PODCAST TRANSCRIPT
AUGUST 2019 HIGHLIGHTS

Carla Reid:

This is Carla Reid, an audit manager with the VA Office of Inspector General in Kansas City, Missouri. Here are the August highlights.

Inspector General Michael Missal released statements confirming the OIG is working with its federal law enforcement partners on two highly-visible investigations into allegations of sexual assaults at the Beckley VA medical center and wrongdoing resulting in patient deaths at the Clarksburg Louis A. Johnson VA medical center, both in West Virginia. The OIG's work with VA to identify risks to patients and ensure their safety remains a top priority.

Inspector General Missal also participated in a news conference with Duane (DAK) Kees, the U.S. Attorney for the Western District of Arkansas, regarding the arrest and indictment of former pathologist Dr. Robert Levy who worked at the Veterans Health Care System of the Ozarks in Fayetteville. Levy was arrested on federal charges stemming from a year-long investigation. A federal grand jury indicted Levy on 31 counts to include involuntary manslaughter. According to the allegations in the indictment, the defendant caused the death of three VA patients by entering incorrect and misleading diagnoses and, on two occasions, by falsifying entries in the patients' medical records to state that a second pathologist concurred with the diagnosis Levy had made. For more information, see the DOJ news release.

Another recent OIG investigation resulted in a former VA employee being sentenced to prison for 60 months and ordered to pay $290,000 in restitution and a $100,000 fine after her conviction for conspiring to commit fraud against the VA. The former employee conspired with a vendor to defraud VA by submitting fake invoices for goods and services never received. The co-conspirator pled guilty in August 2018. For more information, see the Department of Justice news release *Former VA Employee Sentenced to Max in Fake Invoice Scheme.*

There were 10 oversight reports published in August including one Comprehensive Healthcare Inspection Program report for the *Central California VA Health Care System Fresno, California.* The OIG made 11 recommendations for improvement.

In the report *Non-VA Emergency Care Claims Inappropriately Denied and Rejected*, the OIG found that 31 percent of denied or rejected non-VA emergency care claims—with an estimated billed amount of $716 million—were improperly processed from April 1 through September 30, 2017. This created a potential undue financial burden for an estimated 60,800 veterans. The OIG concluded there was a significant risk that some of the errors identified in this audit resulted from pressure and incentives to meet production targets, and insufficient quality assurance of claims processing accuracy. The OIG made 11 recommendations to improve the accuracy of non-VA emergency claims processing. VHA has

initiated improvements in response to the recommendations, including updates to claims processor guidance, offering training, and initiating nationwide quality and accuracy reviews.

In another report, *Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center in Florida*, the OIG reviewed the circumstances of a patient death by suicide. The OIG determined the patient received reasonable care while admitted to a locked inpatient mental health unit but noted other areas of concern. These included the lack of a single patient-specific treatment plan with measurable goals and interventions as required by VHA and The Joint Commission. The OIG also found that a VHA work group and the region's Veterans Integrated Service Network 8 did not ensure identified hazards were abated. The OIG made 11 recommendations to improve patient safety, environment of care, training, and risk mitigation.

Additional reports in August reviewed pathology processing delays, a backlog of unscanned medical documentation measuring more than an estimated 5 miles high, an alleged delay in surgical care, complaints of deficiencies in mental health care, and mismanagement of a patient's resuscitation.

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