



Department of Veterans Affairs

Office of Inspector General

January 2016 Highlights

CONGRESSIONAL TESTIMONY

Deputy Assistant Inspector General for Audits and Evaluations Testifies on Oversight Findings Related to VA's Paperless Claims System

Mr. Brent Arronte, Deputy Assistant Inspector General for Audits and Evaluations, testified before the Committee on Veterans' Affairs, United States House of Representatives, regarding the Office of Inspector General's (OIG) recent reports on the implementation of the Veterans Benefits Management System (VBMS), which examined how effectively VA managed cost, performance, and schedule in VBMS development to meet its claims processing accuracy and backlog elimination goals. Mr. Arronte discussed that although VA stayed on schedule in deploying planned VBMS functionality to all VA regional offices (VARO) in 2013, total VBMS costs increased significantly over a 6-year period from about \$579.2 million to approximately \$1.3 billion and total actual system development costs remain unknown. He also explained that the Veterans Benefits Administration's (VBA) reported progress in reducing the backlog and improving claims processing accuracy cannot be specifically attributed to VBMS because it was one of more than 40 initiatives VA has undertaken as part of its transformation plan, and VBA did not put adequate performance metrics in place to reflect the efficiencies gained from using the new system. Furthermore, recent OIG work related to data manipulation at 11 VAROs raises concerns that claims processing data has not been accurately reported. Mr. Arronte also discussed the results of OIG work conducted at one VARO with regards to scanning veteran documentation required for claims processing. Mr. Arronte was accompanied by Mr. Michael Bowman, Director, Information Technology and Security Audits Division.

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

OIG REPORTS

Follow Up Review on the Mismanagement of Informal Claims Processing at the VARO Oakland, California

In OIG's previous report, *Review of Alleged Mismanagement of Informal Claims Processing at VARO Office Oakland, California*, (Report Number 14-03981-119, February 18, 2015), OIG substantiated the allegation that VARO Oakland staff had not processed or properly stored informal claims for benefits. During an April 2015 House Committee on Veterans' Affairs testimony, the OIG received a request from Congressman Doug LaMalfa to conduct a follow up review at VARO Oakland. This request was based on an allegation that management had a list of 13,184 unprocessed informal claims for benefits. Additionally, Congresswoman Jackie Speier asked OIG to determine whether VARO staff altered dates of claim. OIG did not find evidence of the existence of the alleged list of approximately 13,184 informal claims even after interviews with current and former VARO staff, whistleblowers, and members of a previous VBA management support team. OIG reviewed 60 of 1,308 informal claims and found VARO staff had incorrectly processed 6 claims. Five errors contained incorrect effective dates that resulted in approximately \$26,325 in improper payments.

OIG also determined Oakland staff did not timely process 9 of the 60 claims resulting in significant delays in benefit payments to veterans. The delays ranged from approximately 5 years to 7 years and 8 months. Through information obtained from VARO staff, OIG obtained an additional list of 690 claims. OIG provided management with the list to determine whether staff had correctly processed these potential informal claims. VARO management did not provide the oversight needed to ensure timely and accurate processing of informal claims, to include the 1,308 identified in March 2015. As a result, veterans did not receive accurate or timely benefits payments. OIG recommended the VARO Oakland Director provide training to staff on proper informal claims processing procedures, conduct a complete review of the additional list of 690 claims that may be informal claims, and to conduct another review of the remaining 1,248 informal claims. The VARO Director concurred with OIG's recommendations. VA's planned actions are responsive and OIG will follow up as required. [\[Click here to access report.\]](#)

Patient Care Deficiencies and Mental Health Therapy Availability, Overton Brooks VA Medical Center, Shreveport, Louisiana

OIG conducted inspections in response to two complaints received from Senator Richard Burr, then-Ranking Member of the Senate Veterans' Affairs Committee, concerning patient care deficiencies and the availability of mental health (MH) therapy at the Overton Brooks VA Medical Center (facility), Shreveport, LA. OIG did not substantiate that patients did not have enough linen or that it was of insufficient or poor quality. OIG substantiated the allegation that toiletries were provided by volunteer organizations and unit staff. OIG did not substantiate that a general lack of concern exists among nursing staff for patients or that nursing assistants do not follow the nursing chain of command. OIG substantiated that a patient died on a telemetry unit while not being actively monitored as ordered at the time of his death. OIG's Office of Investigations reviewed the events surrounding the patient's death, reviewed the findings from a facility-conducted Administrative Investigation Board, and ultimately closed the case. OIG did not substantiate that MH group therapy programs are being dismantled or decimated. OIG did not substantiate that MH staff have had to maintain large support groups in order to keep veterans stable while waiting for individual treatment. OIG did not substantiate that the facility is severely understaffed with MH therapists. OIG substantiated an allegation received onsite that some patients who received MH care were lost to follow-up. In early 2014, during the planning and implementation phases of establishing two Behavioral Health Interdisciplinary Program teams, the facility identified roughly 400 patients receiving MH care who were lost to follow-up and subsequently took appropriate actions. OIG recommended that the Facility Director ensure patients are notified and re-assigned timely when their MH providers leave the facility. [\[Click here to access report.\]](#)

Environment of Care and Safety Concerns in Operating Room Areas, Edward Hines Jr. VA Hospital, Hines, Illinois

OIG conducted an inspection at the request of Senator Mark Kirk to assess allegations of environment of care (EOC) and safety concerns at the Edward Hines Jr. VA Hospital, Hines, Illinois. OIG substantiated the allegation that water had flooded the new surgical

operating room (OR) areas and that mold was present. The water infiltration problem was resolved, and the mold was remediated prior to the OR's first use for patient care. OIG substantiated the allegation of years of flooding and water damage in the old OR. OIG observed that no patient care was being conducted in this area. OIG substantiated the allegation that the overhead paging and emergency system was not audible throughout the entire surgical OR area. Review of patients' electronic health records noted no delays in initiating the codes. OIG substantiated the allegation that the adjustment of temperature and humidity in new OR areas was difficult to control. OIG substantiated the allegation that surgical booms (equipment management systems used to store and move surgical equipment) located in the new OR were difficult to manipulate and maneuver around. OIG did not substantiate the allegation that opening of the OR doors required staff to use their backs to push into the doors. OIG recommended that the Acting Facility Director: (1) implement an action plan to remediate water damage in the basement of Building 200; (2) initiate a safety analysis of the current overhead paging and emergency system for communication of a code throughout the entire surgical OR, including the post anesthesia care units, and take action as necessary; (3) implement processes to maintain recommended ranges for temperature and humidity in OR areas; and (4) take actions to prevent staff injury from surgical booms in ORs. [[Click here to access report.](#)]

Audit of Veterans Health Administration's Non-VA Medical Care Obligations

The OIG assessed whether the Veterans Health Administration (VHA) adequately managed non-VA medical care miscellaneous obligation cost estimates and related management and system controls. The Non-VA Care (NVC) Program expenditures of about \$4.8 billion included \$1.9 billion in obligated funds that remained unspent as of the end of fiscal year (FY) 2013. Significant under- or over-obligation of these program funds could affect overall VHA operations. OIG found VHA medical facilities did not adequately manage the obligations used to purchase NVC. From October 1, 2013, through March 31, 2015, VHA medical facility officials determined that they had overestimated the funds needed to pay for these services by about \$543 million. The unnecessary obligation of these funds prevented VHA from using \$543 million of the \$1.9 billion (29 percent) obligated for NVC for any purpose during FY 2013. This occurred because VHA did not: (1) provide the facilities with adequate tools to reasonably estimate the costs of NVC services; (2) require medical facility staff to routinely adjust cost estimates for individual authorized services to better reflect actual costs; (3) ensure NVC staff adjusted the estimated amount of obligated funds in the Veterans Health Information Systems and Technology Architecture after payments are complete; and (4) require facilities to analyze the accuracy of prior year obligation balances. Reducing the over-obligation of NVC funds from about 29 to 10 percent would have freed up about \$358 million to acquire additional NVC services. OIG recommended the Under Secretary for Health (USH) improve cost estimation tools, update system software to ensure unused NVC funds can be periodically deobligated, require facilities to adjust cost estimates for individual authorized services, and monitor VA medical facility NVC obligation estimates. The USH provided a responsive action plan to address OIG's recommendations. OIG will follow up on VA's implementation until all proposed actions are completed. [[Click here to access report.](#)]

Review of Alleged Problems With VBA's VBMS and Claims Processing

In July 2014, the VA OIG Hotline received an allegation from an anonymous complainant stating that significant problems existed with claims processing and VBMS at the VARO in St. Petersburg, FL. The complainant also alleged that a VBMS claims processing tool, "Evaluation Builder," broke down often and incorrectly calculated veterans' disability claims, potentially costing the Government millions of dollars. OIG substantiated the allegation regarding a significant backlog of unprocessed hard copy veteran material resulting from inefficient preparation and handling of veteran-provided documentation at a contractor facility. More specifically, according to VBA personnel and OIG's observation of VBA portal metrics, the St. Petersburg VARO had more than 41,900 mail packages of veterans' claims material that were backlogged and over 1,600 boxes awaiting processing at the CACI International, Inc., scanning facility. OIG also observed a significant amount of hard copy veterans' claims evidence that was improperly stored, comingled with contractor documentation, or was disorganized and not ready for scanning. The significant backlog of unprocessed claims evidence occurred due to a large increase in volume of veterans' claims at the end of 2014 and the VARO's inadequate preparation of hard copy veteran material for scanning at the contractor facility. Furthermore, VBA did not provide effective oversight of contractor personnel to ensure timely processing or safeguarding of veteran information at the contractor facility. OIG did not substantiate the allegation that "Evaluation Builder," broke down often or incorrectly calculated veterans' disability claims. OIG recommended that the Under Secretary for Benefits (USB) ensure the St. Petersburg VARO consistently organizes and mails hard copy veteran material to contractor scanning facilities. Additionally, OIG recommended that the USB initiate onsite reviews of the contractor scanning facilities to ensure efficient scanning practices and the proper safeguarding of sensitive VA information at those facilities. The Acting USB concurred with OIG's findings and recommendations. [[Click here to access report.](#)]

Emergency Department Concerns, Central Alabama VA Health Care System, Montgomery, Alabama

OIG conducted a review in response to allegations of Emergency Department (ED) concerns at the Central Alabama VA Health Care System (CAVHCS), Montgomery, AL. OIG substantiated that CAVHCS was not meeting VHA's ED timeliness measures and that, at times, staff were stretched to provide appropriate special observation to MH patients in the ED. OIG did not substantiate that community based outpatient clinic (CBOC) providers refused to see walk-in patients and instead referred them to the ED, that ED patients' vital signs were not checked as required, that having just one physician on duty in the ED was routinely problematic, that patients were inappropriately referred to other facilities, or that social work staffing in the ED was inadequate. OIG was unable to fully evaluate seven additional allegations due to insufficient information and/or details. OIG did not identify conclusive evidence to either sustain or refute these allegations. OIG made three recommendations. [[Click here to access report.](#)]

Alleged Unsafe Patient Transportation Practices, VA Hudson Valley Health Care System, Montrose, New York

OIG conducted a review in response to allegations of unsafe patient transportation practices. Specifically, the allegations concerned VA sponsored shuttle service between the VA Hudson Valley Health Care System (HCS), Montrose, NY, and the James J. Peters VA Medical Center (VAMC), Bronx, NY. OIG did not substantiate a lack of proper supervision of patients who utilized the shuttle program. OIG also did not substantiate the allegation that patients were at risk for wandering and/or going missing because shuttle drivers drop off vulnerable patients without regard to final destination. While not one of the complainant's allegations, OIG found that the locally developed Passenger Fitness Criteria card used as a guide by VA Hudson Valley HCS shuttle bus drivers to determine patients' fitness for traveling was not vetted adequately to ensure that this new requirement was within the drivers' scope of employment. OIG recommended that VA Hudson Valley HCS Director consult with VA NY/NJ Healthcare Network leadership and Regional Counsel (recently restructured as the Offices of Chief Counsel) regarding the acceptability of shuttle bus drivers' use of the Passenger Fitness Criteria card. [\[Click here to access report.\]](#)

Review of Alleged Supervisory Influence To Expedite a Friend's Disability Claim at VARO New York, New York

On July 24, 2014, the OIG received an anonymous allegation that a supervisor working at the New York VARO instructed claims processing staff to expedite a disability claim belonging to a friend. The supervisor admitted taking these actions to help a friend, an elderly Korean War veteran, obtain benefits as quickly as possible. Despite completing ethics training, the supervisor did not find actions to expedite processing a friend's claim unethical. At the time of their review, OIG benefits inspectors determined claims processing staff at the New York VARO completed this veteran's claim in 117 days, which was 36 days quicker than similar claims. OIG benefits inspectors determined the supervisors actions involved one claim and was considered an isolated incident. Additionally, OIG benefits inspectors reviewed the veteran's claim for accuracy but did not find any irregularities relating to the disability determinations or evaluations. The New York VARO Director agreed to take appropriate action to ensure similar incidents do not occur in the future as well as to ensure there is a venue to report such incidents, should any occur. [\[Click here to access report.\]](#)

Review of Alleged System Access Failures to VBA's eBenefits Program

OIG conducted this review to determine the merits of a complaint alleging that veterans' eBenefits accounts did not allow appropriate system access. The complainant alleged that, during the April/May 2014 timeframe, previously submitted claims could not be tracked. Additionally, the complainant stated VA was unable to assist with resolving the issue. OIG could not determine the reason the complainant experienced this difficulty with system access. OIG's review verified that there were no planned outages during the time the veteran experienced access trouble, though there were numerous issues that could have caused this effect, such as system hardware failures, interconnection issues with VA external partners, or password input issues. After OIG initiated the review, OIG contacted the complainant, who stated that he had subsequently received

assistance from VA eBenefits support staff, was no longer experiencing eBenefits login issues, and was satisfied with eBenefits performance. OIG did not make any recommendations since the issue was not determined to be a systemic problem.

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

Review of Alleged Unauthorized Devices and Equipment on Networks at VHA's Southern Arizona VA HCS, Tucson, Arizona

OIG conducted this review to determine the merits of an anonymous hotline complaint received in July 2014 alleging that a large unauthorized network was operating at the Southern Arizona VA Health Care System (SAVAHCS), in Tucson, AZ. The allegation stated that a network, isolated from the local VA campus network, contained a multitude of unauthorized biomedical devices and other improperly installed equipment. OIG substantiated the allegation that there were unauthorized devices on an isolated SAVAHCS network. However, VA's Office of Information and Technology (OIT) security personnel reviewed the networks and concluded that there was no interconnection between the isolated network and the SAVAHCS's network infrastructure. Further, the systems hosted on the isolated network did not process sensitive patient data or personally identifiable information as defined by VA policy. At the time of OIG's review, OIT Region 1 assumed full configuration control of the biomedical network and authorized the network to operate in support of patient services. In light of OIT's actions, OIG made no recommendations. [\[Click here to access report.\]](#)

Review of Alleged Misuse of Hurricane Sandy Funds at VA New York Harbor HCS, New York, New York

OIG conducted this review to determine the merits of an anonymous allegation that VA wasted millions of dollars of Hurricane Sandy Disaster Relief Funds. The complainant alleged the Associate Director at the VA New York Harbor Healthcare System (VANYHHS) wasted funds by making cosmetic repairs to patient areas of the VANYHHS' Manhattan facility that were not damaged by the hurricane and by overpaying for the purchase of used equipment. Based on OIG's onsite inspection, interviews of VANYHHS employees, and review of the Hurricane Sandy disaster damage, OIG concluded that the completed and ongoing repairs and relocation projects appeared to be reasonable. OIG did not find evidence to substantiate that VANYHHS wasted Hurricane Sandy funds by making cosmetic repairs to undamaged portions of the building. Because OIG did not substantiate the allegations, OIG closed this review without further action. OIG will report the results of additional review work pertaining to Hurricane Sandy funds at a future date. [\[Click here to access report.\]](#)

Review of Alleged Violation of VHA's Datawatch Data Pump Server Software License Agreement

OIG conducted this review to determine the merits of an allegation the VHA Procurement and Logistics Office purchased a single license for the Datawatch Corporation's Data Pump server software, but had allegedly deployed the server software an additional 56 times, in violation of the user license agreement. OIG did not substantiate the allegation that the Datawatch licensing agreement for the Data Pump Server software had been violated. OIG's review indicated that a similarly named

“datapump” software had been installed 56 times. However, information technology installations were not using the Datawatch product. OIG concluded that VHA contracting staff inaccurately communicated to the Datawatch Chief Financial Officer (CFO) that the 56 “datapump” installations were using the Datawatch product. The Datawatch CFO concurred and considered the matter resolved. Because OIG did not substantiate the allegation, OIG closed this review without further action.

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

Pulmonary Medicine Clinic Appointment Cancellations, William Jennings Bryan Dorn VAMC, Columbia, South Carolina

OIG conducted a review of Pulmonary Medicine Clinic appointment cancellations in calendar years 2013–2014 at the William Jennings Bryan Dorn VAMC (facility), Columbia, SC. The purpose of this inspection was to determine whether facility managers had assessed the history and causes of the appointment cancellations, taken appropriate actions to evaluate and provide follow-up for patients affected by the cancellations, and implemented process improvements to prevent recurrence of similar conditions. OIG confirmed that facility managers had evaluated the history and contributing causes of the Pulmonary Medicine Clinic appointment cancellations. OIG confirmed that the facility conducted an evaluation of the patients affected by the Pulmonary Medicine Clinic appointment cancellations. Due to the protected nature of the facility’s review, OIG are unable to discuss the results. OIG reviewed 50 patients whose appointments were cancelled and found they had received appropriate follow-up. OIG confirmed that process improvements including the hiring of pulmonologists as well as the use of non-VA medical care providers were implemented. Facility managers had also augmented the Pulmonary Medicine Clinic staff and implemented processes to improve communication. OIG made no recommendations.

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

Combined Assessment Program Reviews

In January 2016, 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 17 activities:

- (1) Acute Ischemic Stroke Care
- (2) Advanced Directives
- (3) Computed Tomography Radiation Monitoring
- (4) Continuity of Care
- (5) Coordination of Care
- (6) Emergency Airway Management
- (7) EOC
- (8) Magnetic Resonance Imaging Safety
- (9) Mammography Services
- (10) Management of Workplace Violence

- (11) Quality Management
- (12) Quality, Safety, and Value
- (13) Suicide Prevention Program
- (14) Surgical Complexity
- (15) Medication Management – Compounded Sterile Products
- (16) Medication Management – Controlled Substances Inspection Program
- (17) MH Residential Rehabilitation Treatment Program

[Follow-Up Review of the VA St. Louis HCS, St. Louis, Missouri](#)
[VA Western New York HCS, Buffalo, New York](#)
[Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio](#)
[VA Butler Healthcare, Butler, Pennsylvania](#)
[Corporal Michael J. Crescenz VAMC, Philadelphia, Pennsylvania](#)

CBOC Reviews

In January 2016, OIG published five 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) EOC
- (2) Home Telehealth Enrollment
- (3) Outpatient Lab Results Management
- (4) Post-Traumatic Stress Disorder Care

[Edward Hines, Jr. VA Hospital, Hines, Illinois](#)
[VA Western New York HCS, Buffalo, New York](#)
[Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio](#)
[Corporal Michael J. Crescenz VAMC, Philadelphia, Pennsylvania](#)
[VA Texas Valley Coastal Bend HCS, Harlingen, Texas](#)

CRIMINAL INVESTIGATIONS

Husband and Wife Convicted of Major Fraud Against the Government, Wire Fraud, and Conspiracy To Commit Wire Fraud

A husband and wife were convicted at trial of major fraud against the Government, wire fraud, and conspiracy to commit wire fraud. A VA OIG, Department of the Interior OIG, and Small Business Administration (SBA) OIG investigation revealed that the defendants used a “pass-through” scheme to create a Service-Disabled Veteran-Owned Small Business (SDVOSB) in order to qualify for and obtain VA SDVOSB set-aside construction contracts in Kentucky, Tennessee, North Carolina, and other states. The defendants used a service-disabled veteran who was a full-time truck driver and had no construction experience or equipment to establish a construction business and provided fraudulent references to VA and other Government agencies in order to obtain the work. The defendants also created another business to obtain SBA 8(a) set-aside contracts with the two businesses sharing employees, financial assets, and then subcontracting

out the work on most projects. The loss to VA is \$4 million, including *American Recovery and Reinvestment Act* funds. The total loss to the U.S. Government is \$15 million.

Subjects Arrested for Surety Bond Fraud

A veteran was indicted and arrested for major fraud against the Government, mail fraud, and false statements. Two non-veterans were also arrested for conspiracy to commit mail and wire fraud. A multi-agency investigation revealed an extensive Surety Bond fraud scheme involving multiple Federal agencies and over \$935 million in Government construction contracts. The defendants along with other co-conspirators used Government owned lands or fraudulent trusts as assets to back Bid, Payment, and Performance bonding while accepting approximately \$10 million in bonding fees. The affected VA contracts totaled more than \$97 million, including some American Reinvestment and Recovery funds.

Former Nursing Home Company Chief Executive Officer and Chief Financial Officer Sentenced for Wire Fraud

The former Chief Executive Officer (CEO) and CFO of a nursing home company, funded by various Federal health care programs to include VA, were ordered to pay restitution of \$956,050 (jointly) after pleading guilty to wire fraud. A Federal Health Care Fraud Task Force investigation revealed that the defendants conspired when submitting fraudulent loan documents, claiming that the loan was needed to make federally mandated improvements to some of their company's nursing homes. The defendants falsely certified that the improvements had been completed when, in fact, the CEO had spent the loan proceeds on numerous personal expenses.

Former VA Fiduciary Sentenced for Theft of Government Funds

A former VA fiduciary was sentenced to 36 months' probation and \$69,686 in forfeiture after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant failed to report to VA that his son had been incarcerated and during that time used the VA funds for personal expenses.

Veteran Pleads Guilty to Theft of Government Funds

A veteran pled guilty to theft of Government funds. An OIG investigation revealed that the defendant, who was in receipt of VA benefits to include Individual Unemployability (IU), reported to VA that he was unemployed and had no income. However, the investigation revealed that the defendant was the owner, operator, and a senior instructor of a karate and mixed martial arts business. After retiring from the U.S. Marine Corps with multiple reported physical ailments and being granted IU, the defendant opened his martial arts business with two simultaneous operating locations. While still reporting to VA that he was unable to obtain and maintain gainful employment, the defendant became one of the highest ranked instructors in Okinawan Shorin Ryu Karate. The defendant also sponsored tournaments, produced demonstration and instructional videos, and traveled abroad learning and teaching martial arts. The loss to VA is \$190,842.

Veteran Arrested for Threats to Palo Alto, California, VAMC

A veteran was arrested for threats to commit a crime resulting in death or great bodily injury. An OIG and VA Police Service investigation revealed that the defendant made several threats, both telephonic and via text message, stating that he had purchased a gun and that there would be a mass shooting at the Palo Alto, CA, VAMC. The defendant also threatened one specific VA employee stating that he had a gun and that she was on his "hit list."

Friend of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds

The friend of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant received, forged, and negotiated VA benefit checks that were issued after the veteran's death in September 2005. The loss to VA is \$403,291.

Daughter of Deceased VA Beneficiary Arrested for Theft of Government Funds

The daughter of a deceased VA beneficiary was arrested for theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were issued after her mother's death in March 2005. The loss to VA is \$142,494.

Niece of Deceased VA Beneficiary Sentenced for Theft of Government Funds

The niece of a deceased VA beneficiary was sentenced to 5 months' incarceration, 5 months' home detention, 3 years' probation, and was ordered to pay restitution of \$107,452 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after her aunt's death in July 2007.

Bedford, Massachusetts, VAMC Employee Charged With Stealing Government Property

A Bedford, MA, VAMC employee was charged with stealing Government property. An OIG and VA Police Service investigation revealed that the defendant stole approximately \$10,000 worth of laptop computers from the medical center. During the investigation, two of the stolen computers were recovered.

VA Contractor Sentenced for Theft of VA Computers at Hampton, Virginia VAMC

A VA contractor was sentenced to 10 years' incarceration (8 years suspended), 10 years' supervised probation, and was ordered to pay two victims restitution of \$1,250. An OIG and VA Police Service investigation revealed that the defendant, who was contracted by Dell to work as a computer technician at the Hampton, VA, VAMC, stole and then sold two Lenovo T530 laptop computers belonging to the medical center.

Former Bronx, New York, VAMC Warehouse Supervisor Sentenced for Conspiracy To Distribute and Possess With Intent To Distribute Cocaine

A former VA warehouse supervisor was sentenced to 6 months' home confinement and 30 additional months' supervised release after pleading guilty to conspiracy to distribute and possess with intent to distribute cocaine. An OIG, U.S. Postal Inspection Service, VA Police Service, and Drug Enforcement Administration's (DEA) New York Organized

Crime Drug Enforcement Strike Force investigation revealed that six U.S. Postal Service parcels, each containing 1 to 2 kilograms of cocaine, were mailed from Puerto Rico to the Bronx, NY, VAMC. Five defendants have been charged in this case, including two former VA employees.

Former Greenville, North Carolina, CBOC Physician Sentenced for Drug Possession

As part of a Conditional Discharge Agreement, a former Greenville, NC, CBOC physician was sentenced to 12 months' supervised probation, 48 hours' community service, and was ordered to attend and complete a drug education school and the North Carolina Medical Board Physicians Assistance Program for substance abuse treatment after pleading guilty to felony possession of a Schedule II controlled substance (oxycodone). An OIG, local police, North Carolina Medical Board, and DEA diversion investigation revealed that the defendant treated a veteran for a period of time while a legitimate provider/patient relationship existed. However, that relationship became personal and after leaving VA employment the physician continued to prescribe controlled medications to the veteran using VA prescriptions. OIG forensic evidence analysis determined that the defendant authored the illegal prescriptions. Both the defendant and the veteran received pills from the prescriptions that were filled at outside pharmacies. The defendant also surrendered her medical license and DEA number as a result of this investigation.

Veteran Sentenced for VA Travel Benefit Fraud

A veteran was sentenced to 3 years' incarceration after pleading guilty to grand larceny. A VA OIG, New York State Medicaid OIG, and New York District Attorney's Office investigation revealed that on 513 occasions from 2010 to 2013, the defendant fraudulently received a total of \$19,733 in VA travel benefits while Medicaid reimbursed a taxi service for the same travel to and from the Montrose, NY, VAMC.

Fugitive Felons Arrested With Assistance of OIG and VA Police Service

A veteran was arrested at the Northampton, MA, VAMC by VA Police Service and OIG. The fugitive, who was an inpatient and was medically cleared for discharge, was wanted on an outstanding warrant that included indecent assault and battery on a child and open and gross lewdness. Another veteran was arrested by the North Las Vegas Police Department with the assistance of OIG. The veteran was wanted for a rape charge in Arkansas.



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