# Department of Veterans Affairs

## Office of Inspector General

# Semiannual Report to Congress

Issue 63 | October 1, 2009—March 31, 2010

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# Message from the Inspector General

I am pleased to submit this issue of the Semiannual Report to the Congress of the United States. Pursuant to the *Inspector General Act of 1978*, as amended, this report presents the results of our most significant accomplishments during the reporting period October 1, 2009 – March 31, 2010.

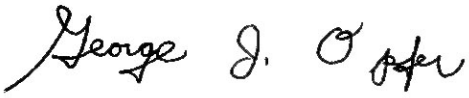
During this reporting period, the Office of Inspector General (OIG) issued 120 reports on VA programs and operations. OIG inspections, audits, evaluations, investigations, and other reviews identified nearly $673 million in monetary benefits, for a return of $14 for every dollar expended on OIG oversight. One audit identified approximately $276 million in funds that could be put to better use if the Veterans Health Administration (VHA) timely reviewed obligations for purchases no longer needed and de-obligated funds so that funding could be used for other purposes.

Our criminal investigators have closed 424 investigations, and made 269 arrests for a variety of crimes including fraud, bribery, embezzlement, identity theft, drug diversion and illegal distribution, computer crimes, and personal and property crimes. OIG investigative work also resulted in 232 administrative sanctions. In one case, a fiduciary was sentenced to 55 months' incarceration after pleading guilty to making a false statement to VA in an effort to conceal her embezzlement of Veterans' funds. A joint Federal and state investigation determined that the defendant had embezzled nearly $1 million from 33 disabled Veterans while acting as their appointed fiduciary.

Another audit of the Veterans Benefits Administration (VBA) Fiduciary Program revealed that program weaknesses identified in a 2006 OIG audit persist, and that VBA still needs to improve its management infrastructure in the areas of information systems, staffing models, and management oversight to protect the financial assets of vulnerable Veterans. OIG's audit of Compensation & Pension examinations found many Veterans do not receive timely medical examinations because VA medical facilities do not commit sufficient resources to them. Increased oversight and greater collaboration between VBA and VHA are needed to reduce delays in examiniations that can impact the delivery of disability benefits to Veterans.

OIG published Combined Assessment Program reviews of 22 VHA medical centers, focusing on a variety of actions critical to ensuring that Veterans receive high quality medical care. OIG made suggestions to improve quality management, credentialing and privileging of providers, and procedures to clean and sterilize reusable medical equipment. In reviews of community based outpatient clinics (CBOCs), OIG made recommendations to ensure that Veterans receive the same high quality of care whether they are treated at medical centers or free standing clinics. OIG also suggested actions to improve contracting for primary care at CBOCs.

We appreciate the ongoing support we receive from the Secretary, Deputy Secretary, and senior management. We will continue to partner with VA and Congress to help transform VA into a 21st Century organization. Most importantly, we will continue to do our part to ensure America's Veterans receive the care, support, and recognition they have earned in service to our country.



GEORGE J. OPFER
Inspector General

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| | For the Reporting Period October 1, 2009—March 31, 2010 | |
|---|---|---|
| DOLLAR IMPACT (in Millions) | Better Use of Funds | $276.0 |
| | Fines, Penalties, Restitutions, and Civil Judgments | $45.9 |
| | Fugitive Felon Program | $63.6 |
| | Savings and Cost Avoidance | $282.3 |
| | Questioned Costs | $.05 |
| | Dollar Recoveries | $5.0 |
| | **Total Dollar Impact** | **$672.9** |
| | **Cost of OIG Operations[1]** | **$47.0** |
| | **Return on Investment (Total Dollar Impact/Cost of OIG Operations)** | **14:1** |
| OTHER IMPACT | ***Reports Issued*** | |
| | Administrative Investigations | 2 |
| | American Recovery and Reinvestment Act | 3 |
| | Audits and Reviews | 9 |
| | Benefits Inspections | 6 |
| | Combined Assessment Program Reviews | 22 |
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| | Healthcare Inspections | 26 |
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| | **Total Reports Issued** | **120** |
| | ***Investigative Activities*** | |
| | Non-Fugitive Felon Arrests | 235 |
| | Fugitive Felon Arrests | 34 |
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| | Indictments | 150 |
| | Criminal Complaints | 80 |
| | Convictions | 169 |
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| | Administrative Sanctions | 232 |
| | Cases Opened | 421 |
| | Cases Closed | 424 |
| | ***Healthcare Inspections Activities*** | |
| | Clinical Consultations | 1 |
| | Administrative Case Closures | 10 |
| | ***Hotline Activities*** | |
| | Cases Opened | 425 |
| | Cases Closed | 514 |
| | Administrative Sanctions | 22 |
| | Substantiation Rate | 46% |
| | Contacts | 14,600 |

1. This figure does not include the $9.4 million operating cost for the Office of Healthcare Inspections (OHI). We do not include this figure because oversight work performed by OHI results in saving lives and not dollars.

## Department of Veterans Affairs

The Department's mission is to serve America's Veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support, and recognition earned in service to the Nation. The VA motto comes from Abraham Lincoln's second inaugural address, given March 4, 1865, "to care for him who shall have borne the battle and for his widow and his orphan."

While most Americans recognize VA as a Government agency, few realize that it is the second largest Federal employer. For fiscal year (FY) 2010, VA is operating under a $127.1 billion budget, with nearly 300,000 employees serving an estimated 23.1 million living Veterans. To serve the Nation's Veterans, VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Republic of the Philippines.

VA has three administrations that serve Veterans: the Veterans Health Administration (VHA) provides health care, the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits, and the National Cemetery Administration provides interment and memorial benefits. For more information, please visit the VA Internet home page at www.va.gov.

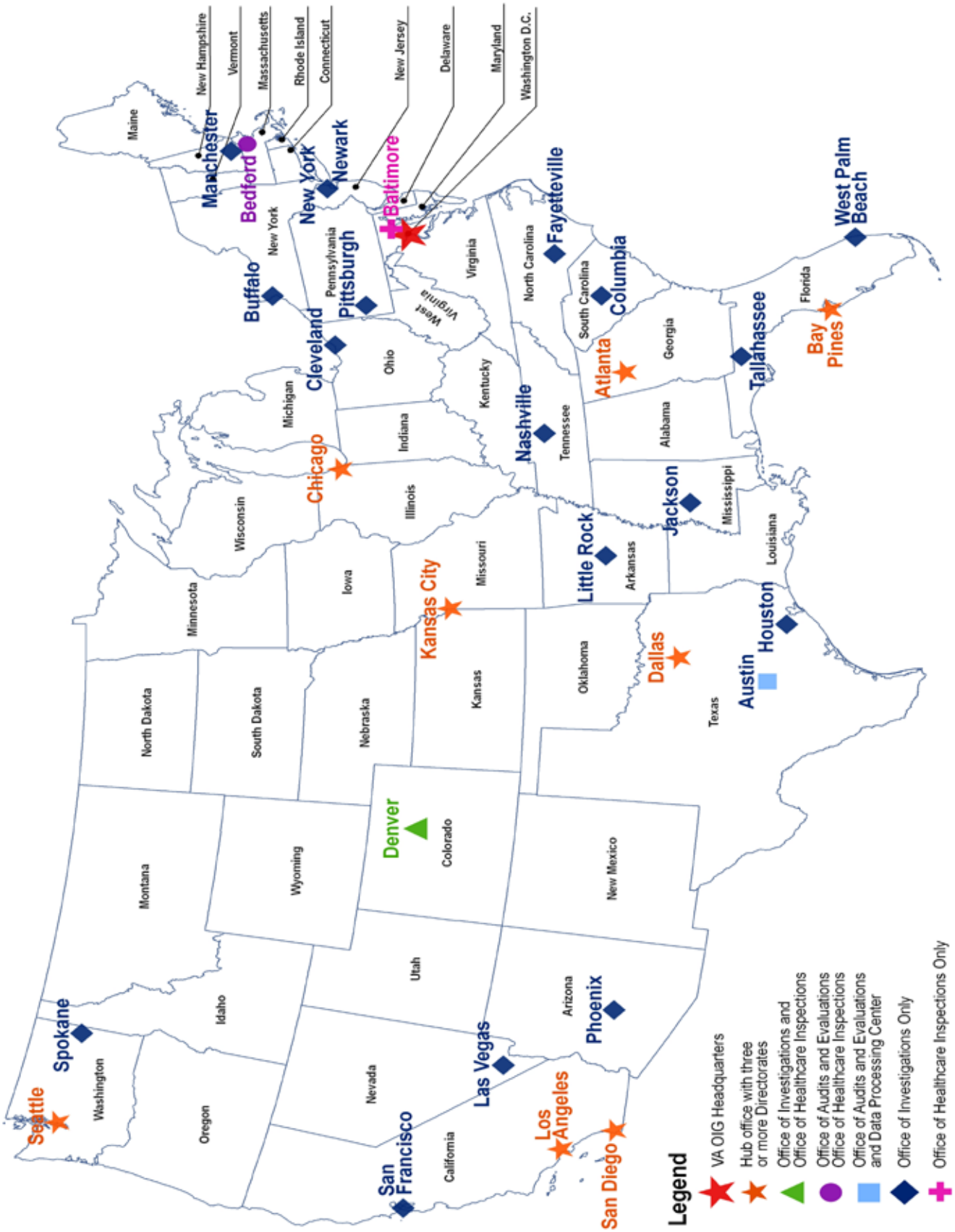
## VA Office of Inspector General

The Office of Inspector General (OIG) was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent organization. In October 1978, the *Inspector General Act*, Public Law (P.L.) 95-452, was enacted, establishing a statutory Inspector General (IG) in VA. It states that the IG is responsible for: (1) conducting and supervising audits and investigations; (2) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect criminal activity, waste, abuse, and mismanagement in VA programs and operations; and (3) keeping the Secretary and Congress fully informed about problems and deficiencies in VA programs and operations and the need for corrective action. The IG has authority to inquire into all VA programs and activities as well as the related activities of persons or parties performing under grants, contracts, or other agreements. Inherent in every OIG effort are the principles of quality management and a desire to improve the way VA operates by helping it become more customer-driven and results-oriented.

OIG, with just over 500 employees from appropriations, is organized into three line elements: the Offices of Investigations, Audits and Evaluations, and Healthcare Inspections, plus a contract review office and a support element. FY 2010 funding for OIG operations provides $109 million from ongoing appropriations. The Office of Contract Review, with 25 employees, receives $3.9 million through a reimbursable agreement with VA for contract review services including preaward and postaward contract reviews and other pricing reviews of Federal Supply Schedule (FSS) contracts. In addition to the Washington, DC, headquarters, OIG has field offices located throughout the country.

OIG keeps the Secretary and Congress fully and currently informed about issues affecting VA programs and the opportunities for improvement. In doing so, OIG staff strives to be leaders and innovators, and to perform their duties fairly, honestly, and with the highest professional integrity. For more information, please visit the OIG Internet home page at www.va.gov/oig.

## OIG Field Offices Map



The health care that VHA provides Veterans is consistently ranked among the best in the Nation, whether those Veterans are recently returned from Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) or are Veterans of other periods of service with different patterns of health care needs. OIG oversight helps VHA maintain a fully functional program that ensures high-quality patient care and safety, and safeguards against the occurrence of adverse events. The OIG Office of Healthcare Inspections focuses on quality of care issues in VHA and assesses medical outcomes. During this reporting period, OIG published 3 national healthcare inspections; 23 Hotline healthcare inspections; 22 Combined Assessment Program (CAP) reviews; and 2 Community Based Outpatient Clinic (CBOC) reports, covering 15 facilities, to evaluate the quality of care.

## Combined Assessment Program Reviews

CAP reviews are part of OIG's efforts to ensure that quality health care services are provided to Veterans. CAP reviews provide cyclical oversight of VHA health care facilities; their purpose is to review selected clinical and administrative operations and to conduct fraud and integrity awareness briefings. During this reporting period, OIG issued 22 CAP reports, which are listed in Appendix A. Topics reviewed in a facility CAP may vary based on the facility's mission. Topics generally run for 6–12 months; the CAP topics in current use since January 2010 are:

- Coordination of care.
- Environment of care.
- Magnetic resonance imaging safety.
- Medication management.
- Physician credentialing and privileging.
- Quality management.
- Reusable medical equipment.
- Suicide prevention safety plans.

When findings warrant more global attention, summary or "roll up" reports are prepared at the conclusion of a topic's use.

### Quality Management Deficiencies Continue at Marion VA Medical Center

OIG performed a CAP review of the Marion, IL, VA Medical Center (VAMC) to follow up on findings from three previous reports. OIG noted that several corrective actions initiated in response to a January 2008 OIG report had not been fully implemented and did not consistently correct the conditions identified. Specifically, the VAMC did not have a comprehensive and effective Quality Management (QM) program that adequately monitored patient care activities and coordinated improvement efforts. The oversight reporting structure for QM reviews was fragmented and inconsistent, and accountability for quality monitoring and performance improvement activities appeared limited. These deficiencies, coupled with a lack of accurate data, seriously hindered managers' abilities to make reasonable, data-driven decisions and to respond to QM results. OIG made recommendations to ensure compliance with VHA policies and other external standards regarding QM, and in Physician Credentialing and Privileging, Environment of Care, and Medication Management.

## Community Based Outpatient Clinic Reviews

As requested in House Report 110-775, to accompany House Resolution 6599, Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, FY 2009, OIG initiated a systematic review of VHA CBOCs. The purpose of the cyclical reviews is to assess whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care in accordance with VA policies and procedures. The CBOC inspection process consists of four components: CBOC site-specific information gathering and review, medical record reviews for determining compliance with VHA performance measures, onsite inspections, and CBOC contract review. The objectives of the reviews are to determine: (1) whether CBOC quality of care measures are comparable to the parent facility clinics, (2) whether CBOC providers are appropriately credentialed and privileged in accordance with VHA policy, (3) whether CBOCs maintain the same standard of care as their parent facility to address the Mental Health (MH) needs of OEF/OIF era Veterans, (4) whether CBOCs are in compliance with standards of operations according to VHA policy in the areas of environmental safety and emergency management planning, (5) the effect of CBOCs on Veterans' perception of care, and (6) whether CBOC contracts were administered in accordance with contract terms and conditions.

During this reporting period, OIG performed 15 CBOC reviews throughout four Veterans Integrated Service Networks (VISNs). These reviews were captured in two reports. We made recommendations for improvements at the following facilities:

- VISN 7: Albany and Macon, GA
- VISN 12: Beaver Dam, WI, and Rockford, IL
- VISN 16: Texarkana, AR; Kosciusko and Meridian, MS; Konawa, Lawton, and Tulsa, OK; and Longview, TX
- VISN 23: Sioux City and Waterloo, IA; Galesburg, IL; and Aberdeen, SD

## National Reports

### Veterans Erroneously Charged for Treatment Due to Billing System Issue

At the request of Senate Veterans' Affairs Committee Chairman Daniel K. Akaka, OIG reviewed allegations against the Austin Outpatient Clinic, which is part of the Central Texas Veterans Health Care System (CTVHCS). Specifically, the complainant alleged that the facility billed Veterans who were eligible for cost-free care for treatment related to military sexual trauma (MST). The review found that the billing system may not automatically cancel copayment charges for MST-related treatments in all instances. OIG also found that erroneous copayments for MST-related care have resulted from staff changing patients' copayment status from "not required to make a copayment" to "copayment required." When manual edits are made to create a copayment bill, proper controls must be in place to ensure that staff consider MST and any other conditions that entitle Veterans to cost-free care. CTVHCS has cancelled all erroneous charges and refunded payments received from Veterans.

### VHA Needs to Improve Compliance with Pharmacy Regulations and Guidance

OIG completed an evaluation of select pharmacy processes related to the management of controlled substances (CS) at 43 VHA medical facilities. Overall, pharmacies complied with CS guidelines, security, and reporting requirements; however, OIG recommended that management reinforce compliance with VHA regulations and United States Pharmacopeia guidelines. OIG also

recommended that management encourage facilities to provide guidance for clinical review of polypharmacy in high-risk populations.

### Increased Documentation of Elderly Veteran Cognitive Assessments Needed

OIG evaluated the extent to which VHA clinicians conduct assessments of elderly patients during hospitalization and ensure post-discharge follow-up care. Reviewers evaluated records for the presence of functional and cognitive assessments that are widely accepted as a basic level of care for vulnerable elders. OIG found that assessments of functional status were completed for more than 97 percent of hospitalized elders and that 94 percent of them had some evidence of care within 6 weeks of hospital discharge. In contrast, less than 40 percent of patients had evidence of any cognitive assessment during their hospitalization or in the 6 months prior to admission. OIG recommended that the Under Secretary for Health develop and implement a plan to ensure that vulnerable elderly Veterans admitted to VA hospitals have a documented assessment of cognitive functioning.

## Hotline Reports

### Scanning Backlog, Nurse Staffing, and Communication Issues Found at Iron Mountain, Michigan, VAMC

At the request of the House Veterans' Affairs Committee Chairman Bob Filner, OIG conducted a review to determine the validity of allegations regarding management decisions impacting patient care and work environment at the Oscar G. Johnson VAMC in Iron Mountain, MI. Three of the allegations resulted in OIG recommending that actions be taken to reduce the scanning backlog and establish a process to assure timely entry of significant information in patients' electronic medical records; managers initiate a review of registered nurse staffing to ensure coverage of the emergency department (ED) and Nursing Officer of the Day; and the VAMC Director communicates, orally and in writing, organizational changes to all employees and that administrative supervisory lines are clearly written and effected in official personnel actions.

### Better Documentation and Assessment of MH Risks Needed at Fayetteville, Arkansas, Health Care System

At the request of Representative Jo Ann Emerson, OIG reviewed the validity of allegations regarding the quality of mental health care provided to a patient at the Fayetteville, AR, Health Care System (HCS). OIG could not find evidence in the medical record documentation that the provider sufficiently explored relevant aspects of the patient's recent suicidal thoughts and/or further inquired about the location of the patient's gun. Primary Care Service did not provide the patient with a MH consult within the required timeframe and did not facilitate further assessment of the patient's MH when he presented to a CBOC for unscheduled visits with MH issues. Although OIG identified these patient care issues, given all the facts in this case, including those relating to the care provided to this patient both at VA and at non-VA facilities, OIG cannot conclude that these deficiencies impacted the patient's outcome. OIG made recommendations to address the deficiencies found in this review.

### Improper Reprocessing of Reusable Medical Equipment Found at San Juan HCS

OIG conducted a healthcare inspection to determine the merit of allegations made against the VA Caribbean HCS, San Juan, Puerto Rico. OIG substantiated that endovaginal transducers were not

properly disinfected at the Mayaguez Outpatient Clinic (OPC); leak testing was not performed on colonoscopes in the Operating Room or on laryngoscopes in Radiotherapy at the hospital in San Juan and at the Ponce OPC; the system inaccurately certified compliance on three occasions; and senior managers were aware of these issues and took no action to assess the risk to patients. OIG also learned that laryngoscopes in Radiotherapy were not properly pre-cleaned and one unit contained a leak. The VISN Director chartered an Administrative Investigation Board (AIB) to investigate and address management responsiveness. OIG recommended that a risk assessment be repeated on the Radiotherapy issue and that the VISN Director take appropriate administrative action on the recommendations from the AIB.

### Patient Record System Outage Attributed to Substandard Maintenance

OIG reviewed allegations surrounding a Veterans Health Information Systems and Technology Architecture (VistA) outage within the VA North Texas HCS. The outage was caused by hard disk failures in conjunction with outdated storage system firmware. The review revealed that the Office of Information and Technology (OI&T) failed to perform a firmware upgrade that had been directed by the vendor 2 years prior. Additionally, a report from the vendor identified significant issues relating to the aging infrastructure with critical recommendations that OI&T has not addressed. Although no patient safety incidents were reported as a result of the VistA outage, the after action report and staff interviews showed the incident seriously affected patient care. OIG also confirmed the allegation that the Office of Risk Management and Incident Response does not manage, track, or trend risks related to these system outages, but only reports incidents to higher echelons within OI&T. OIG made five recommendations to address these issues and OI&T concurred.

### Medication, Phlebotomy Complaints Substantiated at Hines, Illinois, VA Hospital

OIG reviewed three allegations concerning quality of care issues against a nursing unit at the Edward Hines, Jr. VA Hospital in Hines, IL. OIG substantiated that two nurses attempted to administer a medication to a patient with a documented allergy to that medication, and that a nurse failed to remove a tourniquet from the arm of a patient with dementia. OIG did not substantiate that a patient with large wounds on his buttocks was left lying in feces or that the nurse told the patient that the next shift should clean and dress the wounds. Although OIG substantiated two of the three allegations, OIG made no recommendations because inspectors concluded that management took appropriate administrative actions prior to OIG's review.

### Allegations of Inadequate Vision Care Unfounded at James A. Haley VA Hospital in Tampa

OIG conducted a review of the James A. Haley VA Hospital (JAHVAH) in Tampa, FL, after a complainant alleged instances of inadequate vision care, unapproved research activities, and improper research study management. OIG confirmed that some polytrauma and traumatic brain injury (TBI) outpatients did not receive complete eye examinations prior to an October 2008 VHA Directive requiring them; however, the care provided did not deviate from expected standards at the time. Additionally, staff has since mailed letters to patients asking them to follow up with JAHVAH and schedule an eye examination. OIG did not substantiate allegations that an occupational therapist provides all of the diagnostic and therapeutic eye care, that patients' rights were being violated, or that some patients may have received vision restoration therapy (VRT) instead of traditional blind rehabilitation services that have proven benefits. OIG could not confirm or refute the allegation that there was political pressure to conduct a research study related to VRT. OIG made no recommendations.

### End of Life Care Allegations Unfounded at Charleston VAMC

OIG conducted an inspection in response to allegations that the Ralph H. Johnson VAMC in Charleston, SC, provided poor care to a Veteran which contributed to his untimely death. OIG did not substantiate that staff intentionally disregarded the Veteran's medical power of attorney and end of life wishes, kept him overmedicated causing a small bowel obstruction, or cared for the terminally ill Veteran in unsanitary room conditions. OIG also did not substantiate other issues pertaining to nursing care or that the medical record contained discrepancies and lacked documentation of the patient at end of life. OIG made no recommendations.

### Post-Operative Care Allegations Unfounded at VA Central Iowa HCS

The purpose of OIG's review at the VA Central Iowa HCS in Knoxville was to determine the validity of the allegations regarding the lack of post-operative care resulting in a patient's death. A complainant specifically alleged that the patient was denied water, laboratory studies ordered were never performed, and there were inaccuracies in the autopsy report. OIG concluded that the laboratory studies ordered during the course of his admission were performed. In addition, although the patient complained of dehydration, he received oral fluids regularly with meals and during hydration rounds on every shift. Finally, the autopsy report completed at the University of Iowa Hospital did have some documented inaccuracies; however, the information did not impact the care provided or patient outcomes. OIG made no recommendations.

### Delay in Cancer Diagnosis Substantiated Against Milwaukee VAMC

OIG reviewed the validity of allegations regarding a delayed cancer diagnosis, treatment, and disclosure of an adverse event to a patient treated at the Clement J. Zablocki VAMC in Milwaukee, WI. OIG substantiated that there was a delay in cancer diagnosis and treatment, a radiologist failed to identify a lung nodule, the primary physician failed to follow up on the lung nodule, and a second radiologist failed to notify the primary physician. OIG also substantiated that staff initially failed to disclose the adverse event to the patient. OIG recommended that managers conduct a formal peer review and root cause analysis on all activities involving care of the identified patient, staff adhere to VHA and local incident reporting and adverse event disclosure policies and procedures, and managers consult Regional Counsel regarding disclosure to the family and explanation of rights.

### Allegations Not Substantiated Against Harrisonburg, Virginia, Contracted CBOC

OIG conducted an inspection in response to allegations that the Martinsburg, WV, VAMC, through its contracted CBOC in Harrisonburg, VA, provided incomplete physicals and omitted digital rectal examinations (DREs) to a patient over the course of 3 years. OIG did not substantiate that the patient's physicals were not thorough and that DREs were not addressed. OIG made no recommendations.

### Review Finds Mental Health Safety Issues and Credentialing and Privileging Irregularities at Pineville, Louisiana, VAMC

OIG conducted a review to determine the validity of allegations regarding MH safety issues and credentialing and privileging (C&P) irregularities at the Alexandria VAMC in Pineville, LA. OIG substantiated that MH inpatients were put at risk because staff did not comply with requirements for suicide risk assessments, suicide safety plans, an interim life safety plan, and MH environmental hazards inspections and training; there was insufficient follow up for high risk MH outpatients because

of deficiencies with policies and suicide-related issue brief corrective action plans; blank Professional Standards Board (PSB) action forms were given to Service chiefs for signature prior to PSB action; and some renewed licenses were attached to previous license sections in VetPro. These findings resulted in recommendations to the VISN and VAMC Directors.

### Patient Allegations Against Amarillo, Texas, VA HCS Unfounded

OIG did not substantiate any allegations made against the Amarillo, TX, VA HCS. Specifically, a patient and his wife alleged he was entitled to have VA reimburse his air ambulance co-pay, that the ED and inpatient admission wait was excessive, that his Post Traumatic Stress Disorder (PTSD) diagnosis was not considered when assigning a roommate, and that an anti-anxiety injection left him incoherent for 3 days. They also alleged that his diabetes was untreated, he did not see a physician for 24 hours, and the ED and medical unit were filthy. Because the allegations were not substantiated, OIG made no recommendations.

### OIG Examines Allegations Surrounding Patient's Death at North Chicago VAMC

OIG examined allegations regarding the care provided to a patient who died within 24 hours of admission to the North Chicago, IL, VAMC. The complainant suggested that a medical trainee may have been inadequately supervised. OIG found the quality of care reviews conducted by the VAMC to be thorough. Although the review found deficiencies in the quality of care provided for this patient, the evidence did not demonstrate a connection with the patient's death. OIG recommended that managers evaluate this case with Regional Counsel for possible disclosure to the patient's family and that staff comply with the VAMC's policy for rapid intervention in patients with deteriorating clinical conditions.

### Allegations Against CBOCs in Smyrna and Rome, Georgia, Unfounded

OIG reviewed the merits of allegations that a Veteran was denied access to care at a Rome, GA, CBOC and whether that same Veteran was not diagnosed or treated for lip cancer at the Smyrna, GA, CBOC or for decreased renal function at the Rome, GA, CBOC. OIG did not substantiate that the Veteran was denied care or that the lip cancer or decreased renal function were not diagnosed or treated. OIG made no recommendations.

### Allegations Against Central Arkansas Veterans HCS Not Substantiated

OIG did not substantiate allegations that a patient at the Central Arkansas Veterans HCS in Little Rock, AR, was inadequately diagnosed and treated for severe abdominal pain or that he was placed in a locked room where no one checked on him for over 6 hours. OIG was unable to substantiate or refute that someone told the patient's wife he had been discharged but they did not know where he was located. To reinforce effective communication with families, the Director issued a memorandum while OIG was onsite. OIG made no recommendations.

### Quality of Care Allegations Examined at the Salt Lake City HCS

OIG performed a review of the Salt Lake City, UT, HCS to determine the validity of the following allegations: (1) lack of collaboration, inappropriate care, and deaths; (2) unwarranted amputations; and (3) inappropriate management of vein patients. OIG substantiated poor collaboration between Interventional Radiology and Vascular Surgery for two of the four patients identified, but concluded that this did not directly contribute to the fatal outcomes. OIG concluded that the HCS took appropriate actions to review quality of care and make improvements, which included conducting

institutional disclosures in two of the four cases. However, OIG recommended that one case be referred to Regional Counsel to determine whether the HCS has an obligation to report the providers to the National Practitioners Data Base. Since management had already addressed this issue at the time of OIG's review, OIG considers this recommendation closed. OIG did not substantiate the occurrence of unwarranted amputations or inappropriate management of vein patients.

### Quality of Care Issues Reviewed at Clarksburg, West Virginia, VAMC

OIG reviewed the validity of allegations of poor patient care against the Louis A. Johnson VAMC in Clarksburg, WV. Although OIG did not substantiate all allegations, OIG concluded that there were deficiencies in the patient's care that warranted consideration of institutional disclosure to the family. Managers concurred with the recommendation to review the case with Regional Counsel to determine whether disclosure was managed appropriately.

### OIG Recommends Trending, Sharing of Infection Control Data at the Huntington, West Virginia, VAMC

OIG conducted an inspection in response to allegations that a surgeon had poor infection control practices, a higher incidence of Methicillin Resistant Staphylococcus Aureus (MRSA), altered records to reflect lower blood loss for a procedure, and performed surgery on a patient who developed significant complications at the Huntington, WV, VAMC. OIG did not substantiate allegations made against the surgeon, but did identify a lack of integration of infectious disease information between surgical services, the National Surgical Quality Improvement Program, Infection Control, and MRSA programs. OIG recommended that trended and analyzed infection control data be provided to key committee members and clinical managers.

### Allegations of Coding and Billing Irregularities Not Substantiated Against Kansas City, Missouri, VAMC

OIG reviewed allegations regarding a pattern of inappropriate medical coding and billing to increase third party insurance reimbursements at the Kansas City, MO, VAMC. The allegation purported that the Medical Care Collection Fund Billing Department inappropriately added a Current Procedural Terminology "modifier 59," which indicates that a procedure or service was distinct or independent from other services performed on the same day, to the billing records for a patient receiving "Epoetin" injections. Approved claims including a modifier 59 will usually result in higher reimbursements. The complainant also alleged that the Billing Department inappropriately billed for complications attributable to the patient's participation in a voluntary research study. OIG was unable to substantiate the allegations and made no recommendations.

### Telemetry Monitoring Problems Identified at VA Eastern Colorado HCS, Denver, Colorado

OIG performed a review of the VA Eastern Colorado HCS, Denver, CO, to determine the validity of allegations regarding inadequate telemetry heart monitoring practices and lack of staff training that related to two patient deaths. OIG did not substantiate the allegation that the deaths were a result of inadequate telemetry monitoring or lack of staff training. However, OIG substantiated that management had been informed of problems with the telemetry program prior to the patient deaths and had not identified a clear course of action or assigned responsibility to address concerns raised. OIG also substantiated the allegation that there were competency and training issues with medical support assistants and registered nurses assigned to telemetry. Managers concurred with OIG's recommendations to evaluate the telemetry program, require that all staff complete competency

assessments and that training be provided as needed to maintain competency, and that there be clinical oversight of medical support assistants.

### Allegations Not Substantiated at Wilkes-Barre, Pennsylvania, VAMC

OIG conducted an inspection to determine the validity of allegations regarding quality of care received by a patient at the VAMC in Wilkes-Barre, PA. OIG did not substantiate the allegations; however, OIG concluded that communication and documentation could be improved. OIG recommended that providers improve communication with patients and family members to ensure that instructions and plans of care are clearly understood and that they document instructions, plans, and patient and/or family member understanding in the medical record.

### Patient Safety, Resource Management Issues Confirmed at Northern Indiana HCS

OIG reviewed allegations regarding mismanagement of resources and patient safety issues at the Northern Indiana HCS in Fort Wayne and Marion, IN. OIG substantiated five of the allegations and identified other environment and maintenance issues at the Fort Wayne campus that required management attention. OIG recommended that actions be taken to correct the findings.

## Veterans Health Administration Reports

OIG audits and evaluations of VHA programs focus on the effectiveness of health care delivery for Veterans. These audits and evaluations identify opportunities for enhancing management of program operations and provide VA with constructive recommendations to improve health care delivery.

### De-Obligation of Funds for Undelivered Orders Could Save $276 Million

OIG audited VHA's "undelivered orders," which are goods and services ordered that have not been received. The audit determined that internal controls to identify invalid undelivered orders need improvement. As of December 2008, VHA had about 83,000 undelivered orders valued at approximately $6.5 billion. Approximately $276 million could be put to better use in accordance with appropriations law if invalid orders are identified in a timely manner and funds de-obligated to be used for other purposes. OIG recommended VHA establish procedures to ensure proper follow-up and reconciliation of undelivered orders and ensure that all undelivered orders have end dates to allow for follow-up and reconciliation.

### Compensation & Pension Exams Need Greater Oversight To Improve Timeliness

At the request of the Chairman of the Senate Committee on Veterans' Affairs, OIG conducted an audit to determine if VA commits sufficient resources to provide Veterans with timely C&P medical examinations. OIG determined that VA management has not given the C&P exam program the attention needed to ensure it is managed effectively. The audit found limited VA Central Office oversight regarding resource allocation, utilization, and productivity of the program. Furthermore, collaboration between VHA and VBA on issues affecting the timely delivery of exams is not adequate. VA currently lacks a performance standard that enables management to adequately measure whether exam requests are completed in a timely manner. As a result, many Veterans do not receive timely exams which can delay the delivery of disability benefits. OIG made 10 recommendations to help VA improve oversight and timeliness.

### Rate of Duplicate Payments Lower Than Average at VA Pacific Islands HCS

In another request from the Chairman of the Senate Committee on Veterans' Affairs, OIG conducted a review of the VA Pacific Islands HCS (PIHCS) to determine the extent and causes of improper payments for PIHCS' outpatient fee care program. OIG found that PIHCS improperly made duplicate payments for 13 percent of outpatient fee claims, which resulted in overpayments of $49,571 (or less than 1 percent of total outpatient fee expenditures). The error rate at PIHCS was significantly lower than the national error rate identified in a previous OIG audit. Since June 2008, PIHCS managers have provided training for fee staff on avoiding duplicate payments and notified local providers of proper billing requirements. OIG recommended that PIHCS management initiate recovery of the duplicate overpayments identified.

## Veterans Benefits Administration Audits and Evaluations

OIG performs audits and evaluations of Veterans' benefits programs focusing on the effectiveness of benefits delivery to Veterans, dependents, and survivors. These audits and evaluations identify opportunities for enhancing the management of program operations and provide VA with constructive recommendations to improve the delivery of benefits.

### VBA Fiduciary Program Needs Management Infrastructure Improvements

OIG's audit of VBA's Fiduciary Program found that VBA lacks reasonable assurance that VA-derived income and estates of incompetent beneficiaries are used solely for their care, support, welfare, and needs. In FY 2010, the Fiduciary Program will administer approximately $696 million in benefits payments to more than 102,000 beneficiaries, with a cumulative estate value of $3.1 billion. The Fiduciary Program does not consistently pursue delinquent fiduciary accountings and follow up on potential misuse of beneficiary funds. VBA lacks elements of an effective management infrastructure to monitor program performance, effectively utilize staff, and oversee fiduciary activities. As a result, VA Regional Offices (VAROs) are not consistently taking timely or effective actions to ensure VA-derived income and estates of incompetent beneficiaries are protected. VBA needs to improve the management infrastructure to direct the Fiduciary Program nationwide more effectively. In addition, VBA needs to develop and disseminate policies and procedures to improve the effectiveness of analyzing annual accountings filed by fiduciaries and investigating and reporting allegations of misuse of beneficiary funds.

## Veterans Benefits Administration Benefits Inspections

The Benefits Inspection Program is part of OIG's efforts to ensure our Nation's Veterans receive timely and accurate benefits and services. These independent inspections provide recurring oversight of VAROs, focusing on disability compensation claims processing and performance of Veteran Service Center operations. The objectives are to evaluate how well VAROs are accomplishing their mission of providing Veterans with convenient access to high quality benefits services; determine if management controls ensure compliance with VA regulations and policies; assist management in achieving program goals; minimize the risk of fraud, waste, and other abuses; and identify and report systemic trends in VARO operations. Benefits Inspections may also examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

The Benefits Inspection Division issued six reports during this reporting period. Key summary results from those inspections include:

- Claims processing: 27 percent of benefit claims requiring a rating decision were processed in error. These errors involved claims related to PTSD, TBI, disabilities related to herbicide exposure, and temporary 100 percent evaluations.

- Systematic Technical Accuracy Review (STAR) compliance: VARO staff did not correct 38 (31 percent) of 124 errors identified by VBA's STAR Quality Assurance Program. Of those errors identified, 21 (55 percent) were erroneously reported as corrected.

- None of the 6 VAROs are completely following VBA policy for protecting personally identifiable information (PII). OIG work revealed 49 percent of all workstations inspected contained beneficiary PII in unauthorized locations. Inspections have not discovered any instance of shredding of documents. However, at 2 VAROs, we discovered claims related information improperly scheduled for destruction.

- Inspection results show 1 percent of claims had a date recorded in the Veteran's electronic record that was different from the date stamped on the corresponding paper file.

# American Recovery and Reinvestment Act of 2009 Reports

### OIG Assesses VBA Hiring Initiative and New Hire Productivity

OIG conducted a review to assess VBA's efforts to meet its hiring goals and the impact of VBA's increased workforce on C&P claims workload. Between FYs 2007 and 2009, VA received $335 million from congressional appropriations and *American Recovery and Reinvestment Act of 2009* (ARRA) funds to hire about 2,300 C&P claims processors. VBA met its FY 2008 hiring goals and filled almost all of its ARRA-funded positions in FY 2009. However, VBA's rating and non-rating claims inventory is expected to continue to grow in FYs 2010 and 2011. OIG recommended that VBA collect information related to local VARO performance measures and overtime hours worked so that VBA can accurately determine its workforce capacity and future workforce needs. OIG also recommended that VBA issue guidance to VAROs requiring that temporarily promoted supervisors complete a standardized core curriculum of supervisory training.

### VA ARRA Reporting Processes Meet Data Quality Requirements

OIG reviewed VA's process for meeting the reporting requirements related to the awarding and use of funds provided to VA through the enactment of ARRA. Specifically, OIG assessed whether VA established a process to perform limited data quality reviews intended to identify material omissions or significant reporting errors and to notify the recipients of the need to make appropriate and timely changes. VA's Office of Finance developed a data quality review plan that meets Office of Management and Budget (OMB) requirements, as well as a checklist to be used by reviewers to ensure the completeness and accuracy of recipient data. OIG made no recommendations but suggested ways VA could enhance the data quality review process. VA agreed with OIG's suggestions and plans to incorporate these changes after performing a complete evaluation of the plan.

### Strengthened Oversight Needed for ARRA Contract Award Monitoring

OIG reviewed the effectiveness of the VHA ARRA non-recurring maintenance (NRM) contract award monitoring processes. OIG found that improved ARRA NRM oversight would ensure that VHA contract awards met the ARRA's requirements and accountability, efficiency, and transparency objectives. During the initial implementation of the ARRA, contracting officers did not properly publicize and prepare NRM contract solicitations and awards. OIG made four recommendations to strengthen oversight for ARRA NRM contract awards.

# Other Reviews

### VA Receives Unqualified Opinion on Consolidated Financial Statements

OIG contracted with the independent public accounting firm, Deloitte & Touche LLP (Deloitte), to perform the audit of VA's FY 2009 and 2008 consolidated financial statements. Deloitte provided an unqualified opinion on those statements and reported four material weaknesses. Three of the four material weaknesses are repeat conditions from the prior year audit and identified as financial management system functionality, information technology security controls, and financial management oversight. The fourth material weakness, compensation, pension, and burial liabilities, was identified during the FY 2009 audit. Deloitte reported that VA is not in substantial compliance with the *Federal Financial Management Improvement Act (FFMIA) of 1996* because VA did not substantially comply

with Federal financial management systems requirements. Deloitte also identified four other instances of non-compliance with law, including a violation of the *Antideficiency Act.*

**VA's Compliance with *Federal Information Security Management Act* Evaluated**

OIG also contracted with Deloitte to perform an audit of VA's information security program in accordance with the *Federal Information Security and Management Act (FISMA)*. The results of this annual review of the agency's information security program are reported to OMB. OMB uses this data to assist in its oversight responsibilities and to prepare an annual report to Congress on agency compliance with FISMA. VA continues to face significant challenges in complying with the requirements of FISMA due to the nature and maturity of its information security program. The report provides a total of 40 recommendations for improving VA's information security program, including recommendations still open from prior years' assessments.

## Veterans Health Administration Investigations

The OIG Office of Investigations conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for health care benefits, and other frauds relating to the delivery of health care to millions of Veterans. In the area of health care delivery, OIG opened 177 cases, made 130 arrests, and obtained over $2.3 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

During this reporting period, the OIG opened 62 investigations regarding diversion of controlled substances. Subjects of these investigations included VA employees, Veterans, and private citizens. Forty defendants were charged with various crimes relating to drug diversion. OIG also initiated 18 investigations regarding fraudulent receipt of health benefits. Nine defendants were charged with various crimes relating to the fraudulent receipt of health benefits and court ordered payment of fines, restitution, and penalties amounted to $96,301.

**Former Lexington, Kentucky, VAMC Nurse Indicted for Murder**

A former Lexington, KY, VAMC registered nurse was indicted by a Federal grand jury and subsequently arrested for the murder of a patient. The investigation by OIG and a county coroner's office revealed that the Veteran died from lethal levels of morphine.

Nurse linked to 2 other VA deaths

INVESTIGATOR SAYS PATIENTS DIED UNDER SUSPICIOUS CIRCUMSTANCES

By Jennifer Hewlett
jhewlett@herald-leader.com

At least two more patients died under suspicious circumstances while they were under the care of nurse Maria K. Whitt at Lexington's Veterans Affairs Medical Center, an official testified Thursday.

The testimony came during a detention hearing for Whitt, who was indicted by a federal grand jury Oct. 2 in the September 2006 death of Jesse Lee Chain, 90, at the VA hospital off Cooper Drive. Whitt is accused of killing the World War II veteran with lethal levels of morphine.

When asked by Assistant U.S. Attorney Roger W. West whether there were more questionable deaths, Rick Ellison, a special agent with the U.S. Department of Veterans Affairs' Office of Inspector General, said there were.

"How many, sir?" West asked.

"Two. At least two," Ellison said.

The special agent, who is based in Nashville, said one was an 88-year-old man with heart problems, the other a 60-year-old man who had had a massive heart attack. Both died after they were given morphine.

Whitt, 32, of Mount Sterling was arrested Tuesday

See VA, A2

**Former Martinsburg, West Virginia, VAMC Employee Sentenced for Fraud**

A former Martinsburg, WV, VAMC nursing assistant was sentenced to 30 months' incarceration, 36 months' probation, and ordered to pay $56,165 in restitution after pleading guilty to the unauthorized use of an access device. An OIG and VA Police investigation determined that the defendant used the debit cards of two inpatients to obtain money, goods, and services.

**Veterans Indicted for Travel Benefits Fraud at Albuquerque VAMC**

Eleven Veterans were indicted for submitting fraudulent vouchers for reimbursement of travel expenses related to attending their medical appointments at the Albuquerque, NM, VAMC. The cash reimbursement was calculated on a mileage basis and the defendants claimed they were commuting several hundred miles per day, several days per week. The OIG investigation determined that the defendants were actually residing a few miles from the VAMC. The loss to VA is approximately $110,000.

**Veteran's Wife Sentenced for Poisoning Veteran**

The wife of a Veteran was sentenced to 30 months' incarceration, 3 years' supervised release, and was ordered to pay a $1,000 fine after pleading guilty to poisoning her husband while he was an inpatient at the Temple, TX, VAMC. The Veteran survived the poisoning. A joint OIG, Federal Bureau of Investigation (FBI), and VA Police investigation revealed that the defendant introduced various toxic substances into her husband's beverages over a period of approximately 5 weeks, causing him to repeatedly lose consciousness and require multiple hospital admissions. Video surveillance of the Veteran's hospital room revealed that the defendant continued to poison her husband even after he was admitted to the facility for treatment of previous poisonings committed outside the facility.

**Former Hines, Illinois, VA Employee Arrested for Sexual Assault**

A former Hines, IL, VA employee was arrested and charged with two felony counts of sexual assault. During an OIG and local police investigation, the defendant admitted in a signed, sworn statement that he had inappropriate sexual contact with his 13 year-old daughter while she visited him at his VAMC onsite residence. The defendant subsequently resigned from his position with VA.

**Atlanta VAMC Physician Indicted for Abusive Sexual Contact and Assault**

An Atlanta, GA, VAMC physician was indicted for abusive sexual contact, assault, and false statements. An OIG investigation revealed that a female patient was examined at the VAMC without another staff member in the room and was sexually assaulted by the physician. The investigation also revealed that a VAMC nurse was asked by the defendant to provide false statements to reflect that the nurse was present in the room during the examination.

**Former Postal Employee Arrested for Drug Theft**

A multi-agency investigation resulted in the arrest of a former U.S. Postal Service employee suspected of diverting more than 2,000 tablets of VA medication from the mail. The defendant subsequently admitted to selling the stolen VA medication. The defendant was charged with trafficking opium/heroin, maintaining a dwelling house for the keeping or selling of controlled substances, and 153 other criminal violations. The defendant was held under a $1,615,000 secured bond.

**Former Jackson, Mississippi, VAMC Nurse Sentenced for Drug Diversion**

A former Jackson, MS, VAMC nurse was sentenced to 2 months' house arrest and 3 years' probation after pleading guilty to possession of a controlled substance. An OIG investigation disclosed that the defendant diverted at least 120 Schedule II and III pain narcotics from the medical center for personal use. The nurse obtained the diverted narcotics by falsifying VA physician orders.

**Former Postal Employee Arrested for Theft of VA Drugs**

A former U.S. Postal Service employee was arrested after being indicted for theft of mail. An OIG and Postal Service OIG investigation revealed that while the carrier was delivering mail on her route, she unlawfully opened a test package containing VA drugs addressed to a non-existent address as well as envelopes containing marked cash. The investigation also revealed that the mail carrier received cash for stealing VA drugs and providing them to another person who in turn sold the drugs on the street.

**Palo Alto, California, Nursing Instructor Sentenced for Diversion of VA Drugs**

A community college clinical nursing instructor teaching at the Palo Alto, CA, VAMC was sentenced to 3 years' probation after pleading guilty to possession of a controlled substance. An OIG investigation determined that the nurse diverted hydromorphone on at least four different occasions after she fraudulently obtained access to a VAMC Accudose machine.

**Former Albuquerque VAMC Nurse Pleads Guilty to Drug Diversion**

A former Albuquerque, NM, VAMC nurse pled guilty to drug diversion charges. An OIG investigation disclosed that the defendant used the Acudose system to access oxycodone and other controlled substances for personal use. The defendant attempted to conceal the diversion activity by associating the oxycodone to certain patients, many of whom had no standing order to receive that particular medication.

**Tampa Nurse Arrested for Drug Diversion**

A Tampa, FL, VAMC registered nurse was arrested for unauthorized possession of controlled substances and petit theft. An OIG and VA Police investigation revealed that the defendant diverted several pharmaceutical drugs, mainly hydromorphone and Percocet, by removing the drug from syringes located in a Pyxis machine or by giving patients only a portion of the drugs prescribed to them.

**Brockton, Massachusetts, VAMC Employee Arrested for Drug Theft**

A Brockton, MA, VAMC employee was arrested for possession with intent to distribute oxycodone. An OIG, VA Police, Drug Enforcement Administration, and local police investigation determined that since January 2010, the defendant, who was a VA mail courier, had taken approximately 1,300 oxycodone pills from outgoing packages being mailed to VAMC patients. The defendant opened the prescription bottles while they remained sealed in shipping envelopes, emptied a portion of the pills, replaced the cap on the bottle, and tore a small hole in the envelope from which the pills were removed. In most instances, when the envelopes arrived the patients were unaware they were missing narcotics. At the time of his arrest, the defendant had stolen narcotics in his possession, confessed to being addicted to pain medications, and to distributing a portion of the narcotics off VA property.

**Oklahoma City, Oklahoma, VAMC Nurse Pleads Guilty to Assault**

An Oklahoma City, OK, VAMC nurse pled guilty to assault and concealment of a material fact. When initially interviewed by OIG agents, the nurse denied assaulting any patient; however, a video showed that for approximately 2 minutes the nurse assaulted an 82 year-old dementia patient. The patient did not resist the beating and suffered a fractured right humerus bone and severe bruising and swelling in his right arm and hand.

**Two Arrested for Heroin Distribution at West Haven, Connecticut, VAMC**

A VA employee and a second defendant were arrested for distributing heroin at the West Haven, CT, VAMC. A consent search of the second defendant's residence, who was supplying the drugs to the employee, resulted in the seizure of 561 bundles of heroin and $9,000 in cash. An OIG, VA Police, and local police investigation determined that the employee would place orders for heroin from the supplier, who would deliver the heroin to the VA employee in front of the VAMC. The VA employee would then sell the heroin to patients and staff while working at the VAMC.

**Former Syracuse VAMC Employee Sentenced for Bank Fraud**

A former Syracuse, NY, VAMC employee was sentenced to 3 years' probation and ordered to pay restitution of $7,781 after pleading guilty to bank fraud. The defendant used her position at the VAMC to gain access to a Veteran's bank card and personal identification number and subsequently stole funds from the Veteran's account after his death.

**Brother of Veteran Pleads Guilty to Identity Theft**

The brother of a Veteran was arrested and subsequently pled guilty to a criminal information charging him with identity theft. The defendant fraudulently obtained a VA identification card, two credit cards, driver's licenses from two different states, a social security card, and a birth certificate using his brother's identity. An OIG, U.S. Secret Service, and local police investigation revealed that the defendant also assumed his brother's identity in order to fraudulently receive approximately $13,275 in VA medical care for 10 years.

**Three VA Greater Los Angeles HCS Employees Charged With Theft**

Three Sepulveda, CA, VA employees were charged with grand theft after an OIG and VA Police investigation determined that the defendants fraudulently claimed overtime hours they did not work. The loss to VA is approximately $15,000.

**Veteran Sentenced for Identity Theft**

A Veteran was sentenced to 30 months' incarceration, 36 months' probation, and ordered to pay restitution of $43,835 after pleading guilty to theft of Government property and additional charges. An OIG and U.S. Postal Inspection Service investigation revealed that the defendant, who had been dishonorably discharged from the military, assumed the identity of an honorably discharged Veteran and fraudulently received VA medical treatment and benefits in both Tennessee and Washington. The loss to VA is $23,574.

**Birmingham, Alabama, VA Employee Arrested for Fraudulent Use of a Government Credit Card**

A Birmingham, AL, VA employee was arrested following an indictment for fraudulent use of a credit card. An OIG investigation revealed that the defendant misused a Government-issued U.S. Bank travel card over a 3-month period, accruing approximately $3,400 in charges for personal expenses including vacations and vehicle loan payments.

**VA Domiciliary Resident Sentenced for Identity Theft**

A Veteran was sentenced to 2 years' suspended incarceration and 2 years' probation after pleading guilty to the fraudulent use of identifying information. An OIG and VA Police investigation determined that the defendant had been committing identity theft while he was a VA domiciliary resident. The defendant used the Government-furnished phone in his room to fraudulently obtain computers, cell phones, credit cards, and other items by using the identities of individuals he obtained while working at an auto dealership.

## Veterans Benefits Administration Investigations

VA administers a number of financial benefits programs for eligible Veterans and certain family members. Among the benefits are VA guaranteed home loans, education, insurance, and monetary benefits provided by the C&P Service. With respect to VA guaranteed loans, OIG conducts investigations of loan origination fraud, equity skimming, and criminal conduct related to management of foreclosed loans or properties. In the area of monetary benefits, OIG opened 198 cases, made 92 arrests, and had over $15.1 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

C&P investigations routinely concentrate on payments being made to ineligible individuals. For example, a beneficiary may feign a medical disability to deliberately defraud the VA compensation program. The VA pension program, which is based on the beneficiary's income, is often defrauded by individuals who fail to report income in order to stay below the eligibility threshold for these benefits. An ongoing proactive income verification match identifies possible fraud in the pension program. OIG also conducts an ongoing death match project that identifies deceased beneficiaries of the VA C&P program whose benefits continue because VA was not notified of the death. Generally, family members of the deceased are responsible for this type of fraud. In this reporting period, the death match project recovered $3.13 million. Since the inception of this project in 2000, OIG investigations have resulted in recoveries of $42.9 million, with an additional $17.8 million in anticipated recoveries. The 5-year cost avoidance for this project is estimated to be $116.5 million. Thus far, OIG agents have made 409 arrests, with several other cases awaiting judicial action.

During this reporting period, OIG opened 182 investigations regarding death match cases, fiduciary fraud, identity theft, and Veterans/widows fraudulently receiving VA compensation and pension funds. Ninety defendants were charged with crimes and court ordered payment of fines, restitution, and penalties amounted to over $12.6 million. These investigations include 13 "Stolen Valor" cases resulting in 8 defendants being charged and $82,360 in court ordered payment of fines, restitution, and penalties.

**Fiduciary Sentenced for Embezzlement**

A fiduciary was sentenced to 55 months' incarceration after pleading guilty to making a false statement to VA in an effort to conceal her embezzlement of Veterans' funds. A joint Federal and state investigation determined that the defendant had embezzled nearly $1 million from 33 disabled Veterans while acting as their appointed fiduciary. The defendant admitted to taking funds from the Veterans' bank accounts to support her gambling habit as well as to submitting false accountings to VA. The defendant agreed to make restitution to VA, the Social Security Administration (SSA), and a bonding company that reimbursed the Veterans for their losses.

**Incarcerated Veteran Sentenced for Theft of VA Benefits**

A Veteran was sentenced to 9 months' incarceration and ordered to pay restitution after pleading guilty to the fraudulent acceptance of Veterans' benefit payments. The term of incarceration is to run concurrently to the Veteran's current incarceration on unrelated state charges. An OIG investigation determined that the Veteran failed to report to VA that he had been incarcerated in a state prison since May 2000. The Veteran continued to receive disability compensation benefits at the 100 percent rate, while only entitled to compensation at the incarcerated Veteran rate of 10 percent. The Veteran's

10 percent rate will be further reduced and applied to his court ordered restitution. The loss to VA is $126,614.

**VA Employee Indicted for Stolen Valor**

A VA employee was indicted for stolen valor fraud and theft of Government funds after an OIG investigation revealed that he submitted counterfeit documents and false statements to the U.S. Air Force indicating he was wounded while serving in Vietnam. Based upon the counterfeit documents and false statements, the U.S. Air Force awarded the employee a Purple Heart. The employee used the fraudulently obtained Purple Heart and a self-inflicted gunshot wound, received 20 years after his military service, to obtain compensation benefits from VA. The loss to VA is approximately $200,000.

# Purple Heart claim challenged

## VA employee also accused of taking $180,000 in benefits

By CARRI GEER THEVENOT
and KEITH ROGERS
LAS VEGAS REVIEW-JOURNAL

A Veterans Affairs employee from Las Vegas was indicted this week in a case of stolen valor and stolen benefits.

The case against David M. Perelman, who claimed to have received a Purple Heart medal, is the first known prosecution in Nevada under the Stolen Valor Act of 2005, which outlawed false claims of military honor. According to the indictment, Perelman claimed he had been wounded in combat in Vietnam, when in fact he had been wounded by a self-inflicted gunshot in 1991.

"The Purple Heart is a symbol of heroism, patriotism, honor, and symbolic of one's sacrifice and duty to our country," said Daniel Bogden, the U.S. attorney for Nevada. "Those who seek to diminish the sacrifice of others by wearing the Purple Heart when not authorized to do so will be vigorously prosecuted. Federal law calls for imprisonment for up to one year for wearing the Purple Heart when not authorized by law."

Perelman also is accused of stealing about $180,000 in monthly disability benefits from the Veterans Administration, now known as Veterans Affairs, from 1995 until July 2009. He is 56.

Attempts to reach Perelman for comment Thursday were unsuccessful. He faces two charges: theft of government property, a felony, and the unauthorized wearing of a military medal, a misdemeanor.

"I'm glad that finally Mr. Bogden is going to prosecute a stolen valor case," said retired Army Lt. Col. Bill Anton,

▶ SEE MEDAL PAGE 10A

*Suspect once headed Purple Heart organization*

**STOLEN VALOR ACT**

**Veteran Indicted for Stolen Valor**

A Veteran was arrested after being indicted for theft of Government funds. An OIG investigation determined that the defendant submitted a fraudulent Purple Heart certificate to VA in order to support his claim for VA compensation benefits. The loss to VA is approximately $24,000.

**Veteran Convicted of Stolen Valor Fraud**

A Veteran was convicted at trial for making a false claim of being awarded the Medal of Honor and making a false statement. An OIG investigation revealed that the Veteran falsely represented that he had been awarded the Medal of Honor, in violation of the Stolen Valor Act, and fraudulently provided false information to a VARO in an attempt to increase his VA benefit payments.

**Veteran Pleads Guilty To Fraudulently Obtaining VA Benefits**

After 2 days of trial, a Veteran pled guilty to conspiring with a former Disabled American Veterans (DAV) service officer and a former VA employee to fraudulently obtain VA benefits. The defendant also pled guilty to structuring financial transactions to avoid reporting requirements in order to conceal the conspiracy. An investigation by OIG and the FBI revealed that the Veteran, a pilot for a commercial airline carrier, enlisted the assistance of a DAV service officer and a VA employee to receive a disability rating of 100 percent service connection by inserting a fabricated medical examination into his claims file and removing all hearing exams from military service to ensure his

claim for hearing loss was approved. In exchange for getting the claim approved, the Veteran paid the DAV service officer and the VA employee each one-third of his $93,240 retroactive benefit check. Both the DAV officer and VA employee have pled guilty to their part of the scheme and are awaiting sentencing.

**Sister of Deceased Veteran Sentenced for Theft of VA Funds**

The sister of a deceased Veteran was sentenced to 36 months' probation and ordered to pay $125,245 in restitution after pleading guilty to theft of Government funds. An OIG investigation determined that the defendant stole VA benefits that were direct deposited into a joint account after her brother's death in 2002.

**Veteran Sentenced for Wire Fraud and False Statements**

A Veteran was sentenced to 15 months' incarceration, 24 months' probation, and ordered to pay $950,000 in restitution after pleading guilty to wire fraud and false statements. An OIG investigation revealed that between April 1976 and October 2007, the Veteran feigned symptoms and exaggerated his injuries to include paraplegia and complete loss of lower bodily functions requiring daily aid and attendance, constant medical care, clothing reimbursement, and adaptive housing and transportation. It was discovered that during this 31-year period, the Veteran owned an excavation company and operated heavy construction equipment, owned and operated a Federal Aviation Administration repair station and was the chief inspector and airframe power plant mechanic, obtained a private pilot's license without physical restrictions, and was a law enforcement officer in a county sheriff's office. During a VA C&P examination, the Veteran wheeled himself into the VAMC claiming to be a 31-year paraplegic with complete loss of bodily function below the waist, yet walked unassisted into U.S. District Court the following day on unrelated criminal charges.

**Multi-Agency Investigation Results in Wire Fraud Sentencing**

A defendant was sentenced concurrently to 60 months and 78 months' incarceration for wire fraud and conspiracy to commit theft of Government funds. The defendant was also sentenced to 3 years' probation and ordered to pay $92,390 in restitution. A multi-agency, 6-year investigation revealed that the defendant was behind a large criminal enterprise responsible for over $700,000 in fraudulent activity. The investigation disclosed that the defendant and her co-conspirators fraudulently diverted Government retirement funds by stealing the identities of recently deceased Federal retirees, many of whom were Veterans. The investigation identified that the co-conspirators participated in the diversion of Government funds, including VA benefits, and stole identities while establishing mail drops at commercial mail facilities. After obtaining control of the retirement accounts, the defendant diverted the funds from the deceased retirees' accounts to other bank accounts in Mexico and the New Orleans area.

**Defendant Sentenced for Identity Theft**

A defendant was sentenced to 25 months' incarceration, 36 months' probation, and ordered to pay restitution of $29,262 after pleading guilty to theft of Government funds and aggravated identity theft. An OIG investigation determined that the defendant assumed the identity of a disabled Veteran and redirected over $34,000 in VA benefits to another bank account in order to steal the funds.

**Veteran's Daughter Pleads Guilty to Embezzlement**

An OIG investigation revealed that the daughter of a Veteran, who had a power of attorney for her father, embezzled over $100,000 of her father's money, including his VA benefits, while her father was residing in a VA nursing home. Most of the embezzled funds were spent gambling at a casino. The daughter pled guilty to felony embezzlement.

**Veteran Arrested for Compensation Fraud**

A Veteran was arrested for making false statements and wire fraud. The Veteran was rated with a 100 percent service-connected disability and was also collecting special monthly compensation for the complete loss of the use of his lower extremities. An OIG and U.S. Secret Service investigation determined that the defendant continuously submitted false medical claims, testimony, and requests to VA for over 20 years stating that he could not ambulate without assistance, when in fact the Veteran had full mobility. The loss to VA is $526,539.

**Veteran's Daughter Pleads Guilty to Theft of VA Funds**

The daughter of a Veteran, who was also the wife of a state judge, pled guilty to theft of Government funds. An OIG investigation determined that between 2001 and 2008, the defendant fraudulently received VA pension benefits, on behalf of her father, based on false financial statements she made to VA. An OIG investigation revealed that the defendant and her three siblings created an investment company for the purpose of hiding their parents' financial assets. This action then made the parents eligible for various Government benefit programs, to include VA. The investment company's partnership agreement and company itself were created by the defendant's husband while he was still in office. The defendant, who was also her father's fiduciary, subsequently stole most of the fraudulently obtained VA pension benefits. The loss to VA is $110,848.

**Veteran Indicted for Fraud Involving VA Guaranteed Loans**

A Veteran was indicted for mortgage fraud, bank fraud, and identity theft relating to an extensive $1.6 million mortgage fraud scheme that began in 2002. An OIG, U.S. Secret Service, and FBI investigation determined that the defendant supplied VA with fraudulent social security numbers in order to qualify for VA guaranteed loans. The defendant was discharged from the U.S. Army under "other than honorable" conditions and would not have qualified for VA loans using his correct social security number. The loss to VA is approximately $56,000.

**Veteran and Mortgage Broker Indicted for Fraud**

An OIG and local law enforcement investigation resulted in the indictments of a Veteran and a mortgage broker. The Veteran was charged with mortgage fraud and the mortgage broker was charged with engaging in organized criminal activity. The investigation revealed that the Veteran and the mortgage broker conspired to defraud the VA Home Loan Guaranty Program by knowingly presenting falsified tax statements to a loan underwriter in order to purchase a home. The mortgage broker then used the acquired property as a primary residence without making the requisite mortgage payments. In June of 2009, the home was allowed to go into foreclosure, resulting in a potential loss of $104,193 to VA. The total dollar amount of the fraudulent transaction was determined to be $416,772. The Veteran received $11,741 in cash following the sale of the home, disbursed to him by a title company in the form of a realtor's commission.

### Veteran and Co-Defendants Arrested for Theft of Government Benefits

A Veteran, his wife, and his employer were arrested in connection with VA unemployability compensation and social security fraud. The Veteran and his wife were both charged with theft of Government funds, while the employer was charged with false statements. The Veteran was rated with a 70 percent service-connected disability, but was collecting at the 100 percent rate due to his claim of being unemployable as a result of his service-connected disability. An OIG, SSA OIG, and U.S. Secret Service investigation determined that the defendant submitted false certifications concerning his employment to both VA and SSA. The defendant's wife previously provided false information to OIG agents so that her husband could continue to receive VA and SSA benefits. The wife arranged for her husband's wages to be paid using her social security number in order to conceal his wages from VA and SSA. The Veteran's employer submitted false documentation stating he did not employ the Veteran and fraudulently paid wages to the Veteran using the wife's social security number. The loss to VA is approximately $82,000 and the loss to SSA is approximately $48,000.

### Defendants Sentenced for Theft of VA Benefits from Deceased Beneficiary

The son of a VA Dependency and Indemnity Compensation (DIC) beneficiary was sentenced to 4 months' incarceration, credited as time served, and ordered to pay $34,892 in restitution. A co-defendant was sentenced to 2 years' probation and ordered to pay $5,207 in restitution. Both defendants previously pled guilty to theft of Government funds after an OIG investigation determined that both defendants stole, forged, and negotiated VA benefit checks issued after the beneficiary's death in 1994.

### Mother and Daughter Indicted for Defrauding Disabled Veteran

The sister and niece of an incompetent Veteran, who was residing in a VA nursing care facility, were indicted for felony theft and misapplication of fiduciary property in excess of $100,000. An OIG investigation revealed that the two defendants conspired to defraud the Veteran by using a power of attorney to misappropriate over $170,000 in VA benefits belonging to the Veteran. The investigation revealed that the defendants convinced the Veteran that they were saving his benefits in a special savings account. Instead, they utilized the stolen funds for personal purchases and also distributed a portion of the funds to other family members.

### Veteran Indicted for VA Pension Fraud

A Veteran was indicted and subsequently arrested for theft of Government property. An OIG investigation revealed that for 4 years the defendant fraudulently received VA pension benefits by failing to accurately report to VA his employment disability pension and social security earnings. The loss to VA is $44,994.

### Daughter of Deceased Veteran Pleads Guilty to Theft of VA Benefits

The daughter of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant failed to report her mother's death to VA, forged her mother's signature on two VA Marital Questionnaire documents, and subsequently stole VA benefit funds direct deposited into her deceased mother's account. The loss to VA is $68,058.

## Defendant Pleads Guilty to Theft of Government Benefits

Va. veteran guilty of false claims

A veterans group alerted authorities to a Norfolk man's false claims about his military honors.

By Mike Gangloff
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Even as he pleaded guilty to inflating his military record, Thomas James Barnhart insisted he'd received a Purple Heart.

"I was given a Purple Heart with no paperwork in Vietnam, so it was as if I had made up the award myself," Barnhart, 58, said Wednesday in U.S. District Court in Roanoke.

But Assistant U.S. Attorney Jake Jacobsen said Barnhart, who lives in the Norfolk area, didn't stop with one Purple Heart. In paperwork filed when he transferred from the Navy to the Coast Guard, then in applications for disability benefits, Barnhart claimed an increasing array of honors. Ultimately he said he'd been a Navy SEAL, earned five Purple Hearts — each supposedly marking a combat wound — Bronze and Silver stars for valor, and more.

Barnhart's case echoed that of Randall Moneymaker, who in March 2008 was convicted of federal fraud and theft charges linked to false claims of combat missions and wounds that gained him a job as an Army recruiter and veterans disability benefits.

Jacobsen, who had prosecuted Moneymaker, said Barnhart also improperly sought benefits. In 1991 and 2005, Barnhart told Veterans Affairs interviewers tales of combat missions and a pilot dying in his arms. He said he'd been nominated for the Medal of Honor, the highest award for valor.

All of that was bogus, Jacobsen said.

The prosecutor agreed that Barnhart was in the

But investigation showed only that Barnhart earned a medal for offshore duty during the Vietnam War. There was no record of combat or combat awards.

Barnhart pleaded guilty to violating federal Stolen Valor legislation by falsely claiming to have been awarded medals. He also pleaded guilty to a felony embezzlement charge tied to $13,923 in disability payments for supposed post-traumatic stress disorder.

In a short statement, Barnhart said he'd given the wrong reasons for why he suffered from PTSD, but seemed to defend the diagnosis itself.

Judge James Turk accepted Barnhart's guilty pleas and noted that his plea agreement said he would repay the disability payments along with whatever fines and prison term might be imposed. He scheduled sentencing for April 8.

"You've got the real sailors, soldiers and airmen out there putting their lives on the line every day."
Jake Jacobsen
assistant U.S. attorney

After the hearing, Jacobsen, who served with the U.S. Army Reserve in Iraq, said military veterans, like fishermen, are prone to exaggeration. But falsifying service records for financial gain is "just galling," Jacobsen said.

So is claiming false honors during wartime, he added.

"You've got the real sailors, soldiers and airmen out there putting their lives on the line every day," Jacobsen said.

He said authorities were alerted to Barnhart's false claims by the veterans group AMVETS. Mary and Chuck Schantag, who run the group's ReportStolenValor.org Web site, could not be contacted Wednesday.

Doug Sterner, a Vietnam veteran from Colorado who was a leading advocate for the 2005 Stolen Valor legislation, said Barnhart's case shows the need for Congress to push the military to keep better records of medals such as Purple Hearts.

"There are literally tens of thousands of people who were given awards that never

A defendant pled guilty to an indictment charging him with theft of Government funds and Stolen Valor. An OIG and U.S. Coast Guard Investigative Service investigation determined that the defendant obtained fraudulent DD-214s early in his 20-year career with the Navy and Coast Guard. The defendant represented himself as a Navy Seal who received multiple medals for valor for over 10 years while serving in the Coast Guard. Upon retirement, the defendant provided fraudulent DD-214s to VA when applying for benefits claiming PTSD and lied extensively about combat exposure during mental health evaluations. The loss to VA is $13,923.

## Veteran Arrested for Making False Statements

A Veteran was arrested for making false statements after an OIG investigation revealed that he falsified his employment status on a VA Vocational Rehabilitation and Employment application and on other subsequent forms in order to receive VA benefits. The Veteran subsequently received approximately $11,000 for college tuition, supplies, subsistence allowance, and dependency pay over a 3-year period.

## Veteran's Daughter Pleads Guilty to Elder Abuse

The daughter of a Veteran pled guilty to felony elder abuse. An OIG investigation determined that the defendant stole over $70,000 of her father's VA funds and spent them on alcohol and other personal items. The defendant never informed her father that he had received a $70,000 retroactive VA benefit award check.

## Son of Deceased Beneficiary Pleads Guilty to Theft of VA Benefits

The son of a deceased VA beneficiary pled guilty to an indictment charging him with theft of public money. An OIG investigation revealed that the defendant submitted false financial status reports to VA, resulting in the continuation of benefits to his deceased mother. The defendant subsequently stole the VA funds that were direct deposited to his mother's account after her death in April 1987. The loss to VA is approximately $204,000.

## Common-Law Wife Pleads Guilty to Theft of VA Benefits

The common-law wife of a deceased Veteran pled guilty to theft of Government funds. An OIG investigation determined that the defendant failed to report her remarriage to VA and continued to fraudulently receive DIC benefits. The loss to VA is $73,064.

### Veteran Sentenced for VA Education Fraud

A Veteran was sentenced to 48 months' probation and ordered to pay $20,920 in restitution after pleading guilty to theft of Government funds. An OIG investigation determined that the defendant fraudulently received VA education benefits from March 2004 to July 2007. The defendant submitted forged VA monthly certifications reporting that he was attending school when, in fact, he failed to attend classes.

### Veteran Indicted for VA Compensation Fraud

A Veteran was indicted for health care fraud, false statements relating to health care matters, being a felon in possession of a firearm, and making a false statement during the purchase of a firearm. An OIG and a Bureau of Alcohol, Tobacco, Firearms, and Explosives investigation determined that for over 20 years the defendant falsely represented to VA that he had extreme loss of vision in both eyes. This claim allowed the Veteran to receive disability compensation at the 100 percent rate. The investigation further determined that the defendant drove, read, hunted, and performed numerous activities that would not be possible with his purported vision loss. The loss to VA is approximately $804,500.

### Son of Deceased Beneficiary Pleads Guilty to Forgery

The son of a deceased VA beneficiary pled guilty to forgery. An OIG investigation revealed that the defendant failed to report his mother's death to VA, forged his mother's signature on two VA Marital Questionnaire documents, and stole, forged, and negotiated 221 VA benefit checks over a period of approximately 19 years. The loss to VA is $191,669.

NEWPORT NEWS

# Man cashed dead mom's VA checks

## Over 19 years, Gilbert Harges deposited 221 monthly VA benefits cashing in on $191,669

By Peter Dujardin
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NEWPORT NEWS — It might have taken 19 years, but they finally figured it out.

A Newport News man has admitted bilking the federal government out of $191,669 in paychecks to his deceased mother — then blowing much of the money on drugs and booze.

Between 1990 and 2008, Gilbert C. Harges, 54, deposited 221 monthly Department of Veterans Affairs benefit checks in his mother's name, according to a statement of facts that Harges agreed to as part of his guilty plea in Newport News federal court this month.

Harges' mother, Layuna F. Harges, was entitled to receive the checks after the death of her husband, veteran Jack Harges. But the payments were supposed to stop when she died in February 1990. Instead, Gilbert Harges forged his mother's signature on the checks, deposited the money into a Bank of America savings account they held jointly "and later withdrew the funds from the account and used them for his own purposes," according to the statement of facts.

**Crime coverage**
Read more on crime in Hampton Roads at dailypress.com/news/crime

When the VA sent questionnaires to the family's home in both 1992 and 2000 inquiring about his mother's marital status, Gilbert Harges forged his mother's signature, indicating she had not remarried.

The checks could have been reduced or stopped if she had remarried.

In August 2009, Harges was interviewed by agents with the Veterans Affairs' Office of Inspector General.

"He ... admitted spending all the money and stated most of the money was spent on crack cocaine and alcohol, at least through 1999," said the statement of facts. "He knew his actions were wrong ... and characterized his actions as embezzlement."

The statement was agreed to by Harges, Assistant Federal Public Defender Arenda Allen and the prosecutor — Assistant U.S. Attorney Scott W. Putney.

It was not immediately clear why it took the Department of Veterans Affairs 19 years to discover the problem or what led to the eventual discovery. There are several mechanisms government agencies use to keep track of deaths, including alerts from the Social Security Administration.

Though Harges admitted as part of his guilty plea to depositing and using all 221 checks, he pleaded guilty to forging only one — a $1,091 check dated July 1, 2008. Under the plea bargain, the $191,669 that he took is subject to forfeiture.

He'll be sentenced May 7 by U.S. District Judge Mark S. Davis, facing a maximum penalty of 10 years in prison.

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### Remarried Widow Sentenced for Compensation Fraud

The widow of a Veteran was sentenced to 3 months' incarceration, 180 days in a halfway house, 36 months' supervised release, and ordered to pay $147,558 in restitution. An OIG investigation determined that the defendant had remarried more than 14 years ago and falsely certified to VA that she was unmarried in order to continue to receive a DIC benefit. During the investigation, the defendant obtained an annulment from her current husband in an effort to continue to receive benefits. After the annulment was granted, she continued to live with her ex-husband as a married couple.

**Veteran Sentenced for Theft of Government Benefits**

A Veteran was sentenced to 3 years' probation and ordered to pay restitution of $105,528 after pleading guilty to making fraudulent statements to agencies of the United States. The defendant received disability benefits from VA and SSA based on his claim of being unable to walk. An OIG and SSA OIG investigation revealed that the defendant was a licensed commercial truck driver, having passed Department of Transportation physicals requiring full mobility, during the same time period he was in receipt of disability benefits. While working, the defendant used his son's name and social security number to hide his income.

**Veteran's Daughter Sentenced for Theft of VA Benefits**

The daughter of a Veteran was sentenced to 180 days' incarceration, 3 years' probation, and ordered to pay restitution of $70,695. The defendant admitted that she spent her father's VA disability benefits on alcohol, hotel rooms, and other personal items. The Veteran, a double leg amputee, was in the process of being evicted from his nursing home for not paying his rent.

**Veteran Pleads Guilty to Theft of Benefits**

A Veteran pled guilty to theft of Government funds after an OIG investigation revealed that he fraudulently received over $50,470 in VA disability pension benefits from September 2003 to September 2007. The Veteran failed to report that he had returned to work as a truck driver and did not accurately report his income and earnings to VA.

## Other Investigations

OIG investigates allegations of bribery and kickbacks, bid rigging and antitrust violations, false claims submitted by contractors, and other fraud relating to VA procurement activities. In the area of procurement practices, OIG opened 12 cases, made 8 arrests, and had over $41.6 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

OIG also investigates theft of Information Technology (IT) equipment or data, network intrusions, identity theft, and child pornography. In the area of information management crimes, OIG made 4 arrests, and had $37,158 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

**Veteran Arrested for Identity Theft Involving VA Benefits**

A Veteran was arrested and charged with theft of Government funds. The defendant, who was rated ineligible to receive VA benefits, stole the identity of his honorably discharged brother in order to receive VA pension payments and medical care. The defendant admitted to posing as his brother in order to receive VA benefits since 1984. The brother, who died in 2006, had never applied for VA pension or medical care. The loss to VA is approximately $200,000.

**Veteran Sentenced for Theft of Government Funds**

A Veteran was sentenced to 180 days' home confinement, 3 years' supervised release, and a $10,000 fine. Prior to the sentencing, the Veteran paid full restitution of $137,704. This sentencing was based on a VA OIG, Office of Personnel Management (OPM) OIG, and Federal Deposit Insurance

Corporation OIG investigation that determined the Veteran had submitted forged documents to the Government, including a fraudulent DD-214 and a forged letter on VA letterhead, which purported that he had 11 years of active duty service. In actuality, he served only 4 months during basic training in the U.S. Army Reserve. The false claim fraudulently raised the Veteran's creditable civilian service to over 25 years and resulted in the illicit receipt of $137,704 in OPM retirement benefits.

**Employee Sentenced for Possession of Child Pornography**

A researcher at the Memphis, TN, VAMC, who was working as a research specialist under a VA grant program, was sentenced to 12 years' incarceration and 5 years' probation after pleading guilty to the receipt, possession, and transmission of child pornography. An OIG, Immigration and Customs Enforcement, FBI, and VA Police investigation determined that the defendant accessed and used VA computer systems to obtain and transmit child pornography.

**Veteran Sentenced for Possession of Child Pornography at Miami VAMC**

A Veteran was sentenced to 58 months' incarceration after pleading guilty to possession of child pornography. An OIG investigation revealed that the Veteran used a VA computer located in the Miami, FL, VAMC medical library to download material depicting children and adults engaged in sexual acts. The investigation also revealed that the defendant actively stalked young girls and wrote on his e-mail account profile about his desire to molest these girls.

**Chief Executive Officer Sentenced for Making False Statements**

The Chief Executive Officer (CEO) of a biotechnology company was sentenced to 8 months' incarceration, 3 years' probation, a $77,228 fine, and ordered to pay restitution of $22,772 after pleading guilty to making false statements. The CEO also pled guilty on behalf of his company to making false statements. The company was subsequently sentenced to a $20,000 fine. A multi-agency investigation revealed that from 2001 to 2002, the CEO authorized the alteration of data related to the purity of chemical compounds manufactured by the company and sold to VA and other Federal agencies.

**Defendant Pleads Guilty to Health Care Fraud**

A former account manager with a company that provided home health care services to patients covered by various health care programs, including Medicaid and VA, pled guilty to a criminal information charging him with knowingly and willfully defrauding a health care program. An OIG, Health and Human Services OIG, and FBI investigation determined that the defendant altered employee documents to make them appear compliant with State licensing regulations during audits of the company's operations.

**Former Bay Pines, Florida, Employee Indicted for Child Pornography Possession**

A former Bay Pines, FL, VAMC employee was indicted for possession of child pornography after an OIG and FBI investigation revealed that the defendant used his VAMC network folder to store images of child pornography.

**Former Executive Pleads Guilty to Conspiracy and Money Laundering**

The former CEO of a nursing home chain that received Federal funds pled guilty to conspiracy to commit wire fraud and money laundering. A multiagency investigation determined that the defendant

conspired to create false invoices in order to obtain loans from lenders. The loans were intended for the improvement of the nursing home facilities but instead were used to pay for the CEO's personal expenses, including the purchase of a number of apartment complexes. As part of the plea agreement, the CEO agreed to forfeit $500,000 to the Government in the form of a lien placed on one of the complexes. In addition to the CEO, a former director of cash management, a nursing home administrator, and a regional accounts receivable manager were also previously convicted as a result of this investigation and are currently awaiting sentencing.

**Deceased Veteran's Ex-Wife Sentenced for Misappropriation**

The ex-wife of a deceased Veteran was sentenced to 3 years' incarceration, 3 years' probation, and ordered to pay restitution of $362,644 after pleading guilty to misappropriation by a fiduciary. A joint investigation conducted by OIG, FBI, and the Defense Criminal Investigative Service revealed that at the time of the Veteran's death, he had named his minor son as the sole beneficiary for his military life insurance. The Veteran's ex-wife obtained court appointed guardianship over the life insurance funds, totaling approximately $450,000, in order for VA to pay the son. The investigation further determined that in less than 1 year, the defendant embezzled almost all of the funds, spending them on extravagant vacations, gambling, cars, and parties.

# Fallen soldier's ex-wife gets 3 years for embezzling $363K

## SGLI money was meant for young son

By Karen Jowers

The ex-wife of a soldier who died in Iraq has been sentenced to three years in federal prison for embezzling nearly $363,000 of the soldier's Servicemembers Group Life Insurance payout that was intended for their young son.

Trisha Dawn Fish, 31, of Harrah, Okla., spent the money on vacations to Las Vegas and San Antonio, restaurants and nightclubs, cars for relatives, and other expenses, according to court documents filed by U.S. attorneys in the U.S. District Court for the Western District of Oklahoma.

Fish also was ordered to pay $362,644 in restitution to her son. Following the three years in prison, Fish will have three additional years of probation.

Assistant U.S. Attorney James Robinson said he hopes the sentence acts as a deterrent to others. "Military people going overseas don't need to worry that someone is going to disregard their wishes with respect to their beneficiaries," Robinson said.

The FBI and investigators from the departments of Defense and Veterans Affairs worked on the case, he said.

Fish pleaded guilty to embezzlement Aug. 18, a charge that carries a maximum possible sentence of five years. Fish was given the maximum punishment allowed based on this particular case's sentencing guidelines, prosecutors said.

Spc. Jeffrey Stuart Heathorn died in Iraq on Feb. 8, 2005. He had designated his son, now 11, as beneficiary of his $250,000 SGLI policy. When the law was changed in 2006 to increase the SGLI maximum to $400,000 retroactively, another $150,000 was paid to the son.

Instead of investing for their son's future, Fish "took the money and used it for her own benefit and the benefit of just about everyone else other than her son," prosecutors alleged in court documents, which identify the child only as CMH.

Fish burned through most of the money in about seven months. Among the expenditures were a $4,000 trip to Las Vegas for Fish and a former boyfriend; a $12,000 vacation to San Antonio; $6,500 in two bills at a spa resort; $3,000 at restaurants; $395 for a nightclub; more than $25,000 to relatives and friends; a car for her mother; $6,850 to a former boyfriend released from prison; and $350 to a psychic.

"All my brother wanted was for his son to have stability," said Shannon Anstill, Heathorn's sister. "I don't think my brother had any idea she'd have access to this money. If he had, he would have set things up differently."

Heathorn's will could not be found after his death, prosecutors noted.

Joseph Shannonhouse, Fish's attorney, said Fish spent some of the money responsibly, buying a house for her and her son and a car for herself, but she admits to inappropriate spending.

"Clearly, the mother inappropriately dissipated this money, but it should never have been put into her hands in the first place," Shannonhouse said.

Heathorn

Her ability to make decisions was impaired by an undiagnosed emotional disorder that included depression, he said. Fish was abused as a child and was upset over her ex-husband's death, her attorney said. She also has been diagnosed with post-traumatic stress disorder and had become addicted to Xanax, Shannonhouse said.

But the heart of the case, he said, is a breakdown in the system.

Fish was 25 at the time she received the money, had dropped out of high school and later obtained a GED, then earned a degree as a medical assistant. She never earned more than $10 an hour, and her yearly adj gross income on her tax r was never more than $2,46

To receive the death bene behalf of her son, as requir VA's Office of Servicemen Group Life Insurance, Fish be appointed by a cou guardian of the minor c estate or property.

Fish, who is Native Ame filed a petition for guardians the Tribal District Court fo Kickapoo Tribe of Oklahoma, the tribal court judge she wou the funds in trust for her so buy a house. She was appoin guardian, and on March 10, was issued the first check.

"I don't think a [state] would have appointed guardian," Shannonhouse "They just wrote a couple of checks to a woman who absolutely not qualified to de this money, and this is the re

By law, the SGLI progra administered by a comm insurance company, follo state insurance regulations Steve Wurtz, VA's deputy assi director for insurance. VA s vises the insurance program.

"It's absolutely [the compa responsibility to see it's paid proper beneficiary," he said.

## Administrative Investigations

OIG's Administrative Investigations Division independently reviews allegations and conducts administrative investigations generally concerning high-ranking senior officials and other high profile matters of interest to the Congress and the Department. During this reporting period, OIG issued two administrative investigations resulting in $48,913 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

**Administrative Investigation Substantiates Improper Behavior by VA Official**

An administrative investigation substantiated that a National Programs & Special Events senior official misused official time and travel, failed to properly record compensatory time for her subordinates, improperly used hundreds of hours of unauthorized compensatory leave, interfered with an OIG investigation, accepted gratuities from a prohibited source, and circumvented acquisition requirements. The investigation also substantiated that a different senior official and three other VA employees made false statements and interfered with an OIG investigation.

**Doctor Collected Improper VA Pay While Performing Paid Lectures**

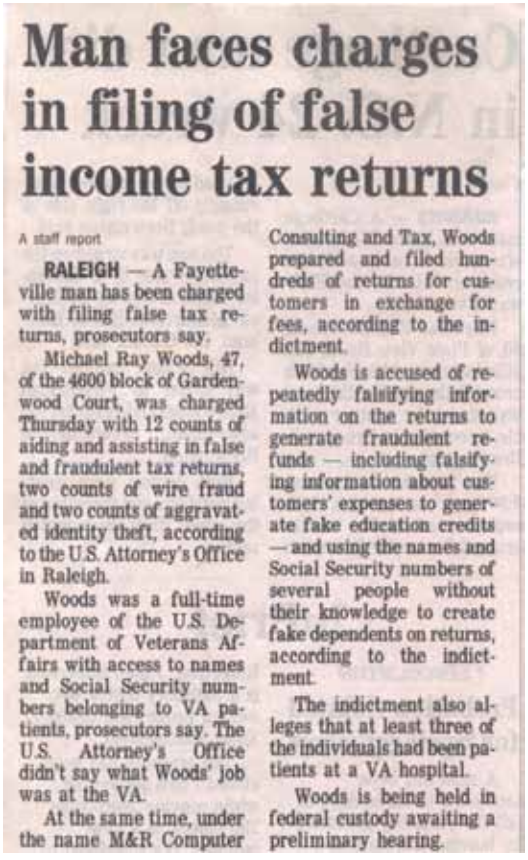
An administrative investigation substantiated that a podiatrist, previously employed at the North Chicago VAMC, provided non-VA related professional services for remuneration during his official VA time. The investigation disclosed that VA improperly paid the podiatrist $22,208 for hours he was away from his VA duty station while traveling, lecturing, and receiving payment for non-VA related professional services. VA issued the podiatrist a bill of collection in the amount of $22,208.

## Employee-Related Investigations

During this reporting period, OIG opened 25 investigations regarding criminal activities by VA employees (not including drug diversion). The types of crimes investigated included Workers' Compensation Fraud, theft from Veterans, and theft of VA property or funds. Twenty-nine defendants were charged with crimes and court ordered payment of fines, restitution, and penalties amounted to $24,912. Among them were the following:

- A VA OI&T employee, working in Fayetteville, NC, was indicted and arrested for filing false and fraudulent tax returns, wire fraud, and aggravated identity theft. An OIG and Internal Revenue Service (IRS) Criminal Investigations Division investigation disclosed that the employee utilized the PII of at least four Veterans without their knowledge to prepare fraudulent tax documents. The defendant used his position to access the Veterans' information.

- A former West Haven, CT, VAMC employee, who had duties as a contracting officer's technical representative, was sentenced to 24 months' incarceration and 24 months' probation after being convicted of receiving bribes and filing a false tax return. A OIG, FBI, IRS Criminal Investigations Division, General Services Administration OIG, and VA Police investigation revealed the defendant received various payments in exchange for steering VA contracts to two companies formed by an attorney for the purpose of doing business with VA. The total value of the bribes exceeded $45,000. The value of the contracts awarded to the attorney's two companies totaled almost $400,000, which included $81,000 in payments for services or supplies authorized by or charged directly to the defendant's



Man faces charges in filing of false income tax returns

A staff report

RALEIGH — A Fayetteville man has been charged with filing false tax returns, prosecutors say.

Michael Ray Woods, 47, of the 4600 block of Gardenwood Court, was charged Thursday with 12 counts of aiding and assisting in false and fraudulent tax returns, two counts of wire fraud and two counts of aggravated identity theft, according to the U.S. Attorney's Office in Raleigh.

Woods was a full-time employee of the U.S. Department of Veterans Affairs with access to names and Social Security numbers belonging to VA patients, prosecutors say. The U.S. Attorney's Office didn't say what Woods' job was at the VA.

At the same time, under the name M&R Computer Consulting and Tax, Woods prepared and filed hundreds of returns for customers in exchange for fees, according to the indictment.

Woods is accused of repeatedly falsifying information on the returns to generate fraudulent refunds — including falsifying information about customers' expenses to generate fake education credits — and using the names and Social Security numbers of several people without their knowledge to create fake dependents on returns, according to the indictment.

The indictment also alleges that at least three of the individuals had been patients at a VA hospital.

Woods is being held in federal custody awaiting a preliminary hearing.

Government credit card. The defendant also admitted to filing a false income tax return when he failed to report the illegal payments. The attorney was previously sentenced in this case.

- A former Philadelphia VAMC employee was sentenced to time served and 9 years' probation and a second former employee was sentenced to 7 years' probation. The two defendants previously pled guilty to felony theft and conspiracy charges after an OIG and VA Police investigation revealed that they stole cash, savings bonds, and credit cards from elderly Veterans who resided at the nursing home. Both defendants were also ordered to make full restitution to the victims.

- A former Providence, RI, VAMC agent cashier was sentenced to 36 months' probation and ordered to pay restitution of $1,527 to VA after pleading guilty to theft of Government funds. A joint OIG, FBI, and VA Police investigation revealed that the cashier initially reported that an armed individual robbed the agent cashier's office. While being interviewed, the cashier recanted his story and admitted that he had stolen the cash, checks, and other items. A search of the cashier's vehicle and residence resulted in the recovery of the stolen funds and blank checks.

- A former Augusta, GA, VAMC nurse's aide was sentenced to 6 months' home confinement, 5 years' probation, 100 hours' community service, and ordered to pay restitution of $8,190. An OIG and Department of Labor OIG investigation determined that the defendant made false statements in order to fraudulently obtain Federal workers' compensation benefits. The investigation revealed that the defendant worked as a home improvement contractor while collecting workers' compensation.

- A former Fort Harrison, MT, VA employee was sentenced to 24 months' incarceration and 10 years' probation after pleading guilty to possession of child pornography. An OIG investigation disclosed that the defendant used his computer at the VAMC to download pornographic images from the internet and transfer them to his iPod.

- A former Houston, TX, VAMC supervisor was indicted for theft by a public servant after an OIG investigation determined that the defendant was simultaneously employed by the Houston VAMC and another Houston area hospital while on the same work schedule. The loss to VA is approximately $15,000.

- A former Providence, RI, VAMC employee was indicted for aiding and abetting and theft of Government property. An OIG and VA Police investigation determined that the defendant and an unknown accomplice stole two computers and flat screen monitors from the medical center.

## Threats Made Against VA Employees

During this reporting period, OIG initiated 21 criminal investigations resulting from threats made against VA facilities and employees. Fourteen defendants were charged with making threats as a result of the investigations. Among them were the following:

- A Veteran was sentenced to time served of almost 15 months, 60 months' probation, and was ordered to obtain narcotic and MH treatment after pleading guilty to threatening to blow up a Federal facility by means of an explosive device. An OIG investigation discovered that in addition to threatening to blow up a VA facility, the Veteran also threatened to kill his VA fiduciary, a VARO

employee, and SSA employees.

- A Veteran was sentenced to 3 years' incarceration and 3 years' probation after pleading guilty to making threats against VA and its employees. The Veteran's sentence was enhanced due to prior threats he made against VA. In October 2008, the defendant sent a letter to the Baton Rouge, LA, VAMC outpatient clinic stating that he would carry out specific threats if his demands were not met within 90 days.

- A Veteran was found guilty at trial of making terroristic threats. An OIG and FBI Joint Terrorism Task Force investigation revealed that the Veteran contacted the Jackson, MS, VAMC and made a threat to blow up the VA facility. The defendant conveyed a detailed plan to use Semtex, a commercially-available explosive, in elevator shafts and the radiology department.

- A Veteran was arrested at the Houma, LA, VA OPC after an OIG and local sheriff's office investigation determined that the Veteran made telephonic and electronic threats to VA employees at the New Orleans VARO and the Houma OPC. The Veteran has a history of making threats and was involuntarily committed in May 2009 as a result of threats he made to the VARO, OIG, and a local sheriff's office.

Friday, March 12, 2010

**Raceland Man Charged with Terrorizing** - *Sgt. Lesley Hill Peters*

Sheriff Craig Webre announced an Air Force veteran is in custody this evening following threats made to federal employees of the U.S. Department of Veterans Affairs by telephone and email. Agents with Veterans Affairs contacted LPSO March 9th after Stephen Davis (B/M, DOB 9/27/1955, 114 St. Louis St, Raceland) placed a threatening call to a worker at the VA community-based outreach clinic in Houma. He told a female worker there that "he was bi-polar, off his meds, and would come here and shoot her white a-- and f--- her up".

Davis has a history of threats against the VA going back to May of 2009: At one point he was the subject of an involuntary commitment and he agreed to seek treatment for mental and anger issues. Between October of 2009 and January 2010, Davis sent 15 emails to the VA in New Orleans which threatened federal employees and employees of the Lafourche Parish Sheriff's Office.

After the March 9th phone call, federal investigators worked with Lafourche detectives. On March 11th, a warrant for Davis' arrest was signed by Judge John Leblanc. When Mr. Davis arrived for a scheduled appointment at the VA clinic in Houma today, he was arrested without incident. He is currently in custody in Terrebonne Parish but will be transferred to the Lafourche Parish Detention Center where bond is set at $25,000.

## Fugitive Felons Arrested with OIG Assistance

Veterans and VA employees continue to be identified and apprehended as a direct result of the OIG Fugitive Felon Program. To date, 34 million felon warrants have been received from the National Crime Information Center and participating states resulting in 50,699 investigative leads being referred to law enforcement agencies. Over 2,048 fugitives have been apprehended as a direct result of these leads. Since the inception of the program in 2002, OIG has identified $706.2 million in estimated overpayments with an estimated cost avoidance of $808.1 million. Forty-two fugitive felon program arrests were made by OIG, VA Police, U.S. Marshals, and local police during this reporting. Three of these arrests were of VAMC employees at various medical centers who were wanted on charges to include cocaine possession, drug violation, and probation violation. Apprehensions included the following:

- OIG, working with a U.S. Marshals Service fugitive apprehension strike team, arrested a Veteran wanted for bank robbery. The Veteran is alleged to be responsible for robbing five banks in the Dallas-Fort Worth, TX, area. The Veteran received health care at VAMCs in Dallas, Temple, and Waco, TX. The Veteran is also suspected in a burglary of the Temple VAMC cafeteria, which occurred a month prior to the bank robberies.

- Houston, TX, VAMC employee, who is also a Veteran, was arrested at the medical center with the assistance of the OIG for violating the terms of his probation following a 1999 homicide conviction. The employee's criminal history includes prior arrests for manslaughter, fraud, controlled substances, and carrying prohibited weapons.

- A Veteran was arrested by OIG and the U.S. Marshals Service for violating his parole after being convicted of robbery and failure to register as a sex offender. The Veteran was held pending extradition to California.

The Office of Management and Administration provides comprehensive support services that promote organizational effectiveness and efficiency through reliable and timely management and administrative support, and through products and services that promote the overall mission and goals of OIG.

## Operations Division

The Operations Division conducts follow-up reporting and tracking of OIG report recommendations; provides strategic, operational, and performance planning; prepares and publishes OIG-wide reports, such as the Semiannual Report to Congress; develops OIG policies and procedures; and electronically distributes all OIG oversight reports. The Operations Division also promotes organizational effectiveness and efficiency by managing all OIG contracting and providing reliable, timely human resources management, and related support services.

## Information Technology and Data Analysis Division

IT staff promote organizational effectiveness and efficiency by ensuring the accessibility, usability, and security of information assets; developing, maintaining, and enhancing the enterprise database application; facilitating reliable, secure, responsive, and cost-effective access to VA databases and electronic mail by all authorized employees; providing internet document management and control; and providing support to all OIG components.

Data Analysis staff provide automated data processing technical support of OIG and other Federal and governmental agencies requiring information from VA files. Data Analysis Division products facilitate the identification of fraud-related activities and support OIG comprehensive initiatives that result in solutions beneficial to VA.

## Administrative and Financial Operations Division

The Administrative and Financial Operations Division promotes OIG organizational effectiveness and efficiency by providing reliable and timely management and administrative support services such as employee travel, credit card purchases, and property management.

## Budget Division

The Budget Division promotes organizational effectiveness by providing a full complement of budgetary formulation and execution services to management and organizational components, including formulation of submissions and operating plans; monitoring allocations, expenditures, and reserves; conducting financial analyses; and developing internal budget policies.

## Hotline Division

The Hotline Division is the focal point for contacts made to OIG, operating a toll-free telephone service 5 days a week, Monday through Friday, from 8:30 AM to 4:00 PM Eastern Time. Phone calls, letters, and e-mails are received from employees, Veterans, the general public, Congress, the Government Accountability Office, and other Federal agencies reporting issues of criminal activity, waste, abuse, and mismanagement. During this reporting period, the Hotline received 14,600 contacts, 425 of which became OIG cases. The Hotline also closed 514 cases during this reporting period, substantiating allegations 46 percent of the time. The following cases were initiated as a direct result of Hotline contacts:

### Violation of Privacy Act Substantiated

A VHA review concluded that over a period of 11 months, medical personnel in two departments at the Danville, IL, VAMC improperly disposed of patient-sensitive documents in regular trash receptacles. Among other actions, the employees involved received refresher education on safeguarding and disposing of sensitive documents. Management also placed sensitive paper bins throughout the facility; contracted on-site shredding services; put processes into practice that ensure all paper documents and printouts, regardless of sensitivity, are placed into the sensitive paper bins; and created a full-time Privacy Officer position.

### Service Chief's Harrassment of Terminally-Ill Employee Substantiated

A VHA review at the Nashville, TN, VAMC determined that a Service Chief harassed and demoralized a terminally-ill employee, ordering that the employee remove head gear that was necessary as a result of hair loss from chemotherapy treatment. Administrative action was taken.

### Veteran Assessed an Overpayment for Failure to Report Additional Income

The Milwaukee, WI, VARO determined that a Veteran in receipt of a pension did not inform VA that he was also receiving state unemployment benefits. The Veteran's account was assessed an overpayment of $23,025.

### Castle Point, New York, VAMC In Violation of *Prompt Payment Act* Incurs Recurring Late Fees

A review conducted by the Castle Point, NY, VAMC found that the VAMC's untimely payment of invoices resulted in late fees of more than $68,000 spanning the last 4 years. To preclude a recurrence, the facility instituted programmatic changes including detailing an accounting technician to the Engineering Service to assist in tracking and expediting utility payments.

### VHA Review Finds Irregularities In Contract Award

A VHA review determined that the Columbus, OH, VA Ambulatory Care Center awarded a contract to a vendor for $237,445, despite the fact that this bid was $97,000 higher than that of another vendor. The review revealed deficiencies in procedures pertaining to source selection evaluation. The contract remains under a stop work order and the Contracting Officer is working with legal counsel to implement corrective action. Management plans to address all procedural irregularities and conduct future VISN-wide training to ensure incorporation of best practices.

### VHA Overturns Decision to Deny $130,561 Fee Basis Claim

The Phoenix, AR, HCS determined that it incorrectly denied a Veteran's claim for fee basis care. Following a VISN 18 review of the case, the facility approved payment of the Veteran's care in a community hospital, resulting in the processing of $130,561 in medical bills.

The Office of Contract Review (OCR) operates under a reimbursable agreement with VA's Office of Acquisition, Logistics and Construction (OALC) to provide preaward, postaward, and other requested reviews of vendors' proposals and contracts. In addition, OCR provides advisory services to OALC contracting activities. OCR completed 50 reviews in this reporting period. The tables that follow provide an overview of OCR performance during this reporting period.

## Preaward Reviews

Preaward reviews provide information to assist VA contracting officers in negotiating fair and reasonable contract prices and ensuring price reasonableness during the term of the contract. Preaward reviews identified $271 million in potential cost savings during this reporting period. In addition to FSS proposals, preaward reviews during this reporting period included 16 health care provider proposals—accounting for almost $21 million of the identified potential savings. Reports resolved through negotiations by contracting officers sustained 33 percent of OIG's recommended savings.

| | October 1, 2009—March 31, 2010 |
|---|---|
| Preaward Reports Issued | 35 |
| Potential Cost Savings | $271,015,783 |

## Postaward Reviews

Postaward reviews ensure vendors' compliance with contract terms and conditions, including compliance with the *Veterans Health Care Act of 1992*, P.L. 102-585, for pharmaceutical products. OCR reviews resulted in VA recovering contract overcharges totaling over $2.2 million, including $1.2 million related to Veterans Health Care Act compliance with pricing requirements, recalculation of Federal ceiling prices, and appropriate classification of pharmaceutical products. Postaward reviews continue to play a critical role in the success of VA's voluntary disclosure process. Of the 15 postaward reviews performed, 12 involved voluntary disclosures. In 5 of the 12 reviews, OCR identified additional funds due.

| | October 1, 2009—March 31, 2010 |
|---|---|
| Postaward Reports Issued | 15 |
| Dollar Recoveries | $2,280,262 |

# Congressional Testimony

### Counselor, Assistant IG for Audits & Evaluations Testify on Acquisition Deficiencies in VA

Counselor to the Inspector General Maureen Regan and Assistant Inspector General (AIG) for Audits and Evaluations Belinda Finn testified before the U.S. House of Representatives' Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations, on acquisition deficiencies in VA. Ms. Regan told the Subcommittee that OIG audits, reviews, and investigations have identified systemic issues that caused or contributed to procurement failures, overpayments, and misuse of funds. These issues include poor acquisition planning, poorly written contracts, inadequate competition, no price reasonableness determinations, and poor contract administration.

### Deputy AIG for Audits and Evaluations Testifies on Mental Health and Orthopedic Services at the VA Pacific Islands HCS

The Deputy AIG for Audits and Evaluations, Linda Halliday, testified at a Senate Veterans' Affairs Committee field hearing in Maui, HI, on MH and orthopedic services for Veterans on the island of Maui. OIG reported that although PIHCS has experienced challenges in providing MH services to Veterans on Maui and the other outlying islands, it is effectively using VA's Mental Health Initiative funding to recruit additional staff and expand telehealth services. OIG also reported that since FY 2006, PIHCS has made significant strides in reducing wait times for elective orthopedic surgery procedures, most notably by hiring two orthopedic surgeons. Walter Stucky, Audit Manager, Seattle Office of Audits and Evaluations, accompanied Ms. Halliday at the hearing.

### Deputy IG Testifies on FY 2011 OIG Budget

Deputy IG Richard Griffin testified before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives, on the OIG budget request for FY 2011. Mr. Griffin highlighted the OIG's accomplishments in FY 2009 and explained how OIG would invest budget resources made available in FY 2011 to provide oversight for VA programs and operations. Mr. Griffin was accompanied by James O'Neill, AIG for Investigations; Belinda Finn, AIG for Audits and Evaluations; John D. Daigh, Jr., MD, AIG for Healthcare Inspections; and Maureen Regan, Counselor to the Inspector General.

### AIG for Audits and Evaluations Testifies on VA Purchased Health Care Services from Non-VA Providers

AIG for Audits and Evaluations Belinda Finn testified before the Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives, on OIG findings regarding VHA purchases of health care services for Veterans from non-VA providers. OIG estimated that VA made over $1 billion in improper payments over a 5-year period. Ms. Finn was accompanied by Gary Abe, Director, Seattle Office of Audits and Evaluations.

### Anchorage VARO Inspection Report Subject of Senate Hearing

AIG for Audits and Evaluations Belinda Finn testified at Senate Veterans' Affairs Committee field hearings in Anchorage and Fairbanks, AK, on the results of an OIG inspection of the Anchorage VARO. OIG reported that the Anchorage VARO faces challenges in providing benefits and services to Veterans and the need for increased management oversight. The VARO did not meet VBA standards for 13 of the 14 operational areas inspected. Ms. Finn was accompanied by Brent Arronte, Director, Benefits Inspections Division.

### AIG for Audits and Evaluations Testifies on VA's Systematic Technical Accuracy Review Program

Assistant Inspector General for Audits and Evaluations Belinda Finn testified before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, U.S. House of Representatives, on OIG findings related to VBA's quality assurance processes. OIG projected VBA's accuracy rate for STAR reviewed claims was only 78 percent, 10 percentage points lower than VBA's reported error rate. She also told the Subcommittee that staff shortages affected VBA's ability to complete consistency reviews in claims with the same diagnostic codes in FY 2009, and that an inadequate infrastructure and management strategy impeded another VBA quality assurance program, the C&P Service's Site Visit program, from accomplishing its mission and goals. Ms. Finn was accompanied by Larry Reinkemeyer, Director, Kansas City Office of Audits and Evaluations.

## Special Recognition

Gerard Sheeran, Office of Audits and Evaluations, Financial Audits Division, received the IG's Good Citizen Award in recognition of the role he played in the apprehension of a suspect in a bank robbery in Alexandria, VA, on October 8, 2009. When the suspect leaped over the teller's gate, Mr. Sheeran seized the moment to exit the bank, warned others from entering, and notified local police. Mr. Sheeran then followed the suspect as he left the bank and provided police with a description and the attempted escape route of the bank robber. Mr. Sheeran later testified in related court proceedings that led to the conviction of the suspect to 27.5 years of confinement.

| Report Title, Number, and Issue Date | Funds Recommended for Better Use | | Questioned Costs |
|---|---|---|---|
| | by OIG | Agreed to by Management | |
| **INTERNAL AUDITS AND REVIEWS ($276,049,571)** | | | |
| Audit of VA's Consolidated Financial Statements for Fiscal Years 2009 and 2008<br>*Report No. 09-00976-25, Issued 11/16/2009* | | | |
| Audit of Veterans Health Administration's Undelivered Orders<br>*Report No. 09-00088-38, Issued 12/02/2009* | 276,000,000 | 276,000,000 | |
| Fiscal Year 2009 Federal Information Security Management Act Assessment<br>*Report No. 09-01682-91, Issued 03/04/2010* | | | |
| Independent Review of VA's Fiscal Year 2009 Detailed Accounting Submission to the Office of National Drug Control Policy<br>*Report No. 10-01106-95, Issued 03/08/2010* | | | |
| Independent Review of VA's Fiscal Year 2009 Performance Summary Report to the Office of National Drug Control Policy<br>*Report No. 10-01105-96, Issued 03/09/2010* | | | |
| Review of Outpatient Fee Payments at the VA Pacific Islands Healthcare System<br>*Report No. 09-02088-106, Issued 03/17/2010* | | | 49,571 |
| Audit of VA's Efforts To Provide Timely Compensation and Pension Medical Examinations<br>*Report No. 09-02135-107, Issued 03/17/2010* | | | |
| Audit of Fiduciary Program's Effectiveness in Addressing Potential Misuse of Beneficiary Funds<br>*Report No. 09-01999-120, Issued 03/31/2010* | | | |
| **ARRA AUDITS AND REVIEWS** | | | |
| VA's Data Quality Review Process under the American Recovery and Reinvestment Act of 2009<br>*Report No. 09-01814-16, Issued 10/30/2009* | | | |
| Veterans Benefits Administration, Review of New Hire Productivity and the American Recovery and Reinvestment Act Hiring Initiative<br>*Report No. 09-01814-85, Issued 02/18/2010* | | | |

# Appendix A: List of OIG Reports Issued

| Report Title, Number, and Issue Date | Funds Recommended for Better Use | | Questioned Costs |
|---|---|---|---|
| | by OIG | Agreed to by Management | |
| American Recovery and Reinvestment Act Oversight Advisory Report—VHA Non-Recurring Maintenance Contract Award Oversight Needs Strengthening<br>*Report No. 09-01814-97, Issued 03/15/2010* | | | |
| **EXTERNAL REVIEW** | | | |
| Peer Review of Department of Transportation Office of Inspector General Quality Control System for Fiscal Year 2009<br>*Report No. 10-00182-100, Issued 03/11/2010* | | | |
| **BENEFITS INSPECTIONS** | | | |
| VA Regional Office, Baltimore, Maryland<br>*Report No. 09-01993-29, Issued 11/19/2009* | | | |
| VA Regional Office, San Juan, Puerto Rico<br>*Report No. 09-01996-41, Issued 12/04/2009* | | | |
| VA Regional Office, Anchorage, Alaska<br>*Report No. 09-01998-42, Issued 12/07/2009* | | | |
| VA Regional Office, Roanoke, VA<br>*Report No. 09-01995-63, Issued 01/14/2010* | | | |
| VA Regional Office, Philadelphia, PA<br>*Report No. 09-03846-93, Issued 03/04/2010* | | | |
| VA Regional Office, Togus, ME<br>*Report No. 09-03659-111, Issued 03/23/2010* | | | |
| **COMBINED ASSESSMENT PROGRAM REVIEWS** | | | |
| Washington, DC, VA Medical Center<br>*Report No. 09-02376-02, Issued 10/05/2009* | | | |
| Salem VA Medical Center, Salem Virginia<br>*Report No. 08-03077-04, Issued 10/06/2009* | | | |
| Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan<br>*Report No. 08-02603-05, Issued 10/07/2009* | | | |
| James E. Van Zandt VA Medical Center, Altoona, Pennsylvania<br>*Report No. 09-01732-10, Issued 10/16/2009* | | | |
| VA Maryland Health Care System, Baltimore, Maryland<br>*Report No. 09-01730-14, Issued 10/21/2009* | | | |

| Report Title, Number, and Issue Date | Funds Recommended for Better Use | | Questioned Costs |
|---|---|---|---|
| | by OIG | Agreed to by Management | |
| Marion VA Medical Center, Marion, Illinois<br>*Report No. 08-03083-17, Issued 11/02/2009* | | | |
| VA Hudson Valley Health Care System, Montrose, New York<br>*Report No. 08-02567-18, Issued 11/04/2009* | | | |
| Huntington VA Medical Center, Huntington, West Virginia<br>*Report No. 08-03087-20, Issued 11/05/2009* | | | |
| W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina<br>*Report No. 08-03078-44, Issued 12/09/2009* | | | |
| Louis Stokes Cleveland VA Medical Center, Cleveland, Ohio<br>*Report No. 09-03550-55, Issued 12/30/2009* | | | |
| VA Roseburg Healthcare System, Roseburg, Oregon<br>*Report No. 09-02921-57, Issued 01/05/2010* | | | |
| Phoenix VA Health Care System, Phoenix, Arizona<br>*Report No. 09-03313-59, Issued 01/11/2010* | | | |
| VA Sierra Nevada Health Care System, Reno, Nevada<br>*Report No. 09-03039-62, Issued 01/14/2010* | | | |
| VA Eastern Kansas Health Care System, Topeka, Kansas<br>*Report No. 09-03742-73, Issued 01/25/2010* | | | |
| James J. Peters VA Medical Center, Bronx, New York<br>*Report No. 09-03272-70, Issued 01/25/2010* | | | |
| VA Southern Nevada Healthcare System, Las Vegas, Nevada<br>*Report No. 09-03613-74, Issued 01/27/2010* | | | |
| Charlie Norwood VA Medical Center, Augusta, Georgia<br>*Report No. 09-03298-80, Issued 02/02/2010* | | | |
| VA Ann Arbor Healthcare System, Ann Arbor, Michigan<br>*Report No. 09-03271-84, Issued 02/16/2010* | | | |

# Appendix A: List of OIG Reports Issued

| Report Title, Number, and Issue Date | Funds Recommended for Better Use | | Questioned Costs |
|---|---|---|---|
| | by OIG | Agreed to by Management | |
| Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin<br>*Report No. 09-03274-110, Issued 03/18/2010* | | | |
| Cincinnati VA Medical Center, Cincinnati, Ohio<br>*Report No. 09-03532-112, Issued 03/19/2010* | | | |
| VA Eastern Colorado Health Care System, Denver, Colorado<br>*Report No. 09-03040-114, Issued 03/24/2010* | | | |
| Overton Brooks VA Medical Center, Shreveport, Louisiana<br>*Report No. 10-00048-118, Issued 03/29/2010* | | | |
| **COMMUNITY BASED OUTPATIENT CLINIC REVIEWS** | | | |
| Macon and Albany, GA; Beaver Dam, WI and Rockford, IL; Sioux City, IA and Aberdeen, SD; Waterloo, IA and Galesburg, IL<br>*Report No. 09-01446-37, Issued 12/02/2009* | | | |
| Kosciusko and Meridian, MS; Tulsa, OK; Konawa and Lawton, OK; Texarkana, AR and Longview, TX<br>*Report No. 09-01446-105, Issued 03/17/2010* | | | |
| **NATIONAL REPORTS** | | | |
| Review of Selected Pharmacy Operations in Veterans Health Administration Facilities<br>*Report No. 07-03254-40, Issued 12/03/2009* | | | |
| Review of Inappropriate Copayment Billing for Treatment Related to Military Sexual Trauma<br>*Report No. 09-01110-81, Issued 02/04/2010* | | | |
| Hospitalized Community-Dwelling Elderly Veterans: Cognitive and Functional Assessments and Follow-up after Discharge<br>*Report No. 09-01588-92, Issued 03/04/2010* | | | |
| **HEALTHCARE INSPECTIONS** | | | |
| Alleged Nursing Quality of Care Issues, Edward Hines, Jr. VA Hospital, Hines, Illinois<br>*Report No. 09-02449-01, Issued 10/02/2009* | | | |
| Alleged Vision Care Issues and Research Improprieties, James A. Haley VA Hospital, Tampa, Florida<br>*Report No. 09-02554-28, Issued 11/18/2009* | | | |

| Report Title, Number, and Issue Date | Funds Recommended for Better Use | | Questioned Costs |
|---|---|---|---|
| | by OIG | Agreed to by Management | |
| Alleged Quality of Care Issues, Ralph H. Johnson VA Medical Center, Charleston, South Carolina *Report No. 09-02538-30, Issued 11/30/2009* | | | |
| Post-Operative Care Case Review at the VA Central Iowa Health Care System's Knoxville Division, Knoxville, Iowa *Report No. 09-02986-31, Issued 11/30/2009* | | | |
| Alleged Quality of Care Issues, Martinsburg VA Medical Center, Martinsburg, West Virginia *Report No. 09-02931-36, Issued 12/01/2009* | | | |
| VistA Outages Affecting Patient Care, Office of Risk Management and Incident Response, Falling Waters, West Virginia *Report No. 09-01849-39, Issued 12/03/2009* | | | |
| Alleged Quality of Care Issues, Amarillo VA Health Care System, Amarillo, Texas *Report No. 09-02797-45, Issued 12/09/2009* | | | |
| Access to Care, Diagnosis, and Treatment at Community Based Outpatient Clinics in Smyrna and Rome, Georgia *Report No. 09-02985-46, Issued 12/10/2009* | | | |
| Alleged Quality of Care Issues, Central Arkansas Veterans Healthcare System, Little Rock, Arkansas *Report No. 09-02397-48, Issued 12/11/2009* | | | |
| Delay in Cancer Diagnosis and Treatment, Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin *Report No. 09-01348-49, Issued 12/14/2009* | | | |
| Review of an Unexpected Death, North Chicago VA Medical Center, North Chicago, Illinois *Report No. 09-03245-53, Issued 12/22/2009* | | | |
| Alleged Quality of Care Issues, VA Salt Lake City Health Care System, Salt Lake City, Utah *Report No. 09-02589-54, Issued 12/28/2009* | | | |

# Appendix A: List of OIG Reports Issued

| Report Title, Number, and Issue Date | Funds Recommended for Better Use | | Questioned Costs |
|---|---|---|---|
| | by OIG | Agreed to by Management | |
| Quality of Care Issues, Louis A. Johnson VA Medical Center, Clarksburg, West Virginia *Report No. 09-02950-58, Issued 01/07/2010* | | | |
| Alleged Denial of Care and Quality of Care Issues, Veterans Health Care System of the Ozarks, Fayetteville, Arkansas *Report No. 09-02987-60, Issued 01/13/2010* | | | |
| Alleged Management Decisions Impacting Patient Care and Work Environment, Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan *Report No. 09-02470-61, Issued 01/13/2010* | | | |
| Alleged Quality of Care Issues, Huntington VA Medical Center, Huntington, West Virginia *Report No. 09-02988-66, Issued 01/19/2010* | | | |
| Review of Allegations of Coding and Billing Irregularities, VA Medical Center, Kansas City, Missouri *Report No. 09-03418-68, Issued 01/20/2010* | | | |
| Telemetry Monitoring Issues, VA Eastern Colorado Health Care System, Denver, Colorado *Report No. 09-01047-69, Issued 01/21/2010* | | | |
| Alleged Quality of Care issues, Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania *Report No. 09-03851-87, Issued 02/23/2010* | | | |
| Alleged Mismanagement of Resources and Patient Safety Issues, VA Northern Indiana Health Care System, Fort Wayne and Marion, Indiana *Report No. 09-02346-90, Issued 03/02/2010* | | | |
| Patient Safety Issues, VA Caribbean Healthcare System, San Juan, Puerto Rico *Report No. 09-03055-103, Issued 03/16/2010* | | | |
| Alleged Mental Health Issues, Fargo VA Medical Center, Fargo, North Dakota *Report No. 09-01636-113, Issued 03/23/2010* | | | |

| Report Title, Number, and Issue Date | Funds Recommended for Better Use | | Questioned Costs |
|---|---|---|---|
| | by OIG | Agreed to by Management | |
| Mental Health Safety Issues and Credentialing & Privileging Irregularities, Alexandria VA Medical Center, Pineville, Louisiana<br>*Report No. 09-02858-121, Issues 03/31/2010* | | | |
| **ADMINISTRATIVE INVESTIGATIONS** | | | |
| Abuse of Authority, Misuse of Position and Resources, Acceptance of Gratuities, & Interference with an OIG Investigation, National Programs and Special Events<br>*Report No. 09-01492-83, Issued 02/05/2010* | | | |
| Misuse of Official Time, North Chicago VA Medical Center<br>*Report No. 08-01589-86, Issued 02/19/2010* | | | |
| **PREAWARD REVIEWS ($271,015,783)** | | | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation 797-FSS-99-0025-R6<br>*Report No. 09-02725-06, Issued 10/06/2009* | | | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation 797-FSS-99-0025-R6<br>*Report No. 09-02484-09, Issued 10/15/2009* | $2,293,392 | | |
| Review of Proposal Submitted under Solicitation Number VA-247-08-RP-0403 for Neuroradiology Services at the Charlie Norwood VA Medical Center, Augusta, Georgia<br>*Report No. 09-03449-11, Issued 10/29/2009* | $168,874 | | |
| Review of Proposal under Solicitation Number VA-245-09-RP-1059 for Emergency Medical Services at the Washington DC VA Medical Center<br>*Report No. 09-03542-19, Issued 11/05/2009* | $1,212,961 | | |
| Review of Proposal Submitted under Solicitation Number VA-245-09-RP-0089 for Emergency Care Services at VA Maryland Health Care System<br>*Report No. 09-03327-21, Issued 11/06/2009* | $2,202,257 | | |

# Appendix A: List of OIG Reports Issued

| Report Title, Number, and Issue Date | Funds Recommended for Better Use | | Questioned Costs |
|---|---|---|---|
| | by OIG | Agreed to by Management | |
| Review of Proposal Submitted under Solicitation Number VA-248-08-RP-0084 for Neurological Surgery Services at Miami VA Healthcare System<br>*Report No. 09-03576-11, Issued 11/09/2009* | $3,776,924 | | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation Number M5-Q50A-03-R2<br>*Report No. 09-02378-24, Issued 11/12/2009* | $7,321,635 | | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation Number M5-Q50A-03-R2<br>*Report No. 09-02800-26, Issued 11/13/2009* | | | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation Number M5-Q50A-03-R2<br>*Report No. 09-02749-23, Issued 11/16/2009* | $75,332,124 | | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation Number M5-Q50A-03-R2<br>*Report No. 09-02216-27, Issued 11/16/2009* | $7,651 | | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation Number M5-Q50A-03-R2<br>*Report No. 09-03448-32, Issued 11/20/2009* | | | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation Number M5-Q50A-03-R2<br>*Report No. 09-03446-33, Issued 11/20/2009* | | | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation Number M5-Q50A-03-R2<br>*Report No. 09-00710-35, Issued 11/24/2009* | | | |
| Review of Proposal to Provide Primary Medical Care Services to Underserved Veterans Residing In and Around El Dorado, Arkansas<br>*Report No. 09-03606-34, Issued 11/25/2009* | $1,316,586 | | |

| Report Title, Number, and Issue Date | Funds Recommended for Better Use | | Questioned Costs |
|---|---|---|---|
| | by OIG | Agreed to by Management | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation 797-FSS-99-0025-R6<br>*Report No. 09-03506-43, Issued 12/02/2009* | $679,302 | | |
| Review of Proposal to Provide Primary Medical Care Services to Veterans Residing In and Around Pine Bluff, Arkansas<br>*Report No. 10-00591-50, Issued 12/17/2009* | $1,027,055 | | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation Number RFP-797-FSS-99-0025-R6<br>*Report No. 09-02983-52, Issued 12/23/2009* | $22,702,167 | | |
| Review of Proposal Submitted under Solicitation Number VA-263-08-RP-0180 for Cardiac-Thoracic Physician Services at VAMC Minneapolis<br>*Report No. 09-03605-36, Issued 01/09/2010* | $1,971,634 | | |
| Pre-Extension Review of Federal Supply Schedule Proposal<br>*Report No. 09-03094-64, Issued 01/14/2010* | $80,041,739 | | |
| Review of Proposal Submitted under Solicitation Number VA-256-09-RP--0083 for Radiology Services at Central Arkansas Veterans Healthcare System<br>*Report No. 10-00592-67, Issued 01/25/2010* | $1,719,101 | | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation Number RFP-797-FSS-99-0025-R6<br>*Report No. 09-02279-71, Issued 01/25/2010* | $8,694,027 | | |
| Review of Proposal Submitted under Solicitation Number VA-69D-09-RP-0223 for Radiation Physicist Services at Clement J. Zablocki VA Medical Center<br>*Report No. 10-00781-72, Issued 01/27/2010* | $729,514 | | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation Number M5-Q50A-03-R2<br>*Report No. 09-03037-77, Issued 01/29/2010* | $32,213,355 | | |

# Appendix A: List of OIG Reports Issued

| Report Title, Number, and Issue Date | Funds Recommended for Better Use | | Questioned Costs |
|---|---|---|---|
| | by OIG | Agreed to by Management | |
| Review of Proposal Submitted under Purchase Order Number 640-10-1-097-0012, for Vascular Interventional Radiology Physicians Services at the VA Palo Alto Healthcare System *Report No. 10-00735-78, Issued 02/03/2010* | $387,947 | | |
| Review of Proposal Submitted under Purchase Order Number 640-10-1-097-0013, for Neuroradiology Physicians Services at the VA Palo Alto Healthcare System *Report No. 10-00733-79, Issued 02/03/2010* | $388,370 | | |
| Review of Proposal Submitted under Solicitation Number VA-259-09-RP-0412, for Cardiothoracic Surgery Services at VA Eastern Colorado Health System *Report No. 10-00946-82, Issued 02/03/2010* | $2,512,127 | | |
| Review of Proposal Submitted under Solicitation Number VA-263-09-RP-0030 for Dermatology Services at VA Medical Center Minneapolis *Report No. 10-01284-88, Issued 02/23/2010* | $109,149 | | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation Number M5-Q50A-03-R2 *Report No. 09-03789-89, Issued 02/25/2010* | $10,150 | | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation Number RFP-797-FSS-99-0025-R6 *Report No. 09-03688-94, Issued 03/05/2010* | $18,524,313 | | |
| Review of Proposal Submitted under Solicitation Number VA-246-09-RP-0035 for Liver Transplant Services to the VA Medical Center in Richmond, Virginia *Report No. 10-00911-99, Issued 03/10/2010* | $1,409,277 | | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation Number M5-Q50A-03-R2 *Report No. 10-00863-101, Issued 03/10/2010* | | | |

| Report Title, Number, and Issue Date | Funds Recommended for Better Use | | Questioned Costs |
|---|---|---|---|
| | by OIG | Agreed to by Management | |
| Review of Federal Supply Schedule Proposal Submitted under Solicitation Number RFP-797-FSS-99-0025-R6<br>*Report No. 10-00463-102, Issued 03/10/2010* | $628,634 | | |
| Review of Proposal to Provide Mental Health and Substance Abuse Services to Underserved Veterans Residing in Aroostook and Washington Counties, Maine<br>*Report No.10-01483-104, Issued 03/17/2010* | $100,122 | | |
| Review of Contract Extension Proposal Submitted under the Federal Supply Schedule<br>*Report No. 10-00771-108, Issued 03/17/2010* | $2,062,187 | | |
| Review of Proposal Submitted under Solicitation Number VA-244-09-RP-0302 for Cardiac Surgery Services at VA Pittsburgh Healthcare System<br>*Report No. 10-00938-117, Issued 03/31/2010* | $1,473,209 | | |
| **POSTAWARD REVIEWS ($2,280,261)** | | | |
| Review of Voluntary Disclosure and Refund Offer under the Federal Supply Schedule<br>*Report No. 09-02912-12, Issued 10/22/2009* | | | $11,822 |
| Review of Voluntary Disclosure and Refund Offer under the Federal Supply Schedule<br>*Report No. 09-03797-13, Issued 10/22/2009* | | | $4,539 |
| Review of Voluntary Disclosure and Refund Offer under the Federal Supply Schedule<br>*Report No. 08-03159-07, Issued 10/29/2009* | | | $153,651 |
| Review of Contract Modification under the Federal Supply Schedule<br>*Report No. 09-02981-08, Issued 10/29/2009* | | | $9,819 |
| Review of Overcharges Related to Removal of a Covered Drug under the Federal Supply Schedule<br>*Report No. 09-03658-03, Issued 11/02/2009* | | | $2,506 |
| Review of Overcharges Relating to the Late Addition of a Covered Drug under the Federal Supply Schedule<br>*Report No. 08-03208-15, Issued 11/02/2009* | | | $108,062 |

# Appendix A: List of OIG Reports Issued

| Report Title, Number, and Issue Date | Funds Recommended for Better Use | | Questioned Costs |
|---|---|---|---|
| | by OIG | Agreed to by Management | |
| Review of Overcharges Relating to Recalculation of Federal Ceiling Prices under the Federal Supply Schedule<br>*Report No. 09-01522-47, Issued 12/16/2009* | | | $11,912 |
| Review of Overcharges Relating to Merck & Co., Inc.'s Recalculation of Federal Ceiling Prices for Vaccine Products under the Federal Supply Schedule<br>*Report No. 09-00345-51, Issued 12/18/2009* | | | $224,829 |
| Post-Award Review under the Federal Supply Schedule<br>*Report No. 07-02487-65, Issued 01/15/2010* | | | |
| Review of Unpaid Rebates for Calendar Year 2008 under the Federal Supply Schedule<br>*Report No. 10-01165-75, Issued 01/26/2010* | | | $480,814 |
| Review of Voluntary Disclosure and Refund Offer under the Federal Supply Schedule<br>*Report No. 09-03313-76, Issued 02/02/2010* | | | $37,988 |
| Review of Overcharges Relating to Recalculation of Federal Ceiling Prices under the Federal Supply Schedule<br>*Report No. 90-00519-98, Issued 03/09/2010* | | | $819,644 |
| Review of Voluntary Disclosure and Refund Offer under the Federal Supply Schedule<br>*Report No. 10-00430-115, Issued 03/23/2010* | | | $370,489 |
| Review of Overcharges Relating to Federal Ceiling Price Recalculations under the Federal Supply Schedule<br>*Report No. 09-03738-116, Issued 03/24/2010* | | | $43,474 |
| Review of Overcharges Relating to Federal Ceiling Price Errors under the Federal Supply Schedule<br>*Report No. 10-00295-119, Issued 03/26/2010* | | | $712 |
| **Totals** | $547,015,783 | $547,015,783 | $2,329,832 |

# Appendix B: Unimplemented OIG Reports and Recommendations

The *Federal Acquisition Streamlining Act of 1994*, P.L. 103-355, requires Federal agencies to complete final action on each OIG report recommendation within 1 year after the report is finalized. OIG is required to identify unimplemented recommendations in its Semiannual Report to Congress until the final action is completed. This table summarizes the status of all unimplemented OIG reports and recommendations. Results are sorted by the action office responsible for implementation. Additionally, the table indicates how many of these unimplemented OIG reports and recommendations are less than or more than 1 year. Some reports and recommendations are counted more than once because they have actions at more than one office. Of the reports open less than 1 year, 7 reports and 14 recommendations have actions at two or more offices. Although the FY 2009 FISMA audit contains unimplemented OIG recommendations from previous years' FISMA audits, the report and its recommendations are considered to be open less than 1 year because it was issued after March 31, 2009.

**Table 1: Total Unimplemented OIG Reports and Recommendations**

| | VHA | VBA | OI&T | OSP[1] | OM[2] | OALC | P&IA[3] | Total |
|---|---|---|---|---|---|---|---|---|
| **Total Reports Open** | **83** | **15** | **9** | **1** | **2** | **5** | **1** | **116** |
| Reports Open Less Than 1 Year | 75 | 14 | 8 | 0 | 2 | 5 | 1 | **105** |
| Reports Open More Than 1 Year | 8 | 1 | 1 | 1 | 0 | 0 | 0 | **11** |
| **Total Recommendations Open** | **438** | **69** | **104** | **1** | **3** | **19** | **20** | **654** |
| Recommendations Open Less Than 1 Year | 419 | 67 | 103 | 0 | 3 | 19 | 20 | 631 |
| Recommendations Open More Than 1 Year | 19 | 2 | 1 | 1 | 0 | 0 | 0 | **23** |

1 Office of Operations, Security, and Preparedness

2 Office of Management

3 Office of Public and Intergovernmental Affairs

# Appendix B: Unimplemented OIG Reports and Recommendations

| Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old | | | |
|---|---|---|---|
| **Report Title, Number, and Issue Date** | **Responsible Organization** | **Number of Open Recommendations** | **Monetary Impact** |
| **Audit of VA Acquisition Practices for the National Vietnam Veterans Longitudinal Study**<br>*Report No. 04-02330-212, Issued 09/30/2005* | VHA | 1 of 3 | - |
| ***Recommendation 1:*** *We recommended that the Under Secretary for Health and the Chief Management Officer initiate formal acquisition planning and proper contracting processes to expeditiously and successfully complete the Study and ensure that assigned project management and contracting staff have the required knowledge and skills to effectively plan, procure, administer, and manage the Study in accordance with pertinent legal, procedural, and technical requirements.* | | | |
| **Review of Access to Care in the Veterans Health Administration**<br>*Report No. 05-03028-145, Issued 05/17/2006* | VHA | 2 of 9 | - |
| ***Recommendation 3a:*** *We recommended that the Under Secretary for Health establish standardized tracking methods and appropriate performance metrics to evaluate and improve the timeliness of elective procedures.*<br><br>***Recommendation 3b:*** *We recommended that the Under Secretary for Health implement prioritization processes to ensure that Veterans receive clinically indicated elective procedures according to their clinical needs.* | | | |
| **Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans**<br>*Report No. 06-02238-163, Issued 07/11/2006* | OI&T | 1 of 6 | - |
| ***Recommendation d:*** *We recommend that the Secretary ensure that all position descriptions are evaluated and have proper sensitivity level designations, that there is consistency nationwide for positions that are similar in nature or have similar access to VA protected information and automated systems, and that all required background checks are completed in a timely manner.* | | | |
| **Audit of the Acquisition and Management of Selected Surgical Device Implants**<br>*Report No. 06-03677-221, Issued 09/28/2007* | VHA | 1 of 7 | $21,913,781 |
| ***Recommendation 1:*** *We recommended that the Under Secretary for Health, within a year, evaluates VHA's aortic valve, coronary stent, and thoracic graft purchases; studies the feasibility of establishing national contracts and BPAs; and where indicated, initiates national contracts and BPAs.* | | | |

# Appendix B: Unimplemented OIG Reports and Recommendations

| Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old | | | |
|---|---|---|---|
| **Report Title, Number, and Issue Date** | **Responsible Organization** | **Number of Open Recommendations** | **Monetary Impact** |
| **Audit of Veterans Health Administration's Oversight of Nonprofit Research and Education Corporations**<br>Report No. 07-00564-121, Issued 05/05/2008 | VHA | 4 of 5 | - |
| ***Recommendation 1:*** *We recommended that the Under Secretary for Health prepare a recommendation to the Secretary defining the oversight authorities of the NPOB, CFO, and NPPO and update VHA Handbook 1200.17 to incorporate these authorities.*<br><br>***Recommendation 3:*** *We recommended that the Under Secretary for Health revise VHA Handbook 1200.17 to clearly define minimum control requirements for all NPCs and provide training to NPC Directors on these requirements.*<br><br>***Recommendation 4:*** *We recommended that the Under Secretary for Health develop and implement oversight procedures to perform substantive reviews of NPC financial and management controls to ensure NPCs fully comply with Federal laws, VHA policies, and control standards.*<br><br>***Recommendation 5:*** *We recommended that the Under Secretary for Health develop and implement procedures to review, monitor, and enforce NPC compliance with conflict of interest laws and policies.* | | | |
| **Audit of Veterans Benefits Administration Transition Assistance for Operations Enduring and Iraqi Freedom Service Members and Veterans**<br>Report No. 06-03552-169, Issued 07/17/2008 | VBA | 2 of 8 | - |
| ***Recommendation 6:*** *We recommended the Acting Under Secretary for Benefits develop a mechanism to obtain the DD-214 information needed to identify discharged Veterans who should receive outreach letters.*<br><br>***Recommendation 8:*** *We recommended the Acting Under Secretary for Benefits establish policies and procedures that require staff to provide special outreach to Veterans who do not have a high school diploma or equivalent.* | | | |
| **Audit of Veterans Health Administration's Government Purchase Card Practices**<br>Report No. 07-02796-203, Issued 09/11/2008 | VHA | 1 of 4 | $799,997 |
| ***Recommendation 2:*** *We recommended the Under Secretary for Health provide approving officials refresher training on using the revised Approving Official Checklist to ensure cardholders maintain adequate documentation supporting purchases.* | | | |

# Appendix B: Unimplemented OIG Reports and Recommendations

| Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old | | | |
|---|---|---|---|
| **Report Title, Number, and Issue Date** | **Responsible Organization** | **Number of Open Recommendations** | **Monetary Impact** |
| **Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreement**<br>Report No. 08-00477-211, Issued 09/29/2008 | VHA | 7 of 7 | $59,895,666 |
| ***Recommendation 1:*** *We recommended that the Under Secretary for Health ensure that VISNs establish standardized written procedures for monitoring FTE-based and per-procedure clinical service sharing agreements.*<br><br>***Recommendation 2:*** *We recommended that the Under Secretary for Health establish VISN-level oversight controls to ensure that COTRs are effectively monitoring contractor performance under the terms of the sharing agreement before certifying invoices for payment.*<br><br>***Recommendation 3:*** *We recommended that the Under Secretary for Health implement procedures to ensure that COTRs verify that Medicare-based sharing agreement charges are accurately calculated prior to certifying contractor invoices.*<br><br>***Recommendation 4:*** *We recommended that the Under Secretary for Health coordinate with VA's Office of Acquisition and Logistics to develop performance monitoring training for COTRs that specifically addresses clinical sharing agreements.*<br><br>***Recommendation 5:*** *We recommended that the Under Secretary for Health instruct the VISN contracting officers to initiate recovery of overpayments identified by our audit, as appropriate.*<br><br>***Recommendation 6:*** *We recommended that the Under Secretary for Health coordinate with VA's Office of Acquisition and Logistics to develop training for VISN contracting officers on negotiating per-procedure sharing agreements with Medicare-based charges.*<br><br>***Recommendation 7:*** *We recommended that the Under Secretary for Health implement oversight mechanisms to ensure that per-procedure sharing agreements for onsite clinical services exclude the Medicare practice component charges from contract rates, as required by VA policy.* | | | |
| **Audit of Procurements Using Prior-Year Funds to Maintain VA Healthcare Facilities**<br>Report No. 08-00244-213, Issued 09/30/2008 | VHA | 2 of 7 | $10,104,678 |
| ***Recommendation 5:*** *We recommended the Under Secretary for Health initiate appropriate administrative action against contracting officers who entered inaccurate contract award dates in the electronic procurement accounting system and later signed the contracts after they should have known the funds had expired.*<br><br>***Recommendation 7:*** *We recommended the Under Secretary for Health consult with the Assistant Secretary for Management to develop plans to implement controls over obligation of expired funds in other VHA programs, projects, or activities.* | | | |

# Appendix B: Unimplemented OIG Reports and Recommendations

| Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old | | | |
|---|---|---|---|
| **Report Title, Number, and Issue Date** | **Responsible Organization** | **Number of Open Recommendations** | **Monetary Impact** |
| **Audit of the Veterans Health Administration's Domiciliary Safety, Security, and Privacy**<br>Report No. 08-01030-05, Issued 10/08/2008 | OSP | 1 of 8 | - |
| **Recommendation 2:** *We recommend the Assistant Secretary for Operations, Security, and Preparedness strengthen controls to ensure physical security surveys are conducted at domiciliaries with controlled substances.* | | | |
| **Combined Assessment Program Review of the VA Central Iowa Health Care System, Des Moines, Iowa**<br>Report No. 08-02597-63, Issued 02/03/2009 | VHA | 1 of 13 | - |
| ***Recommendation 4:*** *We recommended that the VISN Director ensure that the System Director requires that identified safety, IC, and patient privacy deficiencies be corrected.* | | | |
| **TOTALS** | **11** | **23** | **$92,714,122** |

# *Appendix C: Inspector General Act Reporting Requirements*

The table below cross-references the specific pages in this Semiannual Report to the reporting requirements where they are prescribed by the *Inspector General Act*, as amended by the *Inspector General Act Amendments of 1988,* P.L. 100-504, and the *Omnibus Consolidated Appropriations Act of 1997*, P.L. 104-208.

The *Federal Financial Management Improvement Act of 1996*, P.L. 104-208, (FFMIA) requires OIG to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with the Act. The audit of VA's consolidated financial statements for FY 2008 and 2007 reported three material weaknesses, all of which are repeat conditions from the prior year's audit. The audit also indicated that VA is not in substantial compliance with FFMIA because VA did not substantially comply with Federal financial management systems requirements. VA is in the process of revising and expanding existing remediation plans for the three repeat material weaknesses identified in the FY 2008 and 2007 audit.

| IG Act References | Reporting Requirements | Status |
|---|---|---|
| Section 4 (a) (2) | Review of legislative, regulatory, and administrative proposals | Commented on 336 items |
| Section 5 (a) (1) | Significant problems, abuses, and deficiencies | See pages 7-41 |
| Section 5 (a) (2) | Recommendations with respect to significant problems, abuses, and deficiencies | See pages 7-41 |
| Section 5 (a) (3) | Prior significant recommendations on which corrective action has not been completed | See pages 54-58 |
| Section 5 (a) (4) | Matters referred to prosecutive authorities and resulting prosecutions and convictions | See pages 7-41 |
| Section 5 (a) (5) | Summary of instances where information was refused | None |
| Section 5 (a) (6) | List of reports by subject matter, showing dollar value of questioned costs and recommendations that funds be put to better use | See pages 42-53 |
| Section 5 (a) (7) | Summary of each particularly significant report | See pages 7-41 |
| Section 5 (a) (8) | Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports | See page 60 |
| Section 5 (a) (9) | Statistical tables showing number of reports and dollar value of recommendations that funds be put to better use for unresolved, issued, and resolved reports | See page 60 |

# Appendix C: Inspector General Act Reporting Requirements

| IG Act References | Reporting Requirements | Status |
|---|---|---|
| Section 5 (a) (10) | Summary of each audit report issued before this reporting period for which no management decision was made by end of reporting period | See Table 1 and Table 2 below |
| Section 5 (a) (11) | Significant revised management decisions | None |
| Section 5 (a) (12) | Significant management decisions with which the Inspector General is in disagreement | None |
| Section 5 (a) (13) | Information described under section 5(b) of FFMIA | See page 60 |

**Table 1: Resolution Status of Reports with Questioned Costs**

| RESOLUTION STATUS | Number | Dollar Value (In Millions) |
|---|---|---|
| No management decision by 03/31/2009 | 0 | $0 |
| Issued during reporting period | 1 | $49,571 |
| Total inventory this period | 1 | $49,571 |
| Management decisions during the reporting period | | |
| Disallowed costs (agreed to by management) | 1 | $49.571 |
| Allowed costs (not agreed to by management) | 0 | $0 |
| Total management decisions this reporting period | 1 | $49.571 |
| Total carried over to next period | 0 | $0 |

**Table 2: Resolution Status of Reports with Recommended Funds To Be Put To Better Use By Management**

| RESOLUTION STATUS | Number | Dollar Value (In Millions) |
|---|---|---|
| No management decision by 03/31/2009 | 0 | $0 |
| Issued during reporting period | 1 | $276 |
| Total inventory this period | 1 | $276 |
| Management decisions during the reporting period | | |
| Agreed to by management | 1 | $276 |
| Not agreed to by management | 0 | $0 |
| Total management decisions this reporting period | 1 | $276 |
| Total carried over to next period | 0 | $0 |

# *Appendix D: Government Contractor Audit Findings*

The *National Defense Authorization Act for Fiscal Year 2008*, P.L. 110-181, requires each Inspector General appointed under the *Inspector General Act of 1978* to submit an appendix on final, completed contract audit reports issued to the contracting activity that contain significant audit findings—unsupported, questioned, or disallowed costs in an amount in excess of $10 million, or other significant findings—as part of the Semiannual Report to Congress. During this reporting period, OIG issued no contract review reports under this requirement.

# Appendix E: American Recovery and Reinvestment Act Oversight Activities

Enacted in February 2009, ARRA requires OIG to conduct oversight of the VA projects, programs, grants, and initiatives that received a total of $1.4 billion in funding under the Act. OIG's program of oversight includes audits, evaluations, investigation, fraud awareness and prevention training, and other monitoring activities covering the major VA programs that received ARRA funding. The VA programs and the amounts of their ARRA funding include:

- $1.0 billion for VHA medical facility nonrecurring maintenance and energy projects.
- $150.0 million for VHA Grants to States for extended care facilities.
- $50.0 million for National Cemetery Administration headstone, marker, gravesite, and monument repairs; NRM, energy, and road repair projects; and equipment upgrades.
- $157.1 million for VBA claims processing hiring initiative and support of Veterans economic recovery payments.
- $50.1 million for OI&T support of VBA implementation of the new Post 9/11 GI Bill education assistance programs for Veterans.

As of March 31, 2010, OIG has expended $1.53 million (the entire $1.0 million OIG received under ARRA and $530,000 from regular appropriations) in conducting its comprehensive program of ARRA oversight. OIG's ARRA-related accomplishments and activities completed to date include:

- Issuing three final audit and evaluation reports and one interim advisory report on VA management of ARRA program activities.
- Completing four other audits and evaluations for which reports will be issued in the second half of FY 2010.
- Conducted 160 fraud awareness training and outreach sessions across the country attended by over 6,800 VA and other officials responsible for managing or overseeing ARRA programs and projects.
- Opened nine criminal investigations of alleged wrongdoing pertaining to ARRA-funded projects.
- Received 21 Hotline complaints of potential fraud or waste related to ARRA projects.
- Established the OIG Recovery Act Web Site, *http://www.va.gov/oig/recovery*, which provides access to the VA OIG Hotline and information on OIG ARRA reports, activities, plans, and fraud prevention training materials.

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## On the Cover

Soldiers and Tactical Air Control Party Airmen from the 173rd Airborne Brigade, U.S. European Command, prepare for a low-altitude training jump from a UH-60 Black Hawk Helicopter near Maniago, Italy. Photo taken November 19, 2004, by Priscilla Robinson, courtesy of the Department of Defense.

United States Department of Veterans Affairs
Office of Inspector General

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