DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

MARCH 2023 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

Former VA Employee Sentenced in Connection with Medical Supply Bribery Scheme

A former chief of environmental management service at the Philadelphia VA Medical Center, who was responsible for supervising the ordering of goods and services at the facility, and other employees at multiple VA medical centers placed orders for supplies and services in exchange for cash bribes and kickbacks from corrupt vendors. The prices of supplies were often grossly inflated, and some orders were only partially filled or not fulfilled at all. The vendors charged in this case were responsible for over $37.6 million in purchase card orders and contracts. After previously pleading guilty to conspiracy to bribe a public official, the former chief was sentenced in the Eastern District of Pennsylvania to six months' imprisonment, two years' supervised release, and restitution of approximately $443,000.

Pharmaceutical Executive Pleaded Guilty to Conspiring to Sell Excessively Priced COVID-19 Personal Protective Equipment to VA

The owner of a pharmaceutical secondary wholesaler conspired with others to buy and then hoard designated scarce materials—including personal protective equipment—at the height of the COVID-19 pandemic. The defendant used deceitful means to sell the equipment to VA, defrauding at least a dozen VA medical centers by selling the equipment at excessive prices. In total, VA paid $330,000 for this equipment. The defendant pleaded guilty in the Southern District of Mississippi to conspiracy to defraud the United States. The VA OIG, FDA Office of Criminal Investigations, and FBI investigated the case.

Former VA Medical Center Supervisor Charged for Role in Bribery Scheme

A VA OIG investigation resulted in charges alleging that a former supervisor at the Philadelphia VA Medical Center used his government-issued purchase card to place orders with a particular company for medical supplies that totaled over $1.6 million. The former supervisor, who allegedly received cash payments of more than $28,000 from the owner of this company, was charged in the Eastern District of Pennsylvania with accepting gratuities as a public official.

Two Former VA Nurses Made False Statements Regarding Patient's Death

Two former registered nurses at the Oklahoma City VA Medical Center made false statements to investigators related to the suspicious death of an inpatient veteran. Specifically, they stated that they did

not pause medication being administered to the veteran prior to his death. Both nurses pleaded guilty in the Western District of Oklahoma to false statements. The VA OIG investigated the case.

Benefits Investigations

Navy Doctor Admitted to Role in Life Insurance Fraud Scheme

An investigation by the VA OIG, FBI, and Naval Criminal Investigative Service (NCIS) resulted in charges alleging that several coconspirators submitted fraudulent claims through the VA-administered Traumatic Servicemembers Group Life Insurance (TSGLI) program. The scheme involved submitting TSGLI claims that reflected fraudulent narratives of catastrophic injuries and exaggerated the loss of activities of daily living, generating payouts of $25,000 to $100,000 each. The loss to TSGLI is about $2 million. A Navy doctor pleaded guilty in the Southern District of California to conspiracy to commit wire fraud. To date, nine other individuals have been convicted in connection with this scheme.

Spouse of Veteran Sentenced for Compensation Benefits Fraud

According to an investigation by the VA OIG and Social Security Administration (SSA) OIG, a veteran fraudulently sought (and subsequently received) a 100 percent disability rating with special monthly compensation benefits for the alleged loss of the use of both feet based on false statements made during his military out-processing physical and subsequent VA examinations. Based on alleged false statements made by the now deceased veteran and his spouse, the veteran also received Social Security disability payments and VA grants for specially adapted housing and automobile adaptive equipment. After receiving a home from a private charity in 2013, multiple witnesses, local media, and investigators observed the veteran walking, driving, performing yard work, and playing basketball. The total loss is more than $582,000 to VA, nearly $152,000 to SSA, and $339,000 to the private charity. The veteran's spouse was sentenced in the Western District of Texas to 46 months' imprisonment, 36 months' supervised release, restitution of more than $501,000, trial expenses of $100,000, and a fine of $1,800 after previously being found guilty at trial on various related charges.

Veteran Pleaded Guilty in Connection with Unemployability Compensation Benefits Fraud Scheme

A veteran who received VA individual unemployability benefits concealed his employment from VA and SSA by being paid in cash or in his wife's name. The veteran admitted to working while receiving SSA disability benefits and individual unemployability benefits. After pleading guilty in the Western District of Michigan, he agreed to pay full restitution to VA and SSA. The loss to the government is $277,000, including a $136,000 loss to VA. The VA OIG and SSA OIG investigated.

Former VA Fiduciary for Brother Charged with Wire Fraud

A VA OIG investigation resulted in charges alleging that a former VA-appointed fiduciary misappropriated approximately $90,000 in VA benefits meant for her brother through numerous wire

transfers to her own bank account. The former fiduciary was indicted in the Western District of New York on charges of wire fraud.

Investigations Involving Other Matters

Former VA Social Worker Claiming to Be a Purple Heart and Bronze Star Recipient Sentenced for Stolen Valor Scheme That Included Stealing a Veteran's Identity to Gain Benefits

A former social worker at the Providence VA Medical Center in Rhode Island fraudulently claimed to be a wounded US Marine Corps veteran who was the recipient of a Purple Heart and a Bronze Star. The defendant collected more than $250,000 in benefits from veteran-focused charities using the personally identifiable information of an actual Marine to falsely claim she served in the Marine Corps from 2009 to 2016, achieved the rank of corporal, was wounded in action, and was honorably discharged. The defendant also falsely claimed to have cancer due to her alleged military service after using her position to access the VA medical records of a veteran cancer patient. The former social worker was sentenced in the District of Rhode Island to 70 months' imprisonment, three years' supervised release, and full restitution of close to $285,000 to the charities and individual victims. This investigation was conducted by the VA OIG, FBI, NCIS, Defense Criminal Investigative Service, Internal Revenue Service Criminal Investigation, US Postal Inspection Service, and VA Police Service.

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

An investigation by the VA OIG, Small Business Administration (SBA) OIG, and Department of Interior OIG revealed that two nonveterans managed and controlled a service-disabled veteran-owned small business (SDVOSB) and another business that was certified by SBA's 8(a) business development program to fraudulently obtain federal set-aside contracts. The defendants created the businesses with the false appearance that they were owned by family friends, one of whom is a veteran. The investigation further revealed that the defendants provided fraudulent references, created fraudulent documents, and made misrepresentations on government forms to hide their control of these businesses and to obtain entrance into the SDVOSB and 8(a) set-aside programs. The defendants were respectively sentenced in the Eastern District of Tennessee to 48 and 24 months in prison after previously being found guilty at trial of conspiracy to commit wire fraud, wire fraud, and major fraud against the United States. The court also issued a final order of forfeiture against the defendants for over $12.4 million.

VA Employee Indicted for Paycheck Protection Act Loan Scheme

According to a VA OIG investigation, an employee of the Louis Stokes Cleveland VA Medical Center claimed to own a janitorial services business in 2019 and provided receipts of $100,000 to qualify for a Paycheck Protection Act loan in May 2021. The defendant allegedly did not have a business or any business income in 2019, making the VA employee ineligible for the loan. The loss to the government is

about $20,800. The defendant was indicted in Cuyahoga County (Ohio) Court of Common Pleas on charges of grand theft and tampering with government records.

Veteran Pleaded Guilty to Destruction of Property at VA Medical Center

The VA OIG and VA Police Service revealed that a veteran drove his recreational vehicle through a locked entry gate at the Bath VA Medical Center in New York, which caused about $18,500 in damage. The veteran pleaded guilty in the Western District of New York to destruction of government property.

Veteran Sent Threatening Texts to Employees at the Bay Pines VA Medical Center

Between November 2020 and May 2021, a veteran sent more than 100 text messages in which he threatened to assault and murder VA medical center employees and their families using explosives and drones. The veteran pleaded guilty in the Middle District of Florida to the interstate transmission of threats. The VA OIG and FBI Joint Terrorism Task Force conducted this investigation.

Son of a Veteran Sentenced for Punching a VA Registered Nurse

The son of a veteran physically assaulted a VA registered nurse who was providing medical care to his father through a home-based primary care program administered by the Louis Stokes Cleveland VA Medical Center. The investigation, which was completed by the VA OIG and VA Police Service, revealed that the son punched the nurse in the face without provocation because he was angry that she was inside his father's residence. After she fell to the ground unconscious, he punched her again in the head when she tried to get up. The nurse escaped the residence and was transported to the emergency room with multiple injuries. The son was sentenced in the Cuyahoga County (Ohio) Court of Common Pleas to nine months in prison after pleading guilty to attempted felony assault.

Office of Audits and Evaluations

This office provides independent oversight of VA's activities to advance 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 released the following reports.

Benefits

VBA Did Not Ensure Complex Appeals Were Decided by Appropriate Staff

Decision review operations centers (DROCs) are responsible for processing any appeals made by veterans who disagree with Veterans Benefits Administration (VBA) compensation benefits decisions. DROC staff must be designated and trained to decide complex appeals. This review assessed a March 2022 hotline allegation that a DROC was not designating or training the appropriate staff to decide complex appeals. After reviewing three samples of complex appeals, the OIG substantiated that some staff from each of the three DROCs did not meet all requirements and estimated that

1,200 complex appeals were decided by undesignated staff. The OIG found that VBA's Office of Administrative Review did not monitor completed appeals to ensure they were decided by designated staff. In addition, about 400 complex appeals were assigned by the work routing system to undesignated staff because the system required manual updates for staff designations. The OIG made four recommendations related to ensuring correct DROC workload designations are made.

Veterans Are Still Being Required to Attend Unwarranted Medical Reexaminations for Disability Benefits

VBA requires reexaminations for veterans when there is a need to verify the continued existence or the current severity of a disability. VBA's policy is to request reexaminations only when mandated by law or as necessary before reducing an evaluation (i.e., reducing a veteran's disability rating due to improvements in the disability). While required reexaminations are important to ensure taxpayer dollars are spent appropriately, unwarranted reexaminations are a waste of appropriated funds, could cause undue hardships for veterans, and reduce the efficiency and timeliness of claims processing. The OIG found VBA did not require staff to cite objective evidence for why reexaminations were needed per policy. Further, it did not define criteria for claims processors responsible for reviewing reexamination controls, establishing training requirements, or monitoring completion of relevant training. VBA concurred with the OIG's three recommendations to update guidance, training, and information systems to reduce unwarranted medical reexaminations for veterans.

Independent Review of VA's Special Disabilities Capacity Report for Fiscal Year 2021

By law, VA must submit an annual report to Congress documenting VA's capacity to provide specialized treatment comparable to that available as of October 9, 1996, for veterans with spinal cord injuries and disorders, traumatic brain injury, blindness, prosthetics and sensory aids, or mental health issues. Congress requires the VA OIG to report on the accuracy of VA's annual special disabilities capacity report. The OIG found VA's fiscal year 2021 report was accurate but identified minor errors and data omissions that have persisted from last year's review. For example, VA is unable to report mental health capacity data comparable to that from 1996 because of changes in the definition and tracking of treatment outcomes. The capacity report also does not capture community care data or changes in bed capacity at VA's centers for spinal cord injuries and disorders. Modernizing the reporting metrics would better assess VA's capacity to provide care for these veterans.

VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: March 2023

The Transparency Act requires VA to report to Congress its plans to spend COVID-19 relief funding, including funding under the Families First Coronavirus Response Act (FFCRA). The OIG is tasked with overseeing the use of Transparency Act–covered funding. This is the third semiannual report in support of that oversight, which found VA generally complied with the Transparency Act by providing

justification for its programs and activities and largely aligned obligations and expenditures to its detailed plan. However, VA did not provide sufficient documentation for the team to assess line-level details needed to make a full assessment. The OIG will review VA's documentation of FFCRA funding in subsequent reports. Although the OIG did not make recommendations in this report, there are two unimplemented recommendations from a March 2022 OIG report related to Transparency Act funds that could interfere with VA's long-term compliance with the act if not addressed.

Improvements Needed in Integrated Financial and Acquisition Management System Deployment to Help Ensure Program Objectives Can Be Met

To modernize its financial and acquisition management systems, VA established the Financial Management Business Transformation (FMBT) program to replace legacy systems with the Integrated Financial and Acquisition Management System (iFAMS), which will be implemented in 18 waves, starting with the National Cemetery Administration (NCA). On November 9, 2020, iFAMS went live at NCA. The VA OIG conducted this audit as part of its oversight of this extensive modernization program because of risks associated with the legacy financial systems and VA's previous failed attempts to replace them. The OIG identified four system functionality issues and three procedural weaknesses from the first iFAMS deployment at NCA and made five recommendations. Improving risk management, system testing, and communication could help the FMBT Service prevent issues from affecting a significantly greater number of staff at VA's larger administrations. It would also allow the FMBT Service to achieve program goals of promoting operational efficiency, increasing compliance, strengthening automated controls, mitigating audit deficiencies, and improving data reliability and reporting.

Office of Special Reviews

This office conducts administrative investigations and increases the OIG's flexibility and capacity to conduct prompt reviews of significant events and emergent issues not squarely within the focus of a single OIG directorate or office. The Office of Special Reviews released the following report this month.

Featured Report

Stronger Controls Help Ensure People Barred from Paid Federal Healthcare Jobs Do Not Work for VHA

Under federal law, the Veterans Health Administration (VHA) cannot employ individuals who have been formally excluded from having a paid position in a federal healthcare program. Exclusions can result from an individual committing healthcare fraud, patient abuse, controlled substance violations, acts resulting in license revocation, and other misconduct as specified by federal law. The List of Excluded Individuals and Entities (LEIE) is maintained by the Department of Health and Human

Services OIG. LEIE screening is meant to prevent individuals who have been found unsuited for working in a federally funded healthcare program from having access to medical facilities that need to protect their assets, patients, and information systems.

The VA OIG matched VHA personnel pay against LEIE data for the first pay period of January 2022 and found VHA was employing four former nursing professionals excluded from having VHA positions. They had housekeeping, clerical, or support positions—not engaged in patients' health care. Three of them were on the list because of nursing license revocation or suspension, while the fourth was convicted of healthcare fraud. When notified, VA took prompt action to terminate the employees and the OIG confirmed they are no longer with VHA. VHA leaders also outlined actions to address the process failures the OIG identified. In addition, leaders concurred with the report's three recommendations for completing those policy and process improvements, taking additional actions to prevent violations from recurring, and conducting a one-time audit to confirm compliance with the federal law outside the review period. The OIG will continue to monitor VA's progress until sufficient documentation has been received to close the recommendations as implemented.

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.

Healthcare Inspections

Opioid Safety at the VA Northern California Health Care System in Mather

This review focused on opioid therapy management practices by patient aligned care team providers and supervisors at the VA Northern California Health Care System. It also examined facility and Veterans Integrated Service Network (VISN) oversight processes for opioid therapy. Facility care providers and supervisors, along with facility and VISN opioid safety leaders, were found to have followed and implemented VHA requirements and recommendations related to safe opioid therapy prescribing. However, the facility did not meet all VHA requirements related to facility policies; specifically, it did not have a required state prescription drug monitoring program policy, and the pain management policy contained outdated guidance about utilizing opioid pain care agreements. The facility director concurred with the OIG's two recommendations related to creating and updating the policies.

Deficiencies in the Implementation and Leadership Oversight of Ketamine at the Eastern Oklahoma VA Health Care System in Muskogee

Ketamine is a general anesthetic used for medical and surgical procedures and pain control. Due to its hallucinogenic and dissociative effects, the drug has significant potential for abuse. The OIG assessed allegations that an anesthesiologist at the Eastern Oklahoma VA Health Care System self-referred patients who were not approved by the facility for intravenous ketamine to a private practice. While this allegation was not substantiated, the inspection team found that leaders did little to respond to a concern regarding the anesthesiologist's prescribing practices and did not resolve disagreements between prescribers and pharmacists. The team also found that scientific opinions on patient selection for ketamine treatment differ from VA's national ketamine guidance regarding the acceptable number of prior treatment failures in a current episode of depression, and the under secretary for health concurred with the OIG's recommendation to address this discrepancy. The OIG directed four recommendations to the facility director related to non-formulary processes, informed consents, the ketamine standard operating procedure, and development of positive working relations among the anesthesiology, pharmacy, and psychiatry services.

Deficiencies in Emergent and Outpatient Care of a Patient with Alcohol Use Disorder at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana

Following the death of a patient who requested alcohol detoxification from the VA medical center's emergency department, the OIG substantiated allegations that facility staff mismanaged the alcohol withdrawal care of the patient and inadequately responded to the patient's urgent care needs, including reports of "bad" withdrawal symptoms and lack of transportation. The inspection also revealed that leaders had not established procedures for care coordination of patients discharged from the emergency department and did not complete an institutional disclosure. Furthermore, following the patient's earlier visit to a community-based outpatient clinic, the inspection team found that a nurse practitioner failed to thoroughly assess the patient's substance use, schedule follow-up, and discuss immediate safety concerns. The medical center director concurred with the OIG's seven recommendations related to an evaluation of an emergency department alcohol withdrawal management protocol, emergency department discharge planning and care coordination guidance, institutional disclosures, administrative staff protocol for urgent care needs, and primary care procedures for management of intoxicated patients.

Inadequate Coordination of Care for a Patient at the West Palm Beach VA Healthcare System in Florida

This inspection evaluated allegations that West Palm Beach VA Healthcare System staff failed to coordinate care for a patient who died of cancer. Focusing on the period between initial treatment of cancer and when metastatic cancer was found, the inspection determined that although the patient's care *was* coordinated by the primary care provider and the pulmonologist, the latter failed to notify the

patient of chest computerized tomography (CT) scan results and did not use required scheduling processes to ensure follow-up appointments occurred. This may have resulted in delays in care for the patient. The OIG identified additional concerns with the follow-up for community care chiropractic imaging recommendations. The facility director concurred with the OIG's recommendations to ensure (1) pulmonology providers communicate test results to patients, (2) appointment scheduling processes are followed as required, and (3) community care notes are reviewed and actions are taken as needed.

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 inspections. This month's CHIP reports focused on the Amarillo VA Health Care System in Texas and the VA Texas Valley Coastal Bend Health Care System in Harlingen.

Featured Hotline Case

The OIG's hotline staff accept complaints from VA employees, the veteran community, and the public concerning potential criminal activity, waste, abuse, and gross mismanagement of VA programs and operations. The following is a case opened by the Hotline Division that was not included in the inspections, audits, investigations, or reviews detailed above.

Anchorage, Alaska, VA Medical Center Makes Staffing Adjustments to Address Sleep Clinic Backlog

A complainant alleged the Anchorage VA sleep clinic had a backlog of over 500 return-to-clinic patient orders for appointments with sleep techs and providers. The matter was referred to the Anchorage VA Medical Center for further investigation. The medical center's findings shared with the OIG resulted in changes being made to staffing that are meant to reduce the clinic's backlog and open up scheduling availability. These include increasing available sleep tech appointments by 40–45 per week, converting a part-time sleep provider position to full time, and privileging another part-time sleep provider position to see patients in the VA medical center in addition to the Department of Defense hospital.

***

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