Congressional Testimony

Bedford Director for Audits and Evaluations Participates in House Veterans’ Affairs Committee Roundtable on Current Practices and Future Trends in VA Prosthetic Care

Dr. Irene Barnett, Director of the Bedford, Massachusetts, Office of Audits and Evaluations, participated in a roundtable discussion focused on VA prosthetics hosted by the House Committee on Veterans’ Affairs Subcommittee on Health. Roundtables are informal gatherings of members of Congress, VA officials, veteran service organizations, and other stakeholders or subject matter experts that allow for more open dialogue about topics of interest in a small group setting. The roundtable focused on VA’s proposed rule that could affect the process for determining veterans’ eligibility for receiving prosthetic care. The Office of Inspector General (OIG) was invited to attend and discuss its recent report, *VA Southern Nevada Healthcare System’s Alleged Unnecessary Use of Outside Vendors to Purchase Prosthetics*. Dr. Barnett shared insights and findings from that report and highlighted other ongoing relevant OIG projects.

Criminal Investigations for Health Care

Veterans Health Administration Office of Community Care Employee Indicted for Conflict of Interest

A Veterans Health Administration (VHA) Office of Community Care employee in Denver, Colorado, was arrested after being indicted for conflict of interest. An investigation by the OIG, Federal Bureau of Investigation (FBI), and Internal Revenue Service Criminal Investigation Division (IRS-CI) resulted in charges that allege the defendant referred seven spina bifida beneficiaries to a home health agency owned by his wife from September 2017 through June 2018. VA consequently paid his wife approximately $4.3 million during that timeframe, mostly due to retroactive claims. In total, this investigation identified almost $20 million paid to home healthcare agencies owned by the employee’s relatives and associates for the care of 49 beneficiaries. Over 40 seizure warrants were simultaneously executed on accounts owned by the defendant, his relatives, and associated home healthcare agencies, resulting in a forfeiture of nearly $3.2 million. Eight vehicles were also seized under the warrants with a value to be determined.

Home Healthcare Employee Indicted for Destruction, Alteration, or Falsification of Records in a Federal Investigation

A home healthcare company employee, who provided care to veterans as part of the community care program, was indicted for destruction, alteration, or falsification of records in a federal investigation. A VA OIG, FBI, and Department of Health and Human Services (HHS) OIG investigation resulted in charges that allege the defendant altered therapy notes for patients in order to obstruct the investigation.
of a home healthcare company that is under investigation for fraudulently billing VA and Medicare. The projected loss to the government is approximately $1 million; VA’s loss is approximately $600,000.

Individual Sentenced for Identity Theft Scheme
An individual was sentenced to 116 months’ imprisonment, three years’ supervised release, and was ordered to pay over $435,400 in restitution and $26,800 in forfeiture. A VA OIG, IRS-CI, and Tampa Police Department investigation revealed that the defendant illegally obtained numerous records maintained by the James A. Haley Veterans’ Hospital, Tampa, Florida, containing personally identifiable information from at least 20 veterans, and proceeded to file fraudulent tax returns and open lines of credit in the victims’ names.

Providence, Rhode Island, VA Medical Center Intensive Care Unit Nurse Indicted for Drug Tampering and Diversion
A Providence, Rhode Island, VAMC Intensive Care Unit nurse was indicted after confessing to tampering with pre-packaged fentanyl and hydromorphone syringes. A VA OIG, VA Police Service, and Food and Drug Administration (FDA) investigation resulted in charges that allege the defendant would withdraw the narcotic, inject saline back into the syringe, and place the tampered syringe back into the automated medication dispensing system for use on patients.

Veteran Indicted on Child Pornography Charges
A veteran was indicted and arrested for possession of visual depictions of minors engaging in sexually explicit conduct. An OIG investigation resulted in charges that allege the defendant possessed three thumb drives containing approximately 900 images of child pornography while residing at the Brockton Campus of the VA Boston HCS, Massachusetts. The National Center for Missing and Exploited Children confirmed that over 500 of the images were of known victims of child exploitation.

Veteran Pled Guilty to Distribution of Heroin
A VA OIG and FBI investigation revealed that while a veteran was an inpatient at the VA Ann Arbor HCS, Michigan, the defendant introduced a mixture of heroin and fentanyl into the facility and provided a portion to another inpatient that resulted in his death.

Veteran Arrested for the Distribution of Controlled Pharmaceuticals
A veteran was arrested for the distribution of controlled pharmaceuticals at the West Haven Campus of the VA Connecticut HCS. The arrest was based on an ongoing OIG and local police investigation targeting the illegal sale of street and prescription drugs at the campus. When arrested, the defendant was accompanied by a four-year-old child whom he planned to bring to a scheduled drug transaction. As a result, the defendant faces additional criminal charges relating to child endangerment. To date, this investigation has identified multiple defendants involved in the alleged drug distribution at the campus.
Criminal Investigations for Benefits

Veteran Indicted for Bank Fraud, Wire Fraud, and Money Laundering
A veteran, who is a licensed attorney, was indicted and arrested on charges of bank fraud, wire fraud, and money laundering. A VA OIG, Small Business Administration (SBA) OIG, and FBI investigation resulted in charges alleging the defendant executed a scheme that involved the use of false information about his business and personal income to obtain a personal loan for $2.9 million from a federally insured bank. The defendant obtained the loan through VA’s Home Loan Guaranty Program. Because the defendant failed to make the required monthly mortgage payments, the home is now in foreclosure. The defendant also provided false information about his law office’s and personal income to secure a $250,000 business loan through SBA’s loan guaranty program.

Veteran Pled Guilty to False Statements
A veteran pled guilty to false statements after an OIG investigation revealed the defendant obtained VA Individual Unemployability compensation benefits while owning and operating a construction company. The loss to VA is over $235,000.

Nonveteran Pled Guilty to Theft of Government Funds
A nonveteran pled guilty to theft of government funds following an OIG investigation that revealed he forged the discharge certificate (DD-214) he submitted to VA, falsely claiming to have served in the U.S. Marine Corps during the Korean War and received the Purple Heart for being shot during a battle. The defendant received approximately $219,700 in VA pension and healthcare benefits over a 12-year period, to include attending a residential VA Blind Rehabilitation program with limited admissions.

Two Individuals Charged in Compensation Benefits and VA Caregiver Support Scheme
A nonveteran and his veteran brother, a former Miami, Florida, VA HCS police officer and HHS OIG special agent, were indicted for conspiracy, theft of government funds, and false statements. The nonveteran was subsequently arrested at Miami International Airport as he returned from Europe. A VA OIG investigation resulted in charges alleging that while he was employed as a special agent with HHS OIG, the veteran made false statements and provided forged medical records to the Veterans Benefits Administration (VBA) and Miami, Florida, VA HCS. As a result, the veteran obtained increased VA disability benefits. The nonveteran also received VA Caregiver Support stipends because he was named as his brother’s caregiver. The loss to VA is over $100,000.

Criminal Investigations for Other Matters

Defendant Sentenced for Role in Procurement Fraud Scheme
A defendant was sentenced to 72 months’ imprisonment, three years’ supervised release, and ordered to forfeit approximately $2.7 million after pleading guilty to wire fraud. A VA OIG, Air Force Office of Special Investigations, Army Criminal Investigations Division, Defense Criminal Investigative Service
(DCIS), Department of Energy OIG, Department of Agriculture OIG, and SBA OIG investigation revealed that the defendant and associates fraudulently obtained over $350 million dollars in government set-aside construction contracts. Of this amount, VA’s share of the contracts totaled $26.3 million. The subjects provided false information to VA and SBA in order to qualify for the set-aside contracts. Five additional business associates, including a service-connected disabled veteran, were previously sentenced. One remaining defendant is awaiting sentencing. Also resulting from this investigation, 11 associated companies and five defendants were suspended and subsequently debarred from obtaining future government contracts until March 2021.

**Three Subjects Charged for Participating in a Compound Pharmacy Fraud Scheme**

Three owners/controllers of multiple pharmacies were indicted for conspiring and engaging in a scheme to defraud the U.S. government and private healthcare insurance companies of more than $200 million across multiple states. A VA OIG, FBI, IRS-CI, DCIS, Mississippi Bureau of Narcotics, Department of Labor (DOL) OIG, HHS OIG, and U.S. Postal Inspection Service investigation resulted in charges that allege the defendants fraudulently formulated, marketed, prescribed, and billed for compound medications produced and dispensed by pharmacies in southern Mississippi. As a result of the fraudulent activity, the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) paid these pharmacies approximately $2.4 million.

**Thirteen Subjects Charged for Participating in a Workers’ Compensation Scheme**

Thirteen individuals were charged with variations of conspiracy and fraud offenses, as well as violations of the Anti-Kickback Statute, relating to their involvement in a scheme to defraud DOL’s Office of Workers’ Compensation Program. The defendants included doctors, pharmacists, marketers, pharmacy owners, and health clinic owners. A VA OIG, DOL OIG, U.S. Postal Service OIG, and DCIS investigation resulted in charges that allege since September 2014, the defendants conspired to unlawfully bill multiple federal agencies for services that were not medically necessary and for services that were induced by kickbacks and bribes. The loss to VA is currently $2.3 million, and the overall loss to the government is approximately $40 million.

**Construction Company Owner and a Veteran Arrested for Role in Service-Disabled Veteran-Owned Small Business Scheme**

A construction company owner and his veteran brother-in-law were arrested for conspiracy, major fraud against the United States, and false statements. An investigation by the VA OIG and Air Force Office of Special Investigations resulted in charges alleging the defendants participated in a pass-through scheme wherein the veteran, who obtained service-disabled veteran-owned small business (SDVOSB) status for a sham construction company, received set-aside government contracts and passed through all the work to his nonveteran brother-in-law, who owned a legitimate construction company. As a result, the defendants’ companies unlawfully executed 11 VA and Air Force SDVOSB set-aside contracts valued at $3.3 million. The VA contracts were valued at approximately $760,000.
Audits and Reviews

Unwarranted Medical Reexaminations for Disability Benefits
The OIG reviewed reexamination requests by VBA and estimated that, from March through August 2017, VBA spent $10.1 million on unwarranted reexaminations. The OIG estimated that VBA would waste an additional $100.6 million over the next five years unless it ensures that employees only request reexaminations when necessary. VBA policy requires a review of the veteran’s claims folder before requesting a reexamination. VA Regional Office managers routinely bypassed the pre-exam review and routed these cases for scheduling the reexamination. The OIG made four recommendations including establishing internal controls to ensure that a reexamination is necessary, prioritizing the design and implementation of system automation to minimize unwarranted reexaminations, enhancing VBA’s quality assurance reviews of requested reexaminations, and conducting a focused quality improvement review of cases with unwarranted reexaminations to understand and redress the causes of avoidable errors.

Alleged Split Purchases at the VA St. Louis Health Care System, Missouri
The OIG substantiated that purchase cardholders at the VA St. Louis HCS, Missouri, split purchases in violation of regulations and policy to install firestops (passive fire control components) at its facilities. In total, the OIG identified 235 purchases for firestops and other unrelated construction work valued at about $564,000 that were unauthorized commitments and improper payments. The OIG found that employees were following guidance from the HCS Accounting Department that was in direct conflict with Federal Acquisition Regulation requirements and annual purchase card training. Cardholders and approving officials did not have a clear understanding of what represented a “split purchase.” The OIG made three recommendations, including submitting ratification requests for the improperly made purchases, providing additional training on how to avoid split purchases and comply with micro-purchase thresholds, and establishing a rigorous monitoring mechanism to identify and prevent improper purchase card transactions.

Healthcare Inspections

Supervision and Care of a Residential Treatment Patient at a Veterans Integrated Service Network 10 Medical Facility
The OIG evaluated the overdose death of a patient in a residential treatment program at a Veterans Integrated Service Network (VISN) 10 medical facility. The purpose of the inspection was to review the supervision and care of the patient while enrolled in the program. The OIG identified issues relating to the supervision of the patient, including inconsistent facility policy direction for patient check-ins, staff compliance with policies or procedures regarding the management of patient check-ins and missing patients, and random screening of patients for drug and alcohol abuse. The OIG also identified issues relating to the quality of care of the patient. The OIG made five recommendations to the facility Director.
related to the development and implementation of uniform program policies and a comprehensive interdisciplinary plan, provision of daily services, the reassessment of patient privileges, and accurate electronic health record documentation.

**Delays in Urological Care and Alleged Lack of Non-VA Care Funding at the Beckley VA Medical Center, West Virginia**

The OIG conducted an inspection at the Beckley VAMC in West Virginia regarding allegations that delays in urological care and an increase in a kidney lesion’s size adversely impacted a patient’s urological health. The review further evaluated whether other patients experienced delays in urological care. The OIG substantiated the patient experienced delays in urological care, including kidney surgery, and that a kidney lesion increased in size. However, the lesion size was not within the range that necessitated immediate intervention. The OIG did not find that delays caused an adverse clinical impact to the patient’s urological health. The OIG also identified delays in scheduling urology consults for the VAMC’s Outpatient Urology Clinic but determined none of the reviewed patients experienced an adverse clinical impact to their urological health. The OIG made one recommendation related to reviewing consult management practices and ensuring consult timeliness.

**Alleged Inappropriate Anesthesia Practices at the James E. Van Zandt VA Medical Center, Altoona, Pennsylvania**

The OIG conducted an inspection in response to a complainant’s allegations regarding an anesthesiologist who provided outpatient sedation services at the James E. Van Zandt VAMC. The OIG did not substantiate that the anesthesiologist failed to follow VHA and facility policies for controlled medication waste because the anesthesiologist documented that the entire amount was used. The OIG also did not substantiate an allegation that the anesthesiologist failed to individualize patient medication dosing. The OIG did substantiate, however, allegations that the anesthesiologist used more anesthetic/sedation medication for outpatient procedures than FDA-approved manufacturer’s instructions recommended and that facility leaders did not provide adequate oversight of the anesthesiologist according to VHA and facility privileging and monitoring policies. The OIG made four recommendations related to anesthesia needs and services, provider oversight, National Practitioner Data Bank and State Licensing Board reporting, and Patient Advocate Tracking Systems database requirements.

**Alleged Inappropriate Controlled Substance Prescribing Practices at a Veterans Integrated Service Network 20 Medical Facility**

The OIG conducted an inspection in response to a complaint that a primary care provider at a VISN 20 facility continued to prescribe controlled substances to a patient at high risk for overdose. The OIG substantiated that the primary care provider was aware the patient was getting controlled substances from outside pharmacies and had a history of benzodiazepine abuse. The OIG also substantiated that the care provider prescribed the patient with controlled substances when he was no longer the patient’s provider. The OIG could not substantiate that the provider had a reputation of prescribing narcotics.
“recklessly” or that the provider was warned about his prescribing practices. The OIG reviewed the facility’s policies on controlled substance prescribing and identified limitations in oversight. The OIG made one recommendation to the VISN director to review the patient’s care and provider’s practice and seven recommendations to the facility director related to prescribing practices and peer review processes.

**Patient Overdose Death in a Residential Rehabilitation Treatment Program at a Veterans Integrated Service Network 1 Medical Facility**

The OIG reviewed the circumstances surrounding a residential rehabilitation treatment program’s patient death from heroin overdose at a VISN 1 medical facility. The OIG determined that protocols were not in place for initiating patients’ medication-assisted therapy. The OIG made recommendations related to that gap in protocols, compliance with no-show policies, and staff training on no-show procedures.

**Comprehensive Healthcare Inspection Program Reviews**

Comprehensive Healthcare Inspection Program (CHIP) reviews are one element of the OIG's overall efforts to ensure that the nation’s veterans receive high-quality and timely VA healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year. The following are OIG’s current areas of focus:

1. Leadership and Organizational Risks;
2. Quality, Safety, and Value;
3. Credentialing and Privileging;
4. Environment of Care;
5. Medication Management;
6. Mental Health Care;
7. Long-Term Care;
8. Women’s Health; and

In the month of July, CHIP reviews were published for the following sites:

**VA Palo Alto Health Care System, California**

**VA San Diego Healthcare System, California**

To listen to the podcast on the OIG’s July 2018 activity highlights, go to [www.va.gov/oig/podcasts](http://www.va.gov/oig/podcasts).