VA OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDITS & EVALUATIONS

# *Inspection of VA Regional Office Nashville, TN*

**September 29, 2009**
**09-01664-231**

# Office of Inspector General

# Benefits Inspection Program

The Benefits Inspection Program is part of the Office of Inspector General's (OIG's) efforts to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Division contributes to the improvement and management of benefits processing activities and veteran services by conducting onsite inspections at 57 VA Regional Offices (VAROs). The purpose of these independent inspections is to provide recurring oversight of VAROs by focusing on disability compensation claims processing and performance of Veterans Service Center (VSCs) operations. The objectives of the inspections are to:

- Evaluate how well VAROs and VSCs are accomplishing their missions of providing veterans with convenient access to high quality benefit services.
- Determine if management controls ensure compliance with VA regulations and policies; assist management in achieving program goals; and minimize risk of fraud, waste, and other abuses.
- Identify and report systemic trends in VSC operations.

In addition to this standard coverage, inspections may examine issues or allegations referred by VA employees, members of Congress, or others.

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# Report Highlights: Inspection of VA Regional Office, Nashville, TN

## Why We Did This Review

The Benefits Inspection Program conducts on-site inspections at VA Regional Offices (VAROs) to review disability compensation claims processing and Veteran Service Center (VSC) operations. The inspection focused on VSC operations in five established areas of claims processing, data integrity, management controls, information security, and public contact.

## What We Found

The Nashville Regional Office met the requirements for processing benefit claims involving diabetes. The office also met all requirements in the areas of tracking claims folders, systematic analysis of operations, date stamp accountability, and accurately and timely handling congressional inquiries.

The VARO management team needs to provide additional management attention in processing claims identified as Haas cases, post-traumatic stress disorder, and traumatic brain injury. Management also needs to improve controls over the following areas: correction of errors identified by VBA's Systematic Technical Accuracy Reviews (STAR), implementation of the Claims Process Improvement model, safeguards over sensitive information, handling claims-related mail, responding to electronic inquiries, and fiduciary activities.

## What We Recommended

We recommended that the VARO provide refresher training on claims processing and improve management oversight and controls over operations.

## Agency Comments

The Director of the Nashville VARO concurred with all recommendations except for training Legal Instrument Examiners (LIEs). The Nashville RO provided training to LIEs during the course of our inspection. Our review looked at work performed before that training. Therefore, we consider the actions taken by management as responsive to our recommendation and will perform follow-up as required on all actions.

*(original signed by:)*

BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

# Results of Inspection

The inspection focused on 5 protocol areas examining 15 operational activities from July 1, 2008, through April 24, 2009. The VARO met selected standards in 5 activities; they did not meet all selected standards in 10 activities. The protocol areas and operational activities reviewed are described in Appendix A. We also made observations pertaining to issues that are not specifically required by policy but may affect benefits delivery or VARO performance.

## VARO Activities Needing Additional Management Attention

### *Disability Claims Processing*

We reviewed 106 (11 percent) of 979 completed Haas case,[1] post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and diabetes claims for which the VARO made a disability decision regarding these specified issues. The claims decisions were made during the period October 1, 2008, through March 31, 2009. The number of claims reviewed was determined by a random sample of completed claims processed during that time, except for Haas cases, which were selected from VBA's Veterans Service Network (VETSNET) Operations Reports (VOR).

Our analysis revealed errors in 20 (19 percent) of the 106 claims, but the Nashville VARO actually processed only 15 (75 percent) of those errors. The 5 remaining errors were attributable to work completed at other VAROs as part of VBA's efforts to broker claims and expedite the processing of claims decisions. Regardless of where claims decisions are processed, these errors negatively impact the delivery of benefits to veterans. For example, the 5 claims processed at other VAROs contained errors that impacted veteran's benefits. The following table reflects the errors by claim type and those errors impacting veteran's benefits:

**Table 1. Disability Claims Processing Errors**

| Claim Type | Claims Reviewed | Claims With Errors | Errors With Impact On Veteran Benefits |
|---|---|---|---|
| **Haas** | 16 | 8 | 7 |
| **PTSD** | 30 | 9 | 4 |
| **TBI** | 30 | 3 | 2 |
| **Diabetes** | 30 | 0 | 0 |
| **Total** | 106 | 20 | 13 |

[1]A Haas claim is a claim affected by a U.S. Court of Appeals for Veterans Claims decision in *Haas v. Nicholson*. Haas claims involve veterans who served in waters off Vietnam and did not set foot in Vietnam, potentially precluding those veterans from entitlement to presumption of exposure to herbicide agents, including Agent Orange. VA had put a stay of adjudication on these claims; however, VA lifted the stay in January 2009.

**1. VSC personnel made inaccurate disability decisions processing Haas, PTSD, and TBI claims.**

Haas Claims. Of the eight errors identified regarding processing Haas cases, seven impacted veterans' benefits and one error did not impact benefits. The following is a description of the seven errors that impacted the veterans' benefits.

- 3 claims—Veterans not granted service connection although evidence of record supported a grant of service connection.
- 3 claims—VARO staff did not properly develop evidence to support the veterans' claims.
- 1 claim—VARO staff incorrectly identified this claim as a Haas claim and the veteran was provided inaccurate appellate information.

The remaining error was procedural in nature as VARO staff improperly controlled this claim as a Haas case. The veteran's claim never met the criteria for consideration under this legislation.

PTSD Claims. Of the nine errors identified regarding processing of PTSD claims, four errors impacted veterans' and five errors did not impact the veterans' benefits. The following is a description of the four errors regarding processing PTSD claims that impacted the veterans' benefits:

- 3 claims—PTSD claims did not receive the appropriate disability evaluation based on medical evidence provided in the VA medical disability examination. One of these claims was brokered to another VARO for processing.
- 1 claim—VARO staff failed to address the issue of competency for a 100% service connected veteran. This claim was also brokered to another VARO for processing.

The remaining five errors were procedural in nature. For example, VARO staff recorded the incorrect dates of claim in the electronic record. These dates did not affect the veterans' benefits.

TBI Claims. Of the three errors identified regarding the processing of TBI claims, two impacted the veterans' benefits. The following is a description of errors regarding processing TBI claims that impacted the veterans' benefits:

- 2 claims—VA medical center staff provided the VARO inadequate examinations as all residual disabilities related to TBI were not reviewed.

The remaining error was procedural in nature. VARO staff recorded the incorrect date of claim in the electronic record. This date did not affect the veterans' benefits.

The processing errors for Haas, PTSD, and TBI claims occurred because VBA personnel did not follow VBA policies related to processing cases and some of the Rating Veteran Service Representatives (RVSRs) lacked sufficient experience to appropriately process these claims. A senior VSC official indicated approximately 50 percent of the RVSRs had less than 2 years experience. As a result, disability decisions were inaccurate and veterans were not always granted service connection or they received incorrect benefit payments. During the inspection fieldwork, we discussed each processing error with VSC managers who agreed with the identified errors.

**Recommendation 1.** We recommend the VA Regional Office Director provide refresher training emphasizing the correct procedures for processing Haas, PTSD, and TBI cases for Veteran Service Center personnel.

**Management Comment**

The VARO Director commented on the OIG's testing methodology, saying the sample size of 30 PTSD, 30 diabetes, 30 TBI, and 16 Haas claims was not adequate to make valid statistical projections because the OIG sample size changed from fieldwork to the draft report. The Director also said this sample would not portray an accurate representation of station performance. The Director concurred with the recommendation with qualification and provided the dates of completed refresher training. Although the VSC manager agreed with the cited errors on Haas and PTSD claims, the Director noted that several claims were completed at other VAROs and should not be considered an error committed by the Nashville VARO. The Director reiterated his concern about the OIG reviewing only 16 Haas claims and said that the review would not be indicative of overall accuracy in processing these types of claims. Finally, the Director agreed with the OIG's assessment of errors on TBI claims but said that the OIG applied inapplicable criteria to the TBI claims under review because the claims were processed before new guidance was promulgated in January 14, 2009.

**OIG Response**

The Director's comments on the OIG sampling methodology reflect unfamiliarity with OIG's statistical sampling procedures. The Director noted that our sample size changed from audit fieldwork to the report. We deleted some claims from our sample because decisions on PTSD, TBI, and diabetes in those claims did not occur within our scope timeframe and those results would not have provided an accurate review of the Nashville VARO. However, even a very small sample can be a valid statistical sample if that item is selected by truly random means, such as sample selection methodology used by the OIG. Our sample was adequate to project errors across the VARO had we chosen to do so, but in fact, we never reported anything other than the specific errors. The sample size we used enables us to capture sufficient information to identify and report systemic trends in VARO operations as we continue to perform inspections at other VAROs throughout the nation. Finally, we reviewed 100 percent of Haas claims completed

within our scope and available for review. Therefore, data sampling was not required and these 16 cases do more than just represent the VARO's performance on Haas cases during this period, they present the VARO's performance during the period October 2008 through December 2008, in its entirety.

We agree that other VAROs actually completed one Haas case and two of the four PTSD claims with errors. However, these errors negatively impacted the delivery of veterans' benefits and blaming other offices for errors provides little consolation to the affected veterans. The Director's comment on not counting these errors against the Nashville VARO is based upon methodology used by Systematic Technical Accuracy Review (STAR) quality assurance process used by VBA to assess claim rating accuracy.

In March 2009, the OIG issued a report titled *Audit of Veterans Benefits Administration Compensation Rating Accuracy and Consistency Reviews.*[2] We reported that the process does not provide a complete assessment of compensation claim rating accuracy, largely because VBA officials excluded brokered claims from STAR reviews. Our audit results found the accuracy rate of brokered claims was 69 percent. Our results also suggested that the national accuracy rate associated with brokered claims was 11 percent lower than our projection of VBA's accuracy rate for claims reviewed by STAR. In contrast, the audit report supported that the accuracy of brokered claims was 18 percent lower than the national accuracy VBA reported for the 12-month period ending February 2008 in VA's *FY 2008 Performance and Accountability Report*. Therefore, the OIG has chosen to report on the accuracy of brokered cases under the jurisdiction of offices selected for inspection.

The VARO Director noted that VBA Central Office issued significant changes in guidance regarding the processing of TBI claims from October 2008 through January 2009. The three TBI processing errors involved claims decided and processed prior to the October 23, 2008, change in criteria. As a result, the VARO should have separately evaluated all residual disabilities associated with TBI claims according to criteria in effect for these claims. Instead, VARO staff improperly combined residual disabilities to support one evaluation. The OIG inspection team applied the appropriate guidance to each claim based on the timing of the decisions under review. Inspection staff and VARO personnel discussed these errors and they agreed with our assessment. It is inconceivable that those personnel would concur if the OIG had misapplied criteria during our review.

## *Management Controls*

Management controls assessed during this inspection included a review of VARO date stamp accountability, completion of Systematic Analysis of Operations (SAOs),

[2]*Audit of Veterans Benefits Administration Compensation Rating Accuracy and Consistency Reviews* (Report # 08-02073-96), dated March 12, 2009.

correction of errors identified by the Systematic Technical Accuracy Review (STAR) staff, and rotation of employees within the Claims Process Improvement (CPI) business model.

VARO Nashville was compliant with current policy regarding the accountability and safeguarding of date stamps. We observed that the VARO properly maintained an accountability log for all manual date stamps and all date stamps were secured at the end of every business day. In addition, the VARO was compliant with completing the required annual SAOs to include reviewing the required operations and proposing corrective actions when necessary.

**2. VSC personnel failed to take appropriate action to correct VBA's Systematic Technical Accuracy Review (STAR) errors.** We examined the adequacy of the resolution of 16 errors identified by VBA's STAR program review related to claims processing at the VARO between July 1, 2008, and December 31, 2008. Our analysis revealed 2 (13 percent) of the 16 errors were not corrected as directed by the STAR review staff. These VARO errors did not affect veterans' benefits; however, they should have been corrected. Interviews with VARO management revealed these errors occurred due to a lack of oversight to ensure all corrective actions had been completed.

**Recommendation 2.** We recommend the VA Regional Office Director develop a plan to ensure timely corrective action is taken to address errors identified by the Veterans Benefits Administration Systematic Technical Accuracy Review (STAR).

**Management Comment**

The VARO Director concurred with the recommendation and had initiated action to revamp procedures on correcting STAR errors, as recommended during the December 2008 C&P Service Site Visit. Management has taken action to improve and streamline internal controls and ensure STAR errors are corrected timely.

**OIG Response**

Management comments and actions are responsive to the recommendation.

**3. VSC employees were not systematically rotated within the Claims Process Improvement (CPI) model.** VAROs currently use the CPI model as their work management system. VBA's CPI implementation plan states, "in order to maximize management flexibility to handle peak workloads, an orderly rotation plan must be developed." In addition, VBA's implementation plan provides a sample rotation plan indicating experienced Veteran Service Representatives (VSRs) will rotate from one specialized team to another specialized team at least once every 2 years.

VSC management stated no plan was in place to rotate employees. VARO employees were only rotated out of necessity, such as moving employees to other teams based on

workload requirements. Currently, the VSC management leaves experienced staff on the post determination team. This practice does not ensure VSRs maintain the full complement of skills needed to process veterans claims and the practice does not adhere to VBA's CPI implementation plan.

**Recommendation 3.** We recommend the VA Regional Office Director rotate Veteran Service Representatives within the Claims Process Improvement model to maintain their skills.

**Management Comment**

The VARO Director concurred with our recommendation with a qualification. The VARO Director said employees are rotated, resources are added, or workloads are shifted based on workload demand to adequately address all aspects of claims processing. VSC management contends this approach adequately complies with the CPI directive to rotate employees and ensures a higher-level of competence in all areas of the CPI model.

**OIG Response**

Management comments and actions are responsive to the recommendation. While management believed its approach is adequate to comply with the CPI model, our experience shows that a more objective, disciplined and systematic approach to rotating staffing resources would enable them to learn all aspects of claims processing and ensure a high-level of competency.

## *Information Security*

The OIG inspection team conducted random inspections of employee workstations and the VARO mailroom to determine if the VARO was compliant with VBA policies to safeguard veterans' personally identifiable information.

**4. The VARO needs to improve safeguards over veterans' personally identifiable information.** While performing random inspections of employee workstations, we found an unmarked shipping box located within a common area of the VSC. The box contained the following materials:

- Unique Deoxyribonucleic Acid (DNA) specimen pouches (14) each containing a sample of the veteran's DNA, name, and social security number (SSN).
- Laboratory glass vial (1) with a veteran's name and SSN.
- Unique dental X-rays (23) each containing the veteran's name and SSN.

Interviews with the VSC Senior Management and one supervisor revealed these items were associated with veterans' service treatment records. VARO employees would then remove these items from the treatment records and place them in the box for collection.

A Senior VSC Manager stated employees had been trained several years earlier to dispose of this type of information. However, the VBA policy letter providing this guidance was rescinded in March 1999.

The coach of Triage also revealed she had instructed employees to discontinue this practice several weeks prior to our inspection. However, the OIG inspection team discovered this process had continued after the coach's instruction to the employees. A Senior VSC Manager reported the Chief of Support Service would collect the box on a monthly basis to provide the contents to the local VA Medical Center for destruction. The Chief of Support Service confirmed this unwritten procedure but stated the process was discontinued in November 2008 because hospital staff no longer collected the items.

VARO management disclosed VBA does not have procedures prescribing a proper disposal method for this type of information. Furthermore, there were no local policies for employees to follow when disposing of such items. Although the inspection team could not confirm improper destruction of these materials, the lack of an established procedure increased the risk of improper destruction or retention of these materials and inadequate protection of the veteran's personal information. VBA's recently published policy on *Management of Veterans' and other Government Paper Records* does not clearly address proper disposition of medical information contained in veterans' service treatment records.

We additionally found personally identifiable information in training materials at two employees' desks that were not redacted, which does not follow VBA policy regarding management of paper records. At one desk, there were more than 20 pieces of information, including copies of previous claim documents and letters.

**Recommendation 4.** We recommend the VA Regional Office Director suspend the process of removing medical information from veterans' service records until a policy is created to ensure proper safeguarding of veterans' personally identifiable information.

**Management Comment**

The VARO Director concurred with our recommendation and said the Nashville RO always strives to protect the privacy of our veterans, but the wording used infers that the office does not protect PII information. The Director further noted that the OIG team found a closed box in a restricted area not accessible to the public, which contained X-rays, DNA packages, and a vial, which had all been removed in the course of routine reviews of Service Treatment Records (STRs). None of these materials were in clear view and no PII was violated. VBA policy guidance on the destruction of DNA material was rescinded in March 1999. VSC management has issued a directive to all employees to discontinue the practice of removing DNA material from veterans' service records until VBA issues guidance.

The Director further said that the RO has provided extensive training to all employees on safeguarding veterans' PII information, established a records management program, which includes conducting desk audits and proper shredding of ALL paper records, and prohibits the destruction of any veteran records without the prior approval of the Supervisor Division Records Manager and the station Records Manager Officer.

**OIG Response**

Management's comments and actions are responsive to the recommendation. However, we take exception to the Director's characterization of the circumstances surrounding our discovery of the box containing the DNA specimens. We actually found the box **opened** and located next to a trash can. In addition, VSC management informed the inspection team they could not locate the box temporarily and determined that personnel contracted to clean office carpets had moved the box. Therefore, we concluded the box, its contents, and the PII information associated with the medical records were at risk for inappropriate disposal and/or disclosure. The OIG issued a Management Advisory Memorandum to VBA's Under Secretary for Benefits recommending that VBA issue immediate guidance on the handling and storage of DNA specimens to all VAROs.

**5. The Triage team was not timely in picking up claims-related mail from the mailroom.** We identified four claims submitted by veterans in a mailroom distribution box that were over 30 days old and not entered into the electronic record to establish the claim. These claims were in a box designated for claims establishment; however, the coach of Triage reported it was their responsibility to pick up incoming mail from the mailroom and she was unaware of this distribution box or the mail it contained. Mailroom personnel stated VSC employees placed claims-related mail requiring entry in the electronic record by Triage in the distribution box, and the box was not intended to contain documents for mailroom distribution. The Triage coach took action to establish each claim in the electronic record during the inspection visit; however, the lack of obvious distribution locations in the mailroom did not ensure that claim information was processed in a timely manner.

**Recommendation 5.** We recommend the VA Regional Office Director ensures mail distribution points are clearly identified and managed to ensure timely processing of claim information within the Veterans Service Center.

**Management Comment**

The VARO Director concurred with our recommendation with qualification. The Director said this recommendation is a result of the OIG team finding a single mail slot placed on a high shelf in the Mailroom where the contents of the bin were not visible. The mail slot was established by the Triage Team a week before the OIG Site Visit and contained four pieces of mail. All four pieces were over 30 days old, but only one of the four pieces of mail required claims establishment. Two pieces of mail were received in

support of existing claims. The fourth piece of mail could not be associated with an existing claim due to the absence of adequate identifying information. VSC management removed the mail slot in question while the OIG audit team was on station.

**OIG Response**

Management action was responsive as the VSC took immediate action to address the mail slot when the inspection team notified management. Although the VARO Director minimizes this situation in his comments, the fact is that 3 veterans claims were unnecessarily delayed because their mail was misplaced at the VARO.

## *Public Contact*

The Public Contact team provides benefit information to veterans, beneficiaries, and congressional staff through several methods including email and correspondence. As part of the inspection, we reviewed congressional inquiries and VA's Inquiry Routing and Information System (IRIS). In addition, we inspected Fiduciary Program team activities that provide oversight to veterans who are unable to adequately handle their own funds.

VARO Nashville was compliant with VBA policy regarding the timely and accurate processing of congressional inquiries. This included processing congressional inquiries within VBA's 5-day standard.

**6. VARO staff are not consistently providing veterans with accurate and timely responses to electronic inquiries.** We selected 30 completed Inquiry Routing and Information System (IRIS) messages to determine if the VSC provided accurate and timely responses to veteran inquires. IRIS is VA's internet-based public message management system, and is one method used by VSCs to communicate with veterans. Each written correspondence provided to the veteran contains an e-mail address (https://iris.va.gov) that provides a method for veterans to send electronic inquiries to VA. Generally, the inquiries request information regarding the status of a pending claim.

Our analysis revealed 8 (27 percent) of the 30 inquiries did not follow VBA policy that requires accurate responses to be provided within 5 calendar days. Of the eight errors, four related to inaccurate responses and four exceeded the 5-day standard to respond.

The following is an example of an inaccurate response:

> *The veteran's daughter submitted an inquiry to determine if her father was entitled to assisted living care from VA. The VARO responded, "The Privacy Act/Freedom of Information Act does not permit us to provide information to third parties."*

The response should have included general benefit information to the veteran's daughter, as this is not a violation of the Privacy or Freedom of Information Act. VARO management concurred. The inspection team was informed these errors occurred because

of a staffing shortage and the VARO's review process (entailing a quality assessment of a small sample of IRIS responses) did not identify these errors.

**Recommendation 6.** We recommend the VA Regional Office Director develop and implement a plan to improve oversight of Inquiry Routing and Information System responses.

**Management Comment**

The VARO Director concurred with our recommendation with a qualification. The Director said based on the OIG review of 30 IRIS responses, the OIG audit team determined only 4 responses were untimely. The Director also implemented a plan to improve timeliness of these responses. The Public Contact Coach will monitor the timeliness of IRIS responses on a daily basis. Based on the OIG review of 30 IRIS responses, the Nashville RO determined only 1 response was inaccurate. This review shows the Nashville RO has a 97% accuracy rate for IRIS responses.

**OIG Response**

Management planned actions are responsive to the recommendation. However, the Director says that the OIG found **only** 4 responses to be untimely and seems to indicate that the Nashville VARO determined only 1 response was inaccurate. VBA's *Quality Control Standards and Procedures* require 90 percent of IRIS responses be completed within 5-days. Four untimely responses equate to a timeliness rate of 87 percent, therefore, the Nashville VARO is not meeting VBA's standard.

We are puzzled by the Director's comment on the accuracy of IRIS responses as this is the first indication that the Nashville VARO found only 1 response to be inaccurate. The inspection team discussed these responses with VARO personnel during the field visit and those managers agreed with the OIG assessment. Four errors equate to an 87 percent accuracy rate, not the 97 percent rate claimed by the Nashville Director.

**7. Controls over fiduciary activities need strengthening.** We reviewed 41 Principal Guardianship Folder (PGF) cases that were completed during March 1, 2009, through April 20, 2009.

The PGFs included the following type of fiduciary activities:

- Initial Appointments (IA)—IAs involved the qualification and appointment of a fiduciary to receive VA benefits on behalf of an incompetent beneficiary.

- Fiduciary Beneficiary (FB)—Follow-up field examinations involve the reassessment of incompetent veterans' needs and determines whether funds have been properly used and protected. The first FB must be completed within one year of the initial

appointment. Subsequent FB's are determined by the field examiner's assessment of the current status of the beneficiary and the fiduciary.

- Accountings—Fiduciary's written report of the management of a beneficiary's income and estate.

Our analysis revealed 19 (46 percent) of the 41 folders were not processed according to VBA policy. The following table reflects the number of errors by claim type (see Appendix C for a summary of the errors and relevant policy):

**Table 2. Fiduciary Processing Errors**

| Claim Type | Number Reviewed | Number in Error | Errors With Impact On Veterans' Benefits |
|---|---|---|---|
| **Initial Appointment (IA)** | 14 | 10 | 7 |
| **Fiduciary Beneficiary (FB)** | 13 | 4 | 1 |
| **Accountings** | 14 | 5 | 5 |
| **Total** | **41** | **19** | **13** |

Following is a description of errors that may impact the safeguarding of incompetent veterans' benefits:

### Initial Appointments (IA):

- 5 IAs—Fiduciary unit had no assurance funds were released to the claimant because the PGF did not contain required documentation showing when and if funds were actually released.
- 1 IA—Beneficiary was not afforded the maximum benefit under Medicaid provisions.
- 1 IA—Fiduciary unit had no assurance that a claim for additional benefits was adjudicated.

### Fiduciary Beneficiary (FB):

- 1 FB—Fiduciary unit lacked assurance that funds disbursed to the payee prior to the scheduled FB were spent on behalf of the beneficiary.

### Accountings:

- 3 Accountings—Fiduciary unit lacked documentation to support verification of beneficiaries fund controlled by the fiduciary.
- 2 Accountings—Fiduciaries were overpaid for services rendered. VBA policy states a Fiduciary's fee must not exceed 4 percent of the managed funds.

The Assistant Coach of Public Contact reported he had not fully trained his staff of Legal Instrument Examiners (LIEs), and these errors occurred because the LIEs have not received adequate training. In addition, the Assistant Coach revealed VBA has not conducted LIE training since 2006.

**Recommendation 7.** We recommend the VA Regional Office Director provide training to Legal Instrument Examiners emphasizing the correct procedures for processing Initial Appointments, Fiduciary Beneficiaries, and accountings.

**Management Comment**

The VARO Director non-concurred with our recommendation because the entire F&FE staff had received training during the week of the OIG Site Visit. Further, he said all Nashville LIEs have received the requisite 80 hours of training over the past fiscal years and participate in monthly training conference calls.

The Director also said the Nashville RO follows VBA policies and procedures where applicable and has developed local policies and procedures, which have proven to be very effective and timely. The Director indicated the Nashville RO Fiduciary and Field Examination (F&FE) staff is compliant with all national directives, and local procedures are permitted and accepted practices. The Director made the following comments on the specific issues identified in the OIG inspection report.

> Initial Appointments (IA). Of the 14 IA field exams reviewed, 10 errors were cited, 7 of which were said to have affected veterans' benefits. The OIG cited five errors because the PGF did not contain required documentation showing when and if funds were actually released and one error because the Fiduciary unit had no assurance that a claim for additional benefits had been adjudicated. The OIG noted F&FE must use a miscellaneous diary date in the Fiduciary Beneficiary System (FBS) to control for the release of these payments. While a miscellaneous diary could have been inserted into FBS to control for the release of the retroactive payment, there is no manual reference regarding miscellaneous diaries for the monitoring of award actions after the completion of the Form 21-555. Miscellaneous diaries for award actions are not inserted into FBS to follow up, but they are maintained by the F&FE Supervisor on a spreadsheet and checked every 30 days.
>
> The OIG also cited one error because a beneficiary was not afforded the maximum benefit under Medicaid provisions. The field examiner did not identify the widow as a Medicaid recipient. The field examiner stated he discussed the provisions of the effect of Medicaid if the widow entered into a nursing home and became Medicaid eligible. The beneficiary was not a Medicaid recipient.

Fiduciary Beneficiary (FB): Of the 13 FB field exams reviewed, four errors were cited, only one of which had an impact on veterans' benefits. The Nashville RO concurs on the one error but does not concur with the three FB errors which did not affect veterans' benefits. These were not substantive errors and had no bearing on benefit entitlement for the beneficiary.

Accountings. Of the 14 accountings reviewed during the OIG's visit, a total of five errors were cited, all of which were said to have impacted veterans' benefits. OIG cited four errors for the Fiduciary unit lacking documentation to support verification of beneficiaries' funds controlled by the fiduciary. In the cited cases, there is verification of the funds in the control of the payee. The four cited cases did verify the amount of funds on hand for the fiduciary; however, the date of verification was different (by a matter of days) from the end date of the accounting period. Per manual reference (M21-1, Part XI, 3 D b), minor discrepancies are not a reason to disallow an accounting if all other aspects of the accounting are complete and accurate. There were no discrepancies in the accounting balances and the accounting itself did not have any questionable entries or expenditures.

**OIG Response**

The VARO Director stated LIE's had received the requisite number of training hours over the past fiscal year. However, the fiduciary supervisor informed the inspection team that LIEs had not been fully trained in all aspects of their jobs and that he intended to give more training to LIEs because previous training focused on Field Examiners. We agree that the entire F&FE unit received training while the OIG team was on-site. However, the errors were associated with claims processed prior to completing this training. Although the Director did not concur with the recommendation, he has actually taken the recommended action. Therefore, we accept this action as a concurrence and will evaluate the effectiveness of the most recent training during a future follow-up site inspection.

The following OIG responses address each of the VARO Director's concerns regarding fiduciary errors:

- VARO Nashville disagreed with five IA errors stating no manual citation requires the Fiduciary Unit to track the release of retroactive payments (miscellaneous diary dates in FBS). However, the LIE Program Guide states "Always diary for follow-up when you request referrals to the VSC for action to change benefits or competency status." The LIE Program Guide also states "local methods for follow-up are acceptable; use of the FBS Miscellaneous Due Report is recommended for diaries. This will ensure that managers and other fiduciary personnel are aware as diary dates mature in the event that you are unavailable due to illness, vacation, or other absence." In a VBA Fiduciary teleconference held April 19, 2007, transcripts revealed, "local controls can be used, however, the PGF must have clear evidence of the diary to include the date

the diary comes due." The Assistant Coach of Public Contact used a locally created spreadsheet kept on a personal drive of his work computer to which no other staff had access. This spreadsheet had no entries indicating a future date (diary) to show when funds were to be released to the fiduciary. This spreadsheet, maintained outside official files and not accessible to other staff, clearly does not meet the requirement for PGF's to include clear evidence.

- VARO Nashville disagreed with one IA stating "the field examiner did not identify the widow as a Medicaid recipient." This is incorrect. The field examiner's written report stated "she is enrolled in the TN State Medicaid program for healthcare and medication." C&P policy states "if Medicaid is paying the expenses of nursing facility care, the facility qualifies as a "nursing facility". Therefore, the field examiners statement clearly identified the widow as a Medicaid recipient.
- VARO Nashville disagreed with one IA where the inspection team indicated the Fiduciary unit had no assurance that a claim for additional benefits had been adjudicated. The fiduciary unit was aware the beneficiary submitted a claim to the VSC for additional benefits but had no assurance the claim had been processed. The LIE Program Guide states "Always diary for follow-up when you request referrals to the VSC for action to change benefits." The LIE failed to properly track this action in FBS.
- VARO Nashville disagreed with three Accountings where the inspection team indicated there was a lack of documentation to support verification of beneficiaries' funds controlled by the fiduciary. C&P policy (M21-1 XI, Chapter 3, Section C 14(a)) states, "individual fiduciaries who are required to account, must furnish verification of VA and non-VA estate funds on deposit in banks and other financial institutions as of the ending date of the accounting period." In addition, the LIE Program Guide states "an acceptable verification of deposit must verify funds as of the ending date of the accounting." The PGFs reviewed did not contain evidence that the funds on deposit with the fiduciary were verified on the ending date of the accounting period. We do not consider this a minor discrepancy as even low dollar differences in accountings and verifying deposits could allow a dishonest fiduciary to manipulate accounting records. C&P policy further states, "38 U.S.C. 6107 makes clear VA's duty to perform timely analysis of accountings from fiduciaries. When a misuse determination has been made, VA's failure to timely analyze a fiduciary's accounting will be considered in determining whether VA was negligent in supervising the fiduciary." The manual citation provided by VARO Nashville applies to verifying mathematical accuracy on accountings, not the need to verify funds on deposit. The citation used by the inspection team applies to the verification of balance on deposit at the end of the accounting period.

**Recommendation 8.** We recommend the VA Regional Office Director take the appropriate action to recover the funds overpaid to Fiduciaries.

**Management Comment**

The VARO Director provided the following comment to our recommendation:

Nashville RO Response: Concur. Explanation: We will take appropriate action to recover overpaid funds.

**OIG Response**

We consider management actions to recover overpaid funds to Fiduciaries as responsive to our recommendation.

### *Data Integrity*

We assessed data integrity by reviewing VBA's Control of Veterans Records System (COVERS) to determine if the VARO is accurately tracking the location of veterans' claims folders. We reviewed claim folders to determine if the VARO is also complying with VBA policy regarding the correct establishment of date of claim in the electronic record. The date of claim is generally used to indicate when a document arrives at a specific VA facility. Also, VBA relies on an accurate date of claim to establish a key performance measure to determine the average days to complete a claim.

The Nashville VARO is following VBA and local policies governing the use of COVERS to track and identify claims. Our review of 30 claims folders revealed all were accurately entered into COVERS and the physical location of each folder was properly recorded.

**8. VARO staff established the incorrect date of claim**. We selected 30 disability claims to determine if the VSC established the correct date of claim in the electronic record. Our analysis revealed 3 (10 percent) of the 30 claims contained the incorrect date of claim. However, we saw no evidence indicating the incorrect dates of claim were established with intent to inappropriately improve VARO performance standards. VARO management corrected the deficiencies prior to completion of the site inspection.

## *Observations*

Observations pertain to issues that may affect benefits delivery or diminish VARO performance but are not specifically compliance-related issues. Several observations were noted during the on-site inspection:

- Workload Credit for Unfinished Claims. VARO Nashville took credit for completing fiduciary claims prior to all work associated with those claims being finished. VBA policy states "work should be completed as soon as practical." VARO management indicated the policy does not clearly outline a specific standard as to when the work credit should be taken or if all work associated with a fiduciary claim must be

completed prior to taking credit for completing the claim. For example, VARO Nashville took work credit for one claim, however, work continued on that claim for an additional 21 days.

Because the claims are ultimately completed, we did not find that the VARO was non-compliant with procedures regarding when work credit should be taken. However, we are providing this observation as a practice to be aware of because once the work credit has been taken, there is no control to ensure the completion of additional internal actions associated with fiduciary estate administration. Furthermore, senior VBA leadership does not receive accurate information relating to the actual time required to complete fiduciary claims.

- Brokered Claims. VBA has established a brokering plan that allows VAROs to send (broker) claims that are designated as ready-to-rate to other VAROs for processing. VAROs that broker claims typically do not have the rating capacity to complete such work in a specific time. VARO Nashville brokered 1,792 rating related claims to other VAROs for processing.

  In March 2009,[3] we reported that the STAR quality assurance process does not provide a complete assessment of compensation claim rating accuracy, partially because it excluded brokered claims from STAR reviews. The accuracy of brokered claims was 18 percent lower than the national accuracy VBA reported for the 12-month period ending February 2008 in *VA's FY 2008 Performance and Accountability* report. VBA agreed to establish procedures for reviewing quality of brokered claims in response to the audit recommendations. However, until those procedures are in place brokered claims do not receive the scrutiny of a quality assurance review. Therefore, the OIG will review brokered claims for errors and report those errors in the inspection reports for the VARO with jurisdiction of those claims.

- PTSD Evidence. We identified five PTSD claims that were denied because there was a lack of evidence to document the occurrence of a stressful event which is required to properly grant service connection for PTSD. VBA policy (M21-1MR Part IV, subpart ii, Chapter 1, section D 16 (a) & (b)) states a formal finding must be prepared by the Joint Service Records Research Center (JSRRC) Coordinator and approved by the Veterans Service Center Manager (VSCM) or his/her designee when there is a lack of sufficient information in the claims folder to document the occurrence of a stressful event.

  The JSRRC Coordinator correctly prepared the formal finding memorandum. However, neither the VSCM nor a designee other than the JSRRC Coordinator approved this formal finding. The VSCM stated his interpretation of the policy

[3] *Audit of Veterans Benefits Administration Compensation and Rating Accuracy and Consistency Reviews* (Report No. 08-02073-96, March 12, 2009.)

allows the JSSRC Coordinator to prepare and approve the finding. Although VARO management disagreed with these errors, it is our position the intent of this policy is to provide for separation of duties to ensure a thorough independent review of the evidence before a claim is denied for lack of a verifiable stressor. Lack of separation of duties by VARO management creates risk for potential errors to go undetected in this area.

**Management Comment on Observations**

The VARO Director concurred that STAR errors incurred by brokered sites should not be counted against the Nashville VARO. However, the VARO Director did not concur with our observation regarding the issue of separation of duties between the JSRRC Coordinators and the VSCM. The VARO Director stated the Nashville RO is in compliance with all manual provisions concerning JSRRC Coordinator duties, including separation of duties.

**OIG Response to Director's Comments for Observations**

Observations pertain to issues that may affect benefits delivery or diminish VARO performance but are not specifically compliance-related issues. The Director of VARO Nashville provided responses to our observations, although comments to observations are not required. However, we will address the Director's concerns.

Although the Director concurred that brokered errors should not count against the Nashville VARO, these errors negatively impact the delivery of benefits regardless of where the claims are processed. Veterans are concerned only with accurate and timely claims processing, not with which VARO processed their claim. The OIG has chosen not to use the same methodology as the STAR program which excludes brokered claims from accuracy reviews. Therefore, we report all errors found during inspection reviews, although we footnoted the errors we identified to indicate that other VARO's processed some of the claims found to have errors.

The VARO Director contends that Nashville is in compliance with all manual provisions concerning the separation of duties between the JSRRC Coordinator and the VSCM regarding completion of a formal finding verifying the lack of a stressful event to grant service connection for PTSD. VBA policy (M21-1MR Part IV, subpart ii, Chapter 1, D (16)) states the following action is to be completed by the JSRRC Coordinator:

> "The JSRRC coordinator will make a formal finding regarding the lack of sufficient information in the claims folder to document the occurrence of the stressful event(s) and the veteran's involvement in it."

The policy then describes the following requirement for a formal finding:

> "The formal finding must be approved by the Veterans Service Center Manager (VSCM) or his/her designee, should be on a separate page to be

> filed in the claims folder, should note the actions taken to obtain the required information, and that the information required to document the stressful event(s) is unavailable."

The VARO Director stated that formal findings of unavailability were co-signed by other JSRRC Coordinators. In our opinion, having coworkers sign off on determinations violates the separation of duties internal control principle. For the control to be effective, a supervisor outside the JSRRC should be approving the determination that evidence is not available to verify the claimed stressful event.

## VARO Profile

**Organization.** As of March 2009, the Nashville VARO is responsible for delivering non-medical VA benefits and services to veterans and their families in Tennessee and Fort Campbell Military Base in Kentucky. This is accomplished through the administration of Compensation and Pension Benefits (C&P), Vocational Rehabilitation and Employment (VR&E) Assistance, Burial Benefits, and Outreach activities. In addition, the Nashville VARO maintains several out-based offices throughout Tennessee that provide claims processing activities for Fiduciary Field Examiners, VR&E, and Benefits Delivery at Discharge (BDD).

Other VA programs and support services co-located with the VARO are Loan Guaranty (Home Loan), Education Services, and a Nashville Call Center. The call center provides services for Georgia, North Carolina, South Carolina, Virginia, West Virginia, Kentucky, Tennessee, and portions of Florida.

**Resources.** As of March 2009, the VARO had a staffing level of 363 Full-Time Employees (FTE). Of the 363 FTE, 260 (72 percent) were assigned to the VSC.

**Workload.** As of the 2nd quarter of FY 2009, the VARO had 8,175 pending C&P claims that took an average of 147.8 days to complete. Accuracy, as reported by VBA's STAR, for C&P rating and authorization related issues was 90.7 percent and 98.3 percent respectively. According to VBA, accuracy for fiduciary-related activities was 96.4 percent. As of April 2009, VARO Nashville brokered 1,792 rating claims to other VAROs to process.

## Scope of the Inspection

**Scope.** We reviewed select management controls, benefits claims processing, and administrative activities to evaluate if the VARO is following VBA policies as they relate to benefits delivery and non-medical services provided to veterans.

In performing the inspection, we interviewed managers and employees, reviewed veterans claim folders, and inspected work areas. We did not inspect any of the out-based offices or examine work processed at these locations. The disability claims processing review covered VARO operations from October 1, 2008, through March 31, 2009. STAR reviews covered cases reported as errors by STAR staff from July 1, 2008 through December 31, 2008. IRIS reviews covered veteran inquiries received at the VARO from October 1, 2008 to March 30, 2009. Fiduciary activities review covered cases completed from March 1, 2009, to April 20, 2009. The reviews were done in accordance with the President's Council for Integrity and Efficiency's *Quality Standards for Inspections.*

The inspection covered 15 operational activities in the 5 protocol areas of claims processing, data integrity, management controls, information security, and public contact, as detailed in Table 3 that follows:

**Table 3. Protocols With Activities Reviewed.**

| Inspection Protocols | | | | |
|---|---|---|---|---|
| **Claims Processing** | **Data Integrity** | **Management Controls** | **Information Security** | **Public Contact** |
| **15 Activities Reviewed** | | | | |
| **1. Haas Claims** | **5. Date of Claim** | **7. Systematic Analysis of Operations (SAO)** | **11. Mail Handling Procedures** | **13. Inquiry Routing and Information System (IRIS)** |
| **2. Post-traumatic Stress Disorder (PTSD) Claims** | **6. Control of Veterans Record System (COVERS)** | **8. Systematic Technical Accuracy Review (STAR) Compliance** | **12. Destruction of Documents** | **14. Congressional Inquiries** |
| **3. Traumatic Brain Injury (TBI) Claims** | | **9. Employee Rotation in Claims Process Improvement (CPI) Model** | | **15. Fiduciary** |
| **4. Diabetes Claims** | | **10. Date Stamp Accountability** | | |

**Department of Veterans Affairs**

# Memorandum

**Date:** September 2, 2009

**From:** Director, VA Regional Office

**Subj:** Benefits Inspection Division, OIG Visit

**To:** Assistant Inspector General for Audit (52)

1. Attached is the Nashville Regional Office revised response to the OIG Draft Report: Benefits Inspection Division, OIG Visit.

2. Questions may be referred to Shelley Mullins, Senior Management Analyst at (615) 695-6005.

*(original signed by:)*

Brian Corley

Attachment

**Appendix B**

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report: Inspection of VARO Nashville, TN.

The VA Office of the Inspector General (OIG) visited the Nashville Regional Office (RO) April 20, 2009, through April 24, 2009. This paper outlines the Nashville RO concerns regarding the visit.

Prior to this visit, the OIG informed the Nashville RO that they would review approximately 225 claims folders. While on-station, the OIG reviewed 267 cases, as documented in the OIG's "Inspection of VA Regional Office Nashville Exit Briefing," dated April 24, 2009. The draft report indicates a sample size of 177 cases.

The table below illustrates the difference between the sample size of cases reviewed while on-station compared to the number of cases cited in the OIG's draft report.

| Claim Type | OIG On-Station Review | | OIG Draft Report | | OIG Draft Report | |
|---|---|---|---|---|---|---|
| | Claims Reviewed | Errors | Claims Reviewed | Errors | Claims Brokered | Nashville Errors |
| Haas | 16 | 8 | 16 | 8 | 1 | 8 |
| PTSD | 60 | 31 | 30 | 9 | 4 | 5 |
| TBI | 60 | 8 | 30 | 3 | 0 | 3 |
| Diabetes | 60 | 2 | 30 | 0 | 0 | 0 |
| F&FE Initial Appointments (IA) | 14 | 11 | 14 | 10 | 0 | 10 |
| F&FE Fiduciary Beneficiary (FB) | 13 | 6 | 13 | 4 | 0 | 4 |
| F&FE Accountings | 14 | 5 | 14 | 5 | 0 | 5 |
| IRIS | 30 | 10 | 30 | 8 | 0 | 8 |
| **TOTALS** | **267** | **81** | **177** | **55** | **5** | **43** |

Nashville RO leadership is concerned that the OIG's decision to decrease the sample size may not have allowed for a statistically valid sample and will not portray an accurate representation of station performance.

**OIG Recommendation 1:** The VA Regional Office Director provide refresher training emphasizing the correct procedures for processing Haas, PTSD, and TBI cases for Veteran Service Center personnel.

**Nashville RO Response:** Concur, with qualification.

Refresher training on these topics was conducted on the following dates:

- 07-09-09, TBI training for all RVSRs and DROs.

- 07-16-09, PTSD training for all RVSRs and DROs.
- Haas TBD

Haas Claims: Of the sixteen Haas claims reviewed during the OIG's visit, a total of eight errors were cited. One of the eight errors did not have an impact on veterans' benefits. Of the remaining seven cases, one was completed at a brokered work site and should not be considered an error committed by the Nashville RO. Concur with the remaining errors. The RO has concerns that the review of only sixteen Haas Claims is not a valid sample size and is not indicative of overall accuracy in processing these types of claims.

PTSD Claims: Of the nine errors cited by OIG, only four affected veterans' benefits, two of which were completed at brokered sites. Concur with the remaining errors completed by the Nashville RO.

TBI Claims: Of the thirty TBI claims reviewed during the OIG's visit, a total of three errors were cited. The VSC refuted several of the errors which were initially called. As a result, OIG's draft report notes three errors.

Concur on these errors, however, these three cases were rated and promulgated well before significant changes occurred in the regulations governing how VBA rated TBI cases. The three cases in error were completed on the following dates: October 3, 2008, October 8, 2008, and November 3, 2008. OIG used current TBI criteria to audit claims rated by the Nashville RO prior to the latest instruction from VACO. The following guidance was issued by C&P service on TBI this fiscal year:

- 10/22/08—Availability of TBI Rating Demonstration Video on RBA 2000 and Rating Job Aids Page
- 10/24/08—Fast Letter 08-36 Final Rule: Schedule for Rating Disabilities; Evaluation of Residuals of TBI
- 10/29/08—TBI Examination Worksheet Updated
- 01/14/09—Fast Letter 09-02 TBI Outreach Letter (Rev. 2-18-09)
- 01/21/09—Training Letter 09-01, Evaluating Residuals of TBI under Revised Criteria

**OIG Recommendation 2:** The VA Regional Office Director develop a plan to ensure timely corrective action is taken to address errors identified by the Veterans Benefits Administration Systematic Technical Accuracy Review (STAR).

**Nashville RO Response:** Concur. The Nashville RO is already in the process of revamping procedures on correcting STAR errors, as recommended during the December 2008 C&P Service Site Visit. Management has taken action to improve and streamline internal controls and ensure STAR errors are corrected timely.

**OIG Recommendation 3:** The VA Regional Office Director rotate Veteran Service Representatives within the Claims Processing Improvement model to maintain their skills.

**Nashville RO Response:** Concur, with qualification.

Employees are rotated, resources are added, or workload is shifted to adequately address all aspects of claims processing, based on workload demand. VSC management contends this approach adequately complies with the CPI directive to rotate employees and ensures a high-level of competence in all areas of the claims processing model.

**OIG Recommendation 4:** The VA Regional Office Director suspend the process of removing medical information from veterans' service records until a policy is created to ensure proper safeguarding of veterans' personally identifiable information.

**Nashville RO Response:** Concur.

This recommendation is a result of the OIG team finding a closed box in a restricted area not accessible to the public which contained X-rays, DNA packages, and a vial which had all been removed in the course of routine reviews of Service Treatment Records (STRs). None of these materials were in clear view and no PII was violated. VBA policy guidance on the destruction of DNA material was rescinded in March 1999. VSC management has issued a directive to all employees to discontinue the practice of removing DNA material from veterans' service records until VBA issues guidance.

The Nashville RO always strives to protect the privacy of our veterans. The wording used infers we do not protect PII information. We have provided extensive training to all employees on safeguarding veterans' PII information. We have established a records management program which includes conducting desk audits and proper shredding of ALL paper records. We prohibit the destruction of any veteran records without the prior approval of the Supervisor Division Records Manager, and the station Records Manager Officer.

**OIG Recommendation 5:** The VA Regional Office Director ensures mail distribution points are clearly identified and managed to ensure timely processing of claim information within the Veterans Service Center.

**Nashville RO Response:** Concur, with qualification.

This recommendation is a result of the OIG team finding a single mail slot placed on a high shelf in the Mailroom where the contents of the bin were not visible. The mail slot was established by the Triage Team a week before the OIG Site Visit and contained four pieces of mail. All 4 pieces were over 30 days old, but only 1 of the 4 pieces of mail required claims establishment. Two pieces of mail were received in support of existing

claims. The fourth piece of mail could not be associated with an existing claim due to the absence of adequate identifying information.

VSC management has removed the mail slot in question. This task was completed while the OIG audit team was on-station. There were no other deficiencies noted by the audit team.

**OIG Recommendation 6:** The VA Regional Office Director develop a plan to improve oversight of Inquiry Routing and Information System responses.

**Nashville RO Response*:*** Concur, with qualification.

Based on the OIG review of 30 IRIS responses, the OIG audit team determined only 4 responses were untimely. We have already implemented a plan to improve our timeliness. The Public Contact Coach is monitoring the timeliness of IRIS responses on a daily basis.

Based on the OIG review of 30 IRIS responses, the Nashville RO determined only 1 response was inaccurate. This review shows the Nashville RO has a 97% accuracy rate for IRIS responses.

**OIG Recommendation 7:** The VA Regional Office Director provide training to Legal Instrument Examiners emphasizing the correct procedures for processing Initial Appointments, Fiduciary Beneficiaries, and accountings.

**Nashville RO Response:** Nonconcur.

The Nashville RO follows VBA policies and procedures where applicable and has developed local policies and procedures which have proven to be very effective and timely. The Nashville RO F&FE is compliant with all national directives, and our local procedures are permitted and accepted practices.

The OIG Draft Report states the Assistant Coach of Public Contact reported he had not fully trained his staff of Legal Instrument Examiners (LIEs) and these errors occurred because the LIEs have not received adequate training. All Nashville LIEs have received the requisite 80 hours of training over the past fiscal years. The LIEs participate in monthly training conference calls and the entire F&FE unit was on station for training during the week of the OIG Site Visit.

Initial Appointments (IA): Of the 14 IA field exams reviewed, 10 errors were cited, 7 of which were said to have affected veterans' benefits. The OIG cited 5 errors because the PGF did not contain required documentation showing when and if funds were actually released and 1 error because the Fiduciary unit had no assurance that a claim for additional benefits had been adjudicated. The OIG noted F&FE must use a

miscellaneous diary date in the Fiduciary Beneficiary System (FBS) to control for the release of these payments. While a miscellaneous diary could have been inserted into FBS to control for the release of the retroactive payment, there is no manual reference regarding miscellaneous diaries for the monitoring of award actions after the completion of the 21-555. Miscellaneous diaries for award actions are not inserted into FBS to follow up, but are maintained by the F&FE Supervisor on a spreadsheet and checked every 30 days.

The OIG also cited one error because a beneficiary was not afforded the maximum benefit under Medicaid provisions. The field examiner did not identify the widow as a Medicaid recipient. The field examiner stated he discussed the provisions of the effect of Medicaid if the widow entered into a nursing home and became Medicaid eligible. The beneficiary was not a Medicaid recipient.

Fiduciary Beneficiary (FB): Of the 13 FB field exams reviewed, 4 errors were cited, only 1 of which had an impact on veterans' benefits. The Nashville RO concurs on this 1 error, but does not concur with the 3 FB errors which did not affect veterans' benefits. These were not substantive errors and had no bearing on benefit entitlement for the beneficiary.

Accountings: Of the 14 accountings reviewed during the OIG's visit, a total of 5 errors were cited, all of which were said to have impacted veterans' benefits. OIG cited four errors for the Fiduciary unit lacking documentation to support verification of beneficiaries fund controlled by the fiduciary. In the cited cases, there is verification of the funds in the control of the payee. The four cited cases did verify the amount of funds on hand for the fiduciary; however, the date of verification was different (by a matter of days) from the end date of the accounting period. Per manual reference (M21-1, Part XI, 3 D b), minor discrepancies are not a reason to disallow an accounting if all other aspects of the accounting are complete and accurate. There were no discrepancies in the accounting balances and the accounting itself did not have any questionable entries or expenditures.

The OIG cited one case, alleging the fiduciary was overpaid for the services provided. The amount of funds garnished from VA fees by the fiduciary was not excessive. The fiduciary appointed in this case is a professional organization which collects fiduciary fees one month in arrears. This practice has never been questioned by the F&FE STAR staff and is not considered to be unclaimed fees as stated by the OIG in their response spreadsheet.

**OIG Recommendation 8:** OIG recommended the VA Regional Office Director take the appropriate action to recover the funds overpaid to Fiduciaries.

**Nashville RO Response:** Concur.

Explanation: We will take appropriate action to recover overpaid funds.

## Observation Responses

**Brokered Claims:** VBA's STAR quality process does not review brokered claims for quality assurance. Thus, VBA does not have a quality assurance program to review such work. During our review of claims processing, five of the claims were brokered to other ROs and all were in error. Therefore, those claims processed in error could not be attributed to the Nashville RO and would not have been identified by VBA. We plan to examine this issue further in future inspections of other ROs.

**Nashville RO Response:** Concur that STAR errors incurred by brokered sites should not be counted against the Nashville RO; however, all five brokered cases were cited as Nashville RO errors in the OIG Draft Report (one Haas case and four PTSD cases).

PTSD Evidence: The JSRRC Coordinator correctly prepared the formal finding memorandum. However, neither the VSCM nor a designee other than the JSRRC approved this formal finding. The VSCM stated his interpretation of the policy allows the JSSRC Coordinator to prepare and approve the finding. Although RO management disagreed with these errors, it is our position the intent of this policy is to provide for separation of duties to ensure a thorough independent review of the evidence before a claim is denied for lack of a verifiable stressor. Lack of separation of duties by RO management creates risk for potential errors to go undetected in this area.

**Nashville RO Response: Nonconcur.**

M21-1 MR IV.ii.1.D.16 notes a formal finding should be made by the JSRRC Coordinator and approved by the VSCM. All files reviewed by the OIG concerning this issue properly contained memos signed by JSRRC Coordinators, as designated by the VSCM, and were co-signed by a different JSRRC Coordinator, also as designated by the VSCM. The JSRRC Coordinators are the approved VSCM designees to sign these formal findings. Thus, Nashville RO is in compliance with all manual provisions concerning JSRRC Coordinator duties, including separation of duties.

**Appendix C**

# Inspection Summary

| 15 Activities Inspected | Criteria | Reasonable Assurance of Compliance | |
|---|---|---|---|
| | | Yes | No |
| **Claims Processing** | | | |
| 1. Haas | Determine if claims identified as a Haas claim were properly identified and if service connection was correctly granted or denied. (38 CFR 3.313) (M21-1MR Part IV, subpart ii, Chapter 1, Section H) ( Fast Letter 09-07 and 06-26) | | X |
| 2. Post-traumatic Stress Disorder (PTSD) | Determine whether service connection for PTSD was correctly granted or denied. (M21-1MR Part III, Subpart iv, Chapter 4, Section H.28.B) | | X |
| 3. Traumatic Brain Injury (TBI) | Determine whether service connection for TBI and all residual disabilities was correctly granted or denied. (Fast Letters 08-34 and 36, Training Letter 09-01) | | X |
| 4. Diabetes | Determine whether service connection for Diabetes related to herbicide exposure (Agent Orange) and all related disabilities were correctly granted or denied. (38 CFR 4.119) (Fast letter 02-33) (M21-1MR Part III, Subpart iv, Chapter 4, Section F) | X | |
| **Data Integrity** | | | |
| 5. Date of Claim | Determine if VAROS accurately record the correct date of claim in electronic records. (M21-1MR, Part III, Subpart ii, Chapter 1, Section C) | | X |
| 6. Control Of Veterans Records System (COVERS) | Determine if VAROs are complying with the use of COVERS to track claims folders. | X | |
| **Management Controls** | | | |
| 7. Systematic Analysis of Operations (SAO) | Determine if VAROs are performing a formal analysis of their operations through completion of SAOs. (M21-4, Chapter 5) | X | |
| 8. Systematic Technical Accuracy Review (STAR) | Determine if VAROs timely and accurately correct STAR errors. (M21-4, 3.03) | | X |
| 9. Date Stamp Accountability | To determine if VAROs are accounting and safeguarding date stamps. (M23-1 1.12, b. (1), (2), (3), (4)) (VBA Letter 20-09-10 Revised dated 3-19-09) | X | |
| 10. Claims Process Improvement (CPI) | Determine if VAROs are complying with VBA's CPI Implementation Plan 08-05. | | X |
| **Information Security** | | | |
| 11. Mail Handling Procedures | Determine if VAROs are complying with mail handling procedures. (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapter 1 & 4) | | X |
| 12. Destruction of Documents | Determine if VAROs are complying with VBA policy regarding proper destruction of documents. (VBA Letter 20-08-63 dated November 14, 2008) | | X |
| **Public Contact** | | | |
| 13. Inquiry Routing and Information System (IRIS) | Determine if IRIS responses are accurately and timely processed. (Fast Letter 06-10) | | X |
| 14. Congressional Inquiries | Determine if Congressional Inquiries are timely processed. (OFO Letter 201-02-60) (OFO Letter 201-02-64) (Fast Letter 01-40) (VA Directive 8100) | X | |
| 15. Fiduciary | Determine if the Fiduciary unit is properly overseeing the welfare of beneficiaries to include protecting their assets, assuring their benefit entitlement rights, and selecting and monitoring the best suited fiduciary. (38 CFR 13.100-13.111) ( M21-1MR, Part XI) (FBS Users Guide) (LIE Program Guide) | | X |

**Appendix D**

# OIG Contacts and Staff Acknowledgments

| | |
|---|---|
| OIG Contact | Brent Arronte (727) 395-2436 |
| Acknowledgments | Kristine Abramo<br>Brett Byrd<br>Robert Campbell<br>Danny Clay<br>Kelly Crawford<br>Maya Ferrandino<br>Karen Gooden<br>Kerri Leggiero-Yglesias<br>Lisa Van Haeren |

**Appendix E**

# Report Distribution

## VA Distribution

Office of the Secretary
Veterans Benefits Administration
Assistant Secretaries
Office of General Counsel
VBA Eastern Area Director
VARO Nashville Director

## Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Lamar Alexander, Bob Corker
U.S. House of Representatives: David Philip Roe, John J. Duncan, Zach Wamp, Lincoln Davis, Jim Cooper, Bart Gordon, Marsha W. Blackburn, John Tanner, Steve Cohen

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