AUGUST 2018 HIGHLIGHTS

Criminal Investigations for Health Care

Former East Orange, New Jersey, VA Medical Center Physician Sentenced for Fraud Scheme

A VA Office of Inspector General (OIG), Federal Bureau of Investigation (FBI), and Department of Health and Human Services (HHS) OIG investigation revealed that on more than 350 occasions between 2011 and 2015, the defendant submitted documentation to VA in which he claimed to have performed procedures that he had not actually performed. The former VA physician who was contracted to perform medical procedures at the East Orange, New Jersey, Veterans Affairs Medical Center (VAMC) on a fee basis was sentenced to 20 months' imprisonment and 24 months' supervised release. The defendant was also ordered to pay restitution of approximately $238,000 to VA, an additional forfeiture of more than $238,000, and a fine of $7,500. As the result of a civil settlement, the defendant must pay an additional $476,460.

Non-Veteran Pled Guilty to Aggravated Identity Theft and Theft of Government Funds

An OIG investigation revealed that the defendant assumed the identity of a veteran patient for the purposes of obtaining VA medical care. From 2005 to 2018, the defendant used the name, social security number, and date of birth of an eligible veteran to fraudulently receive medical care, narcotics, medical equipment, and housing assistance from VA, which were collectively valued at over $133,000.

Former Marion, Indiana, VA Medical Center Nursing Assistant Convicted of Criminal Deviant Conduct

A former Marion, Indiana, VAMC nursing assistant was convicted of criminal deviant conduct after a four-day jury trial. An OIG and VA Police Service investigation revealed that the defendant performed a sexual act on a patient who was living in the VAMC's dementia ward.

Criminal Investigations for Benefits

Owner of a Dog-Handling School Indicted for Charges Related to Educational Benefits Fraud

An OIG, Internal Revenue Service Criminal Investigation (IRS-CI), and FBI investigation resulted in charges that allege the owner of a San Antonio-based dog-handling school fraudulently obtained VA approval to receive licensure to operate in the state by submitting multiple material false statements regarding its certifications and instructors on staff as well as falsified certification materials to the State of Texas. The owner of the school was indicted for wire fraud, aggravated identity theft, and money laundering. The loss to VA is approximately $1.2 million in educational benefits.

Former Philadelphia, Pennsylvania, Veterans Affairs Regional Office Employee Pled Guilty to Wire Fraud and Identity Theft

A former Philadelphia Veterans Affairs Regional Office employee pled guilty to wire fraud and aggravated identify theft in a scheme to defraud VA of approximately $838,000. An OIG investigation revealed the defendant's duties included the review, approval, and authorization of veterans' benefits claims. The defendant accessed the personally identifiable information (PII) of veterans and their spouses to manipulate preexisting claims and to create fake claims. Prior to authorizing the fictitious or altered claims, the defendant changed the direct deposit claim information to divert the stolen funds to his co-conspirators' accounts. After receiving the direct deposits from VA, his co-conspirators provided the defendant with a kickback. The defendant manipulated records internally to avoid detection in this scheme. As a result of this investigation, nine individuals were arrested and convicted.

Former VA Field Examiner Convicted of Multiple Criminal Charges

A VA OIG and Office of Personnel Management (OPM) OIG investigation revealed that while the defendant was a field examiner, he drafted a will for an incompetent veteran and deceptively inserted his name as the sole beneficiary of the veteran's finances, valued at approximately $680,000. The defendant also lied to VA about his own purported disabilities to obtain a 100-percent permanent and total disability rating. After resigning, the defendant lied on his application to be a "background investigator" with OPM. The loss to VA due to his false benefit claims is approximately $320,000. He was convicted of wire fraud, mail fraud, theft of public money, conflict of interest, and false statements.

Veteran and Spouse Indicted for Conspiracy and Theft of Government Property

A VA OIG and Social Security Administration (SSA) OIG investigation resulted in charges that allege the veteran, with assistance from his wife, fraudulently led VA and SSA to believe he was completely blind, which qualified him for special monthly compensation and other VA benefits. The investigation determined that the veteran was able to drive, operate machinery, and perform other normal daily activities without the assistance of another person or low-vision aids. The total loss to the government is over $227,000, which includes VA's loss of over $116,000.

Veteran Pled Guilty to Theft of Government Funds

A VA OIG and SSA OIG investigation revealed that the defendant made false statements to VA and SSA to receive VA Individual Unemployability benefits and increased SSA benefits. The total loss to the government is approximately $262,000, which includes VA's loss of approximately $108,000.

Criminal Investigations for Other Matters

Former Government Contractor Sentenced for Role in Procurement Fraud Scheme

A former government contractor who illegally managed and controlled a Kansas City Service-Disabled Veteran-Owned Small Business (SDVOSB) construction company was sentenced to 18 months' imprisonment without parole and three years' supervised release for his role in a "Rent-A-Vet" scheme

to fraudulently obtain $13.7 million in VA contracts for work in nine states. The defendant also consented to a federal civil forfeiture of approximately $2.1 million. A VA OIG investigation, with assistance from the General Services Administration OIG, revealed that the defendant used a veteran's Service-Disabled Veteran (SDV) status to create a "pass-through" company to obtain 20 set-aside SDVOSB and Veteran-Owned Small Business contracts. The work was then subcontracted to the defendant's non-SDVOSB company, which he owned. Sentencing is pending for the veteran.

Business Owner Sentenced for Role in Procurement Fraud Scheme

An OIG investigation revealed that the defendant recruited an SDV to falsely claim majority ownership in his small business to fraudulently obtain SDVOSB status. As a result, the defendant's Houston-based company unlawfully obtained 12 VA set-aside contracts valued at approximately $1.64 million. The company owner was sentenced to 12 months and one day of incarceration, two years' supervised release, and was ordered to pay approximately $450,000 in restitution to VA.

Individual Sentenced for Healthcare Fraud Scheme

An individual who previously pled guilty to conspiracy to commit healthcare fraud was sentenced to 36 months' imprisonment, three years' supervised release, and was ordered to repay over $4.7 million in restitution to the government. Of this amount, approximately $655,000 will be paid to VA. The VA OIG, Defense Criminal Investigative Service, OPM OIG, FBI, and HHS OIG investigation revealed that the defendant and three codefendants created a fraud scheme by which TRICARE and the Civilian Health and Medical Program of the VA were billed approximately $5 million for unnecessary lab testing. Sentencing of the other three defendants is pending.

Construction Company Owner Pled Guilty to Major Fraud against the United States

An OIG and FBI investigation revealed the defendant falsely claimed to VA that the construction company had paid its bond premium and was entitled to reimbursement under Federal Acquisition Regulations. The defendant sent correspondence to VA seeking reimbursement for a bond premium of roughly $532,500 and made false representations concerning the bond premium payment to the surety, to include documents that purported to be copies of canceled checks indicating full payment of the bond premium. The construction company also received approximately $3.7 million from VA before workers walked off the job site and VA terminated the contract for default.

Former Case Manager of a Nonprofit Organization Sentenced for Grant Fraud

A former case manager of a nonprofit organization funded by a Supportive Services for Veteran Families (SSVF) grant was sentenced to 12 months' imprisonment and 36 months' probation. The OIG investigation revealed that the defendant diverted SSVF grant funds by fraudulently using the PII of homeless veterans. The SSVF grant funds were supposed to be used to assist homeless veterans find housing, but the defendant instead used those funds to pay his own rent. The loss to VA is approximately $26,300.

San Diego, California, VA Medical Center Outpatient Arrested for Threatening a VA Employee

A San Diego, California, VAMC outpatient was arrested for "influencing, impeding, or retaliating" against a federal official. An OIG investigation resulted in charges that allege the defendant threatened a VA employee by telephone after he was denied caregiver-related benefits. A prior OIG investigation resulted in the indictment and arrest of this same defendant for similar threats in 2016.

Administrative Investigations

Misuse of Time and Resources within the Veterans Engineering Resource Center in Indianapolis, Indiana

The VA OIG Administrative Investigations Division sustained an allegation that a Supervisory Industrial Engineer misused VA time and resources to start a privately-owned business and solicited subordinate staff to join this business. The OIG found that the engineer, who worked within the Veterans Health Administration (VHA) Office of Strategic Integration's Veterans Engineering Resource Center (VERC), used a VA email account to communicate with subordinate staff, criticize VERC restructuring, and propose they use their collective experience to create a company to offer services to outside organizations. The OIG found VA time and resources were misused to conduct non-VA business during and after official duty hours. At one point, 43 VA employees, most of whom have since left VA, were on the company roster. The OIG also found that the engineer misused his VA email on several occasions to manage multiple personally-owned rental properties.

Audits and Reviews

Program of Comprehensive Assistance for Family Caregivers: Management Improvements Needed

The OIG audited VHA's Program of Comprehensive Assistance for Family Caregivers, which pays a monthly stipend to caregivers of eligible veterans, from June 2017 through June 2018 to determine if VHA effectively provided program services. The OIG found that coordinators did not determine eligibility within the required 45 days for about 65 percent of the 1,822 veterans approved from January through September 2017. The OIG also found that four percent of the 1,604 veterans discharged from the program from January through September 2017 were never eligible. As a result, VHA made about $4.8 million in improper payments. The OIG recommended ensuring additional program oversight, proper program criteria application to ensure eligibility, application processing within required timelines, consistent monitoring and documenting of veterans' health status, and guidelines for when a veteran's need for care changes.

Processing Inaccuracies Involving Veterans' Intent to File Submissions for Benefits

The OIG conducted a review to determine whether Veterans Benefits Administration (VBA) staff assigned correct effective dates on claims for compensation benefits with an intent to file (ITF). An ITF

allows claimants the opportunity to provide minimal information related to the benefit sought and up to one year to submit a complete claim. VA may use the date of receipt of an ITF as an earlier effective date for paying benefits. The OIG found that VBA staff did not always assign correct effective dates from March 24, 2015, to September 30, 2017, resulting in over $72 million in improper payments. Most errors occurred during the initial period of ITF implementation. This was largely due to lack of standard operating procedures, inadequate procedural guidance for electronic ITF submissions, deficient and delayed training, and lack of functionality in the Veterans Benefits Management System (VBMS). The OIG recommended modernizing the ITF system and possibly integrating submissions into the VBMS. In addition, the OIG recommended a special review of ITFs submitted during the period of concern.

Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma

The OIG reviewed VBA's denied claims related to veterans' military sexual trauma (MST) to determine whether staff correctly processed the claims. Due to multiple factors, service members often do not report MST when it occurs. If the MST leads to posttraumatic stress disorder, it is often difficult for victims to produce supporting evidence. VBA policy requires additional steps for processing these claims. The OIG estimated that about half of the MST-related claims denied during the audit period from April 2017 through September 2017 were incorrectly processed due to the lack of reviewers' specialization, no additional level of review, discontinued special focus reviews, and inadequate training.

Use of Not Otherwise Classified Codes for Prosthetic Limb Components

The OIG substantiated allegations received in 2016 alleging VHA was overpaying for prosthetic items because it incorrectly used Not Otherwise Classified (NOC) codes on items for payment to vendors. Incorrectly using an NOC code can result in an overpayment because the payments are not based on preestablished reimbursement rates. The OIG found that VHA overpaid vendors about $7.7 million from October 2014 through July 2017. Prosthetists incorrectly used NOC codes because they were either unaware of the existing codes or because they allowed vendors to classify the items. The OIG made five recommendations, including determining which codes are appropriate to classify prosthetic items for reimbursement, establishing oversight for the approval of recommended classification codes, developing processes to monitor the use of NOC codes, and establishing pricing guidance that ensures VA pays a fair price for items classified using an NOC code.

Accuracy of Effective Dates for Reduced Evaluations Needs Improvement

The OIG reviewed whether VBA accurately notified veterans of proposed reductions based on their disability evaluations and assigned correct effective dates for those reductions. The OIG estimated that 38 percent of cases reviewed were processed incorrectly by VBA staff, resulting in an average improper payment rate of $2,000 per veteran. If no changes were made to VBA practices, OIG estimated that over a five-year period, similar errors would result in improper payments to 22,300 veterans totaling over $27.5 million. The OIG recommended VBA implement a plan to ensure the timely processing of these cases, modify the Veterans Benefits Management System to apply correct effective dates, provide

refresher training to processors, update guidance on when to send notifications when a reason for reduction changes, and conduct periodic reviews for veterans who had benefits reduced based on erroneous notification dates.

Healthcare Inspections

Postoperative Care Concerns for a Vascular Surgical Patient at the Martinsburg VA Medical Center, West Virginia

The OIG conducted a healthcare inspection at the request of Senator Joe Manchin to review the postoperative care of a patient who had vascular surgery at the Martinsburg VAMC. In general, the OIG team found the patient's immediate postoperative care was proper. However, the OIG had concerns with the Community Based Outpatient Clinic's (CBOC) care management when the patient presented with signs and symptoms of a known vascular procedure complication 10 days following surgery. The OIG found the CBOC lacked an adequate policy or standard operating procedure on the management of health emergencies and had inconsistent health record documentation for the patient. The OIG made three recommendations related to care coordination, health emergency management, and health record documentation.

Review of Two Mental Health Patients Who Died by Suicide, William S. Middleton Memorial Veterans Hospital Madison, Wisconsin

The OIG reviewed congressional concerns regarding the care and management of a patient who died by suicide after discharge from the Madison VA hospital. A second patient who died by suicide was also identified and the patient's mental health care was reviewed. The OIG found that the first patient's death was correctly classified by the hospital staff as a sentinel event and was reported as required. The OIG also found a 72-hour hold was not required. However, the root cause analysis was deficient; there were ethical concerns regarding a research study's enrollment; a community monitoring agency was not informed of court settlement agreement violations; and both discharge planning and follow-up were inadequate. The psychiatric clinical pharmacists' mental health care for both patients was also found inadequate. The OIG made 11 recommendations related to institutional disclosures, the research study ethics review, an expanded evaluation of the first patient's death, the court settlement agreements, policy revisions, prescribing practices and black box warnings, prescribers' collaborative agreements and assignments for complex mental health patients, and psychiatric clinical pharmacists' supervision.

Review of Environment of Care Conditions at Mississippi VA-Contracted Clinics

After environment of care (EOC) deficiencies were identified at a contracted clinic on May 23, 2018, the OIG conducted a healthcare inspection of six other contracted clinics of the Jackson, Mississippi, G.V. (Sonny) Montgomery VAMC. The OIG inspectors found problems with general safety, medication safety and security, infection prevention and environmental cleanliness, and information technology. While OIG inspectors did not find that the conditions placed patients or staff at risk, corrective actions were needed to ensure a clean and safe environment. The OIG team found inconsistencies between the

requirements for VHA oversight described in the respective CBOC contracts, the expectations of the Contracting Officer's Representative, and facility managers' approach to conducting CBOC site visits. Facility managers did not consistently keep written records of deficiencies found on site visits or document the required dates for completing corrective action. The OIG made two recommendations related to comprehensive reviews of EOC issues and consistent oversight of the CBOC operations.

Intraoperative Radiofrequency Ablation and Other Surgical Service Concerns, Samuel S. Stratton VA Medical Center, Albany, New York

The OIG reviewed allegations regarding a surgical oncologist's intraoperative radiofrequency ablation (IORFA) practices at the Albany VA medical facility and related oversight. The IORFA procedure involves using a special type of needle that produces heat sufficient to destroy metastatic and small primary tumors. The OIG found deficiencies in peer reviews and in credentialing and privileging processes. The OIG also substantiated that the surgical oncologist completely or partially missed tumors when performing IORFA in three patients, and subsequently told patients they had residual tumors. Facility leaders did not provide required disclosures for the patients reviewed. The OIG did not substantiate the surgical oncologist performed surgery on patients who did not have cancer or that adverse events occurred during cancer surgeries. The report includes nine recommendations related to improving oversight and peer review, better monitoring patient care and IORFA outcomes, making institutional disclosures, ensuring external IORFA reviews, and evaluating appropriate actions for relevant staff.

Comprehensive Healthcare Inspection Program Reviews

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
(9) High-Risk Processes.

In August, CHIP reviews were published for the following sites:

Tomah VA Medical Center, Wisconsin

Chillicothe VA Medical Center, Ohio

Beckley VA Medical Center, West Virginia

Dayton VA Medical Center, Ohio

VA Ann Arbor Healthcare System, Michigan

Erie VA Medical Center, Pennsylvania

John J. Pershing VA Medical Center, Poplar Bluff, Missouri

Ralph H. Johnson VA Medical Center, Charleston, South Carolina

VA St. Louis Health Care System, Missouri

Bay Pines VA Healthcare System, Florida

Central Arkansas Veterans Healthcare System, Little Rock, Arkansas

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