Department of Veterans Affairs
Office of Inspector General
November 2017 Highlights

CONGRESSIONAL TESTIMONY

INSPECTOR GENERAL TESTIFIES BEFORE SENATE APPROPRIATORS AT HEARING FOCUSED ON PREVENTING OPIOID OVERMEDICATION OF VETERANS

Inspector General Missal testified before the U.S. Senate Committee on Appropriations' Subcommittee on Military Construction, Veterans Affairs, and Related Agencies. The testimony focused on the findings and recommendations from the Office of Inspector General's (OIG) recent report, *Healthcare Inspection—Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care*. Mr. Missal acknowledged that VA has made some significant steps in battling the opioid crisis, but noted there is much more work to be done. He explained that health information sharing between VA and non-VA providers has been a significant problem throughout the history of the Veterans Health Administration's purchased care programs. With respect to the Veterans Choice Program, the OIG found that a significant risk exists for patients who are prescribed opioid prescriptions outside of VA. Specifically, gaps in health information exchanges between VA and non-VA providers can put certain patients at significant risk for serious medication interaction and overdose. Those especially at risk include patients suffering from chronic pain and mental illness who receive opioid prescriptions from non-VA clinical settings where opioid prescribing and monitoring guidelines may conflict with VA guidelines. To close this gap and improve care coordination between VA and non-VA providers, the OIG made four recommendations: (1) requiring that all non-VA providers receive and review VA's opioid prescribing guidelines, (2) implementing a process to ensure all purchased care consults for non-VA care include a complete up-to-date list of medications and medical history, (3) requiring non-VA providers to submit opioid prescriptions directly to a VA pharmacy, and (4) ensuring that VA takes immediate action if a non-VA provider's opioid prescribing practices are determined to be in conflict with Opioid Safety Initiative guidelines. Mr. Missal stressed that the issues raised in his testimony and in the OIG's report merit serious consideration as Congress and VA work together to revamp Choice.

CRIMINAL INVESTIGATIONS

Veterans Health Administration Investigations

Former Leavenworth, Kansas, VA Medical Center Physician Assistant Sentenced for Sexual Battery

A former Leavenworth, KS, VA Medical Center (VAMC) physician assistant was sentenced to 187 months' incarceration, 36 months' supervisory probation, and was ordered to register as a sex offender for life after being convicted at trial of aggravated criminal sodomy, aggravated sexual battery, and sexual battery. An OIG and Leavenworth County Sheriff's Office investigation revealed that the defendant

committed sexual assaults during physical examinations. The defendant served as a primary care provider for the Operation Enduring Freedom/ Operation Iraqi Freedom (OEF/OIF) section that included 750 to 1,000 patients. During the investigation, the defendant confessed to over-prescribing narcotic medication as well as exceeding standard examination practices by administering unnecessary and excessive genital examinations to multiple male patients.

Bradenton, Florida, VA Community Based Outpatient Clinic Advanced Medical Support Assistant Pleads Guilty to Drug Diversion

An OIG investigation revealed that for over six months the defendant changed the addresses of 19 veterans in the Computerized Patient Record System (CPRS) to her own address. The defendant subsequently called the VA's consolidated mail outpatient pharmacy and ordered refills of the veterans' Tramadol prescriptions utilizing the veterans' Social Security numbers and prescription numbers. After receiving the shipments of Tramadol, the defendant changed the veterans' addresses in CPRS back to their correct address. The defendant diverted 28 shipments of Tramadol, totaling 4,020 pills. The defendant resigned from VA as a result of the investigation.

Sunrise, Florida, VA Community Based Outpatient Clinic Nurse Pleads Guilty to Drug Diversion

An OIG investigation revealed that the defendant diverted Fentanyl and Versed by substituting saline solution during gastrointestinal procedures. The defendant confessed to the diversion and resigned from VA employment.

A Former Fresno, California, VAMC Nurse Pleads No Contest to Obtaining a Controlled Substance by Fraud and Deceit

During an OIG investigation, the defendant admitted that she diverted Fentanyl from veterans for her own use.

Four Subjects Arrested for Drug Distribution at Bedford, Massachusetts, VAMC

OIG and Drug Enforcement Agency agents arrested four subjects and executed two search warrants related to illegal drug distribution at the Bedford, MA, VAMC. A fifth defendant remains a fugitive. The investigation determined that two veterans allegedly distributed crack cocaine from their apartments, located at the medical center, to veterans in VA substance abuse treatment programs. Further investigation identified the veterans' crack cocaine source as two known Boston, MA, gang members. In addition, the investigation developed evidence that an unrelated former VAMC employee was selling morphine and hydromorphone at the medical center.

Veterans Benefits Administration Investigations

Former Veterans Benefits Administration Employee Arrested for Wire Fraud, Bribery, and Theft of Government Funds

An OIG investigation resulted in charges that allege that the defendant fraudulently used the identities of multiple veterans to prepare special monetary payments that VA directly deposited into multiple bank accounts held either by the defendant or a co-defendant. The loss to VA is approximately $67,000.

Former VA Fiduciary Sentenced for Misappropriation

A former VA fiduciary was sentenced to four years' incarceration, three years' probation, and was ordered to pay restitution of $1,079,857 ($252,992 to VA) after pleading guilty to wire fraud, misappropriation by a federal fiduciary, and preparing fraudulent tax returns. An investigation by the OIG, Federal Bureau of Investigation (FBI), and Internal Revenue Service Criminal Investigations (IRS CI) revealed that from 2007 to 2012, the defendant served as a VA fiduciary for eight disabled veterans. The investigation further determined that the defendant embezzled VA-issued funds and used the money for personal expenses, including his own mortgage.

Veteran and Wife Plead Guilty to VA Compensation Fraud

A veteran pled guilty to conspiracy to commit an offense against the United States and his wife pled guilty to aiding and abetting in the theft of government funds. A VA OIG and Social Security Administration OIG investigation resulted in charges that the veteran exaggerated his injuries sustained while serving in OIF. The fraud resulted in the veteran being awarded service-connected disabilities for the loss of use of both feet and 100 percent post-traumatic stress disorder (PTSD). As a result of the fraudulent ratings, the veteran received services and benefits that he would not normally be entitled to receive, including housing adaptation, homemaker/home health care, and education benefits for his children. The veteran, while serving in Iraq, was injured by an improvised explosive device. After receiving surgery and treatment for his injury, the veteran improved but falsely claimed to various VA health care professionals that his condition was worse and he was unable to walk. Additionally, his wife falsified Social Security documents that resulted in the veteran obtaining additional government benefits. The loss to the government is approximately $837,000, including a loss to VA of approximately $594,000.

Veteran and Wife Indicted for VA Compensation Fraud

A veteran and his wife were indicted for wire fraud, mail fraud, conspiracy to commit health care fraud, false statements related to a health care matter, and aiding and abetting. An OIG investigation resulted in charges that allege that the veteran fraudulently received a 100 percent disability rating in 2012 for his loss of use of both feet, neurogenic bowel and bladder, PTSD, and migraines based on false statements made in 2011 during his military out-processing physicals and subsequent VA compensation and pension exams. Based on statements the veteran and his wife

made, the veteran also received Specially Adapted Housing and Automobile Adaptive Equipment grants. After receiving a home from a private charity in 2013, multiple witnesses, local media, and investigators observed the veteran walking, driving, performing yardwork, and playing basketball. The investigation resulted in VA canceling the veteran's service-connected disability. The loss to VA is $687,000, and the loss to the private charity Homes for Our Troops is $339,000.

Veteran Indicted for VA Compensation Fraud

A veteran was indicted for health care fraud and false statements relating to health care matters. An OIG and FBI investigation resulted in charges that allege that the defendant used an altered DD-214 reporting that he had 23 years of military service, to include serving in combat during the Gulf War and OIF. The investigation revealed that the defendant never left the United States during his two brief enlistments in the Army Reserve. The defendant falsely claimed to various VA health care professionals that while serving in Iraq he was exposed to gunfire, witnessed other solders die, and that he was injured by an improvised explosive device. The defendant was subsequently awarded an 80 percent service connection for multiple conditions including PTSD and was paid at 100 percent due to Individual Unemployability (IU). The defendant's spouse was also paid over $40,000 in VA Caregiver Support Program payments. The loss to VA is approximately $250,000.

Veteran Pleads Guilty to Theft of Government Funds and Wire Fraud

An OIG and U.S. Secret Service investigation resulted in charges that allege that the veteran and his girlfriend engaged in a scheme to defraud VA by having the veteran report to VA that he was unable to maintain substantially gainful employment as a result of his service-connected disabilities. The veteran subsequently received VA IU benefits from 2009 to 2017. The investigation further revealed that the veteran did maintain substantially gainful employment during most, if not all, of the time he was receiving IU benefits. The veteran's girlfriend admitted that she took steps to assist the veteran in concealing his employment from VA. The loss to VA is approximately $134,500.

Daughter of Deceased VA Beneficiary Pleads 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. The loss to VA is $186,947.

Son of Deceased VA Beneficiary Charged with Theft

An OIG investigation resulted in charges that allege that the defendant stole VA compensation benefits that were direct deposited after his father's death in September 2007. The defendant admitted to using the funds for various expenses related to his martial arts studio. The loss to VA is $167,193.

Grandson of Deceased Veteran Sentenced for Theft

The grandson of a deceased veteran was sentenced to 13 months' incarceration, three years' supervised probation, and was ordered to pay VA $143,106 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 his grandfather's death in May 2008.

Other Investigations

Parking Services Company Owner Arrested for Major Fraud Against the United States

An OIG, FBI, and IRS investigation resulted in charges that allege that the defendant bribed a VA Contracting Officer (CO) in order to commit fraud against VA. The defendant entered into a sharing agreement with VA, which required the defendant to pay 60 percent of collected gross parking revenue to VA. Instead, the defendant allegedly paid the CO approximately $286,000 in bribes between 2003 and 2017, which included "hush money," in order to continue the conspiracy even after the CO retired from VA. In addition, the defendant allegedly underreported income and overreported improvements to VA. Between 2003 and 2016, the defendant is alleged to have defrauded VA of approximately $11.4 million, not including unreported cash revenue. The execution of a search warrant at the defendant's residence resulted in the seizure of approximately $218,000, two brokerage accounts, six luxury vehicles, and one racing boat. The defendant is being held pending further judicial action.

Welding School Owner Charged with Wire Fraud Conspiracy and Making and Subscribing a False Tax Return

A VA OIG and IRS CI investigation resulted in charges that allege that the defendant provided false information to VA concerning the number of hours of instruction and the manner and quality of the instruction provided to enrolled veterans whose tuition was paid by VA. Investigators discovered that enrolled veterans rarely, if ever, received instruction from school employees. Many enrolled veterans visited the school only to sign-in to create the appearance that they were attending the required number of hours. In addition, the owner hired a recruiter who enrolled at least 20 veterans at the school. These veterans were told they would not have to attend classes, but that they could still receive their monthly housing allowance from VA. To date, VA has paid over $1.4 million to the school in tuition and over $1.1 million to veteran enrollees in housing allowances and book and supply stipends.

Defendants Sentenced for Service Disabled Veteran Owned Small Business Fraud

Two defendants were sentenced to three years' probation and each defendant was ordered to forfeit a personal money judgment of $250,000 to the United States after pleading guilty to attempt and conspiracy to commit wire fraud. A VA OIG, Small Business Administration (SBA) OIG, Defense Criminal Investigative Service, Department of Labor OIG, and FBI investigation revealed that the defendants were

owners of and/or officers in multiple companies, all being classified and operated as small businesses. All companies were, at some point, operated under the SBA 8(a) program or the VA Service Disabled Veteran Owned Small Business (SDVOSB) program. The investigation further revealed that beginning in February 2003 and continuing until October 2014, the defendants conspired with each other and other persons to defraud the United States and its agencies of over $140 million in contract payments from 8(a) and SDVOSB contracts for a profit of approximately $24 million. The VA contracts included *American Recovery and Reinvestment Act* funds and were worth approximately $7.9 million.

Construction Company Owner Indicted for Major Fraud Against the United States

An OIG and FBI investigation resulted in charges that allege that the defendant falsely claimed to VA that the construction company had paid its bond premium and was entitled to reimbursement under the Federal Acquisition Regulations. The defendant sent correspondence to VA seeking reimbursement for a bond premium of $532,000 and made false claims concerning the bond premium payment to the surety, including documents that purported to be copies of canceled checks indicating full payment of the bond premium. The construction company received approximately $3.7 million before they walked off the job site and VA terminated the contract for default.

Pharmacist Pleads Guilty to Conspiracy

A pharmacist, the first of numerous defendants, pled guilty to conspiracy to defraud the United States. A multi-agency investigation revealed that four compounding pharmacy companies falsely billed Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), TRICARE, and other health care benefit programs for compounded pharmaceuticals. From January 2012 to May 2015, the defendant dispensed prescriptions for high-yield compounded medications to beneficiaries of CHAMPVA, TRICARE, and other health care benefit programs for medications not necessary and induced by kickback payments. As a result, CHAMPVA, TRICARE, and other health care benefit programs were falsely billed by this company approximately $192 million for high-yield compounded medications. CHAMPVA was billed over $5 million and reimbursed this particular pharmacy $4.7 million in claims. Of that amount, VA was falsely billed $1,732,000.

Veteran Arrested for Sexual Exploitation of a Minor

An OIG, VA Police Service, FBI, and local police investigation resulted in charges that the defendant possessed child pornography images on his personal Apple iPad while at the Seattle, WA, VAMC.

Assaults and Threats Made Against VA Employees

Veteran Involuntarily Committed for Threats Against Las Vegas, Nevada, VAMC

A veteran was involuntarily committed for mental health treatment at the Las Vegas, NV, VAMC after threatening to shoot armed guards and anyone wearing a white coat at

the medical center. The veteran stated that he wanted to create as much publicity as possible by shooting VA employees with the intent of encouraging other veterans to do the same and also threatened violence if approached by law enforcement. The veteran was detained at his residence and agreed to a consent search that resulted in the seizure of a .45 caliber handgun and ammunition.

RECENTLY RELEASED REPORTS AND WORK PRODUCTS

Review of VA's Reimbursements to the Treasury Judgment Fund – The House of Representatives Committee on Appropriations requested an OIG review of VA's reimbursement of the Department of the Treasury's Judgment Fund relating to the payment of contractors for major medical construction projects to settle claims arising from contract disputes.

Review of Alleged Use of Inappropriate Wait Lists for Group Therapy and PTSD Clinic Team, Eastern Colorado Health Care System – The OIG reviewed allegations that the Eastern Colorado Health Care System (HCS) used unofficial wait lists for veterans waiting for various mental health group therapies. OIG also reviewed allegations that the Colorado Springs Community Based Outpatient Clinic (CBOC) did not take timely action on PTSD Clinic Team consults and falsified medical documentation following a veteran's suicide.

Audit of VA's Compliance with the Digital Accountability and Transparency Act – The OIG contracted with an independent public accounting firm for a performance audit to assess VA compliance with the *Digital Accountability and Transparency Act of 2014*.

Review of Claims Processing Actions at Pension Management Centers – The OIG conducted a review of Pension Management Centers' rating decisions that addressed original pension benefits and claims processing actions related to Medicaid-covered nursing homes.

Audit of Veterans Benefits Administration's National Pension Call Center – An audit was conducted to determine whether the National Pension Call Center is providing timely and quality assistance to veterans and their families.

Audit of VA's Financial Statements for Fiscal Years 2017 and 2016 – The independent public accounting firm, CliftonLarsonAllen LLP, under contract to the OIG, audited VA's financial statements as of September 30, 2017 and 2016. This audit is an annual requirement of the *Chief Financial Officers Act of 1990*.

Unexpected Death of a Patient: Alleged Methadone Overdose, Grand Junction VA HCS, Grand Junction, Colorado – The OIG conducted a healthcare inspection in response to an allegation received in 2016 that a patient died of an accidental methadone overdose two days after receiving a prescription for methadone from a primary care physician at the Grand Junction VA HCS.

Mental Health Care Concerns, Atlantic County CBOC, Northfield, New Jersey –In response to requests from Senator Cory Booker, Senator Robert Menendez, and

Congressman Frank LoBiondo, the OIG conducted a healthcare inspection to assess concerns that a patient's insufficient access to timely mental health care may have contributed to the patient's suicide and that general access to mental health care was limited at the Atlantic County CBOC, Northfield, NJ.

Patient Death Following Failure to Attempt Resuscitation, VA Ann Arbor HCS, Ann Arbor, Michigan – The OIG conducted a healthcare inspection to evaluate the circumstances that led to the failure to resuscitate a patient with full-code resuscitation status who died at the VA Ann Arbor HCS.

Administrative and Clinical Concerns, Central California VA HCS, Fresno, California – To address concerns received from Congressman Jim Costa in 2014, the OIG conducted a healthcare inspection regarding allegations from an anonymous complainant of Emergency Department-boarded patients' length of stay, poor inpatient flow, and nurse staffing shortages at the Central California VA HCS.

Evaluation of System-Wide Clinical, Supervisory, and Administrative Practices, Oklahoma City VA HCS, Oklahoma City, Oklahoma – The OIG conducted an inspection in response to Senator James Inhofe's request to evaluate clinical, supervisory, and administrative practices at the Oklahoma City VA HCS. OIG staff also evaluated the HCS Director's concerns and coordinated parts of this review with The Joint Commission. OIG's comprehensive review identified multiple program areas, processes, and operations needing improvement.

Comprehensive Healthcare Inspection Program Reviews

Comprehensive Healthcare Inspection Program (CHIP) reviews are performed approximately every three years for each facility. OIG selects and evaluates specific areas of focus on a rotating basis each year. OIG has seven current areas of focus:

(1) Leadership and Organizational Risks
(2) Quality, Safety, and Value
(3) Medication Management
(4) Coordination of Care
(5) Environment of Care
(6) High-Risk Processes
(7) Long-Term Care

VA Long Beach HCS, Long Beach, California

James J. Peters VAMC, Bronx, New York

Administrative Investigation Advisory

Alleged Misuse of Official Time, VA Long Beach HCS, Long Beach, CA – The OIG reviewed allegations that a physician frequently falsified his own timecards to work in private practice, gave preferential treatment to three other physicians to arrange their schedules irrespective of veterans' needs, and provided personal medical services to an

employee of Veterans Integrated Services Network 22 at his private practice during his VA tour of duty.

Administrative Summary of Investigation

Allegations Regarding Patient Wait Times, VAMC Fayetteville, North Carolina – The OIG conducted an investigation pursuant to complaints alleging that 1,400 Dermatology Clinic appointments were canceled from 2011 through 2012, senior leaders had improperly instructed staff to delete the appointments and consults, and Radiology Clinic staff deleted several old imaging studies with no concern as to whether the patients ever received the needed care.

Internal OIG Investigation

Discriminatory Hiring Action by Senior OIG Staff (2015–2016) – An internal OIG investigation focused on an allegation that in 2015 and early 2016, several senior OIG employees discriminated against an individual with a hearing impairment who applied for an information technology-related position.

MICHAEL J. MISSAL
Inspector General