



# DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

## PODCAST TRANSCRIPT NOVEMBER 2018 HIGHLIGHTS

NOVEMBER 2018

Tamara Schulman:

This is Tamara Schulman, an attorney advisor with the VA Office of Inspector General in Washington, DC. Here are the November highlights:

Inspector General Michael Missal testified before the House Committee on Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs. His testimony focused on changes to the OIG's oversight model for the Veterans Benefits Administration (or VBA). The model allows the OIG to enhance its review of national policy changes affecting veterans, taxpayers, and VA. It also sharpens the OIG's focus on high-impact VBA programs. The OIG's emphasis is on identifying the root causes of problems and making meaningful recommendations that can lead to long-term improvements. Inspector General Missal highlighted concerns and trends the OIG identified in four recent OIG reports regarding VBA's ability to review and process claims accurately. The four reports addressed unwarranted medical reexaminations, denied military sexual trauma-related claims, intent to file submissions, and claims related to ALS (or Lou Gehrig's Disease).

*"These reports identified common systemic issues that contributed to our findings. The primary root causes of the problems we found were deficient internal controls, inadequate program leadership and monitoring, a lack of information technology system functionality, and the unintended impacts of VBA's national work queue implementation."* — Inspector General Michael Missal

In the most recent of the four reports on the accuracy of claims involving service-connected ALS, released November 20<sup>th</sup>, the OIG found that VBA's ALS claims processing should be improved to reduce errors. About 45 percent of ALS claims completed from April through September 2017 had erroneous decisions. These errors resulted in estimated underpayments of about \$750,000 and overpayments of about \$649,000 over a six-month time period alone. These errors were due to the complexity of these claims and because most rating personnel do not decide ALS claims often enough to maintain proficiency. The OIG recommended that VBA implement a plan to improve decisions and additional reviews of claims involving service-connected ALS and monitor these claims to ensure staff demonstrate proficiency. The OIG also recommended that VBA implement a plan to ensure veterans with ALS receive notices regarding additional special monthly compensation benefits that may be available, after finding that generally veterans were not advised of these benefits.

# VA Office of Inspector General

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The OIG also released the report *Patient and Radiation Safety Concerns at the John D. Dingell VA Medical Center*. Among the findings, the OIG substantiated that a radiologist performed fluoroscopy procedures without having current training or privileging and the radiology department did not conform to VHA radiation safety standards. Although the OIG found deficiencies in the facility's radiation safety program and made recommendations, the OIG did not identify deficiencies that put patients and staff at immediate risk or warranted stopping patient care. The OIG made six recommendations related to equipment testing, fluoroscopy training, clinical privileges, radiation safety measures, and tracking and monitoring corrective actions to completion.

Two Comprehensive Healthcare Inspection Program reports were also released for the Central Texas Health Care System in Temple, Texas, and the VA Maine Healthcare System in Augusta, Maine. For these two facilities, the OIG issued 25 recommendations for improvement.

For more information on the congressional hearing, the highlighted reports, or to report wrongdoing, visit the OIG website at [www.va.gov/oig](http://www.va.gov/oig). You can also hear other podcasts by clicking on the media tab of our website, including one posted in November on an OIG review of the mental health care provided by clinical pharmacists at a Wisconsin VA facility to two patients who later died by suicide.