VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Benefits Administration

Inspection of
the VA Regional Office
Seattle, Washington

August 3, 2017
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ACRONYMS

AVSCM	Assistant Veterans Service Center Manager
DOC	Date of Claim
FY	Fiscal Year
NWQ	National Work Queue
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SMC	Special Monthly Compensation
SVSR	Supervisory Veterans Service Representative
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center
VSCM	Veterans Service Center Manager
VSR	Veterans Service Representative

Highlights: Inspection of the VARO Seattle, WA

Why We Did This Review

In October 2016, we evaluated the Department of Veterans Affairs Regional Office (VARO) in Seattle, Washington, to determine how well Veterans Service Center (VSC) staff processed disability claims, how timely and accurately they processed proposed rating reductions, how accurately they entered claims-related information, and how well they responded to special controlled correspondence.

What We Found

Claims Processing—Seattle VSC staff did not consistently process the two types of disability claims we examined. We reviewed 30 of 821 veterans' traumatic brain injury (TBI) claims (4 percent) and found that Rating Veterans Service Representatives (RVSRs) incorrectly processed three of the 30 claims (10 percent). We also reviewed 30 of 71 veterans' special monthly compensation (SMC) claims (42 percent) and found that RVSRs incorrectly processed four of the 30 claims (13 percent). Overall, RVSRs inaccurately processed seven of 60 veterans' disability claims (12 percent) reviewed, resulting in 10 improper monthly payments made to three veterans totaling approximately $23,900. Errors occurred due to TBI cases being assigned to RVSRs not on a specialized team responsible for working TBI cases. SMC errors were generally due to ineffective training, including training on effective dates to pay benefits.

Proposed Rating Reductions—VSC staff generally processed proposed rating reductions accurately but they needed to prioritize workloads to ensure timely action. We reviewed 30 of 836 proposed rating reduction cases (4 percent) and found that staff delayed or incorrectly processed 12 of 30 of those cases (40 percent). Delays were due to prioritization of other workloads and resulted in about $78,400 in overpayments.

Systems Compliance—VSC staff needed to improve the accuracy of claims-related information input into the electronic systems at the time of claims establishment. We reviewed 30 of 2,027 established claims (1 percent) and found that Claims Assistants and Veterans Service Representatives (VSRs) did not correctly establish four of 30 claims (13 percent) because of ineffective training. Consequently, the potential existed for claims to be misrouted and processing to be delayed.

Special Controlled Correspondence—VSC staff needed to improve timeliness and accuracy in the processing of special controlled correspondences. We reviewed 30 of 381 special correspondences (8 percent) and found that staff incorrectly processed 14 of these 30 (47 percent) because of a lack of training and inadequate oversight. As a result, congressional staff were not timely made aware of the status of cases about which they had inquired, and Veterans Benefits Administration (VBA) staff would not be able to review issues pertaining to timeliness and accuracy of special controlled correspondence in the veterans' electronic claims folders.

What We Recommended

We recommended the VARO Director implement plans to provide refresher training for TBI, effective dates, special controlled correspondence, and establishing claims in the electronic record. We also recommended the Director ensure TBI claims are assigned to qualified RVSRs and ensure RVSRs follow VBA policies for processing TBI and SMC claims. Finally, we recommended the Director prioritize benefit reductions and provide oversight of special controlled correspondence.

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

Objectives

The Benefits Inspection Program is part of the VA OIG's efforts to ensure our nation's veterans receive timely and accurate benefits and services. We conduct onsite inspections at randomly selected VA Regional Offices (VAROs) to assess their effectiveness. In FY 2017, we looked at four mission operations—Disability Claims Processing, Management Controls, Data Integrity, and Public Contact. Our inspections help identify risks within each operation or VARO program responsibility. In FY 2017, our objectives are to assess the VARO's effectiveness in:

- Disability claims processing by determining whether Veteran Service Center (VSC) staff accurately processed traumatic brain injury (TBI) claims and claims related to special monthly compensation (SMC) and ancillary benefits
- Management controls by determining whether VSC staff timely and accurately processed proposed rating reductions
- Data integrity by determining whether VSC staff accurately input claim and claimant information into the electronic systems
- Public contact by determining whether VSC staff timely and accurately processed special controlled correspondence

When 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. Errors that affect benefits have a measurable monetary impact on veterans' benefits. Errors that have the potential to affect benefits are those that either had no immediate effect on benefits or had insufficient evidence to determine the effect to benefits.

Seattle VA Regional Office

As of October 2016, Veterans Benefits Administration (VBA) reported the Seattle VARO had a staffing level of 590 full-time employees; the VARO was authorized to have 611 employees. Of this total, the VSC had 254.4 employees assigned; the VSC was authorized 263 employees. In FY 2016, VBA reported the Seattle VARO completed 27,662 compensation claims—averaging 4.7 issues[1] per claim.

[1] Under M21-1 Adjudication Procedures Manual, Part III, Subpart iv, Chapter 6, Section B, *Determining the Issues*, "issues" are disabilities and benefits.

RESULTS AND RECOMMENDATIONS

I. Disability Claims Processing

Finding 1 Seattle VSC Staff Needed To Improve Disability Claims Processing Accuracy

The Seattle Rating Service Representatives (RVSRs) did not always process entitlement to TBI or SMC and ancillary benefits consistent with VBA policy. The TBI errors were due to claims being assigned to RVSRs not on a specialized team tasked with working TBI claims. Generally, the errors for SMC were due to ineffective training, as VSC staff noted they found the office's training process to be insufficient, as it did not ensure full participation. Overall, RVSRs incorrectly processed seven of the 60 disability claims we sampled, resulting in 10 improper monthly payments to three veterans totaling approximately $23,900[2] at the time of our review, in September 2016.

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

Table 1. Seattle VARO Disability Claims Processing Accuracy

		Veterans' Claims Inaccurately Processed		
Type of Claim	**Reviewed**	**Affecting Veterans' Benefits**	**Potential To Affect Veterans' Benefits**	**Total**
TBI	30	0	3	3
SMC and Ancillary Benefits	30	3	1	4
Total	**60**	**3**	**4**	**7**

Source: VA OIG analysis of the VBA's TBI disability claims completed from March 1 through August 31, 2016, and SMC and ancillary benefits claims completed from September 1, 2015 through August 31, 2016.

[2] All calculations in this report have been rounded when applicable.

VBA Policy Related to TBI Claims

VBA defines a TBI event as a traumatically induced structural injury or a physiological disruption of brain function resulting from an external force. The major residual disabilities of TBI fall into three main categories—physical, cognitive, and behavioral/emotional.[3] VBA policy requires staff to evaluate these residual disabilities. VBA policy states that all rating decisions that address TBI as an issue must only be worked and reviewed by an RVSR or a Decision Review Officer (DRO) who has completed the required TBI training. Rating decisions for TBI require two signatures until the decision-maker has demonstrated an accuracy rate of 90 percent or greater, based on the VARO's review of at least 10 TBI decisions.[4]

VBA policy requires that one of the following specialists must make the initial diagnosis of TBI: physiatrists, psychiatrists, neurosurgeons, or neurologists.[5] A generalist clinician who has successfully completed the required TBI training may conduct a TBI examination, if the diagnosis is of record and was established by one of the aforementioned specialty providers.[6]

Review of TBI Claims

We randomly selected and reviewed 30 of 821 veterans' TBI claims (4 percent) completed from March 1 through August 31, 2016 to determine whether VSC staff decided them according to Federal regulation. For example, we checked to see if VSC staff obtained an initial medical examination, as required.[7]

RVSRs inaccurately processed three of the 30 veterans' TBI claims—all three of the errors had the potential to affect veterans' benefits. Our review of initial TBI examinations found no improper diagnoses of TBI. We provided the acting Veterans Service Center Manager (VSCM) with the specifics of the claims and asked for management's review. The acting VSCM and an Assistant VSCM (AVSCM) concurred with the errors we identified. Summaries of the errors follow.

- In two cases, RVSRs incorrectly assigned compensable evaluations for TBI based on symptoms attributed to other service-connected conditions. Federal regulation requires staff to assign a separate evaluation if the symptoms of TBI and a coexisting mental, neurologic, or other physical disorder are clearly separable.[8] Federal regulation also requires that the evaluation of the same disability under various diagnoses is to be avoided.[9] These two errors did not affect the veteran's monthly benefits;

[3] M21-1 Adjudication Procedures Manual, Part III, subpart iv, Chapter 4, Section G, Topic 2, *TBI*
[4] *Ibid.*
[5] Chapter 3, Section D, Topic 2, *Examination Report Requirements*
[6] *Ibid.*
[7] 38 CFR §3.159(c)(4)
[8] §4.124a
[9] §4.14

however, they had 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 at some future date.

- An RVSR prematurely denied an incarcerated veteran service connection for TBI without a VA medical examination. VBA policy requires that the VARO and/or the local Veterans Health Administration (VHA) Medical Examination Coordinator confer with prison authorities to determine if the veteran should be examined at the prison by prison medical providers at VA expense, or fee-basis providers contracted by VHA.[10] There is no evidence of an attempt to conduct an examination at the facility where the veteran was incarcerated. Without a VA medical examination, we could not determine if the veteran would have been entitled to benefits.

Errors related to veterans' TBI claims processing occurred because the RVSRs who made the errors were not assigned to the specialized team responsible for processing TBI claims. Despite the Workload Management Plan directing that all TBI cases be completed by a specialized team, the AVSCMs allowed TBI cases to be distributed to other teams for processing. The acting VSCM stated that there was uncertainty about the types of cases the VARO would receive from a newly implemented national workload distribution tool and management did not want to overload the specialized team with TBI cases.

VBA policy states that all rating decisions that address TBI as an issue must only be worked and reviewed by a RVSR or DRO who has completed the required TBI training. Rating decisions for TBI require two signatures until the decision-maker demonstrates an accuracy rate of 90 percent or greater, based on the VARO's review of at least 10 TBI decisions.[11] In the 30 veterans' cases reviewed, 16 did not have the required second signature. Of the three TBI decisions with errors, two did not have the required second signature. Generally, interviews with staff revealed they had an inconsistent understanding of the second signature policy. The acting VSCM stated that this was a training issue and that management would send reminders to RVSRs and supervisors to reinforce the consistent application of this requirement. As a result of improper workload distribution, lack of oversight, and ineffective training, veterans may not always receive correct benefits payments.

Previous OIG Inspection Results

In our previous report, *Inspection of the VA Regional Office, Seattle, Washington* (Report No. 14-01502-259, September 24, 2014), we identified 29 TBI claims available for our review that VSC staff correctly processed. As a result, we determined that the Seattle VARO was generally in compliance with

[10] M21-1 Adjudication Procedures Manual, Part III, subpart iv, Chapter 3, Section A, Topic 9, Sub-topic d. *Examinations of Incarcerated Veterans*
[11] Chapter 4, Section G, Topic 2, *TBI*

VBA's policy to process TBI claims. Therefore, we made no recommendations for improvement in this area.

VBA Policy Related to SMC and Ancillary Benefits

VBA assigns SMC to recognize the severity of certain disabilities or combinations of disabilities by adding an additional compensation to the basic rate of payment when the basic rate is not sufficient for the level of disability present. 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. Ancillary benefits are secondary benefits that are considered when evaluating claims for compensation, which include eligibility for educational,[12] automobile,[13] and housing benefits.[14]

VBA policy requires staff to address the issues of SMC and ancillary benefits whenever they can grant entitlement.[15] VBA policy also states that all rating decisions involving SMC above a specified level require a second signature.[16]

In our report, *Review of VBA's Special Monthly Compensation Housebound Benefits* (Report No. 15-02707-277, September 29, 2016), we reviewed SMC housebound benefits. Our Benefits Inspection reports reviewed a higher level of SMC that included those payment rates related to disabilities such as loss of limbs, loss of eyesight, and paralysis. These reviews did not overlap because this review involved different types of SMC that cannot be granted simultaneously with SMC housebound benefits.

Review of SMC and Ancillary Benefit Claims

We randomly selected and reviewed 30 of 71 veterans' claims (42 percent) involving SMC and ancillary benefits completed from September 1, 2015 through August 31, 2016. We examined whether VSC staff accurately decided 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. We found that four of 30 veterans' claims contained errors. Three errors affected veterans' benefits and resulted in improper payments totaling approximately $23,900. These errors represented 10 improper monthly payments from May to December 2015. We provided the acting VSCM with the specifics of the claims and asked for

[12] Dependents' Educational Assistance under Title 38 Code of Federal Regulations Section 3.807, provides education benefits for the spouse and children of eligible veterans.
[13] Automobiles or Other Conveyances and Adaptive Equipment under Title 38 Code of Federal Regulations Section 3.808, provides eligible veterans payments toward the purchase of an automobile, or other special equipment or assistive devices such as power seats.
[14] Specially Adapted Housing (SAH) Grants under Title 38 Code of Federal Regulations Section 3.809 and Special Home Adaptation (SHA) Grants under Title 38 Code of Federal Regulations Section 3.809a, provide eligible veterans the purchase or construction of barrier-free homes or remodeling an existing home to accommodate disabilities.
[15] M21-1 Adjudication Procedures Manual, Part III, Subpart iv, Chapter 6, Section B, Topic 2, *Considering Subordinate Issues and Ancillary Benefits*
[16] Section D, Topic 7, *Signature*

management review. The acting VSCM concurred with the errors we identified.

The three errors that affected veterans' benefits all involved RVSRs assigning incorrect effective dates for SMC. In the case with the most significant improper payment, an RVSR assigned an incorrect effective date for SMC involving loss of use of a veteran's upper and lower extremities. As a result, the veteran was underpaid approximately $11,900. One of the errors had the potential to affect a veteran's benefits. In this case, an RVSR did not grant eligibility to the Special Home Adaptation grant for a veteran with loss of use of his hands as required.[17] As a result, the veteran was not notified of an entitlement worth up to $15,462.

Generally, the errors involved the use of incorrect dates to pay benefits. Although training was conducted on the proper procedure for establishing effective dates in November and December 2015, staff stated that they still found policy regarding effective dates confusing. A Supervisory Veterans Service Representative (SVSR) advised that RVSRs would benefit from refresher training. Based on interviews with staff, and the fact that three of four errors were a result of applying incorrect effective dates, we concluded that the previous training was ineffective.

In the 30 veterans' cases reviewed, eight did not have the required second signature. Of the four SMC decisions that contained processing errors, two did not have the required second signature. Generally, interviews with VSC staff revealed that they were aware that some SMC decisions required a second signature but were unsure of which types, as they did not process these SMC claims frequently. As a result of ineffective training and not following VBA policy regarding second signature requirements, veterans received incorrect benefits payments.

Previous OIG Inspection Results

In our previous report,[18] we identified six errors involving SMC evaluations out of the 30 claims reviewed. We determined that staff found SMC training confusing and that there was no mechanism in place to evaluate the effectiveness of training. We recommended the VARO Director develop and implement a plan to ensure staff receive refresher training involving SMC claims and to monitor the effectiveness of the training. The VARO Director concurred with our recommendation; he also stated that refresher training would be completed at a later date and that Quality Review staff would conduct additional reviews of all SMC claims completed during selected months and provide training on any errors identified. Since we found no errors involving SMC evaluations, the VARO's response to our recommendation appears to have been effective.

[17] 38 CFR §3.809a

[18] *Inspection of the VA Regional Office, Seattle, Washington,* (Report No. 14-01502-259, September 24, 2014.

Recommendations

1. We recommended the Seattle VA Regional Office Director implement a plan to ensure traumatic brain injury claims are assigned to qualified Rating Veterans Service Representatives for processing.

2. We recommended the Seattle VA Regional Office Director implement a plan to provide refresher training on traumatic brain injury and monitor the effectiveness of that training.

3. We recommended the Seattle VA Regional Office Director implement a plan to ensure Rating Veterans Service Representatives follow second signature policy requirements for traumatic brain injury and special monthly compensation rating decisions.

4. We recommended the Seattle VA Regional Office Director develop and implement a plan to provide refresher training to Rating Veterans Service Representatives regarding proper procedure for applying effective dates.

Management Comments

The Director concurred with our findings and recommendations. The Director noted TBI claims will be routed to qualified RVSRs for processing and the VARO has implemented a plan to expand mentor reviews. The target completion date for these actions is August 31, 2017.

The VARO Director stated that the VARO would conduct refresher TBI training on June 20, 2017 and that the Training Manager and Quality Review Team Coach would monitor local and national error rates in order to track the effectiveness of the training. The target completion date for these actions is June 30, 2017.

In order to ensure RVSRs follow second signature policy requirements for TBI, in addition to the June 2017 training, the VSC will institute a monthly audit of 20 TBI completions to ensure the proper process is followed. Furthermore, the Quality Review Team will review completed rating decisions granting SMC at level L or higher for two weeks each quarter to audit for the proper signature requirements. The target completion date for these actions is August 31, 2017. Finally, the Director stated that the VARO had provided training on the proper use of effective dates for all RVSRs on December 13, 2016.

OIG Response

The Director's comments and actions are responsive to the recommendations. To address Recommendation 4, the VARO developed and implemented a plan to provide refresher training for RVSRs regarding the proper procedure for applying effective dates. Therefore, we consider Recommendation 4 closed and we will follow up as required.

II. Management Controls

Finding 2 Seattle VSC Staff Generally Processed Proposed Rating Reductions Accurately But Needed To Prioritize Workload To Ensure Timely Action

We randomly selected and reviewed 30 of 836 cases (4 percent) in which benefits were proposed to be reduced to determine whether VSC staff accurately and timely processed them. Overall, 12 of the 30 cases we reviewed contained an inaccuracy or delays. All 12 cases involved delays, and one case also had an accuracy error. Of these, 11 affected veterans' benefits and resulted in overpayments totaling approximately $78,400 and an underpayment totaling approximately $2,100, representing 75 improper monthly payments from September 2014 to September 2016. Per Federal regulation, VBA does not recover these overpayments because the delays were due to VA administrative errors.[19] The remaining case had the potential to affect benefits. These processing delays occurred because of the SVSR, Assistant VSCM, and VARO Director not prioritizing these cases to ensure action would be taken on the date the due process notice period expired.

VBA Policy Related to Proposed Rating Reductions

Federal regulation provides compensation payments to veterans for conditions they incurred or aggravated during military service.[20] 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.[21] Such instances are attributable to VSC staff not taking the actions required to ensure veterans receive correct payments for their current levels of disability.

When the VARO obtains evidence which demonstrates that a disability has improved, and the lower evaluation would result in a reduction or discontinuance of current compensation payments, VSRs must inform the beneficiary of the proposed reduction in benefits.[22] 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.[23] If the veteran does not provide additional evidence within that period, an RVSR may make a final determination to reduce or

[19] M21-1 MR Adjudications Procedures Manual, Part III, Subpart v, Chapter 1, Section I, Topic 3, *Consideration of the Cause of Erroneous Benefits*, and 38 CFR §3.500
[20] 38 CFR §3.303
[21] Public Law 107-300
[22] 38 CFR §3.103
[23] §3.105

discontinue the benefit[24] beginning on the 65th day following notice of the proposed action.[25]

On April 3, 2014,[26] and again on July 5, 2015,[27] VBA leadership modified its policy regarding the processing of claims requiring benefits reductions. The current policy no longer includes the requirement for VSC staff to take "immediate action" to process these reductions. VBA noted this change was made to avoid implying the next action on a proposed reduction must be immediate. VBA policy also no longer includes a measurable standard for VSC staff to make final determinations to reduce benefits following expiration of the due process period. 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.

Review of Cases To Assess Accuracy

We randomly selected and reviewed 30 of 836 cases (4 percent) completed from June 1 through August 31, 2016 in which benefits were proposed to be reduced by rating decisions. RVSRs accurately processed 29 of 30 cases involving benefits reductions. In the case that was inaccurately processed, an RVSR assigned an incorrect effective date of August 1, 2016 for the disability reduction. A VSR did not provide the veteran with a prospective date of reduction until a notification letter was sent on August 5, 2016. According to Federal regulation, the date of the reduction should have been effective on November 1, 2016, the beginning of the month following the 60-day period from the date of the notification to the veteran. As a result of this processing inaccuracy, VA underpaid the veteran approximately $2,100 over a one-month period at the time of our review. Because we identified only one accuracy error, we made no recommendations for improvement in this area.

Review of Cases To Assess Timeliness

Processing delays that required rating decisions to reduce benefits occurred in 12 of 30 claims. We considered cases to have delays when RVSRs did not process them on the 65th day following notice of the proposed action and the resulting effective date of reduction was affected by at least one month. For the 12 cases with processing delays, the delays had resulted in an average of over six monthly overpayments at the time we began our review.

The most significant improper payment occurred when an RVSR proposed to reduce a veteran's evaluation for prostate cancer, based on the veteran's failure to report for a review examination. The due process expired on January 16, 2015 without the veteran providing additional evidence.

[24] 38 CFR §3.105
[25] M21-4 Appendix B, Section II, *End Products - Compensation, Pension, and Fiduciary Operations*
[26] M21-1MR Adjudications Procedures Manual, Part I, Chapter 2, Section B, Topic 7, *Establishing and Monitoring Controls*
[27] M21-1 Adjudications Procedures Manual, Part I, Chapter 2, Section C, Topic 2, *Responding to the Beneficiary*

However, an RVSR did not take final action to reduce benefits until August 5, 2016. As a result, VA overpaid the veteran approximately $37,300 over a period of one year and six months at the time of our review.

One of the errors had the potential to affect a veteran's benefits. In this case, an RVSR proposed to reduce a veteran's evaluations for knee and spine conditions, as they were shown to have improved. The due process expired on June 6, 2016 without additional development of evidence needed. However, an RVSR did not take final action to reduce benefits until July 29, 2016. The reduction in the veteran's benefits would have been effective September 1, 2016. As a result of the delayed final rating decision to reduce benefits, the veteran could receive future improper benefit payments.

We provided the details on the delays and accuracy errors that affected benefits, or had the potential to affect benefits, to the acting VSCM, for appropriate action. An AVSCM agreed with our accuracy error but the acting VSCM and an AVSCM did not agree with the 12 delay errors we identified, noting that policy does not provide a specific time frame for completion of the final rating decision to reduce benefits. Prior to the policy change in April 2014, VBA policy had required that maturing due-process cases were to be processed immediately on the 65th day to minimize overpayments. In an interview, VBA Compensation Service staff noted the requirement was removed, but it was generally understood that workload management decisions were under the purview of VARO management and Office of Field Operations. VARO management, including an SVSR, an Assistant VSCM, and the Director, agreed that had RVSRs taken action at the expiration of the due process period, $78,400 would not have been paid for medical conditions shown to have improved.

Generally, these processing delays occurred because VARO management, including an SVSR, an Assistant VSCM, and the Director, did not prioritize these cases to ensure action would be taken on the date the due process period expired. Interviews with VSC staff and an SVSR, an Assistant VSCM, and the VARO Director confirmed that rating reduction cases are a lower priority compared to other work directed by VBA's Central Office to be processed. As a result of the processing delays, veterans continued to receive their current benefits payment amounts despite objective medical evidence showing their medical conditions had improved to the point of warranting a reduction in their benefit entitlement. Without a timeliness standard to measure the workload, VBA will continue to provide unsound financial stewardship of veterans' monetary benefits and fail to minimize improper payments.

Previous OIG Inspection Results

In our previous report, *Inspection of the VA Regional Office, Seattle, Washington* (Report No. 14-01502-259, September 24, 2014), we identified 11 errors involving proposed rating reductions, out of the 30 claims

reviewed. We determined that other priorities prevented staff from taking immediate action on benefits reductions. We recommended the VARO Director implement a plan to ensure claims processing staff prioritize actions related to benefits reductions to minimize improper payments to veterans. However, the Director's response noted that, due to updated guidance, staff were no longer required to take immediate action to process benefits reductions. As a result of VBA removing this timeliness measure, there was no clear requirement to determine when the final reduction should be made, and the recommendation was closed. However, the lack of criteria does not ensure rating reductions are performed timely, so that monthly benefits for disabilities shown to have improved do not continue to be processed. Timely processing is important to ensure taxpayer funds are spent appropriately.

Recommendation

5. We recommended the Seattle VA Regional Office Director implement a plan to ensure prioritization of proposed rating reduction cases for completion at the end of the due process time period.

Management Comments

The VARO Director concurred with our finding and recommendation. The Director reported that VBA provides oversight and prioritization of proposed rating reduction cases at the national level and that VBA will continue to monitor improvements in EP 600 timeliness, making prioritization adjustments as necessary.

OIG Response

The Director's comments and actions are responsive to the recommendation and the VARO has requested closure of this report recommendation. Based on the information provided, we consider Recommendation 5 closed at this time. We will follow up as required.

III. Data Integrity

Finding 3 Seattle VSC Staff Needed To Improve the Accuracy of Information Input Into the Electronic Systems at the Time of Claims Establishment

We randomly selected and reviewed 30 of 2,027 pending rating claims (1 percent) selected from VBA's corporate database to determine whether VSC staff accurately input claim and claimant information into the electronic systems at the time of claim establishment. In four of the 30 claims we reviewed, Claims Assistants and a VSR did not enter accurate and complete information in the electronic systems when the claims were established. These errors were due to ineffective training and lack of oversight. VSC staff noted training was insufficient as it was conducted in an informal meeting format, and VBA does not have a national focused training program for Claims Assistants. Consequently, these claims could have been misrouted in the National Work Queue (NWQ), delayed claims processing, and affected data integrity, thus misrepresenting the VARO's performance measurements.

VBA Policy Related to Data Integrity

VBA relies on data input into electronic systems to accurately manage and report its workload to stakeholders and to properly route claims within its electronic workload management tool, the NWQ. The NWQ centrally manages the national claims workload by prioritizing and distributing claims across VBA's network of VAROs using rules that assign workload based on certain claimant and claim information within the electronic systems.[28] Veterans Benefits Management System is an electronic processing system the NWQ uses to distribute work.[29] Because the NWQ relies on the accuracy of data, claims misidentified or mislabeled at the time of claims establishment can result in improper routing and therefore lead to untimely processing of claims and delays in veterans' benefits. In addition, if not controlled by accuracy reviews at the time of the claim establishment, personally identifiable information could be disclosed without authorization.

Initial claims routing begins at the time of claims establishment. Claims Assistants or VSRs must input claim and claimant information into the electronic systems to ensure compliance.

[28] Department of Veterans Affairs, Veterans Benefits Administration, National Work Queue, Phase 1 Playbook
[29] *Ibid.*

Table 2 reflects nine claim establishment terms.

Table 2. Claim Establishment Terms

Term	Definition
Date of Claim	Earliest date the claim or information is received in any VA facility
End Product	The end product system is the primary workload monitoring and management tool for the VSC
Claim Label	A more specific description of the claim type that a corresponding end product represents
Claimant Address	Mailing address provided by the claimant
Claimant Direct Deposit	Payment routing information provided by the claimant
Power of Attorney	An accredited representative of a service organization, agent, non-licensed individual, or attorney representative chosen by the claimant to represent him or her
Corporate Flash Indicator	Claimant-specific indicators that can represent an attribute, fact, or status that is unlikely to change
Special Issue Indicator	Claim-specific indicators that can represent a certain claim type, disability or disease, or other special notation that is only relevant to a particular claim
Claimed Issue with Classification	Specifies the claimed issue and its medical classification

Source: VA OIG presentation of definitions from VBA's M21-1 and M21-4

Systems Compliance

We randomly selected and reviewed 30 of 2,027 claims (1 percent) established in August 2016 that were pending rating decisions as of September 8, 2016. In four of the 30 claims we reviewed, Claims Assistants and a VSR did not enter accurate and complete information in the electronic systems. The acting VSCM and an AVSCM concurred with the errors we identified.

In two cases, a VSR and a Claims Assistant did not establish the correct dates of claims (DOCs) relating to reminder notifications generated for decision-makers to review continued eligibility of service-connected disability evaluations. VBA policy states that the DOC for these cases is the date of the reminder notification.[30] Using an incorrect DOC could lead to incorrect and delayed routing in the NWQ. An incorrect DOC could also

[30] M21-1 Adjudication Procedures Manual, Part III, Subpart v, Chapter 10, Section A, Topic 2.b *Establishing Date of Claim When 800 Series Work Item Requires Action*

affect data integrity and misrepresent VARO performance for pending workload(s).

In the two remaining cases, Claims Assistants did not enter a special issue indicator in the electronic systems when the claims were established. Special issue indicators are claim-specific and identify a certain claim type, disability or disease, or other special notation. VBA policy states that VSC staff must select the correct special issue indicator when establishing a claim.[31] Although these special issues were not added upon claims establishment, staff added them later in the claims process. However, the omission of the proper special issue could have led to incorrect and delayed routing in the NWQ. Furthermore, the omission of the proper special issue indicator could have affected data integrity and misrepresented VARO performance for pending workload(s).

Generally, the processing errors occurred due to a lack of effective training. VSC staff noted they could not remember receiving training related to establishing DOCs for reminder notifications. Furthermore, staff stated that they did not receive formal training related to special issue indicators but instead had informal meetings they described as ineffective. Staff who conducted the informal meetings noted VBA did not have a national focused training program for Claims Assistants.

In addition, oversight of claims establishment was ineffective. There is no requirement that oversight be performed at the time claims are established. A quality reviewer stated that oversight was performed randomly with no assurance a newly established claim would be selected for review. Therefore, the quality reviewer was unable to determine whether Claims Assistants or VSRs initially established the claim correctly. As a result of the ineffective training and oversight, there is the potential to misroute claims in the NWQ, delay claims processing, and misrepresent the VARO's performance measurements.

Recommendations

6. We recommended the Seattle VA Regional Office Director implement a plan to conduct comprehensive training for claims establishment staff that emphasizes the importance of ensuring all elements are considered when establishing claims, and assess the effectiveness of that training.

7. We recommended the Seattle VA Regional Office Director implement a plan to ensure data input at the time of claims establishment are reviewed.

[31] M21-1Adjudication Procedures Manual Part III, Subpart iii, Chapter 1, Section D, Topic 2 *Utilizing Contentions and Special Issue Indicators Associated with Claimed Issues.*

Management Comments

The VARO Director concurred with our findings and recommendations. The Director stated that the vast majority of claims are established by Claims Assistants who have undergone formal training specific to claims establishment. Furthermore, the VSC has completed quality reviews on work completed by Claims Assistants and will continue to track the effectiveness of the training by monitoring local error rates.

In addition, the VSC established a quality review program to ensure that data input at the time of claims establishment are reviewed. The Director noted that random quality reviews are completed within a few days of when the claims establishment action is taken. The Director provided a copy of the Quality Review Checklist used by the VSC to evaluate the claims establishment process.

OIG Response

The Director's comments and actions are responsive to the recommendations. Based on the information provided, we consider Recommendations 6 and 7 closed at this time. We will follow up as required.

IV. Public Contact

Finding 4 Seattle VSC Staff Needed To Improve Timeliness and Accuracy In Processing Special Controlled Correspondence

We randomly selected and reviewed 30 of 381 special controlled correspondence cases (8 percent) to determine whether congressional liaisons timely and accurately processed them. Overall, 14 of the 30 cases we reviewed contained delays or inaccuracies. All 14 cases involved inaccurate processing and three cases also contained untimely responses. The errors were due to a lack of training, as VSC staff noted they did not receive training on certain procedures. As a result of the delays, congressional staff were not timely made aware of the status of cases about which they had inquired. As a result of the inaccuracies, VBA staff would not be able to review issues pertaining to timeliness and accuracy of special controlled correspondence in the veterans' electronic claims folders.

VBA Policy Related to Special Controlled Correspondence

Special controlled correspondence is mail that requires expedited processing, control, and response. Examples of special correspondence include mail received from the White House, members of Congress, national headquarters of service organizations, and private attorneys. VBA policy requires the VARO Director or the VSC manager to establish a specific tracking code for all special controlled correspondence.[32] Staff are required to send an acknowledgement letter within 5 business days after receipt in the VARO if they cannot provide a full response.[33]

According to VBA policy, all correspondence generated by VA must provide complete, accurate, and understandable information.[34] In addition, VSC staff must either file these documents in a claims folder or upload them into an electronic folder.[35]

Review of VARO Processing of Special Controlled Correspondence To Assess Timeliness

We randomly selected and reviewed 30 of 381 special controlled correspondences (8 percent) completed from June 1 through August 31, 2016. Congressional liaisons responded to 29 of 30 claims reviewed within 20 days after receipt—averaging 5 days. Staff did not respond to one of the inquiries. In three cases, congressional liaisons did not timely respond to special controlled correspondences. In these cases, evidence in the file showed congressional liaisons provided responses to inquiries from congressional staff from 8 to 13 business days after receipt. These responses indicated congressional liaisons had previously

[32] M21-4 Appendix B, Section II, *End Products - Compensation, Pension, and Fiduciary Operations*
[33] M27-1 Benefits Assistance Service Procedures, Part I, Chapter 5, Topic 3, *Acknowledging Correspondence.*
[34] Topic 1, *General Guidance for Processing Correspondence*
[35] M21-1 Adjudication Procedures Manual, Part III, Subpart ii, Chapter 1, Section B, Topic 2, *Handling Incoming Mail*

acknowledged the inquiries; however, there was no documentation of timely acknowledgments in the claims folders. Congressional liaisons should have acknowledged the correspondences within 5 business days and ensured that these responses were filed in veterans' electronic claims folders, as required. The acting VSCM and an AVSCM concurred with the errors we identified.

Review of VARO Processing of Special Controlled Correspondence To Assess Accuracy

Congressional liaisons incorrectly processed 14 of the 30 special controlled correspondence inquiries reviewed. In 11 cases, congressional liaisons did not upload, or only partially uploaded, email inquiries from congressional staff into veterans' electronic claims folders. The partially uploaded inquiries did not contain specific information such as who sent the email and on what date. Therefore, VBA staff would not be able to review issues pertaining to timeliness and accuracy of these documents in the veterans' electronic claims folders. The acting VSCM and an AVSCM concurred with the errors we identified.

Generally, the errors involving improper uploading of email inquiries occurred because congressional liaisons never received training on how to properly upload them into the electronic claims folders. In the three cases with untimely responses, the letters indicated congressional liaisons had acknowledged the correspondences by email or telephone within 5 business days. However, there was no evidence in the claims file documenting these communications. VSC staff stated that they were not aware they needed to document emails or telephone calls acknowledging inquiries to ensure a complete electronic record.

Management officials were not aware of these issues until our review and they did not provide training on these topics until we brought them to their attention. Management stated that oversight for special controlled correspondence mainly focused on other types of correspondence VA Central Office considered higher priority, such as those originating from the White House. As a result of our findings, VSC staff stated, and management verified, that they received training the week before our site visit on the uploading of emails into the electronic claim folders, to ensure cases were complete and timely for reviews.

Recommendations

8. We recommended the Seattle VA Regional Office Director monitor the effectiveness of the training regarding how to properly upload emails into electronic claims folders, and conduct refresher training as necessary.

9. We recommended the Seattle VA Regional Office Director implement a training plan to ensure all status updates on inquiries are made part of the electronic records, and monitor the effectiveness of that training.

10. We recommended the Seattle VA Regional Office Director implement a plan to provide oversight and quality review of all types of special controlled correspondence.

Management Comments

The VARO Director concurred with our findings and recommendations. The Director reported that training had been provided on October 19, 2016 to congressional liaisons regarding the need to upload the email provided to inquirers. To monitor the effectiveness of the training, the training manager will ensure that all required employees have received and completed the necessary training, and the congressional liaison coach will monitor the training effectiveness by conducting random audits.

The Director noted refresher training was provided to congressional liaisons to confirm their understanding of the policy that requires status updates to be part of the electronic record. Furthermore, training will continue on a bi-annual basis and will be tracked by VSC management and the VARO training manager.

To address the recommendation on special controlled correspondence, VSC management stated that it will perform five independent quality reviews on a monthly basis. Furthermore, the Director stated that the signing official in the Director's office will review the action(s) noted.

OIG Response

The Director's comments and actions are responsive to the recommendations. Based on the information provided, we consider Recommendations 8, 9, and 10 closed at this time. We will follow up as required.

Appendix A Scope and Methodology

Scope and Methodology

In October 2016, we evaluated the Seattle VARO to see how well it provides services to veterans and processes disability claims.

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. Before 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.

We randomly selected and reviewed 30 of 821 disability claims related to TBI (4 percent) that the VARO completed from March through August 2016. We randomly selected and reviewed 30 of 71 veterans' claims involving entitlement to SMC and related ancillary benefits (42 percent) completed by VARO staff from September 2015 through August 2016. In addition, we randomly selected and reviewed 30 of 836 proposed rating reductions (4 percent) completed from June through August 2016. Furthermore, we randomly selected and reviewed 30 of 381 special controlled correspondence inquiries (8 percent) that the VARO received and responded to from June through August 2016. Finally, we randomly selected and reviewed 30 of 2,027 claims (1 percent) VARO staff established in the electronic record for systems compliance in August 2016.[36]

Data Reliability

We used computer-processed data from the Corporate Data Warehouse. 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. Furthermore, 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.

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.

[36] During the inspection, while determining our sample size of 30 claims, we determined some claims were outside of the scope of our review; therefore, we removed these claims from the universe of claims.

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 Management Comments

Department of Veterans Affairs Memorandum

Date: June 2, 2017

From: Director, VA Regional Office Seattle, Washington

Subj: OIG Draft Report - Inspection of the VA Regional Office, Seattle, Washington

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

1. The Seattle VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Seattle, Washington*.

2. Please refer questions to Harold Bucher, Management Analyst, at 206-341-8560.

(Original signed by:)

PRITZ NAVARATNASINGAM
Director

Attachment

Attachment

SEATTLE VA REGIONAL OFFICE (346)
COMMENTS ON OIG DRAFT REPORT

OIG Recommendations:

Recommendation #1: We recommend the Seattle Regional Office Director implement a plan to ensure traumatic brain injury claims are assigned to qualified Rating Veterans Service Representatives for processing.

Seattle Regional Office (RO) Response: Concur

Action: In conjunction with implementation of the NWQ in April 2016, the Seattle RO determined additional flexibility was needed with regard to claims that were previously routed to RVSRs on the Special Operations lane. As a result, the RO continues to implement a plan to train all RVSRs on TBI claims. Initial training was held on April 7, 2016.

In response to this recommendation, it is noted that RVSRs must have 10 reviews completed before they are granted single signature authority for processing TBI claims. 21 RVSRs have not received enough TBI reviews to be granted single signature authority due to fluctuations with incoming workload. Out of the 21 RVSRs still needing reviews, 15 RVSRs need between 6 to 10 cases, and the remaining 6 need 1 to 5 cases to be reviewed. RO will route TBI claims to qualified RVSRs for processing while also expanding mentor reviews for these 21 RVSRs to enable them to gain single signature authority.

Target Completion Date: August 31, 2017

Recommendation #2: We recommend the Seattle Regional Office Director implement a plan to provide refresher training on traumatic brain injury and monitor the effectiveness of that training.

Seattle RO Response: Concur

Response: The Seattle RO will conduct refresher training for TBI on June 20, 2017. The Training Manager and Quality Review Team Coach will track the effectiveness of the training by monitoring local and national error rates. This training will be tracked in the Talent Management System (TMS).

Target Completion Date: June 30, 2017.

Recommendation #3: We recommend the Seattle Regional Office Director implement a plan to ensure Rating Veterans Service Representatives follow second signature policy requirements for traumatic brain injury and special monthly compensation rating decisions.

Seattle RO Response: Concur

Response: As stated on Recommendation #1, the Seattle RO will utilize NWQ rules to expedite the process of RVSR mentorship. This will ensure additional RVSRs can process TBI cases under single signature authority. In the meantime, the VSC will hold TBI refresher training in June 2017 as well as institute monthly audits whereby 20 TBI completions are reviewed to ensure the proper process was followed. This audit will continue until all RVSRs are granted single signature authority on TBI.

In addition, reminders on proper second signature policy requirements were presented to all employees via Quality Review Update Training in November 2016 and March 2017. Since all SMC cases above level L require a second signature, the VSC will review all SMC rating decisions completed for 2 weeks each quarter to audit the proper signature requirements. During the designated audit period, all SMC grants of level L or higher will be routed to the Quality Review Team for inspection; any instances of non-

compliance will be documented. To date there have no recorded instances of noncompliance. This inspection period will last until the end of Fiscal Year 2018.

Target Completion Date: August 31, 2017

Recommendation #4: We recommend the Seattle VA Regional Office Director develop and implement a plan to provide refresher training to Rating Veterans Service Representatives regarding the proper procedure for applying effective dates.

Seattle RO Response: Concur

Response: The Seattle RO conducted training on proper use of effective dates for all RVSRs on 12/13/2016. This training was recorded in TMS.

Target Completion Date: Completed

Recommendation #5: We recommended the Seattle VA Regional Office Director implement a plan to ensure prioritization of proposed rating reduction cases for completion at the end of the due process time period.

Seattle RO Response: Concur.

Response: VBA provides oversight and prioritization of proposed rating reduction cases at the national level. As of April 9, 2017, all Regional Offices receive a daily distribution of actionable due process work that is either priority - homeless, terminally ill, etc. - or our oldest pending claims. Nationally, Regional Offices are held to a standard that all work must be completed on a claim that is distributed to them within five days. Regional and District Office leadership, as well as the Office of Field Operations, routinely monitor stations performance related to the five day Time In Queue (TIQ) standard. Since NWQ began managing distribution of EP600s (due process EPs), timeliness of these claims improved by 30 days.

VBA will continue to monitor the improvements in EP600 timeliness and make prioritization adjustments as necessary. VBA requests closure of this recommendation.

Recommendation #6: We recommend the Seattle Regional Office Director implement a plan to conduct comprehensive training for claims establishment staff that emphasizes the importance of ensuring all elements are considered when establishing claims, and assess the effectiveness of that training.

Seattle RO Response: Concur

Action: The vast majority of claims are established by Claims Assistants (CAs.) The RO has placed an increased focusing on training and development of the CAs. The RO conducts training in formal classroom settings, online Lync training, TMS, refresher training at team huddles and on-the-job training, as needed. The CAs have all undergone the following formal training items specific to claims establishment:

- 11/17/2016- Date of Claim and Introduction to Claims Establishment Procedures (TMS ID 1279927 and 61975) 3 Hours (Classroom)
- 2/23/2017- Date of Claim and Introduction to Claims Establishment Procedures (TMS ID 1279927 and 61975) 3 Hours (Refresher) (Classroom)
- 4/18/2017- Claims Establishment and Mail Management (TMS ID 1279927 and 61975) 2 hours (all VSC CA/VSR/SVSRs) (Lync)

The VSC will continue to track the effectiveness of the training by monitoring local error rates. The early success of the training is shown by the fact that FYTD, the VSC has completed 685 quality reviews on

work completed by CAs with an overall accuracy rate of 99%. This accuracy rate is well above the required minimum CA quality standard of 90%.

Target Completion Date: Completed

Recommendation #7: We recommend the Seattle Regional Office Director implement a plan to ensure data input at the time of claims establishment is reviewed.

Seattle RO Response: Concur

Action: The VSC has established a Quality Review program to ensure that data input at the time of claims establishment is reviewed. Each month the VSC completes quality reviews on 5 randomly-selected claims processed by CAs. The VSC completes each month's quality reviews throughout the month with all required reviews to be completed no later than the 15th of the following month.

Quality reviews are completed within a few days of when the claims establishment action is taken. As such, the results of these randomly-selected quality reviews assess the accuracy of the data entered at the time the claim is established. Furthermore, the quality review checklist specifically evaluates 16 different areas of the Claims Establishment process (see attachment). The checklist is used on all quality reviews. The VSC currently has 5 CA trainees and are evaluated under a comprehensive training criterion (see attachment) which focuses on accuracy.

FYTD, the VSC has completed 685 quality reviews on CAs with an overall accuracy rate of 99%. These quality reviews serve as an important feedback and training tool for employees as well as to prevent instances of reoccurrence; any instances of non-compliance results in immediate correction with minimal impact to the timeliness of the claim. Supervisors responsible for the Intake Processing Center ensure corrections are completed in a timely manner.

Target Completion Date: Completed

Recommendation #8: We recommend the Seattle Regional Office Director monitor the effectiveness of the training regarding how to properly upload emails into electronic claims folders, and conduct refresher training as necessary.

Seattle RO Response: Concur

Action: On October 19, 2016, training was provided to the Seattle Congressional Liaisons regarding the need to upload the actual email provided to inquirers. Prior to this time, the congressional response was uploaded into VBMS but the corresponding email containing the response was not. For this reason, OIG auditors stated they were unable to independently validate the timeliness of the response.

In order to monitor the effectiveness of this training and process the Training Manager coordinates with the divisional training staff to ensure all required employees have received and completed the necessary training. The Congressional Liaison Coach monitors the effectiveness of the training by conducting random audits to ensure the appropriate correspondence items are properly uploaded into VBMS.

Note: The Seattle RO uses a local database for tracking the timeliness of all Congressional inquiries and responses. This database was shared with OIG, and it provides validation that congressional responses were indeed timely; but as noted in the recommendation, responses to congressional offices were not uploaded into Veterans' electronic folders.

Target Completion Date: Completed

Recommendation #9: We recommend the Seattle Regional Office Director implement a training plan to ensure all status updates on inquiries are made part of the electronic records, and monitor the effectiveness of that training.

Seattle RO Response: Concur

Action: On April 28, 2017, refresher training was provided to the Seattle Congressional Liaisons confirming their understanding of this policy. Training will continue on a bi-annual basis and will be tracked by the VSC division management and the station training manager.

Target Completion Date: Completed

Recommendation #10: We recommend the Seattle Regional Office Director implement a plan to provide oversight and quality review of all types of special controlled correspondence.

Seattle RO Response: Concur

Action: Five independent quality reviews per employee are performed on a monthly basis. Action(s) noted in the special controlled correspondence is also reviewed by the signing official in the Director's Office.

Target Completion Date: Completed

For accessibility, the format of the original memo has been modified to fit in this document.

Appendix C OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Dana Sullivan, Director Daphne Brantley Brett Byrd David Pina Michael Stack Michele Stratton Rachel Stroup

Appendix D Report Distribution

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This report is available on our website at www.va.gov/oig.