VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

# Veterans Benefits Administration

*Inspection of*
*VA Regional Office*
*Cleveland, Ohio*

**July 30, 2015**
**14-04983-412**

# ACRONYMS

| | |
|---|---|
| OIG | Office of Inspector General |
| RVSR | Rating Veterans Service Representative |
| SMC | Special Monthly Compensation |
| TBI | Traumatic Brain Injury |
| VA | Department of Veterans Affairs |
| VARO | Veterans Affairs Regional Office |
| VBA | Veterans Benefits Administration |
| VSC | Veterans Service Center |

# Report Highlights: Inspection of VA Regional Office Cleveland, OH

## Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and a Veterans Service Center in Wyoming, that process disability claims and provide services to veterans. We evaluated the Cleveland VARO to see how well it accomplishes this mission. OIG Benefits Inspectors conducted this work in December 2014.

## What We Found

The Cleveland VARO did not consistently process the three types of disability claims we reviewed. Overall, staff did not accurately process 30 of 90 disability claims (33 percent) reviewed. As a result, 404 improper monthly payments were made to 18 veterans totaling approximately $737,231. 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.

In our 2012 inspection report of the Cleveland VARO, the most frequent errors associated with temporary 100 percent disability evaluations occurred because staff did not establish suspense diaries. During this 2014 inspection, we did not identify similar errors. However, in September 2012, the VARO was provided with a list of 712 temporary 100 percent disability evaluations to process. As of December 2014, staff had not taken action on seven of those claims. Therefore, we find the actions taken by VARO staff, as it relates to VBA's national review plan, ineffective. We also reported in 2012 that TBI claims processing errors resulted from staff misinterpreting VBA policy. During this inspection we found similar issues and determined the VARO's actions in response to our previous recommendation were not effective.

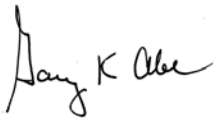
VARO staff established incorrect dates of claim in VBA's electronic systems of record for 3 of 30 claims we reviewed. Staff also did not timely or accurately complete 24 of 30 proposed benefits reduction cases due to other higher workload priorities.

## What We Recommended

We recommended the Director review the 880 temporary 100 percent disability evaluations pending as of October 8, 2014; certify action has been accomplished on the 7 cases from our 2012 inspection; and provide training on temporary 100 percent disability evaluations, SMC, and dates of claim. Further, ensure staff follow VBA's second-signature requirements for TBI claims, monitor the effectiveness of TBI training, and prioritize benefits reduction cases.

## Agency Comments

The VARO Director concurred with our 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.

We provide this information to help the VARO make procedural improvements to ensure enhanced stewardship of financial benefits. We do not provide this information to require the VARO to adjust specific veterans' benefits. Processing any adjustments per this review is clearly a Veterans Benefits Administration (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 Cleveland 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 Cleveland 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
- Traumatic brain injury (TBI) claims
- 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 Cleveland VARO Needs To Improve the Processing of Three Types of Disability Claims

The Cleveland VARO did not consistently process the three types of disability claims we reviewed. Overall, VARO staff incorrectly processed 30 of the total 90 disability claims we sampled, resulting in 404 improper monthly payments to 18 veterans totaling approximately $737,231 at the time of our inspection in December 2014. Table 1 reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Cleveland VARO.

**Table 1. Cleveland VARO Disability Claims Processing Accuracy for Three High-Risk Claims Processing Areas**

| Type of Claim | Claims Reviewed | Claims Inaccurately Processed: Affecting Veterans' Benefits | Claims Inaccurately Processed: Potential To Affect Veterans' Benefits | Claims Inaccurately Processed: Total |
|---|---|---|---|---|
| Temporary 100 Percent Disability Evaluations | 30 | 11 | 5 | 16 |
| TBI Claims | 30 | 0 | 6 | 6 |
| SMC and Ancillary Benefits | 30 | 7 | 1 | 8 |
| **Total** | **90** | **18** | **12** | **30** |

*Source: VA OIG analysis of the VBA's temporary 100 percent disability evaluations paid at least 18 months, and TBI disability claims and SMC and ancillary benefits claims completed in fiscal year 2014.*

***Temporary 100 Percent Disability Evaluations***

VARO staff incorrectly processed 16 of 30 temporary 100 percent disability evaluations we reviewed. 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.

When the VARO obtains evidence that a lower disability evaluation would result in reduced compensation payments, Rating Veterans Service Representatives (RVSRs) 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. On the 65th day following due process notification, action is required to reduce the evaluation and thereby minimize overpayments.

Effective management of these temporary 100 percent disability ratings can reduce VBA's risks of paying inaccurate financial benefits and provide improved stewardship of taxpayer funds. Available medical evidence showed 11 of 16 processing errors we identified affected veterans' benefits and resulted in 239 improper monthly payments to 11 veterans totaling approximately $616,504 from October 1, 2006, to November 1, 2014. Details on the errors affecting benefits follow.

- In seven cases, VSC staff delayed requesting medical reexaminations as required to determine if the veterans' temporary 100 percent disability evaluations should continue. These delays resulted in 200 improper monthly benefits payments to 7 veterans totaling approximately $519,539. These improper monthly benefits payments ranged from October 2006 to November 2014. Monthly benefits payments continue at the 100 percent disability rate if no corrective actions are taken.
- In two cases, staff either delayed requesting a medical reexamination, which resulted in the proposal to reduce the veteran's temporary 100 percent disability evaluation to be untimely, or they delayed processing the medical reexamination results, which led to the untimely processing of the veteran's proposed reduction. These delays resulted in

nine improper monthly benefits payments to two veterans totaling approximately $25,340 from June 2014 to November 2014.

- In one case, an RVSR proposed to reduce a veteran's temporary 100 percent disability evaluation for prostate cancer based on medical evidence dated May 19, 2012, that showed improvement warranting a new and lower combined disability evaluation of 20 percent. However, no actions occurred until October 23, 2014, over 2 years later. Additionally, this medical evidence showed the veteran was entitled to the additional SMC benefit, based on loss of use of a creative organ for a medical condition associated with prostate cancer. At the time of our review, VARO staff had not taken action to pay this benefit. As a result, the veteran still received 29 improper benefits payments totaling approximately $71,523 from June 2012 to November 2014.
- In the remaining case, an RVSR correctly granted entitlement to the additional SMC benefit, based on loss of use of a creative organ for a medical condition associated with the veteran's prostate cancer. However, the RVSR used an incorrect effective date of May 8, 2014, to pay benefits. The RVSR should have used April 18, 2014, the date medical evidence showed prostate cancer caused the associated medical condition. As a result, the veteran was underpaid approximately $102, over 1 month.

The remaining 5 of 16 total errors had the potential to affect veterans' benefits. Following are details on these five errors.

- In four cases, VSC staff received reminder notifications to request the medical reexaminations needed to determine if the veterans' temporary 100 percent disability evaluations should continue. Review of the evidence shows staff took from 9 to 15 months to request the appropriate medical reexaminations needed to reassess the veterans' service-connected disabilities. As a result of not requesting the medical reexaminations timely, the veterans may have received improper monthly benefits.
- In the remaining case, an RVSR prematurely proposed to reduce a veteran's temporary 100 percent disability evaluation prior to the mandated period of treatment. If not for our review, the veteran may have received improper monthly benefits.

Inaccuracies associated with temporary 100 percent disability evaluations generally occurred because VARO management placed emphasis on processing other work. Management implemented guidance in a Systematic Analysis of Operations that instructed staff to process temporary 100 percent disability claims weekly, and the local Workload Management Plan directed staff to review these cases weekly. However, management stated, and staff confirmed, these procedures were not followed because these cases do not

have the same priority as other work that is being directed by VBA's Central Office. As a result, veterans may receive benefits payments in excess of their entitlement. We provided VARO management with 880 claims remaining from their universe of 910 claims for review to determine if action is required.

VARO management nonconcurred with the 16 errors; however, they did confirm the cases were not processed as swiftly as desired. In response to our use of the word "delay" to describe VARO staff not taking timely actions to process these claims, a manager stated, "You're implying that we intentionally delayed these." We disagree. VBA criteria states that as a suspense diary matures, a reminder notification is generated to alert VSC staff to schedule the medical reexamination, and staff have 30 days to process the reminder notification and establish the appropriate control to initiate action.

Further, when evidence is received showing a lower disability evaluation would result in reduced benefits payments, RVSRs must inform the beneficiary. In order to provide beneficiaries due process, VBA allows 60 days for the beneficiary to submit additional evidence showing why compensation payments should continue at their present level. On the 65th day following due process notification, action is required to reduce the evaluation and thereby minimize overpayments.

*Follow-Up to Prior VA OIG Inspection*

In our previous report, *Inspection of the VA Regional Office, Cleveland, Ohio* (Report No. 12-00241-296, September 27, 2012) VARO staff incorrectly processed 16 of 30 temporary 100 percent disability evaluations we reviewed. The majority of the errors resulted from VARO staff not establishing suspense diaries in the electronic record so they would receive reminder notifications to schedule required VA medical reexaminations. Four of these errors involved confirmed and continued rating decisions. There were no systemic trends found in the remaining processing inaccuracies and they were determined to have occurred because of human error.

During our 2014 inspection, we did not identify any cases where VSC staff failed to input a suspense diary for future medical reexaminations in the electronic system. However, 7 of the 16 processing errors that we found were initially part of VBA's national review for temporary 100 percent disability evaluations. In September 2012, OIG provided a list of 712 temporary 100 percent disability evaluations to the Cleveland VARO with instructions to take necessary actions to complete these evaluations. As of December 2014, VARO staff had not taken any action to process the seven temporary 100 percent disability evaluations. Therefore, we find the actions taken by VARO staff in response to addressing pending temporary 100 percent disability claims as part of the national review plan to have not been effective.

***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 previous annual 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.

VARO staff incorrectly processed 6 of 30 TBI claims—all 6 inaccuracies had the potential to affect veterans' benefits. Following are details on those errors.

- An RVSR prematurely evaluated a veteran's TBI without a medical examiner distinguishing which overlapping symptoms were attributable to TBI and his coexisting mental condition. Without the required evidence, neither VARO staff nor we can determine the correct evaluation for TBI and the coexisting mental condition. VARO management agreed with this error.
- An RVSR prematurely denied a TBI claim without obtaining a VA medical examination. The veteran's service treatment records noted head trauma due to a motor vehicle accident, and VA treatment reports noted his clinical symptoms were consistent with a diagnosis of TBI sustained during service. VBA policy requires staff obtain a medical examination when the evidence of record contains an event or injury in service and associated symptoms of disability, but does not contain sufficient medical evidence to decide the claim. VARO management did not agree with this error stating that a VA exam was not warranted. However, based upon the veteran's current complaints, his service treatment records, and VA treatment records provided sufficient evidence of an in-service event with current residuals to warrant a TBI medical examination. Without a VA medical examination, neither VARO staff nor we can determine if the veteran would have been entitled to benefits.
- An RVSR prematurely evaluated a veteran's TBI without a medical examiner distinguishing which overlapping symptoms were attributable to TBI and his coexisting mental condition. VARO management did not

agree with this error stating that the RVSR correctly evaluated TBI separately from the coexisting mental condition because the RVSR did not use the same symptoms to evaluate each condition. However, VBA policy states that when there is an overlap of symptoms between coexisting mental disorders and residuals of TBI, the examiner has the task of determining the etiology of the symptoms that are present, not the RVSR. Without the required evidence, neither VARO staff nor we can determine the correct evaluation for TBI and the coexisting mental condition.

- An RVSR failed to consider headaches as a residual of TBI. Although the TBI examiner noted that the veteran had headaches attributable to the TBI, no separate headaches examination was completed as required. VARO management did not agree with this error stating that the RVSR determined that the evidence of record was sufficient to decide the claim. However, VBA policy states that a claim for TBI is a claim for all residuals of TBI, and residual disabilities noted on the TBI examination require the completion of an additional medical examination questionnaire. Without the additional VA examination, neither VARO staff nor we can determine the correct evaluation for the TBI related residual.
- An RVSR prematurely evaluated a veteran's TBI without a medical examiner distinguishing which overlapping symptoms were attributable to a TBI and a coexisting mental condition, and failed to consider a residual of TBI. The TBI examiner noted that the veteran had headaches attributable to TBI but did not complete the additional headaches examination as required. VARO management did not agree with this error stating that it was unable to locate the decision in the claims file. In response, we identified the decision and all related evidence in the claims file for VARO management. Without the required evidence, neither VARO staff nor we can determine the correct evaluation for TBI related residuals.
- An RVSR incorrectly assigned separate evaluations for a veteran's TBI and coexisting mental condition, and incorrectly denied service connection for associated migraine headaches. VARO management disagreed with this error stating that the RVSR correctly evaluated TBI and the coexisting mental condition because the RVSR did not use the same symptoms to evaluate each condition, and used the headaches as a subjective symptom to support the TBI evaluation. However, VBA policy requires staff to assign a single evaluation when the VA examiner cannot separate symptoms of TBI and a coexisting mental disorder. Further, migraine headaches are required to be separately evaluated as they are a distinct diagnosis. These errors did not affect the veteran's monthly benefits; however, they have the potential to affect future benefits if the veteran's other service-connected disabilities worsen or if service connection is granted for a new disability.

Although the VSC Manager stated the VARO follows VBA's second-signature policy for TBI claims processing, four of the six cases we identified with processing errors did not receive a second level review, as required by VBA policy. The RVSRs who processed these cases had not demonstrated 90 percent accuracy in TBI claims processing, as required.

Generally, the errors we identified were the result of lack of VARO management oversight to ensure staff complied with VBA's second-signature review policy for TBI claims. Had management ensured RVSRs met the required accuracy rate prior to rating TBI claims independently, they may have prevented the errors in those cases. Further, even though VARO staff completed VBA's revised mandatory TBI training in February 2014 and additional training in September 2014, staff stated that the VARO does not have a process to measure the effectiveness of training. As a result of this lack of management oversight, veterans may not always receive correct benefits payments.

*Follow-Up to Prior VA OIG Inspection*

In our previous report, *Inspection of the VA Regional Office, Cleveland, Ohio* (Report No. 12-00241-296, September 27, 2012), we determined 5 of 30 TBI cases reviewed contained processing errors. We attributed the errors to staff incorrectly interpreting VBA policy and using their own interpretations of medical examination results to decide claims. In response to our recommendation, the Director agreed to ensure RVSRs receive refresher training on evaluating TBI claims that involve coexisting medical conditions. Further, the Director stated that VARO staff would conduct quarterly random sampling reviews of TBI claims until noted improvement. As a result, the OIG closed the recommendation in April 2014.

Because the results of our December 2014 benefits inspection disclosed similar problems, we concluded that the corrective actions in response to our 2012 report were inadequate. Despite refresher training, we continued to see a high error rate associated with TBI claims processing. Further, the VSC manager could not provide us with documentation of quarterly random sampling reviews of TBI claims. Had management maintained adequate records and oversight of these reviews, training may have been tailored to address VARO specific claims processing deficiencies.

***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 Title 38, United States Code, Chapter 35
- 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 or loss of use of two or more extremities, or bilateral blindness with visual acuity of 5/200 or worse.

VARO staff incorrectly processed 8 of 30 veterans' claims involving SMC and ancillary benefits. Seven of the eight inaccuracies affected veterans' payments. These inaccuracies resulted in 165 improper payments totaling $120,728 to 7 veterans, from July 2008 until November 2014. Details on the seven errors affecting benefits follow.

- In two cases, VARO staff did not grant a higher level of SMC for veterans with loss of use of both feet and an additional permanent disability evaluated at 100 percent disabling. As a result, one veteran was underpaid approximately $2,948 over a period of 8 months, and the other veteran was underpaid approximately $8,046 over a period of 22 months. Additionally, in one of these cases, VARO staff did not grant a veteran entitlement to specially adapted housing, a benefit currently worth up to $70,465.
- An RVSR incorrectly assigned a higher level of SMC for aid and attendance. However, the available medical records did not show the veteran required aid and attendance for disabilities other than the loss of

use of both feet. As a result, the veteran was overpaid approximately $83,963 over 25 months.

- In one case, an RVSR under evaluated a veteran's SMC. As a result, the veteran was underpaid approximately $7,467 over a period of 28 months. Additionally, the RVSR did not grant entitlement to a special housing adaption grant, a benefit currently worth up to $14,093.
- In two different decision documents, RVSRs did not grant a higher level of SMC for a veteran with loss of use of both feet and additional permanent disabilities evaluated at 50 percent disabling. As a result, the veteran was underpaid approximately $13,337 over a period of 76 months.
- An RVSR used an incorrect effective date to assign entitlement for a higher level of SMC. The decision document granted the entitlement as of June 29, 2011; however, the evidence of record shows the veteran actually submitted his claim on January 6, 2011. As a result, the veteran was underpaid $4,905 over a period of 5 months.
- In the final case, an RVSR assigned an incorrect SMC code to determine the veteran's disability benefits payments while he was hospitalized at Government expense. As a result, VA overpaid the veteran approximately $63 over a period of 7 days.

The remaining error had the potential to affect a veteran's benefits. In this case, the RVSR used incorrect SMC codes to determine the veteran's disability benefits payments. Although the error did not affect the veteran's current monthly benefits, it may affect future monthly benefits. For example, if the veteran becomes hospitalized at Government expense, the monthly payment could be reduced to an incorrect SMC rate.

Generally, these errors occurred due to a lack of training and oversight of these complex cases. According to VARO training records, SMC training had not been provided to staff since 2011. VARO management stated they were not aware that this was the last time the station completed SMC training. During our inspection, a member of VBA's Systematic Technical Accuracy Review (STAR) staff provided SMC training to VARO staff. We reviewed a copy of this training and found that it covered some of the types of errors that we identified; however, we could not assess the effectiveness of the training. Finally, we received a current copy of the fiscal year 2015 VARO training schedule, and found that no additional SMC training has been scheduled.

During our interviews, VARO staff and management stated that it was easy for issues to be missed because higher level SMC cases were complex and infrequently seen. One of the errors we identified was processed by the quality review staff, and another error was reviewed by quality review staff without any deficiencies noted.

Quality review staff stated that the VARO had not identified any training issues related to higher levels of SMC. Although at the time of our inspection, VBA policy allowed the VSC manager the discretion to require a second-level review for SMC claims, VARO management informed us that the Cleveland VARO did not require a second-level review on higher level SMC cases.

VARO staff stated that a second-level review for these cases could be helpful if a qualified person was assigned to complete the review. On April 3, 2015, VBA implemented policy requiring a second-level review on all cases involving higher levels of SMC. As a result of this lack of training and oversight, veterans did not always receive correct SMC benefits payments and may not be aware of entitlement to ancillary benefits.

## Recommendations

1. We recommended the Cleveland VA Regional Office Director conduct a review of the 880 temporary 100 percent disability evaluations remaining from their universe as of October 8, 2014, and take appropriate actions.

2. We recommended the Cleveland VA Regional Office Director provide training on prioritizing temporary 100 percent disability evaluation claims and assess the effectiveness of that training.

3. We recommended the Cleveland VA Regional Office Director certify that corrective action has been accomplished for the seven cases still requiring action from our September 2012 inspection.

4. We recommended the Cleveland VA Regional Office Director implement a plan to monitor the effectiveness of training on traumatic brain injury claims.

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

6. We recommended the Cleveland VA Regional Office Director implement a plan to assess the effectiveness of the recent special monthly compensation training and continue to provide refresher training on higher levels of special monthly compensation and ancillary benefits.

***Management Comments***

The VARO Director concurred with our recommendations. The VSC will conduct a review of the 880 temporary 100 percent disability evaluations remaining as of October 8, 2014, and take appropriate actions. Further, staff will receive refresher training regarding prioritizing temporary 100 percent

disability evaluations, including a review mechanism to ensure improvement is measurable. We will monitor the Temporary 100 Percent Review Performance Analysis and Integrity (PA&I) reports following training to ensure timely processing. In addition, VSC staff will take corrective action on the seven cases still requiring action as of December 2014, from the September 2012 inspection. The VSCM will certify compliance to the Director.

The VSC will monitor the effectiveness of training for TBI claims. We will review random sampling of TBI ratings to begin no later than October 1, 2015, and quarterly thereafter until measurable improvement is attained. Further, the VSC will monitor compliance with second-signature requirements of TBI ratings, to include tracking and trending errors in processing to identify local training needs.

The VSC will assess the effectiveness of recent SMC training and continue to provide refresher training on higher levels of SMC and ancillary benefits, as needed. We will review random sampling of SMC ratings to begin no later than October 1, 2015, and quarterly thereafter until measurable improvement is attained. Refresher training will be provided if a need is identified.

***OIG Response*** The Director's comments and actions are responsive to the recommendations.

## II. Data Integrity

***Dates of Claim***

To ensure all claims receive proper attention and timely processing, VBA policy directs staff to 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. We focused our review on whether VSC staff followed VBA policy for establishing dates of claim in the electronic record.

### Finding 2 Cleveland VARO Needs To Improve Date of Claim Accuracy

VARO staff incorrectly established 3 of 30 dates of claim we reviewed in VBA's electronic systems of record. None of these errors affected veterans' monthly benefits or had potential to affect the veterans' benefits. However, incorrect dates of claim can misrepresent VBA performance measures. Details on these errors follow.

- In one case, a veteran's original claim for benefits was established using the date of claim of September 23, 2014. However, review of the evidence shows the claim was actually received at the VARO on March 27, 2014—a difference of 180 days.
- In another case, a veteran's claim for dependency benefits was established using the date of claim of August 6, 2014. However, review of the evidence shows the claim was actually received at the VARO on February 12, 2014, a difference of 175 days.
- In the remaining case, VARO staff incorrectly established the date of claim as July 24, 2014, for a veteran's claim for increased benefits. We identified evidence showing the claim was actually received on June 11, 2014—a difference of 43 days.

Generally, these errors occurred due to lack of effective training and oversight to ensure accurate dates of claim were established in VBA's electronic systems of record. Although VARO management provided division guidance on processing dates of claim in July, August, and December 2014, staff responsible for established dates of claim in the electronic systems of records, reported still being confused about what specific date to use when establishing dates of claim.

For example, a document received from a veteran's appointment representative may show multiple dates stamped on the form; however, only one date is correct when establishing the date of claim. VSC management acknowledged it had not identified any error trends for dates of claim. As a result of using the incorrect dates of claim in the electronic systems of record, veterans may not have received benefits as entitled, and there is an increased risk in misrepresenting the statistics of VARO performance for pending workloads.

VARO management nonconcurred with the three errors we identified. In its response for two cases, it stated the dates of claim were established in other VAROs. We acknowledged agreement and explained that was not the basis for the error. After the Cleveland VARO staff accepted jurisdiction of these claims, incorrect dates of claim were established in the electronic systems of record. In the last case, management stated a later date of claim was established because additional evidence was needed to decide the claim. However, the evidence needed to take the required action was actually received on the same date as the original claim.

## Recommendations

7. We recommended the Cleveland VA Regional Office Director implement a plan to provide refresher training to staff on establishing accurate dates of claim in the Veterans Benefits Administration's electronic systems of record and assess the effectiveness of the training.

8. We recommended the Cleveland VA Regional Office Director implement a plan to ensure staff establish accurate dates of claim in the Veterans Benefits Administration's electronic systems of record.

***Management Comments***

The VARO Director concurred with our recommendations. The VSC will conduct refresher training on establishing accurate dates of claim in the electronic system of record. The VSC will implement a review mechanism to ensure improvement is measurable on accurate establishment of dates of claim in the electronic system of record. Further, we will review random sampling of dates of claim to begin no later than October 1, 2015, and quarterly thereafter until measurable improvement is attained.

***OIG Response***

The Director's comments and actions are responsive to the recommendations.

## III. Management Controls

***Benefits Reductions***

VBA policy provides for 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. Such instances are attributable to VARO staff not taking the actions required to ensure veterans receive correct payments for their current 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 veteran does not provide additional evidence within that period, an RVSR must 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 3 Cleveland VARO Needs To Ensure Timely Action on Proposed Benefits Reductions

VARO staff delayed or incorrectly processed 24 of 30 cases involving benefits reductions—22 affected veterans' benefits and 2 had the potential to affect veterans' benefits. Processing inaccuracies delays resulted in overpayments totaling approximately $212,715 representing 177 improper monthly payments to 22 veterans from January 2013 to November 2014.

***Processing Delays***

Processing delays occurred in 24 of 30 claims that required rating decisions to reduce benefits. In the case with the most significant overpayment, VSC staff sent a letter to the veteran on April 11, 2013, proposing to reduce the evaluation for larynx cancer. The due process period expired on June 17, 2013, without the veteran either providing additional evidence to support the claim, or requesting a pre-determination hearing. However, VSC staff did not reduce the benefits until September 22, 2014. As a result, VA overpaid the veteran approximately $42,113 over a period of 14 months.

Generally, these processing delays occurred because VARO management did not view this work as a priority, although the station's Workload Management Plan directed staff to review rating reduction cases weekly. Interviews with management and staff confirmed that rating reductions were considered a lower priority compared with other work being directed by VBA's Central Office. As a result of the processing delays, veterans received erroneous benefits payments.

VARO management nonconcurred with all 24 of the processing delays we identified, stating there is no requirement for action on the 65th day following due process notification. Management also stated the criteria only requires action not be taken prior to the 65th day. We disagree with this response. VBA criteria states VARO staff must take immediate action at the end of the due process period with the only allowance for delays based on either a hearing request from the veteran, or a need for development for more evidence. In all these cases, none met the provisions outlined in VBA's policy that allow for an extension to complete this work.

*Accuracy Errors*

VARO staff incorrectly processed 1 of the 24 cases with a processing delay. In this case, VSC staff assigned an incorrect effective date for the reduction. As a result of this processing inaccuracy, the reduction was delayed by an additional 2 months. VARO management did not concur with this error, but did not provide any supporting criteria. The overpayment amount of this processing inaccuracy is reported in our processing delays. As we only identified one accuracy error and did not identify a common trend, pattern, or systemic issue, we make no recommendation for improvement in this area.

## Recommendation

9. We recommended the Cleveland VA Regional Office Director implement a plan to ensure oversight and prioritization of benefits reduction cases.

***Management Comments***

The VARO Director concurred with our recommendation. The VSC will ensure that benefit reduction cases are prioritized and have proper oversight. We will review benefit reduction case workload to ensure timely processing, to begin no later than October 1, 2015, and quarterly thereafter until measurable improvement is attained.

***OIG Response***

The Director's comments and actions are responsive to the recommendation.

# Appendix A VARO Profile and Scope of Inspection

***Organization***

The Cleveland VARO administers a variety of services and benefits, including compensation and pension benefits; home loan guaranty; vocational rehabilitation and employment assistance; specially adapted housing grants; benefits counseling; outreach to homeless, elderly, minority, women veterans; and public affairs.

***Resources***

As of November 2014, the Cleveland VARO reported a staffing level of 545.2 full-time employees. Of this total, the VSC had 305.7 employees assigned.

***Workload***

As of September 2014, VBA reported the Cleveland VARO had 11,346 pending compensation claims with 4,728 (42 percent) pending greater than 125 days.

***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 December 2014, we evaluated the Cleveland 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 910 temporary 100 percent disability evaluations (3 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 October 8, 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 880 claims remaining from our universe of 910 for review. We reviewed 30 of 528 disability claims related to TBI (6 percent) and 30 of 60 claims involving entitlement to SMC and ancillary benefits (50 percent) completed by VARO staff during fiscal year 2014.

We reviewed 30 of 6,109 dates of claim recorded in VBA's Corporate Database from July through September 2014 as of October 14, 2014. Additionally, we looked at 30 of 238 completed claims (13 percent) that proposed reductions in benefits from July through September 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 150 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI claims, SMC and ancillary benefits, dates of claim, and completed claims related to 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 reviewed in conjunction with our inspection of the VARO did not disclose any problems with data reliability.

This report references VBA's STAR data. As reported by STAR as of September 2014, the overall claims-based accuracy of the VARO's compensation rating-related decisions was 89.7 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. Cleveland 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 |
| **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) | No |
| **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:** June 23, 2015

**From:** Director, VA Regional Office Cleveland, Ohio

**Subj:** Inspection of the VA Regional Office Cleveland, Ohio

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

1. During the week of December 8, 2014, OIG conducted an inspection of the Veterans Service Center operations at the Cleveland VA Regional Office. Our responses to the recommendations are incorporated in the attached report. Specific responses to each OIG recommendation of the subject report are provided in the attachment to this memorandum.
2. 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 216-522-3600.

*(Original signed by)*

Anthony Milons
Director

Attachment

Attachment

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

| | |
|---|---|
| Recommendation 1: | We recommended the Cleveland VA Regional Office Director conduct a review of the 880 temporary 100 percent disability evaluations remaining from their universe as of October 8, 2014, and take appropriate actions. |
| **RO Response:** | **Concur. The VSC will conduct a review of the 880 temporary 100 percent disability evaluations remaining as of October 8, 2014, and take appropriate actions. The start date of this review is October 1, 2015, and the VSCM will certify compliance to the Director.**<br><br>**Target Completion Date: April 30, 2016 based on due process requirements and on competing workload priorities as set forth by the Under Secretary for Benefits through the remainder of FY15.** |
| **Applicable Attachment(s):** | n/a |
| Recommendation 2: | We recommended the Cleveland VA Regional Office Director provide training on prioritizing temporary 100 percent disability evaluation claims and assess the effectiveness of that training. |
| **RO Response:** | **Concur. The VSC will conduct refresher training regarding prioritizing temporary 100 percent disability evaluations, including a review mechanism to ensure improvement is measurable.**<br><br>**We will monitor the Temporary 100 Percent Review Performance Analysis and Integrity (PA&I) reports following training to ensure timely processing. The review will begin no later than October 1, 2015 and quarterly thereafter until measurable improvement is attained. Refresher training will be provided by January 4, 2016.**<br><br>**Target Completion Date: January 4, 2016** |
| **Applicable Attachment(s):** | n/a |
| Recommendation 3: | We recommended the Cleveland VA Regional Office Director certify that corrective action has been accomplished for the seven cases still requiring action from our September 2012 inspection. |

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| **RO Response:** | **Concur. The VSC will take corrective action on the seven cases still requiring action as of December 2014, from the September 2012 inspection. The start date of this review was June 9, 2015, and the VSCM will certify compliance to the Director.**<br><br>**Target Completion Date: December 1, 2015 based on due process requirements and on competing workload priorities as set forth by the Under Secretary for Benefits through the remainder of FY15.** |
| **Applicable Attachment(s):** | n/a |
| Recommendation 4: | We recommended the Cleveland VA Regional Office Director implement a plan to monitor the effectiveness of training on traumatic brain injury claims. |
| **RO Response:** | **Concur. The VSC will monitor the effectiveness of training for TBI claims.**<br><br>**We will review random sampling of TBI ratings to begin no later than October 1, 2015 and quarterly thereafter until measurable improvement is attained. Special reviews will continue on these cases to ensure improvement closer to the Division's overall 3-month issue based quality level.**<br><br>**Target Completion Date: January 4, 2016** |
| **Applicable Attachment(s):** | n/a |
| Recommendation 5: | We recommended the Cleveland VA Regional Office Director implement a plan to ensure staff comply with Veterans Benefits Administration's second-signature requirements for traumatic brain injury claims, including tracking and trending errors in processing to identify local training needs. |
| **RO Response:** | **Concur. The VSC will monitor compliance with second-signature requirements of TBI ratings, to include tracking and trending errors in processing to identify local training needs.**<br><br>**We will review random sampling of TBI ratings to begin no later than October 1, 2015 and quarterly thereafter until measurable improvement is attained. Refresher training will be provided if a need is identified.**<br><br>**Target Completion Date: January 4, 2016** |

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| **Applicable Attachment(s):** | n/a |
| Recommendation 6: | We recommended the Cleveland VA Regional Office Director implement a plan to assess the effectiveness of the recent special monthly compensation training and continue to provide refresher training on higher levels of special monthly compensation and ancillary benefits. |
| **RO Response:** | **Concur. The VSC will assess the effectiveness of recent SMC training and continue to provide refresher training on higher levels of SMC and ancillary benefits, as needed.**<br><br>**We will review random sampling of SMC ratings to begin no later than October 1, 2015 and quarterly thereafter until measurable improvement is attained. Refresher training will be provided if a need is identified.**<br><br>**Target Completion Date: January 4, 2016** |
| **Applicable Attachment(s):** | n/a |
| Recommendation 7: | We recommended the Cleveland VA Regional Office Director implement a plan to provide refresher training to staff on establishing accurate dates of claim in the Veterans Benefits Administration's electronic systems of record and assess the effectiveness of the training. |
| **RO Response:** | **Concur. The VSC will conduct refresher training on establishing accurate dates of claim in the electronic system of record. Refresher training will be provided by January 4, 2016**<br><br>**Target Completion Date: January 4, 2016** |
| **Applicable Attachment(s):** | n/a |
| Recommendation 8: | We recommended the Cleveland VA Regional Office Director implement a plan to ensure staff establish accurate dates of claim in the Veterans Benefits Administration's electronic systems of record. |
| **RO Response:** | **Concur. The VSC will implement a review mechanism to ensure improvement is measurable on accurate establishment of dates of claim in the electronic system of record.**<br><br>**We will review random sampling of dates of claim to begin no later than October 1, 2015 and quarterly thereafter until measurable** |

| | |
|---|---|
| | **improvement is attained.**<br><br>**Target Completion Date: January 4, 2016** |
| **Applicable Attachment(s):** | n/a |
| Recommendation 9: | We recommended the Cleveland VA Regional Office Director implement a plan to ensure oversight and prioritization of benefits reduction cases. |
| **RO Response:** | **Concur. The VSC will ensure that benefit reduction cases are prioritized and have proper oversight.**<br><br>**We will review benefit reduction case workload to ensure timely processing, to begin no later than October 1, 2015 and quarterly thereafter until measurable improvement is attained.**<br><br>**Target Completion Date: January 4, 2016** |
| **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 | Brent Arronte, Director<br>Jason Boyd<br>Orlan Braman<br>Daphne Brantley<br>Bridget Byrd<br>Dana Sullivan<br>Nelvy Viguera Butler<br>Claudia Wellborn |

# Appendix E Report Distribution

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Veterans Benefits Administration Eastern Area Director
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