VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Pittsburgh, Pennsylvania

May 20, 2015
14-04878-205

ACRONYMS

FY	Fiscal Year
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SMC	Special Monthly Compensation
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the VA Regional Office, Pittsburgh, PA

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and a Veterans Service Center in Cheyenne, WY, that process disability claims and provides services to veterans. We evaluated the Pittsburgh VARO to see how well it accomplishes this mission.

What We Found

Overall, 10 of the 84 (12 percent) claims reviewed contained processing inaccuracies that resulted in approximately $496,000 in improper payments paid from February 2008 until September 2014. We sampled claims we considered at increased risk of processing errors. These results do not represent the accuracy of all disability claims processing at this VARO; however, accountability for public resources is not reasonably assured without timely and accurate actions.

We found that VARO staff incorrectly processed 8 of 30 temporary 100 percent disability evaluations. Six of the eight errors occurred when VARO staff failed to take timely action to schedule required medical reexaminations. We noted a significant improvement in the number of processing errors from our 2011 inspection. Also noteworthy, VARO staff processed all 30 traumatic brain injury claims we sampled correctly; another significant improvement from our 2011 inspection which showed 7 of the 28 cases reviewed contained errors. VARO staff generally processed Special Monthly Compensation and ancillary benefits claims accurately, with only 2 of the 24 cases reviewed containing processing errors. Further, VARO staff generally followed policy and accurately established the dates of claims for 28 of 30 claims in VBA's electronic system of records. However, VARO staff also delayed processing 5 of the 16 benefits reduction cases staff completed from April through June 2014. Delays occurred because other workload was prioritized higher.

What We Recommended

We recommended the VARO Director implement plans to ensure staff schedule medical reexaminations timely and take appropriate action on the 352 temporary 100 percent disability evaluations remaining from our inspection universe as of August 28, 2014. The Director should also ensure staff timely process benefits reductions to minimize improper payments to veterans.

Agency Comments

The Director of the Pittsburgh VARO concurred with all recommendations. The Director's planned corrective actions are responsive. We will follow up as required.

LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

TABLE OF CONTENTS

INTRODUCTION

Objective

The Benefits Inspection Program is part of the 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 the 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.

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. 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 Pittsburgh 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 Pittsburgh 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 evaluating the accuracy in processing the following three types of disability claims and determined their effect on veterans' benefits:

- Temporary 100 percent disability evaluations, and
- Traumatic brain injury (TBI) claims, and
- Special monthly compensation (SMC) and ancillary benefits.

We sampled claims related only to specific conditions that we considered at increased risk of claims processing errors. As a result, the errors identified do not represent the universe of disability claims or the overall accuracy rate at this VARO.

Finding 1 Improvement Needed in Processing Temporary 100 Percent Disability and Special Monthly Compensation Claims

The Pittsburgh VARO did not consistently process temporary 100 percent disability evaluations. Overall, VARO staff incorrectly processed 10 of the total 84 (12 percent) disability claims we sampled, resulting in 218 improper monthly payments to 8 veterans, totaling $495,834 from February 2008 until September 2014.[1] Table 1 below reflects processing errors identified during this review.

Table 1. Pittsburgh VARO Disability Claims Processing Accuracy for Three High Risk Claims Processing Areas

Type of Claim	Total Claims Reviewed	Inaccuracies Affecting Benefits	Inaccuracies Potentially Affecting Benefits	Total Claims Inaccurately Processed
Temporary 100 Percent Disability Evaluations	30	7	1	8
TBI Claims	30	0	0	0
SMC and Ancillary Benefits	24	1	1	2
Total	**84**	**8**	**2**	**10**

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 third quarter FY 2014, and SMC and ancillary benefits claims completed from July2013 through June 2014.

[1] All calculated percentages in this report have been rounded where applicable.

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 8 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 a 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 an increased risk of paying inaccurate financial benefits. Available medical evidence showed 7 of the 8 processing errors we identified affected veterans' benefits and resulted in 193 improper monthly payments to 7 veterans totaling approximately $492,720 from February 2008 to September 2014. The remaining error had the potential to affect a veteran's benefits. Following are descriptions of all eight errors we identified.

- Six errors occurred when VARO staff failed to take timely action to schedule required medical reexaminations. Summaries of the errors affecting benefits related to delayed examination request follow.

  - The most significant overpayment occurred when a Rating Veterans Service Representative (RVSR) granted a temporary 100 percent disability evaluation for a veteran's Non-Hodgkin's lymphoma in August 2007 and failed to annotate the need for an immediate examination. In fact, medical evidence dated May 2007 showed the non-Hodgkin's lymphoma was no longer active and warranted a non-compensable evaluation. As a result, the veteran was overpaid approximately $216,392 over a period of 6 years and 7 months.
  - One error occurred when VARO staff removed a reminder notification without scheduling a review examination. Medical evidence showed the veteran's liposarcoma was no longer active and warranted a non-compensable evaluation. As a result, the veteran was overpaid approximately $98,277 over a period of 2 years and 10 months.

- Two errors occurred when RVSRs granted a temporary 100 percent evaluation for prostate cancer and annotated the need for at-once review examinations. In one of the cases, VARO staff erroneously ordered an unnecessary peripheral nerve examination. In the other case, the correct examination was ordered but at the wrong VA facility. Medical evidence in both cases showed the veteran's prostate cancers were not active and warranted reduced evaluations. The errors and associated delays resulted in overpayments totaling approximately $68,499 over a period of 2 years and $28,482 over a period of 1 year and 6 months.
- In a September 2012 rating decision, an RVSR granted a temporary 100 percent disability evaluation for a veteran's prostate cancer and documented the need for a required medical reexamination. However, the examination was not completed until March 2013. This examination showed the veteran completed his cancer treatment in July 2012, and was no longer entitled to the 100 percent evaluation. As a result, the veteran was overpaid approximately $19,710 over a period of 1 year and 1 month.
- One error occurred when VARO staff delayed scheduling an examination for prostate cancer despite receiving a reminder notification that the reexamination was due. Medical evidence showed the prostate cancer was no longer active and warranted a 20 percent evaluation. As a result, the veteran was overpaid approximately $16,553 over a period of 6 months.

- In the seventh case, an error occurred when VARO staff incorrectly continued the temporary 100 percent evaluation for the veteran's prostate cancer condition. However, the medical evidence showed the veteran's cancer condition was no longer active and warranted a 40 percent disability evaluation. Consequently, the veteran was overpaid approximately $44,807 over a period of 1 year and 7 months.
- In the final case, in September 2013, an RVSR, proposed to reduce the veteran's prostate cancer evaluation from 100 percent to 20 percent based on medical evidence showing improvement in the condition. In the same month, the veteran requested a personal hearing related to the proposed reduction action. VBA policy allows staff to extend the proposal period for benefit reductions by 30 to 60 days if a veteran requests a hearing. However, at the time of our review, over 1 year following the request, the hearing had not been scheduled.

Generally, the errors occurred because VARO management did not ensure staff took timely action to schedule medical examinations. In

the errors we reviewed, processing delays averaged about 1 year and 8 months until the time staff took action to order the required medical reexaminations. We provided VARO management with 352 claims remaining from our universe of 382 in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of August 18, 2014, for its review to determine whether action is required.

Interviews with VARO management and staff revealed other claims processing activities had higher priority. VARO management stated it put more resources on meeting goals directed by VBA that did not include taking timely action to schedule medical reexaminations. As a result, veterans may receive benefits payments in excess of amounts warranted for their level of disability and evaluations are not supported with current medical evidence.

VARO management did not concur with five of the eight errors we identified. Management responded:

> *Although this Regional Office understands its responsibilities to take actions to reduce benefits when appropriate, our inability to execute these in a timely manner is a workload issue, and not a quality error that would be cited by Compensation Service's Quality Assurance staff.*

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

Follow-Up to Prior VA OIG Inspection

During our prior inspection of the Pittsburgh VARO, conducted in October 2011, *Inspection of the VA Regional Office, Pittsburgh, Pennsylvania* (Report No. 11-042160103, February 27, 2012), VARO staff incorrectly processed 27 of 30 temporary 100 percent disability evaluations we reviewed as part of our sample. The majority of errors occurred because VARO staff did not establish suspense diaries for future examinations or take action to schedule medical reexaminations after receiving reminder notifications to do so. In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each had a future

examination date entered in the electronic record. As such, we did not make a specific recommendation for improvement to the VARO during our October 2011 benefits inspection report. However, we recommended, and the VARO Director agreed, to implement a plan to ensure staff processed reminder notifications to schedule medical reexaminations. The OIG closed this recommendation on September 30, 2012.

During our October 2014 benefits inspection, we observed some VARO staff continued to delay scheduling medical reexaminations despite receiving reminder notifications to do so. However, we concluded that the VARO's actions to address recommendations made during our October 2011 benefits inspection had resulted in significant improvements.

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 to complete training on TBI claims processing.

In response to a recommendation in our report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-167, 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.

During this October 2014 inspection, we found VARO staff correctly processed all 30 TBI claims reviewed in our sample. Since FY 2013, only two other VARO's have demonstrated this sort of accuracy when processing TBI related disability claims. VARO management and staff attributed the high accuracy rate for processing TBI claims to the following:

- The experience level of staff processing TBI claims.
- Effective communication between the VARO and VA hospital staff to ensure the accuracy of VA examinations.
- Successful implementation of VBA's second-signature policy.

- Improved communication between RVSRs and the VARO's claims processing internal quality review staff.

Based on our interviews with RVSR's and the VARO's internal quality review staff, we agree with the VARO's assessments. The VARO's ability to process TBI claims are closely related to the experienced level of staff processing the cases, effective communication with VA hospital staff and internal quality reviewers, as well as the successful implementation of VBA's second-signature policy.

Follow-Up to Prior VA OIG Inspection

In our 2012 report, *Inspection of the VA Regional Office, Pittsburgh, Pennsylvania* (Report No. 11-042160103, February 27, 2012), 7 of the 28 TBI cases reviewed contained errors. We determined the errors occurred because staff used insufficient VA medical examinations for rating decisions. We recommended and the VARO Director agreed to develop and implement a plan to ensure staff returned inadequate TBI examination reports to healthcare facilities for correction. The OIG closed this recommendation on September 30, 2012. During this 2014 inspection, we did not identify any TBI-related claims processing errors. As such, we determined the VARO's actions in response to our October 2011 benefits inspection contributed to the VARO's improved performance in this area.

Special Monthly Compensation and Ancillary Benefits

As the concept of rating disabilities evolved, it was realized that for certain types of disabilities, the basic rate of compensation was not sufficient for the level of disability present. Therefore, SMC was established to recognize the severity of certain disabilities or combinations of disabilities by adding an 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 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. 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 generally processed SMC and related ancillary benefits claims correctly. However, we identified VARO staff incorrectly processed 2 of 24 SMC claims. Details on the two errors follow.

- In one case, 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. As a result, the veteran was underpaid approximately $3,114 over a period of 2 years and 1 month.
- In the other case, an RVSR denied a veteran's claim for increased SMC without requesting the required VA examination. Without required medical evidence, neither VBA, nor we, can determine if the missing examination results would have affected the veteran's monthly benefits.

The two SMC cases reviewed that contained processing inaccuracies occurred for different reasons but these cases did not constitute a common trend, pattern, or systemic issue for the Pittsburgh VARO. As such, we determined VARO staff generally followed VBA policy when processing these claims and we made no recommendation for improvement.

Recommendations

1. We recommended the Pittsburgh VA Regional Office Director develop and implement a plan to ensure staff take timely action on reminder notifications for medical reexaminations.

2. We recommended the Pittsburgh VA Regional Office Director conduct a review of the 352 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate actions.

Management Comments

The VARO Director concurred with the recommendations and implemented a plan to assist with review of the 653 pending reminder notifications for medical reexaminations—further advising the total number of pending notifications had been reduced to 50 as of March 2015. Additionally, the Workload Management Plan was updated to assign responsibility of this workload to specific teams. The Director also reported staff reviewed the 352 temporary 100 percent disability evaluations remaining from OIG's universe but also noted final actions had not been taken. The Director reported the VSC and Director's Office monitor the pending cases weekly.

OIG Response

The Director's comments and actions are responsive to the recommendations. We will follow up as required on actions as deemed appropriate in the future.

II. Data Integrity

Dates of Claim

To ensure all claims receive proper attention and timely processing, VBA policy directs staff use the earliest date stamp shown on the claim document as the date of claim. VBA relies on accurate dates of claim to establish and track key performance measures, including the average days to complete a claim. However, in May 2013, VBA leadership modified its policy by issuing guidance authorizing the establishment of dates of claim for previously unaddressed claims as the date staff discovered the claim instead of the date of the earliest date stamp.[2] In June 2014, VBA leadership suspended this guidance, and in January 2015, terminated its policy for using the discovery date as the date of claim for previously unaddressed claims. We focused this review on whether VSC staff followed VBA policy for establishing dates of claim in the electronic record and assessed whether VARO staff were no longer following the terminated guidance.

VARO staff established claims in the electronic systems of record using correct dates of claim for 28 of the 30 claims we reviewed; however, the remaining two cases were established using incorrect dates of claims. Summaries of those two cases follow.

- In one case, a veteran's claim for benefits was established using July 17, 2014, as the date of claim; however, we identified evidence showing VA had previously received an unprocessed claim on October 30, 2012. As such, the age of the current claim was misrepresented by 625 days.
- In the second case, VARO staff established a claim using July 18, 2014, as the date of claim; however, the evidence showed VARO staff actually received the claim on May 13, 2013; 431 days earlier.

Our review focused on whether VSC staff followed VBA policy for establishing dates of claim in the electronic record and to verify staff no longer followed the guidance in Fast Letter 13-10. Because VARO staff accurately captured dates of claims for 28 of the 30 claims we reviewed, we concluded staff generally followed VBA policy when establishing claims in the electronic systems of records. As such, we made no recommendation for improvement in this area. However, the amount of time these two veterans had been waiting to receive benefits decisions was considered significant. Further, recording incorrect dates of claims in the electronic record reduces the data integrity associated timeliness metrics for pending claims workload.

[2] Fast Letter 13-10, *Guidance on Date of Claim Issues*

III. Management Controls

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 to which a veteran is entitled may change because his or her service-connected disability may improve. Improper payments associated with benefits reductions generally occur when beneficiaries receive payments to which they are not entitled because VAROs do not take the actions required to ensure correct payments for their levels of disability.

When the VARO obtains evidence that a lower disability evaluation would result in a reduction or discontinuance of current compensation payments, VSC staff must inform the beneficiary of the proposed reduction in benefits. 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 65th 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 benefits reductions. 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 ensure sound financial stewardship of these monetary benefits.

Finding 2 Pittsburgh VARO Lacked Oversight To Ensure Timely Action on Benefits Reductions

VARO staff delayed processing 5 of 16 benefits reductions claims that VARO staff completed from April through June 2014. This occurred because management prioritized other work higher. As a result, VA made 44 improper payments to 5 veterans from January 2013 until July 2014, totaling approximately $41,562.

For the five cases with processing delays, an average of 9 months elapsed before staff took the required actions to reduce benefits. The most significant improper payment occurred when VARO staff proposed to reduce a veteran's benefits after medical evidence showed the medical condition had improved. Staff proposed the reduction action in July 2012; however, the final rating decision to discontinue

benefits did not occur until March 2014—18 months beyond the date when the reduction action should have occurred. As a result, the veteran was overpaid approximately $31,142 in improper payments.

VARO management did not agree with our assessments in the five cases we identified as having errors. Although the VARO workload management plan included steps for oversight of rating-related benefits reduction cases, management did not follow the plan. Management told us they prioritized other workload considered by VBA to be a higher priority, and also cited a lack of staff to work these claims timely to be a cause for the delays. However, it is a VBA management responsibility to ensure this workload is processed timely because it has the potential to entail millions of dollars in improper payments. Without ensuring this work is processed timely, delays in processing benefits reductions result in unsound financial stewardship of veterans' monetary benefits and fail to minimize improper payments. Further, where VBA lacks sufficient staff to properly address its management responsibilities, it should make its case for an increase in staff resources through the normal budget process.

Recommendation

3. We recommended the Pittsburgh VA Regional Office Director implement a plan to ensure staff timely process claims related to benefits reductions to minimize improper payments to veterans.

Management Comments

The VARO Director concurred with the recommendation and reported adding an RVSR to the non-rating team. Additionally, the team coach distributes the oldest cases for expedited actions and the VSC manager monitors progress and assesses the need for future adjustments.

OIG Response

The Director's comments and actions are responsive to the recommendation. We will follow up as required on all actions.

Appendix A VARO Profile and Scope of Inspection

Organization

The Pittsburgh VARO administers a variety of services and benefits, including compensation benefits; vocational rehabilitation and employment assistance; specially adapted housing grants; benefits counseling; and outreach to homeless, elderly, minority, and women veterans.

Resources

As of August 2014, VBA's Office of Field Operations reported the Pittsburgh VARO had a staffing level of 132.2 full-time employees. Of this total, the VSC had 98.3 employees assigned.

Workload

As of October 2014, VBA reports the Pittsburgh VARO had 5,875 veterans rating claims pending with 2,923 (50 percent) pending greater than 125 days. VBA's Systematic Technical Accuracy Review reported the 12 month claim-based accuracy rate for compensation rating-related issues was 87.7 percent, which is 10.3 percentage points below the 2015 national target of 98.0 percent.

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 October 2014, we evaluated the Pittsburgh 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 382 temporary 100 percent disability evaluations (8 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 August 28, 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 352 claims remaining from our universe of 382 claims as of August 28, 2014, for review. We reviewed 30 of 71 available disability claims related to TBI (42 percent) that the VARO completed from April 1, 2014, through June 30, 2014. We examined 24 of 29 veterans' claims involving entitlement to SMC and related ancillary benefits (83 percent) completed by VARO staff from July 1, 2013, through June 30, 2014.

We assessed 30 of 2,097 cases (1 percent) in which VARO staff established a date of claim for increase during the period July 2, 2014, through October 1, 2014. Additionally, we looked at 16 completed claims that proposed a reduction in benefits between April 1, 2014, and June 30, 2014.

Data Reliability

We used computer-processed data from the Veterans Service Network's Operations Reports and Awards. To test for reliability, we reviewed the data to determine whether any data 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 130 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI claims, SMC and ancillary benefits, and completed claims related to benefits reductions, and dates of claim establishment.

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 reviewed in conjunction with our inspection of the VARO did not disclose any problems with data reliability.

As reported by VBA's Systematic Technical Accuracy Review program as of October 2014, the overall accuracy of the Pittsburgh VARO's compensation rating-related decisions was 87.7 percent—10.3 percentage points below VBA's FY 2015 target of 98 percent. We did not test the reliability of these 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. Pittsburgh 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)	Yes
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)	Yes
Data Integrity		
Dates of Claim	Determine whether VARO staff accurately established claims in the electronic records. (38 CFR 3.1 (p) and (r)), (M21-4, Appendix A and B), (M21-1MR, III.ii.1.C.10.a), (M21-1MR, III.ii.1.B.6 and 7), (M21-1MR, III.ii.2.B.8.f), (M21-1MR, III.i.2.A.2.c) (VBMS User Guide), (M21-4, Chapter 4.07), (M23-1, Part 1, 1.06)	Yes
Management Controls		
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: April 9, 2015

From: Director, VA Regional Office Pittsburgh (311/00)

Subj: Draft Report, Inspection of the VA Regional Office, Pittsburgh, Pennsylvania

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

1. During the week of October 27 - 31, 2014, OIG conducted an inspection of the Veterans Service Center operations at the Pittsburgh 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 Jason Brown, Acting Veterans Service Center Manager, at 412-395-6085.

(original signed by:)

J. Stone-Barash
Director

cc: Eastern Area Director's Office

Attachment

OIG Site Visit Response

Pittsburgh Veterans Affairs Regional Office

Recommendation 1:	We recommended the Pittsburgh VA Regional Office Director develop and implement a plan to ensure staff take timely action on reminder notifications for medical reexaminations.
RO Response:	Concur. In December 2014, the Regional Office developed and implemented a plan which utilized all RVSRs to assist with review of 810 (631A and 631R) work items to ensure that all routine future examinations and review evaluations were timely completed in the Veterans Service Center. In December 2014, the Regional Office had 653 810 631A and 631R evaluations pending. By end of month March 2015, the Regional Office had reduced the total future examination reviews to 50 pending reviews, a reduction of 76.5%. Our Express and Foreign Teams have been assigned responsibility for completing new reviews and taking any necessary actions as future diaries mature each month. This workload assignment is reflected in the VARO's Workload Management Plan. Target Completion Date: April 15, 2015
Applicable Attachment(s):	n/a

Recommendation 2:	We recommended the Pittsburgh VA Regional Office Director conduct a review of the 352 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate actions.
RO Response:	Concur. All 100% evaluations identified by OIG have been reviewed and appropriate action initiated. In addition, controls were reviewed to ensure that appropriate suspense diaries were set for future reviews. All final actions have not yet been taken. To ensure timely completion of the remaining pending claims, specific individuals have been identified to complete this workload. The pending cases are being monitored weekly by the VSC and Director's Office. The Pittsburgh RO requests closure of this item.
Applicable Attachment(s):	n/a
Recommendation 3:	We recommended the Pittsburgh VA Regional Office Director implement a plan to ensure staff timely process claims related to benefits reductions to minimize improper payments to veterans.
RO Response:	Concur. In order to prioritize benefits reduction actions and minimize improper payments, we added an RVSR to the Non-rating Team in October 2014. In a continuing effort to address this workload, the Non-Rating Coach is distributing the oldest cases to employees for expedited action. The Regional Office has attempted to properly balance this priority with the other workload in the RO. The VSCM closely monitors the progress and will assess the need for additional adjustments based on workload and staffing. The Pittsburgh RO requests closure of this item.
Applicable Attachment(s):	n/a

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 Kristine Abramo Nelvy Viguera Butler Robert Campbell Karen Cobb Casey Crump Ramon Figueroa Kerri Leggiero-Yglesias

Appendix E Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Assistant Secretaries
Office of General Counsel
Veterans Benefits Administration Eastern Area Director
VA Regional Office Pittsburgh Director

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Robert P. Casey, Jr., Patrick J. Toomey
U.S. House of Representatives: Lou Barletta, Mike Doyle, Mike Kelly, Tom Marino, Tim Murphy, Keith Rothfus, Bill Shuster, Glenn Thompson

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