Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Regional Office Portland, Oregon

Report No. 05-02926-64 **January 30, 2006**

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 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 September 19–23, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Regional Office Portland, OR. 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 benefits claims processing and financial and administrative controls. We also provided fraud and integrity awareness training to 111 regional office employees.

Results of Review

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

- Automated Information Systems Security
- Benefits Delivery Network (BDN) Security
- Convenience Checks
- Employee Claim Folder Security
- Incarcerated Veterans
- Large Retroactive Payment Controls

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

- Improve management controls over fiduciary bonding, field examinations, and fiduciary estate accountings.
- Improve timeliness of processing system error messages.
- Strengthen controls over the compensation and pension (C&P) benefits death match.
- Reduce benefit payments for veterans hospitalized at Government expense for extended periods.
- Strengthen post-traumatic stress disorder (PTSD) claim development practices.
- Ensure purchase cardholders have proper warrant authority.

This report was prepared under the direction of Ms. Claire McDonald, Director, and Mr. Gary Abe, CAP Review Coordinator, Seattle Audit Operations Division.

Western Area and Regional Office Director Comments

The Western Area and Regional Office Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 11–17, for the full text of the Directors' comments.) VBA C&P Service also reviewed the six PTSD cases we identified as containing development deficiencies and agreed with our conclusions. We will follow up on the implementation of recommended improvement actions.

(original signed by:)

JON A. WOODITCH
Deputy Inspector General

Introduction

Regional Office Profile

Organization. The regional office provides C&P and Vocational Rehabilitation and Employment (VR&E) benefits to veterans, dependents, and survivors residing in Oregon and five adjacent counties in Washington. The estimated veteran population served by the regional office is 365,600.

Resources. In fiscal year (FY) 2004, regional office operating expenditures were about $11.7 million. As of August 2005, the regional office had 146 full-time equivalent employees.

Workload. In FY 2004, C&P benefits of $495.2 million were paid to 49,307 beneficiaries, and VR&E benefits of $3.2 million were paid to 2,415 beneficiaries. As of August 31, 2005, the Fiduciary and Field Examinations (F&FE) activity provided oversight for 2,001 active fiduciary cases with estate values totaling $60.3 million.

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

The review covered regional office operations for FYs 2003, 2004, and 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 3–10). 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.

Results of Review

Opportunities for Improvement

Fiduciary and Field Examinations – Management Controls Should Be Improved

Conditions Needing Improvement. Veterans Service Center (VSC) management needed to ensure that the F&FE activity improved management controls over fiduciary bonding, field examinations, and fiduciary estate accountings. The purpose of the F&FE program is to protect the interests of minors and incompetent beneficiaries through effective estate supervision. To assess controls over the F&FE activity, we reviewed a sample of 15 of 2,001 Principle Guardianship Folders (PGF) and analyzed VBA and Fiduciary Beneficiary System reports.

Fiduciaries Were Not Adequately Bonded. F&FE staff needed to ensure that court-appointed fiduciaries were adequately bonded to protect the interests of beneficiaries. VA policy requires the bond amount cover the beneficiary's VA assets plus the anticipated annual VA benefit income. From the 15 PGFs, we reviewed the bonding of 5 fiduciaries responsible for the estates with the highest total assets (VA and other assets). Three (60 percent) were not sufficiently bonded. In one case, the beneficiary's VA assets were valued at $474,000, but the fiduciary was bonded for only $10,000. The F&FE activity supervisor agreed the bonding of fiduciaries had not been monitored appropriately.

Field Examinations Were Not Timely. Initial and follow-up field examinations were not timely. When beneficiaries are deemed incapable of managing their financial affairs, VA field examiners are required to conduct initial field examinations to assess the beneficiary's physical, mental, and living conditions. Initial field examinations should be performed within 45 days of a beneficiary incompetence notification. In addition, follow-up field examinations must be completed within 120 days of the 1-year anniversary and then every 1 to 3 years depending on the beneficiary's circumstances.

During the 11-month period October 2004 to August 2005, 43 percent of initial field examinations were not completed within 45 days of a beneficiary incompetence notification, and 29 percent of follow-up field examinations were not completed within 120 days of the 1-year anniversary. Our review of the 15 PGFs found that 2 (40 percent) of 5 initial field examinations were 11 and 21 days late, and 5 (50 percent) of 10 follow-up examinations were 120 to 299 days late.

Fiduciary Estate Accountings Were Not Controlled. F&FE staff did not notify fiduciaries when accountings were required and did not follow up when accountings were late. To protect an incompetent beneficiary's assets from fraud and unusual or questionable

expenses, VA Legal Instruments Examiners (LIEs) monitor and analyze fiduciaries' annual estate accountings that list beneficiary assets, income, and expenses. VA policy requires regional offices to notify fiduciaries in writing of the date accountings are due and verify that accountings are received. If an accounting is not submitted within 90 days of the required date, LIEs should refer the case to a field examiner, the OIG, or VA Regional Counsel.

Of the 15 PGFs we reviewed, 11 (73 percent) did not contain documentation that fiduciaries had been notified of required accountings. In addition, 10 (67 percent) PGFs had accountings that were late, ranging from 3 to 21 months. Of the 10 PGFs that had late accountings, none contained documentation that LIEs had taken follow-up actions or that the delinquent accounts had been reported to a field examiner, the OIG, or VA Regional Counsel. In addition, regional office records showed that as of August 2005, 100 (48 percent) of 208 required accountings were delinquent.

Recommendation 1. We recommended that the Western Area Director ensure that the Regional Office Director implements procedures to require that: (a) fiduciaries are adequately bonded to protect beneficiaries' assets; (b) field examinations are completed according to VBA timeliness standards; and (c) notifications are sent to fiduciaries requesting that estate accountings be submitted within 90 days of the required dates and LIEs refer delinquent cases to a field examiner, the OIG, or the VA Regional Counsel.

The Western Area Director and Regional Office Director agreed with the findings and recommendations and reported that as of November 30, 2005, regional office procedures were in place to ensure fiduciaries are adequately bonded and that by July 1, 2006, the regional office would be completing field examinations within VBA timeliness standards. In addition, since the CAP review, the regional office has sent follow-up letters to fiduciaries with delinquent accountings and has referred to field examiners the cases where fiduciaries failed to provide accountings. By March 31, 2006, the regional office plans to reduce the number of delinquent accountings to 15. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

System Error Messages – Messages Should Be Promptly Processed

Condition Needing Improvement. VSC management needed to improve the timeliness of processing C&P system error messages. The BDN system generates various system messages indicating that benefits adjustments or corrections to BDN records are necessary. When system error messages are received, VSC staff must review the messages and complete any necessary actions.

As of August 2005, the regional office had a backlog of 843 system messages dating from June 2004 through September 2005 that had not been reviewed or processed. VSC management stated that reviewing and processing system messages was given low priority because of other workload demands. To evaluate system message processing, we

reviewed a sample of 50 (45 percent) of 111 messages generated during August 2005. Of the 50 system messages and associated veteran claim folders reviewed, 5 (10 percent) veterans received overpayments totaling $9,372.

Recommendation 2. We recommended that the Western Area Director ensure that the Regional Office Director directs VSC management to: (a) recover overpayments made to the five veterans, (b) review and process the backlog of system messages, and (c) promptly review and process future system messages.

The Western Area Director and Regional Office Director agreed with the findings and recommendations and reported that in November 2005, actions were taken to recover overpayments made to the five veterans identified during our review and the backlog of system messages had been reviewed and processed. In addition, in October 2005, a Veteran Service Representative (VSR) was assigned to review and control all new system messages. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Compensation and Pension Benefits Death Match – Controls Should Be Strengthened

Conditions Needing Improvement. VSC management needed to strengthen management controls and pursue C&P benefit overpayments when there was a match between C&P master records and Social Security Administration (SSA) death records. The VA Hines Benefits Delivery Center (BDC) matches these records and reports possible veteran or spouse deaths to regional offices on a monthly basis. VSC staff are required to determine if there is any evidence that contradicts SSA's report that the beneficiary has died. If there is no contradictory evidence and no other dependents on the award, VSC staff should terminate C&P benefit payments and pursue the recovery of any overpayments.

As of August 2005, there was a backlog of 131 unreviewed death match reports, some dating as far back as November 2004. To evaluate controls over selected benefit payments, we reviewed BDN records and claim folders for all 52 beneficiaries who were listed on SSA death records as of June 2005. Benefit payments were appropriately terminated for 29 (56 percent) of the beneficiaries. However, we found problems with the benefit payments for the remaining 23 beneficiaries:

- Benefit payments for 5 (22 percent) of the 23 beneficiaries should have been terminated. The dates of death reported by SSA went as far back as March 7, 2004. We estimated that overpayments in these five cases through September 30, 2005, would be $27,405.

- Benefit payments for 18 (78 percent) of the 23 beneficiaries had been suspended and should have been reviewed for possible termination. Of the 18 cases, 14 (78 percent)

were in a suspended status because checks were returned to the Department of Treasury, which is a strong indicator that the payees are deceased. Two of these cases had been in suspense since December 1, 2002.

Recommendation 3. We recommended that the Western Area Director ensure that the Regional Office Director requires VSC staff to: (a) promptly process all SSA death match cases, (b) terminate the five running awards and pursue recovery of any benefit overpayments, and (c) review the cases currently in suspense and take appropriate action to continue the suspense or terminate the benefit payments.

The Western Area Director and Regional Office Director agreed with the findings and recommendations and reported that on October 1, 2005, the VSC began reviewing death match reports and completing all necessary actions. In addition, the five running awards have been reviewed by the regional office and corrective action has been taken. The regional office will review and take appropriate action on all the suspense cases identified during our review. The target completion date is December 5, 2005. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

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

Conditions Needing Improvement. VSC management needed to improve the processing of hospital adjustments. In certain situations, Federal law requires the reduction of C&P payments for veterans hospitalized at Government expense for extended periods. As of August 2005, there were 57 veterans under the jurisdiction of the regional office who had been hospitalized continuously for 90 days or more at VA contracted community nursing homes or the VA medical center in Portland, OR.

To determine if VSC staff had properly processed hospital adjustments, we reviewed BDN records, selected claim folders, and VA medical center admission records for all 57 veterans. Payments to 13 (23 percent) of 57 veterans required adjustments. Of the 13 veterans, the VSC did not properly process adjustments for 8 (62 percent). We identified three deficiencies, two of which resulted in overpayments of $74,841 to six veterans.

Evidence of Hospitalization Not In Claim Folders. For four veterans, the claim folders did not contain documentation of their hospitalizations, resulting in overpayments totaling $49,301. In order to promptly process hospital adjustments, the regional office obtains monthly admissions data for all veterans in their jurisdiction who are hospitalized at Government expense. Regional office officials reported that an employee did not correctly assess the admission information provided by the VA Medical Center Portland and discarded it without taking proper action.

Hospital Adjustments Not Timely. For two veterans, evidence of hospitalization had been in the claim folders for 8 months before the regional office made adjustments. One

veteran's folder contained VA medical records while the second veteran's folder had a report of contact from a VA field examiner. In both cases, the information revealed that the veterans were under contract nursing home care. The delays in processing this information resulted in overpayments totaling $25,540.

C&P Benefit Payments Reduced Without Notifying the Veteran. For two veterans, the regional office reduced their benefit payments without notifying them of their due process and appeal rights. VA policy does not allow VSC to reduce benefit payments without notifying the veteran of the decision and effective dates, their right to a hearing and representation, and the procedures and time limits to initiate an appeal.

Recommendation 4. We recommended that the Western Area Director ensure that the Regional Office Director requires VSC to: (a) recover overpayments made to the six veterans, (b) train staff on the use of hospital admission information to process hospital adjustments, (c) begin the adjustment process upon notification that veterans are hospitalized, and (d) notify veterans of their due process and appeal rights prior to reducing their benefit payments.

The Western Area Director and Regional Office Director agreed with the findings and recommendations and reported that by February 1, 2006, final action would be taken to recover overpayments made to the six veterans identified during our review and by December 31, 2005, all VSRs would receive training on the use of hospital admission information to process hospital adjustments. To ensure adjustments are processed promptly, monthly reviews of hospitalization reports will be performed and a VSR will process and monitor hospital adjustments weekly. In addition, on November 1, 2005, the regional office began to notify veterans who received erroneous benefit payments of their due process and appeal rights. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

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

Conditions Needing Improvement. VSC management needed to strengthen PTSD claim development practices by improving the process of confirming a stressor event and ensuring that adequate medical evidence is obtained. 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 connected benefits for PTSD when: (1) there is medical evidence establishing a 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 month of August 2005, the regional office made 68 original PTSD rating decisions. Of the 68 decisions, 28 were granted and 40 were denied service connection for PTSD. To determine if VSC staff had properly developed PTSD claims, we reviewed a sample of 30 claim folders (20 granted and 10 denied claims). Of the 30 claims, 6 (20 percent) were not properly developed. Of these six claims, three were granted and three were denied. We identified the following two claim development deficiencies.

Combat Stressors Not Adequately Confirmed. Before granting a combat-related PTSD claim, VSC staff should obtain credible supporting evidence to confirm the claimed stressor. Conversely, before denying a combat-related PTSD claim, VSC staff should make reasonable efforts to obtain evidence that may confirm the claimed stressor. Sources of credible supporting evidence for combat-related stressors include the veteran's medical, personnel, and unit service records. If the veteran received certain VBA-recognized combat awards, such as the Purple Heart or the Combat Action Badge, the veteran's claimed combat stressors should be conceded.

For two granted claims, VSC staff did not adequately confirm the claimed combat-related stressors. In addition, for two denied claims, VSC staff did not attempt to obtain evidence that may have confirmed the claimed stressors. These deficiencies are illustrated by the following two examples:

> **Granted Claim.** The Army veteran served in Vietnam with the Military Occupation Specialty (MOS) of helicopter repairman. The veteran's claimed stressors included wounding and killing enemy soldiers and being exposed to several mortar attacks. VSC staff did not confirm any of the veteran's claimed stressors. Instead, they conceded the veteran's stressors based on his receipt of the Air Medal for meritorious service. However, unless the Air Medal is awarded for valor, VBA does not recognize it as a combat award. VSC staff should have confirmed the claimed stressors before granting service connection for PTSD.
>
> **Denied Claim.** The Army veteran served in Vietnam as an engineering equipment repairman. His claimed stressor was that in June 1966, while serving in Vietnam, he experienced mortar attacks. Without making reasonable attempts to confirm the claimed stressor, VSC staff denied the claim, stating in the rating decision that the regional office was "unable to verify the stressors." However, before denying the veteran's claim, VSC staff should have attempted to confirm the mortar attacks by obtaining his unit service records.

Adequate Medical Evidence Not Obtained. Before granting a PTSD claim, VSC staff must obtain medical evidence of a PTSD diagnosis. If the medical evidence of a PTSD diagnosis is insufficient, before granting or denying the claim, VSC staff should request a

PTSD C&P examination. For one granted claim, VSC staff did not obtain sufficient medical evidence of a PTSD diagnosis. In addition, for one denied claim, VSC staff did not attempt to obtain sufficient evidence of a PTSD diagnosis by requesting a C&P examination.

> **Granted Claim.** The Army veteran served in Vietnam with the MOS of field artillery unit commander. In June 2005, a C&P examination found that the veteran did not meet the criteria for a PTSD diagnosis. In an August 2005 rating decision, VSC staff acknowledged that the veteran did not meet the criteria. However, instead of requesting clarification from the C&P examiner or denying the claim, VSC staff granted service connection for PTSD.
>
> **Denied Claim.** The Army veteran served in Germany from February 1955 to February 1959 as an armored tank driver. In a February 2003 rating decision, VSC staff granted the veteran service connection for residuals of cold weather injury (frostbite) based on his claim of being stranded in an armored tank in extreme weather for a week. In March 2004, the veteran claimed service connection for PTSD based on the same incident. In June 2004, the veteran was diagnosed with PTSD by a non-VA examiner. In an August 2005 rating decision, VSC staff denied the veteran's claim because there "was no medical evidence giving a diagnosis of PTSD" and the stressor "being stranded in a cold tank for a week, cannot be verified." Instead of denying the claim prematurely, VSC staff should have attempted to confirm the incident by obtaining the veteran's unit service records. If VSC staff had obtained the unit service records and they had confirmed the claimed stressors, VSC staff should have then requested a PTSD C&P examination. Additionally, if the examination had resulted in a PTSD diagnosis, VSC staff should have granted the claim.

Recommendation 5. We recommended that the Western Area Director ensure that the Regional Office Director requires VSC management to strengthen PTSD claim development practices by making adequate efforts to (a) confirm combat-related stressors and (b) obtain medical evidence of PTSD diagnoses.

The Western Area Director and Regional Office Director agreed with the findings and recommendations and reported that during the week of December 12, 2005, all VSRs would receive training on the confirmation of combat-related stressors. In addition, the regional office will work closely with VA medical facilities to obtain adequate medical evidence of PTSD diagnoses. VBA C&P Service also reviewed the six PTSD cases we identified as containing development deficiencies and agreed with our conclusions. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Government Purchase Card Program – Cardholders Should Have Proper Warrant Authority

Condition Needing Improvement. Regional office management needed to ensure that cardholders have proper warrant authorities. To make purchases up to $2,500, cardholders are required to complete basic Government Purchase Card training. To make purchases above $2,500, cardholders must receive additional procurement training and be issued a warrant with a specific dollar limit that the cardholder cannot exceed for single purchases.

During FYs 2004 and 2005, 7 cardholders made 1,172 purchases totaling $946,681. Our review of a sample of 40 purchase card transactions found that all the purchases were made for valid purposes. However, one cardholder did not have a warrant to make purchases above the $2,500 limit. For the period of our review, the cardholder made eight purchases above the limit (ranging $2,736 to $5,850). Without a warrant, the cardholder did not have authority to commit the Government to these purchases.

Recommendation 6. We recommended that the Western Area Director ensure that the Regional Office Director takes action to provide proper training and warrants to cardholders who make purchases exceeding the $2,500 limit.

The Western Area Director and Regional Office Director agreed with the findings and recommendations and reported that by January 31, 2006, cardholders would receive annual training. In addition, effective September 26, 2005, all non-VR&E purchases above $2,500 will be obligated and paid through Centralized Accounting instead of using the Government purchase card. Warrants for VR&E purchase cardholders have been in place since October 1, 2004. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Appendix A

Western Area Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 23, 2005

From: Western Area Director

Subject: Combined Assessment Program Review of the VA Regional Office Portland, Oregon

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

I reviewed the Draft Report of the CAP review for the VA Regional Office in Portland, Oregon. As the Western Area Director, I appreciate the information provided by your report.

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.

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

Regional Office Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 21, 2005

From: Director, VA Regional Office (348/00)

Subject: Combined Assessment Program Review of the VA Regional Office Portland, Oregon

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

1. I reviewed the Draft Report of the CAP review for the VA Regional Office in Portland, Oregon. As the Regional Office Director, I appreciate the information provided by your report.

2. Attached is the Regional Office's response to the OIG CAP Site Review.

3. I appreciate the courtesy and cooperativeness displayed by you and all members of the IG Team throughout this review process.

4. If you have any questions, please contact me at (503) 326-2515.

(Original signed by)
Gerard F. Lorang
Director

Attachment

Portland Regional Office

Response to the Office of Inspector General Combined Assessment Report

Comments and Implementation Plan

1. Fiduciary and Field Examinations – Management Controls Should Be Improved

Recommendation 1. We recommend that the Western Area Director ensure that the Regional Office Director implements procedures to require that: (a) fiduciaries are adequately bonded to protect beneficiaries' assets; (b) field examinations are completed according to VBA timeliness standards; and (c) notifications are sent to fiduciaries requesting that estate accountings be submitted within 90 days of the required date and LIEs refer delinquent cases to a field examiner, the OIG, or the VA Regional Counsel.

Concur with recommended improvement actions

a. Fiduciaries are adequately bonded to protect beneficiaries' assets

Planned Action: Implement additional training for Legal Instrument Examiners (LIEs). Procedures requiring personal surety bonds to be reviewed to ensure its ability to meet the estate's liability as required by M21-1MR, Part XI, 3.E.25.b will be in place by **November 30, 2005.** Procedures to determine the delivery of the PGFs, the expected time that Regional Council will have to review the file, and when it will be returned will be part of the procedures worked out with Regional Council. In October 2005, the LIEs were trained that on each accounting, the bond must be reviewed for adequacy. The current cases, totally approximately 600 will be audited when the accountings come due over the course of the next year or as the need arises.

b. Field examinations are completed within VBA timeliness standards

Planned Action: We expect to meet our timeliness goals for initial appointments by **March 1, 2006**. It is expected we will meet our timeliness targets for our Fiduciary Beneficiary by **July 1, 2006**.

c. Notifications are sent to fiduciaries requesting that estate accountings be submitted within 90 days of the required date and LIEs refer delinquent cases to a field examiner, the OIG, or the VA Regional Counsel

Planned Action: Since the CAP Review, improvements have been made in the accountings. On October 31, 2005, 122 accountings were pending with 99 past timeliness standards. On November 14, 2005, 100 accountings were pending with 64 past timeliness standards. Follow-up letters have been sent to fiduciaries with past due accountings and cases are referred to field examiners when fiduciaries have failed to provide accountings. Regional Counsel was contacted November 8, 2005 and is ready to assist in cases that cannot be resolved. In October 2005, LIEs were notified to submit cases suspected of fraud to the OIG. Weekly monitoring and reporting to the Regional Office Director has been established to ensure continued improvement. It is expected that our accountings past due list will be reduced to 60 by the end of **December, 2005**, to 45 by the end of **January 2006**, and 30 by the end of **February 2006**, and 15 by the end of **March 2006**.

2. System Error Messages – Messages Should Be Promptly Processed

Recommendation 2. We recommend that the Western Area Director ensure that the Regional Office Director directs VSC management to: (a) recover overpayments made to the five veterans, (b) review and process the backlog of system messages, and (c) promptly review and process future system messages.

Concur with recommended improvement actions

a. Recover overpayments made to the five veterans

Planned Action: We reviewed the overpayments and completed corrective actions on October 14, 2005 to include recovery of the overpayment.

b. Review and process the backlog of system messages:

Planned Action: Of the original 843 system error write outs that were discovered on station at the time of the OIG review, 99 remain to be completed. This will be done by **November 30, 2005.**

c. Promptly review and process future system messages

Planned Action: Beginning in October 2005, a Veterans Service Representative (VSR) was designated to control and review all system error messages upon arrival on station.

3. Compensation and Pension Benefits Death Match – Control Should Be Strengthened

Recommendation 3. We recommend that the Western Area Director ensure that the Regional Office Director requires VSC staff to: (a) promptly process all SSA death match cases, (b) terminate the five running awards and pursue

recovery of any benefit overpayments, and (c) review the cases currently in suspense and take appropriate action to continue the suspense or terminate the benefit payments.

Concur with recommended improvement actions

a. Promptly process all SSA death match cases

Planned Action: Beginning October 1, 2005, a VSR was designated to review and take necessary action as the SSA death match reports arrive on station.

b. Terminate the five running awards and pursue recovery of any benefits overpayments

Planned Action: All cases identified during the OIG review as overpayments have been reviewed and corrective action taken.

c. Review the cases currently in suspense and take appropriate action to continue the suspense or terminate the benefit payments

Planned Action: Cases in suspense during the OIG review have been reviewed and appropriate action taken. Of the 131 un-reviewed death match reports found during the OIG review, 34 remain to be reviewed. Of the reports dating September 2005 to present, 24 cases remain to be reviewed. The remaining cases will be reviewed and completed by **December 5, 2005**.

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

Recommendation 4. We recommend that the Western Area Director ensure that the Regional Office Director requires VSC to: (a) recover overpayments made to the six veterans, (b) train staff on the use of hospital admission information to process hospital adjustments, (c) begin the adjustment process upon notification that veterans are hospitalized, and (d) notify veterans of their due process and appeal rights prior to reducing their benefit payments.

Concur with recommended improvement actions

a. Recover overpayments made to the six veterans

Planned Action: The six cases where the appropriate adjustments had not been made were placed under control on November 8, 2005, due process notification sent, and will be final action will be taken on **February 1, 2006.**

b. Train staff on the use of hospital admission information to process hospital adjustments

Planned Action: All VSRs on the Post Determination team will be trained on the use of hospital admission information to process hospital adjustments, to include notification of due process and appeal rights prior to reducing benefit payments. The two cases where due process was not appropriately provided are being used as training cases. Training of all VSRs will be conducted by **December 31, 2005**

c. Begin the adjustment process upon notification that veterans are hospitalized:

Planned Action: Monthly review will ensure that the proper actions are implemented and that the reductions are proposed in a timely manner. A single VSR will process hospital adjustments to ensure continuity and EP135s will be monitored weekly.

d. Notify veterans of their due process and appeal rights prior to reducing their benefit payments

Planned Action: This topic will be addressed during the VSR training to be completed by **December 31, 2005**. For the cases found in error, veterans were properly notified of their due process and appeal rights beginning **November 1, 2005**.

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

Recommendation 5. We recommend that the Western Area Director ensure that the Regional Office Director requires VSC management to strengthen PTSD claim development practices by making adequate efforts to (a) confirm combat-related stressors and (b) obtain medical evidence of PTSD diagnoses.

Concur with recommended improvement actions

a. Confirm combat-related stressors

Planned Action: Trainee VSRs received training during Centralized VSR training in September 2005. All VSRs are scheduled to undergo training during the week of **December 12, 2005.** Lessons learned during this station's part of the national 2100 PTSD Case Review will be shared with VSRs during this training. Currently, Portland has a 92% accuracy on rating claims, which shows improvement from the time of the OIG review.

b. Obtain medical evidence of PTSD diagnoses

Planned Action: We continue to work closely with the VA medical facilities to ensure all necessary factors are included in PTSD examinations.

6. Government Purchase Card Program – Cardholders Should Have Proper Warrant Authority

Recommendation 6. We recommend that the Western Area Director ensure that the Regional Office Director takes action to provide proper training and warrants to cardholders who make purchases exceeding the $2,500 limit.

Concur with recommended improvement actions

a. Provide proper training and warrants to cardholders who make purchases exceeding the $2,500 limit

Planned Action: Implement local guidance instructing purchase cardholders of purchase procedures by **November 30, 2005.** Conduct annual training for purchase cardholders no later than **January 31, 2006.** Warrants for Vocational Rehabilitation and Employment purchase cardholders have been correctly in place since October 1, 2004; other divisions' purchases requiring $2,500 or above will be obligated and paid through Centralized Accounting instead of using a government purchase card. Purchase cardholders were informed of this change September 26, 2005.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds
2	Pursue recovery of system error overpayments.	$ 9,372
3	Pursue recovery of death match overpayments.	27,405
4	Pursue recovery of hospital adjustment overpayments.	74,841
	Total	$111,618

Appendix D

OIG Contact and Staff Acknowledgments

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Appendix E

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