DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS BENEFITS ADMINISTRATION

Little Rock VA Regional Office Employee Inaccurately Established and Decided Claims

Arkansas

REVIEW | REPORT #19-06757-70 | JANUARY 30, 2020

The mission of the Office of Inspector General is to serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs through independent audits, inspections, reviews, and investigations.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Executive Summary

The VA Office of Inspector General (OIG) conducted this review in response to an anonymous allegation that an employee at the Little Rock, Arkansas, VA Regional Office (VARO) established invalid claims for disability benefits and inaccurately decided claims, which resulted in payments that were not warranted. Four specific claims were identified in connection with the allegation. *Establishing* a claim occurs when a VA employee enters the claim into the electronic claims processing system. Employees who *decide* claims typically issue decisions that evaluate disabilities and grant or deny entitlement to compensation for service-connected diseases and injuries. The employee cited in the allegation was part of a group of specially qualified employees, called rating veterans service representatives, who are responsible for deciding claims. However, establishing claims was not part of the employee's job function.

The allegation also noted a possible conflict of interest for the employee who was establishing a nonprofit organization website with information about the VA disability claims process.

What the Review Found

The OIG substantiated the allegation that an employee of the Little Rock VARO established invalid claims and inaccurately decided claims for disability benefits. The review team assessed the four claims associated with the allegation. In addition, the team assessed 15 decisions completed by the employee that were associated with claims established by him as of March 8, 2019, for a total of 19 claims and decisions reviewed. The review team found 11 of the 19 claims and decisions reviewed were in error because required forms were not provided by veterans to establish a claim, the benefits granted in the decisions by the employee were not warranted, or both. As a result of the inaccurate decisions, the Veterans Benefits Administration (VBA) made nearly $311,000 in improper payments to beneficiaries. The review team did not find that the employee received any financial benefit from the inaccurate processing of claims.

The VARO director and the employee's managers noted they were not aware he was establishing and deciding the same claims until the OIG review team brought it to their attention. According to VBA policy, the employee should not have had permission in the electronic claims processing system to perform the claims establishment task. The employee had previously been in a position that was permitted to establish claims, therefore the director of the VARO noted the employee's ability to establish claims was kept in place in the event other types of work would be done on overtime. Also, the employee's work was not always subject to mandated informal quality reviews because managers were not aware that he was required to have these reviews for a certain period. Some decisions completed by the employee required a third level of review that did not happen, as the veterans service center manager demonstrated she misunderstood the local policy that required the third-level reviews.

Regarding the allegation concerning the website connected to the employee's nonprofit, the OIG found that information on the site could have created the appearance of an ethical violation. The OIG also concluded the language on the website sent mixed messages in terms of the site's purpose and presented a source of potential ethical violations if a veteran submitted information related to active or possible future claims. However, the review team concluded the employee did not use the website to assist veterans with claims he processed.

Following the review team's site visit to the Little Rock VARO and assessment of the employees' processed claims, the team was informed the employee had resigned from his position with VA to work in a different field.

What the OIG Recommended

The OIG recommended the director of the Little Rock VARO review and correct rating decisions made by the employee. The director should also ensure rating decisions intended to resolve clear and unmistakable errors are approved by the proper authority, and that rating veterans service representatives are not capable of establishing claims.

Management Comments

The Little Rock VARO acting director concurred with Recommendations 1–3 and provided acceptable action plans for all recommendations. The OIG considers Recommendation 2 closed and will monitor the Little Rock VARO's progress and follow up on the implementation of Recommendations 1 and 3 until all proposed actions are completed.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

Contents

Abbreviations

OIG	Office of Inspector General
RVSR	rating veterans service representative
VARO	Veterans Affairs regional office
VBA	Veterans Benefits Administration

Introduction

The VA Office of Inspector General (OIG) received an anonymous allegation in January 2019 that an employee at the Little Rock, Arkansas, VA Regional Office (VARO) established invalid claims for disability benefits and inaccurately decided claims, which resulted in payments that were not warranted. The complainant provided the OIG with four specific claims to support the allegation. These claims were noted to have resulted in payments to claimants that may not have been warranted.

The allegation also indicated there was a possible conflict of interest because the employee was establishing a website for a nonprofit organization with information concerning the VA claims process related to his expertise. The OIG conducted this review to assess the merits of the allegation and to determine whether the employee at the Little Rock VARO made decisions that led, or could have led, to improper payments.

VBA Compensation Claims Process

The Veterans Benefits Administration's (VBA) compensation program provides tax-free monthly benefits to veterans as compensation for the effects of disabilities caused by diseases or injuries incurred or aggravated during active military service. These benefits are called service-connected disability compensation benefits. VBA pays disability compensation benefits monthly, and the amount varies according to the rating assigned to the degree of the disability and the number of dependents a veteran has. Generally, for a claim to be valid it must be submitted on a required standard form. Once a claim for benefits is submitted, it is electronically transferred through VBA's web-based application throughout the claims processing lifecycle shown in Figure 1. This review focused specifically on the establishment procedures through the rating stage of the process.

Figure 1. *VBA claims processing lifecycle*
Source: Veterans Benefits Management System User Guide

The claims establishment step includes activities related to creating and monitoring disability compensation claims. Generally, claims for service-connected disability compensation benefits should only be established if the claims are submitted on required standard forms. VBA staff use web-based applications to establish claims for disability compensation benefits in an electronic system. The development step includes activities required to plan, identify, request, and receive all the documents necessary to evaluate and decide disability compensation claims. The rating

step includes activities required to evaluate and provide decisions generated on documents for disability compensation claims.

Rating Veterans Service Representatives

The Little Rock VARO employee noted in the allegation was a rating veterans service representative (RVSR). An RVSR is part of a group of specially qualified employees vested with the authority to make decisions and take other actions on claims that require rating decisions. Rating decisions typically involve RVSRs evaluating disabilities and granting or denying entitlement to service connection for diseases and injuries. RVSRs must consistently and conscientiously exercise sound, equitable judgement in applying laws, regulations, policies, and procedures to accurately disseminate information to veterans and accurately decide all benefit claims.

RVSRs are not permitted to establish claims in VBA's electronic system. The duty of establishing claims is typically assigned to other staff such as claims assistants and veterans service representatives. Local managers are responsible for assigning the type of work to be completed by RVSRs. All work completed by RVSRs is subject to a quality review. All rating decisions require the signatures of two decision makers, unless the RVSR has been approved as a single-signature decision maker by the veterans service center manager. Single-signature authority is restricted to RVSRs whose ability to produce quality work independently without additional oversight has been demonstrated by review.

Results and Recommendations

Finding 1: An RVSR at the Little Rock VARO Inaccurately Processed Claims and Granted Unwarranted Benefits

The OIG substantiated the allegation that an RVSR at the Little Rock VARO established invalid claims and made inaccurate decisions on veterans' entitlement to service-connected disability compensation benefits. As a result of the inaccurate rating decisions, VBA made nearly $311,000 in improper payments to beneficiaries. In addition, nearly $6,700 in improper payments were being paid on an ongoing monthly basis at the time of the review.

The review team assessed the four claims associated with the anonymous allegation. In addition, the team reviewed another 15 rating decisions completed by the RVSR that were also established by the RVSR. These 15 decisions were reviewed because RVSR functions should not include the ability to establish claims. Of the 19 claims and decisions reviewed, 11 were in error because required forms were not provided by veterans to establish a claim, the benefits granted in rating decisions were not warranted, or both.

Several significant control breakdowns occurred that contributed to these errors:

- For two months, the RVSR did not have required informal quality reviews conducted on rating decisions he completed. VBA's national performance plan notes during the first 180 days following the completion of training, informal quality assessments should occur for RVSRs and they must use the approved performance tracking system for the informal assessments. Managers were not aware the RVSR was required to have these informal quality reviews.[1]
- Rating decisions completed by the RVSR that required a third level of review did not have that level of review.[2] The veterans service center manager noted she was aware of the national policy that she must approve decisions requiring this review. However, she demonstrated she was not aware of the local policy that quality review staff must also sign all decisions requiring this review.
- According to a VBA policy document, the RVSR should not have had the function to establish claims in VBA's electronic system.[3] The director of the VARO noted this function was kept in place for RVSRs in the event they would be doing other types of work while potentially working overtime assignments. However, the

[1] Department of Veterans Affairs, National Performance Plan Rating Veterans Service Representative, February 2018, p.2.

[2] Veterans Service Center Manager Memo 21-18-01, "Single Signature Authority," July 2017 and September 2018.

[3] Department of Veterans Affairs, *VBMS User Roles Quick Guide*, February 2019, p.37.

director and other managers noted they were not aware the RVSR was completing rating decisions for claims he established, and they noted this functionality has since been taken away from all RVSRs at the office.

The review team did not find that the RVSR received any financial benefit from the inaccurate processing of claims. On September 9, 2019, the acting director of the Southeast District Office informed the OIG that the RVSR had resigned from his position with VA.

What the OIG Did

The review team assessed the four claims associated with the allegation and 15 rating decisions completed by the RVSR associated with claims also established by the RVSR as of March 8, 2019. The team then determined whether the RVSR correctly established the claims, made correct rating decisions, or both. The team used VBA's electronic systems, including the Veterans Benefits Management System, to review veterans' electronic claims folders and relevant documentation for its assessment. The team also interviewed the RVSR, managers, and other staff at the Little Rock VARO. Appendix A provides additional details on the review team's actions and methodology.

This report discusses the following issues that support the OIG's finding:

- The RVSR did not follow procedures for establishing claims and also inaccurately decided claims.
- Managers did not follow internal controls to ensure decisions made by the RVSR were accurate.
- No measures were taken to prevent the RVSR from establishing claims.

The RVSR Did Not Follow Procedures for Establishing and Deciding Claims

The review team conducted a detailed assessment of the four claims associated with the allegation, and 15 rating decisions completed by the RVSR at the Little Rock VARO and determined the RVSR did not follow procedures for 11 claims and rating decisions he processed. Specifically, the review team found that

- The RVSR improperly established or decided all four of the claims associated with the anonymous allegation, and
- The RVSR inaccurately issued seven of the 15 other rating decisions associated with claims that he established.

VBA Quality Assurance concurred with all errors identified by the review. Table 1 summarizes the number and the types of errors.

Table 1. Number of Errors by Type

Type of errors	Number of errors
Inaccurate decisions on invalid claims	8
Inaccurate decisions for valid claims	2
Claims inaccurately established	1
Total number of errors	**11**

Source: VA OIG analysis of four claims associated with the allegation, and 15 rating decisions completed by the RVSR associated with claims established by the RVSR as of March 8, 2019

Inaccurate Decisions on Invalid Claims

Generally, claims for service-connected disability compensation benefits can only be valid and established if the claims are submitted on required standard forms.[4] VA noted this requirement was in place because the lack of a standardized process contributed to delays in claims processing and the potential for inaccuracies. In addition, new and material evidence is required to reopen and make decisions on previously denied claims.[5] Example 1 provides details of one of the eight inaccurate decisions on an invalid claim.

Example 1

The Little Rock RVSR issued a rating decision that granted entitlement to service-connected disability compensation benefits for a medical condition. These benefits were previously denied because the medical condition was not shown to have occurred during, or to have been caused by, the veteran's military service. The veteran submitted no required forms to reopen a valid claim. Further, the RVSR used medical evidence that was not new and material to reopen the claim. Per VBA policy in effect at the time of the decision, new and material evidence was required before VA would reopen a finally denied claim. Because of the inaccurate rating decision associated with the invalid claim, the veteran was overpaid approximately $8,300 at the time of the review team's assessment.

Inaccurate Decisions for Valid Claims

Example 2 provides details of one of the two claims that other employees correctly established but the RVSR inaccurately decided.

[4] 38 C.F.R. § 3.150 (2014).

[5] New evidence is evidence not previously considered in a decision. Material evidence means existing evidence that, by itself or when considered with previous evidence of record, relates to an unestablished fact necessary to substantiate the claim. 38 C.F.R. § 3.156(a) (2011).

Example 2

The Little Rock RVSR issued a rating decision that granted entitlement to unemployment benefits for a veteran. However, the rating decision was premature because the evidence used to make the decision was incomplete. Forms from the claimant's previous employers used to support the claim were incomplete and unsigned. No additional development was conducted to obtain completed forms. Per VBA policy, when incomplete employment forms are received, follow-up requests are to be sent to the employer and the claimant notified it is the claimant's responsibility to obtain the information.[6] As a result of the premature grant of entitlement to unemployment benefits, the veteran received approximately $13,200 in improper payments at the time of the review team's assessment.

Claim Inaccurately Established

One claim in the allegation was confirmed to be established in error without an associated rating decision. The RVSR established the claim for an issue that was previously denied, not resubmitted by the veteran, and in the process of being appealed. VBA policy prohibits the establishment of claims under these circumstances.[7] Further, the RVSR ordered an unnecessary medical opinion examination when existing medical evidence provided sufficient analysis. Following the examination, the claim was canceled by staff at another VARO, who acknowledged it was established in error. Consequently, the time Veterans Health Administration medical personnel spent conducting the unnecessary medical opinion examination could have been better used for essential examinations or opinion requests.

Errors Resulted in Improper Payments to Beneficiaries

Claimants received approximately $311,000 in improper payments related to the claims for which the RVSR did not follow procedures.[8] In addition to the $311,000 in improper payments, nearly $6,700 in improper payments were continuously being paid monthly at the time of the review. As the erroneous payments were not the fault of the veterans, but rather the RVSR, the veterans are not required to return the overpayments.

[6] VA Manual 21-1, part 4, sub. 2, chap. 2, sec. F, topic 2, "Requesting Employment Information From Employers," April 19, 2018.

[7] VA Manual 21-1, part 3, sub. 4, chap. 2, sec. B, topic 1, "Significance of Final and Binding Determinations," November 19, 2018.

[8] Department of Veterans Affairs, *Financial Policy*, vol. 7, chap. 9, January 2019.

Managers Did Not Follow Internal Controls to Ensure Decisions by the RVSR Were Accurate

The review team determined the erroneous decisions by the RVSR could have potentially been prevented if required internal controls to ensure the accuracy of rating decisions were followed. The internal controls consisted of second-signature reviews, informal quality assessments, and third-signature reviews for certain types of decisions.

Quality Reviews Not Conducted

As established by VBA policy, all rating decisions require the signatures of two decision makers unless the rating was made by an individual with single-signature authority. The veterans service center manager decides who has single-signature ratings authority.[9] The RVSR's manager noted the RVSR was approved for single-signature ratings in April 2018. Staff from the VARO's quality review team recommended the RVSR's single-signature status to his manager but noted they did so cautiously and that periodic spot checks should be done to ensure accuracy.[10]

VBA's national performance plan notes that during the first 180 days following the completion of training, informal quality assessments should occur for RVSRs and they must use the approved performance tracking system for the informal assessments. The RVSR completed training in November 2017. As the RVSR was approved for single-signature status in April 2018, the RVSR still should have had informal quality assessments conducted for about two months, as it had been less than 180 days since he completed his training. However, no quality review oversight was conducted on the RVSR's decisions for this two-month period. The RVSR's managers informed the review team that they did not conduct informal quality assessments of his work, and that they were unaware that the informal assessments needed to be done. The review team concluded that if the RVSR had been on second-signature review status for a longer period or had the required informal quality assessments conducted, errors might have been prevented.

When the review team interviewed the RVSR, he demonstrated a sufficient understanding of policy regarding claims processing. The RVSR disagreed with the OIG's and VBA Quality Assurance staff's analyses of his errors, noting he went by the law in all his decisions. However, the RVSR did acknowledge he could have made mistakes, and he has had numerous disagreements with the VARO's quality review team staff regarding interpretation of the law.

[9] VA Manual 21-1, part 3, sub. 4, chap. 6, sec. D, topic 7, "Two-Signature Rating Decisions," June 27, 2016.

[10] Each VARO has a quality review team with a focused emphasis on station quality in processing compensation claims. The quality review team at the Little Rock VARO assisted with second signatures for trainees' work in addition to other tasks.

Third-Signature Reviews for Certain Types of Decisions Were Not Done

A previous rating decision may be reversed or amended if a clear and unmistakable error is established. Clear and unmistakable errors are undebatable and compel the conclusion that if not for the error the previous outcome would have been different.[11] Clear and unmistakable errors require an additional rating decision to fix the error. Generally, VBA policy requires all rating decisions based on clear and unmistakable errors to have the approval of the veterans service center manager or a designee in addition to the RVSR's signature.[12] The Little Rock veterans service center manager had a local policy in effect, since at least July 2017, that quality review staff add a second signature to all clear and unmistakable error decisions and then send the decisions for third-signature review to the veterans service center manager or the assistant veterans service center manager. An assistant veterans service center manager noted the policy was put in place to ensure additional quality controls.

The RVSR incorrectly created four clear and unmistakable errors in the decisions assessed by the review team. Of these four clear and unmistakable errors, three did not include the signature of a quality review staff member as required by local policy. The VARO's managers and quality review staff noted they were not aware this policy was not followed by other RVSRs. The veterans service center manager noted she was aware of the national policy that she must approve clear and unmistakable errors. However, she demonstrated she was not aware of the local policy that quality review staff must also sign all clear and unmistakable errors. The review team determined that had the clear and unmistakable errors gone through the local third—signature review process, these errors could have been prevented.

The RVSR Was Not Prevented from Establishing Claims

According to VBA policy, RVSRs are not permitted to establish claims in VBA's electronic system.[13] However, the review team found that the RVSR established 18 claims in the cases assessed, of which 10 were not warranted because no claims were submitted.[14] Further, the RVSR issued eight erroneous rating decisions for the claims he improperly established. The director of the VARO noted the ability to establish claims was kept in place for veterans service representatives who got promoted to RVSRs (such as the one noted in this review) in the event they were to do other types of work such as requesting necessary documents for decisions instead of issuing rating decisions while on overtime. The RVSR's managers noted they were not

[11] 38 C.F.R. § 3.150(a)(1)(i) (2014).

[12] VA Manual 21-1, part 3, sub. 4, chap. 6, sec. D, topic 7, "Two-Signature Rating Decisions," November 8, 2018.

[13] "VBMS User Roles Quick Guide", VA website document, February 2019, https://vbaw.vba.va.gov/VBMS/VBMS_UserRolesUserGuide_Release16-1.pdf.

[14] Of the 10 claims established and rated by the RVSR, two claims were established by the RVSR and addressed in one decision.

aware the RVSR was establishing and rating the same claims until the review team brought it to their attention. The review team determined that had the RVSR not had the ability to establish claims, errors potentially could have been prevented. The director and veterans service center manager noted RVSRs no longer had the ability to establish claims in VBA's electronic system as this access had been removed.

Conclusion

The RVSR inaccurately established and decided claims, resulting in improper payments of nearly $311,000. The inaccuracies occurred because managers at the Little Rock VARO did not follow internal controls to prevent them from happening. Specifically, managers did not conduct sufficient quality assessments of the employee's rating decisions. Managers also did not restrict the RVSR from establishing claims. Because the RVSR resigned from his position at the VARO, no recommendations were made regarding administrative action. However, the Little Rock VARO director can minimize further improper payments by reviewing and correcting rating decisions the RVSR previously made. The VARO director can minimize additional improper payments and incorrectly established claims by ensuring rating decisions involving clear and unmistakable errors are signed by quality review staff and the veterans service center manager (or proper designee), and that RVSRs do not have the function to establish claims within VBA's electronic system.

Recommendations 1–3

The OIG made the following recommendations to the director of the Little Rock VA Regional Office:

1. Review rating decisions made by the rating veterans service representative since being released on single-signature status, and correct any decisions found to be made in error.
2. Ensure rating decisions involving clear and unmistakable errors are signed by a quality review specialist and the veterans service center manager, or their designee.
3. Ensure rating veterans service representatives do not have the function to establish claims in VA's electronic system.

Management Comments

The Little Rock VARO acting director concurred with Recommendations 1–3 and provided acceptable action plans for all recommendations.

To address Recommendation 1, the Little Rock VARO acting director stated his office identified 256 cases the RVSR completed. These cases will be reviewed, and any errors identified will be corrected. The acting director also stated the VARO will work with VBA's Office of

Performance Analysis and Integrity to obtain a complete list of all cases rated by the RVSR, from the time he was released to single signature, to the time he resigned from his position. Target completion date is September 30, 2020.

To address Recommendation 2, the Little Rock VARO acting director stated the VARO maintains a local policy more stringent than VBA's Compensation Service that requires a third signature by a quality review specialist on clear and unmistakable errors. The newly appointed veterans service center manager sent a reminder of this local policy on December 23, 2019, to all employees of the Little Rock Veterans Service Center. Further, the director's office management analyst will conduct a review of clear and unmistakable errors twice a year to ensure adherence to the policy. The acting director requested closure of this recommendation.

To address Recommendation 3, the Little Rock VARO acting director stated the VARO performed a VBA application and command review to ensure employees had appropriate access for their present positions. The VARO contacted the information system security officer on December 19, 2019, to obtain the most current listing of access for all of its employees. The VARO will again complete a 100 percent review of its RVSRs to confirm none of them have authorization to establish claims in VA's electronic system. On an ongoing basis, the Little Rock VARO will conduct VBA application and command reviews twice per year to ensure all employees have appropriate access for their positions. The acting director requested closure of this recommendation. The target completion date was January 10, 2020.

OIG Response

The Little Rock VARO acting director's comments and actions are responsive to the recommendations, and the OIG considers Recommendation 2 closed. For Recommendation 1, the OIG will monitor the Little Rock VARO's progress and follow up on implementation of the recommendation until all proposed actions are completed. Although the acting director has requested closure for Recommendation 3, the OIG will need to review the December 19, 2019, documents from the VARO's information system security officer to confirm rating veterans service representatives do not have authorization to establish claims in VA's electronic record.

Finding 2: The RVSR Operated a Private VA-Related Website, Potentially Violating Ethics Standards

The anonymous allegation also reported that the RVSR was establishing a nonprofit organization with a website that was designed to be an outlet for information regarding the VA disability claims process. The OIG determined the RVSR had established a website titled "Veteran Claim Information" that was noted to be an outlet for VA information designed to assist veterans, attorneys, and veterans service officers with navigating the claims process. The RVSR informed the OIG that he had not received VA claims from the website, and therefore did not inform his managers of the website. Although it was not shown that the RVSR used the website to assist veterans with claims he processed, viewing the website as a whole, the OIG determined the language on the website sent mixed messages in terms of the site's purpose. The language also presented an avenue for potential ethics violations to occur if a veteran submitted information related to active or possible future claims. In this regard, although the website states that it is just an outlet for information, in another section the public is invited to provide contact information through twitter or email using a form that requests the name, email, subject of inquiry, and a narrative message.

The RVSR Had Not Made Management Aware of the Website

The review team interviewed the RVSR, and he acknowledged he operated the website. The RVSR's managers at the Little Rock VARO told the review team they had not been made aware of the website from the RVSR and had not learned of its existence until recent investigations. The director of the VARO informed the review team that after becoming aware of the website, she did not see anything detrimental about it as it did not state the RVSR was speaking for VA.

The RVSR's Website Created the Appearance of Ethics Standards Violations

Government employees "shall not engage in outside employment or activities, including seeking or negotiating for employment, that conflict with official government duties and responsibilities."[15] Based on this standard and reviewing the duties of RVSRs, the OIG determined that it would be a conflict of interest for the RVSR to use the website to carry out aspects of his official government role such as collecting or analyzing information related to veterans' claims. Also based on this standard, he could not use the website to obtain veterans' contact information and then contact them to discuss their claims. However, after assessing the evidence, the review team could not conclude the RVSR used the website to assist veterans with

[15] Executive Order 12731, Part 1 – Principles of Ethical Conduct, Section 101 (j), October 17, 1990.

claims. Specifically, there was no evidence that claim information was actually submitted through the website.

In addition, federal regulations require that federal employees avoid any actions that create the appearance that they are violating the law or ethical standards.[16] This point is emphasized in VA training guidance the RVSR completed.[17] Determining whether there is the appearance that a law or ethical standard has been violated is from the perspective of a reasonable person with knowledge of the relevant facts.[18] The team found in this situation that a reasonable person knowing facts such as the following could conclude that the RVSR's website creates the appearance of an ethics violation: 1) the RVSR works with veterans' claims in his official government position; 2) the website is called Veteran Claim Information and invites questions to be submitted along with identifying information such as name, subject and a narrative; 3) the RVSR states on the website that he is in law school and a veteran whose "relevant experience allows him to develop and manage an information plan and approach necessary to successfully advocate for Veterans"; 4) the website characterizes the VA process of handling claims as complex and "unforgiving"; and 5) the website includes a statement that says "Know your Opposition."

Conclusion

The OIG concluded the language on the RVSR's website sent mixed messages in terms of the site's purpose and presented an avenue for potential ethics violations. However, the RVSR resigned from his position as a VA employee during the review reducing the potential for such violations. Therefore, the OIG did not make any recommendations regarding operation of the website.

[16] 5 C.F.R. § 2635.101(b)(10) and (14) (1990).

[17] Department of Veterans Affairs, Government Ethics – The Essentials.

[18] 5 C.F.R. § 2635.101(b)(14) (1990).

Appendix A: Scope and Methodology

Scope

The review team conducted its work from February 2019 through December 2019. The team evaluated four cases associated with an anonymous allegation that was received on January 31, 2019. The review team also assessed 15 rating decisions completed by the RVSR, that were also associated with claims established by the RVSR as of March 8, 2019 (the date the data were obtained).

Methodology

To accomplish its objective, the review team identified and reviewed applicable laws, regulations, policies, procedures, and guidelines related to establishing and deciding claims for VA benefits. In March through July 2019, the team interviewed managers and staff at the Little Rock VARO, as well as the RVSR identified in the allegation.

The review team assessed the four cases associated with the anonymous allegation, and 15 rating decisions completed by the RVSR that were associated with claims he established. The team then determined whether the RVSR correctly established the claims, made correct rating decisions, or both. The team used VBA's electronic systems, including the Veterans Benefits Management System, to review the veterans' electronic claims folders and relevant documentation for its assessment. The team discussed the findings with VBA officials and included their comments as appropriate.

Fraud Assessment

The review team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this review. The review team exercised due diligence in staying alert to any fraud indicators by taking actions such as

- Soliciting the OIG's Office of Investigations for indicators, and
- Completing the Fraud Indicators and Assessment Checklist.

The OIG did not identify any instances of fraud or potential fraud during this review.

Data Reliability

The review team used computer-processed data from VBA's Corporate Data Warehouse. To test for reliability, the team determined whether any data were missing from key fields or were not associated claims established and decided by the RVSR noted in the allegation. The team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Furthermore, the

review team compared veterans' names, file numbers, dates of claims, and decision dates as provided in the Veterans Benefits Management System electronic claims folders reviewed.

Testing of the data disclosed that they were sufficiently reliable for the review objective. Comparison of the data with information contained in the veterans' claims folders reviewed did not disclose any problems with data reliability.

Government Standards

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.*

Appendix B: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1–3	The incorrectly decided claims resulted in improper payments to beneficiaries that were not resolved at the time of OIG's review.		$311,000*
	Total		**$311,000***

**Estimates are rounded and can result in imprecise totals.*

Appendix C: Management Comments

Date: January 2, 2020

From: Acting Director, Little Rock VA Regional Office (350/00)

Subj: Regional Office Response to Draft Report, Little Rock VA Regional Office Employee Inaccurately Established and Decided Claims Arkansas (Project Number 2019-06757-SD-0003)

To: Assistant Inspector General for Audits and Evaluations (52)

The Little Rock VA Regional Office submits the following response to the Office of Inspector General project referenced above:

Finding 1: An RVSR at the Little Rock VARO Inaccurately Processed Claims and Granted Unwarranted Benefits

The Little Rock VA Regional Office concurs with Finding 1.

Finding 2: The RVSR Operated a Private VA-Related Website, Potentially Violating Ethical Standards

The Little Rock VA Regional Office concurs with Finding 2.

Recommendation 1: Review rating decisions made by the rating veterans service representative since being released on single-signature status, and correct any decisions found to be made in error.

The Little Rock VA Regional Office concurs with Recommendation 1. To address this recommendation, the Little Rock VA Regional Office has reviewed our system of records and identified 256 cases the Rating Veterans Service Representative completed. These cases will be reviewed and action will be completed to correct any errors identified. Additionally, to ensure our office has identified all cases the Rating Veterans Service Representative completed, we will work with VBA's Office of Performance Analysis and Integrity to obtain a complete claim number listing of all cases rated by the Rating Veterans Service Representative from the time he was released on single-signature authority to the time he resigned from his position. We want to ensure every case the Rating Veterans Service Representative worked will be reviewed. As the complete volume of the cases involved is not yet known, it is anticipated our review will be completed by September 30, 2020.

Target completion date: September 30, 2020.

Recommendation 2: Ensure rating decisions involving clear and unmistakable errors are signed by a quality review specialist and the veterans service center manager, or their designee.

The Little Rock VA Regional Office concurs with Recommendation 2. The Little Rock Regional Office maintains a local policy, which requires a third signature by a Quality Review Specialist on clear and unmistakable errors. This policy is designed to have a third individual involved in the review of clear and unmistakable errors, a policy more stringent than what VBA's Compensation Service requires. The local policy is being followed and a list of these cases is being maintained. A reminder of this policy was sent to all employees of the Little Rock Veterans Service Center on December 23, 2019, over the signature of the newly appointed Veterans Service Center Manager. A copy of the most current policy, along with a copy of the policy in place at the time this incident was investigated, are attached. Point forward, the Little Rock Director's Office Management Analyst will conduct a review of the listing of clear and unmistakable

errors twice per year to ensure this policy is being adhered to. This recommendation was completed on December 23, 2019.

We request closure of this recommendation.

Recommendation 3: Ensure rating veterans service representatives do not have the function to establish claims in VA's electronic system.

The Little Rock VA Regional Office concurs with Recommendation 3. In May 2019 and November 2019, the Little Rock VA Regional Office conducted VBA Application and Command Reviews in order to ensure all employees of our office had appropriate access for their current positions. We reached out to the Information System Security Officer on December 19, 2019, to obtain the most current listing of access for all of our employees and will again complete a 100 percent review of our Rating Veterans Service Representatives to confirm none of them have authorization to establish claims in VA's electronic system. The target completion date for this recommendation is January 10, 2020. On an ongoing basis, the Little Rock VA Regional Office will conduct VBA Application and Command Reviews twice per year to ensure all employees of our office have appropriate access for their current positions.

We request closure of this recommendation.

(Original signed by)

CORY A. HAWTHORNE

OIG Note: The attachments were not included in this report. Copies may be obtained from the OIG Information Officer.

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Review Team	Dana Sullivan, Director Brett Byrd Elyce Girouard Richard Johnson Charlma Quarles

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, Little Rock, Arkansas, VA Regional Office

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and 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: John Boozman, Tom Cotton
U.S. House of Representatives: Rick Crawford, French Hill, Bruce Westerman, Steve Womack

OIG reports are available at www.va.gov/oig.