CONGRESSIONAL TESTIMONY
Inspector General Testifies on Veterans Crisis Line at House and Senate Hearings
The Honorable Michael J. Missal testified at two separate hearings on the Office of Inspector General’s (OIG) recent work related to the operations of VA’s Veterans Crisis Line (VCL). Mr. Missal testified before the Committee on Veterans’ Affairs, United States House of Representatives, at an April 4, 2017 hearing titled, “An Assessment of Ongoing Concerns at the Veterans Crisis Line.” He also testified about the OIG’s VCL work on April 27, 2017 before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, United States Senate, at a hearing on “Preventing Veteran Suicide.” Mr. Missal’s testimony emphasized that the tragedy of veteran suicide is one of the most significant issues facing the Veterans Health Administration (VHA). In discussing OIG’s two VCL reports—*Healthcare Inspection – Veterans Crisis Line Caller Response and Quality Assurance Concerns Canandaigua, New York* (Report No. 14-03540-123, February 11, 2016) and *Healthcare Inspection – Evaluation of the Veterans Health Administration Veterans Crisis Line* (Report No. 16-03985-81, March 20, 2017)—he highlighted numerous deficiencies related to governance, operations, and quality assurance. Mr Missal emphasized that until VHA fully implements OIG’s 23 recommendations, it will continue to face challenges meeting the VCL’s critically important mission to provide “suicide prevention and crisis intervention services to veterans, service members, and their family members.”
[Click here to access House testimony.] [Click here to access Senate testimony.]

OIG REPORTS
Follow-Up Review of Management of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, Maine
OIG conducted a healthcare inspection at the request of Senators Susan M. Collins and Angus S. King, Jr., and Representatives Chellie Pingree and Bruce Poliquin to follow up on recommendations made in our original report, *Healthcare Inspection – Mismanagement of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, Maine* (Report No. 14-05158-377, June 17, 2015). The purpose of the follow-up inspection was to evaluate the VA Maine Healthcare System’s progress in implementing action plans in response to the report to ensure that the consult package is used when referring patient for Mental Health (MH) care; MH consults are reviewed and closed in accordance with VHA policy; and VHA appointment schedule guidance is followed, including the use of the electronic wait list. OIG found the system implemented and sustained corrective actions to improve consult package use for patients referred for MH services and the consult review and closure processes were consistent with VHA policy. OIG found the system was noncompliant with the requirement to make direct contact with patients when scheduling MH appointments. At the time of our follow-up review in 2016, system staff was unable to schedule MH appointments for service-connected veterans timely and no longer needed to use the
electronic wait list; therefore, OIG was unable to determine if staff responsible for scheduling MH appointments utilized the electronic wait list correctly. Although not part of the original recommendations OIG was evaluating, OIG found documentation of initial and annual scheduling competencies for medical support assistants responsible for scheduling was missing or incomplete. OIG recommended the System Director ensure (1) that MH schedulers consistently make direct contact with patients prior to scheduling appointments and that compliance is monitored for a minimum of three months and (2) training and competencies are documented, complete, and up to date for all staff responsible for scheduling MH appointments. [Click here to access report.]

Review of Unauthorized System Interconnection at the VA Regional Office in Wichita, Kansas

The OIG Hotline Division received an allegation that an unauthorized system interconnection existed between a Veterans Service Organization (VSO) network and the Wichita, KS, VA Regional Office (VARO). More specifically, the allegation stated that a system interconnection existed without a required Interconnection Security Agreement in place to define applicable information security requirements. The complaint also stated that the system interconnection was not disclosed to OIG during a recent Federal Information Security Modernization Act audit. OIG substantiated the allegation that an unauthorized system interconnection existed between the Wichita VARO and the Kansas Commission on Veterans Affairs network. OIG also substantiated the allegation that the system interconnection was not disclosed to OIG because Office of Information Technology (OIT) staff did not believe the connection constituted a formal system interconnection according to VA policy. The unauthorized system interconnection occurred because OIT technical staff did not have the technical knowledge or exercise due diligence to identify the system interconnection in accordance with VA policy; OIT technical staff did not follow VA’s change management procedures for reviewing and approving significant network and system changes; and the Wichita VARO did not have a formal process in place for managing VSO system change requests that may adversely affect VA’s network environment. As a result, the unauthorized system interconnection violated VA policy and the computers used by VSO representatives were inappropriately allowed to use client software to establish simultaneous network connections between VA’s and the VSO’s networks. OIG recommended the Assistant Secretary for Information Technology, in conjunction with the Wichita VARO Facility Director, ensure that the network interconnection with the Kansas Commission on Veterans Affairs is brought into compliance with VA information security requirements. The Principal Deputy Under Secretary for Benefits and the Acting Assistant Secretary for OIT concurred with OIG’s findings and recommendations. OIG will follow up on the implementation of corrective actions. [Click here to access report.]

Peer Review for Quality Management Concerns, Huntington VA Medical Center, Huntington, West Virginia

OIG conducted a healthcare inspection of the peer review process for quality management at the Huntington VA Medical Center (facility), Huntington, WV. OIG identified concerns while conducting a Clinical Assessment Program review of the
facility, which included an evaluation of Peer Review Committee activities. OIG found that in the cases evaluated that were referred for peer review, peer reviewers did not consistently address and document a comprehensive exploration of possible event causes. OIG also found (1) incomplete Peer Review Committee oversight of initial peer reviews; (2) an inappropriate but otherwise qualified individual conducted initial peer reviews; (3) that an individual was uncomfortable about conducting a peer review; and (4) that a peer reviewer conducting an initial review lacked qualifications required of a peer relative to the episode of care under review. OIG made six recommendations for improvement of the facility's peer review process. [Click here to access report.]

Evaluation of Computed Tomography Radiation Monitoring in Veterans Health Administration Facilities
OIG completed a healthcare evaluation of computed tomography (CT) radiation monitoring in VHA facilities. The purpose of the evaluation was to determine whether facilities complied with selected VHA radiation safety requirements. CT combines a series of x-ray images to create cross-sectional images of the body. Sophisticated computers process the data to generate three-dimensional CT images of the inside of the body that can reveal the presence of disease or injury. CT scans are extremely helpful in diagnosing serious injuries to the head, chest, abdomen, spine, and pelvis. CT scans can also pinpoint the size and location of tumors. However, CT scans also contribute significantly to the amount of total patient radiation exposure and could result in the development of future cancers. For this reason, clinicians should eliminate avoidable exposure. OIG conducted this review at 56 VHA medical facilities during Combined Assessment Program reviews performed across the country from April 1, 2015, through March 31, 2016. OIG noted high compliance in multiple areas, for example: facilities had designated Radiation Safety Officers; clinicians documented radiation doses as required by facility policy; and CT technologists were certified, received selected training, and had dosimetry monitoring. However, OIG identified a system weakness in which medical physicists did not consistently inspect CT scanners after repairs or modifications that affected the dose or image quality prior to returning the scanners to clinical service. [Click here to access report.]

Interim Summary Report on Patient Safety Concerns at the Washington DC VA Medical Center, Washington, DC
On March 21, 2017, a confidential complainant forwarded to OIG documents describing equipment and supply issues at the Washington DC VA Medical Center (the Medical Center) sufficient to potentially compromise patient safety. OIG promptly reviewed the documentation. On March 29, 2017, OIG deployed a Rapid Response Team to assess the allegations. OIG’s team conducted interviews, collected documents, and conducted a physical inspection of the Medical Center’s satellite storage areas on March 29–30, 2017. The team returned for an additional site visit on April 4–6, 2017, and was on-site for a third inspection at the time of this report’s publication. OIG has preliminarily identified a number of serious and troubling deficiencies at the Medical Center that place patients at unnecessary risk. Although OIG has not identified at this time any adverse patient outcomes, OIG found other issues. At least some of these issues have been known to VHA senior management for some time without effective remediation.
Although OIG’s work is continuing, OIG believed it appropriate to publish this Interim Summary Report given the exigent nature of the issues OIG has preliminarily identified and the lack of confidence in VHA adequately and timely fixing the root causes of these issues. OIG is also including recommendations for immediate implementation.

[Click here to access report.]

Clinical Assessment Program Reviews
In April 2017, OIG published three Clinical 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 ten activities:

1. Quality, Safety, and Value;
2. Environment of Care;
3. Medication Management;
4. Coordination of Care;
5. Moderate Sedation;
6. Community Nursing Home Oversight;
7. Management of Disruptive/Violent Behavior;
8. Mental Health Residential Rehabilitation Treatment Program;
9. Post-Traumatic Stress Disorder Care; and
10. Diagnostic Care.

Orlando VA Medical Center, Orlando, Florida
VA Central Iowa Health Care System, Des Moines, Iowa
Lebanon VA Medical Center, Lebanon, Pennsylvania

CRIMINAL INVESTIGATIONS

Veterans Health Administration Investigations

Non-Veteran Indicted for Theft in Connection with Health Care and Demands Against the United States
A non-veteran was indicted for theft in connection with health care and demands against the United States. An OIG and local sheriff’s office investigation resulted in charges that the defendant allegedly enrolled at the Minneapolis, MN, VA Medical Center (VAMC) using a fraudulent DD-214 and obtained over $100,000 in health care benefits. In addition, the defendant allegedly submitted the fraudulent DD-214 to the Veterans Benefits Administration, obtained a 30 percent disability rating, and subsequently received over $25,000 in disability compensation benefits.

Former Columbia, Missouri, VAMC Nurse Sentenced for Drug Diversion
A former Columbia, MO, VAMC licensed practical nurse was sentenced to 5 years’ supervised probation, 5 years’ incarceration (suspended), and was ordered to pay
restitution and court costs of $331 after pleading guilty to receiving stolen property. An OIG investigation revealed that for approximately 6 months the defendant diverted for personal use anywhere between 342 to 456 controlled substances from the medical center.

**Veterans Benefits Administration Investigations**

**Former VA Fiduciary Pleads Guilty to Exploitation and Fraud**
A former VA fiduciary pled guilty to financial exploitation of a disabled person, Medicaid fraud, and income tax fraud following their spouse being found guilty at trial of the financial exploitation of a disabled person. An OIG, Missouri Attorney General’s Medicaid Fraud Control Unit, Missouri Department of Health and Senior Services, and Missouri Department of Revenue investigation revealed that the two defendants, who co-owned a residential care facility and were assigned as the fiduciary for a mentally disabled veteran, embezzled a $209,235 retroactive VA benefit check. The defendants were supposed to deposit the check into a resident trust account, but instead, deposited the check into their own business account and used the funds for their personal gain to include purchasing three vehicles for their family. In addition, the defendants submitted over 1,000 false claims to Medicaid for nursing services that were not provided to the residents of their facility amounting to over $28,000 in Medicaid fraud. Finally, the defendants failed to file an income tax return, failed to pay their income tax liability, and attempted to evade income tax liability for tax year 2012.

**Former VA Fiduciary Arrested for Embezzling Funds**
A former VA fiduciary was arrested for embezzling VA, Social Security, and personal funds intended for her mother. An OIG, Social Security Administration (SSA) OIG, and local police investigation resulted in the defendant being charged with stealing $53,000 in VA beneficiary payments, $34,000 in Social Security payments, and $10,000 in personal funds. The fiduciary also allegedly failed to pay $28,000 in nursing home care for her mother.

**VA-Appointed Fiduciary Sentenced for Theft of Government Funds**
A VA-appointed fiduciary was sentenced to 5 years’ probation and was ordered to pay restitution of $47,720 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant misused funds intended for her veteran brother by using the funds to pay personal church tithes, her own mortgage, and various other expenses.

**Veteran Sentenced for “Stolen Valor”**
A veteran was sentenced to 21 months’ incarceration and was ordered to pay VA restitution of $322,654 after pleading guilty to wire fraud and “Stolen Valor.” An OIG and Federal Bureau of Investigation (FBI) investigation revealed that the defendant falsely claimed that he was awarded a Combat Action Ribbon (CAR) along with two Purple Heart medals after being injured by an Improvised Explosive Devise (IED) while serving in Iraq. As a result of his claims, the defendant fraudulently obtained VA compensation benefits, in addition to receiving a mortgage-free house from the Military
Warrior Support Foundation. The investigation further revealed that while the defendant did serve in the US Marine Corps, he was not awarded a CAR or Purple Heart medals. Also, the defendant was not injured by an IED explosion and did not engage in combat.

**Daughters of Deceased Beneficiaries Sentenced for Theft of Government Funds**
The daughter of a deceased VA and SSA beneficiary was sentenced to 5 years’ probation and was ordered to pay VA $262,163 and SSA $247,617 in restitution after pleading guilty to theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant received, forged, and negotiated VA and SSA benefit checks that were issued after her mother’s death in October 1988. In a separate case, the daughter of a deceased VA beneficiary was sentenced to 5 years’ probation and was ordered to pay VA $194,807 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after her mother’s death in January 1998.

**Son of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds**
The son of a deceased VA beneficiary pled guilty to theft of Government funds and also paid VA full restitution of $188,406. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited into his deceased mother’s bank account after her death in June 2003.

**Son of Deceased VA Beneficiary Indicted for Theft of Government Funds**
The son of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing approximately $182,000 in VA benefits that were direct deposited after his mother’s death in December 1995. The defendant wrote checks payable to himself and forged his deceased mother’s signature.

**Daughters of Deceased VA Beneficiaries Plead Guilty to Theft of Government Funds**
The daughter of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG and Department of the Treasury OIG investigation revealed that the defendant stole VA funds that were direct deposited after her mother’s death in July 1999. The defendant, who also forged VA documents, admitted to using the VA funds for her personal expenses. The loss to VA is $179,466. In a second case, the daughter of a deceased VA beneficiary pled guilty to theft of Government funds and Forging Endorsements on U.S. Treasury Checks. An OIG and FBI investigation resulted in the defendant being charged with stealing, forging, and negotiating approximately $147,000 in VA benefit checks that were issued after her mother’s death in August 1997.

**Son of Deceased VA Beneficiary Sentenced for Theft of Government Funds**
The son of a deceased VA beneficiary was sentenced to 3 years’ probation and was ordered to pay VA restitution of $126,821 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after his mother’s death in November 2004.
Other Investigations

Seven Defendants Sentenced for Health Care Fraud
Seven defendants pled guilty to various health care fraud related charges and were subsequently sentenced to a combined 295 months’ incarceration, 168 months’ supervised release, and were ordered to forfeit $66,704,316 in proceeds obtained by defrauding multiple Federal Government and private insurance programs. A VA OIG, Defense Criminal Investigative Service, Office of Personnel Management, Food and Drug Administration (FDA), Army Criminal Investigation Command, and U.S. Postal Service OIG investigation revealed that the defendants submitted false claims to the Department of Defense TRICARE health care program, the VA Civilian Health and Medical Program (CHAMPVA), other Federal insurance programs, and private insurance companies for compounded prescriptions. The compounded prescriptions were fraudulently dispensed without a physician’s authorization, were never dispensed, were returned, or were dispensed to TRICARE, CHAMPVA, and privately insured recipients without FDA approval.

Trucking School Officials Indicted for Wire Fraud
The president, vice president, and student coordinator of a trucking school were indicted for wire fraud for their roles in fraudulently enrolling at least 108 veterans who allegedly never attended or received training at the school. The vice president was subsequently arrested. A nationwide VA OIG, FBI, and Department of Justice OIG investigation resulted in charges that between 2011 and 2015 the defendants and veterans allegedly conspired to defraud VA of over $4.3 million. The involved veterans included Federal and State correctional officers, Federal employees, and a local police officer. The school received inflated, unearned tuition and fees ranging from between $5,000 and $13,000 per course, while the veterans received basic housing allowance and a books-and-supplies stipend totaling over $2,000 per month.

Health Care Company and Former Company President Plead Guilty to Charges Involving Manufactured Medical Devices
A health care company and its former president pled guilty to charges that included manufacturing medical devices without registering and introducing misbranded medical devices into commerce. As part of the plea agreement, the defendants are required to pay restitution of $211,691 to VA and a $500,000 fine. An OIG and FDA investigation revealed that the defendants produced bariatric beds, a Class II medical device, for sale and lease to VA at unregistered facilities. Subsequently, a new VA nursing care facility was delayed from opening on time because the beds were deemed to be defective and unusable.

Veteran and Non-Veteran Indicted for Service-Disabled Veteran-Owned Small Business Fraud
A veteran and a non-veteran business owner, as well as their respective companies, were indicted on multiple charges to include conspiracy, major fraud against the United States, wire fraud, and false statement. An OIG investigation resulted in charges that allege the defendants participated in a conspiracy to defraud the Government by
forming a joint venture and falsely representing that the joint venture and another company qualified as a Service-Disabled Veteran-Owned Small Businesses (SDVOSB). The defendants fraudulently obtained approximately $11 million in VA funded SDVOSB set-aside construction contracts or task orders. Four separate Federal search warrants executed at various business locations yielded vital documents and information supporting the indictment.

Kansas City, Missouri, Clinic Owner Pleads Guilty to Health Care Fraud and False Statements
The owner of a Kansas City, MO, clinic pled guilty to health care fraud and false statements after being charged in a health care fraud scheme. An OIG investigation revealed that the clinic was subcontracted by a VA contractor to provide VA disability examinations for local veterans. The examinations were performed in violation of the prime contractor’s contract with VA, which required that the examinations be conducted by a licensed and credentialed provider who had a clear and unrestricted license and was not excluded from participating in Federal health care programs. The investigation revealed that a total of 209 examinations were submitted for 53 veterans by an unlicensed person utilizing another doctor’s name and license without his permission.

Health Care Company Agrees to Reimburse VA
A contracted health care company agreed to reimburse VA $260,179 related to overcharging for MH care treatment visits. An OIG investigation revealed that the company overbilled VA by improperly coding Veterans’ care as a “vesting visit” when the care provided fell below the contractually defined level. The improper coding allowed the company to charge VA an increased monthly capitated rate. The company has further agreed to a continued review by VA of enrollment numbers at the affected facilities.

Veteran Pleads Guilty to Child Pornography
A veteran pled guilty to illegal use of a minor in nudity-oriented material or performance, pandering sexually oriented material involving a minor, and possessing criminal tools, with a forfeiture specification. An OIG and Ohio Adult Parole Authority investigation revealed that the defendant, while on post-release control through the state of Ohio, was viewing child pornography in the computer lab at the Cleveland, OH, VAMC domiciliary as well as on his personal electronic devices.

Undocumented Immigrant Sentenced for Identity Theft
An undocumented immigrant was sentenced to 60 days' incarceration, 48 months’ probation, and was ordered to pay restitution of $35,662 after pleading guilty to forgery and taking the identity of another. A VA OIG and SSA OIG investigation revealed that the defendant stole the identity of a deceased veteran approximately 20 years ago and used the identity to obtain SSA benefits in 2012 and VA benefits in 2016.

Non-Veteran Sentenced for Robbery
A non-veteran was sentenced to 84 months’ incarceration and 5 years’ supervised probation after pleading guilty to robbery of a post office located at the Perry Point, MD,
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VAMC. An OIG and U.S. Postal Inspection Service investigation revealed that the defendant and a second subject stole U.S. currency and more than 60 blank postal money orders during the robbery. The money orders were subsequently negotiated for $19,340.

Assaults and Threats Made Against VA Employees

Veteran Pleads Guilty to Making Threats
A veteran pled guilty to making an interstate threat to injure another. An OIG investigation resulted in the defendant being charged after he made a phone call to a Veterans’ crisis line operator in Portland, OR, and threatened to kill everyone at the Albany, NY, VAMC. The defendant is being held pending sentencing.

Administrative Investigation Advisories

OIG independently reviews allegations and conducts administrative investigations generally concerning high-ranking senior officials and other high profile matters of interest to Congress and the Department. While these reviews and investigations may result in the issuance of a formal report, they may also lead to the issuance of an administrative advisory to VA senior leadership. Administrative advisories are issued if allegations are substantiated but no recommendations are made or are unsubstantiated during the course of the investigation and there is a need to notify VA leadership of the investigative results.

A major component of OIG’s vision is an unwavering commitment to being a transparent organization. In keeping with this vision, OIG is maintaining transparency with veterans, Congress, and the public by releasing administrative investigation advisories issued by OIG. As other administrative investigation advisories are completed, they will be available on our website if they are not prohibited from public disclosure.

You may view and download these administrative investigation advisories and closure memoranda by clicking on the links below on our webpage.


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Michael J. Missal
Inspector General