



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

OCTOBER 2023 HIGHLIGHTS

Office of Investigations

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

Healthcare Investigations

Medical Imaging Company and Chief Executive Officer Agreed to Pay \$85.4 Million to Resolve False Claims Act Allegations

A medical imaging company and its chief executive officer entered into settlement agreements of \$75 million and \$10.4 million, respectively, for allegedly paying kickbacks to cardiologists in exchange for patient referrals, which resulted in fraudulent claims to various federal healthcare programs. Both settlements are based on their ability to pay. The total loss to VA is about \$4.4 million. This case was investigated by the VA OIG, Department of Health and Human Services (HHS) OIG, Defense Health Agency OIG, and Railroad Retirement Board OIG.

Medical Marketer Found Guilty for \$55 Million Prescription Drug Fraud Conspiracy

A multiagency investigation resulted in charges alleging that numerous defendants participated in a scheme to defraud federal healthcare programs by billing for nonreimbursable medications in compounded prescriptions. Although intended to be tailored to individual patient needs, these medications were designed to maximize reimbursements regardless of medical necessity. Compounding pharmacy owners and others paid illegal kickbacks to medical marketers that recruited area doctors to write these expensive prescriptions by offering “investment opportunities” so that the doctors could profit from the scheme. The total loss to the government is approximately \$55 million. Of this amount, the loss to VA is approximately \$3 million. A medical marketer for several compounding pharmacies was found guilty by a federal jury in the Northern District of Texas on charges of receiving unlawful kickbacks, conspiracy to defraud the United States, and money laundering. This investigation was conducted by the VA OIG, Defense Criminal Investigative Service (DCIS), FBI, Department of Labor (DOL) OIG, and HHS OIG.

Compounding Pharmacy Owner Sentenced to Prison for Role in Fraud Scheme

The owner of two compounding pharmacies paid kickbacks to physicians as an inducement for patients’ compounding prescriptions. The fraudulent prescriptions resulted in over \$6 million paid for by federal healthcare programs, including more than \$369,000 by CHAMPVA. The loss to DOL’s Office of Workers’ Compensation Programs (OWCP) that pertains to VA employees is over \$242,000. (OWCP

seeks reimbursement from VA for these claims through “charge backs.”) The defendant was sentenced in the Northern District of Oklahoma to 18 months in prison, 24 months of supervised release, and restitution of over \$6 million. This case was investigated by the VA OIG, FBI, US Postal Service OIG, DCIS, DOL OIG, and HHS OIG.

Medical Technology Company President Sentenced for Scheme Involving Fraudulent COVID-19 and Allergy Tests

The president of a medical technology company conspired to improperly bill healthcare insurers for approximately \$77 million in false claims for allergy and COVID-19 testing. The president and others schemed to manipulate the company’s stock price by making numerous misrepresentations to potential investors concerning the company’s ability to provide accurate, fast, and cheap COVID-19 tests in compliance with federal and state regulations. These misrepresentations included the false claim that the company was in a \$2.5 million agreement with VA when in reality it was not. The defendant was sentenced in the Northern District of California to 96 months and 60 months of incarceration to be served concurrently, 36 months of supervised release, forfeiture of \$2.7 million, and restitution of \$25 million after being found guilty at trial of conspiracy to commit healthcare fraud, conspiracy to commit wire fraud, healthcare fraud, conspiracy to pay kickbacks, payment of kickbacks, and securities fraud. This investigation was conducted by the VA OIG, US Postal Inspection Service, DCIS, and HHS OIG.

Benefits Investigations

Two Veterans Sentenced for Disability Insurance Fraud

A multiagency investigation resulted in charges alleging that several coconspirators submitted fraudulent claims through the VA-administered Traumatic Servicemembers Group Life Insurance (TSGLI) program, which is intended to help traumatically injured servicemembers and their families with financial burdens associated with recovering from severe injuries. The scheme involved submitting TSGLI claims that reflected fraudulent narratives of catastrophic injuries and exaggerated the loss of activities of daily living, generating payouts of \$25,000 to \$100,000 each. The loss to the TSGLI program is about \$2 million. One veteran was sentenced to 30 months of incarceration, 36 months of supervised release, forfeiture of \$400,000, and restitution of \$2 million. A second veteran was sentenced to 12 months and one day of incarceration, 36 months of supervised release, forfeiture of \$150,000, and restitution of \$1.5 million. Both defendants pleaded guilty in the Southern District of California to conspiracy to commit wire fraud. To date, 10 defendants have been convicted in connection with this scheme. The VA OIG, Naval Criminal Investigative Service, and FBI investigated the case.

Veteran Indicted for Exaggerating Disabilities to Obtain VA Benefits

A VA OIG and FBI investigation, based on a hotline complaint, resulted in charges alleging that a veteran exaggerated the nature of his disability. The false statements led to the fraudulent receipt of VA compensation benefits, including special monthly compensation, to which the veteran was not entitled.

The investigation further alleges that when filing for bankruptcy in 2020 and 2022, the veteran did not inform the court of a VA retroactive payment of approximately \$300,000 that he received in June 2020. The loss to VA is approximately \$630,000. The veteran was indicted in the Southern District of Illinois on charges of wire fraud, false statements, and concealing assets in a bankruptcy.

Civil Complaint Filed against Barber School and Owner for Defrauding GI Bill Program

A VA OIG investigation led to the filing of a civil complaint in the Southern District of Mississippi alleging that a barber school and the school's owner defrauded VA's Post-9/11 (Chapter 33) GI Bill education assistance program. From 2017 to 2019, the school allegedly enrolled VA students in year-long barber courses at a cost of \$22,400, while similarly situated nonveteran students were only charged approximately \$2,400. The complaint further alleges that the school did not maintain accurate records or provide course instruction and certificates of completion to VA students in accordance with program rules. The loss to VA is approximately \$235,000.

Defendant Sentenced for Stealing VA Benefits Intended for Her Deceased Great Aunt

A West Virginia woman fraudulently received VA Dependency and Indemnity Compensation payments intended for her great aunt who died in February 1999. The woman forged the deceased beneficiary's signature, endorsed the checks to herself, and deposited the funds into accounts under her control to pay for her personal living expenses. After pleading guilty to theft of government money, the defendant was sentenced in the Southern District of West Virginia to four months in prison to be followed by four months of home confinement and three years of supervised release. She was also ordered to pay over \$181,000 in restitution. The VA OIG and FBI conducted the investigation.

Former Fiduciary Sentenced for Misappropriating Funds Meant for Veteran Uncle

A former VA-appointed fiduciary spent over \$115,000 in VA compensation benefits that were intended for her veteran uncle. The stolen funds were used as a down payment for a home and to pay for subsequent home improvement projects. She was sentenced in the Eastern District of Louisiana to 18 months in prison and 36 months of supervised release after pleading guilty to misappropriation by a veteran's fiduciary. Restitution will be determined at a future hearing. This investigation was also completed by the VA OIG and FBI.

Another Former Fiduciary Sentenced for Misappropriating Veteran Inpatient's Funds

Between September 2019 and January 2021, a former VA-appointed fiduciary stole approximately \$50,000 in VA benefits from a veteran who, before passing away in December 2020, had been an inpatient at multiple medical facilities. The former fiduciary also admitted to willfully failing to submit any required accountings to VA, as required by law. The defendant was sentenced in the Northern District of New York to three months in prison; two years of supervised release, which includes three months of home detention; and over \$50,000 in restitution to the veteran's estate. The VA OIG conducted the investigation.

Investigation Involving Other Matters

VA Employee Charged with Sending Sexually Explicit Content to a Minor

A VA employee at the Seattle Regional Office allegedly sent sexual photos and illicit messages to an undercover officer posing as a 13-year-old child. According to the investigation, the communications occurred during regular duty hours, with some of the photos having been taken in a restroom near the employee's VA office. The defendant was arrested after being charged in King County (Washington) Superior Court with communicating with a minor for immoral purposes. The VA OIG and Seattle Police Department investigated the case.

Office of Audits and Evaluations

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

Benefits

VHA Should Continue to Improve Water Safety and Oversight of Prevention Practices to Minimize the Effects of *Legionella*

Veterans Health Administration (VHA) Directive 1061 establishes standards to prevent and control healthcare-associated *Legionella* disease at VHA-owned buildings where patients, residents, visitors, or staff stay overnight. The OIG audited whether VHA complies with the directive and effectively prevents and controls *Legionella* bacteria in potable water distribution systems. The OIG determined the four VA medical facilities reviewed—in Salem, Virginia; Brooklyn, New York; Pittsburgh, Pennsylvania; and Dublin, Georgia—did not fully comply with VHA requirements on components of their *Legionella* disease prevention plans, water safety testing validation collection, remediation actions, and reporting practices. VHA leaders also did not receive complete water safety test results needed for effective oversight. In addition, VA medical facility leaders responsible for notifying its clinical staff of *Legionella* conditions did not communicate positive test results to ensure awareness of elevated diagnostic levels. The OIG made eight recommendations to improve oversight of water sampling, fix identified problems, and ensure VHA Directive 1061 is followed.

VBA Generally Helped Veterans Obtain Damaged or Destroyed Records

In 1973, a fire damaged or destroyed up to 18 million Army and Air Force official military personnel files at the National Archives and Records Administration's National Personnel Records Center in

St. Louis, Missouri. This disaster makes it difficult for affected veterans to obtain records when filing claims for benefits. As required by the National Defense Authorization Act of 2023, the VA OIG assessed the assistance the Veterans Benefits Administration (VBA) provided to these veterans with damaged or destroyed records. The OIG found that VBA staff did not always follow procedures in a timely manner or in the order outlined in the Adjudication Procedures Manual and did not consistently complete required follow-up procedures. The under secretary for benefits concurred with the OIG's three recommendations to improve VBA's efforts to help veterans whose records were damaged or destroyed by the 1973 fire.

Office of Healthcare Inspections

This office assesses VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections prompted by OIG hotline complaints, congressional requests, and other leads. The office also performs inspections of vet centers and individual medical centers, healthcare systems, networks, and community providers. The Office of Healthcare Inspections released the following reports this month.

Healthcare Inspections

Featured Report

Deficiencies in Facility Leaders' Response to Critical Surgical Events at the Michael E. DeBakey VA Medical Center in Houston, Texas

Healthcare inspections staff evaluated Veterans Integrated Service Network (VISN) and facility leaders' responses to critical surgical events from 2018 through 2021 and assessed actions to prevent reoccurrence. While facility leaders, in consultation with VISN leaders, were found to have taken progressive actions to address a provider's surgical practices, completed root cause analyses (RCAs) for each critical surgical event, and implemented additional actions to improve processes, the OIG identified failures in reporting to state licensing boards and the national practitioner data bank, as well as deficiencies in RCAs' timeliness, measurability, and sustainability. The inspection team determined that three critical surgical events may have been prevented in the absence of the RCA deficiencies. The medical center director concurred with the OIG's three recommendations related to professional evaluation, reporting, and RCAs.

Deficiencies in Quality Management Processes and Delays in the Communication of Test Results and Follow-Up Care at the Phoenix VA Health Care System in Arizona

The OIG received an allegation that leaders at this healthcare system failed to complete clinical and institutional disclosures (notifications to patients or their representatives of adverse events) for three

patients. Healthcare inspection staff substantiated that one of these three patients received a delayed institutional disclosure from the medical facility and did not receive a clinical disclosure from the healthcare team. During its inspection, the OIG also identified concerns related to deficiencies in quality management and safety processes, including failure to enter events posing risks to patients or actual harm into the Joint Patient Safety Reporting system. Deficiencies also included failures to review adverse events and initiate required RCAs, as well as insufficient documentation and explanation of decision-making within Peer Review Committee meeting minutes. Additionally, facility providers failed to properly communicate abnormal imaging and laboratory test results to patients as required by policy. The healthcare system director concurred with the OIG's five recommendations to conduct and document clinical disclosures; evaluate quality management processes that impede the timeliness of conducting institutional disclosures; adhere to Peer Review Committee documentation standards; ensure adverse events or close calls are entered into the system, reviewed, and required actions are conducted per policy; and evaluate the process for the communication of abnormal test results to patients.

Improvements Needed in Lung Cancer Screening through Use of Community Care

As part of its evaluation of lung cancer screening with low-dose computed tomography (CT) scans provided through the VA community care program, the OIG surveyed 139 VHA facilities. The findings include that while VHA requires facilities conducting this screening to have a lung cancer screening coordinator and use a patient management tool and registry to track and manage patients, these same requirements do not govern community care facilities' screening. Survey respondents identified barriers to managing community care low-dose CT consults, which included delays in receiving results. The OIG healthcare inspections team reviewed electronic health records for veterans that had a community care consult for lung cancer screening and similarly found deficiencies in VHA acquiring low-dose CT scan results from community providers, notifying providers and patients of results, and following up on both normal and abnormal low-dose CT scan results. The OIG made five recommendations related to timely and quality screening for patients receiving community care lung cancer screening.

Comprehensive Healthcare Inspections

Comprehensive Healthcare Inspection Program (CHIP) reports are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis. See the Purpose and Scope section of each report for the areas of focus at the time of the inspections. October's CHIP reports focused on the following facilities:

- [Royal C. Johnson Veterans' Memorial Hospital in Sioux Falls, South Dakota](#)
- [Veterans Health Care System of the Ozarks in Fayetteville, Arkansas](#)

- [James E. Van Zandt VA Medical Center in Altoona, Pennsylvania](#)

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