Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Regional Office Fargo, North Dakota

Report No. 04-03271-77 **February 4, 2005**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the period October 25–29, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Regional Office Fargo, ND. The regional office is collocated with the Fargo VA Medical Center (VAMC) and is part of the Veterans Benefits Administration (VBA) Central Area. The purpose of the review was to evaluate selected regional office operations, focusing on benefits claims processing and financial and administrative controls. We also provided fraud and integrity awareness training to 29 regional office employees.

Results of Review

The CAP review covered six operational activities. The regional office complied with selected standards in four activities:

- Incarcerated Veterans
- Large Retroactive Payments
- System Error Messages
- Vocational Rehabilitation and Employment

We made two recommendations to improve regional office operations:

- Properly secure sensitive claims folders and perform required semiannual audits of these folders.
- Ensure that benefit payments for certain veterans hospitalized at Government expense are reduced.

This report was prepared under the direction of Mr. David Sumrall, Director, and Mr. Kent Wrathall, CAP Review Coordinator, Seattle Audit Operations Division.

Central Area and Regional Office Directors' Comments

The Central Area and Regional Office Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 5–8, for the full text of the Directors' comments.) We will follow up on the implementation of recommended improvement actions.

(original signed by:)
RICHARD J. GRIFFIN
Inspector General

Introduction

Regional Office Profile

Organization and Programs. The regional office provides compensation and pension (C&P), Vocational Rehabilitation and Employment (VR&E), and burial benefits to eligible veterans, dependents, and survivors in North Dakota and northwestern Minnesota. The estimated veteran population served by the regional office is 89,200.

During Fiscal Year (FY) 2004, the regional office authorized about $95.7 million in C&P payments for 13,158 beneficiaries. VR&E benefits totaling about $72,000 were paid to 400 beneficiaries. In addition, the regional office provided fiduciary oversight for 721 incompetent veterans and other beneficiaries.

Resources. In FY 2004, regional office operating expenditures were about $3.2 million. As of September 2004, the regional office had 36 full-time employees.

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, quality management, benefits, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected benefits claims processing, financial, and administrative activities to evaluate the effectiveness of benefits delivery and general management controls. Benefits delivery is the process of ensuring that veterans' claims for benefits and requests for services are processed promptly and accurately. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. In performing the CAP review, we interviewed managers and employees, reviewed beneficiary files and financial and administrative records, and inspected work areas. The review covered the following six activities:

Hospital Adjustments	Security of Claims Folders
Incarcerated Veterans	System Error Messages
Large Retroactive Payments	Vocational Rehabilitation and Employment

The review covered regional office operations for FY 2004 and was done in accordance with OIG standard operating procedures for CAP reviews.

In this report we make recommendations for improvement. These recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results of Review

Opportunities for Improvement

Security of Claims Folders – Sensitive Folders Should Be Properly Secured and Audits Performed

Conditions Needing Improvement. The regional office did not comply with VBA policies requiring that sensitive claims folders be securely stored in locked cabinets or rooms and audited semiannually. Sensitive folders include those for employees and their family members, high-level VA officials, and representatives of veterans service organizations. We identified two deficiencies in claims folders security.

Sensitive Folders Not Secured and Tracked. VBA policy requires that sensitive folders for regional office and collocated medical center employees and their family members be transferred to designated regional offices. All other sensitive folders must be stored in locked cabinets or rooms. In addition, regional offices should use an electronic or manual system to ensure that folders are tracked and returned to locked storage at the end of each day.

To determine if the regional office properly secured sensitive folders, we compared the list of folders that should have been secured with the folders stored in designated locked cabinets located in the Assistant Service Center Manager's office. We found that six folders had been improperly stored in rating specialists' or general storage cabinets for extended periods from 6 to 292 days. These folders had not been returned to locked storage because regional office staff were not consistently using the Control of Veterans Records System or any other folder tracking system.

Semiannual Audits Not Performed. VBA policy requires regional offices to conduct semiannual audits of sensitive claims folders. As part of these audits, regional offices must perform an inventory of folders stored in locked cabinets or rooms. Veterans Service Center (VSC) management acknowledged that the regional office had never performed an audit of these folders. However, in preparation for our review, the regional office compiled a list of 134 sensitive folders that should have been secured in locked cabinets. We found this list was inaccurate because it included two folders that had been permanently transferred to another regional office and did not include two folders that were appropriately stored in locked cabinets.

Recommended Improvement Action 1. We recommended that the Regional Office Director ensure that sensitive claims folders are: (a) effectively tracked and secured in the designated locked cabinets at the end of each day and (b) audited semiannually in accordance with VBA policy.

The Director agreed with the finding and recommendation and reported that as of November 1, 2004, a sensitive claims folder tracking system had been established to ensure that these folders are properly secured at the end of each day. In addition, audits of locked folders will be performed semiannually. The improvement actions are acceptable, and we consider the issues resolved.

Hospital Adjustments – Benefit Payments for Hospitalized Veterans Should Be Properly Reduced

Condition Needing Improvement. VSC management needed to improve the processing of hospital adjustments. In certain situations, VBA policy requires regional offices to reduce benefit payments to veterans hospitalized at Government expense for extended periods. In order to make the required adjustments, regional offices must obtain monthly hospitalization data from VAMCs.

As of September 28, 2004, 27 veterans had been hospitalized continuously for 90 days or more at the Fargo VAMC. For 23 of the 27 veterans, benefit payments were either not subject to reduction or had been properly reduced. However, the remaining four veterans had received overpayments totaling $19,512. These overpayments occurred because VSC staff had overlooked medical records in the claims folders and had not requested hospitalization information from the VAMC.

Recommended Improvement Action 2. We recommended that the Regional Office Director ensure that VSC staff: (a) receive training emphasizing the importance of reviewing medical records in claims folders to identify situations requiring benefit payment adjustments, (b) coordinate with Fargo VAMC staff to ensure that the VSC is notified when veterans are hospitalized, (c) properly reduce payments for the four veterans identified during the CAP review, and (d) pursue recovery of all overpayments made to these veterans.

The Director agreed with the finding and recommendation and reported that as of January 5, 2005, VSC staff had received refresher training on identifying situations requiring hospital adjustments and had coordinated with the Fargo VAMC to receive monthly listings of hospitalized veterans. In addition, payments for the four veterans identified during the CAP review had been properly adjusted, and recovery of the overpayments was in progress. The improvement actions are acceptable, and we consider the issues resolved.

Appendix A

Central Area Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 12, 2005

From: Central Area Director

Subject: CAP Review of the VA Regional Office Fargo, ND

To: Director, Seattle Audit Operations Division (52SE)

The Director, Central Area Office, has reviewed the Dakotas Regional Office Director's response to the Combined Assessment Program Review Draft Report. I concur with recommendations and suggested improvement actions and am forwarding the report to you for your consideration.

(original signed by:)

WILLIAM D. FILLMAN, JR.

Appendix B

Regional Office Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 10, 2005

From: Regional Office Director

Subject: CAP Review of the VA Regional Office Fargo, ND

To: Director, Central Area

Enclosed is the Dakotas Regional Office, Fargo Campus, response to the Combined Assessment Program (CAP) Review Draft Report. I concur with the recommendations and suggested improvement actions for our station. Attached is information concerning specific corrective actions.

We appreciate the analysis and cooperation provided by the audit team. Their findings, along with our corrective actions, provides opportunity to improve our operation.

Should you have any questions regarding our reply, please contact me at (605) 333-6825.

(original signed by:)

JOHN SMITH

Enclosure

Regional Office Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General Report:

OIG Recommendations

OIG Recommended Improvement Action 1. We recommend that the Regional Office Director ensure that sensitive claims folders are: (a) effectively tracked and secured in the designated locked cabinets at the end of each day and (b) audited semiannually in accordance with VBA policy.

Regional Office Director Concurs

Implementation Completion Date: November 1, 2004

(a) A tracking system established to control locked folders ensures that all folders are secured daily. A sign out log is annotated showing removal of the folder from locked files and the folder is identified with a special tag. All files are returned daily and the file log updated. Management will review and initial the log at the end of each day to verify that all folders are secured.

(b) Audit of the locked folders will be performed semiannually with an inventory listing maintained. Documented results will be incorporated as part of the Internal Control SAO.

Recommended Improvement Action 2. We recommend that the Regional Office Director ensure that VSC staff: (a) receive training emphasizing the importance of reviewing medical records in claims folders to identify situations requiring benefit payment adjustments, (b) coordinate with Fargo VAMC staff to ensure that the VSC is notified when veterans are hospitalized, (c) properly reduce payments for the four veterans identified during the CAP review, and (d) pursue recovery of all overpayments made to these veterans.

Regional Office Director Concurs

Implementation Completion Date: 1/5/05

(a) Training on hospital adjustments was immediately given to all employees following the OIG visit and refresher training given on January 5, 2005. The importance of identifying situations requiring benefit adjustment has been stressed and that all staff members refer these cases to the Post-Determination Team immediately.

(b) VA Medical Center staff will provide monthly listings of all contract nursing home patients and hospitalized patients.

(c) The four cases identified during the CAP review have been properly adjusted.

(d) Recovery of overpayments is in progress.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
2	Better use of funds by recovering overpayments caused by not reducing benefits for certain veterans hospitalized at Government expense.	$19,512

OIG Contact and Staff Acknowledgments

OIG Contact	David Sumrall (206) 220-6654
Acknowledgments	Kent Wrathall Angie Fodor Theresa Kwiecinski Tom Phillips

Appendix E

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