

**Pension & Fiduciary Service**

**Inquiry Response Highlights**

**January 2020**

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# **Pension Management Center Related Inquiries**

# Medical Expenses Submitted Along With, But Not On, A Prescribed Form

**Target Audience**: PMC Claims Processors

If a claimant submits a VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance, Care Expense Statement (assisted living facility), or Attendant Affidavit in conjunction with a prescribed form for a running or non-running award, but does not report the expense(s) on a completed prescribed form that was simultaneously submitted (VA Form 21P-527EZ, Application for Pension, VA Form 21P-534EZ, Application for DIC, Survivors Pension, and/or Accrued Benefits, or VA Form 21P-8416, Medical Expense Report), can the expense(s) be allowed as a deduction? There are several references that seem to conflict with one another.

**Question 1**:Can medical expenses be received orally or do they need to be on a fully complete standard form?

**Response 1**: A claim for medical expenses that will result in an increased benefit must be initiated on a proper standard form. However, once a claim is properly received, development can be completed by telephone. (M21-1 V.111.1.G.4.a and b)

Medical expense adjustments that will result in decreased benefit payment may be made on the basis of information submitted orally, by e-mail or fax, or by other electronic means under the provisions of 38 CFR 3.217.

**Question 2**: Can PMCs consider medical expenses submitted along with, but not on, a completed and signed prescribed form?

**Response 2**: A claim for a medical expense deduction that will result in increased benefit payments must be supported by a

* substantially complete VA Form 21P-8416, Medical Expense Report, or
* substantially complete standard form listed in M21-1, Part III, Subpart ii, 2.B that requests information consistent with what is requested on VA Form 21P-8416. Examples include VA Form 21P-527EZ, Application for Pension and VA Form 21P-534EZ, Application for DIC, Survivors Pension, and/or Accrued Benefits. (M21-1 V.III.1.G.4.b and M21-1 I.1.B.1.b)

However, additional expenses can be attached to the standard form if more space is needed.

Medical expense adjustments that will result in decreased benefit payment may be made on the basis of information submitted orally, by e-mail or fax, or by other electronic means under the provisions of 38 CFR 3.217. If a form is submitted, it must be signed by the beneficiary or their fiduciary. If submitted orally, the information must be documented in the beneficiary's VA records with the specific information or statement provided using a VA Forms 21-0820, Report of General Information. The documented information should contain the date such information or statement was provided, the identity of the provider, the steps taken to verify the identity of the provider as being either the beneficiary or his or her fiduciary, and that he or she informed the provider that the information would be used for the purpose of calculating benefit amounts. (M21-1 III.iii.1.B.1.d, e, and f)

**Question 3**: Does the form or additional information submitted with the claim which includes medical expenses that qualify for deduction, but not submitted on a prescribed form, need to be signed by the claimant in order to allow the expenses?

**Response 3**: Yes, please see Response 2 above. An acceptable signature is a requirement of a substantially complete signed form. (M21-1 III.ii.1.C.2 and M21-1 I.1.B.1.b)

**Question 4**: If PMCs cannot allow expenses because they were not submitted on a prescribed form, are they still considered claimed expenses?

**Response 4**: For claims not filed on the prescribed form when required, adjudicators should treat them as a request for application and forward the claimant the proper form(s) to complete as instructed in M21-1 III.ii.2.C.

Expenses submitted in addition to a standard form as an extension of the standard form can be accepted.

**Question 5**: If the expenses indicated in the evidence submitted but not on a prescribed form are considered claimed expenses, is development necessary?

**Response 5**: Any accepted medical expenses that require development must be developed.

**Question 6**: If development is necessary because the expenses were not submitted on the proper prescribed form, would it be sufficient to include a 8416 (or other prescribed form depending on the action we are taking) in our final action letter and tell the claimant if they would like to submit medical expenses, to return the completed form?

**Response 6**: Only develop a claim if the expenses were submitted properly per M21-1 V.III.1.G.4.a and b. For claims not filed on the prescribed form when required, adjudicators should treat them as a request for application and forward the claimant the proper form(s) to complete as instructed in M21-1 III.ii.2.C.

**Result:** M21-1 updated on December 16, 2019.

# SBP Update

**Target Audience**: PMC Claims Processors

**Question:** The PMC is wondering if the news regarding the “military widow’s tax,” included in the VA Daily News Brief email below, will eliminate the SBP offset.  If so, can we anticipate interim guidance and/or manual updates to reflect this change to aid in claims processing?

Per the article (<https://www.timesdaily.com/news/military-widow-s-tax-repealed-with-passage-of-defense-bill/article_d34224f2-9d25-5b8f-904a-48eeda502ae6.html>):

* The so-called “military widow’s tax” was repealed last week with the passage of the National Defense Authorization Act (NDAA)
* Previously, military widows and widowers who qualify for the DIC were required to take a dollar-for-dollar offset from the SBP, even though their retired spouses elected to pay into the program

**Response:**  Pension and Fiduciary (P&F) Service has consulted with the Defense Finance and Accounting Service (DFAS) and the Survivors Benefits (SBP) team. For now there will be no changes to the Pension Management Center requirements to request the withholding information from DFAS. As the law is being interpreted by DFAS, the elimination of the offset will be phased in from 2021 to 2023 and will result in the beneficiary receiving an additional 1/3 of their SBP each year. There is no offset to benefits payable from 2023 forward. However, if Dependency and Indemnity Compensation (DIC) is granted prior to 2023, VA must still withhold DIC benefits to offset any resulting SBP overpayment prior to 2023.

P&F Service will continue to monitor this issue and provide additional information as it becomes available.

**Result:** Clarification provided.

# Clarification Requested: October and November Field Inquiry Response Highlights – Due Process

**Target Audience**: PMC Claims Processors

P&F is revising the Due Process guidance that was issued in the October 2019 Inquiry Response document.

**Amended P&F Response:** VARegulations do not require that notices of proposed adverse action necessarily list all income, medical expenses, and associated calculations. Due process letters may contain this greater level of detail, but it is not required. “Detailed reasons for the proposed reduction” and “facts and reasons” as noted in M21-1 I.2.B will continue to be required to inform the beneficiary of why the action is being proposed. Changes to M21-1 I.2.B.2.b to clarify this issue were published on January 15, 2020.

**Inquiry:** Due process – October/November Field Inquiry Responses

While we understand the need to provide as best an explanation as possible in a due process letter, this guidance as to the specificity required (all income and medical expenses to be listed) is new to this office and has never been previously communicated as being a requirement. The PCGL shell letters for due process do not provide this level of detail. Therefore, we are asking the following questions:

1. Is it possible for PCGL to be updated so that this additional information can more easily be entered?

**P&F Response:** Given the amended response noted above, there are no plans to update PCGL to include all income and medical expenses in notices of proposed adverse action.

1. If that is not possible, can P&F provide some examples of how these new letters should look?

**P&F Response:** No examples are needed in conjunction with the amended response.

1. Many existing due process letters that were prepared by PMC Employees did not provide this detail, should these letters be reissued with the detail required in this guidance?

**P&F Response:** No.

1. If question #3 is no, please explain why the existing letters without this level of detail are sufficient if this level of detail is needed?

**P&F Response:** Regulations do not require PMC issued notices of proposed adverse action list all income and medical expenses. Due process letters may contain this greater level of detail, but it is not required. P&F updated M21-1.I.2.B.2.b to clarify this issue.

1. Our understanding is that if *some* due process requires a certain level of detail, then *all* due process requires this, as it is all under the same regulatory authority. It is difficult to explain to employees, beneficiaries, VSOs and other stakeholders why there are two different sets of rules for due process. We understand that they are distinct and separate process, in that one is released through automation and the other by an end user. However, the ultimate result is we are proposing to reduce a claimant’s benefits. In due process prepared by the field, we are asked to provide a greater amount of detail than we have ever provided and if one part is missing, the due process is deficient and would be subject to quality error and will need to be reissued which will delay the process. Yet in automated due process, we can take whatever action is warranted even if no detail is provided.

**P&F Response:** See the response to D.

**Result:** M21-1 updated on January 15, 2020.

# In-Home Attendant Expenses

**Target Audience**: PMC Claims Processors

**Question:** Regarding in-home care (IHC) expenses, 38 CFR 3.278(d)(2) and M21-1 V.iii.1.G.3.m state that “payments must be commensurate with the number of hours that the provider attends to the disabled person.”  It seems all three PMCs are not addressing this issue in the same way.

We have interpreted this to mean that *some* type of frequency (not necessarily broken down by hour) must be claimed/confirmed in order to allow a deduction for IHC expenses.  Without this information, we would not be able to determine if the expenses claimed are commensurate to the number of hours of care provided.  For example, to determine if $6,000.00 in monthly IHC fees is reasonable, we need to know how often the care is being provided (e.g. does the caregiver come in once a week or once a month?).  Requiring this information is supported by the aforementioned references as well as the fact that the newest applications and Medical Expense Report specifically request this information (30E on the 527EZ, 45E on the 534EZ, 21B on the 8416, and the last step on the “Worksheet for In-Home Attendant Expenses”).

A review of the Federal Register (<https://www.federalregister.gov/documents/2018/09/18/2018-19895/net-worth-asset-transfers-and-income-exclusions-for-needs-based-benefits>) indicates that the original intent was to limit the hourly rate of IHC, but that part of the rule was ultimately removed:

*Numerous commenters expressed their opinion that our proposal, at § 3.278(d)(2), to limit the deductible hourly rate for in-home attendants was a bad idea for many reasons: (1) It is patently unfair to set a national average as a limit, so there must be a geographical component; (2) using an average does not take into consideration overtime or holiday time; (3) there was no cap proposed on facility costs; (4) the proposed limit was far too low and based on an outdated source (the MetLife Mature Market Institute no longer produces its Market Survey of Long-Term Care Costs); and (5) the authorizing statute (*[*38 U.S.C. 1503*](https://api.fdsys.gov/link?collection=uscode&title=38&year=mostrecent&section=1503&type=usc&link-type=html)*(a)(8)) does not permit VA to set a limit on the medical expense amount.*

While we disagree with this comment regarding our authority, we agree with many of the other commenters, and the final rule does not include a limit to the hourly rate of in-home care.

An argument *against* requiring frequency information is that the language regarding commensurate pay may have been based on the original intent of the rule, which was later removed.

Clarification requested on the following items:

1. If information regarding the frequency of care is required to accept IHC fees, can M21-1 be updated to make this requirement clear?
2. If M21-1 is updated for this purpose, please also clarify if frequency of care must be confirmed by the in-home caregiver, or reported by the claimant (as requested in the sections of the forms mentioned above)?
3. If information regarding the frequency of care is NOT required, please update M21-1 to include a definition of the term “commensurate” and how it relates to pension claims.

Proposed solution: Require that information regarding frequency of care is of record before allowing IHC fees and can be submitted by either the claimant or the caregiver.

**Response**: The hourly rate of an in-home attendant is required to determine if the rate is excessive.  An hourly rate in excess of $35 now requires verification and documentation.  If documentation is received, claims processors are to allow the medical expense.  Please see the changes to M21-1, Part V, Subpart iii, 1.G.3.m-o published on January 16, 2020.

**Result:** M21-1 updated on January 16, 2020.

# **Fiduciary HUB Related Inquiries**

# Clarification Requested - Competency Conflicting Evidence

**Target Audience**: Fiduciary Service Representatives

**Question**: Please help provide additional clarification to your August 8 clarification (see below). Work is unnecessarily being routed to VSCs based upon the current loose guidance on “conflicting evidence” including statements from the beneficiary’s friend and family. We believe this is criteria has many levels and propose the below enhanced guidance for consideration, which will leave the determination in the Fid Hub for quick and efficient resolution. If you do not agree (which is fine), then please provide whatever clarification you can that resolves this issue. We are finding that when the Fid Hub sends these to the VSC, some are being routed by the NWQ to other stations. The other stations are deferring them because the statement from the Veteran has no evidentiary weight. Therefore, these are counting against the VSCs deferral rate and delaying service to the Veteran. Thank you in advance. R/ Charles

While conflicting evidence could include lay statements from the beneficiary's friend and family, evidence is considered conflicting ONLY when it was not available for review during the proposed rating decision AND it directly calls into question the determination of incompetency AND that evidence carries the same evidentiary weight as what was used in the proposed incompetency decision. It conflicts only when all criteria are met. An example would be two letters from physicians – one that notes the Veteran is competent, the other that states he’s not. An example where this does not apply is when the doctor’s note says the Veteran is incompetent, but a family member or social worker says he is…this evidence does not have the same weight and is, therefore, not conflicting. Mere statements from the Veteran that they do not agree with the proposal are not conflicting.

**Response**: A change to M21-1, Part III, Subpart iv, 8.A.3.b was published on December 30, 2019, to provide clarification for what constitutes conflicting evidence.

Please note that Fiduciary Service Representatives are not medical rating specialists trained to fully evaluate the weight of all evidence used in the proposed rating decision. If the VA receives new evidence directly calling into question the determination of incompetency and that evidence is not identical to evidence already reviewed in making the proposed rating decision, the FSR must follow the guidance outlined in M21-1, Part III, Subpart iv, 8.A.3.b.

If the regional office defers the proposed rating back to the fiduciary hub, the deferral should be categorized as New Records/Needs Review. This will correspond to an unavoidable deferral, making mitigation unnecessary.

**Result:** M21-1, Part III, Subpart iv, 8.A.3.b was updated on December 30, 2019.

# Fiduciary Program Manual Updates - Surety Bond Question

**Target Audience**: Field Examiners and Legal Instruments Examiners

**Question:**  We received several manual updates today. Many of them change the language for surety bonds to allow us to accept bonds payable to the court and not the VA.

2.D.8.a

**Note**: In the event a VA-appointed fiduciary also serving as a court-appointed fiduciary already has a surety bond established with the court of jurisdiction, accept this bond if it covers the value of the VA FUM. If the value of the court ordered surety bond does not cover the VA FUM, follow the guidance in FPM 4.G.1.i, to have the fiduciary update the amount of the surety bond. Notify the proposed fiduciary that a copy of the surety bond must be submitted as proof of coverage..

Our understanding of 28 CFR 13.230 – Protection of Beneficiary funds, under d.3.ii, it requires the bond to be payable to the Secretary of Veterans Affairs.

**Response**: FPM procedures are correctly directing VA to accept surety bonds payable to the court in lieu of bonds titled to the Secretary of Veterans Affairs.

P&F Service consulted with the Office of General Counsel and was advised that allowing the bonds to be payable to a court of competent jurisdiction is an acceptable practice when

* the surety bond covers the amount of the VA funds under management is and
* the fiduciary relationship is in the best interest of the beneficiary.

P&F Service is in the process of submitting a change to the regulation, which may take many months. In the interim, FPM procedures should continue to be followed on this matter. Additional guidance has been published to FPM 3.C.2 and 7.A.1. on December 30, 2019 to support the practice outlined in FPM 2.D.8.a and 4.G.1.i.

**Result:** FPM updated on December 30, 2019.

# Fiduciary Program Manual Updates - Misuse

**Target Audience**: Hub Management and Field Examiners

**Question:**  Will the same changes identified below in the field exam due diligence process exceptions be carried over to Misuse Investigations in 5.C.1.c Due Diligence as exceptions their as well?

**Friday, December 20, 2019**

This week we published changes to the following content in the Fiduciary Program Manual:

|  |
| --- |
| **Change** |
| [FPM 2.A.1 General Information on Field Examinations](https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001030/content/554400000051887/FPM-2.A.1-General-Information-on-Field-Examinations)  |

Please see the [Changes by Date](https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001030/content/554400000111443/Changes%20By%20Date) page for a list and brief description of recent FPM changes.

**Response**: The changes made to Fiduciary Program Manual 2.A.1 on December 17, 2019, pertain only to the taking of credit for field examinations and not to the due diligence principle. P&F Service last updated 5.C.1 on October 21, 2019, and provided additional instances where the face-to-face contact and an alternate misuse investigation may be completed. Specifically, 5.C.1.d provides for instances in which additional attempts at contact would not be beneficial and or successful. Therefore P&F Service declines to make any changes to due diligence as it pertains to misuse investigations.

**Result:** Clarification provided.

# VA Form 21-0845

**Target Audience**: Field Examiners and Legal Instruments Examiners

On the 21-0845, Authorization to Disclose Personal Information to a Third Party, the Veteran is able to assign a third party to assist them with their VA affairs.  The current M21-1 manual reads, “The signature cannot be someone other than the individual whose information is being released, except in cases where the individual is incompetent.  When the individual is found incompetent, the VA Form 21-0845 must be signed by the court-ordered or VA-appointed fiduciary.”

When a fiduciary is appointed:

**Question 1**: When a fiduciary is appointed Is the fiduciary notified about the 21-0845 and its purpose?

**Response 1**: It is contemplated that the field examiner will review the electronic record before the field examination and will inform the proposed fiduciary of any relevant information included in the eFolder which will include the 21-0845. Outside of this practice, there is no formal process by which the fiduciary is notified of the VA Form 21-0845 and its purpose. We are currently exploring adding guidance to the Fiduciary Program Manual that would direct field examiners to discuss the use of the VA Form 21-0845 prior to finalizing the initial appointment of a fiduciary.

**Question 2**: Have you historically voided 0845’s that predate the fiduciary appointment?

**Response 2**: The practice is that the VA Form 21-0845 is to be automatically voided at the time of the fiduciary appointment. The VA Form 21-22 is not impacted by the fiduciary appointment. As noted in Response 1, we are currently exploring adding guidance to the Fiduciary Program Manual to formally make voiding of the VA Form 21-0845 a part of the fiduciary appointment process.

**Question 3**: I’m assuming that a fiduciary cannot give a 3rd party authority over the finances. Is there any formal policy about what duties the fiduciary is allowed to authorize on a 21-0845?

**Response 3**: Please note that the VA Form 21-0845 only gives VA authority to disclose information in a beneficiary’s VA record to the designated individual or organization. A fiduciary cannot be allowed to authorize to allow any other person authority over VA benefits. 38 U.S.C. 5502 a(1) provides VA the sole authority to appoint someone over VA payments, which would prevent a fiduciary from granting any other person the authority over VA benefits. The selections made on the VA Form 21-0845 will dictate whether the disclosure of information the beneficiary’s VA record will be limited to certain types of information, and if the authorization is during a limited time frame.

**Result:** Clarification provided.

# **P&F Service Information**

# P&F Service Contact Information

Policy and Procedure questions from the PMCs or Fiduciary Hubs should be submitted to P&F Service at VAVBAWAS/CO/P&F POL & PROC by the Quality Review coach or PMC/Fiduciary HUB Division Management.

P&F Service would like to remind you that all inquiries sent to the Policy and Procedures Mailbox must include the references previously researched, key words or phrases used to search in CPKM. P&F Service is available to assist when there is confusion about a certain policy or procedure, however, PMCs and Fiduciary Hubs are required to research and attempt to resolve the issue before sending the question to the P&F Service Policy and Procedures Mailbox. Additionally, including all words used to search topics in CPKM will allow P&F Service to add those search words into CPKM if they were not already in the metadata for a certain manual reference.

Training and Quality questions can be directed to: VAVBAWAS/CO/P&F TNG QUAL OVRST.

Systems-related questions can be directed to: VAVBAWAS/CO/P&F BUS MGMT.

# Disclaimer

Please note that all responses provided are for informational purposes only. If changes to the M21-1 Adjudication Procedures Manual or Fiduciary Program Manual (FPM) are needed, they are made in conjunction with the response. The M21-1 and FPM supersede any inquiry response.