



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

APRIL 2023 HIGHLIGHTS

Congressional Testimony

Principal Deputy AIG for Healthcare Inspections Testifies on Residential Substance Use Disorder Treatment Programs before the House Veterans Affairs' Subcommittee on Health

Dr. Julie Kroviak, the principal deputy assistant inspector general for the Office of Healthcare Inspections, testified before the Subcommittee on Health on April 18, 2023. Her testimony focused on the findings and recommendations of the healthcare inspection, [*Noncompliance with Community Care Referrals for Substance Abuse Residential Treatment at the VA North Texas Health Care System*](#), which was initiated in response to allegations that staff at the facility's substance use disorder treatment program placed patients on waitlists for two to three months and failed to offer them non-VA community residential care referrals. During the hearing, Dr. Kroviak emphasized the need for staff to adhere to community care policies, as well as for VA to improve its collaboration with third-party administrators and community care providers for high-risk veterans with complex mental health conditions. In response to questions, Dr. Kroviak discussed the hallmarks of a high-quality community care residential rehabilitation program and the challenges in coordinating care for high-risk veterans with substance use disorders.

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

Doctor to Pay \$7 Million to Resolve Civil Fraud Allegations

A VA OIG investigation resolved allegations that a doctor and others engaged in a scheme to defraud VA's CHOICE/Patient-Centered Community Care program by submitting claims for higher levels of service than was medically reasonable or necessary. The doctor entered into a civil settlement in the Eastern District of Oklahoma under which he agreed to pay \$7 million to resolve these allegations.

Defendant Charged for Role in Conspiracy Involving Fraudulent Prescriptions for Durable Medical Equipment

According to a multiagency investigation, numerous defendants allegedly owned and operated call centers through which they obtained prescription orders for durable medical equipment, such as orthotic braces, for patients without regard to medical necessity. They allegedly provided these orders in

exchange for bribes from certain companies that provided the braces to the patients. The loss to VA's Civilian Health and Medical Program (CHAMPVA) is approximately \$330,000. One defendant was arrested after being charged in the District of New Jersey with conspiring to violate the federal Anti-Kickback Statute. This investigation was conducted by the VA OIG, FBI, Department of Health and Human Services (HHS) OIG, and Defense Criminal Investigative Service (DCIS).

VA Psychiatrist Pleaded Guilty for Scheme to Sell Opioids to Patients

A psychiatrist at the Marion VA Medical Center in Illinois used her position to intentionally sell prescription opioids to her patients for financial gain. She pleaded guilty in the Southern District of Illinois to conspiracy to distribute controlled substances. The VA OIG and FBI investigated the case.

Benefits Investigations

Featured Investigation

Business Owner Charged for Defrauding VA of More than \$4 Million

The owner of a business that claimed to provide home health services to veterans allegedly conspired with others to submit, on behalf of unwitting VA beneficiaries, fraudulent applications to VA for pension with aid and attendance benefits. Aid and attendance is a higher monthly pension amount paid to a qualified veteran or surviving spouse for assistance with activities of daily living. The investigation, which was conducted by the VA OIG, alleges that the coconspirators falsely claimed to have provided home assistance to the beneficiaries before submitting the applications, disguised their role in the application process during their interactions with the victims, and received over \$4 million in VA funds intended for over 300 veterans or their surviving spouses. The business owner was charged in the Eastern District of Louisiana with wire fraud.

Dive School Training Director Sentenced in Connection with Education Benefits Fraud Scheme

The director of training at a for-profit, non-college degree dive school made false representations regarding the school's compliance with VA regulations, dates of students' attendance, and hours of instruction. The defendant, who also served as the school certifying official, falsely represented that the school complied with a VA rule designed to prevent abuse of GI Bill funding. The rule requires that no more than 85 percent of students in any course are VA education beneficiaries. By requiring that at least 15 percent of students have not used VA education benefits to pay for a course, VA can maintain assurance that it is paying fair market value. The defendant was sentenced in the Southern District of Georgia to eight months' probation and ordered to pay restitution to VA of more than \$722,000 after

previously pleading guilty to false statements. The loss to VA was approximately \$1.1 million. The VA OIG and DCIS conducted the investigation.

Veteran Indicted for Compensation Benefits Fraud Scheme

According to a multiagency investigation, a veteran allegedly received more than \$938,000 in government benefits to which he was not entitled by making false statements regarding the nature of his service-connected disabilities. Of this amount, the loss to VA is approximately \$589,000. The defendant was indicted in the Northern District of Florida for theft of government funds. The VA OIG, Social Security Administration (SSA) OIG, and HHS OIG investigated the case.

Deceased Veteran's Spouse Charged for Allegedly Defrauding VA of Survivor Benefits for Nearly 30 Years

A VA OIG investigation based upon a hotline referral resulted in charges alleging that the spouse of a deceased veteran fraudulently received VA Dependency and Indemnity Compensation (DIC) benefits between November 1995 through April 2023. The defendant allegedly failed to report two subsequent marriages to VA, which would have made him ineligible to receive these benefits. The loss to VA is approximately \$364,000. The defendant was arrested after being indicted in the Middle District of Florida for theft of government funds.

Defendant Indicted for Another Survivor Benefits Fraud Scheme

The VA OIG and FBI investigated a woman who may have fraudulently received VA DIC payments intended for her great aunt who died in February 1999. The woman allegedly forged the deceased beneficiary's signature, endorsed the checks to herself, and deposited the funds into accounts under her control to pay for her personal living expenses. She was indicted in the Southern District of West Virginia for theft of government funds. The loss to VA is approximately \$329,000.

Nonprofit Owner Charged with Misappropriating Funds from a Veteran

The director of a nonprofit company that provides housing and other services to veterans was indicted in the District of New Mexico on charges of fiduciary misappropriation and false statements. The defendant, who was serving as the fiduciary for a service-connected disabled veteran, allegedly deposited two cashier's checks totaling over \$163,000 intended for the veteran into her company's account. When VA asked the defendant to provide bank statements showing the disposition of the veteran's money, the investigation alleges that she falsely led VA to believe that she invested the funds in a mortgage for one of her company's properties, which would, through interest, earn additional funds for the veteran. While the defendant allegedly recorded a mortgage that purported to grant the veteran an interest in a property, the mortgage referred to a property that was not owned by the company. It is further alleged that when the defendant was subsequently removed by VA as the veteran's fiduciary, she never forwarded the veteran's funds to the successor fiduciary. This case was investigated by the VA OIG.

Former VA Fiduciary Indicted for Wire Fraud

A VA OIG and SSA OIG investigation resulted in charges alleging that the sister of a veteran used his government benefits for her personal expenses after he became a full-time resident at the Orlando VA Medical Center's Community Living Center. The defendant, who previously served as her brother's VA-appointed fiduciary and SSA representative payee, allegedly conducted large monthly wire transfers from his bank account to her own personal bank account after the deposits of his VA and Social Security benefits. She was arrested after being indicted in the Middle District of Florida for wire fraud. The loss to VA is approximately \$150,000.

Investigations Involving Other Matters

Former VA Medical Center Supervisor Pleaded Guilty for Role in Bribery Scheme

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, pleaded guilty in the Eastern District of Pennsylvania to accepting gratuities as a public official. The VA OIG conducted the investigation.

Nine Defendants Sentenced in Connection with Workers' Compensation Fraud Scheme

A multiagency investigation resulted in charges alleging that a Texas company recruited injured federal employees by offering to assist in filing their claims with the Department of Labor's Office of Workers' Compensation Programs. The defendants allegedly funneled those employees to medical clinics where doctors wrote prescriptions for compounded medications in exchange for kickbacks from compounding pharmacies. The coconspirators billed the Department of Labor, as well as the Department of Defense's TRICARE program, for more than \$126 million for these prescriptions. The portion of the billed amount attributable to VA employees is approximately \$1.3 million. Nine defendants were sentenced in the Southern District of Texas after previously pleading guilty to charges associated with this scheme. The sentences included prison terms of 20 years and 15 years for the two former co-owners of one compounding pharmacy, 10 years for the former owner of another compounding pharmacy, five years for both a medical doctor and a pharmacist, three years for another pharmacist, and 18 months for a compounding pharmacy employee and two patient recruiters. This investigation was conducted by the VA OIG, US Postal Service OIG, Department of Labor OIG, and DCIS.

Defendant Indicted in Connection with COVID-19 Fraud Scheme

An investigation by the VA OIG and Internal Revenue Service Criminal Investigation alleges that a purported business owner fraudulently obtained Payroll Protection Program loans for himself as a sole proprietor and Economic Impact Disaster Loans for nonexistent and/or defunct businesses. The total loss to the government is approximately \$1 million. The defendant was indicted in the Eastern District of Louisiana on charges of false statements, theft of government funds, and money laundering. This

investigation was a result of a referral from the COVID-19 Pandemic Response Accountability Committee (PRAC). As a member of the PRAC, the VA OIG provides assistance to the government's efforts to prosecute instances of fraud even if these cases do not have a direct nexus to VA's programs and operations.

Former VA Licensed Practical Nurse Pleaded Guilty to Distribution and Possession of Child Pornography

A former licensed practical nurse at the Northampton VA Medical Center in Leeds, Massachusetts, used the facility's public Wi-Fi to upload and download thousands of files to his personal computer that contained child pornography. The nurse pleaded guilty in the District of Massachusetts to distribution and possession of child pornography. The investigation was conducted by the VA OIG, US Secret Service, and VA Police Service.

Former Contract Supervisor Charged with Aggravated Sexual Abuse of Subordinate at the Palo Alto VA Medical Center in California

A VA OIG and VA Police Service investigation resulted in charges alleging that a former contract janitorial supervisor at the VA medical center in Palo Alto forced a subordinate VA contract employee to engage in a sex act at the facility. The defendant also allegedly lied to a VA OIG agent during a subsequent interview by claiming that he never had sexual intercourse with the victim. The defendant was arrested after being indicted in the Northern District of California on charges of aggravated sexual abuse, sexual abuse, and false statements to a federal agent.

VA Housekeeping Aide and Another Individual Face Charges Related to Theft of Winning Lottery Ticket from Terminally Ill Patient

A VA OIG and Massachusetts State Police investigation alleges that a housekeeping aide at the West Roxbury VA Medical Center in Massachusetts stole a \$5,000 winning scratch ticket from a terminally ill veteran who was receiving end-of-life treatment at the facility. To conceal the theft, the aide allegedly directed a codefendant with no connection to VA to redeem the winning ticket. Both were charged in West Roxbury District Court (Massachusetts) with larceny and fraud-related offenses.

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.

Healthcare Access and Administration

Office of Emergency Management Has Not Deployed a Functional Last-Resort Emergency Communications System

In response to a hotline complaint, the VA OIG conducted this audit to determine if the Veterans Health Administration (VHA) provided effective oversight of the installation and deployment of its resilient, high-frequency radio network to ensure reliable communications capabilities during crises and natural disasters. The complainant alleged (1) the network was not functioning as intended; (2) waste, fraud, and abuse had occurred in the network's approval and implementation; and (3) the radio at the VA Butler Healthcare System in Pennsylvania had not been properly maintained. The OIG substantiated that the network was not functioning as intended, waste had occurred, and the Pennsylvania radio and others had not been properly maintained. The OIG concluded 82 percent of sites with radios did not have two-way voice communication three years after installation should have finished. The OIG recommended that VA medical facilities maintain enough trained staff to operate the network; VHA clarify the program office responsible for the network and finalize the operations plan; and OEM outline requirements for acceptance if additional equipment is purchased, issue guidance about where radios should be installed and monitored, and ensure sites can obtain repairs for network equipment.

Audie L. Murphy Memorial Veterans' Hospital Missed Opportunities to Distribute Excess Ventilators during the COVID-19 Pandemic

The OIG reviewed whether the Audie L. Murphy Memorial Veterans' Hospital in San Antonio, Texas, properly requested, procured, received, and accounted for ventilators during the pandemic. The review team found the hospital acquired more than were needed for veteran care. Duplicate purchases were made due to hospital officials' concerns about delays and supply chain disruptions, with 56 ventilators being ordered from both a local and national contract. The 56 national-contract ventilators, worth about \$2.5 million, were never used for patient care. They were stored for more than 19 months while other VA facilities reported shortages. VA concurred with the OIG's recommendations to (1) document a methodology for determining the number of ventilators required during routine and emergency operations and (2) determine whether the remaining ventilators are all needed or can be turned in. VA submitted documentation of corrective actions resulting in the OIG's closure of the recommendations.

Benefits

The Medical Disability Examination Office Needs to Better Monitor Mileage Requirements for Contract Exams

Veterans have a right to undergo disability exams within a reasonable distance of their homes. Because some veterans have expressed concerns regarding the excessive distances they've traveled for exams, the OIG reviewed how VBA's Medical Disability Examination Office (MDEO) monitors mileage

requirements in the contract exam process. The team found that, because MDEO leaders do not consider monitoring a priority, the office is not monitoring whether vendors who perform the exams obtain and document veterans' express consent to travel beyond contractual mileage limits as required. If vendors are not obtaining this consent, it is possible that veterans are not aware of their right to undergo exams within reasonable distances, potentially burdening elderly veterans or those with disabilities that make travel difficult. The OIG recommended the under secretary for benefits monitor compliance with contractual mileage limits and ensure vendors document the consent of veterans who agree to travel beyond these limits.

Financial Efficiency

A Summary of Preaward Reviews of VA Federal Supply Schedule Nonpharmaceutical Proposals Issued in Fiscal Year 2021

To help contracting officers negotiate fair and reasonable prices, the VA OIG reviews nonpharmaceutical proposals for VA FSS contracts with an annual value of \$10 million or more for high-tech medical equipment, \$3 million or more for all other contracts, or \$100,000 or more for dealers/resellers without significant sales to the public, or as requested by VA. This report summarizes reviews conducted during fiscal year 2021 of 26 nonpharmaceutical proposals. The OIG's recommendations assisted in obtaining \$41 million in contract savings for VA. Commercial sales practices disclosures were accurate, complete, and current for nine proposals. The OIG reviewed vendor commercial selling practices and recommended lower prices for 17 proposals, resulting in adjusted recommended cost savings of approximately \$182 million. The OIG also evaluated and suggested alternative tracking customers for 10 proposals. This report does not propose any additional recommendations that necessitate any action or VA response.

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.

National Review

Review of Access to Telehealth and Provider Experience in VHA Prior to and During the COVID-19 Pandemic

The OIG reviewed implementation and use of VA Video Connect (VVC) prior to and during the pandemic, why providers used telephone communication more frequently than VVC upon the onset of

the pandemic, and how VHA resolved technology issues. According to the review, telephone and VVC encounter use increased as presumed in-person encounters decreased at the onset of the pandemic, and telephone use decreased and VVC encounters continued to increase following the initial months of the pandemic. The OIG concluded the pandemic served as the impetus for VVC use. VHA providers stated the pandemic served as a turning point; identified benefits of using VVC, such as convenience and increased patient engagement; and described barriers to VVC use such as patient obstacles with VVC technology, VVC appointments not emulating in-person appointments, and difficulty with scheduling VVC appointments. VHA concurred with the OIG's recommendations related to provider knowledge and utilization of VVC technology, clinical and administrative support, and VVC scheduling processes.

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 [VA Long Beach Healthcare System in California](#) and [VA MidSouth Healthcare Network in Nashville, Tennessee](#).

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.

Patients Experience a Temporary Harmful Event and an Adverse Event Due to Medication Errors at Phoenix VA Medical Center

The OIG hotline received a complaint alleging deficiencies in pharmacy and nursing processes may have contributed to two separate clinical events at the Carl T. Hayden VA Medical Center in Phoenix, Arizona. The allegation was referred to the medical center for further review, which determined that the emergency department mistakenly gave a patient cisatracurium, a drug used to relax muscles during surgery, instead of octreotide, a drug used to control diarrhea and flushing caused by some tumors, due to incorrect labeling. The patient was transferred to the intensive care unit and intubated after their health continued to decline. Medication was stopped when staff noticed the incorrect labeling.

The review also found that a second patient mistakenly received nicardipine, a drug used to treat high blood pressure, instead of norepinephrine, a drug used to treat abnormally low blood pressure. This

occurred because an intravenous bag of nicardipine was incorrectly stocked in the automated dispensing cabinet as norepinephrine. The patient rapidly declined following the error and ultimately expired.

The medical center's reported findings and corrective actions include the following:

- Adding cisatracurium and norepinephrine to the high-alert medication list
- Changing storage processes and implementing standardized labeling of batched IV medications
- Requiring pharmacy staff to complete verification of both labels (front and back) on all batched IV medication
- Standardizing pharmacy handling processes to include physical separation of all medication during the pulling and filing process
- Requiring nurses to scan each individual medication when pulling medication from the automated dispensing cabinet
- Adding verbiage to a medication safety training module reinforcing the need to verify medication labels
- Implementing medication management tracers in the intensive care unit
- Hosting a high-reliability organization forum on serious safety events within 60 days to anticipate risk, strive for zero harm, and support enhanced psychological safety

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