Department of
Veteran's Affairs

Memorandum

Date: October 3l, 2001
From: Assistant Inspector General for Auditing (52)
Subj: Review of Hotline Complaint: VA Programs in New York State Prisons,
Report No. 01-00290-22
To: Network Director, VA Healthcare Network Upstate New York (10N2)

1. The Office of Inspector (OIG) reviewed the following allegations to determine their validity and whether or not corrective actions are needed:

- A registered nurse (RN) and other Veterans Integrated Service Network (VISN) 2 providers may have provided care to veterans incarcerated at a New York State prison which was beyond the scope of care for which they were credentialed and privileged.

- VISN 2 staff was coding the RN's sessions with incarcerated veterans as psychotherapy treatments instead of psych-education treatments in order to increase the VISN 2 budget. The Department of Veterans Affairs' (VA) funding system Veterans Equitable Resource Allocation (VERA) funds psychotherapy treatments at approximately $40,000 per inmate; per year. Psych-education treatments are funded at approximately $100 per inmate, per year.

2. We concluded that the first allegation was partially substantiated. VISN 2 staff conducted a peer review and concluded that the RN provided care outside the scope of care for which he was credentialed and privileged. We reviewed the RN's documentation of care provided to incarcerated veterans and agreed that the allegation was substantiated. You developed a corrective action plan in response to the peer review report. We suggested that you closely monitor the corrective actions planned to ensure full implementation. We found no evidence that other VISN 2 providers provided care outside the scope of care for which they were credentialed and privileged.

3. The second allegation was not substantiated. We determined that the RN's sessions were coded as psychotherapy treatments rather than psych-education treatments. We also found that coding was done by the RN in question and there was no evidence that VISN 2 staff was involved with the coding errors. However, while some coding errors were made by medical center staff, care provided to VISN 2 incarcerated veterans was not funded at the rate of $40,000 per inmate, per year. We found That VERA over funding totaling $36,060 occurred for treatment provided to 12 incarcerated veterans as a result of coding errors by medical center staff. VISN 2 management reported these coding errors to the Assistant Deputy Under Secretary for Health and indicated its intention to return the funding to the Veterans Equitable Resource Allocation (VERA) system for redistribution nationally.

4. Thank you for your cooperation. If you have any questions, please contact me (781-687-3120) or Philip D. McDonald, Audit Manager (781-687-3140).

For the Assistant Inspector General for Auditing

THOMAS L. CARGILL. JR.
Director. Bedford Audit Operations Division (52BN)

Attachment

cc: Under Secretary for Health (I05E)
Assistant Secretary for Management (004)
Director. Office of Management and Financial Reports Service (047GB2)

ATTACHMENT

OIG REVIEW OF HOTLINE COMPLAINT:
VA PROGRAMS IN NEW YORK STATE PRISONS
Hotline Complaint Case No. 2001 HL-0066. Audit Project No. 2001-00290-R1-0065
Report No. 01-00290-22

SUMMARY

The Office of Inspector General (GIG) conducted a review at the Department of Veterans Affairs (VA) Healthcare Network Upstate New York Veterans Integrated Service Network (VISN 2) and VA Medical Center (VAMC) Canandaigua New York. The purpose of the review was to determine the validity of allegations related to providers providing care for which hey were not credentialed and privileged, coding accuracy, and relates Veterans Equitable Resource Allocation (VERA) funding. The allegations claimed that: (1) A registered nurse (RN) and other VISN 2 providers may have provided care to New York prison inmates beyond the scope for which they were credentialed and privileged; and (2) that VISN 2 staff was coding the RN's incarcerated veterans sessions as psychotherapy treatments instead of psyche-education in order to increase the VISN 2 budget. VA's funding system VERA funds psychotherapy treatments at approximately $40,000 per inmate, per year, while psyche-education / non intervention treatments are funded at approximately $100 per inmate, per year.

We concluded that the first allegation was partially substantiated. VISN 2 staff conducted a peer review and concluded that the RN provided care outside the scope of care for which he was credentialed and privileged. We reviewed he RN's documentation of care provided to incarcerated veterans and agreed that the allegation was substantiated. A corrective action plan was developed by the Network Director in response to the peer review report. We suggested that the Network Director closely monitor the corrective actions planned to ensure full implementation, We found no evidence that other VISN 2 providers provided care outside the scope of care for which they were credentialed and privileged.

The second allegation was not substantiated. We determined that the RN's sessions were coded as psychotherapy treatments rather than psych-education treatments but that coding was done by the provider and there was no evidence that supported VISN 2 staff involvement with the coding errors. However, while some coding errors were made by medical center staff, care provided to VISN 2 incarcerated veterans was not funded at the rate of $40,000 per inmate, per year. We found that VERA overfunding totaling $36,060 occurred in the cases of 12 incarcerated veterans as a result of incorrect coding by the providers. VISN 2 management reported these coding errors to the Assistant Deputy Under Secretary for Health and indicated its intention to return the funding to the VERA system for redistribution nationally.

SCOPE/METHODOLOGY

To determine the validity of the allegations, we interviewed the Network Director and the following members of his staff: the Behavioral Care Line Director, the Clinical Coordinator, the Chief Operating Officer, and the Health Systems Specialist. We also interviewed the Director, Physician Executive, Behavioral Care Line Manager, Compliance Officer, and the RN from VAMC Canandaigua. In addition, we reviewed data from the Patient Care Encounter (PCE) and Computerized Patient Record System (CPRS) files and other documents related to care provided to incarcerated veterans by the RN and by other VISN 2 medical staff who provided services to New York State prisoners. Our review covered the period of Fiscal Year (FY) 2000.

BACKGROUND

Policy

In 1986, Congress amended 38 United States Code (U.S.C.) p 1710(g) by adding language providing that the statute does not require VA to furnish care to a veteran to whom another agency of Federal, State, or local government has a duty under law to provide care in an institution of such government. Subsection (g) of 38 U.S.C. p 1710 did not prohibit VA from caring for incarcerated veterans and thus from 1986 until late 1999, VA did provide such care.

In October 1999, VA established a new benefits package and the Veterans Health Administration (VHA) changed its longstanding policy and expressly excluded from the benefits package, by regulation, hospital and outpatient care for a veteran who is a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services. Under the Eighth Amendment of the United States Constitution, a State or local government has a duty to provide such services to the incarcerated.

VERA

VERA includes three pricing groups for budget allocation: Complex Care, Basic Vested Care, and Basic Non-Vested Care. These pricing groups contain 46 patient classes. Patients who are reliant on VA health care are considered “vested”. Each patient who receives V-A medical care is assigned to one patient class that is dependent upon the international Classification of Diseases (ICD-9) code and Current Procedural Terminology (CPT) code assigned to the care provided. Patients may remain in a specific class for a specified timeframe after the first fiscal year of initial qualification. The patients in our review fell into the 3-year classification whereby patients were maintained in the class for two fiscal years after the initial year of classification, A brief description of the patient classes under each group follows:

- **Complex Care Group**

This group includes patients who rely on VA health care with special or complex, and generally chronic, health care needs that are relatively expensive. This includes patients with transplants. Acquired Immune Deficiency Syndrome or Human Immunodeficiency Virus, end stage renal disease, chronic Post Traumatic Stress Disorder, spinal cord injury, stroke, oncology, addictive disorders, schizophrenia, and dementia. Classification in this care group requires an inpatient stay.

- **Basic Vested Care Group**

This group includes patients who rely on VA health care for their routine health care needs. Classification in this care group requires the completion of one thorough medical evaluation during the past three years which should include at least a disease specific history and physical examination, This eligibility classification will be determined through the presence in the PCE files of a CPT "vesting" code that is inclusive of an appropriate medical evaluation.

- **Basic Non-Vested Care Group**

This group includes patients who use some VA health care services but are less reliant on the VA system than those who rely on the VA for more extensive care, Patients who have not had a thorough medical evaluation or an admission in the last three years are classified in this care group.

RESULTS OF REVIEW

The two allegations are discussed below. Following each allegation is the conclusion we reached, a description of the review work performed, and recommended corrective action where appropriate.

Allegation 1: An RN and other VISN 2 providers may have provided care to incarcerated veterans in a New York State prison which was beyond the scope of care for which they were credentialed and privileged.

The allegation was partially substantiated, A VISN 2 nurse executive, and an RN veteran's readjustment counselor from VAMC Albany conducted a peer review and concluded that the RN did conduct psychotherapy treatments with incarcerated veterans for which they were not credentialed and privileged.

The peer review report, dated January 5, 2001, concluded the following:

1. Documentation reviewed from available records reflects psychotherapeutic rather than psych-educational services provided by the RN in question. This is outside the scope of nursing practice.

2. Documentation, when evident, reflects neither the functional statements nor critical element competencies for the employee, or the standards for documentation,

3. There is no documented evidence in the records available of clinical supervision of the RN.

4. There are pronounced errors in visit and procedure coding.

The peer review report recommended that VAMC Canandaigua review supervision of he provision of nursing care and services, re-educate staff to role responsibilities, and review workload measurement, in response to the peer review report, the Network Director requested that a corrective action plan be implemented (see Appendix A for detailed action plan).

We reviewed the RNs documentation in the incarcerated veterans medical records for all veterans treated by the RN In FY 2000 and found descriptions of treatments outside the scope of care for which be was credentialed and privileged and substantiated the conclusions of the peer review report. In addition, the RN had provided care to the same group of incarcerated veterans on a weekly basis for over a year. This frequency of care is not expected or necessary for psych-education treatments.

To determine if other VISN 2 providers had provided care beyond the scope of care fcr which they were credentialed and privileged, we requested and obtained from VAMC Canandaigua management a listing of 640 veteran incarcerated at prison facilities located within the geographical boundaries of VISN 2, We selected a sample of 60 incarcerated veterans who received care from 10 providers and reviewed related information in the PCE and CPRS files, We found no documentation in the incarcerated veterans' records that described treatment outside the scope of care for which they were credentialed and privileged for these providers.

We suggested that the Network Director closely monitor the corrective actions planned in Appendix A to ensure full implementation.

Allegation 2: VISN 2 staff was coding the RN's sessions with incarcerated veterans as psychotherapy treatments instead of psych-education treatments in order to increase the VISN 2 budget. VERA funds psychotherapy treatments at approximately $40,000 per inmate, per year. Psych-education treatments are funded at approximately $100 per inmate, per year.

The allegation was not substantiated. We did not conclude that VISN 2 staff coded the nurse's sessions as psychotherapy treatments rather than psych education treatments. We determined that coding was done by the providers and there was no evidence that supported VISN 2 involvement with the coding.

However, in reviewing for coding compliance with the American Medical Association Current Procedural Terminology manual, we determined that a number of veterans were placed in the Basic Vested Patient category in VERA due to the inappropriate use of CPT "vesting" codes, As a result of OIG inquiry, VISN 2 management identified eight incarcerated veterans who were "vested" (placed in a higher funded group) as a result of the coding errors by the RN. In addition, a psychology technician from VAMC Canandaigua "vested" four incarcerated veterans as a result of coding errors.

None of the incarcerated veterans treated by the RN or psychology technician were rated in the Complex Care Pricing Group; therefore their care was not funded at $40,000 per inmate per year as alleged. The eight incarcerated veterans treated by the RN and the four incarcerated veterans treated by the psychology technician during FY 2000 were newly "vested" as a result of the providers' use of incorrect CPT codes. All twelve incarcerated veterans were rated in the Basic Vested Care Group and their care as funded at $3,126 each. Psych-education treatments, which these incarcerated veterans were supposed o be furnished, are "non-vested" care and is funded instead at the rate of $121 per inmate per year. The total funding impact amounts to $36,060 based on the difference between the Basic Vested and Basic Non-Vested Care groups reimbursement rates.

On July 3 2001 the Network Director sent a letter to the Assistant Deputy Under Secretary for Health hat responded he coding compliance issues and the overfunding of $36,060. VISN 2 management indicated its intention to return the funding to the VERA system for redistribution nationally. The letter also explained that the Behavioral VA Health Care Line and implemented a standardized health care encounter form VISN-wide and provided training to all clinical staff members on the appropriate use of diagnostic ICD-9 and CPT codes, The Network Director emphasized that CPT “vesting” codes would not be used for encounters with veterans who are incarcerated The letter further states that the services currently being provided by VISN 2 staff to incarcerated veterans were limited to psych-education treatments.

CONCLUSION

We concluded that the first allegation was partially substantiated. The allegation claimed that an RN and other VISN 2 providers conducted psychotherapy sessions outside the scope of care for which they ware credentialed and privileged with incarcerated veterans at a New York State prison. A VISN 2 peer review concluded the RN did provide care outside of the scope of care for which they were credentialed and privileged, We reviewed the RN's documentation in the incarcerated veterans' medical records and substantiated the conclusions of the peer review report. However, we found no evidence that other VISN 2 providers were providing care outside the scope of care for which they were credentialed and privileged.

The second allegation was not substantiated. VISN 2 staff did not code the RNs sessions as psychotherapy treatments instead of psych-education treatments, None of the incarcerated veterans treated were rated in the Complex Care Pricing Group; therefore their care was not funded at $40,000 per inmate per year as alleged. However, it was determined that VERA overfunding totaling $36,060 occurred in the case of 12 incarcerated veterans improperly vested” by health care providers. VISN 2 management indicated its intention to return the funding to the VERA system for redistribution nationally.

SUGGESTION

We suggested that the Network Director closely monitor corrective actions planned in response to the peer review report to ensure they are fully implemented.

Network Director's Action Plan
For Addressing Peer Review Report

Recommended Actions	Implementation Plan	Target Completion Date
Behavioral Health Care Line		
a. The Canandaigua Nurse Executive, the Canandaigua Behavioral Health Lead Nurse along with the Nursing Clinical Practice Council will review nursing functional statements and competency assessments for psych-educational nursing model as supported by nursing literature.	a. The Nurse Executive has initiated quarterly nurse competency reviews by the Nurse Manager, following the development and implementation of program specific nurse competency statements. This process will include all Registered Nurses delivering psycho educational programs. Additionally, staff nurse and Nurse Manager education will be accomplished prior to implementation of the reviews.	June 2001
b. Nursing competency assessments will be completed by clinical nurse supervisors on her yearly basis.	b. The Canandaigua nurse executive and Behavioral Health Head Nurse, have defined a nurse competency review which includes provision for follow-up and tracking through the office of Nurse Executive. The review is an annual one, with quarterly review of specific selected requirements within the various competency review is identified. The nurse executive has also implemented nurse leadership meetings to insure cross care line implementation of nursing practice.	March 2001
c. Training will be conducted on (1) documentation standards; (2) (2) psych-education vs. psychotherapeutic care; (3) coding methodology for clinicians.	c. (1) Training will occur during our an orientation before implementation of nurse-led psych-education program delivery and after evaluation of competency for RNs will conduct psych-educational groups and those identified in the quarterly review. (2) The Canandaigua Nurse Executive and Behavioral Health Lead Nurse had established a process to ensure appropriate education / training and regular review of competencies. (3) Behavioral Health has initiated education to all providers on application of appropriate codes for services and will continue to educate providers. A standardized encounter form was implemented during October 2000, which has helped eliminate inappropriate codes.	(1) Ongoing (2) Ongoing (3) Ongoing

Recommended Actions	Implementation Plan	Target Completion Date
d. Chart reviews / audits will be conducted courtly for one year by appropriate clinical nursing supervisors, for scope of practice and documentation appropriateness.	d. The quarterly nursing record reviews conducted by the nurse manager and our qualified evaluator will help ensure the standards have been and will continue to be met for all RNs.	Ongoing
Health Information Management System (HIMS)		
a. Network HIMS to conduct a review of 234[1] unique patients seen between July 1, 2000 and December 31, 2000 to ascertain correct coding of these visits, reflecting the care documented and the appropriate provider level codes.	a. Network HIMS presented the results of their review of the 234 unique patients representing 1014 encounters from July through December 2000, which identified coding problems that were corrected.	August 2001
b. HIMS is to work in conjunction with the Network Veterans Service Center (VSC) Manager to determine if any adjustments are necessary for workload reported during that time frame and make corrections as appropriate and necessary.	b. Encounter forms for VISN 2 Behavioral VA Care Line are reviewed and redesigned. The redesigned forms have been deployed across the care line within the VISN with attendant education for care providers utilizing the redesigned forms. Additionally, VISN-wide education regarding nationally recognized industry wide standards as to provide or documentation and coding was accomplished for all providers in the VISN. The VISN will continue external monitoring of this issue through an auditing contract to independently assess stability of provide or documentation and coding, as well as medical record CPT and ICD coding by health information professionals.	Ongoing
c. HIMS is to coordinate with the network revenue officer to determine if any inappropriate bills were generated to first and / or third-party payers and make refunds as necessary.	c. The VISN Revenue Office performed a comparison of these episodes of care with bills generated for the same time frame. The review revealed that the Veteran health Information Systems and Technology Architecture package generated a few bills but each bill was canceled because services was not covered. Therefore, no first or third-party revenue was derived and no reimbursement is necessary.	August 2001

[1] The 234 unique patients were all patients seen by the provider, including the incarcerated veterans as well as those seen at other clinics where he worked.

Recommended Actions	Implementation Plan	Target Completion Date
d. Upon completion of this review, send a disclosure report to the VHA Compliance Office citing the review Findings and corrective actions.	d. The VHA Acting Compliance Officer advised that no further action was required based upon no risk to the VA for potential claims of fraudulent billing.	August 2001
Nurse Executive Council		
a. Activate / utilize the Nurse Professional Standards Board as the Nursing Peer Review Board across the network.	a. The Geriatric and Extended Care Director stated that peer reviews conducted by the Nurse Professional Standards Board are appropriate for only nurses in probationary phase of employment. The decision is to have the Nurse Executive at each VISN 2 facility responsible for constructing a Nurse Peer Review Board. A network policy / procedure for this activity is being developed.	Ongoing
b. Nurse Executives at each facility will collaborate with local care line leaders to review the roles and competencies are nurses in all outpatient areas.	b. The Nurse Executives at each facility will collaborate with local care line leaders to review the roles and competencies are nurses in all outpatient areas.	September 2001

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ANALYSTS OF DEP'T OF VETERAN'S AFFAIRS

INSPECTOR GENERAL REPORT # 01-00290-22

By:

David J. Todeschini – Written Jan 20, 2003

STATEMENT

The following analysis is accurate and true to the best of my knowledge, and for those things herein alleged, I believe it to be true. This analysis is a synopsis of an investigation and inquiries done by several veterans at Groveland Correctional Facility who were enrolled or involved with the Veterans Residential Therapeutic Program (VRTP) This analysis addresses ONLY the allegation that was substantiated by the V.A. Inspector General in case # 2001-HL-0066, report # 01-00290—27 (dated October 31-01)

David J. Todeschini

NOTARY SEAL

Sworn before me on _____/_____/_____

Signature of Notary_____

David J. Todeschini _____

INSPECTOR GENERAL REPORT # 01-00290-22

ANALYSIS of DVA-IG REPORT

EXHAUSTION OF LOCAL REMEDY:

re: Wende Grievance # WDE 17366-02 and # WDE 19026-03

NOTE: The page numbers in this document refer to the page number of the DVA-IG Attachment (above). I have transcribed the original documents verbatim into this file, and added line numbers to this entire document to make locating a particular bit of text easier. The "*Id* at" references the original documents.

In the wake of a flurry of complaints beginning in the spring of 2000 from veterans incarcerated at Groveland Correctional Facility about *"bogus programs"* and *"uncredentialed counselors"* in the Veterans Residential Therapeutic Program VRTP), the Inspector General for the Department of Veteran's Affairs in Washington DC (DVA-IG) conducted an investigation that verified the complaints. I subsequently obtained report #01-00290-22 and an attached memorandum from DVA-IG under the Freedom of Information Act (FOIA/FOIL 5 USC §552), from Richard Griffin, Esq.

The following is an analysis of the report that establishes that a registered nurse (RN) working for the Canandagiua$_1$ New York Veterans Administration, had engaged in the unlicensed practice of psychiatry according to the DVA-IG report, with 12 (twelve) incarcerated veterans for a period exceeding one year. Subsequent FOIL requests to the Department of Veteran's Affairs and to the V.A. Medical Center (VAMC) on Bailey Avenue in Buffalo New York failed to disclose the name of the RN in question: i.e.: to get the Veteran's Administration to put it Writing. However, I believe the RN's name is **Jim Robinson**. I also attempted to ascertain the exact nature of the entries that were made in my medical records for 10 instances of ***"OUTPATIENT CARE"*** cited in an invoice I received from the Department of Veteran's Affairs and they have NOT RESPONDED to MULTIPLE requests for this information, which is MY RIGHT to have. I have searched (by FOIL and PERSONALLY) my FACILITY medical and psychiatric records, and have not discovered any entries that appear to have been made by *"the RN in question"*. I believe these records are Veteran's Administration records, NOT DOCS records.

I have filed several grievances (cited above) On this issue, and have therefore exhausted all local remedy by attempting to resolve the issue of the invoices at the facility level since the invoices were generated while I was incarcerated at Groveland Correctional Facility. DOCS in Albany refuses to accept responsibility for this action, and disavows any knowledge or involvement with the RN cited in the OVA-IC report. They had responded to my grievance on this matter, that it is MY responsibility to deal with the Veteran's Administration on this matter.

ALLEGATION #1 *"…The RN did conduct psychotherapy treatments with incarcerated veterans for which he was not credentialed and privileged".* - *Id* at 3 ¶5

A review of the RN's documentation and veterans medical records: *"…found descriptions of treatments outside the scope of care for which he was credentialed and privileged… The RN had provided care to the same group of veterans on a weekly basis for over a year".* - *Id* at 4, ¶2

ALLEGATION #2 *"….VERA [Veteran's Equitable Resource Allocation] funds psychoTHERAPY at approximately $40,000 per innate per year whereas psych EDUCATION treatments are funded at $100 per inmate per year."* - *Id* at 4, ¶ 5 (brackets and emphasis mine) The second allegation was written off as a coding error, primarily because: *"…none of the incarcerated veterans treated by the RN or the psychology technician were rated in the complex care pricing group, therefore, their care was not funded at $40,000 per inmate per year as alleged".* - *Id* at 4, ¶ 8

The contradiction here is not immediately apparent. However, we know this RN was preparing a "paper trail" to show that veterans were INDEED undergoing psychotherapy. None of us were. In addition, some veterans (including myself) started getting invoices and threatening letters from the Department of Veterans Affairs billing us co-payments for multiple instances of *"OUT-PATIENT CARE"*, and demands for payment. Some of the invoices were over $600.00

Since the "ground work" - the medical and psyche records - were prepared to show "psychotherapy"; something that the RN was NOT qualified to do, it is therefore inconceivable that the "treatment provider" made a *"coding error"*, since the record of the "care" he provided was NOT an error. The *"coding"* of the care provided, and the documentation of the treatments in the veteran's medical records ACTUALLY MATCHED.

It is more likely that this RN was impersonating a qualified psychotherapist, and somehow would have had access to the money [approximately $480,000], perhaps by retroactively changing the rating of these vets to indicate eligibility for *"complex care"* in the *"pricing group"* (*Id* at 4, ¶ 8) and getting paid via some (nebulous to this deponent) "cost recovery" through the Department of Correctional Services (DOCS).

That Groveland Correctional Facility (if not DOCS was involved, there can be no question, since the question that never arose in the DVA Inspector General's report must be asked:

H0W DOES A REGISTERED NURSE (male) WORKING IN THE VETERAN'S ADMINISTRATION GET ONTO STATE PROPERTY RUN BY THE DEPARTMENT OF CORRECTIONS, WITHOUT DOCS CHECKING HIS CREDENTIALS? HOW DOES THIS SAME MAN GET ACCESS TO VETERAN'S MEDICAL RECORDS WITHOUT THEIR KNOWLEDGE OR PERMISSION, AND AVOID BEING EXPOSED AS A FRAUD FOR OVER A YEAR?

The Inspector General's report reveals that the veteran's medical records had *"…descriptions of treatments outside the scope of care for which he was credentialed." — Id* at 4, ¶12, and also that the RN's sessions were coded as psychoTHERAPY treatments rather than psych EDUCATION treatments; that *"coding was done by the RN in question … no evidence that the VISN-2 VA [Regional Office] staff was involved..."* (Memo *Id* at 1, ¶ 3 (brackets and emphasis mine throughout).

In other words, the "treatments" recorded in the medical records, and the "coding" of those treatments were consistent with each other, and done by *"the RN in question"*.

The DVAIG report calls the coding of these treatments *"coding errors"* throughout the report; particularly: *"4. There are pronounced errors in visit procedure and coding." - Id* at 3. THIS IS A *NON SEQUITUER*. If the "treatment provider" had documented "psychotherapy" in the medical records of a dozen veterans and had actually rendered such treatments, it is MALPRACTICE. When he correctly codes his sessions as such, it is NO ERROR, since DOCS at Groveland Correctional Facility NEVER VERIFIED HIS CREDENTIALS, and in fact, the counselors on staff had represented him as *"A specialist in Post-Traumatic Stress Disorder PTSD)* and as *"a psychologist from the Canandaigua Veteran's Administration."* The coding therefore, was NOT erroneous; it was FRAUDULENT.

DOCS at Groveland Correctional Facility is NEGLIGENT as well as LIABLE, and obviously was involved in a well-planned CRIMINAL ENTERPRISE until 4 veterans known as "The V-Team" started to do legal research and ask questions. In addition, the Veteran's Health Administration (VHA) had changed its policy in October 1999:

"…expressly excluded.., by regulation, hospital and out-patient care for a veteran who is a patient in an institution of another government agency". - *Id* at 2 ¶3.

It therefore follows that 10 occurrences of "out-patient care" recorded on the "cost recovery" invoices I received from the Department of Veteran's Affairs (DVA) [attached to grievance #WDE17366-02] were against VHA's own policy since I was incarcerated). Somehow, this "error" also managed NOT to be detected for over a year, possibly longer.

Multiple FOIL requests for a copy of the entries made in MY medical records from the Department of Veteran's Affairs and the V.A. Medical Center on Bailey Ave., in Buffalo, N.Y., went unanswered. I checked BOTH my medical and psyche records (prison records), and discovered NO entries that appeared to have been made by *"the RN in question"*.

EXHAUSTION OF LOCAL REMEDY - As regards the invoices for "out-patient care" that I received from the Dep't of Veteran's Affairs, I have now exhausted local remedy by filing a grievance at Wende Correctional Facility **# WDE-17366-02**. DOCS/CORC denied the grievance in November 2002. DOCS disavows any knowledge of, or culpability for these invoices that were incurred while I was incarcerated at Groveland Correctional Facility, and enrolled in the Veteran's Residential Therapeutic Program (VRTP), under whose auspices *"the RN in question"* was operating. I had never had any dealings with the Veteran's Administration for medical or psychiatric treatment prior to my incarceration at Groveland Correctional Facility. The denial is in the face of the DVA-IG's investigation, which despite denials by DOCS officials in Albany, investigation(s) DID indeed find improprieties AS ALLEGED in the VRTP program.

On March 5, 2003, I have filed another grievance from Wende CF **# WDE-1 9026-03**, pertaining to the V.A. "RN" being allowed on DOCS property, and allowed to "play shrink" for over a year, without any verification of his credentials. For THIS allegation, I have proof from the DVA Inspector General. This grievance was sent to Groveland CF from Wende CF by the IGRC at Wende. Groveland has denied the grievance saying that it was "filed untimely". However, the injury was not discovered, nor could it be realistically proven without the DVA IG report, which was concluded on October 31, 2001 and by that time, I was already off the facility due to bogus tickets written in retaliation for being part of the "team' that initiated the DVA-IG investigation.

I have also filed a CRIMINAL COMPLAINT with the NY State Police on Feb 10, 2003, which was forwarded to DOCS Inspector General he Captain David L. McNulty of the Criminal Investigation Bureau on / about Feb 21, 2003. In this complaint it was also alleged that DOCS at Groveland Correctional Facility along with the Parole Board, had conspired to hold veterans incarcerated by the

(Parole Board's) ability to arbitrarily and capriciously deny parole despite the issuance of Earned Eligibility Certificates to a vast majority of the participants.

On March 27, 2003, I was interviewed by DOS Inspector General Senior Investigator Thomas R. Todd. He took my statement, and gave me **file # 288-03** for his investigation into this matter. I had subsequently sent him copies of this document, the DVA-IG report, and all materials to support the allegations made herein.

FOOTNOTES / ABBREVIATIONS

CF	Correctional Facility
CORC	Review committee in Albany for inmate grievances
DOCS	Department of Correctional Services
EEC / CEE	Earned Eligibility Certificate / Certificate of Earned Eligibility
FOIL	Freedom of Information Laws / Act 5 USC §552, §552a
VRTP	Veteran's Residential Therapeutic Program
IG	Inspector General
Non Sequituer	(Latin) "It does not follow"
RN	Registered Nurse
VERA	Veteran's Equitable Resource Allocation
VISN-2	A veteran's Administration Regional office
VA	Veteran's Administration
VHA	Veteran's Health Administration
V-Team	Four veterans at Groveland who did legal research and data collection at Groveland CE to expose fraud in the VRTP program.

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