 $143,019 for the fraudulent DME orders and $671,730 in overcharges for DME. The vendor has been convicted and is awaiting sentencing.

Former VA Northern California HCS Engineer Charged With Receiving Gratuities From VA Contractors
A former VA Northern California HCS engineer was charged with receiving gratuities from VA contractors. An OIG and Federal Bureau of Investigation (FBI) investigation revealed that the defendant received $7,000 in cash from a VA subcontractor and $9,230 worth of roofing work on his residence paid for by a VA prime contractor. During the time that the gratuities were provided, the contractors received an MRI machine installation contract worth $1,488,802.

Veteran's Spouse Arrested for Attempted First Degree Murder
The spouse of a veteran was arrested for attempted first degree murder. An OIG and local sheriff's office investigation revealed that for several years the defendant attempted to murder the veteran by poisoning him. The poisoning resulted in the veteran receiving treatment on several occasions at the Mountain Home, TN, VAMC for life-threatening issues. The defendant subsequently shot the veteran in the back leaving him paralyzed. Due to the OIG poisoning investigation, premeditation was able to be shown which enhanced the charge from attempted second degree murder to attempted first degree murder.

Veteran Sentenced for Fraud
A veteran was sentenced to 10 years' incarceration, 3 years' supervised release, and ordered to pay $7,280,253 in restitution after pleading guilty to wire fraud, aggravated identity theft, and filing a false tax return. A multi-agency investigation revealed that from 2007 to 2013 the defendant created a series of fraudulent charter schools in order

to receive approximately $30 million in surplus government computer equipment under a General Services Administration program, which included computers from VA facilities located in multiple states. The loss to VA is $1,932,070.

Veteran Arrested for Making Threats to VA and U.S. Army
A veteran was arrested for making threats to the staff at the Fayetteville, NC, VAMC and staff at Fort Bragg, NC. An OIG, FBI, VA Police Service, and local law enforcement investigation revealed that the defendant made threats to come to the facilities and use a firearm to kill VA and Fort Bragg employees.

Veteran Arrested for Making Threat To Kill Hampton, Virginia, VAMC Physician
A veteran was arrested for threatening to kill a Hampton, VA, VAMC physician whom he blamed for "horrible" care following an accident in 1987 prior to the physician's employment with VA. During interviews with OIG agents, the defendant repeated the threatening statements that he had previously communicated to a VA staff member.

Former VA Fiduciary Sentenced for Theft
A former VA fiduciary was sentenced to 5 years' probation, 48 hours' community service, and ordered to pay restitution of $41,086 after pleading guilty to theft by deception. An OIG investigation determined that the defendant, a fiduciary for his veteran brother, embezzled VA funds and used the money for gambling and other personal expenses.

Veteran's Compensation Reduced After OIG Investigation
An OIG investigation revealed that a veteran was receiving VA disability compensation for multiple sclerosis based on false documents he submitted beginning in 1989 that exaggerated the nature and extent of his disability. The investigation further revealed that the veteran was incarcerated prior to and after conviction for state charges of kidnapping and armed robbery. The veteran never complained about nor had any symptoms related to his alleged disability while incarcerated. Due to the lengthy state sentence of 12 years, the U.S. Attorney's Office declined prosecution of the VA fraud. VBA reviewed the veteran's claims based on this investigation, and, as a result, the veteran was re-rated and an overpayment of $1,248,251 was established.

Non-Veteran Sentenced for Identity Theft and Conspiracy To Obtain Property by False Pretenses
A non-veteran was sentenced to 15 to 18 months' incarceration after pleading guilty to identity theft and conspiracy to obtain property by false pretenses. An OIG and local law enforcement investigation revealed that the defendant used 26 victims' identities, 13 of whom were veterans, to fraudulently open more than 150 cable accounts and then sell those accounts.

Kaplan University Employee Arrested for Possession of Unauthorized Access Devices and Aggravated Identity Theft
A Kaplan University employee was arrested for possession of unauthorized access devices and aggravated identity theft. An OIG, FBI, and Internal Revenue Service Task

Force investigation revealed that the defendant stole veterans' and military service members' identities that he obtained while overseeing VA education benefits at Kaplan University. During the investigation, undercover law enforcement personnel purchased VA and Kaplan documents containing identity information for 195 veterans who either attended or applied to Kaplan University and later seized similar documents for another 147 veterans during the execution of a search warrant.

Non-Veteran Pleads Guilty to Identity Theft
A non-veteran pled guilty to identity theft. An OIG and state police investigation revealed that the defendant used his veteran brother's identity to obtain controlled substances, health care, and beneficiary travel payments from the Louisville, KY, VAMC. The loss to VA is $20,567.

Veteran and Sister Indicted for Fraud and False Statements
A veteran and his sister were indicted for wire fraud, mail fraud, and making false statements. A multi-agency investigation revealed that the defendants provided false statements to VA regarding the veteran's eligibility for the VA Care Giver Support Program. The loss to VA is approximately $85,000.

Niece of Deceased VA Beneficiary Sentenced for Theft
The niece of a deceased Dependency and Indemnity Compensation beneficiary was sentenced to 6 months' incarceration, 60 months' probation, 100 hours' community service, and ordered to pay VA $112,064 in restitution. A VA OIG and Social Security Administration OIG investigation revealed that the defendant withdrew VA funds from a joint account after her aunt's death in October 2005.

Daughter of Deceased VA Beneficiary Indicted for Theft
The daughter of a deceased beneficiary was indicted for theft of Government funds and making a false statement. An OIG investigation revealed that the defendant received, forged, and negotiated VA benefit checks and also stole VA funds from direct deposits after her mother's death in October 2009. The defendant also admitted to forging and submitting a VA Marital Status Questionnaire to make it appear that her mother was still alive in order to continue to receive the VA benefits. The loss to VA is $78,939.

Business Owner Pleads Guilty to Fraud and Theft
A business owner pled guilty to mail fraud, bank fraud, forgery, and theft of Government property. 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 $115,444.

Non-Veteran Sentenced for "Stolen Valor" Fraud
A non-veteran was sentenced to 18 months' incarceration and ordered to pay VA $31,696 in restitution after pleading guilty to making false statements. An OIG investigation revealed that the defendant fraudulently claimed to be a Marine Corps veteran with service in Vietnam in order to receive VA health care benefits.

Veteran Charged With Making False Statements
A veteran was charged with making false statements in connection with VA compensation claims that he submitted to VA in an unsuccessful attempt to get monetary benefits. Staff at the VA in Roanoke, VA, alerted OIG that they had received four applications for compensation benefits for four different veterans and all of the forms included identical (or similar) written statements. OIG's investigation identified more than 90 fraudulent forms for 21 different veterans that had been submitted to the Roanoke VARO. The veterans whose names were on these forms did not have any knowledge of the forms being submitted, and they did not know how their personal information had been compromised. OIG's investigation identified a veteran who submitted these forged forms. He had included his own address on the forms and said he had no bank account so VA would mail VA benefit checks to his residence. VBA suspicions and OIG investigation prevented the payment of any monetary benefits to the defendant.

Defendant Sentenced for Drug Distribution at Bedford, Massachusetts, VAMC
A defendant was sentenced to probation for 1 year and ordered to stay away from all VAMCs after pleading guilty to distribution of contraband narcotics. An OIG, Drug Enforcement Administration, and VA Police Service investigation determined that the defendant sold heroin to a confidential informant on five occasions, with four of those sales occurring at the Bedford, MA, VAMC. The defendant was arrested in the act of selling approximately 7.5 grams of heroin to the informant.

Former VA Contractor Sentenced for Drug Theft
A former VA contractor was sentenced to 30 days' incarceration and 2 years' probation after pleading guilty to burglary and possession of controlled substance paraphernalia. An OIG and VA Police Service investigation revealed that the defendant stole sharps containers full of used syringes and mostly empty narcotic vials from the Palo Alto, CA, VAMC. The defendant used his position as an exterminator to convince VA employees to allow him 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. The defendant admitted that he used syringes from the stolen sharps containers to inject himself with morphine and dilaudid.

Former Bank Manager Sentenced for Theft
A former bank manager was sentenced to 5 months' incarceration, 36 months' supervised release, 200 hours' community service, and ordered to pay restitution of $37,830 after pleading guilty to Theft by a Bank Officer. An OIG investigation determined that while the defendant was employed by a bank, he embezzled VA funds that were deposited into the account of a deceased veteran beneficiary. The defendant also embezzled funds from another bank customer and used the stolen money from both accounts to support a gambling habit.

Veteran Arrested for Travel Benefit Fraud Submitted to Asheville, North Carolina, VAMC

A veteran was arrested for false, fictitious, or fraudulent claims. This defendant is one of 13 veterans charged with submitting fraudulent travel claims to the Asheville, NC, VAMC for travel benefits to which they were not entitled by exaggerating the distance they traveled to receive care. The loss to VA in these cases is approximately $100,000.

Veteran Sentenced for Travel Benefit Fraud

A veteran was sentenced to time served, 36 months' supervised release, and ordered to pay VA restitution of $6,914 after pleading guilty to theft of public money. An OIG and VA Police Service investigation revealed that the defendant submitted fraudulent travel vouchers claiming an inflated distance of travel. This investigation was one of eight travel fraud investigations resulting in indictments in the Eastern District of Tennessee.

Richard J. Griffin
Deputy Inspector General