



Department of Veterans Affairs

Office of Inspector General

August 2015 Highlights

CONGRESSIONAL TESTIMONY

Chief of Staff for Healthcare Oversight Integration Testifies on Challenges Alaska Veterans Face Getting Timely Care

Dr. Andrea C. Buck, Office of Inspector General (OIG) Chief of Staff for Healthcare Oversight Integration, testified at a field hearing in Eagle River, AK, before the Committee on Veterans' Affairs, United States Senate, on "Exploring the Veterans Choice Program's Problems in Alaska." She highlighted the challenges some veterans have faced in receiving timely access to care in Alaska. Although the Veterans Health Administration (VHA) reported that as of May 2014 the Alaska VA Healthcare System (VAHCS) provided overall good access to care, Dr. Buck discussed that an OIG healthcare inspection conducted in August 2014 revealed that there were significant access to care problems at the Mat-Su clinic in Wasilla, AK. She emphasized that meeting the health care needs of Alaska veterans must remain one of VA's highest health care priorities and discussed several additional OIG oversight projects planned or underway that focus on the Alaska VAHCS and/or issues related to veterans' access to health care. Dr. Buck was accompanied by Ms. Sami O'Neill, Director of the Seattle, WA, Office of Healthcare Inspections. [[Click here to access testimony.](#)]

ADMINISTRATIVE INVESTIGATIONS

OIG Investigators Substantiate Improper Usage of Private Social Networking Website with Vulnerable Security Features

Some VA employees improperly used Yammer.com, a web-based collaboration technology, which was not approved or monitored as required by VA policy. Further, the website had vulnerable security features, there were recurring website malfunctions, and users engaged in a misuse of time and resources. Although one VA Technical Reference Model approved, with constraints, the installation of Yammer's Notifier, a Windows desktop application, use of the Yammer social network was not VA-approved for employee use. Further, it was not only promoted by a number of VA employees, but it was used and showcased in June 2013 by the former VA Executive in Charge of the Office of Information & Technology (OIT) and Chief Information Officer (CIO), for an open chat forum, as well as in a June 2014 CIO message reminding employees to comply with VA Directive 6515 when using Yammer, giving the false impression that VA approved the use of Yammer.com.

The Yammer website did not have an administrator or system set in place to ensure removal of former VA or contractor employees. Additionally, the relatively simple process to post to Yammer made VA vulnerable to current and former users purposely or accidentally uploading personally identifiable information, protected health information, or VA sensitive information. Yammer users violated VA policy when they downloaded and shared files, videos, and images, risking malware or viruses spreading quickly from the site. Further, Yammer regularly spammed and excessively emailed users, as well as VA employees who had no interest in joining the site, and users were

unable to remove the Online Now instant messaging feature, resulting in every user violating VA policy simply by logging onto the site. There were numerous user posts that were non-VA related, unprofessional, or had disparaging content that reflected a broad misuse of time and resources. Moreover, the continuous data streams, instant messaging, video, audio, large files and attachments, and other uploaded non-VA content to the site may cause congestion, delay, or disruption of service and degrade the performance of VA's network. [[Click here to access report.](#)]

OIG REPORTS

OIG Issues Report on Unexpected Death of Patient During Treatment with Multiple Medications at Tomah, Wisconsin

OIG conducted an inspection at the request of Senator Tammy Baldwin and Senator Ron Johnson to assess the merit of an allegation made by a father after his son died unexpectedly during the course of treatment for mental health (MH) problems at the Tomah VA Medical Center (VAMC) (facility), Tomah, WI. The father alleged that his son (patient) died from an overdose of medications administered at the facility. The medical examiner concluded that the patient's cause of death was mixed drug toxicity. OIG enlisted the services of a non-VA forensic toxicologist to serve as a consultant and subject matter expert. The consultant agreed with the medical examiner's conclusion. OIG determined the patient died in the facility and that he was prescribed medications with potential for respiratory depression. Among the medications the patient received, the additive respiratory depressant effects of buprenorphine and its metabolite norbuprenorphine, along with diazepam and its metabolites, were the plausible mechanism of action for a fatal outcome. These drugs were prescribed by the treating psychiatrists at the facility. However, the consultant forensic toxicologist noted the following, "the possibility that the decedent received additional drug (Suboxone® [buprenorphine/naloxone]) in some form or fashion, cannot be excluded."

OIG found deficiencies in the informed consent process and cardiopulmonary resuscitation (CPR) efforts. OIG did not find evidence of written informed consent for buprenorphine treatment. Both psychiatrists involved in the ordering of buprenorphine acknowledged they did not discuss the risks inherent in off-label use of the drug with the patient. CPR deficiencies included role confusion as well as delays in initiating CPR, calling for medical emergency assistance, and applying defibrillator pads to determine cardiac rhythm for possible intervention. Further, certain medications used in emergency situations to reverse effects of possible drug overdose were not available on the unit. OIG made four recommendations. [[Click here to access report.](#)]

OIG Finds VHA Could Better Use 25 Percent of Psychiatrists' Clinic Time To Improve Veterans' Access to Mental Health

OIG conducted this audit to evaluate VHA's efforts to improve veterans' access to outpatient psychiatrists. OIG determined that VHA has not been fully effective in its use of hiring opportunities or its use of existing personnel to improve veterans' access to psychiatrists. From fiscal year (FY) 2012 through FY 2014, VHA increased outpatient psychiatrist full-time equivalents (FTEs) by almost 15 percent. During that time, the number of veterans' outpatient encounters with psychiatrists increased by about

10 percent, and the number of individual veterans who received outpatient care from a psychiatrist increased about 9 percent. OIG found that VHA did not have an effective method for establishing psychiatrist staffing needs. Throughout recent hiring initiatives, VHA did not stress a specific need for psychiatrists; instead, facilities determined their own staffing needs. This resulted in 94 of 140 health care facilities that needed additional psychiatrist FTEs to meet demand as of December 2014.

In addition, OIG found that VHA did not ensure facilities used consistent and effective clinic management practices. Because of this, OIG determined that VHA facilities could have better used about 25 percent of psychiatrist FTE clinical time to see veterans in FY 2014, which equated to nearly \$113.5 million in psychiatrists' pay. Over the next 5 years, this would equate to over \$567 million if VHA does not strengthen clinic management now. OIG recommended the Under Secretary for Health (USH) ensure facilities incorporate the Office of Mental Health Operations staffing model to determine the appropriate number of psychiatrists needed, and attain appropriate staffing levels or identify alternative options. OIG also recommended the USH develop clinic management business rules, reassess the appropriateness of VHA's productivity target for psychiatrists, and develop a mechanism to monitor the variance in which psychiatrists code encounters. The USH concurred with OIG's findings and recommendations and plans to complete all corrective actions by September 2016. [\[Click here to access report.\]](#)

Unprocessed Documents for Nine Veterans' Claims Found in Shred Bins Awaiting Destruction at Los Angeles VA Regional Office

OIG substantiated that VA Regional Office (VARO) Los Angeles staff were not following Veterans Benefits Administration's (VBA) policy on management of veterans' and other Governmental paper records. OIG found nine pieces of claims-related mail that VARO staff failed to properly process. Eight of the documents had the potential to affect veterans' benefits, while one had no effect on a veteran's benefits. Although OIG could not substantiate that the VARO inappropriately shredded some claims-related documents, OIG found sufficient evidence to conclude the VARO staff likely would have inappropriately shredded the nine documents OIG found. OIG's review determined that the Los Angeles VARO's implementation of VBA's established processes for the disposition of paper records were not adequate. OIG found that the Los Angeles VARO Records Management Officer (RMO) position was vacant from August 2014 until OIG's inspection in February 2015. This was because the VARO's Assistant Director had determined that it was not necessary to fill the RMO position when the incumbent was promoted. Not filling the RMO position eliminated the final certification in the VARO's authorized shredding process, which VBA established to prevent improper shredding of claims-related documents. If not for OIG's review, it is likely that the VARO staff would have inappropriately destroyed these nine claims-related documents OIG found.

OIG recommended the VARO Director implement a plan and provide training to ensure all VARO staff comply with VBA's policy for handling, processing, and protection of claims-related documents and other Government records. OIG also recommended that the VARO Director take proper action on the eight cases that had the potential to affect

veterans' benefits. In order to determine whether this is an isolated problem or a systemic issue, OIG initiated surprise inspections at 10 selected VAROs across the nation. These 10 sites are Atlanta, GA; Baltimore, MD; Chicago, IL; Houston, TX; New Orleans, LA; Oakland, CA; Philadelphia, PA; Reno, NV; San Juan, PR; and St. Petersburg, FL. OIG expects to publish a final report and offer additional recommendations for improvement once the results of the 10 VARO inspections are complete. OIG will request the Under Secretary for Benefit's (USB) comments and publish the Los Angeles VARO Director's action plan when OIG publishes the summary results of the surprise inspections. [[Click here to access report.](#)]

Review Finds Veterans Health Administration Misused \$2.6 Million of Medical Support and Compliance Appropriations for IT Project

OIG conducted this review to evaluate the merits of allegations that VHA mismanaged the Service-Oriented Architecture Research and Development (SOARD) pilot project. OIG substantiated an allegation that VHA misused Medical Support and Compliance (MS&C) appropriations to pay for SOARD instead of using congressionally-mandated IT systems appropriations. This occurred because the former Assistant Deputy Under Secretary for Health for Administrative Operations inappropriately authorized \$2.6 million of MS&C appropriations for SOARD. In addition, the former USH inappropriately approved an additional \$48.8 million of MS&C appropriations to deploy Maximo, the underlying software for SOARD. OIT denied VHA's request for additional IT systems appropriations for SOARD, thus ending nationwide deployment of Maximo before VHA could obligate the \$48.8 million. Additionally, although OIT used Project Management Accountability System (PMAS) to manage SOARD, OIT lacked controls to prevent VHA's improper use of MS&C appropriations before using PMAS. OIG did not substantiate two other allegations. OIG recommended the Interim USH establish an oversight mechanism, remedy all MS&C appropriations used to pay for SOARD, and determine if VA should take administrative action against VHA senior officials involved in SOARD funding decisions. OIG also recommended the Executive in Charge of OIT obtain Chief Financial Officer certifications that VA is using proper appropriations to fund IT projects. [[Click here to access report.](#)]

VA Pittsburgh Healthcare System Cannot Be Sure Hours Invoiced for Physician Contracts Were Received Due to Inadequate Monitoring

OIG reviewed three separate physician contracts awarded by VA Pittsburgh Healthcare System (VAPHS) to University of Pittsburgh Physicians, Inc. (UPP). OIG found that VAPHS did not have an adequate system or process to monitor contract performance and cannot be sure that VAPHS received all the hours invoiced by UPP. Because of the inadequate review of invoices, OIG found that VA was being billed twice the hours and FTE level than the contract requirements for one of the contracts. OIG also found that VA was reimbursing UPP 100 percent of the call-back hours for a dual-appointed physician even though his call-back hours should have been pro-rated based on his dual employment status. OIG also found that VAPHS awarded administrative and overhead expenses on all three contracts without appropriate supporting documentation as required in VA Directive 1663. OIG recommended that VAPHS implement a process to adequately administer the performance for all its physician contracts, consult with

Regional Counsel concerning the billed call-back hours for the dual appointed physician, and ensure future sole-source physician contracts that contain administrative and overhead costs are compliant with VA Directive 1663. Management concurred with OIG's findings and recommendations. [[Click here to access report.](#)]

VBA Not Taking Timely Action To Protect Veterans' Funds From Misuse by Those Entrusted To Manage Their Finances

OIG conducted this audit to determine whether VBA protects the VA-derived income and estates of beneficiaries who are unable to manage their financial affairs when misuse of beneficiary funds is alleged. VBA did not timely process 147 of 304 (48 percent) required actions associated with 122 beneficiaries or according to policy in response to allegations or indications of misuse of beneficiary funds during calendar year (CY) 2013. VBA also did not replace two fiduciaries who misused beneficiary funds. Specifically, VBA did not: timely complete 117 of 265 (44 percent) required actions to determine if misuse of funds occurred in response to allegations and indications of beneficiary fund misuse; complete 30 of 39 (77 percent) required actions after VBA concluded misuse of funds occurred, such as reissuing (restoring) misused funds, performing effective collection actions, and completing internal negligence determinations; or replace two fiduciaries who misused beneficiary funds and allowed both to continue to manage the combined estates of 48 other beneficiaries. Fiduciary Hub management generally attributed untimely misuse actions to increases in Fiduciary Hub workload. Required actions after VBA concluded misuse of funds occurred were not completed due to a lack of policies and VBA staff not being clear about some policies. Also, VBA did not monitor or perform quality reviews of all misuse activities, which contributed to untimely and uncompleted misuse actions. If VBA does not timely complete misuse actions, beneficiary funds are at increased risk of misuse. OIG projects that during CY 2013, VBA did not timely complete required misuse actions to ensure the protection of 758 beneficiaries' VA derived estates valued at about \$45.2 million. VBA also did not restore approximately \$2.1 million of misused beneficiary funds. Additionally, unless VBA improves the timeliness of actions in response to allegations and indications of misuse, OIG projects VBA may not adequately protect annual benefit payments to beneficiaries valued at approximately \$16 million, or \$80 million during CYs 2014 through 2018. [[Click here to access report.](#)]

Oklahoma City VAMC Inappropriately Discontinued Ophthalmology and Teleretinal Imaging Consults

OIG substantiated an anonymous allegation that Oklahoma City VAMC ophthalmology staff, teleretinal imaging staff, and referring providers acted inappropriately on discontinued consults. VAMC ophthalmology staff discontinued about 31 percent more consults than the national average in FY 2014, and about 42 percent more in FY 2015 (as of March 10, 2015). Ophthalmology staff discontinued consults without adequate justification and often because they could not provide eye exams to the patients within 30 days. In addition, ophthalmology staff and referring providers did not take the necessary steps to refer the patients to non-VA care staff to obtain their medical care outside of the VA. Referring providers did not ensure that discontinued teleretinal imaging consults received the appropriate ophthalmology clinic follow-up. As a result of

OIG's inquiries about inappropriate consult actions, Oklahoma City VAMC leadership initiated a follow-up review of ophthalmology consults discontinued from January 1, 2014, through March 3, 2015, and identified issues with 439 of 1,937 discontinued consults (about 23 percent). Ophthalmology leadership did not provide sufficient oversight for processing consults and the VAMC did not have well-defined guidance to ensure staff took appropriate actions when processing consults. OIG recommended the Interim Director of the Oklahoma City VAMC take appropriate action on patients affected by ophthalmology and teleretinal imaging consults, as well as formalize guidance and train staff on initiating and processing consults.

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

Results of Benefits Inspection of St. Petersburg, Florida, VARO

Overall, OIG benefits inspectors determined St. Petersburg VARO claims processing staff incorrectly processed 17 of the 90 (19 percent) disability claims selected for review. The claims processing errors resulted in approximately \$44,900 in improper benefits payments at the time of OIG's inspection in January 2015. OIG benefits inspectors sample disability claims considered at increased risk of processing errors so inspection results do not represent the accuracy of all disability claims processed at the St. Petersburg VARO. OIG staff found VARO staff incorrectly processed 8 of 30 claims related to temporary 100 percent disability evaluations, but processed 28 of the 30 traumatic brain injury (TBI) claims correctly. Results in these two areas suggest improvement since the VARO was last inspected in 2012. However, OIG reported 7 of the 30 sample cases relating to Special Monthly Compensation (SMC) and ancillary benefits contained errors. St. Petersburg VARO staff did not accurately establish the correct date of claim in an electronic system of records for 4 of 30 claims sampled. OIG inspectors also determined VARO staff delayed taking action in processing 7 of the 30 benefits reduction cases because VARO management did not prioritize this workload. The USB and the Director of the St. Petersburg VARO concurred with OIG's recommendations for improvement. [\[Click here to access report.\]](#)

Results of Benefits Inspection of Winston-Salem, North Carolina, VARO

Overall, OIG benefits inspectors determined Winston-Salem VARO claims processing staff incorrectly processed 15 of the 90 (17 percent) disability claims selected for review. The claims processing errors resulted in approximately \$179,000 in improper benefits payments from May 2008 until November 2014. OIG benefits inspectors sample disability claims considered at increased risk of processing errors so inspection results do not represent the accuracy of all disability claims processed at the Winston-Salem VARO. OIG staff found VARO staff incorrectly processed 9 of 30 claims related to temporary 100 percent disability evaluations but processed 29 of the 30 TBI claims correctly. Results in these two areas suggest improvement since the VARO was last inspected in 2012. However, OIG reported 5 of the 30 sample cases relating to SMC and ancillary benefits contained errors. Winston-Salem VARO staff followed policy and accurately established claims in an electronic system of records using correct dates of claims for the 30 claims sampled. Inspectors also determined VARO staff delayed or incorrectly processed 14 of the 30 benefits reduction cases which resulted in over \$139,000 in improper benefit payments from August 2012 until November 2014. The

improper payments resulted from delays in taking actions to reduce the benefits because VARO management considered other work to be a higher priority. The Director of the Winston-Salem VARO did not respond to all recommendations but indicated concurrence with three of the four recommendations OIG made for improvement. However, OIG also indicated the planned corrective actions lacked the urgency expected to minimize improper benefits payments.

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

Results of Benefits Inspection of Wichita, Kansas, VARO

Overall, OIG benefits inspectors determined Wichita VARO claims processing staff incorrectly processed 12 of the 72 disability claims (17 percent) selected for review. The claims processing errors resulted in over \$73,700 in improper benefits payments to six veterans from February 2011 to December 2014. OIG benefits inspectors sample disability claims considered at increased risk of processing errors so inspection results do not represent the accuracy of all disability claims processed at the Wichita VARO. The OIG report indicated VARO staff incorrectly processed 8 of 30 claims related to temporary 100 percent disability evaluations but accurately processed 29 disability claims related to TBIs. Results in these two areas showed improvement since the VARO was last inspected in 2012. However, OIG reported 3 of the 12 cases relating to SMC and ancillary benefits that VARO staff processed during FY 2014 contained errors. Wichita VARO staff followed policy and accurately established claims in an electronic system of records using correct dates of claims for the 30 claims sampled. OIG inspectors also determined VARO staff delayed processing actions in 15 of the 30 benefits reduction cases sampled that resulted in \$33,500 in improper benefit payments from March 2014 until December 2014. The improper payments resulted from delays in taking actions to reduce the benefits because VARO management considered other work to be a higher priority. VARO staff also incorrectly processed 2 of the 30 cases involving proposed benefits reductions that resulted in approximately \$2,000 in improper benefit payments from October 2014 until December 2014. The Director of the Wichita VARO concurred with all recommendations. OIG has plans to follow up in the future to ensure the planned corrective actions were implemented.

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

Combined Assessment Program Reviews

In August 2015, 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 reviews covered the following nine activities:

- (1) Quality Management
- (2) Environment of Care
- (3) Medication Management
- (4) Coordination of Care
- (5) Computed Tomography Radiation Monitoring

- (6) Advance Directives
- (7) Surgical Complexity
- (8) Emergency Airway Management
- (9) MH Residential Rehabilitation Treatment Program

[San Francisco VAHCS, San Francisco, California](#)
[Battle Creek VAMC, Battle Creek, Michigan](#)
[G.V. \(Sonny\) Montgomery VAMC, Jackson, Mississippi](#)
[Northport VAMC, Northport, New York](#)
[VAPHS, Pittsburgh, Pennsylvania](#)

Community Based Outpatient Clinic Reviews

In August 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 five operational activities:

- (1) Environment of Care
- (2) Alcohol Use Disorder Care
- (3) Human Immunodeficiency Virus Screening
- (4) Outpatient Documentation
- (5) Outpatient Lab Results Management

[San Francisco VAHCS, San Francisco, California](#)
[G.V. \(Sonny\) Montgomery VAMC, Jackson, Mississippi](#)
[Northport VAMC, Northport, New York](#)
[Mann-Grandstaff VAMC, Spokane, Washington](#)

CRIMINAL INVESTIGATIONS

Miami, Florida, VAMC Nurse Arrested for Obstruction and Altering Computer Records

A Miami, FL, VAMC nurse was arrested after being indicted for obstruction and altering VA computer records. An OIG investigation revealed that the defendant manipulated patient data and withheld information from physicians that caused the patient, who was in a Surgical Intensive Care Unit, to be discharged to a less acute care unit, where the patient later died. The defendant altered the patient's record to reflect that their vital signs were stable, when in fact they were not, and failed to provide medications to the patient that were prescribed by the treating physicians. The investigation further revealed that the defendant made additional alterations to the patient's record after his death in order to conceal the patient's true condition and to obstruct an administrative inquiry into the patient's death.

OIG, Federal Bureau of Investigation Results in Conviction of Design Contractor Who Received Inside Information from Former VA Executive

An architect, formerly employed by a VA contractor, was convicted at trial of conspiracy, wire fraud, mail fraud, theft of Government property, and of violating the Hobbs Act. An

OIG and Federal Bureau of Investigations (FBI) investigation revealed that the defendant bribed the former Director of the Cleveland and Dayton VAMCs in order to receive non-public information concerning VA contracts. As a result, the defendant obtained an advantage over other companies in the awarding of approximately \$750 million in VA contracts to his former employer. The former VAMC Director improperly obtained the information from the VA Office of Asset and Enterprise Management. The former VAMC Director has already pled guilty to corruption-related charges in a separate case and awaits sentencing.

Sacramento, California, VAMC Engineer Pleads Guilty to Receipt of a Gratuity by a Public Official

A Sacramento, CA, VAMC engineer pled guilty to receipt of a gratuity by a public official. An OIG and FBI investigation revealed that the engineer, while acting as a Contracting Officer's Representative on several VA construction projects, accepted from a VA contractor two Disneyland vacation packages, a new Ford F-150 pickup truck, and at least \$25,000 in cash. After providing the illegal gratuities to the defendant, the VA contractor received favorable treatment from VA. Upon signing the plea agreement, the engineer resigned in lieu of termination.

Former Memphis, Tennessee, VAMC Employee Arrested for Purchase Order Fraud

A former Memphis, TN, VAMC employee and another subject were indicted and subsequently arrested for conspiracy, theft of Government funds, wire fraud, and engaging in monetary transactions of property derived from specified unlawful activity. An OIG and VA Police Service investigation revealed that the defendants conspired to create a fraudulent pharmaceutical supply company that was operated from the non-veteran's FedEx office. From 2008 to 2013, the defendants submitted hundreds of duplicate fraudulent purchase orders to VA, resulting in a loss of approximately \$1.1 million.

Subject Arrested for Conspiracy To Commit Wire Fraud

A subject was arrested for conspiracy to commit wire fraud. A multi-agency investigation revealed that the defendant, a previously convicted felon, obtained Government contracts under fraudulent pretenses and utilized the U.S. Government to commit fraud. The defendant would obtain a Government contract and apply for and obtain credit from a third party vendor by using shell companies. The defendant then had the third party vendors fulfill the Government contracts. However, the defendant's company did not pay the third party vendors after receiving payment from the Government. The losses claimed by the multiple vendors totaled over \$900,000.

Asheville, North Carolina, VAMC Employee Sentenced for Purchase Card Fraud

A VA employee was sentenced to 13 months' incarceration, 3 years' supervised release, and ordered to pay \$43,816 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant, who was employed as a purchasing agent at the Asheville, NC, VAMC, utilized and allowed

others to utilize his VA purchase card to buy personal items. Items were bought online and from local merchants, including a truck for his personal use.

Pittsburgh, Pennsylvania, VAMC Contract Specialist Pleads Guilty to Theft of Government Funds

A Pittsburgh, PA, VAMC contract specialist, who is currently under suspension, pled guilty to theft of Government funds. An OIG and VA Police Service investigation revealed that the employee used a VA-issued Government purchase card to make 29 unauthorized transactions for personal use. The transactions, for merchandise and gift cards, totaled \$28,361.

Former U.S. Postal Service Employee and Daughter Arrested for Conspiracy and Falsification of Records

A former U.S. Postal Service employee and his daughter were indicted and arrested for conspiracy for receiving kickbacks and falsification of records. A multi-agency investigation determined that the former employee, affiliated with a business that assisted Federal employees in filing for workers compensation benefits, received more than \$250,000 for referring employees to a health care company suspected of defrauding VA and other Federal agencies by keeping employees on workers compensation longer than necessary and billing for services not provided. The former employee also laundered a portion of the payments through his daughter's bank account. After learning of the investigation, the employee and his daughter falsified documentation by transferring the business to her. The loss to the Government is over \$1 million.

Veteran Sentenced for Assault of Miami, Florida, VAMC Police Officer

A veteran was sentenced to 9 months' home confinement and 1 year of probation after pleading guilty to assault on a Federal employee. An OIG investigation revealed that the defendant assaulted a VA police officer at the Miami, FL, VAMC during a traffic stop. After the police officer stopped the vehicle, the defendant attacked and repeatedly punched the officer, inflicting multiple injuries to the officer's face.

Assailant of a Memphis, Tennessee, VAMC Physician Sentenced for Aggravated Assault

The son of a Memphis, TN, VAMC physician was sentenced to 5 years' incarceration after pleading guilty to aggravated assault. An OIG, FBI, and local police investigation revealed that the defendant traveled from Virginia and stabbed his father at the medical center.

Veteran Indicted for Threatening To Kill a Palo Alto, California, VAMC Nurse

A veteran was indicted for transmitting a threat in interstate commerce and making threats to a Federal official. An OIG and VA Police Service investigation revealed that the defendant threatened to kill a Palo Alto, CA, VA nurse who he believed interfered with his "life/medical situation." The defendant used the My HealthVet website to transmit the threats, which included a statement about using his .357 firearm to blow the nurse's brains out. On the same day that the threat was transmitted to the nurse, the

local police went to the veteran's home, seized a .22 caliber Hi-Point semiautomatic pistol, and transported him to a local hospital for psychological evaluation. The next day, the defendant threatened to strike the nurse in the head with an aluminum baseball bat if the nurse "crosses the line and affects his lifestyle."

Veteran Sentenced for Possession of a Firearm at the West Palm Beach, Florida, VAMC

A veteran was sentenced to 5 months' incarceration and 1 year of supervised release after pleading guilty to possession of a firearm on Federal property. An OIG investigation was initiated after the defendant's daughter notified the local police that the defendant took a firearm from his daughter's home and was on his way to the West Palm Beach, FL, VAMC. The defendant was subsequently stopped in the parking lot of the medical center with the weapon in his possession. The investigation also revealed that the defendant previously made numerous threats against VA employees at multiple VAMCs and had a non-expiring order of protection against him.

Non-Veteran Pleads Guilty to Identity Theft Charges

A non-veteran pled guilty to multiple identity theft related charges. An OIG and Internal Revenue Service Criminal Investigation Division investigation revealed that the defendant conspired to steal the personal identifying information of veterans and used the information to submit \$3.5 million in fraudulent tax returns.

Non-Veteran Convicted of Bank Fraud and Aggravated Identity Theft

A non-veteran was convicted at trial of bank fraud and aggravated identity theft. An OIG investigation revealed that the defendant used the identity of his father, a veteran, in an attempt to obtain a VA mortgage loan for a home valued at approximately \$490,000. The defendant falsely claimed to the bank that he served in the military for 30 years and earned a Purple Heart.

Fiduciary Indicted for Theft

The brother of a veteran who is unable to manage his financial affairs was indicted for theft of Government funds. An OIG investigation revealed that the defendant, while acting as his brother's fiduciary, embezzled VA benefits for his own use. The loss to the veteran is \$26,405.

Veteran Pleads Guilty to Theft of Government Funds

A veteran pled guilty to theft of Government funds. A VA OIG and Social Security Administration (SSA) OIG investigation revealed that the defendant stole VA and SSA benefits since approximately 1987. The defendant filed fraudulent VA and SSA documents purporting that his 103-year-old mother was still alive. Evidence indicates that the beneficiary is deceased. Her remains have not yet been located. The loss to VA is approximately \$304,000.

Non-Veteran Pleads Guilty to VA Education Benefits Fraud

A non-veteran pled guilty to conspiracy to defraud the United States, theft of Government funds, and mail fraud. An OIG investigation revealed that the defendant

fraudulently received Chapter 33 education benefits and also assisted veterans with submitting fraudulent applications for educational benefits they were not entitled to receive. The loss to VA is approximately \$108,000.

Daughter of Deceased VA Beneficiary Sentenced for Theft of VA Benefits

The daughter of a deceased VA beneficiary was sentenced to 5 years' probation, ordered to pay VA restitution of \$78,939, and to participate in a substance abuse and MH program after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant received, forged, and negotiated VA benefit checks and also stole direct deposits after her mother's death in October 2009. The defendant also admitted to forging and submitting a Marital Status Questionnaire to VA to make it appear her mother was still alive in order to continue to receive the VA benefits.

Veteran Indicted for Theft and Fraud

A veteran was indicted for theft of Government funds and Social Security fraud. A VA OIG and SSA OIG investigation revealed that the veteran received \$199,311 in VA individual unemployability benefits and Social Security disability insurance benefits while working as an IT specialist for a collectibles company. The veteran did not report his employment to VA or SSA. The loss to VA is \$86,197, and the loss to SSA is \$113,114.

Widow Pleads Guilty to Theft of Government Funds

The widow of a deceased veteran and mother of two minor VA beneficiaries (children of the veteran) pled guilty to theft of Government funds. An OIG investigation revealed that the defendant concealed her employment income and her children's Social Security income in order to continue to fraudulently receive VA benefits. The loss to VA is \$41,170.

Former Greenville, North Carolina, VA Health Care Center Physician Indicted for Fraudulently Obtaining a Controlled Substance

A former Greenville, NC, VA Health Care Center physician was indicted for obtaining a controlled substance by fraud or forgery. An OIG, Drug Enforcement Agency (DEA), local police, and North Carolina State Medical Board investigation revealed that the former VA physician had an inappropriate relationship with a veteran while employed by VA, and after leaving VA employment the physician continued to prescribe controlled medications to the veteran using VA prescription pads. Both the physician and the veteran received controlled substances from the prescriptions that were filled at outside pharmacies. The physician surrendered her medical license and DEA number as a result of this investigation.

Two Former Muskogee, Oklahoma, VAMC Employees and Two Other Subjects Plead Guilty to Drug Conspiracy

Two former Muskogee, OK, VAMC employees and two other subjects pled guilty to drug conspiracy. An OIG and DEA investigation revealed that a former VAMC employee stole VA prescription pads from the medical center and used those pads to illegally

obtain prescription pills. The former employee organized a loose affiliation of friends and associates to obtain and distribute these narcotics throughout southeast Oklahoma.

West Haven, Connecticut, VAMC Employee Arrested for Selling Narcotics

A West Haven, CT, VAMC housekeeping employee was arrested for selling narcotics. An OIG and statewide narcotics task force investigation determined that the defendant was selling prescription narcotics and heroin on and near VAMC property. The employee's vehicle was also seized by the task force when a drug dog alerted to the presence of narcotics inside the vehicle.

Non-Veteran Arrested for Drug Distribution Through the Bronx, New York, VAMC

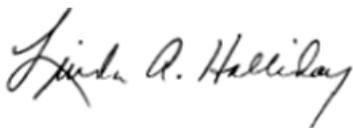
A non-veteran was arrested after being indicted for his involvement in the distribution of cocaine through the Bronx, NY, VAMC. An OIG, U.S. Postal Inspection Service, DEA, and VA Police Service investigation resulted in the identification of the subject's fingerprints on the interior packaging of five parcels mailed from San Juan, PR, to the VAMC. Each parcel contained 1–2 kilograms of cocaine.

Six Veterans Plead Guilty to VA Travel Benefit Fraud, West Palm Beach, Florida, VAMC

Six veterans pled guilty to false statements, and one veteran was convicted at trial of false statements and theft of Government funds. The aggregate sentences amounted to 4 months' incarceration, 252 months' probation, and \$74,889 in restitution. An OIG investigation revealed that the defendants submitted fraudulent travel vouchers using incorrect and/or fictitious addresses, indicating that they were traveling much farther distances to and from the West Palm Beach, FL, VAMC in order to receive greater travel benefit reimbursements. The total loss to VA is \$116,870.

Veteran Pleads Guilty to VA Travel Benefit Fraud, Montrose, New York, VAMC

A veteran pled guilty to grand larceny relating to beneficiary travel fraud. A VA OIG, New York State Medicaid OIG, and New York 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.



Linda A. Halliday
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