Department of Veterans Affairs
Office of Inspector General
November 2011 Highlights

CONGRESSIONAL TESTIMONY

Assistant Inspector General Belinda Finn Outlines Potential VA Budgetary Savings at House Veterans' Affairs Committee Hearing

Belinda J. Finn, Assistant Inspector General for Audits and Evaluations, testified before the Committee on Veterans' Affairs, United States House of Representatives, on Office of Inspector General (OIG) work related to recommendations made by the Veterans Service Organizations (VSOs) for budgetary savings. Ms. Finn discussed OIG work in several areas raised by the VSOs including fee basis care and VA's claims brokering system. She also discussed OIG work related to savings in VA management of the rural health initiative, information technology contracts, and acquisition process. Ms. Finn was accompanied by Linda Halliday and Sondra McCauley, Deputy Assistant Inspectors General for Audits and Evaluations. [Click here to access testimony.]

OIG REPORTS

Audit Finds 80 Percent of Retention Bonuses Poorly Justified, Questions $1.06 Million in VA Spending

This audit determined the adequacy of Veterans Health Administration (VHA) and VA Central Office (VACO) processes for awarding retention incentives. In fiscal year (FY) 2010, VA paid nearly $111 million in retention incentives to 16,487 employees. OIG found VHA and VACO approving officials did not adequately justify and document retention incentive awards in accordance with VA policy. VA lacked clear guidance, oversight, and training to effectively support the program. Officials did not effectively use the Personnel and Accounting Integrated Data system to generate timely review notices and did not always stop retention incentives at the end of set payment periods. Based on these findings, OIG questioned the appropriateness of 96 (80 percent) of 120 VHA incentives and 30 (79 percent) of 38 VACO incentives OIG reviewed. These incentives totaled about $1.06 million in FY 2010. OIG recommended revised and clarified guidance, as well as controls to ensure proper documentation and training was applied throughout the program. [Click here to access report.]

Weak Controls Over Non-VA Fee Care Results in $11.4 Million Budget Shortfall at Phoenix, Arizona, Health Care System

The Phoenix, AZ, Health Care System (HCS) allegedly experienced a budget shortfall at the end of FY 2010 due to mismanagement of their Non-VA Fee Care Program. OIG substantiated that the Phoenix HCS experienced an $11.4 million budget shortfall, which was equivalent to 20 percent of the Non-VA Fee Care Program funds for that year. The shortfall was due to the lack of effective pre-authorization procedures. They also lacked adequate procedures to obligate sufficient funds to pay for all fee care services processed during this period, over $56 million. In addition, HCS staff did not determine if the patients could receive services in a VA inpatient facility to avoid using the Non-VA Fee Care program. Since the discovery of the budget shortfall, the HCS has initiated several corrective actions to reduce the risk of future shortfalls and

strengthen the management of their Non-VA Fee Care Program. [Click here to access report.]

Benefits Inspection Division Visits Regional Offices in Indianapolis, Indiana; Manchester, New Hampshire; and Fort Harrison, Montana

OIG evaluated how well the Indianapolis, IN, VA Regional Office (VARO) accomplishes its mission. The staff timely processed homeless Veterans' claims and effectively provided outreach efforts to homeless shelters and service providers. Inaccuracies in temporary 100 percent disability evaluations resulted from not scheduling medical reexaminations. In addition, an incorrect interpretation of VA policy resulted in inadequate medical exams for processing traumatic brain injury (TBI) claims. The quality assurance program did not identify errors in herbicide exposure-related disability claims. Overall, the VARO did not correctly process 41 percent of disability claims reviewed. Better management oversight would ensure errors identified by internal reviews were corrected, improve mail processing, and increase accuracy when addressing entitlement issues pertaining to the mental health (MH) treatment for Gulf War Veterans. [Click here to access report.]

In a similar review, OIG evaluated how well the Manchester, NH, VARO accomplishes its mission. OIG found the staff accurately addressed entitlement to MH treatment for Gulf War Veterans. They were generally effective in processing TBI and herbicide-related claims, correcting errors identified by internal reviews, as well as ensuring Systematic Analyses of Operations (SAOs) were timely and complete, and properly handling claims-related mail. However, the VARO lacked accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations occurred when staff did not schedule required medical reexaminations. Overall, VARO staff did not accurately process 18 (26 percent) of 68 disability claims OIG reviewed. Management did not have mechanisms in place to timely process competency determinations. Further, outreach efforts to homeless shelters and service providers were not always effective. [Click here to access report.]

Lastly, OIG found the Fort Harrison, MT, VARO staff did well in processing herbicide exposure-related and processing homeless Veterans' claims, and correcting Systematic Technical Accuracy Review errors, as well as being generally effective in processing TBI claims and handling claims-related mail. From the sample of disability claims reviewed, the VARO accurately processed 84 percent (70 of 83), putting them within the top five of VAROs inspected thus far. However, management did not complete all elements of the SAOs as required, misinterpreted policy, and erroneously thought it had the discretion to omit certain elements of VARO operations from its analyses. They were not always considering whether Gulf War Veterans were eligible to receive health care treatment for mental disorders and their outreach to homeless shelters and service providers was not always effective. OIG recommended the Director implement and monitor a plan to correct the issues identified. The Director concurred with OIG's recommendations and the planned actions are responsive. OIG will follow up as required on all actions. [Click here to access report.]

Community Based Outpatient Clinics Reviewed in Five Veterans Integrated Service Networks

OIG reviewed nine Community Based Outpatient Clinics (CBOCs) during the week of July 25, 2011. CBOCs were reviewed in Veterans Integrated Service Networks (VISN) 19 at Gillette and Powell, WY; and Pueblo, CO; and, in VISN 22 at Anaheim and Laguna Hills, CA; Escondido and Oceanside, CA; and Lancaster and Sepulveda, CA. The parent facilities of these CBOCs are Sheridan VA Medical Center (VAMC), VA Eastern Colorado HCS, VA Long Beach HCS, VA San Diego HCS, and VA Greater Los Angeles HCS, respectively. The purpose of the review was to assess whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care. The review covered the following focused topic areas: MH continuity of care, short-term fee basis care, women's health, credentialing and privileging, skills competency, environment and emergency management, Primary Care Management Module, and contracts. OIG noted opportunities for improvement and made 38 recommendations to the VISN and facility managers. [Click here to access report.]

In a second, similar review, OIG reviewed six CBOCs during the week of August 29, 2011. CBOCs were reviewed in VISN 1 at Bennington, VT, and Littleton, NH; in VISN 2 at Jamestown and Lackawanna, NY; and, in VISN 5 at Hagerstown, MD, and Petersburg, WV. The parent facilities of these CBOCs are White River Junction VAMC, VA Western New York HCS, and Martinsburg VAMC, respectively. OIG noted opportunities for improvement and made 59 recommendations to the VISN and facility managers. [Click here to access report.]

CRIMINAL INVESTIGATIONS

Business Owner Indicted for Service-Disabled Veteran-Owned Small Business Fraud

A business owner was indicted for wire and major fraud after a case referral from the Government Accountability Office resulted in the initiation of a multiagency investigation conducted by the VA OIG, Small Business Administration OIG, U.S. Department of Agriculture (USDA) OIG, and Army Criminal Investigations Division. The investigation determined the defendant used the status of a legitimate service-disabled Veteran to fraudulently create a Service-Disabled Veteran-Owned Small Business (SDVOSB) company. The defendant subsequently created a joint venture by partnering his business with the SDVOSB to qualify and bid on SDVOSB set-aside contracts. The defendant also forged the signature of the service-disabled Veteran on VA contracts and other documents. The company received $1,085,207 in VA set-aside SDVOSB contracts to which it was not entitled. The defendant also received three additional fraudulent SDVOSB contracts from the Department of the Army, USDA, and the U.S. Coast Guard, totaling $1,761,625.

Defendants Sentenced for Home Health Care Fraud

A former regional account manager for a home health care services company was sentenced to 5 months' incarceration, 5 months' home confinement, 24 months' probation, and ordered to pay a $10,000 fine. The mother of a patient receiving

services from the same home health care services company was also sentenced to 5 months' home confinement, 36 months' probation, and ordered to pay a $1,000 fine. In addition, a recruiter formerly employed by the same company was sentenced to 24 months' probation and ordered to pay a $500 fine. The judicial actions are the result of a previous deferred prosecution agreement resulting from a multiagency investigation, which revealed various fraudulent activities related to services the company claimed to provide to various recipients of Federal and state benefits, including those provided by VA.

Three Former Executives Sentenced for Medical Device Fraud
Three former Synthes Inc. executives were sentenced pursuant to a plea agreement charging them with violation of the "responsible corporate officer" doctrine with the strict liability offense of introducing into interstate commerce medical devices that were adulterated. Two of the defendants were sentenced to 9 months' incarceration and 3 months' supervised release while the third defendant was sentenced to 5 months' incarceration and 7 months' supervised release. Each defendant was also ordered to pay a $100,000 fine. A fourth defendant has yet to be sentenced. A multiagency investigation determined that the defendants were involved in the unapproved trial of a bone-cement drug in which three patients died.

Former Togus, Maine, VAMC Employee Sentenced for Compensation Benefits Fraud
A former Togus, ME, VAMC employee was sentenced to 18 months' incarceration, 36 months' supervised release, and ordered to pay VA $47,229 in criminal restitution. An OIG investigation revealed that the defendant manufactured a fraudulent document that VA relied upon as the basis for an award of service-connected compensation benefits for a back condition. When interviewed, the former employee acknowledged creating the document that purported his involvement in a vehicle crash while running a roadblock in a foreign country, which he claimed caused injuries to his back and ribs. The sentencing included enhancements for obstruction after the judge agreed with the Government's contention that the defendant had manufactured another document in an attempt to exonerate himself from charges relating to dependency benefits fraud.

Veteran Pleads Guilty to VA Pension Benefit Fraud
A Veteran pled guilty to theft of Government funds after fraudulently receiving over $100,000 in VA pension benefits. An OIG investigation revealed that the defendant earned significant income in the scrap metal business while informing VA that he had no income.

Veteran's Daughter Arrested for VA Home Loan Fraud
The daughter of a Veteran was arrested for falsifying business records and identity theft after an OIG investigation revealed that she submitted fraudulent employment records in order to secure a VA home loan in her father's name. The loan was subsequently approved based on the false records and the home is now in foreclosure.

Son of Deceased VA Beneficiary Pleads Guilty to Theft of VA Funds
The son of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant failed to report to VA that his mother died in April 2006 and subsequently used her ATM card to steal $59,548 in VA benefits from her account.

Seven Orlando, Florida, VAMC Employees and Volunteer Charged with Theft
Seven Orlando, FL, VAMC employees, to include a VA police officer, and an eighth individual who was a volunteer, were charged with the exploitation of an elderly or disabled adult and grand theft. An OIG and VA Police Service investigation revealed that the defendants solicited and received checks totaling $55,000 from a resident of the VAMC's nursing home who suffers from dementia.

Fiduciary Arrested for Embezzlement
The daughter of a Veteran, who was also his fiduciary, was arrested after being charged in a criminal information with misappropriation by a fiduciary and conversion of Social Security benefits. An OIG investigation disclosed that the defendant became the Veteran's fiduciary in 2005 and embezzled over $200,000 in VA compensation benefits and over $20,000 in Social Security benefits. After initially claiming that a VA field examiner told her that she could spend the money, the defendant admitted to OIG agents that she fraudulently spent the money intended for her father.

Veteran Arrested for Assault of VA Police Officer
A Veteran was charged with assault on a Federal officer after assaulting a VA police officer at the Seattle, WA, VAMC. An OIG and VA Police Service investigation revealed that the Veteran checked into the emergency room (ER) and informed an ER nurse that he was having suicidal thoughts to include "suicide by cop." When a VA police officer attempted to conduct a security screening, the defendant failed to comply with the officer's instructions and assaulted the officer. During the struggle, the defendant was able to obtain the officer's baton and attempted to take the officer's weapon until subdued by the officer and other responders. The assault resulted in injuries to the officer.

Veteran Sentenced and VA Employee's Son Arrested for Drug Distribution
A Veteran was sentenced to 14 days' incarceration and a $719 fine after pleading guilty to a drug sale. A VA employee's son was also arrested for conspiracy to distribute oxycodone in excess of 28 grams. Both judicial actions stemmed from a 7-month OIG and local drug diversion task force investigation. Operation Tango Vax focused on combating the sale and distribution of illicit and controlled prescription pharmaceutical drugs at the West Palm Beach, FL, VAMC and the surrounding community. The investigation determined that the majority of criminal activity occurred at the VAMC and resulted in the seizure of over 6,000 oxycodone pills and $180,920.

Defendants Plead Guilty to Drug Trafficking Charges at Cleveland, Ohio, VAMC
Three defendants pled guilty to felony drug trafficking charges for selling heroin and VA prescription medication at the Cleveland, OH, VAMC. Information was received that

illicit drugs and VA prescription medication were being sold on VA property to Veterans in drug treatment programs. An OIG and local police investigation resulted in multiple controlled buys of heroin and prescription pain medication.

Veteran and Asheville, North Carolina, VAMC Nurse Arrested for Prescription Fraud

A Veteran and an Asheville, NC, VAMC nurse were arrested for obtaining prescription drugs by fraud. An OIG and local drug task force determined that while under the care of a VA physician, the Veteran obtained pain medication from non-VA pharmacies using assumed names. On one occasion, the Veteran posed as a VA physician and obtained pain medication for himself. The VA nurse assisted the Veteran in the scheme by picking up pain medications at non-VA pharmacies, which were dispensed by means of fraudulent prescriptions. A search of the nurse's residence resulted in the seizure of crack cocaine and various pill bottles.

Former Providence, Rhode Island, Nurse Sentenced for Drug Diversion

A former intensive care unit nurse at the Providence, RI, VAMC was sentenced to 24 months' incarceration, 9 months' probation, and ordered to pay $2,500 in restitution. The defendant previously pled guilty to diversion of a controlled substance after an OIG and VA Police Service investigation revealed that he diverted hydromorphone and falsified VA controlled substance records to conceal the theft. The case was initiated after an internal VAMC analysis showed that the defendant had a high frequency of Pyxis system overrides when compared to other nurses on the ward.

Former United Parcel Service Employee Sentenced for Drug Theft

A former United Parcel Service employee was sentenced to 36 months' incarceration and 3 years' supervised release after pleading guilty to possession of controlled substances with intent to deliver. An OIG and Drug Enforcement Administration investigation revealed that the defendant stole at least nine VA packages containing various controlled narcotics that were shipped to Veterans from a VA medical facility.

Veteran Indicted for Travel Benefits Fraud

A Veteran was indicted for theft of Government property after an OIG investigation revealed that, from February 2010 to July 2011, he filed 234 fraudulent travel claims at the Gainesville, FL, VAMC. The defendant claimed that he was traveling 152 miles round trip from St. Augustine, FL, when in reality he was residing in Gainesville, FL. The loss to VA is $14,333.

(original signed by Richard J. Griffin,
Deputy Inspector General for:)
GEORGE J. OPFER
Inspector General