Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Regional Office Honolulu, Hawaii

Report No. 05-02531-18 **November 3, 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 August 22–26, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Regional Office Honolulu, HI. The regional office is part of the Veterans Benefits Administration (VBA) Western Area. The purpose of the review was to evaluate selected regional office operations, focusing on benefit claims processing and financial and administrative controls. We also provided fraud and integrity awareness training to 65 employees.

Results of Review

The CAP review covered 12 operational activities. The regional office complied with selected standards in nine activities:

- Automated Information Systems Security
- Benefits Delivery Network Security
- Compensation and Pension (C&P) Benefits Death Match
- Employee Claim Folder Security
- Fiduciary and Field Examinations
- Government Purchase Card Program
- Large Retroactive Payment Controls
- System Error Messages
- Vocational Rehabilitation and Employment

We identified three activities that needed additional management attention. To improve operations, the following recommendations were made:

- Strengthen post-traumatic stress disorder (PTSD) claim development practices.
- Improve controls over benefit payments to incarcerated veterans.
- Reduce benefit payments for veterans hospitalized at Government expense for extended periods.

This report was prepared under the direction of Ms. Claire McDonald, Director, and Mr. Orlando Velásquez, CAP Review Team Leader, Seattle Audit Operations Division.

Western Area and Acting Regional Office Directors Comments

The Western Area and Acting Regional Office Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 8–12, for the full text of the Directors' comments.) We will follow up on the implementation of recommended improvement actions.

(original signed by:)
JON A. WOODITCH
Acting Inspector General

Introduction

Regional Office Profile

Organization and Programs. The regional office provides benefit programs to eligible veterans, dependents, and survivors residing in Hawaii, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands. In 2003, the Honolulu VA Medical and Regional Office Center was reorganized, and the medical center and regional office became separate entities. The estimated veteran population served by the regional office is 118,000. During fiscal year (FY) 2004, the regional office authorized approximately $311.5 million in C&P payments for 21,430 beneficiaries.

Resources. In FY 2004, regional office operating expenditures were about $6.2 million. As of July 2005, the regional office had 71.5 full-time equivalent 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 12 activities:

Automated Information Systems Security
Benefits Delivery Network Security
C&P Benefits Death Match
Employee Claim Folder Security
Fiduciary and Field Examinations
Government Purchase Card Program
Hospital Adjustments
Incarcerated Veterans
Large Retroactive Payment Controls
PTSD Claim Development
System Error Messages
Vocational Rehabilitation and Employment

The review covered regional office operations for FYs 2003, 2004, and 2005 through August 2005 and was done in accordance with OIG standard operating procedures for CAP reviews.

Activities needing improvement are discussed in the Opportunities for Improvement section (pages 3–7). In this report we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For the activities not discussed in the Opportunities for Improvement section, we did not identify any reportable deficiencies.

During the review, we also presented fraud and integrity awareness training to 65 regional office employees. The briefings covered procedures for reporting suspected criminal activities to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Follow-Up on Prior CAP Review Recommendations. As part of this review, we followed up on recommendations made during the prior CAP review *(Combined Assessment Program Review of the Spark M. Matsunaga VA Medical & Regional Office Center Honolulu, Hawaii*, Report No. 01-01254-10, October 9, 2001*)*. We recommended that the regional office improve management of the Government purchase card program, benefits delivery network security, and automated information systems security. During this CAP review, we determined that the regional office had adequately addressed the recommendations and conditions cited during the prior review.

Results of Review

Opportunities for Improvement

Post-Traumatic Stress Disorder Claim Development – Adequate Medical Evidence Should Be Obtained and Stressors Confirmed

Conditions Needing Improvement. Veteran Service Center (VSC) management needed to strengthen PTSD claim development practices by obtaining adequate medical evidence and improving the process of confirming stressors. To be diagnosed with PTSD, a veteran must have experienced the stress of being exposed to a traumatic event of an extreme nature. While PTSD stressors for veterans are usually combat-related, they can also be noncombat-related (for example, duty on a burn ward or in a graves registration unit). Veterans are entitled to service connection for PTSD when: (1) there is medical evidence establishing a clear diagnosis of PTSD, (2) the medical evidence links current PTSD symptoms with an in-service stressor, and (3) there is credible supporting evidence that the claimed stressor occurred.

VBA's Rating Board Automation 2000 database reported that during the 2-month period June–July 2005, the regional office made 46 original PTSD rating decisions. Of the 46 decisions, 23 were granted and 23 were denied service connection for PTSD. To determine if VSC staff had properly developed PTSD claims, we reviewed a judgment sample of 25 claim folders (15 granted and 10 denied claims). All 10 of the denied claims had been properly developed. However, 9 (60 percent) of the 15 granted claims had 1 or more of the following 4 claim development deficiencies.

Medical Evidence Did Not Include Clear Diagnosis. A clear PTSD diagnosis that reconciles multiple mental health diagnoses and resolves any inconsistent diagnoses is needed before granting a PTSD claim. When multiple mental health diagnoses are made, VSC staff should ensure that the medical evidence differentiates between the disabilities associated with each diagnosis. If the medical evidence does not make this differentiation or includes inconsistent diagnoses from examiners, VSC staff should request clarification from VA medical facility C&P examiners. For two claims, the medical evidence did not include a clear PTSD diagnosis. This problem is illustrated by the following example:

> The Army veteran served in Korea as a light weapons infantryman. During his C&P examination he was diagnosed with PTSD and depression. The examination report did not differentiate between the disabilities associated with PTSD and depression. VSC staff should have requested a reconciliation of the two diagnoses from the C&P examiner.

Medical Evidence Did Not Link Symptoms to Stressor. A link between current PTSD symptoms and an in-service stressor is required before granting a PTSD claim. VSC staff should ensure that medical evidence includes this link. For one claim, the medical evidence did not link the veteran's PTSD symptoms to the claimed stressor:

> The Army veteran, who served in Vietnam, claimed stressors of killing enemy soldiers, experiencing enemy attacks, and witnessing a fellow soldier dying. A VA examination report described the veteran's PTSD symptoms as anger, heavy drinking, trouble sleeping, suicidal thoughts, and intrusive memories of experiences in Vietnam. Another VA examination report described symptoms of uncontrollable rage and homicidal thoughts. Neither of the examination reports linked the veteran's symptoms with the claimed stressors.

Claim Folders Not Available to Medical Examiners. To assist medical examiners in linking PTSD symptoms and stressors and in making clear PTSD diagnoses, VSC staff should ensure examiners have access to veteran claim folders. Claim folders often include medical and stressor-related information that examiners should consider before making a PTSD diagnosis. Examiner review of claim folders is especially important when interviewing noncombat veterans because their testimony is insufficient to establish the occurrence of in-service stressors without additional supporting evidence.

For two claims, the claim folders were not made available to medical examiners. For one claim, the combat veteran's folder included his service medical and personnel records, stressor statements, and private medical records that showed he had several significant medical conditions. Because the examiner did not review the claim folder, none of this information was considered when making the PTSD diagnosis. For the other claim, because the examiner did not review the claim folder, he was unaware that the noncombat veteran's testimony provided during the examination contradicted evidence in the claim folder. The veteran told the examiner that while in Vietnam his Military Occupation Specialty (MOS) was a combat engineer. However, the evidence in the claim folder showed that his MOS was a heavy vehicle driver.

Combat-Related Stressors Not Adequately Confirmed. Claimed PTSD stressors must be confirmed with credible supporting evidence. Sources of credible supporting evidence for combat-related stressors include the veteran's medical, personnel, and unit service records. For three claims, VSC staff did not adequately confirm the claimed combat-related stressors. This problem is illustrated by the following example:

> The Army veteran served in Vietnam with the MOS of a fixed station attendant. The veteran's claimed stressors included witnessing many of his friends being killed, a civilian bus exploding, and exchanging weapons fire with enemy snipers on several occasions. In October 1997, December 1999, and June 2002, VSC staff denied his PTSD claims because

the veteran had not provided specific dates, locations, or names of military units that would allow for the claimed stressors to be verified. However, in June 2005, without receiving any additional information that would allow the stressors to be verified, VSC staff conceded the stressors based on the veteran's participation in the Tet Counteroffensive Phase IV.

Recommendation 1. We recommended that the Western Area Director ensure that the Acting Regional Office Director requires VSC management to strengthen PTSD claim development practices by: (a) obtaining adequate medical evidence, (b) ensuring that medical evidence links symptoms to stressors, (c) making claim folders available to medical examiners, and (d) confirming combat-related stressors.

The Acting Regional Office Director agreed with the findings and recommendations and reported that on September 13, 2005, the VSC employees involved in claim processing received training that addressed PTSD claim development, including evidence requirements. The Western Area Director stated that she had requested C&P Service to review the claims discussed in the report. In addition, she stressed the importance of addressing PTSD claim development issues at a national level. We agree that a C&P Service review of these claims and other PTSD claims will be beneficial as VBA continues to address concerns about processing PTSD claims nationwide. The improvement actions are acceptable, and we will follow up on the completion of the planned actions.

Incarcerated Veterans – Controls Over Benefit Payments Should Be Strengthened

Condition Needing Improvement. VSC management needed to strengthen controls over benefit payments to incarcerated veterans. Federal law requires that VA C&P benefit payments be reduced or discontinued for veterans who are convicted of crimes resulting in imprisonment of more than 60 days. The VA Hines Information Technology Center provides regional offices monthly Social Security Administration (SSA) Prisoner Match reports and periodic Bureau of Prisons Match reports listing new veteran incarcerations. To determine whether benefits to these veterans should be reduced or discontinued, regional offices must obtain certain information from local law enforcement agencies, such as whether the veteran has been convicted of a crime, the type of offense committed, and the release date.

During the 6-month period January–June 2005, SSA Prisoner Match reports for the regional office listed 53 incarcerated veterans. We selected a judgment sample of 25 of these cases for review. For 22 of the 25 cases, regional office staff had appropriately reduced or discontinued C&P benefit payments. However, for the three remaining cases, sufficient information had not been obtained from local law enforcement agencies to determine whether the veterans' benefits should have been reduced. The necessary

information was not obtained because regional office staff had not followed up with the law enforcement agencies after initially determining that the required information was not yet available. Follow-up actions did not occur because the regional office had not established controls to ensure that incarcerated veteran cases were tracked until the appropriate determination was made regarding benefit adjustments.

As of August 26, 2005, overpayments to the three incarcerated veterans totaled $4,790. If adjustments are not made, overpayments for two of the veterans, serving prison sentences of 10 and 20 years, respectively, will continue at a combined rate of $2,876 per month, or $34,512 per year. For the third veteran, no additional overpayments were incurred after April 2005, when he completed his sentence.

Recommendation 2. We recommended that the Western Area Director ensure that the Acting Regional Office Director requires VSC management to (a) recover overpayments made to the three incarcerated veterans identified by our review and (b) implement procedures to better track incarcerated veteran cases until the appropriate benefit adjustments are made.

The Western Area and Acting Regional Office Directors agreed with the findings and recommendations and reported that as of September 20, 2005, VSC had initiated the process of recovering overpayments made to the three incarcerated veterans. In addition, on September 1, 2005, the regional office implemented procedures for reviewing and tracking each incarcerated veteran case. The improvement actions are acceptable, and we will follow up on the completion of the planned actions.

Hospital Adjustments – Benefit Payments for Hospitalized Veterans Should Be 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. To make the required adjustments, regional offices must obtain monthly hospitalization data from VA medical facilities.

As of July 2005, there were 83 veterans under the jurisdiction of the regional office who had been hospitalized continuously for 90 days or more within the VA Pacific Islands Health Care System. For 73 of the 83 veterans, no hospital adjustments were required. However, for 1 of the remaining 10 veterans, the required adjustment was not made, resulting in overpayments totaling $1,116. The overpayment occurred because VSC staff did not follow up with the health care system to ensure that complete hospitalization data was received every month. In August 2005, VSC management began the process of adjusting benefit payments for this veteran.

Recommendation 3. We recommended that the Western Area Director ensure that the Acting Regional Office Director requires VSC management to (a) recover overpayments made to the veteran identified by our review and (b) coordinate with VA Pacific Islands Health Care System staff to ensure that VSC is notified when veterans are hospitalized.

The Western Area and Acting Regional Office Directors agreed with the findings and recommendations and reported that as of August 26, 2005, VSC initiated the process of recovering overpayments made to the veteran. In addition, on September 23, 2005, the regional office reminded the VA Pacific Islands Health Care System to notify VSC when veterans are hospitalized. The improvement actions are acceptable, and we will follow up on the completion of planned actions.

Appendix A

Western Area Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 4, 2005

From: Director, Western Area Office

Subj: Combined Assessment Program Review of the VA Regional Office Honolulu, Hawaii

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

I reviewed the Draft Report of the CAP review for the VA Regional Office Honolulu. As the Western Area Director, I appreciate the feedback from the review. The station recently became a stand alone Regional Office so your insights are timely and appreciated.

Attached are the Regional Office's implementation plans for your recommendations and suggestions. We will work with the Regional Office to ensure all open remaining actionable plans are implemented by the set target dates.

My only concerns with the Honolulu CAP review are with the comments regarding PTSD and obtaining medical evidence. I have asked Compensation and Pension Service to also review the cases and to provide me with their feedback. As we move forward with the nationwide PTSD review, I want to ensure that these comments and concerns are addressed at a National Level.

Again, thank you for your review. If you have any questions, please don't hesitate to contact me at (602) 627-2746.

Thank you,

(original signed by)
Diana M. Rubens
Western Area Director

Appendix B

Acting Regional Office Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 28, 2005

From: Acting Director, VA Regional Office Honolulu, Hawaii

Subj: Combined Assessment Program Review of the VA Regional Office Honolulu, Hawaii

To: Western Area Director (20F4)

Enclosed is the Honolulu Regional Office's response to the Combined Assessment Program (CAP) Review Draft Report, dated September 19, 2005. This office concurs with each of the recommendations for our station. Attached is our implementation plan, which includes specific planned corrective actions and target completion dates.

We appreciate the review conducted by the audit team. They were professional and very thorough in their work. Their findings, and our corrective actions, should significantly improve the delivery of benefits and services to the veterans in Hawaii and the Pacific Rim.

(original signed by:)
James A. Carilli
Acting Director, Honolulu Regional Office

VA Regional Office Honolulu

Response to the Office of Inspector General Combined Assessment Report

Comments and Implementation Plan

1. Post-Traumatic Stress Disorder Claim Development – Adequate Medical Evidence Should Be Obtained and Stressors Confirmed

Recommendation 1. We recommend that the Western Area Director ensure that the Regional Office Director requires VSC management to strengthen PTSD claim development practices by: (a) obtaining adequate medical evidence, (b) ensuring that medical evidence links symptoms to stressors, (c) making claim folders available to medical examiners, and (d) confirming combat-related stressors.

Concur with recommended improvement actions

a. Obtaining adequate medical evidence:

Planned Action: VSC employees involved in the development of claims subsequently attended the **September 13, 2005** national broadcast training titled "Post Traumatic Stress Disorder (PTSD) Development," which clarified evidence requirements for PTSD claims.

b. Ensuring that medical evidence links symptoms to stressors:

Planned Action: VSC employees involved in the development of claims subsequently attended the **September 13, 2005** national broadcast training titled "Post Traumatic Stress Disorder (PTSD) Development," which clarified evidence requirements for PTSD claims.

c. Making claim folders available to medical examiners:

Planned Action: VSC employees involved in requesting PTSD examinations received refresher training on **September 21, 2005**. They were reminded of the station policy to deliver claims folders to the outgoing carts (which are subsequently taken to the local VAMC) for claims involving service-connection of PTSD in Hawaii. For those claims in Guam, the staff was reminded not to send

claims folders, but rather to make copies of any relevant records to be sent and reviewed by examiners. This special procedure is a result of a history of lost and delayed folders at the Guam CBOC.

d. Confirming combat-related stressors:

Planned Action: VSC employees involved in the development of claims subsequently attended the **September 13, 2005** national broadcast training titled "Post Traumatic Stress Disorder (PTSD) Development," which clarified evidence requirements for PTSD claims.

2. Incarcerated Veterans – Controls Over Benefit Payments Should Be Strengthened

Recommendation 2. We recommend that the Western Area Director ensure that the Regional Office Director requires VSC management to (a) recover overpayments made to the three incarcerated veterans identified by our review and (b) implement procedures to better track incarcerated veteran cases until the appropriate benefit adjustments are made.

Concur with recommended improvement actions

a. Recover overpayments made to the three incarcerated veterans identified by our review:

Planned Action: VSC initiated due process on **August 26, 2005** for two cases in question. Once due process has expired on these two cases, we will take appropriate coding actions to create overpayments in BDN. VSC initiated due process for the third incarcerated veteran on **September 20, 2005**. This veteran has already been released and we will begin recouping the overpayment once his due process period has expired.

b. Implement procedures to better track incarcerated veteran cases until the appropriate benefit adjustments are made:

Planned Action: Effective **September 1, 2005**, the Post-Determination Coach conducts the initial review of each incarcerated veteran case, and contacts the prison to determine the veteran's incarceration status. If the veteran has been convicted of a felony, the case is referred to the Post-Determination Team to initiate due process. If we receive a reply that the veteran is incarcerated as a pre-trial felon, but is not yet convicted, the Post-Determination Coach manually tracks that case on a monthly basis until the veteran is either convicted or released.

3. Hospital Adjustments – Benefit Payments for Hospitalized Veterans Should Be Reduced

Recommendation 3. We recommend that the Western Area Director ensure that the Regional Office Director requires VSC management to (a) recover overpayments made to the veteran identified by our review and (b) coordinate with VA Pacific Islands Health Care System staff to ensure that the VSC is notified when veterans are hospitalized.

Concur with recommended improvement actions

a. Recover overpayments made to the veteran identified by our review:

Planned Action: Due process was initiated on **August 26, 2005** for the veteran.

b. Coordinate with VA Pacific Islands Health Care System staff to ensure that the VSC is notified when veterans are hospitalized.

Planned Action: On **September 23, 2005**, the Regional Office reminded the Pacific Islands Health Care System of its requirement to notify the VSC when veterans are hospitalized. Earlier, on **September 2, 2005**, the Pacific Islands Health Care System's Program Analyst agreed to submit a separate quarterly report to VSC showing hospital admissions within the System. Upon receipt, this report will be reviewed by VSC for reconciliation and appropriate adjustment.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds
2	Recover overpayments to three incarcerated veterans.	$4,790
3	Recover overpayments to a veteran who was hospitalized at Government expense for an extended period.	1,116
	Total	$5,906

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Claire McDonald (206) 220-6654
Acknowledgments	Gary Abe Randall Alley Theresa Kwiecinski Lisa Marie Mantione Thomas Phillips Walter Stucky Orlando Velásquez Kent Wrathall

Appendix E

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