



Department of Veterans Affairs

Office of Inspector General

February 2016 Highlights

CONGRESSIONAL TESTIMONY

Deputy Inspector General Testifies Before House Appropriations Subcommittee on Need for Increased Funds to “Right-Size” Office of Inspector General

Linda A. Halliday, Deputy Inspector General, testified before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, United States House of Representatives, regarding the fiscal year (FY) 2017 budget request for the Office of Inspector General (OIG). Ms. Halliday explained OIG’s process for prioritizing work based on those areas in VA with the highest risk either to patient care, employee safety, or other financial and contractual risks. She stressed that OIG needs to have the appropriate level of funding to provide for the necessary oversight of VA programs and operations. She thanked Congress for the \$10 million increase over the President’s request for FY 2016, and noted that the FY 2017 budget request of \$160.1 million continues the effort to appropriately proportion OIG’s staff and resources to the scale of its oversight mission. Ms. Halliday was accompanied by John D. Daigh, Jr., MD, CPA, Assistant Inspector General (AIG) for Healthcare Inspections. [[Click here to access testimony.](#)]

Deputy AIG for Audits and Evaluations Discusses Oversight Findings on VA’s Purchased Care Programs

Gary K. Abe, Deputy AIG for Audits and Evaluations, testified before the Subcommittee on Health, Committee on Veterans’ Affairs, United States House of Representatives, on OIG’s work concerning VA’s purchased care programs. He discussed recent OIG reports which have shown that VA faces challenges in administering its purchased care programs in such areas as authorizing, scheduling, ensuring contractors provide medical information to VA in support of the services provided, ensuring VA inputs the medical information from contractors into the veteran’s VA medical record, and timely and accurate payment for care purchased outside the VA health care system. Mr. Abe explained that while purchasing health care services from non-VA providers may afford VA flexibility in terms of expanded access to care and services that are not readily available at VA medical facilities, it also poses a significant risk to VA and veterans when adequate controls are not in place. He warned that, without adequate controls, VA’s purchased care consolidation plan is at increased risk of not achieving its goal of delivering timely and efficient health care to veterans. Mr. Abe was accompanied by Mr. Larry Reinkemeyer, Director, Kansas City Office of Audits and Evaluations. [[Click here to access testimony.](#)]

OIG REPORTS

Review of Alleged Untimely Care at Veteran Health Administration’s Community Based Outpatient Clinic, Colorado Springs, Colorado

In January 2015, OIG received an allegation that the PFC Floyd K. Lindstrom Outpatient Clinic, a Community Based Outpatient Clinic (CBOC) in Colorado Springs, CO, did not provide veterans access to the Veterans Choice Program (VCP) when the CBOC did

not provide veterans timely VA care. One affected veteran sent the complaint, along with examples of issues affecting clinic services provided in audiology, mental health, neurology, optometry, orthopedic, and primary care. OIG substantiated the allegation that the veteran, as well as other eligible Colorado Springs veterans, did not receive timely care in the six reviewed services. OIG reviewed 150 referrals for specialty care consults and 300 primary care appointments. Of the 450 consults and appointments, 288 veterans encountered wait times in excess of 30 days. For all 288 veterans, VA staff either did not add them to the Veterans Choice List or did not add them to the Veterans Choice List in a timely manner. For 59 of the 288 veterans, scheduling staff used incorrect dates that made it appear the appointment wait time was less than 30 days. For 229 of the 288 veterans with appointments over 30 days, Non-VA Care Coordination (NVCC) staff did not add 173 veterans at the CBOCs in the Eastern Colorado Health Care System (ECHCS) to the Veterans Choice List in a timely manner and did not add 56 veterans to the list at all. In addition, scheduling staff did not take timely action on 94 consults and primary care appointment requests. As a result, VA staff did not fully use VCP funds to afford CBOC Colorado Springs veterans the opportunity to receive timely care. OIG recommended that the ECHCS Director take actions to ensure appointments are scheduled using clinically indicated or preferred appointment dates, all veterans eligible for the VCP are added to the Veterans Choice List in a timely manner, and scheduling staff timely act on consults and appointment requests. The Acting Director of the ECHCS concurred in principle with our recommendations. The ECHCS executed a number of corrective actions to become compliant with current Veteran Health Administration (VHA) scheduling guidance. Based on actions already implemented, OIG considers Recommendation 1 closed. OIG will follow up on the implementation of the remaining recommendations until all proposed actions are completed. [[Click here to access report.](#)]

Review of Alleged Patient Scheduling Issues at the VA Medical Center in Tampa, Florida

OIG determined the merits of allegations received in December 2014 about the VCP at the James A. Haley Veterans' Hospital (JAHVH). OIG substantiated the allegation that JAHVH staff did not always cancel the VA appointment when a VCP appointment was made. OIG examined 56 records of veterans who completed a VCP appointment and found that for 12 of the veterans (21 percent), staff did not cancel the veterans' corresponding VA appointment. This occurred because NVCC staff did not receive prompt notification from the contractor, Health Net, when a veteran scheduled a VCP appointment and no longer needed the VA appointment. OIG also substantiated that prior to May 2015, the Performance Improvement (PI) supervisor did not notify schedulers of errors identified during scheduling audits. The PI supervisor stated that the PI team corrected the errors and notifying schedulers was not his priority. In addition, OIG substantiated that JAHVH did not add all eligible veterans to the Veterans Choice List when their scheduled appointment was greater than 30 days from their preferred date, and that staff inappropriately removed veterans from the Veterans Choice List. This occurred because JAHVH schedulers thought they were appropriately removing the veteran from the Electronic Wait List when they were actually removing the veteran from the Veterans Choice List. OIG recommended the Director of JAHVH

ensure the facility receives prompt notification of scheduled VCP appointments and determine if the contractor complies with the requirements. OIG also recommended the Director ensure appropriate staff receive scheduling audit results, PI staff verify correction of errors, and staff receive training regarding management of the Veterans Choice List. The Director of the JAHVH concurred with OIG's report and recommendations. Based on actions already implemented, OIG considered four of the recommendations closed and will follow up on the implementation of the one remaining recommendation. [[Click here to access report.](#)]

Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York

OIG conducted an inspection at the Veterans Crisis Line (VCL), located in Canandaigua, NY, in response to allegations involving unanswered phone calls or calls routed to a voicemail system, lack of immediate assistance to callers, ambulance timeliness, untrained staff, and confusing contact information. OIG also received complaints from the U.S. Office of Special Counsel that VCL social service assistants were not properly trained and that callers to the VCL were forwarded to volunteer backup call centers that lack appropriately trained staff. OIG substantiated that some calls routed to backup centers went into a voicemail system and that the VCL and backup center staff did not always offer immediate assistance to callers. OIG also substantiated that VCL management did not provide social service assistants (who do not answer calls) with adequate orientation and ongoing training. The VCL program does not provide or monitor backup centers' staff training; therefore, OIG could not substantiate that backup center staff did not receive adequate training. OIG did not substantiate the allegations that staff who respond to callers did not receive proper training or that VCL staff were responsible for the 3-hour delay a veteran experienced while waiting for an ambulance. In addition, OIG did not substantiate that the VCL phone number was difficult to use during a crisis. OIG identified gaps in the VCL quality assurance process: an insufficient number of required staff supervision reviews, inconsistent tracking and resolution of VCL quality assurance issues, and a lack of collection and analysis of backup center data. OIG determined that a contributing factor for the lack of organized VCL quality assurance processes was the absence of a VHA directive or handbook to provide guidance for VCL quality assurance and other processes and procedures. OIG made seven recommendations.

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

Review of Alleged Mismanagement of Group Therapy Access at VA Outpatient Clinic, Austin, Texas

In July 2014, a VA employee contacted OIG's Hotline Division alleging 195 veterans were waiting to get into a specific mental health group therapy session at the Austin Outpatient Clinic (AOPC). OIG examined available compensation and pension records interchange system (CAPRI) records of a judgment sample of 40 veterans from the list of 195 veterans. OIG found that AOPC personnel contacted 34 out of 40 veterans. However, AOPC personnel contacted only 13 of the 34 veterans in 30 days or less. On average, it took 192 days for AOPC personnel to contact the remaining 21 veterans. Although AOPC contacted 34 veterans to notify them that group therapy sessions were

available, only 15 veterans attended. The remaining 19 signed up for the therapy sessions but did not attend. To ensure the Temple VA Medical Center (VAMC) completed appropriate actions to provide veterans at the AOPC the opportunity to participate in group therapy in a timely manner, OIG Hotline Division referred the findings through VHA to Veterans Integrated Service Network (VISN) 17 for their review and action. [[Click here to access report.](#)]

Review of Alleged Wasted Funds in VHA's Southern Arizona VA Health Care System, Tucson, Arizona

OIG received an allegation in February 2015 that the Southern Arizona VA Health Care System's (HCS) Tucson facility was leasing \$1.5 million worth of urology equipment that had not been used since October 2014. The complainant alleged that the HCS had not used the equipment because of installation delays and the updating of equipment cleaning procedures. OIG substantiated the allegation that the HCS leased, but did not use, approximately 360 pieces of urology equipment from November 2014 through March 2015. The 3 year lease was valued at about \$1.8 million. The HCS delayed using the urology equipment because of inadequate acquisition planning and coordination with its support services. The lack of coordination occurred, in part, because the HCS had not established policies and procedures to ensure support services staff review leased equipment requests during acquisition planning. As a result, the HCS missed the opportunity to provide veterans services using endoscopic urology equipment with improved visualization. In addition, OIG estimated the HCS spent approximately \$217,000 on wasteful lease expenses while the equipment was idle from November 2014 through March 2015. OIG recommended the VISN 18 Director ensure the HCS develop and implement a policy requiring coordination and review of leased equipment requests with HCS support services during the acquisition process. The Director of VISN 18 concurred with our finding and recommendation. The HCS management provided evidence of its new local policy, and OIG considers the recommendation closed. [[Click here to access report.](#)]

Follow-Up Audit of the Veterans Benefits Administration's Internal Controls Over Disability Benefits Questionnaires

OIG conducted this audit to assess the Veterans Benefits Administration's (VBA) implementation of our 2012 recommendations to strengthen internal controls over public-use Disability Benefit Questionnaires (DBQs) and determine whether VBA could use DBQs more effectively. OIG found VBA did not establish adequate controls to identify and minimize potential DBQ fraud or fully implement OIG's prior recommendations to address control weaknesses. OIG estimated during the 6 months ending March 2014, claims processors did not identify approximately 23,100 of approximately 24,700 claims (93 percent) including DBQs. Specifically, OIG found they did not consistently and correctly record special issue indicators in VBA's electronic systems to identify claims that included DBQs. VBA controls also did not electronically capture DBQ information, adequately ensure DBQs provide notification that information is subject to verification, confirm claims processors consistently and correctly identify claims including DBQs, or ensure DBQ clinician information was complete. Once VBA strengthens controls, VBA can use DBQs more effectively to improve claims

processing. Control weaknesses existed because VBA did not evaluate options to capture DBQ information and revise DBQ forms promptly. VBA also lacked adequate policies and procedures and quality assurance reviews. As a result, VBA lacked reasonable assurance of detecting potential fraud when processing claims including DBQs. Further, unnecessary medical examinations caused veterans and VA to needlessly expend time and money and may have delayed veterans receipt of benefits. If VBA does not use DBQs more effectively, OIG estimates VHA will spend at least \$4.8 million annually and at least \$24 million over the next 5 years for unnecessary examinations. OIG recommended the Acting Under Secretary for Benefits develop controls to electronically capture DBQ information, revise DBQ forms, establish and revise policies and procedures, and revise quality assurance reviews.

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

Benefits Inspection Results of VA Regional Office, Manila, Philippines

In November 2015, OIG sampled claims at the Manila VA Regional Office (VARO) that OIG considered at increased risk of processing errors. These claims do not represent the accuracy of all disability claims processing at this VARO. Manila VARO staff correctly processed entitlement to temporary 100 percent disability evaluations. The VARO did not process any traumatic brain injury or special monthly compensation (SMC) claims within the scope of our review. Staff correctly processed the two temporary 100 percent disability evaluation cases OIG reviewed. In our 2012 inspection report, the most frequent processing errors associated with temporary 100 percent disability evaluation cases occurred because management did not have an oversight process to ensure staff entered suspense diaries as required. During this inspection, OIG did not identify similar errors. Therefore, OIG determined VBA's response to our previous recommendation was effective. Manila VARO staff followed VBA's policy for establishing dates of claim in 29 of the 30 claims OIG reviewed. VARO staff delayed processing 6 of 21 benefits reduction cases because management prioritized other workload higher. Additionally, Manila VARO staff correctly processed all 33 Filipino Veterans Equity Compensation (FVEC) claims, and 15 of the 16 FVEC appeals OIG reviewed. OIG recommended the Manila VARO Director implement a plan to ensure oversight and prioritization of benefits reduction cases. The VARO Director concurred with our recommendation. [\[Click here to access report.\]](#)

Benefits Inspection Results of VARO, Oakland, California

In October 2015, OIG sampled claims at the Oakland VARO that OIG considered at increased risk of processing errors. These results do not represent the accuracy of all disability claims processing at this VARO. The Oakland VARO did not consistently process one of the three types of disability claims OIG reviewed. Overall, staff did not accurately process 8 of 70 disability claims (11 percent) reviewed. As a result, 20 improper monthly payments were made to 3 veterans totaling approximately \$17,100. Staff incorrectly processed 4 of 30 temporary 100 percent disability evaluation cases OIG reviewed; however, OIG did not identify a systemic trend. These results showed improvement from our previous inspection in 2012, where 16 of 30 contained processing inaccuracies. Results from our current inspection also showed claims processing staff accurately processed all 30 traumatic brain injury claims—a significant

improvement from our 2012 inspection, where 17 of the 30 claims sampled contained errors. Oakland VARO staff incorrectly processed 4 of 10 SMC claims, but followed VBA's policy for establishing dates of claim in 29 of the 30 claims OIG reviewed. Furthermore, staff did not correctly process, or delayed processing, 3 of 30 benefits reductions cases. However, OIG did not identify a systemic trend. OIG recommended the Oakland VARO Director conduct a review of the 58 temporary 100 percent disability evaluations remaining from the inspection universe. OIG also recommended the Director implement a plan to ensure staff comply with the second signature requirements for higher-level SMC claims. Furthermore, OIG recommended the Acting Under Secretary for Benefits ensure that the approved training materials for higher levels of SMC are updated and accurate. The Acting Under Secretary for Benefits and VARO Director concurred with our recommendations. Management's planned actions are responsive and OIG will follow up as required. [\[Click here to access report.\]](#)

Benefits Inspection Results of VARO, Little Rock, Arkansas

In September 2015, OIG sampled claims at the VARO Little Rock that OIG considered at increased risk of processing errors. These results do not represent the overall accuracy of disability claims processing at this VARO. Generally, VARO Little Rock staff accurately processed the three types of disability claims OIG reviewed. Overall, 3 of the 34 disability claims (9 percent) reviewed contained processing inaccuracies resulting in approximately \$29,822 in improper benefits payments (including overpayments and underpayments) to 3 veterans. During this inspection, VARO staff incorrectly processed 2 of 27 temporary 100 percent disability evaluations OIG reviewed. OIG also noted a significant improvement from our 2012 inspection where 18 of the 30 sampled cases contained errors. OIG also observed that VARO staff generally processed traumatic brain injury claims accurately for two consecutive benefits inspections. During the 2012 inspection, 1 of the 29 cases sampled contained an error. However, during the 2015 inspection, all five cases completed from January through June 2015 were processed correctly. One of the two SMC and ancillary benefits claims completed by VARO staff from July 2014 through June 2015 was accurate. VARO staff established the correct dates of claim for 30 cases reviewed in the electronic record. OIG also determined VARO staff delayed processing 4 of the 30 benefits reduction cases OIG reviewed. However, despite having to prioritize other workload higher, the VARO managed these cases more timely than 12 of 16 VAROs inspected during FY 2015. Effective management of this workload can reduce the risk of improper payments and provide better stewardship of taxpayer funds. OIG recommended the Director implement a plan to ensure claims processing staff prioritize actions related to benefits reductions to minimize improper payments to veterans. The Director of VARO Little Rock concurred with our recommendation. Management's planned actions are responsive and OIG will follow up as required. [\[Click here to access report.\]](#)

Combined Assessment Program Reviews

In February 2016, OIG published six 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 12 activities:

- (1) Advanced Directives
- (2) Computed Tomography Radiation Monitoring
- (3) Continuity of Care
- (4) Coordination of Care
- (5) EOC
- (6) Mammography Services
- (7) EOC
- (8) Quality, Safety, and Value
- (9) Suicide Prevention Program
- (10) Medication Management – Compounded Sterile Products
- (11) Medication Management – Controlled Substances Inspection Program
- (12) MH Residential Rehabilitation Treatment Program

[VA Central California Health Care System, Fresno, California](#)

[Edward Hines, Jr. VA Hospital, Hines, Illinois](#)

[VA Maryland Health Care System, Baltimore, Maryland](#)

[Coatesville VA Medical Center, Coatesville, Pennsylvania](#)

[VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas](#)

[Sheridan VA Healthcare System, Sheridan, Wyoming](#)

CBOC Reviews

In February 2016, OIG published four 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

[VA Central California Health Care System, Fresno, California](#)

[VA Maryland Health Care System, Baltimore, Maryland](#)

[VA Butler Healthcare, Butler, Pennsylvania](#)

[Coatesville VA Medical Center, Coatesville, Pennsylvania](#)

CRIMINAL INVESTIGATIONS

Former Memphis, Tennessee, VAMC Employee and Co-Conspirator Sentenced for Fraud

A former Memphis, TN, VAMC employee and a non-veteran co-conspirator were each sentenced to 30 months' incarceration, 3 years' supervised release, and were ordered to pay restitution of \$1,137,694 after pleading guilty to conspiracy, theft of Government funds, wire fraud, and engaging in monetary transactions in property derived from specified unlawful activity. An OIG, Department of Justice, and VA Police Service investigation revealed that the defendants created a fictitious medical supply company and then the former VAMC employee had the company approved as a vendor to provide medical supplies to VA. From 2007 to 2013, the defendants created fraudulent purchase orders for medical supplies that were never delivered to VA. Fraudulent invoices were then paid using the former VAMC employee's Government-issued purchase card. The fraudulently obtained payments were then divided between the defendants.

Three Defendants Sentenced for Service-Disabled Veteran-Owned Small Business Fraud in San Juan, Puerto Rico

Three defendants were sentenced to a combined total of 48 months' probation, 250 hours' community service, and a \$2,700 fine. The defendants also agreed to pay \$30,000 in civil monetary penalties to VA as part of the related civil case. A VA OIG and Small Business Administration 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 at the San Juan, PR, VAMC. The defendants created the fraud scheme by using a service-disabled sibling who was a full time U.S. Postal Service employee and had no construction experience or equipment to establish a new construction business. The defendants created the SDVOSB after learning that construction contracts would only be awarded to SDVOSBs as a result of a Government stimulus package. The VA contracts included *American Recovery and Reinvestment Act* funds and were worth approximately \$8.4 million.

Son of Service-Disabled Veteran Convicted of Theft and Aggravated Identify Theft

The son of a service-disabled veteran was convicted at trial of theft and aggravated identify theft. A VA OIG, Army Criminal Investigation Command, Defense Criminal Investigative Service, General Services Administration OIG, and Social Security Administration (SSA) OIG investigation revealed that the son used his father's identity and military history to create two SDVOSB companies. The son fraudulently certified both businesses as SDVOSBs and obtained 15 SDVOSB set-aside contracts. The service-disabled veteran was not aware that his identity was used and was not involved with either business. The loss to VA is \$1.2 million, and the total loss to the U.S. Government is \$2.7 million.

Former Sacramento, California, VAMC Engineer Sentenced for Receiving Illegal Gratuity

A former Sacramento, CA, VAMC engineer was sentenced to 5 months' house arrest, 2 years' probation, a \$2,000 fine, and was ordered to forfeit the \$2,250 value of a 2010 vacation package after pleading guilty to receipt of a gratuity by a public official. An OIG and Federal Bureau of Investigation (FBI) investigation revealed that while acting as a Contracting Officer's Representative on several construction projects, a VA contractor provided the defendant with at least \$25,000 in cash, a new Ford F-150 pickup truck, and Disneyland vacation packages. After providing the illegal gratuities, the VA contractor received favorable treatment from VA.

Former Palo Alto, California, VAMC Contracting Officer's Representative Sentenced for Receiving Illegal Gratuity

A former Palo Alto, CA, VAMC Contracting Officer's Representative was sentenced to 12 months' house arrest, 5 years' probation, and a \$25,000 fine after pleading guilty to receipt of a gratuity by a public official. An OIG and FBI investigation revealed that while overseeing a project to install a new MRI scanner, the defendant received \$7,000 in cash from a VA sub-contractor and \$9,230 worth of roofing work on his home paid for by a VA general contractor.

Former Hampton, Virginia, VAMC Nurse Convicted of Aggravated Sexual Abuse and Making a False Statement

A former Hampton, VA, VAMC nurse was convicted at trial of aggravated sexual abuse and making a false statement. An OIG investigation revealed that the defendant administered morphine to a patient against the patient's wishes and then sexually assaulted her multiple times. When questioned by investigators, the defendant lied about the assault.

Former Northampton, Massachusetts, VAMC Nursing Assistant Sentenced for Assault

A former Northampton, MA, VAMC nursing assistant was sentenced to 27 months' probation after pleading guilty to the assault on an elderly and disabled veteran. An OIG and VA Police Service investigation revealed that the defendant forcefully took the veteran to the ground during a psychiatric intervention on a locked ward, causing injury. The defendant continued to verbally and physically assault the veteran after the patient had been taken to his room. Additionally, administrative action was taken against three employees who witnessed the matter and did not report it to management or law enforcement. Two nursing assistants received a suspension and a charge nurse resigned after VA proposed removal.

Veteran Arrested for Making Threats to Federal Officials

A veteran was arrested for threats to Federal officials. An OIG investigation revealed that the defendant went to the Fayetteville, AR, VAMC and threatened to kill a VA social worker. On the same day, the defendant was arrested by local police for a non-related incident. During a custodial interview, the defendant made additional threats to kill the

OIG interviewing agents. The defendant was subsequently arrested for making threats towards Federal officials. The defendant was held pending further judicial action.

Veteran Convicted of VA Compensation and Social Security Fraud

A veteran was found guilty at trial of theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant, who since 1997 has received SMC to include Aid and Attendance, claimed loss of use of both hands and feet due to Multiple Sclerosis, all while living an active lifestyle to include participating in adult baseball leagues, completing a 2008 "Marine Corps Mud Run," operating a small car with a manual transmission, being a personal trainer and a high school athletic strength coach, and participating in other physically involved activities. The defendant received approximately \$8,700 per month from VA due to his reported constant inability to function and care for his daily needs. The defendant also received additional VBA adaptation grants to help him cope with his reported disabilities, all while feigning the severity of his disabilities in front of various VAMC clinicians. The loss to VA is \$1,545,890, and the loss to SSA is \$133,107.

Veteran Indicted for VA Compensation Fraud

A veteran was indicted for wire fraud, health care fraud, and false statements. An OIG investigation revealed that the defendant falsely claimed to suffer from symptoms of narcolepsy and received a medical discharge from the Navy in 1997. The defendant subsequently applied for VA compensation benefits for service-connected narcolepsy and was subsequently rated 100% disabled. The defendant claimed the condition rendered him homebound and unable to work. The defendant later became a Federal employee for the U.S. Army Corps of Engineers and used his Federal Employee Health Benefits to obtain treatment and medication for the fraudulently claimed condition in furtherance of his scheme to defraud VA. The defendant also provided false statements to OIG, a VA physician, and VBA about his condition and symptoms. The loss to VA is over \$270,000.

Non-Veteran Sentenced for Identity Theft

A non-veteran was sentenced to 48 months' incarceration, 3 years' supervised release, a \$2,000 fine, and was ordered to participate in drug treatment therapy and to pay VA restitution of \$42,912 after pleading guilty to theft of Government funds and aggravated identity theft. An OIG investigation revealed that the defendant stole monthly VA compensation benefits from a veteran by use of a fraudulently established eBenefits account. In addition, the defendant assumed the identity of the veteran in order to fraudulently receive VA health care benefits.

Daughter of Deceased VA Beneficiary Indicted for Theft of Government Funds

The daughter of a deceased VA Dependency and Indemnity Compensation beneficiary was indicted for theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant failed to report her mother's death to VA and SSA. The defendant subsequently received, forged, and negotiated VA and SSA benefit checks that were issued after her mother's death in October 1988. The loss to VA is \$307,000, and the loss to SSA is \$248,000.

Daughter of Deceased VA Beneficiary Sentenced for Theft of Government Funds

The daughter of a deceased VA beneficiary was sentenced to 60 months' probation and was ordered to pay restitution of \$137,763 (forfeiture order) after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited after her mother's death in June 2008.

Daughter of Deceased VA Beneficiary Indicted for Theft of Government Funds

The daughter of a deceased beneficiary was indicted for theft of Government funds. An OIG investigation revealed that the defendant failed to report her mother's death to VA and stole VA benefits that were direct deposited after her mother's death in May 2008. The defendant admitted to using the VA funds for personal expenses. The loss to VA is \$95,658.

Non-Veteran Pleads Guilty to "Stolen Valor"

A non-veteran pled guilty to theft in connection with health care, theft of Government property, a fraudulent demand against the United States, and fraudulently holding oneself out to be a recipient of military decorations or medals. An OIG investigation revealed that the defendant falsely represented himself as both a decorated United States Marine Corps veteran and a California Army National Guard veteran in order to obtain VA health care benefits. The defendant has spent the majority of his adult life in prison. The loss to VA is \$13,623.

Subject Indicted for Health Care Fraud

A subject was indicted for health care fraud. An OIG and VA Police Service investigation revealed that the defendant received \$63,000 in VA services to include medical care, housing benefits, Compensated Work Therapy pay, and beneficiary travel pay that he was not entitled to receive. The defendant was ineligible for these benefits as he failed to complete boot camp in the National Guard. The defendant's false statements to VA included the claims that his DD-214 was destroyed in the St. Louis fire and that he was shot twice as a door gunner while rescuing POWs in Vietnam.

Coatesville, Pennsylvania, VAMC Employee Arrested for Preparing False Tax Returns and Theft of Government Funds

A Coatesville, PA, VAMC employee was arrested for preparing false tax returns and theft of Government funds. An OIG and Internal Revenue Service criminal investigation revealed that the defendant prepared approximately 176 Federal income tax returns for other individuals, including co-workers, that fraudulently sought tax refunds of approximately \$610,526. The tax returns the defendant prepared contained false financial information regarding the filers' business expenses, medical expenses, and charitable deductions. In addition to charging his co-workers a fee for preparing their returns, the defendant stole a portion of the refunds that he generated for his clients. The investigation also revealed that the defendant used VA computers to commit some of the fraud.

Former Albany, New York, VAMC Nurse Pleads Guilty to Drug Tampering

A former Albany, NY, VAMC licensed practical nurse pled guilty to tampering with a consumer product with reckless disregard and extreme indifference to the danger of death or bodily injury, and obtaining a controlled substance by deception and subterfuge. The defendant, assigned to the hospice ward, removed oxycodone hydrochloride from syringes inside the locked narcotic dispensing unit and replaced it with the anti-psychotic medication Haloperidol. The defendant's actions caused the incorrect medication to be administered which resulted in undue patient pain and suffering. Due to the potential number of victims and the seriousness of his actions, the defendant is facing a sentencing guideline of 78 to 97 months' incarceration.

Former Providence, Rhode Island, VAMC Nurse Pleads Guilty to Drug Diversion

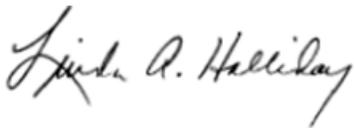
A former Providence, RI, VAMC registered nurse pled guilty to theft of Government property and making false statements. An OIG and Drug Enforcement Agency investigation revealed that the defendant diverted oxycodone, morphine, hydrocodone, hydromorphone, and lorazepam from the Pyxis system (an automated medication dispensing system). A search warrant was executed at the defendant's residence and VA controlled pharmaceuticals, empty controlled substance packaging, and syringes were seized from the residence. The defendant admitted to stealing 240 controlled substances and ingesting them either while on duty or at her residence. In addition, the investigation revealed that the defendant had previously been terminated from a private hospital for allegedly diverting controlled substances. However, the defendant falsely denied this information in response to VA employment application questions.

Final Co-Conspirator Pleads Guilty to Travel Benefit Fraud

The final co-conspirator of a group consisting of nine veterans and two former Seattle, WA, VAMC employees pled guilty to false claims. An OIG investigation revealed that the nine veterans participated in a scheme in which two VA Travel Clerks recruited them to submit inflated and fictitious travel benefit vouchers. The clerks then received kickback payments from the veterans. The final co-conspirator veteran had been a fugitive since 2013 and was arrested at the Albuquerque, NM, VAMC. The loss to VA is in excess of \$180,000.

Veteran Arrested for Theft of Travel Benefits

A veteran was arrested for grand larceny. A VA OIG, New York State Medicaid OIG, and NY District Attorney's Office investigation revealed that on 747 occasions from 2009 to 2014, the defendant fraudulently requested VA travel benefits while Medicaid reimbursed a taxi service for the same travel to and from the Montrose, NY, VAMC. The loss to VA is \$19,079.



LINDA A. HALLIDAY
Deputy Inspector General