VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Reno, Nevada

June 10, 2014
13-04324-170

ACRONYMS

FY	Fiscal Year
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
SMC	Special Monthly Compensation
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center
WMP	Workload Management Plan

Report Highlights: Inspection of the VA Regional Office, Reno, Nevada

Why We Did This Review

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

What We Found

Overall, VARO staff did not accurately process 36 (51 percent) of 71 disability claims reviewed. We sampled claims we considered at higher risk of processing errors, thus these results do not represent this VARO's overall accuracy in processing disability claims. Claims processing that lacks compliance with VBA procedures can risk paying inaccurate financial benefits.

Twenty-two of 29 temporary 100 percent disability evaluations were inaccurate, generally because staff did not timely act on reminder notifications for medical reexaminations. VARO staff incorrectly processed 4 of 14 traumatic brain injury (TBI) claims, primarily by using insufficient medical examination reports. VARO staff also incorrectly processed 10 of 28 special monthly compensation (SMC) and ancillary benefit claims due to lack of training.

Nine of 11 Systematic Analyses of Operations (SAO) were untimely; 7 of the 9 were also incomplete. Management did not timely complete the SAOs scheduled for fiscal year 2014 due to lack of oversight. Further, VARO staff delayed completion of 15 of 30 benefit reduction cases because management did not prioritize this work.

What We Recommend

We recommend the VARO Director implement a plan to ensure timely and appropriate action on reminder notifications for medical reexaminations, review and take appropriate action on the 275 temporary 100 percent disability evaluations remaining from our inspection universe, ensure required staff receive training on identifying insufficient TBI examinations and properly processing SMC and ancillary benefit claims, provide oversight and training on SAOs, and develop a plan to prioritize action on benefit reduction cases.

Agency Comments

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

LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

TABLE OF CONTENTS

Introduction 1

Results and Recommendations 2

I. Disability Claims Processing 2

Finding 1 Reno VARO Could Improve Disability Claims Processing Accuracy 2

Recommendations 8

II. Management Controls 10

Finding 2 VARO Lacked Oversight To Ensure Timely SAOs 10

Recommendations 11

Finding 3 VARO Lacked Oversight To Ensure Immediate Action On Benefit Reductions 12

Recommendation 13

Appendix A VARO Profile and Scope of Inspection 14

Appendix B Inspection Summary 16

Appendix C VARO Director's Comments 17

Appendix D OIG Contact and Staff Acknowledgments 20

Appendix E Report Distribution 21

INTRODUCTION

Objective

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

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

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

Other Information

- Appendix A includes details on the VARO and the scope of our inspection.
- Appendix B outlines criteria we used to evaluate each operational activity and a summary of our inspection results.
- Appendix C provides the Reno 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 accuracy in processing temporary 100 percent disability evaluations, traumatic brain injury (TBI) claims, and special monthly compensation (SMC) and ancillary benefits. We evaluated these claims processing issues and assessed their effect on veterans' benefits.

Finding 1 Reno VARO Could Improve Disability Claims Processing Accuracy

The Reno VARO did not consistently process temporary 100 percent disability evaluations, TBI-related cases, or entitlements to SMC and ancillary benefits. Overall, VARO staff incorrectly processed 36 of the total 71 disability claims we sampled, resulting in 244 improper monthly payments to 12 veterans totaling $65,419.

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. The table below reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Reno VARO.

Table 1. Reno VARO Disability Claims Processing Accuracy

Type of Claim	Reviewed	Claims Inaccurately Processed that Affected Veterans' Benefits	Claims Inaccurately Processed with the Potential To Affect Veterans' Benefits	Total Claims Inaccurately Processed
Temporary 100 Percent Disability Evaluations	29	5	17	22
TBI Claims	14	0	4	4
SMC and Ancillary Benefits	28	7	3	10
Total	**71**	**12**	**24**	**36**

Source: VA OIG analysis of VBA's temporary 100 percent disability evaluations paid at least 18 months, TBI disability claims completed in the fourth quarter FY 2013, and SMC and ancillary benefits claims completed in FY 2013.

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 22 of 29 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a veteran's service-connected disability following surgery or when specific treatment is needed. At

the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

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

Without effective management of these temporary 100 percent disability ratings, VBA is at increased risk of paying inaccurate financial benefits. Available medical evidence showed 5 of the 22 processing errors we identified affected benefits and resulted in 17 improper monthly overpayments to 4 veterans totaling $23,165. These improper payments occurred from June 2013 until January 2014. Details on the most significant overpayments follow.

- A Rating Veterans Service Representative (RVSR) granted a temporary 100 percent evaluation to a veteran for a total right knee replacement from April 11, 2012. At the time of our review, VARO staff had not taken action on an April 2013 reminder notification to schedule a reexamination. As a result, VA overpaid the veteran $11,792 over a period of 7 months. Monthly benefits will continue to be paid at the 100 percent disability rate if no action is taken to assess potential change in the veteran's disability through required medical reexamination.
- An RVSR proposed reducing a veteran's temporary 100 percent evaluation for residuals of prostate cancer to 60 percent disabling effective June 1, 2013. At the time of our review, VARO staff had not taken action on the proposed reduction. As a result, VA overpaid the veteran $8,270 over a period of 5 months and monthly benefits will continue to be paid at the 100 percent disability rate if no corrective action is taken.

The remaining 17 of the total 22 errors had the potential to affect veterans' benefits. We could not determine whether the evaluations would have continued because the veterans' claims folders did not contain medical evidence needed to evaluate each case. Fifteen of these errors occurred when VSC staff received reminder notifications but did not schedule medical reexaminations as required. In these cases, claims processing delays ranged from 1 month to 1 year and

2 months. An average of 8 months elapsed from the time staff should have scheduled these medical reexaminations until January 1, 2014.

In one of the two remaining cases that had the potential to affect veterans' benefits, staff did not timely follow up on a proposed reduction. VARO staff received a timely request from the veteran for a personal hearing. However, at the time of our review, more than a year had passed and staff had not yet scheduled the hearing. In the remaining case, staff did not take action to decide a claim upon receipt of a medical reexamination report. The VARO received this report on September 21, 2013, for a disability that had been assigned a temporary 100 percent evaluation. However, VARO staff had not taken action to reevaluate the claim at the time of our review.

Generally, processing inaccuracies resulted from a lack of VARO management oversight to ensure timely action on these cases. Further, management and staff we interviewed noted that the Western Area Office gave the VARO instructions to complete specific cases; however, the instructions did not include taking required or timely action to schedule medical reexaminations after receiving reminder notifications. As a result, the VARO may have continued benefits payments and overpaid veterans who are no longer entitled to temporary 100 percent evaluations. We provided VARO management with 275 claims remaining from our universe of 304 for its review to determine if action is required.

VARO management initially concurred with the errors we found in all 22 cases but later withdrew all concurrences, responding that Notification of Errors solely based on timeliness were not an appropriate issue for concurrence or non-concurrence. When asked why the office changed its responses, the VARO Director stated the changes were directed by VBA's Compensation Service and Western Area Headquarters. It is clearly within the OIG's purview to provide oversight of this high-risk area of temporary 100 percent disability evaluation processing. Management's lack of response is not helpful in addressing the errors we identify as a means of improving claims processing and ensuring accurate benefits delivery.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Reno, Nevada* (Report No. 11-00517-204, June 24, 2011), we reported VARO staff incorrectly processed 18 of 30 temporary 100 percent disability evaluations we reviewed. The most frequent processing inaccuracies occurred because staff did not enter suspense diaries in the electronic system to ensure they received reminder notifications to schedule medical reexaminations. VARO management did not provide oversight to ensure VSC staff entered suspense diaries. We did not

provide a recommendation as VBA had implemented a national review plan to address this issue. We stated that we would monitor implementation progress and gauge effectiveness of this plan as we move forward in conducting our individual VARO inspections.

During this current inspection, we did not identify any cases where staff did not input suspense diaries in the electronic system to generate reminders to follow up on temporary 100 percent disability evaluations. As such, we made no further recommendation in this area.

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 Decision Review Officers and RVSRs assigned to the appeals team, the special operations team, and the quality review team complete TBI training.

In response to a recommendation in our summary 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.

We determined VARO staff incorrectly processed 4 of 14 TBI claims. In all four cases, VSC staff prematurely evaluated TBI residuals using insufficient VA medical examination reports. Specifically, the medical examiners did not delineate which symptoms were due to TBI and which were due to a coexisting mental condition. Also, in two of the cases, examiners did not properly complete the disability benefits questionnaires as required when additional symptoms were present. All of the errors had the potential to affect veterans' benefits. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without an adequate or complete medical examination.

Generally, these errors occurred because VSC staff misinterpreted VBA policy for rating a TBI with a coexisting mental condition. A review of VARO training records showed that only one VSC employee completed TBI-related training from November 2011 to the time of our inspection. Further, there were no procedures in place to review and

return insufficient TBI examination reports. As a result, veterans may not have always received correct benefit decisions.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Reno, Nevada* (Report No. 11-00517-204, June 24, 2011), we also determined errors in processing TBI claims occurred due to RVSRs prematurely evaluating TBI-related disabilities based on insufficient medical examination reports. In response to our recommendations, the VARO Director agreed to ensure staff received refresher training on identifying insufficient TBI examination reports, develop and implement a process to return insufficient reports to medical examiners, and establish an additional level of review for all TBI claims prior to finalizing rating decisions. The OIG closed these recommendations based on VBA's national second-signature policy, as well as the VARO's documentation of TBI training from July through October 2011, and a plan to ensure staff returned insufficient exams to the appropriate VA medical facilities.

Interviews with VSC staff revealed that the additional reviews of TBI medical examinations for adequacy were effective. They also indicated that the VARO discontinued these reviews in December 2012 due to other organizational priorities. During our February 2014 inspection, we again identified errors in processing TBI claims due to staff using insufficient examination reports.

Special Monthly Compensation and Ancillary Benefits

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

- Anatomical loss or loss of use of specific organs, sensory functions, or extremities
- Disabilities that render the veteran permanently bedridden or in need of aid and attendance
- Combinations of severe disabilities that significantly affect locomotion
- Existence of multiple, independent disabilities that are evaluated as 50 to 100 percent disabling

- Existence of multiple disabilities that render the veteran in need of such a degree of special skilled assistance that, without it, the veteran would be permanently confined to a skilled-care nursing home

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

- Dependents' Educational Assistance under section 35, title 38, United States Code
- Specially Adapted Housing Grant
- Special Home Adaptation Grant
- 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 focused our review on 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 10 of 28 claims involving SMC and ancillary benefits—7 affected veterans' benefits and resulted in underpayments of $42,254, representing 227 improper monthly payments. Details on the two most significant underpayments follow.

- An RVSR did not grant SMC for a veteran's additional permanent disability independently evaluated at 50 percent disabling, and entitlement to specially adapted housing as required by VBA policy. As a result, VA underpaid the veteran $17,830 over a period of 8 years and 11 months.
- An RVSR incorrectly evaluated a veteran's bladder condition as 30 percent disabling when medical evidence showed that the condition warranted a 60 percent disability evaluation. Subsequently, the RVSR did not grant SMC for the veteran's additional permanent disability, independently evaluated at 60 percent, as required by VBA policy. As a result, VA underpaid the veteran $7,410 over a period of 2 years and 4 months.

The remaining three errors had the potential to affect veterans' benefits. Summaries of those errors follow.

- In one error, an RVSR did not grant entitlement to specially adapted housing, a benefit worth up to $67,555. The RVSR also did not grant entitlement to an automobile and adaptive equipment allowance, a benefit currently worth up to $19,817.
- In one error, an RVSR used the incorrect SMC codes to determine a veteran's disability benefits payments. Although this error did not affect the veteran's monthly benefits, it may affect future monthly benefits. For example, if the veteran becomes hospitalized at government expense, his monthly payment would be reduced to an incorrect SMC rate.
- In one error, an RVSR incorrectly continued entitlement to additional SMC without required medical evidence. Because the claims folder did not contain sufficient medical evidence, neither we nor VARO staff could determine the correct SMC level for this veteran.

Generally, errors related to SMC and ancillary benefits were due to a lack of training. The VARO provided training records from October 2012 to the present that did not show training for SMC and ancillary benefits. VSC management and staff stated they could not remember the last time VARO staff received training on SMC and ancillary benefits. Staff also expressed confusion regarding VBA's policy for granting SMC for additional permanent disabilities independently evaluated at 50 percent or more. Six of the incorrect decisions we identified occurred because staff did not follow this policy. As a result, veterans did not always receive accurate benefit payments. The training deficiencies identified, if unaddressed, increase the risks associated with VBA's efforts to consistently process and ensure the accuracy of claims processing.

Recommendations

1. We recommend the Reno VA Regional Office Director implement a plan to ensure timely and appropriate action on reminder notifications for medical reexaminations.
2. We recommend the Reno VA Regional Office Director conduct a review of the 275 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.
3. We recommend the Reno VA Regional Office Director ensure required staff receive refresher training on how to identify insufficient traumatic brain injury medical examination reports and return them to the appropriate VA medical facilities for correction.

4. We recommend the Reno VA Regional Office Director conduct training on the proper processing of special monthly compensation and ancillary benefits claims and implement a plan to assess the effectiveness of that training.

Management Comments

The VARO Director concurred with our recommendations and amended the workload management plan to include a review of reminder notifications related to medical reexaminations. Management created a centralized spreadsheet to track and review the 275 temporary 100 percent disability claims remaining from our inspection universe and expects completion by August 2014. Further, VARO staff will receive refresher training on how to properly identify insufficient TBI medical examinations and process SMC and ancillary benefits claims. The Director anticipates completion of this training by August 31, 2014.

OIG Response

The Director's comments and actions are responsive to the recommendations. We will follow up on management's actions during future inspections.

II. Management Controls

Systematic Analysis of Operations

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

Finding 2 VARO Lacked Oversight To Ensure Timely SAOs

Nine of the 11 SAOs were untimely. The delays ranged from 94 to 366 days past the assigned due dates. Seven of the nine untimely SAOs were also incomplete. Due to competing priorities, VARO management did not provide adequate oversight and training to staff assigned to complete SAOs.

VBA policy requires that the VSC Manager establish the annual SAO schedule by October 1st of each fiscal year (FY). We notified VARO management of our inspection on January 6, 2014, at which time management assigned staff 6 of 11 FY 2013 SAOs. The temporary Acting VSC Manager approved the FY 2014 schedule the following day on January 7, 2014—97 days after it was required. Interviews with VARO staff revealed that management gave them 24 hours to complete the assigned SAOs and did not provide training on how to accomplish them.

VARO staff completed the Claims Processing Timeliness SAO on January 7, 2014—191 days after its scheduled completion date. The SAO noted the station's Workload Management Plan (WMP) did not adequately discuss VARO requirements to address VBA's national initiatives and growing workload. The SAO also noted the WMP did not include effective timeliness measures. During our review of temporary 100 percent evaluations and benefit reductions, we identified 37 cases where VARO staff did not take timely action on claims. If the Reno VARO staff had timely completed this SAO, they may have developed procedures in the WMP to minimize these deficiencies.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Reno, Nevada* (Report No. 11-00517-204, June 24, 2011), we determined that 6 of the 11 SAOs we reviewed were incomplete, untimely, or not completed at all due to a lack of adequate VARO management oversight. The Director of the Reno VARO concurred with our recommendation to develop and implement a plan to ensure timely and accurate completion of SAOs. The Director assigned oversight of the SAOs to a management analyst. The OIG closed this recommendation on February 23, 2012, after the VARO submitted its FY 2012 SAO schedule along with two timely completed SAOs.

During our February 2014 inspection, we found that VARO management did not provide SAO oversight during FY 2013 due to vacancies in management positions and competing priorities. Interviews with the Director and staff showed that the prior VSC Manager routinely completed the majority of the SAOs; however, he was out of the office frequently during the last 6 months before he retired in November 2013. As a result, VSC staff did not have the experience needed to complete the SAOs on their own. Additionally, during FY 2013, the VARO's focus was on national initiatives and management did not prioritize SAOs.

Recommendations

5. We recommend the Reno VA Regional Office Director develop and implement a plan to ensure adequate and continuous oversight is provided for the timely completion of the annual Systematic Analyses of Operations schedule and the required 11 Systematic Analyses of Operations.
6. We recommend the Reno VA Regional Office Director ensure that staff assigned to complete Systematic Analyses of Operations receive training on Veterans Benefits Administration policy regarding the purpose and requirements for completing Systematic Analyses of Operations.

Management Comments

The VARO Director concurred with our recommendations and implemented an SAO schedule that includes a reminder sent to each designee 60 days prior to the date each SAO is due. Further, the VSC manager will provide SAO training to each coach with an anticipated completion date of June 30, 2014.

OIG Response

The Director's comments and actions are responsive to the recommendations. We will follow up on management's actions during future inspections.

Benefit Reductions

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

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

On April 3, 2014, VBA leadership modified its policy regarding the processing of claims requiring benefit reductions. The new policy no longer included 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 VARO Lacked Oversight To Ensure Immediate Action On Benefit Reductions

VARO staff delayed processing 15 of the 30 claims that required rating decisions to reduce or discontinue benefits. This occurred because of a lack of VARO management oversight. In addition, the VARO's WMP was ineffective because it did not address the processing of benefit reduction cases requiring rating decisions. As a result, VA overpaid 15 veterans, resulting in 76 improper monthly payments totaling $98,133. These improper payments occurred from December 2012 to January 2014.

In the case with the most significant overpayment and delay, VSC staff sent a letter to the veteran on July 20, 2012, proposing to reduce a veteran's temporary 100 percent disability evaluation. The due process period expired on September 23, 2012. However, staff did not take the action required to reduce the evaluation until August 15, 2013, almost

1 year after the due process period ended. As a result, VA overpaid the veteran $24,717 in improper payments over a period of 11 months.

The remaining 14 cases showed claims processing delays ranging from 1 to 11 months. An average of 5 months elapsed from the time staff should have taken action to reduce the benefits for the 15 cases.

Generally, these delays occurred because VARO management did not view this workload as a priority. Interviews with management and staff disclosed that the VBA's Western Area Headquarters Office gave the VARO instructions to complete specific types of cases that did not include benefit reductions. VSC staff told us benefits reduction cases are easy to complete and would not interfere with achieving their individual daily production requirements; however, management had prioritized the completion of other work. Furthermore, the station's WMP did not include procedures for management of these cases.

VARO management initially concurred with the delays we found in all 15 cases, but later withdrew all concurrences and responded that Notification of Errors solely based on timeliness were not an appropriate issue for concurrence or non-concurrence. Again, it is clearly within the OIG's purview to provide oversight of this high-risk area of benefit reductions. Management's unresponsiveness is not helpful in addressing the errors we identify as a means of improving claims processing and ensuring accurate benefits delivery.

Recommendation

7. We recommend the Reno VA Regional Office Director amend the workload management plan to ensure oversight and prioritization of benefit reduction cases.

Management Comments

The VARO Director concurred with our recommendation and amended the WMP to include a review of notifications that may require a medical reexamination.

OIG Response

The Director's comments and actions are responsive to the recommendation. We will follow up on management's actions during future inspections.

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of December 2013, the Reno VARO reported a staffing level of 85.4 full-time employees. Of this total, the VSC had 69.4 employees assigned.

Workload

As of December 2013, VBA reported 5,640 pending compensation claims. The average days pending for claims was 164.6 days—49.6 days more than the national target of 115.

Scope and Methodology

VBA has 56 VAROs and a VSC in Cheyenne, WY, that process disability claims and provide a range of service to veterans. We evaluated the Reno 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 29 (10 percent) of 304 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented instances in which VBA staff had granted temporary 100 percent disability evaluations for at least 18 months as of December 11, 2013. 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 275 claims remaining from our universe of 304 for its review. We reviewed all 14 available disability claims related to TBI that the VARO completed from July through September 2013. We examined all of the 28 veterans claims available involving entitlement to SMC and related ancillary benefits that VARO staff completed from October 1, 2012, through September 30, 2013.

Prior to VBA consolidating Fiduciary Activities nationally, each VARO was required to complete 12 SAOs. However, since the Fiduciary consolidation, VAROs are now required to complete 11 SAOs. Therefore, we reviewed 11 SAOs related to VARO operations. Additionally, we looked at 30 (56 percent) of 54 completed claims that proposed reductions in benefits from July through September 2013.

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

Data Reliability

We used computer-processed data from the Veterans Service Network's Operations Reports 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 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 101 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI claims, SMC and ancillary benefits, and completed claims involving benefits reductions.

Our testing of the data disclosed that they were sufficiently reliable for our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders 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 VBA's STAR program as of December 2013, the overall issue-based accuracy of the VARO's compensation rating-related decisions was 96 percent, the same as VBA's target of 96 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. Reno 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, 3.808, 3.809, 3.809a)	No
Management Controls		
Systematic Analysis of Operations	Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs. (M21-4, Chapter 5)	No
Benefits Reductions	Determine whether VARO staff timely and accurately processed disability evaluation reductions or terminations. (38 CFR 3.103(b)(2), 38 CFR 3.105(e), 38 CFR 3.501, M21-1MR.IV.ii.3.A.3.e, M21-1MR.I.2.B.7.a, M21-1MR.I.2.C, M21-1MR.IV.ii.2.f, M21-4, Chapter 2.05(f)(4), Compensation & Pension 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: May 29, 2014

From: Director, VA Regional Office Reno, Nevada

Subj: Inspection of the VA Regional Office, Reno, Nevada

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

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

2. Please refer questions to the Director's office at (775) 321-4700.

Edward Russell
Director

Attachment

VARO Reno OIG SITE VISIT
March, 2014
RO Response *(draft)*

Recommendation 1: The Reno VA Regional Office Director implement a plan to ensure timely and appropriate action on reminder notifications for medical reexaminations.

RO Response: Concur. Workload management plan to be amended to include review of write outs for reexamination. Anticipated completion on June 15, 2014.

Recommendation 2: The Reno VA Regional Office Director conduct a review of the 275 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

RO Response: Concur. Centralized spreadsheet created to track review/completion of 275 temporary 100 percent disability claims. Anticipated completion on August 31, 2014.

Recommendation 3: The Reno VA Regional Office Director ensure required staff receive refresher training on how to identify insufficient traumatic brain injury medical examination reports and return them to the appropriate VA medical facilities for correction.

RO Response: Concur. Refresher training scheduled for all DRO's, RQRS's and Spec Ops. Personnel. Anticipated completion on July 31, 2014.

Recommendation 4: The Reno VA Regional Office Director conduct training on the proper processing of special monthly compensation and ancillary benefits claims and implement a plan to assess the effectiveness of that training.

RO Response: Concur. Training to be scheduled by VSCM. Anticipated completion on August 31, 2014.

Recommendation 5: The Reno VA Regional Office Director develop and implement a plan to ensure adequate and continuous oversight is provided for the timely completion of the annual Systematic Analyses of Operations schedule and the required 11 Systematic Analyses of Operations.

RO Response: Concur. SAO schedule implemented and reminders sent to respective designee 60 days prior to due date. SAO's are due to

VSCM 10 workdays prior to the due date for concurrence. Completed on May 1, 2014.

Recommendation 6: The Reno VA Regional Office Director ensure that staff assigned to complete Systematic Analyses of Operations receive training on Veterans Benefits Administration policy regarding the purpose and requirements for completing Systematic Analyses of Operations.

RO Response: Concur. VSCM to provide training to coaches. (Site Visit SAO Best Practices). Anticipated completion on June 30, 2014.

Recommendation 7: The Reno VA Regional Office Director amend the workload management plan to ensure oversight and prioritization of benefit reduction cases.

RO Response: Concur. Workload management plan to be amended to include review of write outs for reexamination. Anticipated completion on June 30, 2014.

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.
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