PODCAST TRANSCRIPT
FEBRUARY 2020 HIGHLIGHTS

March 23, 2020:

This is Quintin Durden, a Deputy Director with the VA Office of Inspector General in Washington, D.C. Here are the February highlights.

Deputy Assistant Inspector General for Healthcare Inspections Dr. Julie Kroviak testified at a February 5, 2020, hearing before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations and Women Veterans Task Force. The hearing examined how VA supports survivors of military sexual trauma (MST). Dr. Kroviak's testimony discussed the results of the Office of Inspector General's (OIG) fiscal year 2019 Comprehensive Healthcare Inspection Program, which in part evaluated VA medical facilities' compliance with selected Veterans Health Administration (VHA) requirements related to MST. These included processes carried out by MST coordinators, the provision of care to patients after positive screening, and mandatory staff training. Dr. Kroviak discussed that, while VHA had high compliance with several of the selected requirements, the OIG noted opportunities for improvement such as ensuring MST coordinators communicate issues concerning MST services and initiatives with local leaders, making facility staff aware of MST issues, and ensuring that new staff receive required training. Dr. Kroviak also provided updated information on the status of recommendations contained in the Office of Audits and Evaluations' 2018 report "Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma."

A recent OIG criminal investigation resulted in a former VA prosthetics vendor being ordered to pay restitution of almost $480,000 to VA. The vendor was previously sentenced in the Eastern District of California to 60 months' imprisonment and 36 months' supervised release after being convicted by a federal jury of healthcare fraud and conspiracy to commit healthcare fraud. An investigation by the VA OIG, Homeland Security Investigations, and VA Police Service resulted in charges that between March 2008 and February 2015, the vendor and the former chief of podiatry for the Sacramento, California, VA Medical Center engaged in a scheme to defraud VA by billing for custom prescription footwear containing carbon graphite plates but instead providing veterans with inferior footwear containing preinstalled components.

As a result of another OIG investigation, two former bank employees and three coconspirators were arrested after being charged in the Eastern District of New York with bank fraud conspiracy and money laundering conspiracy. An investigation by the VA OIG, Social Security Administration (SSA) OIG, US Postal Inspection Service, Internal Revenue Service Criminal Investigation, Manhattan District Attorney's Office, New York City Police Department, and Homeland Security Investigations resulted in charges alleging the defendants embezzled funds from deceased or elderly account holders at a major financial institution. With the assistance of an accountant, the bank employees allegedly laundered the

stolen funds to relatives, associates, or shell companies owned by relatives and associates. The subjects allegedly misappropriated more than $7.6 million from the bank account holders. The total loss to VA is still being calculated.

The OIG published 8 oversight reports in February. In the report "Telehealth Public-Use Questionnaires Were Used Improperly to Determine Disability Benefits," the OIG reviewed whether evidence supporting veterans' claims for disability benefits was being submitted on public-use questionnaires without care providers seeing the veterans in person. VBA prohibits the use of telehealth for benefit rating purposes. The OIG found claims processors improperly used benefits questionnaires to make determinations without ensuring an in-person examination was conducted. For example, VBA made improper determinations in 41 of 81 claims the OIG reviewed, amounting to about $613,000 in benefit payments. VBA did not provide consistent staff guidance, adequately monitor use of telehealth questionnaires, or modify forms to reflect prohibited uses. VBA's internal controls were inadequate to prevent the inherent potential for fraud when relying on publicly available questionnaires, despite VBA's risk-mitigation efforts. The OIG recommended the under secretary for benefits consider whether to discontinue using publicly available questionnaires or, if used, to improve fraud safeguards and notices of prohibited uses.

In another report, "Quality of Care Issues in the Community Living Center and Emergency Department at the Dayton VA Medical Center, Ohio," an OIG inspection was initiated regarding a patient who died after transfer from the facility's CLC to the emergency department. Deficiencies were identified in an emergency department physician's medical decision-making, provision of care, and handoff communication. Also, an emergency department registered nurse failed to adequately monitor the patient. Deficits in the physician's practices were not limited to this case and the physician's privileges were revoked. The OIG did not substantiate that the registered nurse under review was involved in additional patient deaths or that emergency department staffing was inadequate. Thirteen recommendations were made that addressed the above and other findings including provider and peer review training, transitions of care policies, standing orders, critically ill patient care, Peer Review Committee documentation, leaders' responses to care concerns, supplies, bar code medication administration compliance, and document management procedures.

Finally, in a special review, "Alleged Improper Locality Pay for Teleworking Employee," the OIG investigated an allegation that an employee was approved to change duty stations from Pittsburgh to Altoona, Pennsylvania, but continued to improperly receive the higher locality pay for the Pittsburgh area. The OIG substantiated that the employee's telework agreement did not comply with applicable regulations requiring employees to report to the official worksite twice per pay period when the employee is not in a permanent telework arrangement. Although temporary exceptions can be granted, there is no discretion to grant a permanent exception. The OIG determined that the employee and the employee's supervisors took appropriate corrective action once the issue became known, prior to OIG's investigation. The OIG did not identify any evidence to suggest that maintaining higher locality pay was

intentional. Accordingly, the OIG did not substantiate misconduct. The OIG made one recommendation to clarify the authority and obligations of telework-approving supervisors within the Office of General Counsel.

OIG podcasts are produced by OIG staff. You will find other OIG podcasts in the media section of our website. For more information on the congressional hearings and all February publications—or to report fraud, waste, abuse, or possible criminal activity—visit the OIG website at https://www.va.gov/oig/.