VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office New York, New York

June 24, 2014
14-00383-171

ACRONYMS AND ABBREVIATIONS

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

Report Highlights: Inspection of VA Regional Office New York, NY

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 New York VARO to see how well it accomplishes this mission.

What We Found

Overall, VARO staff did not accurately process 27 (30 percent) of 90 disability claims reviewed. We sampled claims we considered at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Claims processing that lacks compliance with VBA procedures can result in the risk of paying inaccurate and unnecessary financial benefits.

Thirteen of 30 temporary 100 percent disability evaluations we reviewed were inaccurate, generally because VARO staff delayed ordering medical reexaminations on average for 9 months after receiving reminder notifications. VARO staff incorrectly processed 8 of 30 traumatic brain injury claims (TBI). Most of the errors occurred because staff misinterpreted VBA policy for rating a TBI with a coexisting mental condition. Staff also incorrectly processed 6 of 30 claims related to special monthly compensation (SMC) and ancillary benefits. Generally, these errors occurred because VARO staff did not follow VBA policy to forward these complex claims to a specialized team for evaluation.

VARO managers ensured Systematic Analyses of Operations were complete and timely. However, staff inaccurately processed and delayed completion of 14 of 30 rating reduction claims we reviewed because management did not prioritize this work.

What We Recommend

We recommend the VARO Director develop and implement the plans needed to ensure timely and appropriate action on reminder notifications for medical reexaminations, appropriate action on the 320 temporary 100 percent disability evaluations remaining from our inspection universe, accurate second-signature reviews of TBI claims, routing of higher-level SMC claims to a specialized team for processing as required, and prioritization of benefits reduction actions in order to minimize improper payments to veterans.

Agency Comments

The New York VARO Director concurred with all recommendations. Management's planned actions are responsive and we will follow up on all actions.

LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

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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 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 New York 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 New York VARO Could Improve Disability Claims Processing Accuracy

The New York 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 27 of the total 90 (30 percent) disability claims we sampled, resulting in 285 improper monthly payments to 16 veterans totaling $195,331.

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 New York VARO.

Table 1. New York VARO Disability Claims Processing Accuracy

Type of Claim	Total Claims 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	30	5	8	13
TBI Claims	30	5	3	8
SMC and Ancillary Benefits	30	6	0	6
Total	**90**	**16**	**11**	**27**

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 fiscal year (FY) 2013, and SMC and ancillary benefits claims completed in FY 2013.

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 13 of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a veteran's service-connected disability following 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, Veterans Service Center (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 has increased risk of paying inaccurate financial benefits. Available medical evidence showed 5 of the 13 processing errors we identified affected benefits and resulted in 51 improper monthly payments to 5 veterans totaling $49,540 from May 2011 until December 2013. Details on the most significant overpayment and underpayment follow.

- VARO staff did not take timely action to reduce benefits after notifying the veteran of the intent to do so in September 2012. Available medical evidence showed the veteran's prostate cancer was no longer active and therefore no longer supported the temporary 100 percent disability evaluation. As a result, the veteran was overpaid $25,344 over a period of 9 months.
- A Rating Veterans Service Representative (RVSR) coded a rating decision for entitlement to a special monthly compensation using an incorrect payment code. As a result, the veteran was underpaid $3,060 over a period of 2 years and 7 months.

The remaining 8 of the total 13 errors had the potential to affect veterans' benefits. Neither we nor VBA could determine whether the evaluations would have continued because the veterans' claims folders did not contain the medical examination reports needed to evaluate each case.

The types of errors we identified in the 13 cases follow.

- Seven errors occurred when VARO staff delayed scheduling required VA reexaminations despite receiving reminder notifications that the reexaminations were due. An average of approximately 9 months elapsed from the time staff scheduled or should have scheduled these medical reexaminations until December 1, 2013.

- Four errors occurred when VARO staff did not take timely action to reduce benefits after notifying veterans of the intent to do so. Staff delays averaged 5 months before resulting in reduced benefits.
- One error occurred when an RVSR used the incorrect payment code for a rating decision involving entitlement to special monthly compensation. As a result, the veteran's benefits were underpaid by $3,060 over a period of 2 years and 7 months.
- In the remaining case, an RVSR extended a veteran's reexamination date 5 years and 11 months beyond the February 2013 reexamination date initially established. Contrary to VBA policy, the claims folder did not contain the required documentation to explain the reason for extending the reexamination date.

Generally, processing inaccuracies resulted from a lack of adequate VARO oversight to ensure staff take timely action on reminder notifications to schedule VA medical reexaminations. According to VBA policy, VARO staff have 30 days to act on reminder notifications by establishing an appropriate workload management control to ensure reexaminations are ordered. Although the VARO had a workload management plan designating staff and their responsibilities for managing this work, VARO staff and management stated there was no priority or adequate oversight provided to ensure the work was completed. Instead, VARO staff stated they focused on other priorities as directed by VA Central Office, which involved completing rating-related claims, but did not include taking action on reminder notifications to schedule medical reexaminations. Because of the lack of priority on processing reminder notifications, delays in ordering VA medical reexaminations to support continued temporary 100 percent disability evaluations resulted. As such, improper recurring monthly benefits may continue to be paid.

VARO management disagreed with our assessments in 12 of the 13 cases we identified as having errors. VARO management stated it disagreed with the errors because failure to take timely action is a workload issue that would not result in an error from quality assurance staff. Additionally, management acknowledged the VARO's responsibility for ensuring staff take timely and appropriate action on work items, but indicated workload demands had impacted their ability to do so.

Follow-Up to Prior VA OIG Inspection

In our previous inspection report, *Inspection of the VA Regional Office, New York, New York* (Report No. 11-00516-240, July 28, 2011), VARO staff incorrectly processed 20 of 30 temporary 100 percent disability evaluations we reviewed. The majority of the errors occurred because management did not provide adequate oversight to ensure VSC staff entered suspense diaries in the electronic record so they would receive reminder notifications to schedule VA medical reexaminations. We did not provide a recommendation to the New York VARO for improvement in this area in

2011 because, in response to our national *Audit of 100 Percent Disability Evaluations* (Report Number 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed and took corrective action to modify the electronic system to automatically populate suspense diaries in the electronic record. The suspense diaries, when mature, result in reminder notifications for staff to request the required VA reexaminations.

During our current inspection, we did not identify any errors where staff did not enter suspense diaries in the electronic record. The suspense diaries were generating reminder notifications; however, staff were not taking timely action to request reexaminations from VA medical facilities.

TBI Claims

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

In response to a recommendation in our summary report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-167, 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 8 of 30 TBI claims. Five of these claims affected veterans' benefits and resulted in 148 improper monthly payments totaling $85,890 from March 2009 until December 2013. Generally, errors in processing TBI claims occurred because VARO management did not have oversight procedures in place to ensure staff complied with VBA policy as well as local policy requiring secondary reviews of TBI claims. As a result, veterans received incorrect benefits payments.

Errors in six cases occurred when RVSRs over-evaluated TBI-related disabilities. One of these errors did not affect the veteran's ongoing monthly benefits, but if left uncorrected could affect future benefits in the event of additional compensable disabilities. In the majority of the cases, RVSRs incorrectly established separate evaluations for the veterans' TBI and post-traumatic stress disorder when medical examiners indicated they could not determine which symptoms were attributable to which disability. VBA

policy requires staff to assign a single evaluation when medical examiners cannot ascribe overlapping symptoms to either a TBI-related disability or to a coexisting mental condition.

VARO management did not agree with the errors we identified in four of these six cases. VARO managers indicated RVSRs considered the totality of all medical evidence when assessing disability evaluations. Managers were steadfast that RVSRs have the latitude to assign symptoms to specific disabilities, even though medical examiners indicated they could not do so. However, VBA policy requires the examiner to determine the etiology of symptoms—not the RVSR. The RVSR is to evaluate the claim based on the examiner's determination of the etiology.

The two remaining errors occurred when RVSRs used insufficient VA medical examination reports to evaluate TBI-related disabilities. In one of the cases, a required neurological disability benefits questionnaire was missing. The other case had conflicting diagnoses that needed to be resolved before the examination report could be used to evaluate the veteran's disability. In both cases, and contrary to VBA policy, RVSRs did not return the insufficient examination reports to the issuing clinics or health care facilities for clarification, but proceeded to rate the cases using the information available. VARO managers did not agree with the errors we identified in these two cases and insisted the medical evidence used to evaluate these claims was adequate to provide disability evaluations. However, without adequate or complete medical evidence, such as the required neurological disability benefits questionnaire or clear diagnoses, neither VARO staff nor we can ascertain all of the residual disabilities of a TBI.

Most of the RVSRs we interviewed were unaware of VBA's second-signature requirements. However, staff were aware of the local policy that required the Special Operations team to process these claims and undergo second-signature review by management. Although VARO managers stated they were aware of VBA's second-signature review policy, they were generally not complying due to staff workloads and competing priorities. VARO management agreed oversight procedures were lacking to ensure TBI claims received second-signature reviews for accuracy.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, New York, New York* (Report No. 11-00516-240, July 28, 2011), we identified five of eight TBI processing errors attributed to staff using insufficient examinations to make final disability determinations. Specifically, RVSRs prematurely granted or continued service-connection evaluations for TBI-related residuals based on insufficient VA medical examination reports. However, the OIG did not make a previous recommendation based on these TBI errors. At the time of that inspection, the VSC had just implemented a Quality and Training Plan that included assigning one full-time employee to pre-screen VA

examinations to identify insufficient examinations to be returned to VA facilities for correction. Because the plan was new, we could not fully assess the effectiveness of VBA implementation actions.

During our current inspection, we identified two errors related to staff using insufficient VA examinations. Although these types of errors were not occurring frequently, we found that staff used insufficient examinations to evaluate disability claims. Had VBA's second-signature review policy been used as intended, these errors may have been prevented.

Special Monthly Compensation and Ancillary Benefits

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

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

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

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

VBA policy requires staff to address the issues of SMC and ancillary benefits whenever they can grant entitlement. We examined whether VARO staff accurately processed entitlement to SMC and ancillary benefits

associated with anatomical loss or loss of use of two or more extremities, or bilateral blindness with visual acuity of 5/200 or worse.

VARO staff incorrectly processed 6 of 30 veterans' claims involving SMC and related ancillary benefits—all of the errors affected veterans' benefits and resulted in 86 improper monthly payments totaling $59,901 from December 2010 until December 2013. The majority of the errors occurred because oversight measures were lacking to ensure complex, higher-level SMC claims were evaluated by staff assigned to the Special Operations team, as required by local policy. VARO staff told us that generally, RVSRs are required to self-identify these higher-level SMC claims for routing to the team for processing. Additionally, VARO staff indicated some errors might occur because they were not familiar with higher-level SMC cases, which typically are rare. VARO management agreed with our assessments in the six cases we identified as having errors.

Summaries related to errors in processing SMC and ancillary benefits follow.

- An RVSR incorrectly established SMC in one claim based on a need for aid and attendance with the activities of daily living. However, the medical evidence did not indicate the veteran's disabilities met the requirements for this level of care. As a result, the veteran was overpaid approximately $36,480 over a period of 1 year.
- An RVSR did not use the correct date to grant SMC to a veteran with diabetes who underwent a series of amputations that eventually resulted in anatomical loss of both feet. The RVSR properly increased the evaluation of the veteran's diabetes, but did not grant an increased SMC level for diabetic complications. The RVSR also did not provide a separate evaluation for diabetic kidney disease. As a result, the veteran was underpaid $8,489 over a period of 3 years.
- In one case, an RVSR used outdated VBA policy and over-evaluated a veteran's combat injuries, which resulted in erroneously awarding a higher level of SMC. As a result, the veteran was overpaid $5,550 over a period of 1 year and 8 months.
- Another error occurred when an RVSR used an incorrect date to establish benefits. In this case, the RVSR used the date of a VA medical examination rather than the date the claim was received by VA. As a result, this veteran was underpaid $5,403 over a period of 3 months.
- An RVSR established SMC for a veteran's chronic fatigue syndrome, but did not assign the correct level of SMC as required when a veteran has another disability separately evaluated as 50 percent disabling. Consequently, VA underpaid the veteran $2,117 over a period of 1 year and 8 months.

- An RVSR established a higher level of SMC than required for a veteran who no longer had the use of his hands. However, the RVSR did not increase SMC for other related disabilities, as required. As a result, the veteran was underpaid $1,862 over a period of 7 months.

Operating under VBA's business model involving segmented lanes, the New York VARO delegated responsibility for evaluating claims with higher levels of SMC to staff assigned to the Special Operations team. Staff assigned to the Special Operations team process complex or sensitive claims, such as those involving high-level SMC, military sexual trauma, TBI, or multiple sclerosis. However, the VBA business model related to segmented lanes lacked specific guidance regarding the lane assignments for routing and processing SMC cases.

Staff other than specialized team members processed four of the six SMC cases that included errors while staff assigned to the Special Operations team processed two of the six cases with processing errors. Two of the cases with errors also received a secondary review by the VARO's Quality Review team; however, the reviewers also did not identify the errors.

Although local policy delegated the evaluation of SMC claims to the Special Operations team, VARO staff told us the Special Operations team does not always process these cases. Our inspection results showed staff outside of the Special Operations team processed four of the six SMC cases with errors. Additionally, two of the six cases with errors received a secondary review by the VARO's Quality Review team; however, that team also did not identify the errors. Generally, when a veteran specifically claimed a SMC benefit, VARO staff routed the claims to the Special Operations team to complete. However, when the SMC benefit was inferred (conveyed indirectly based on the severity of disabilities), other claims processing staff completed those cases as part of their regular workload.

Recommendations

1. We recommend the New York VA Regional Office Director implement a plan to ensure timely and appropriate action on reminder notifications for medical reexaminations.
2. We recommend the New York VA Regional Office Director develop and implement a plan to review for accuracy the 320 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate actions.
3. We recommend the New York VA Regional Office Director develop and implement a plan to ensure staff comply with VBA and local second-signature requirements for traumatic brain injury claims.

4. We recommend that the New York VA Regional Office Director implement a plan to ensure staff comply with VARO policy requiring evaluation of higher-level special monthly compensation claims by staff assigned to the Special Operations team.

Management Comments

The VARO Director concurred with our recommendations. In May 2014, the Director designated staff responsible for managing and processing reminder notifications related to medical reexaminations. As of May 30, 2014, the VARO reported it no longer had a backlog of unprocessed reminder notifications. Management also completed its review of the 320 temporary 100 percent disability claims remaining from our inspection universe. VARO management created a log to track all TBI rating decisions generated by VARO staff to ensure the cases received the required secondary reviews. Additionally, the Quality Review team tailored recurring TBI training to address errors identified from its reviews of TBI claims processing. Further, the VARO Director mandated all higher levels of special monthly compensation claims to have second-signature reviews, regardless of which team processes the claims.

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 publish 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.

Generally, VARO management ensured SAOs were submitted by the required due date, contained thorough analyses, used appropriate data, and included recommendations for improvements where appropriate. Of the 11 mandatory SAOs, we found staff delayed submitting the Internal Controls SAO by 51 days. VARO management did not concur with our assessments and indicated an extension for the SAO had been given; however, management was unable to demonstrate a new due date for the SAO.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, New York, New York* (Report No. 11-00516-240, July 28, 2011), we reported that four of the mandatory SAOs were late or incomplete. In response to our recommendation, the VARO Director implemented a plan requiring VSC staff to submit in writing all requests to complete SAOs past their scheduled due dates and created a compliance checklist to ensure staff complete all required sections of the SAOs.

During our 2014 inspection, we found that only one SAO was untimely. Because we found no systemic problems with SAOs during our January 2014 inspection, we concluded the VARO's corrective actions in response to our 2011 recommendation were generally adequate. As such, we made no recommendation for improvement in this area.

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 a reduction or discontinuance of current compensation payments,

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

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

Finding 2 VARO Lacked Oversight To Ensure Immediate Action On Benefit Reductions

VARO staff delayed 14 of 30 claims that required rating decisions to reduce or discontinue benefits. This occurred because of a lack of VARO management oversight to ensure staff processed the reductions. As a result, VA made 121 improper payments to 14 veterans from April 2009 to December 2013. As result of delays averaging 9 months, VA continued to pay recurring monthly benefits that totaled approximately $170,860 in improper payments.

The most significant overpayment and delay occurred when staff proposed reducing a veteran's benefits after he advised that he had returned to the workforce. While VARO staff proposed the action in April 2009, the final action to discontinue benefits did not occur until September 2013—4 years and 8 months beyond the date the reduction should have occurred. As a result, the veteran received approximately $82,480 in improper payments.

Generally, delays in processing benefits reduction cases occurred because VARO managers did not provide oversight to ensure staff processed these cases timely. Although the VARO had a workload management plan that designated staff and their responsibilities for processing this work, no priority or management oversight was provided to ensure the work was completed. Instead, the VARO focused on other priorities, such as working on the VARO's oldest rating-related claims, as directed by the VA Central Office.

Although VSC management acknowledged the VARO's responsibility for ensuring timely and appropriate action on rating decisions involving benefits reduction, the VARO disagreed with our assessments in 13 of the 14 cases we identified as having processing delays. Further, management indicated

that failure to take timely action to process these claims would not result in an error by quality assurance staff.

In response to the VARO's non-concurrences with the errors we identified during the inspection, we reviewed the 13 cases once again but continued to find the VARO non-compliant with VBA policy. We reminded VARO management that VBA policy requires action to reduce benefits after the due process period has ended. We pointed out that the VARO's own workload management plan required staff to take immediate action to resolve due process actions. Further, we reemphasized that our inspections are strictly compliance reviews, designed to identify as errors any conditions where the VAROs do not adhere to VBA policy. We concluded that providing oversight of this high-risk area of benefit reductions to ensure sound financial stewardship and minimize improper benefits payments is clearly necessary and within the OIG's purview.

Recommendation

5. We recommend the New York VA Regional Office Director implement a plan to ensure claims processing staff prioritize actions related to benefit reductions to minimize improper payments to veterans.

Management Comments

The VARO Director concurred with our recommendation and designated staff to monitor and prioritize cases related to adverse actions, including benefits reductions. On a weekly basis, VARO staff will prioritize cases that are ready for decisions, pending awards, pending authorization actions, and cases with expiring suspense dates.

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 New York VARO administers a variety of services and benefits, including compensation and pension benefits; vocational rehabilitation and employment assistance; benefits counseling; and outreach to homeless, elderly, minority, and women veterans.

Resources

As of December 2013, VBA reported the New York VARO had a staffing level of 191 full-time employees. Of this total, the VSC had 156 employees assigned.

Workload

As of December 2013, the VARO reported 10,514 pending compensation claims. The average number of days pending for claims was 182 days, 67 days more than the national target of 115 days.

Scope and Methodology

VBA has 56 VAROs and a VSC in Cheyenne, Wyoming, that process disability claims and provide a range of service to veterans. We evaluated the New York VARO to see how well it accomplishes this mission.

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

Our review included 30 (9 percent) of 350 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of November 5, 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 320 claims remaining from our universe of 350 for its review. We reviewed 30 (48 percent) of 63 disability claims related to TBI that the VARO completed from July through September 2013. We also examined 30 (42 percent) of 71 veterans' claims involving entitlement to SMC and ancillary benefits completed by VARO staff from October 2012 through September 2013.

Prior to VBA consolidating Fiduciary Activities nationally, each VARO was required to complete 12 SAOs. However, since the Fiduciary consolidation, VAROs are now only required to complete 11 SAOs. Therefore, we reviewed 11 SAOs related to VARO operations. Additionally, we looked at 30 (11 percent) of 276 completed claims that proposed reductions in benefits from July through September 2013.

Where we identify potential procedural inaccuracies, we provided 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 120 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.

As reported by VBA's Systematic Technical Accuracy Review program as of December 2013, the overall accuracy of the New York VARO's compensation rating-related decisions was 88.6 percent—5.4 percentage points below VBA's FY 2014 target of 94 percent. We did not test the reliability of this data.

Inspection Standards

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

Appendix B Inspection Summary

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

Table 2. New York VARO Inspection Summary

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

Source: VA OIG

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

Appendix C VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: May 27, 2014

From: Director, VA Regional Office New York, New York (306/00)

Subj: Inspection of the VA Regional Office, New York, New York

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

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

2. Please refer questions to VSCM Joe Corretjer at 212-807-3421.

(original signed by:)

Sue Malley, Director
New York Regional Office

Enclosure

Enclosure

OIG Recommendations

Recommendation 1: *We recommend the New York VA Regional Office Director implement a plan to ensure timely and appropriate action on reminder notifications for medical reexaminations.*

New York RO Response: Concur

According New York RO's Workload Management Plan, the Non-Rating Team is responsible for running all 800 work items, to include future examinations, ensuring these are processed in a timely manner. The supervisor of the Non-Rating team runs the list of "new" work items daily to give the staff the best chance to have the end products established timely and to not have a negative impact on our control time. Effective May 8, 2014, new procedures were put in place to reduce hand offs between teams and to streamline this process. The VOR work items report is now sent from the Non-Rating team supervisor to the two Express teams to be processed. Between September 2013 and February 2014, 650 backlogged work items were cleared, with an additional average of 80 to 90 work items per month. As of May 30, 2014, the New York Regional Office does not have any work items pending.

While the NY VARO does not dispute this workload was historically out of line, as were a number of other areas due to our backlog. The steps we have taken to address this issue have been successful and we request this item be considered closed.

Target Completion Date: Completed

Recommendation 2: *We recommend the New York VA Regional Office Director develop and implement a plan to review for accuracy the 320 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate actions.*

New York RO Response: Concur

New York Regional Office has reviewed 100 percent of the temporary 100 percent disability evaluations identified. New York will continue to get a new listing of temporary 100 reviews monthly and will work them as they are received.

The Target Completion Date: Completed

Recommendation 3: *We recommend the New York VA Regional Office Director develop and implement a plan to ensure staff comply with VBA and local second-signature requirements for traumatic brain injury claims.*

New York RO Response: Concur

The New York Regional Office has a local policy, where all cases require review, which exceed the national requirements requiring a second signature on each TBI case an RVSR evaluates until the RVSR demonstrates 90 percent accuracy in TBI claims processing. In the New York Regional Office, a second signature is required on all TBI cases. A log has been established on an electronic drive showing each TBI rating generated, the RVSR who generated the rating, the result of each review and the reviewer. The log tracks errors found and ensures all TBI ratings are reviewed. The reviewers come from a pool of coaches, DROs and staff used to conduct local station quality reviews. QRT training is tailored to include recurring TBI errors found.

Target Completion Date: June 20, 2014

Recommendation 4: *We recommend that the New York VA Regional Office Director implement a plan to ensure staff comply with VARO policy requiring evaluation of higher-level special monthly compensation claims by staff assigned to the Special Operations team.*

New York RO Response: Concur

All special monthly compensation claims involving a higher level of special monthly compensation are handled by the Special Operations team or Express team addressing FDC claims.

Claims for special monthly compensation are assigned to the Special Operations team and Express teams as mandated by VBA's business model involving segmented lanes. However, there are occasions when a claim may be being handled on a Core team and the issue of special monthly compensation, although not claimed, in fact becomes inferred based on the level of disability. In those instances, since the RVSR has spent time reviewing the evidence and is familiar with the facts, in the interest of not wasting valuable rating resources, the claim has been rated on the Core team

The NYRO established a local policy mandating all rating decisions establishing entitlement to special monthly compensation (l) or higher be reviewed and have a second signature. In addition, the claims with special monthly compensation (l) or higher that are rated on a Core team will be referred to the Special Operations team or QRT for second signature

Target Completion Date: Completed

Recommendation 5: *We recommend the New York VA Regional Office Director implement a plan to ensure claims processing staff prioritize actions related to benefit reductions to minimize improper payments to veterans.*

New York Response: **Concur**

The New York Regional Office is currently operating in concert with the national workload strategy. According to the Workload Management Plan, the Non Rating Team is responsible for processing all 600 EPs. The due process cases that require rating decisions are routed to the respective Express, Core or Special Operations Lane for processing to ensure better workload management. The current process is that as the respective lanes promulgate rating decisions on any cases involving proposals on potential adverse actions, the 600 end products are established in VBMS and assigned a lane. On a weekly basis the respective teams monitor their 600 end products, prioritizing cases in ready for decision status, pending award, pending authorization and cases in open status (pending evidence cycle) with an expired suspense date. Effective May 23, 2014, our office has a total of 986 600 end products pending. Of these, approximately 379 are 600 end products involving rating actions. Of the 379 cases, 64 are ready for decision, 10 are awaiting initial development, 26 are pending award, 6 are pending authorization and of 273 cases in pending evidence cycle time, 113 are expired.

Target Completion: TBD. Completion will be determined based on national workload directives.

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Nora Stokes, Director Nelvy Viguera Butler Robert Campbell Kyle Flannery Lee Giesbrecht Lisa Van Haeren Ambreen Husain Suzanne Love Michelle Santos-Rodriguez

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