



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

DECEMBER 2022 HIGHLIGHTS

Office of Investigations

This office investigates potential crimes and civil violations of law involving VA programs and operations concerning VA employees, contractors, beneficiaries, and other individuals. These investigations focus on a wide range of matters, including healthcare, procurement, benefits, construction, and other fraud; cybercrime and identity theft; bribery and embezzlement; drug offenses; and violent crimes. The following investigations had significant developments this month.

Healthcare Investigations

Business Owner Sentenced for Multimillion-Dollar COVID-19 Scam

In March 2021, a business owner made fraudulent misrepresentations in an attempt to secure orders from VA for face masks and other personal protective equipment (PPE) that would have totaled more than \$806 million. This individual promised that he could obtain millions of genuine 3M masks from domestic factories but knew that fulfilling the orders would not be possible. He attempted to acquire an upfront payment from VA of over \$3 million and received approximately \$7.4 million from state governments and private entities by making similar false representations regarding his ability to get PPE. The defendant was sentenced in the Western District of New York to 244 months in prison and restitution of \$107 million after previously pleading guilty to wire fraud in connection with this COVID-19 scam and an unrelated Ponzi scheme. He also agreed to forfeit approximately \$3.2 million that was seized by the VA OIG and Homeland Security Investigations.

Former Compounding Pharmacy Executives Sentenced in Connection with 2012 Fungal Meningitis Outbreak

The former vice president and former director of operations of a now-defunct compounding pharmacy center were sentenced for introducing adulterated and misbranded drugs into interstate commerce. The pharmacy was at the center of a 2012 nationwide fungal meningitis outbreak that killed 64 individuals and caused infections in 793 patients. Although no known VA patients died or became ill, VA purchased approximately \$516,000 of these medications, which were produced in unsanitary conditions and in an unsafe manner. The former vice president, who also served as the pharmacy's general manager, was sentenced in the District of Massachusetts to one year in prison and one year of supervised release. The former director of operations was sentenced to five months in prison and one year of supervised release. Both defendants were previously found guilty at trial of conspiracy to defraud the United States. The investigation was conducted by the VA OIG, FBI, US Postal Inspection Service (USPIS), Defense Criminal Investigative Service (DCIS), and the Food and Drug Administration Office of Criminal Investigations (FDA OCI).

Cardiac Monitoring Companies Agreed to Pay More Than \$44.8 Million to Resolve False Claims Act Allegations

A multiagency investigation resolved allegations that a cardiac monitoring company and its subsidiary submitted claims to federal healthcare programs for heart-monitoring tests that were performed in part outside the United States, which violates federal law, and in many cases by technicians who were not qualified to perform such tests. The defendants entered into a civil settlement in the Eastern District of Pennsylvania under which the companies agreed to pay more than \$44.8 million to resolve these alleged False Claims Act violations. Of this amount, VA will receive \$681,000. The VA OIG, Office of Personnel Management (OPM) OIG, Department of Health and Human Services (HHS) OIG, and DCIS investigated.

Healthcare Device Manufacturer Agreed to Pay \$11.36 Million to Resolve False Claims Act Allegations

Another multiagency investigation involving alleged False Claims Act violations resulted in a healthcare device manufacturer entering into an \$11.36 million civil settlement in the Eastern District of Pennsylvania. The false claims were allegedly made in premarket approval applications submitted to FDA that pertained to radio frequency emissions generated by some of the company's cochlear implant sound processors. VA was one of several federal agencies that purchased cochlear implant systems containing the allegedly noncompliant sound processors. The \$11.36 million civil settlement includes more than \$5.6 million in restitution, of which VA will receive approximately \$522,000. This investigation was also conducted by the VA OIG, OPM OIG, HHS OIG, and DCIS.

Three Defendants Pleaded Guilty in Compounding Pharmacy Scheme

Multiple individuals engaged in a fraud scheme that involved charging inflated prices for medically unnecessary compounded medications to TRICARE (the healthcare program for active-duty service members), CHAMPVA, and private insurance companies. The defendants looked for compounded medication ingredients that could be billed at the highest rate and then provided doctors with blank prescription pads that listed those specific compounded medications. The compounded prescriptions were fraudulently dispensed by doctors located in different states than the patients, and for whom no doctor-patient relationship existed. The compounded prescriptions were often fraudulently dispensed to patients by unlicensed pharmacies; dispensed without a physician's authorization; dispensed to TRICARE, CHAMPVA, and privately insured recipients without approval; or billed for but never provided. The estimated loss to the government and private insurance is approximately \$29.3 million. Of this amount, the loss to VA is more than \$450,000. Three defendants pleaded guilty in the Southern District of Florida to conspiracy to commit wire fraud. This investigation was carried out by the VA OIG, Army Criminal Investigation Division, Department of Labor Employee Benefits Security Administration, FDA OCI, and DCIS.

Owner of Two Companies Indicted in Connection with Healthcare Fraud Scheme

A multiagency investigation resulted in charges alleging the owner of two companies that provide physical therapy and chiropractic services submitted multiple false claims to VA, TRICARE, Medicare, and Hawaii Medical Services Association (HMSA). From July 2013 to December 2018, the defendant was allegedly paid about \$3.3 million based on these false claims. Of this amount, VA paid about \$220,000. The defendant was indicted in the District of Hawaii on charges of healthcare fraud and aggravated identity theft. The VA OIG, HMSA, HHS OIG, and DCIS conducted the investigation.

Defendant Sentenced for Drug Diversion Scheme

A pharmacy technician employed at the VA medical center in Kerrville, Texas, stole more than 40 packages containing controlled substances intended for veterans from mailboxes in and around Kerrville and sold the substances to accomplices for further distribution. One of the accomplices was sentenced in the Western District of Texas to 35 months in prison and 36 months of supervised release. The investigation was conducted by the VA OIG, Drug Enforcement Administration, Kerr County Sheriff's Office, and USPIS.

Former VA Psychologist Indicted for Submitting False Documents

A former VA licensed clinical psychologist was indicted for allegedly submitting fraudulent information in connection with multiple schemes while employed at the Marion VA Medical Center in Illinois. According to the investigation, which was conducted by the VA OIG and HHS OIG, she allegedly submitted false and forged doctor's notes to obtain special accommodations related to her VA employment and in connection with a 2020 lawsuit she filed against VA. The defendant also allegedly submitted false claims to Medicare for treatment at a local nursing home that she did not provide. The loss to Medicare is approximately \$54,000. She was indicted in the Southern District of Illinois on charges of false statements, obstruction of justice, and healthcare fraud.

Benefits Investigations

Defendant Sentenced for Role in Multiple Education Benefits Fraud Schemes

A VA OIG proactive investigation involved an individual who served as a school-certifying official and course director for a for-profit, non-college-degree-granting diving school and subsequently became a consultant and an instructor for another diving school. The investigation revealed that the defendant made false representations to VA regarding the schools' hours of instruction for each of their VA-approved courses, attendance and course completion dates, payments received from non-VA students, and compliance with the "85/15 rule." To qualify for Post-9/11 GI Bill funding, a school must certify that no more than 85 percent of the students in any course are receiving VA benefits. This requirement, commonly referred to as the "85/15 rule," is intended to prevent abuse of GI Bill funding by ensuring that VA is paying fair market value tuition rates since at least 15 percent of the students would be paying the same rate with non-VA funds. The defendant was sentenced in the Southern District of Georgia to 54 months in prison, three years of probation, and restitution of more than \$6 million.

Technology Education Company Sued for Submitting False Claims for Inflated Post-9/11 GI Bill Tuition Benefits

A VA OIG investigation also resulted in a civil complaint alleging that a company that provides technology education courses violated the False Claims Act by knowingly submitting inflated tuition benefit claims to VA. Under the Post-9/11 GI Bill, VA pays the actual net cost for tuition and fees charged by the school after it has applied any scholarships, waivers, grants, or other assistance to defray those costs. This requirement is commonly referred to as the “last payer rule,” which ensures that VA is the payer of last resort and receives the benefit of any tuition-based financial support available to a student. The complaint alleges that the company repeatedly reported tuition and fees to VA on student invoices that did not include deductions for the tuition scholarships, grants, or waivers it provided to certain veterans. The “last payer rule” was allegedly violated by the company at five school locations in Illinois, Ohio, and Michigan. The civil complaint was filed in the Eastern District of Michigan.

Veteran Sentenced for Misrepresenting Symptoms to Obtain Compensation Benefits

According to an investigation by the VA OIG and Social Security Administration (SSA) OIG, a veteran misrepresented symptoms of conversion disorder (a functional neurological system disorder) and choreiform gait disorder (irregular and involuntary movements exhibited when walking) to obtain a 100 percent service-connected disability rating, VA Aid and Attendance benefits, and VA Survivors’ and Dependents’ Educational Assistance. The veteran was sentenced in the District of Kansas to 37 months in prison, three years of supervised release, and restitution of nearly \$538,000 after being found guilty at trial of wire fraud and theft of government funds.

Veteran Pleaded Guilty to Theft of Government Funds

A multiagency investigation revealed that a veteran purported to be blind in order to receive government disability benefits. Despite claiming to be blind, the veteran maintained a valid Nebraska driver’s license, drove almost every day, and obtained a Nebraska concealed carry weapons permit. The defendant pleaded guilty in the District of Nebraska to theft of government funds. The total loss to the government is approximately \$604,000, with the loss to VA approximately \$211,000. The VA OIG, SSA OIG, and HHS OIG conducted the investigation.

Veteran Convicted of Lying to the Federal Aviation Administration

A VA OIG and Department of Transportation OIG investigation resulted in charges alleging that a veteran submitted false statements to the Federal Aviation Administration (FAA) on his pilot’s medical certificates when he claimed that he did not have a history of criminal convictions and was not receiving any medical disability benefits. The investigation alleges that the veteran had a criminal record before he submitted forms to the FAA and had been receiving VA service-connected disability benefits for many years. The defendant was convicted after a two-day jury trial in the Northern District of New York of making false statements.

Investigations Involving Other Matters

Three Defendants Indicted in Connection with Service-Disabled Veteran-Owned Small Business Fraud Scheme

Three defendants allegedly conspired to obtain a service-disabled veteran-owned (SDVOSB) set-aside contract at the Salem VA Medical Center in Virginia that was valued at approximately \$5.3 million. The defendants allegedly moved an electrical subcontractor's employees onto the SDVOSB's payroll to make it appear as if the company was complying with a contract requirement to perform at least 15 percent of the labor with their own employees. The three defendants, along with another individual, also allegedly conspired to fraudulently obtain construction contracts at a Department of Defense facility that were reserved for companies run by socially and economically disadvantaged individuals through the Small Business Administration's 8(a) Business Development Program. The defendants were indicted in the Middle District of Pennsylvania on charges of violating the Major Fraud Act and conspiracy to defraud the United States and to commit violations of the Major Fraud Act. The VA OIG, Small Business Administration OIG, Army Criminal Investigation Division, and DCIS investigated the case.

Incarcerated Veteran Pleaded Guilty to Threatening VA Employees

An incarcerated veteran sent a communication to VA in which he threatened employees at VA and a nonprofit organization after he received a notification from VA that, per policy, his monetary benefits would be reduced during his incarceration. The veteran pleaded guilty in the District of Massachusetts to the interstate transmission of a threatening communication. The investigation was conducted by the VA OIG, Federal Bureau of Prisons, and FBI.

Former Physician at the Chula Vista VA Clinic Sentenced for Invasion of Privacy

A VA OIG and VA Police Service investigation revealed that a former physician at the Chula Vista VA Clinic secretly planted a concealed video recorder in the facility to record numerous staff members as they used the restroom. The former physician was sentenced in San Diego County Superior Court to 30 days of home detention and 12 months of probation, and was also ordered to stay away from all VA hospitals and surrender his medical license for five years.

Office of Audits and Evaluations

This office provides independent oversight of VA's activities to improve the integrity of its programs and operations. Its work helps VA improve its program results, promotes economy and efficiency, strengthens controls over the delivery of benefits, identifies potential fraud, verifies compliance with laws and regulations, and enhances veteran care and support. The Office of Audits and Evaluations released the following reports this month.

Healthcare Access and Administration

Featured Report

VBA's Compensation Service Did Not Fully Accommodate Veterans with Visual Impairments

This review examined whether VBA's Compensation Service complied with accessibility requirements for communicating benefits-related information to veterans with visual impairments. The OIG found that the Compensation Service did not fully comply with section 504 of the Rehabilitation Act, which requires that visually impaired veterans have "meaningful access" to federal programs, including benefit programs operated by VBA. The Compensation Service's continued lack of coordination with relevant agencies, along with its failure to comply with VA-wide accessibility implementation requirements, will continue to make it more difficult for veterans with visual impairments to participate fully in the disability compensation program. The OIG made five recommendations to the under secretary for benefits: (1) update the process for accommodating visually impaired veterans; (2) update the adjudication procedures; (3) develop and implement a quality assurance mechanism; (4) assign accessibility coordinators; and (5) coordinate a process to ensure visually impaired veterans are informed of the availability of accommodations.

Inappropriate Community Care Consult Edits Unsubstantiated at the VA Puget Sound Health Care System in Seattle, Washington

This review assessed the merits of a January 2022 allegation to the OIG hotline of inappropriate edits to community care consults (referrals) at the Puget Sound VA Health Care System in Seattle, Washington. The VA MISSION Act of 2018 allows veterans to receive care from local non-VA healthcare providers, known as community care, under certain circumstances. Community care schedulers are required to notify veterans of their eligibility, including if veterans are eligible to make such appointments themselves (self-scheduling). The OIG did not or could not substantiate (based on available evidence) the complainant's three allegations: (1) a leader at the Puget Sound facility inappropriately edited community care consults to reduce the backlog; (2) a community care scheduler enrolled patients in self-scheduling without asking them; and (3) facility leaders encouraged staff to inappropriately edit consults to reduce backlog and improve wait times. Given the lack of substantiation, the OIG made no recommendations to VA for corrective action.

Financial Efficiency

Audit of VA's Financial Statements for Fiscal Years 2022 and 2021

The OIG contracted with the independent public accounting firm CliftonLarsonAllen LLP (CLA) to audit VA's financial statements for fiscal years (FY) 2022 and 2021. CLA provided an unmodified opinion on these financial statements but noted material weaknesses and significant deficiencies in internal control and instances of noncompliance with laws and regulations. CLA is responsible for the

audit report and its conclusions. The OIG does not express opinions on VA's financial statements, internal controls, or compliance with the Federal Financial Management Improvement Act of 1996, nor does the OIG express conclusions on VA's compliance with laws and regulations. The independent auditors will follow up on these internal control and compliance findings and evaluate the adequacy of corrective actions taken during the FY 2023 audit of VA's financial statements.

Improvements Needed to Reduce Duplicate Payments by VHA and Medicare and Ensure VHA Has Authorized Community Medical Services

This review was conducted to determine whether providers were receiving duplicate payments for the same healthcare services from the Veterans Health Administration (VHA) and Medicare, as well as assessing whether VHA paid these claims without authorization. The OIG determined that VHA and Medicare made duplicate payments for services authorized by VHA. Without an interagency system, duplicate payment risks are increased. The report includes three recommendations to the under secretary for health, including working with the Centers for Medicare and Medicaid Services to establish a data-sharing agreement with VA. The OIG also recommended identifying overpayments made for care provided to dual-eligible veterans that were not authorized by VHA and ensure documentation of care is completed or that VA seeks reimbursement for any unauthorized care. The final recommendation called on VHA to make sure all nonemergency community care is preauthorized and that documentation for all authorizations is complete and properly stored before services are provided.

Management Advisory Memo

VBA Has Opportunities to Further Incorporate I CARE Values When Planning, Implementing, or Overseeing Programs

This management advisory to VA was issued to raise awareness among Veterans Benefits Administration (VBA) leaders about OIG concerns with decision-making on specific issues, highlighted in four reports, that adversely affected some beneficiaries. It is meant to strengthen VA's efforts to advance I CARE principles codified in 2012 that emphasize veteran-centric experiences and high standards in services and care. The highlighted OIG reports found VBA failed to fully consider outcomes when making decisions: Some veterans did not receive home loan funding fee refunds, some faced increased risk of their personal information being disclosed, and some underwent unnecessary disability medical examinations. The advisory suggests VBA could better institutionalize I CARE values by fully considering outcomes for beneficiaries when improving processes and systems. In their detailed response, VBA "strongly oppose[s] the implication that VBA did not always fully consider the effect organizational decisions would have on Veterans, beneficiaries, and their families."

Office of Healthcare Inspections

This office assesses VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections prompted by OIG

hotline complaints, congressional requests, and other leads. The office also performs inspections of vet centers and individual medical centers, healthcare systems, networks, and community providers. The Office of Healthcare Inspections released the following reports this month.

Comprehensive Healthcare Inspections

Comprehensive Healthcare Inspection Program (CHIP) reports 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 inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis. See the Purpose and Scope section of each report for the areas of focus at the time of the inspection. This month's CHIP reports focused on the [Louisville VA Medical Center](#) and the [Lexington VA Health Care System](#), both in Kentucky.

Other Reports

Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic

The Pandemic Response Accountability Committee's Health Care Subgroup developed this report to share insights about the expansion—and the emerging risks—of telehealth in selected programs across six agencies during the first year of the COVID-19 pandemic. The programs included VHA, Medicare, TRICARE, Federal Employees Health Benefits Program, Office of Workers' Compensation Programs, and Department of Justice prisoner healthcare services. The expansion of telehealth services clearly helped millions of individuals access health care during the crisis but also introduced several integrity risks associated with billing, including high-volume billing, duplicate claims, and inappropriate charges for the most expensive telehealth services. The study found that program integrity can be strengthened by implementing ongoing monitoring of telehealth services, developing controls to prevent inappropriate payments, educating providers and individuals about telehealth, collecting additional data to support oversight, and collecting and reviewing data about the impact of telehealth on quality of care. The PRAC's Health Care Subgroup consists of the inspectors general from the Departments of Veterans Affairs, Justice, Defense, Labor, Health and Human Services, and the Office of Personnel Management.

To listen to the podcast on the December highlights, go to www.va.gov/oig/podcasts.

