



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

NOVEMBER 2018 HIGHLIGHTS

Congressional Testimony

Inspector General Missal Testifies before the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs

Inspector General Missal testified before the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs on November 29, 2018. The hearing focused on several recent Office of Inspector General (OIG) reports on Veterans Benefits Administration (VBA) implementation of programs and initiatives. Mr. Missal explained that the OIG modified its VBA oversight model in October 2017 to better review national policy changes and focus on VBA's high-impact programs and operations. The new model allows the OIG to identify systemic issues that affect veterans' benefits and services, determine root causes of the identified problems, and make useful recommendations that drive positive change across VBA. To illustrate that point, he highlighted the common systemic issues the OIG identified in four recent reports: deficient control activities, inadequate program leadership and monitoring, lack of information technology system functionality, and the unintended impact of transitioning from regional claims processing to a national work queue. The OIG will continue to work on matters designed to improve the delivery of benefits to veterans and their families. For example, in 2019, the OIG anticipates publishing additional nationwide reviews identifying systems-level barriers to effective and efficient implementation of VBA's Decision Ready Claims program, as well as canceled contract medical examinations for benefits.

Criminal Investigations Involving Health Care

Individual Sentenced for Submitting False Claims to VA

A sales representative who previously served the VA St. Louis Health Care System (HCS) in Missouri was sentenced to serve five years of probation and pay restitution to VA in the amount of \$614,380. An OIG investigation revealed that from July 2012 to August 2017, the defendant submitted 220 false orders to the Jefferson Barracks Division of the VA St. Louis HCS, which totaled \$644,380. These orders were primarily for drill bits and other supplies that were never requested nor received by the facility. The defendant provided false invoices to a VA employee who believed them to be legitimate based on the defendant's reputation and long-standing history as a sales representative to the VA St. Louis HCS. After the VA employee processed the orders, the defendant kept the items for himself and sold what he could at flea markets. During the investigation, the defendant turned over approximately \$30,000 worth of supplies that were stored in his garage.

Former Temple, Texas, VA Medical Center Maintenance and Operations Supervisor and Two Accomplices Pled Guilty in Theft Scheme

A former Temple, Texas, VA Medical Center (VAMC) Maintenance and Operations Supervisor, his wife, and a third-party vendor pled guilty to theft of government funds and conspiracy. An OIG investigation resulted in charges that allege the defendants created a scheme to use the wife's company to steal funds from VA. The former supervisor and his wife provided the vendor with fraudulent invoices from her company for goods and services that were not provided to the vendor. The vendor paid the wife's company for the fictitious goods and services and then fabricated his own set of fraudulent invoices that he used to bill VA for goods and services that he never provided to VA. The amount of the invoices billed to VA equaled the amount the vendor paid to the wife's company plus a 30 percent commission. The former supervisor then used a VA purchase card to pay the vendor's fraudulent invoices. The loss to VA is approximately \$308,380.

Veteran Arrested for Abusive Sexual Contact

A veteran was arrested based on a criminal complaint for abusive sexual contact with another veteran. An OIG investigation resulted in charges that allege the defendant kidnapped and raped a female veteran on the property of the VA Greater Los Angeles HCS in California. The defendant drove a commercial truck that he used in the commission of these crimes. The defendant was arrested in Virginia and his vehicle was seized.

Former Muskogee, Oklahoma, VA Medical Center Psychiatrist Sentenced for Witness Intimidation and Tampering

A former Muskogee, Oklahoma, VAMC psychiatrist was sentenced to 21 months' incarceration, three years' supervised release, and the permanent loss of his medical license after previously pleading guilty to felony witness intimidation and tampering. An OIG investigation revealed the defendant engaged in a long-term sexual relationship with one of his psychiatric patients, who had suffered a service-connected traumatic brain injury that resulted in numerous psychological conditions. The defendant attempted to manipulate the victim through coercion and intimidation into lying to investigators about the nature of their relationship. The defendant ordered the victim to lie about their sexual encounters, financial assistance and excessive narcotic prescriptions he provided to the victim, and his paternity to their unborn child.

Former Tampa, Florida, VA Medical Center Physician Sentenced for Drug Distribution Scheme

A former Tampa, Florida, VAMC physician was sentenced to three years' probation and ordered to pay \$59,345 in forfeiture. An OIG and Drug Enforcement Administration (DEA) investigation revealed that the defendant was a former full-time VA doctor with a DEA registration that limited his authorization to write prescriptions for controlled substances only to his official federal duties. From August 2017 to March 2018, after resigning from VA to work at a private pain management clinic in Tampa, the

defendant used his VA DEA registration to write over 2,000 prescriptions for controlled substances, to include over 1,000 prescriptions for oxycodone and over 600 prescriptions for hydromorphone.

Veteran Sentenced for Drug Distribution

A veteran was sentenced to 48 months' imprisonment and four years' supervised release. An OIG investigation revealed that while he was an inpatient at the Ann Arbor, Michigan, VAMC, the defendant introduced a mixture of heroin and fentanyl into the facility and provided a portion to another inpatient that resulted in their death.

VA Outpatient Pled Guilty to Criminal Charge Involving Child Pornography

A Cleveland, Ohio, VAMC outpatient pled guilty to activities relating to material constituting or containing child pornography. An OIG investigation revealed that a VA computer, which had been issued to the defendant to aid with his visual impairment, contained approximately 4,700 suspected images of child pornography, to include 16 that were verified by the National Center for Missing and Exploited Children as depicting known child victims. This investigation was initiated after the facility's Blind Rehabilitation staff observed several explicit photos while repairing this VA computer.

Veteran Sentenced for Making Threats Against Northern Arizona VA Healthcare System Employees

A veteran who previously pled guilty to threatening to shoot VA employees and physically damaged government property at the Prescott, Arizona, Northern Arizona VA HCS was sentenced to nine months' imprisonment and three years' supervised release and ordered to pay restitution to VA in the amount of \$5,214. An OIG, Federal Bureau of Investigation (FBI), U.S. Marshals Service, and Bureau of Alcohol, Tobacco, Firearms, and Explosives investigation was initiated after a VA employee reported that the defendant uttered, "If I have to go home and get a weapon and come back and shoot everybody, then that is what I am going to do." The defendant also attempted to throw a service kiosk across the room. After the defendant departed the facility, VA employees became aware of additional telephonic threats that he left via voicemail.

Criminal Investigations Involving Benefits

Veterans Sentenced for Compensation Benefits Fraud

A veteran was sentenced to 18 months' incarceration and three years' probation and ordered to pay restitution of \$165,174. An OIG investigation revealed that the defendant submitted an altered DD-214 (documentation issued upon a military servicemember's retirement, separation, or discharge from active duty) characterizing of his service as 'Honorable' and his reason for separation as 'medical.' The defendant's original DD-214 listed a 'Bad Conduct' discharge resulting from a court-martial. Because of the altered DD-214, the defendant received \$165,174 in VA compensation benefits to which he was not entitled.

Former VA Fiduciary Sentenced for Theft Scheme

A former VA fiduciary was sentenced to 12 months' imprisonment and three years' supervised release and ordered to pay restitution to VA in the amount of \$162,624. An OIG and FBI investigation revealed the defendant misappropriated approximately \$162,624 of her brother's VA compensation benefits.

Former VA Fiduciary Arrested for Theft Scheme

A former VA fiduciary was arrested as a result of an OIG and South Carolina Attorney General's Office investigation. The investigation resulted in charges that allege the defendant misappropriated \$130,852 in Dependency and Indemnity Compensation benefits that should have been used for the care of her grandmother. This investigation also determined the defendant stole an additional \$100,000 from the sale of her grandmother's property.

Veteran Indicted for Theft of Government Funds and False Statements

An OIG investigation resulted in charges that allege the defendant manufactured and forged fraudulent home healthcare records to obtain VA disability benefits based upon his alleged need for aid and attendance. While receiving VA aid and attendance benefits and claiming that he was unemployed, the defendant owned and operated a construction and home remodeling company, which had approximately \$650,000 in business over a two-year span. The loss to VA is \$117,496.

Criminal Investigations Involving Other Matters

Nonveteran Business Owner and His Construction Company Convicted for Roles in Fraud Scheme

A nonveteran business owner and his construction business were found guilty at trial of several fraud related charges. An OIG investigation revealed the nonveteran and a veteran participated in a conspiracy to defraud the government by forming a joint venture and falsely represented that the joint venture and another company qualified as service-disabled veteran-owned small businesses (SDVOSBs). The defendants fraudulently obtained approximately \$11 million in VA funded SDVOSB set-aside construction contracts or task orders. The veteran previously pled guilty to the charges against him.

Investigative Reports

Alleged Misuse of Government-Owned Vehicles at the Sacramento VA Medical Center, California

The OIG did not find that the VA Northern California HCS Director violated VA policy regarding the use of government vehicles. The Director was unaware employees drove these vehicles between work and home. The OIG found that the Associate Director of the Sacramento VAMC improperly authorized a local policy permitting her to delegate authority for the approval of no-cost travel orders to the Chief of Logistics Management Service. The Chief used this authority to allow employees to take government vehicles home overnight and on weekends under the provisions applicable to temporary duty assignment

travel with the use of no-cost travel orders. The Director said that upon learning of this policy, he immediately rescinded it.

Administrative Summary of Investigation in Response to Allegations Regarding Patient Wait Times at the Baltimore VA Medical Center, Maryland

The OIG investigated allegations that an unnamed “Chief” at the Baltimore VAMC in Maryland instructed his or her staff to immediately close consults for Audiology examinations upon receipt. The complainant alleged that as a result, the consults were closed before the Audiology examinations could take place. The OIG substantiated this allegation. The OIG also substantiated that the Opioid Agonist Treatment Program (OATP) transferred patients who wanted VA care but were currently receiving non-VA care from the Electronic Wait List (EWL) to a new “non-count” transfer clinic, some providers would not schedule appointments in VistA until after the appointments had taken place, and the Medical Administration Service had been prematurely closing Non-VA Care Coordination consults prior to receiving the supporting medical documentation from private medical providers. The OIG did not substantiate that an employee was pressured to remove patients from the OATP EWL who were unreachable, the VISN wanted the EWL to contain less than 20 patients, or a veteran’s death was related to his EWL status.

Audits and Reviews

Accuracy of Claims Involving Service-Connected Amyotrophic Lateral Sclerosis

The OIG conducted this review to determine whether VBA accurately decided veterans’ claims involving service-connected Amyotrophic Lateral Sclerosis (ALS). The OIG found that claims processing involving service-connected ALS needs improvement. About 45 percent of ALS claims completed from April through September 2017 had erroneous decisions. These errors resulted in estimated underpayments of about \$750,000 and overpayments of about \$649,000. The errors were due to the complexity of ALS claims. Also, VBA staff generally do not tell veterans about special monthly compensation (SMC) benefits that may be available because VBA believes they are not required to do so. The OIG recommended that VBA implement a plan to improve and monitor decisions involving service-connected ALS. The OIG also recommended that VBA implement a plan to provide notice regarding additional SMC benefits that may be available to veterans with service-connected ALS.

Healthcare Inspection

Patient and Radiation Safety Concerns at the John D. Dingell VA Medical Center, Detroit, Michigan

In response to radiation safety concerns, the OIG reviewed the facility’s radiation safety program and radiologists’ fluoroscopy training and privileging. The OIG substantiated that annual radiologic equipment inspections were not performed as required, a radiologist performed fluoroscopy procedures without current training or privileging, and the radiology department did not conform to Veterans Health

Administration radiation safety standards. The OIG substantiated that the Chief of Radiology changed the radiology privileging form and that the facility's Master Materials License permit was revoked in 2009, resulting in cancellation of nuclear medicine studies for that year. The permit was reinstated in 2010. Although the OIG found additional radiation safety issues and made recommendations, the deficiencies did not put patients and staff at immediate risk or warrant stopping patient care.

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 OIG's fiscal year 2019 areas of focus include

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| (1) Leadership and Organizational Risks; | (6) Mental Health; |
| (2) Quality, Safety, and Value; | (7) Women's Health; |
| (3) Medical Staff Privileging; | (8) Geriatric Care; and |
| (4) Environment of Care; | (9) High-Risk Processes. |
| (5) Medication Management; | |

The CHIP reports listed below may include topics that differ from those listed above if they were initiated in the prior fiscal year.

VA Maine Healthcare System, Augusta, Maine

Central Texas Veterans Health Care System, Temple, Texas

To listen to the podcast on the OIG's November 2018 activity highlights, go to www.va.gov/oig/podcasts.