VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

# Inspection of the VA Regional Office Boston, Massachusetts

**February 24, 2015**
**14-02689-122**

# ACRONYMS

| | |
|---|---|
| FY | Fiscal Year |
| OIG | Office of Inspector General |
| RVSR | Rating Veterans Service Representative |
| SAO | Systematic Analysis of Operations |
| SMC | Special Monthly Compensation |
| TBI | Traumatic Brain Injury |
| VARO | Veterans Affairs Regional Office |
| VBA | Veterans Benefits Administration |
| VFW | Veterans of Foreign Wars |
| VSC | Veterans Service Center |

# Report Highlights: Inspection of the VA Regional Office, Boston, MA

## Why We Did This Review

We evaluated the Boston VA Regional Office (VARO) to see how well its staff processes disability claims and provides a range of services to veterans. The Boston VARO is one of Veterans Benefits Administration's (VBA) 56 VAROs. We also interviewed VARO staff to gain a better understanding of how a VARO implemented Fast Letter 13-10 *"Guidance on Date of Claims Issues."*

## What We Found

Overall, VARO staff did not accurately process 21 (23 percent) of 90 disability claims we reviewed. We sampled claims we considered at increased risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. For the disability claims and processing actions reviewed:

- Ten of 30 temporary 100 percent evaluations were inaccurate, primarily because staff did not take timely action on reminders for medical reexaminations. In contrast, in February 2011 we reported errors in 25 of 30 cases, mainly due to staff not taking action to input suspense diaries in the electronic record.
- Five of 30 traumatic brain injury (TBI) claims were inaccurate, primarily because oversight was lacking to ensure staff complied with VBA's second-signature policy. This area improved since our February 2011 report where 11 of 30 TBI cases had errors due to a lack of training.
- Six of 30 special monthly compensation and ancillary claims were inaccurate due to insufficient refresher training.
- Lacking authority to deviate from VBA's policy requiring Systematic Analysis of Operations (SAO), the Director suspended SAOs in 2013 due to VBA's emphasis on production requirements.
- Staff delayed completing 6 of 30 benefits reductions cases because management prioritized other work higher.

While conducting research related to the implementation of Fast Letter 13-10, we determined one Boston VARO employee misapplied the guidance by adjusting the dates of claims that were 2 weeks or older. The employee indicated the 2-week standard was his own interpretation and not provided by management.

## What We Recommended

The Boston VARO Director needs to implement plans to ensure timely action on reminders for medical reexaminations; take appropriate action on the 189 temporary 100 percent disability evaluations remaining from our inspection universe; ensure secondary reviews and conduct training on processing TBI and special monthly compensation claims; improve management of SAOs; and prioritize actions related to benefit reduction cases.

## Agency Comments

The Director of the Boston VARO concurred with all recommendations. Management's planned actions are responsive and we will follow up as required.

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# INTRODUCTION

***Objective***

The Benefits Inspection Program is part of the VA Office of Inspector General's (OIG) efforts to ensure our nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Divisions contribute to improved management of benefits processing activities and veterans' services by conducting onsite inspections at VA Regional Offices (VAROs). These independent inspections provide recurring oversight focused on disability compensation claims processing and performance of Veterans Service Center (VSC) operations. The objectives of the inspections are to:

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

In addition to this oversight, inspections may examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

***Other Information***

- Appendix A includes details on the VARO and the scope of our inspection.
- Appendix B outlines criteria we used to evaluate each operational activity and a summary of our inspection results.
- Appendix C provides the Boston VARO Director's comments on a draft of this report.

# RESULTS AND RECOMMENDATIONS

## I. Disability Claims Processing

***Claims Processing Accuracy***

The OIG Benefits Inspection team focused on the accuracy in processing disability claims. We reviewed three types of disability claims to evaluate claims processing issues and their effect on veterans' benefits. The three types of claims reviewed included temporary 100 percent disability evaluations, traumatic brain injury (TBI), and special monthly compensation (SMC) and ancillary benefits

## Finding 1 Boston Needs To Improve the Processing of Three Types of Disability Claims

The Boston VARO did not consistently process temporary 100 percent disability evaluations, TBI-related cases, or entitlement to SMC and ancillary benefits. Overall, VARO staff incorrectly processed 21 of the total 90 disability claims we sampled, resulting in 150 improper monthly payments to 9 veterans totaling approximately $306,317, from May 2010 through May 2014.

We sampled claims related to specific conditions that we considered at higher risk of processing errors. As a result, the errors identified do not represent the universe of disability claims or the overall accuracy rate at this VARO. Table 1 reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Boston VARO.

**Table 1. Boston VARO Disability Claims Processing Accuracy for Three Types of Claims**

| Type of Claim | Claims Reviewed | Claims Inaccurately Processed: Affected Veterans' Benefits | Claims Inaccurately Processed: Potential To Affect Veterans' Benefits | Claims Inaccurately Processed: Total |
|---|---|---|---|---|
| Temporary 100 Percent Disability Evaluations | 30 | 3 | 7 | 10 |
| TBI Claims | 30 | 1 | 4 | 5 |
| SMC and Ancillary Benefits | 30 | 5 | 1 | 6 |
| **Total** | **90** | **9** | **12** | **21** |

*Source: VA OIG analysis of the Veterans Benefits Administration's temporary 100 percent disability evaluations paid at least 18 months, TBI disability claims completed in the second quarter fiscal year (FY) 2014, and SMC and ancillary benefits claims completed from April 2013 through March 2014.*

### *Temporary 100 Percent Disability Evaluations*

VARO staff incorrectly processed 10 of 30 temporary 100 percent disability evaluations we reviewed. Veterans Benefits Administration (VBA) policy requires a temporary 100 percent disability evaluation for a veteran's service-connected disability following surgery or when specific treatment is needed. At the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

For temporary 100 percent disability evaluations, VSC staff must input suspense diaries in VBA's electronic system. A suspense diary is a processing command that establishes a date when VSC staff must schedule a medical reexamination. As a suspense diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the medical reexamination. VSC staff then have 30 days to process the reminder notification by establishing the appropriate control to initiate action.

Without effective management of these temporary 100 percent disability ratings, VBA is at increased risk of paying inaccurate financial benefits. Available medical evidence showed 3 of the 10 processing errors we identified affected benefits and resulted in 34 improper monthly payments to 3 veterans totaling $45,498. These improper payments occurred from October 2012 to May 2014. Descriptions of the three errors affecting benefits follow.

- VARO staff cancelled a reminder notification when it came due in February 2013 and did not request the VA medical examination. In this case, the required examination did not occur until March 2014—more than 1 year later. Because VARO staff delayed scheduling the required reexamination, the medical evidence needed to support the temporary 100 percent evaluation was missing. As a result of the delayed examination, the veteran was overpaid approximately $26,183 over a period of 9 months.
- In the second case affecting benefits, VARO staff delayed requesting a required medical reexamination despite receiving a reminder notification to do so. As a result, the veteran was overpaid approximately $12,915 over a period of 6 months.
- A Rating Veterans Service Representative (RVSR) did not grant a veteran additional SMC benefits based on evaluations of multiple, service related disabilities as required. As a result, the veteran was underpaid approximately $6,399 over a period of 1 year and 7 months.

Seven of the total 10 errors had the potential to affect veterans' benefits. Summaries of the seven cases follow.

- For five of the errors, staff delayed requesting required medical reexaminations after receiving reminder notifications to do so. Because medical evidence was lacking, we nor VBA did not have the information needed to evaluate each case to determine whether the temporary 100 percent disability evaluations should have continued.
- One error occurred when VARO staff did not take timely action to schedule a veteran's hearing request related to a proposed benefit reduction. VBA policy allows staff to extend the proposal period for benefit reductions by 30 to 60 days if a veteran requests a hearing. At the time of our review in May 2014, the veteran's request for a hearing had been pending more than 1 year and 2 months but VARO staff had not taken the action to schedule to the hearing. Consequently, the veteran's monthly benefits payments continued to be paid monthly at the 100 percent disability despite improvement in the veterans medical condition.
- In the remaining error, VARO staff proposed to reduce a veteran's evaluation for a medical condition that had improved, but did not take final actions to reduce the benefits. At the time of our review in May 2014, more than 2 months had passed since the reduction should have occurred but staff still had not taken action to reduce the benefits.

The majority of the processing inaccuracies resulted from a lack of VARO management oversight to ensure staff took timely action to schedule medical reexaminations upon receipt of reminder notifications. At the time of our review in May 2014, VARO staff had delayed requesting reexaminations on average for 5 months. Until VARO staff obtain the medical evidence needed to reevaluate each case, the temporary 100 percent disability evaluations continue uninterrupted. We provided VARO management with 189 claims remaining from our universe of 219 after completing our sample review of 30 claims for its review to determine whether similar action is required.

VARO management agreed with our assessments in all of the cases we identified as having errors. However, both VARO management and staff indicated they did not request medical reexaminations because available resources focused on other national workload priorities to process the oldest rating-related compensation claims. Management also stated it did not have the authority to prioritize these cases above the national workload priorities.

Regardless, it is a VBA management responsibility to address this issue, which results in processing improper payments. Where VBA lacks sufficient staff to properly address its management responsibilities, it should make its case for an increase in full-time equivalents through the normal budget

process. Without appropriate priority for this type of work, delays in requesting required medical reexaminations result in unsound financial stewardship of veterans' monetary benefits and fail to minimize overpayments.

*Follow-Up to Prior VA OIG Inspection*

In our previous report, *Inspection of the VA Regional Office, Boston, MA* (Report No. 10-03564-86, February 10, 2011), VARO staff incorrectly processed 25 (83 percent) of 30 temporary 100 percent disability evaluations we reviewed. The most frequent errors occurred because management did not provide adequate oversight to ensure VSC staff entered suspense diaries in the electronic record to provide reminder notifications to schedule VA medical reexaminations. During our June 2014 inspection, we did not identify any errors where VARO staff did not input suspense diaries in the electronic system. Rather, the suspense diaries were generating reminder notifications, but staff were not taking timely actions to process them as required.

***TBI Claims***

The Department of Defense and VBA commonly define a TBI as a traumatically induced structural injury or a physiological disruption of brain function caused by an external force. The major residual disabilities of TBI fall into three main categories—physical, cognitive, and behavioral. VBA policy requires staff to evaluate these residual disabilities. Additionally, VBA policy requires that employees assigned to the appeals team, the special operations team, and the quality review team complete training on TBI claims processing.

In response to a recommendation in our summary report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-67, May 18, 2011), VBA agreed to develop and implement a strategy for ensuring the accuracy of TBI claims decisions. In May 2011, VBA provided guidance to VARO Directors to implement a policy requiring a second signature on each TBI case an RVSR evaluates until the RVSR demonstrates 90 percent accuracy in TBI claims processing. The policy indicates second-signature reviewers come from the same pool of staff as those used to conduct local station quality reviews.

We determined VARO staff incorrectly processed 5 of 30 TBI claims—1 of the errors affected a veteran's benefits. In that case, an RVSR used an incorrect date to establish benefits for a headache condition associated with TBI. As a result, the veteran was underpaid $7,440 over a period of 1 year and 4 months. The remaining four cases had the potential to affect veterans' benefits. Although the current monthly benefits for these four veterans' were not affected, if left uncorrected, future claims for benefits may be affected. VARO managers agreed with our assessments in the cases we identified as having errors.

Following are summaries of the four cases with the potential to affect veterans' benefits.

- In two cases, RVSRs did not grant entitlement to service connection for headaches associated with veterans' TBI conditions. Medical examiners provided separate examinations and diagnoses of the headache conditions and related the headaches to TBIs. In these two cases, the veterans' overall monthly disability payments were not affected; however, should the veterans' request an increased evaluation or submit a new claim at a later date, benefits payments may be affected.
- In one case, an RVSR erroneously granted entitlement to a separate evaluation for a veteran's headache condition associated with TBI, and over—evaluated the veteran's TBI condition. However, the examination reports did not provide medical evidence to support assigning a separate evaluation for headaches. Further, the medical evidence supported a non-compensable evaluation for the TBI condition rather than the 10 percent evaluation assigned.
- In the remaining case, an RVSR over-evaluated a veteran's headache condition associated with TBI as 30 percent disabling; however, the medical examiner indicated the veteran did not suffer from prostrating attacks of headache pain—a requirement needed to support a 30 percent evaluation. Based on the medical evidence, the veteran's headache condition warranted a 10 percent evaluation.

Although VARO management implemented a second-signature requirement for all TBI ratings, it did not track the accuracy of individual RVSRs to ensure they met the 90 percent accuracy requirement. However, VARO managers could not demonstrate the staff conducting the second-signature reviews had attained the required 90 percent accuracy rate to do so. Two of the five cases with errors did not undergo a second-signature review. Further, VARO managers did not track errors identified during second-signature reviews to identify trends and issues for local training.

*Follow-Up to Prior VA OIG Inspection*

In our previous report, *Inspection of the VA Regional Office, Boston, MA* (Report No. 10-03564-86, February 10, 2011), we determined 11 of 30 TBI cases reviewed contained processing errors. We attributed the errors to a lack of training as staff had not received TBI-related training since January 2009. In response to our concerns, the Director planned TBI training for staff and also implemented the quality control procedure to require a second-signature review for accuracy of all TBI claims. Consequently, the OIG closed the recommendations in August 2011.

Because the results of our 2014 benefits inspection disclosed similar problems, we concluded that the corrective actions VBA took in response to

our 2011 report were inadequate. Despite refresher training and implementation of a second-level review for TBI claims, the current inspection still showed an unacceptable TBI claims processing error rate. The errors identified were the result of inadequate VARO management oversight to ensure staff complied with the second-signature review policy. Had management followed this policy and ensured RVSRs met the required 90 percent accuracy, it may have prevented the errors we identified. Further, had management monitored and trended the types of errors identified during the second-level reviews, it may have been able to tailor training to address VARO-specific claims processing deficiencies.

### *Special Monthly Compensation and Ancillary Benefits*

As the concept of rating disabilities evolved, VBA realized that for certain types of disabilities, the basic rate of compensation was not sufficient for the level of disability present. Therefore, VBA established SMC to recognize the severity of certain disabilities or combinations of disabilities by adding additional compensation to the basic rate of payment. SMC represents payments for "quality of life" issues, such as the loss of an eye or limb or the need to rely on others for daily life activities like bathing or eating. Generally, VBA grants entitlement to SMC when the following conditions exist.

- Anatomical loss or loss of use of specific organs, sensory functions, or extremities
- Disabilities that render the veteran permanently bedridden or in need of aid and attendance
- Combinations of severe disabilities that significantly affect locomotion
- Existence of multiple, independent disabilities that are evaluated as 50 to 100 percent disabling
- Existence of multiple disabilities that render the veteran in need of such a degree of special skilled assistance that without it, the veteran would be permanently confined to a skilled-care nursing home

Ancillary benefits are secondary benefits that are considered when evaluating claims for SMC. Examples of ancillary benefits are:

- Dependents' Educational Assistance under chapter 35, title 38, United States Code
- Specially Adapted Housing Grants
- Special Home Adaptation Grants
- Automobile and Other Conveyance and Adaptive Equipment Allowance

VBA policy requires staff to address the issues of SMC and ancillary benefits whenever they can grant entitlement to these benefits. We examined whether VARO staff accurately processed entitlement to SMC and ancillary benefits associated with anatomical loss, loss of use of two or more extremities, or bilateral blindness with visual acuity of 5/200 or worse.

VARO staff incorrectly processed 6 of 30 veterans' claims involving SMC and ancillary benefits—5 errors affected veterans' benefits and resulted in 100 improper monthly payments totaling approximately $253,379 from May 2010 through May 2014. VARO management agreed with our assessments in all six of the cases. Summaries of the errors identified in processing SMC and ancillary benefits follow.

- In the first case, an RVSR improperly granted SMC based on the veteran's loss of use of both hands based on limitation of motion. However, the available medical records did not provide objective evidence to support entitlement for loss of use of both hands. As a result, the veteran was overpaid approximately $159,143 over a period of 4 years.
- An RVSR incorrectly granted SMC based on loss of use of the lower extremities, bowel impairment, urinary incontinence, and aid and attendance when the veteran did not meet VBA's evaluation requirements for these grants. In addition, staff incorrectly granted entitlement to special adapted housing and automobile and adaptive equipment. Because of the error, the veteran was overpaid approximately $38,206 over a period of 9 months.
- On multiple occasions in different decision documents, RVSRs improperly granted SMC based on the veteran's loss of use of the upper and lower extremities. In addition to establishing benefits incorrectly, one of the errors involved an RVSR using an incorrect date to begin paying benefits. However, available medical records did not support granting SMC for loss of use of the extremities nor did the evidence support an earlier effective date for the veteran's disabilities. As a result, the veteran was overpaid approximately $32,364 over a period of 1 year and 3 months.
- An RVSR improperly granted SMC, special home adaptation and automotive and adaptive equipment based on the loss of use of both hands. However, the available medical records did not show the veteran had lost the use of both hands as required. As a result, the veteran was overpaid approximately $10,532 over a period of 11 months.
- An RVSR did not grant higher levels of SMCs based on disabilities evaluated at 50 percent or more or for a disability evaluated as 100 percent disabling. In addition, the RVSR did not grant entitlement

for the veteran's loss of use of an upper and lower extremity. As a result, the veteran was underpaid approximately $13,134 over a period of 1 year and 5 months.

The remaining error had the potential to affect the veteran's benefits. In this case, an RVSR did not grant the veteran the required higher level of SMC for an additional service-connected disability evaluated at 100 percent. If left uncorrected, VARO staff may inaccurately reduce the veteran's benefits during periods of hospitalization.

Generally, errors occurred because staff based the evaluations on what a veteran's disabilities could be in the future rather than current medical evidence and VBA's criteria. The VARO manager stated a lack of training caused the errors and indicated additional training would be provided. In February 2014, VARO management implemented a second-level review policy to ensure staff correctly evaluate disability claims related to higher levels of SMC. We could not determine the effectiveness of the second-level reviews because the cases we reviewed were processed before the policy was implemented.

## Recommendations

1. We recommended the Boston VA Regional Office Director implement a plan to ensure staff take timely action on reminder notifications for medical reexaminations for temporary 100 percent disability evaluations.

2. We recommended the Boston VA Regional Office Director develop and implement a plan to review for accuracy the 189 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate actions.

3. We recommended the Boston VA Regional Office Director develop and implement a plan to ensure staff comply with the Veterans Benefits Administration's second-signature requirements for traumatic brain injury claims, including tracking and trending errors in processing these claims to identify local training needs.

4. We recommended the Boston VA Regional Office Director provide refresher training for staff on processing traumatic brain injury claims and implement a plan to monitor the effectiveness of this training.

5. We recommended the Boston VA Regional Office Director ensure claims processing staff receive refresher training on processing special monthly compensation and ancillary benefits.

***Management Comments***

The VARO Director concurred with our recommendations. The Director's planned action to designate staff responsible for reviewing reminder notifications related to temporary 100 percent disability evaluations and update the workload management plan by February 28, 2015 adequately addresses the recommendation. The Director also planned to have staff review the 189 temporary 100 percent disability evaluations remaining from our inspection universe by September 2015. In July 2014, the VARO updated its "Special Issue Ratings Requiring Two Signatures" procedures to be in line with VBA's policy for processing TBI-related disability claims. Further, in April 2015, the Director planned refresher training for staff who process TBI-related disability claims as well as claims related to SMC and ancillary benefits.

***OIG Response***

The Director's planned actions are responsive to the recommendations. We will follow up as required on all actions.

## II. Management Controls

***Systematic Analysis of Operations***

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs). We also considered whether VSC staff used adequate data to support analyses and recommendations identified within each SAO. An SAO is a formal analysis of an organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and to propose corrective actions. VARO management must prepare annual SAO schedules designating the staff required to complete the SAOs by specific dates. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 11 SAOs annually.

## Finding 2 Boston VARO Needs to Strengthen its Management of Systematic Analysis of Operations Requirements

The Boston VARO did not undertake any SAOs during FY 2013 so we could not determine whether they were complete or timely. The VARO Director made a conscious decision to suspend SAOs in FY 2013 due to VBA's emphasis on having staff focus on meeting production requirements. However, the VARO Director lacks the authority to deviate from VBA's policy for VAROs to complete SAOs according to the annual schedule. VARO management agreed with our assessment of this SAO deficiency.

This condition was further complicated when the VSC Manager's position became vacant in June 2013, given that the completion of SAOs is the responsibility of the VSC Manager. Because VARO management did not ensure staff completed SAOs according to the annual schedule, it missed opportunities to identify existing and potential problems requiring corrective actions. For example, VARO management did not complete the Claims Processing Timeliness SAO; however, we identified multiple instances among proposed benefits reduction cases where VARO staff did not take timely action to reduce payments as required. Had the VARO completed the Claims Processing Timeliness SAO, it could have identified this area of noncompliance earlier and developed recommendations to resolve deficiencies.

*Follow-Up to Prior VA OIG Inspection*

In our previous report, *Inspection of the VA Regional Office, Boston, MA* (Report No. 10-03564-86, February 10, 2011), we indicated the majority of SAOs reviewed were incomplete or untimely due to inadequate VARO oversight. The Director agreed to ensure staff complete SAOs timely and address all required elements. Consequently, the OIG closed this recommendation in August 2011. During our June 2014 inspection, we noted continued deficiencies in this area. As such, the corrective actions taken in response to our prior benefits inspection were not effective in addressing the recommendation for improvement in this area.

## Recommendation

6. We recommended the Boston VA Regional Office Director ensure Systematic Analyses of Operations are completed timely according to the annual schedule and that they contain thorough analyses, use appropriate data, and include recommendations with time frames for implementation.

***Management Comments***

The VARO Director concurred with our recommendation and reported staff completed all past due SAOs for FY 2015. Additionally, a SharePoint site was established to facilitate compliance with SAO requirements and to assist with timely reviews/approvals.

***OIG Response***

The Director's planned actions are responsive to the recommendation. We will follow up as required.

***Benefits Reductions***

VBA policy provides for the payment of compensation to veterans for conditions they incurred or aggravated during military service. The amount of monthly compensation a veteran is entitled to may change because the service-connected disability may improve. Improper payments associated with benefits reductions generally occur when beneficiaries receive payments they are not entitled to because VAROs do not take required actions to ensure veterans receive correct payments for their levels of disability.

When the VARO obtains evidence that a lower disability evaluation would result in reduction or discontinuance of current compensation payments, VSC staff must inform the beneficiary of the proposed benefits reduction. In order to provide beneficiaries due process, VBA allows 60 days for the veteran to submit additional evidence to show that compensation payments should continue at their present level. If the VARO does not receive additional evidence within that period, RVSRs will make a final determination to reduce or discontinue the benefit. On the 65$^{th}$ day following due process notification, action is required to reduce the evaluation and thereby minimize overpayments.

On April 3, 2014, VBA leadership modified its policy regarding the processing of claims requiring reductions in benefits. The new policy no longer includes the requirement for VARO staff to take "immediate action" to process these reductions. In lieu of merely removing the vague standard, VBA should have provided clearer guidance on prioritizing this work to better ensure sound financial stewardship of these monetary benefits.

## Finding 3 Boston VARO Lacked Oversight To Ensure Timely Action on Proposed Benefits Reductions

VARO staff delayed processing 6 of 30 claims that required rating decisions to reduce or discontinue benefits. This occurred because VARO managers did not prioritize this workload to ensure staff processed benefits reductions cases timely. As a result, VA made 29 improper overpayments to 6 veterans from June 2013 through April 2014, totaling approximately $17,960.

For the 6 cases with processing delays, an average of almost 5 months elapsed before staff took the required actions to reduce benefits. The most significant improper payment occurred when a veteran did not return the required verification form certifying that he was still unemployed due to service-related disabilities. In this case, VARO staff delayed taking final action by 2 months and used an incorrect date to reduce the benefits. As a result, the veteran received approximately $9,275 in improper payments.

VARO management agreed with our assessments in all six cases. Although the local workload management plan included steps for oversight of rating reduction cases, VARO management did not follow the plan. Management prioritized other workload considered by VBA to be a higher priority.

We disagree. It is a VBA management responsibility to address this issue, which entails millions of dollars in improper payments. Where VBA lacks sufficient staff to properly address its management responsibilities, it should make its case for an increase in full-time equivalents through the normal budget process. Without appropriate priority for this type of work, delays in processing reductions result in unsound financial stewardship of veterans' monetary benefits and fail to minimize overpayments.

### Recommendation

7. We recommended the Boston VA Regional Office Director implement a plan to ensure claims processing staff prioritize actions related to benefits reductions to minimize improper payments to veterans.

***Management Comments***

The VARO Director concurred with our recommendation. In January 2015, VARO staff began identifying work related to benefits reductions on a weekly basis and distributing the work to ensure actions are timely. The Director designated Veterans Service Center staff to monitor progress and assess the impact of this plan.

***OIG Response***

The Director's planned actions are responsive to the recommendation. We will follow up as required.

## III. Other Area of Concern

Beginning in May 30, 2014, we began receiving complaints through the VA OIG Hotline, alleging staff at other VARO's were misapplying the rules associated with Fast Letter 13-10, *"Guidance on Date of Claim Issues,"* dated May 20, 2013. According to the allegation, this misapplication resulted in staff inputting incorrect dates of claims in the electronic record. As part of our research work related to allegations at the other VARO's, we interviewed Boston VARO staff to gain a better understating of how a VARO implemented the Fast Letter guidance.

VBA policy defines the date of claim as being the earliest dates VA received the claim at a VA facility. Generally, dates of claims are used to control and manage claims workloads within the electronic processing environment and the date to establish benefits payments if awarded. However, the guidance in Fast Letter 13-10 required VARO staff to adjust the dates of claims for unadjudicated claims previously overlooked by claims processing staff to a current dates—the dates claims were discovered in claims files. The Fast Letter also instructed VARO staff to use a special designator, "Unadjudicated Claims Discovered," to identify these unprocessed claims in the electronic record.

We learned that one VARO employee responsible for establishing claims applied the Fast Letter guidance for all claims, discovered or otherwise, that were 2 weeks old or older. The employee reported using the special designator as required in the Fast Letter. The employee indicated the 2-week standard was his own interpretation because VARO management did not provide guidance regarding Fast Letter 13-10. Despite using his own interpretation, he stated no one had instructed him to do otherwise.

On June 20, 2014, based on allegations of data manipulation at other VAROs, we issued a management advisory memorandum to the Under Secretary for Benefits, recommending VBA discontinue the use of Fast Letter 13-10 and use the earliest date claims are received by VA as the date of claim to ensure all claims receive proper attention and timely processing. In response, the Under Secretary for Benefits reported Fast Letter 13-10 was temporarily suspended on June 27, 2014, while VBA reviews its implementation and determines the appropriate way to move forward. Because the Fast Letter was suspended, we concluded our research-related review regarding implementation of the guidance found in Fast Letter 13-10 at the Boston VARO.

# Appendix A VARO Profile and Scope of Inspection

***Organization***

The Boston VARO administers a variety of services and benefits, including compensation benefits, vocational rehabilitation and employment assistance, and outreach to homeless and women veterans.

***Resources***

As of June 15, 2014, the Boston VARO reported a staffing level of 128.5 full-time employees. Of this total, the VSC had 102.5 employees assigned.

***Workload***

As of May 2014, the VARO reported 6,488 pending compensation claims. The average days pending for claims was 168.9−which is 53.9 days more than VBA's FY 2014 target of 115.

***Scope and Methodology***

VBA has 56 VAROs and a VSC in Cheyenne, WY, that process disability claims and provide a range of services to veterans. In June 2014, we evaluated the Boston VARO to see how well it accomplishes this mission.

We reviewed selected management, claims processing, and administrative activities to evaluate compliance with VBA policies regarding benefits delivery and nonmedical services provided to veterans and other beneficiaries. We interviewed managers and employees and reviewed veterans' claims folders. Prior to conducting our onsite inspection, we coordinated with VA OIG criminal investigators to provide a briefing designed to alert VARO staff to the indicators of fraud in claims processing.

Our review included 30 of 219 temporary 100 percent disability evaluations (14 percent) selected from VBA's Corporate Database. These claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of April 21, 2014. This is generally the longest period a temporary 100 percent disability evaluation may be assigned without review, according to VBA policy. We provided VARO management with 189 claims remaining from our universe of 219 for its review. We reviewed 30 (59 percent) of 51 TBI-related disability claims that the VARO completed from January through March 2014. We examined 30 (53 percent) of 57 veterans' claims involving entitlement to SMC and related ancillary benefits that VARO staff completed from April 2013 through March 2014.

Prior to VBA consolidating Fiduciary Program Activities nationally, each VARO was required to complete 12 SAOs. Since the Fiduciary Activities consolidation, the VAROs are now required to prepare only 11 SAOs. However, this VARO did not undertake any of the required 11 SAOs. Additionally, we examined 30 (31 percent) of 97 completed claims that

proposed reductions in benefits. We also interviewed VARO staff related to implementation of Fast Letter 13-10, *"Guidance on Date of Claim Issues."*

Where we identify potential procedural inaccuracies, we provide this information to help the VARO understand the procedural improvements it can make for enhanced stewardship of financial benefits. We do not provide this information to require the VAROs to adjust specific veterans' benefits. Processing any adjustments per this review is clearly a VBA program management decision.

### Data Reliability

We used computer-processed data from the Veterans Service Network's Operations Reports. To test for reliability, we reviewed the data to determine whether any were missing from key fields, included any calculation errors, or were outside the time frame requested. We also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Further, we compared veterans' names, file numbers, Social Security numbers, VARO numbers, dates of claim, and decision dates as provided in the data received with information contained in the 120 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI, SMC and ancillary benefits, and completed claims involving benefits reductions.

Our testing of the data disclosed that they were sufficiently reliable for our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders we reviewed did not disclose any problems with data reliability.

As reported by VBA's Systematic Technical Accuracy Review program, as of May 2014, the overall accuracy of the VARO's compensation rating-related decisions was 89.5 percent which is 4.5 percentage points below VBA's FY 2014 target of 94 percent. We did not test the reliability of this data.

### Inspection Standards

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

## Appendix B Inspection Summary

Table 2 reflects the operational activities inspected, applicable criteria, and whether or not we had reasonable assurance of VARO compliance.

**Table 2. Boston VARO Inspection Summary**

| Operational Activities Inspected | Criteria | Reasonable Assurance of Compliance |
|---|---|---|
| **Disability Claims Processing** | | |
| Temporary 100 Percent Disability Evaluations | Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations. (38 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1 MR Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e) | No |
| Traumatic Brain Injury Claims | Determine whether VARO staff properly processed claims for service connection for all disabilities related to in-service TBI. (FL 08-34 and 08-36) (Training Letter 09-01) | No |
| Special Monthly Compensation and Ancillary Benefits | Determine whether VARO staff properly processed SMC and correctly granted entitlement to ancillary benefits. (38 CFR 3.350, 3.352, 3.807, 3.808, 3.809, 3.809a, 4.63, and 4.64) (M21-1MR IV.ii.2.H and I) | No |
| **Management Controls** | | |
| Systematic Analysis of Operations | Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs. (M21-4, Chapter 5) | No |
| Benefits Reductions | Determine whether VARO staff timely and accurately processed disability evaluation reductions or terminations. (38 CFR 3.103(b)(2)), (38 CFR 3.105(e)), (38 CFR 3.501), (M21-1MR.IV.ii.3.A.3.e), (M21-1MR.I.2.B.7.a), (M21-1MR.I.2.C), (M21-1MR.I.ii.2.f), (M21-4, Chapter 2.05(f)(4)), (*Compensation & Pension Service Bulletin*, October 2010) | No |

*Source: VA OIG*

CFR=Code of Federal Regulations, FL=Fast Letter, M=Manual, MR=Manual Rewrite

## Appendix C VARO Director's Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** January 30, 2015

**From:** Director, VARO Boston (301/00)

**Subj:** Draft Report, Inspection of the VA Regional Office, Boston, Massachusetts

**To:** Linda A. Halliday, Assistant Inspector General for Audits and Evaluations (52)

1. During the week of June 16 - 20, 2014, OIG conducted an inspection of the Veterans Service Center operations at the Boston VA Regional Office. Our responses to the recommendations are incorporated in the attached report.
2. Specific responses to each OIG recommendation of the subject report are provided in the attachment to this memorandum.
3. We appreciate the courtesy and cooperation your staff showed during the Inspection. If you have any questions or would like to discuss our response, please contact me at 617-303-4250.

*(original signed by:)*

Bradley G. Mayes
Director

cc: Eastern Area Director's Office

**OIG Site Visit Response**
**Boston Veterans Affairs Regional Office**

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| **Recommendation I:** | We recommended the Boston VA Regional Office Director implement a plan to ensure staff takes timely action on reminder notifications for medical reexaminations for temporary 100 percent disability evaluations. |
| **RO Response:** | Concur. In order to ensure timely action on reminder notifications for medical re-examinations due to temporary 100 percent disability evaluations, Intake Analysts are now required to review all work items to determine which are related to temporary 100 percent evaluations. Following establishment of an EP 310, the Intake Analyst sends a weekly list to the appropriate Coach. The Coach then ensures the proper assignments have been made, and confirms action completed within 180 days of establishment. This plan is to be incorporated in the VARO's Workload Management Plan NLT 02/28/2015. |
| **Applicable Attachment(s):** | |
| **Recommendation 2:** | We recommended the Boston VA Regional Office Director develop and implement a plan to review for accuracy the 189 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate actions. |
| **RO Response:** | Concur. The Quality Review Team has been tasked with the review of 189 temporary 100 percent disability evaluations remaining from the inspection universe for accuracy. The Boston QRT has been assigned, and will work this assignment along with In Process Reviews during overtime hours. Expected completion date is September 2015. |
| **Applicable Attachment(s):** | |

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| **Recommendation 3:** | We recommended the Boston VA Regional Office Director develop and implement a plan to ensure staff comply with the Veterans Benefits Administration's second-signature requirements for traumatic brain injury claims, including tracking and trending errors in processing these claims to identify local training needs |
| **RO Response:** | Concur. On July 17, 2014, the Boston RO updated the "Special Issue Ratings Requiring Two Signatures" Standard Operating Procedure to include the VACO requirement for second signature from a Quality Review Specialist for traumatic brain injury claims until an RVSR attains 90 percent accuracy on TBI claims. On this date, the Quality Review Team (QRT) implemented this process. TBI quality is reviewed on a quarterly basis to determine if RVSRs are eligible to be released on single signature authority for TBI rating decisions. |
| **Applicable Attachment(s):** | |
| **Recommendation 4:** | We recommended the Boston VA Regional Office Director provide refresher training for staff on processing traumatic brain injury claims and implement a plan to monitor the effectiveness of this training. |
| **RO Response:** | Concur. Refresher training is scheduled for April 2015. The QRT conducts quarterly analyses of TBI quality, using the TBI quality tracking spreadsheet referenced in Recommendation 3. |
| **Applicable Attachment(s):** | |
| **Recommendation 5:** | We recommended the Boston VA Regional Office Director ensure claims processing staff receive refresher training on processing special monthly compensation and ancillary benefits. |
| **RO Response:** | Concur. Refresher training is scheduled for April 2015. |
| **Applicable Attachment(s):** | |
| **Recommendation 6:** | We recommended the Boston VA Regional Office Director |

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| | ensure Systematic Analyses of Operations are completed timely according to the annual schedule and that they contain thorough analyses, use appropriate data, and include recommendations with time frames for implementation. |
| **RO Response:** | Concur. The VA Regional Office has completed all past due SAOs. An SAO SharePoint site was implemented to facilitate compliance with SAO requirements. All SAOs for FY 2015 are current. Completed SAOs are tracked utilizing a Regional Office Spreadsheet and SharePoint workflow functionality prompting timely Assistant Director and Director reviews for approval |
| **Applicable Attachment(s):** | |
| **Recommendation 7:** | We recommended the Boston VA Regional Office Director implement a plan to ensure claims processing staff prioritize actions related to benefits reductions to minimize improper payments to veterans. |
| **RO Response:** | In order to prioritize benefits reduction actions and minimize improper payments to Veterans, the VSC tailors the VOR report to identify these EP 600s. This report is pulled weekly and sent to the Non-Rating Coach. The Coach distributes work to employees for timely action. This was first implemented January 14, 2015. The VSC will continually monitor progress and assess the impact of this plan. |
| **Applicable Attachment(s):** | |

# Appendix D OIG Contact and Staff Acknowledgments

| | |
|---|---|
| OIG Contact | For more information about this report, please contact the Office of Inspector General at (202) 461-4720. |
| Acknowledgments | Nora Stokes, Director<br>Kristine Abramo<br>Kelly Crawford<br>Casey Crump<br>Ramon Figueroa<br>Lee Giesbrecht<br>Ambreen Husain<br>Kerri Leggiero-Yglesias<br>Nelvy Viguera Butler<br>Mark Ward |

# Appendix E Report Distribution

## VA Distribution

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## Non-VA Distribution

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This report is available on our Web site at **www.va.gov/oig**.