VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Atlanta, Georgia

August 5, 2014
14-00902-207

ACRONYMS

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
VA	Veterans Affairs
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of VA Regional Office Atlanta, GA

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 Atlanta VARO to see how well it accomplishes this mission. We also assessed the merits of a complaint involving deceptive VARO mail management practices.

What We Found

Overall, VARO staff did not accurately process 34 (38 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.

Seventeen of 30 temporary 100 percent disability evaluations reviewed were inaccurate. Generally, the errors occurred because VARO staff did not take timely action on reminder notifications for medical reexaminations. VARO staff incorrectly processed 8 of 30 traumatic brain injury (TBI) claims because oversight was lacking to ensure staff complied with VBA's second-signature policy. Further, staff incorrectly processed 9 of 30 special monthly compensation and ancillary benefits claims due to a lack of training.

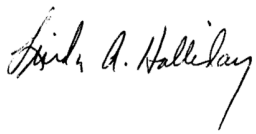
VARO managers ensured Systematic Analyses of Operations were complete, timely, and contained the analysis and recommendations needed to address deficiencies. However, VARO staff delayed completing 16 of 30 benefit reduction cases because management assigned staff to address other priorities. We did not substantiate an anonymous allegation concerning deceptive mail management practices at the Atlanta VARO.

What We Recommended

We recommended the VARO Director develop and implement a plan to ensure staff take timely action on reminder notifications for medical reexaminations; review and take appropriate action on the 776 temporary 100 percent disability evaluations remaining from our inspection universe; ensure effective second-signature reviews and training on processing TBI, special monthly compensation, and ancillary benefits claims; and develop a plan to prioritize actions on benefit reduction cases.

Agency Comments

The VARO Director concurred with all recommendations and the planned corrective actions are responsive. We will follow up on these actions, as deemed appropriate.



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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 Atlanta 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 their effect on veterans' benefits.

Finding 1 Atlanta VARO Needs To Improve Disability Claims Processing Accuracy

The Atlanta VARO did not consistently process temporary 100 percent disability evaluations, TBI-related cases, or entitlement to SMC and ancillary benefits. Overall, VARO staff incorrectly processed 34 of the total 90 disability claims we sampled, resulting in 327 improper monthly payments to 11 veterans totaling $386,013.

We sampled claims related 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 Atlanta VARO.

Table 1. Atlanta VARO Disability Claims Processing Accuracy

Type of Claim	Claims Reviewed	Claims Inaccurately Processed: Affected Veterans' Benefits	Claims Inaccurately Processed :Potential To Affect Veterans' Benefits	Claims Inaccurately Processed: Total
Temporary 100 Percent Disability Evaluations	30	4	13	17
TBI Claims	30	2	6	8
SMC and Ancillary Benefits	30	5	4	9
Total	**90**	**11**	**23**	**34**

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 17 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, 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 evaluation ratings, VBA is at increased risk of paying inaccurate financial benefits. Available medical evidence showed 4 of the 17 processing errors we identified affected benefits and resulted in 116 improper monthly overpayments to 4 veterans totaling $139,052. These improper payments occurred from June 2009 until January 2014.

Details follow on the 17 cases we identified with errors.

- The most significant overpayment occurred when a Rating Veterans Service Representative (RVSR) assigned a temporary 100 percent disability evaluation for a veteran's heart condition in a December 2008 rating decision. In that decision, the RVSR determined an immediate examination was required to assess the current level of impairment following the veterans' surgery; however, VARO staff did not request the VA examination. In June 2012, while reviewing the veterans' claims folder for another claim, VARO staff did not identify that the required examination had never occurred. Available VA medical treatment records showed the veteran did not have residual disabilities following the heart surgery in 2007. Because VARO staff missed two opportunities to schedule the required VA examination, the veteran was overpaid $89,593 over a period of 4 years and 7 months.

- The most significant underpayment occurred when an RVSR did not grant a veteran entitlement to additional special monthly benefits based on evaluations of multiple disabilities and for loss of use of a creative organ, as required. As a result, the veteran was underpaid $19,154 over a period of 3 years and 9 months.

- Eight errors occurred when VARO staff delayed requesting required medical reexaminations after receiving reminder notifications to do so. VBA policy requires VARO staff to establish appropriate work product controls in the electronic system within 30 days to ensure requests for reexaminations are processed. On average, approximately 6 months elapsed from the time staff should have requested the examinations until January 2014.
- Four errors occurred when VARO staff cancelled reminder notifications to request required reexaminations but did not take action to have the examinations scheduled. The claims folders also did not contain the documentation needed to explain the reason staff cancelled the required reexaminations. Generally, once reminder notifications are removed from the electronic system, VARO staff lose the ability to manage requests for reexamination. As such, a temporary 100 percent disability evaluation has the potential to continue throughout a veteran's lifetime until an action on the claim by the veteran or VBA calls the case into question again.
- Two errors occurred when VARO staff proposed reducing veterans' evaluations for medical conditions that had improved, but did not take final actions to reduce the benefits. In January 2014, at the time of our inspection, more than 1 year had passed and VARO staff still had not taken action to reduce these benefits.
- One error occurred when VARO staff did not take timely action to schedule a veteran's hearing request related to a proposed benefit reduction. VBA policy allows staff to extend the proposal period for benefit reductions by 30 to 60 days if a hearing is requested. In this case, the veteran requested the hearing more than 10 months prior to our inspection, yet no hearing had been scheduled and the final benefit reduction did not occur.

Thirteen of the total 17 errors had the potential to affect veterans' benefits. Neither we nor VARO staff could determine whether the evaluations would have continued because the veterans' claims folders did not contain the medical evidence needed to evaluate each case.

Most frequently, the processing inaccuracies resulted from a lack of VARO management oversight to ensure staff took timely action to schedule medical reexaminations upon receipt of reminder notifications. An average of 13 months elapsed from the time staff should have scheduled the medical reexaminations until January 2014. As a result of the delays in obtaining the medical evidence needed to reevaluate each case, improper disability benefits payments may have occurred.

VARO management disagreed with our assessment in 14 of the 17 cases we identified as having errors. Although we referenced VBA policy indicating

that VARO staff have 30 days to process reminder notifications, VARO management did not agree a timeliness standard for processing reminder notifications existed. Both VARO staff and management also indicated that their priority was on processing the oldest rating-related compensation claims rather than processing reminder notifications and taking actions to request medical reexaminations.

Follow-Up to Prior VA OIG Inspection

In our previous inspection report, *Inspection of the VA Regional Office, Atlanta, Georgia* (Report No. 11-00512-179, May 27, 2011), VARO staff incorrectly processed 24 (80 percent) 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 to ensure they received reminder notifications to schedule VA medical reexaminations. During our inspection work at the Atlanta VARO in January 2014, we did not identify any errors where staff did not enter suspense diaries in the electronic record.

In our prior May 2011 inspection, the second most frequent processing inaccuracy involved VSC staff not following up on reminder notifications or proposals to reduce disability benefits. In response to our recommendations for improvement, VARO staff amended the workload management plan and designated responsibility for reviewing and processing medical reexamination reminder notifications. Consequently, the OIG closed this recommendation in December 2011.

During this inspection, 11 of the 17 inaccuracies we identified involved VSC staff not following up on reminder notifications or proposals to reduce benefits. In November 2012, the VARO updated its workload management plan to no longer designate responsibility for reviewing and processing reminder notifications for medical follow-up. Further, VARO management acknowledged there was no local guidance in place for processing reminder notifications. As such, we concluded the VARO did not fully implement corrective actions they agreed to take in response to our 2011 inspection report.

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 TBI training.

In response to a recommendation in our summary report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-67, 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; 2 affected veterans' benefits and resulted in 26 improper monthly payments totaling $8,223, from March 2012 to January 2014. Generally, errors in processing TBI claims occurred because VARO management did not have oversight procedures in place to ensure staff complied with VBA's second-signature review policy. As a result, veterans received incorrect benefit payments. Following are details related to the two errors affecting veterans' benefits payments. Both errors involved overpayments.

- An RVSR incorrectly granted a veteran a separate evaluation for residuals of TBI when there was an existing co-morbid mental disorder for which an examiner could not delineate symptoms. In cases where medical examiners cannot make such delineations, VBA policy requires that staff use the symptoms to establish a single disability evaluation. Because the RVSR did not follow the policy, the veteran was overpaid $4,213, spanning a period of 1 year and 9 months. VARO staff did not agree with our assessment in this case, stating that VA policy was not clear about what to do in situations when examiners identify additional symptoms. Management indicated that in cases where RVSRs cannot determine which symptoms are related to each disability, they compensate the veterans for all of the symptoms.
- A $4,010 overpayment occurred when an RVSR used the incorrect date to establish benefits for a TBI-related disability. The RVSR used a date that preceded the veteran's claim for the condition by approximately 5 months.

The remaining six of eight errors had the potential to affect veterans' benefits. Details on the six cases follow.

- In two cases, RVSRs erroneously assigned separate evaluations for TBI and coexisting mental disorders, although the examiners indicated the symptoms for each condition could not be separated. VARO staff agreed with one error, but disagreed with our assessment in the other case. Staff said VBA's training letter did not provide clear instructions on how to evaluate TBI-related disability claims when symptoms overlap between the TBI injury and a mental disorder. Further, VARO management stated VBA instructions only clearly addressed what RVSRs should do in cases where medical examiners could not differentiate which symptoms were attributable to which condition. According to VARO management, RVSRs did their best to process the cases using the unclear instructions

VBA had provided. We referenced VBA guidance that specifically showed how to address symptoms that overlap between TBI injuries and coexisting mental disorders.

- In four other cases, VARO staff prematurely evaluated TBI residuals using insufficient medical examination reports. According to VBA policy, VARO staff are required to return insufficient examination reports to the issuing clinics or health care facilities for clarification. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without adequate or complete medical evidence. Details on the four cases evaluated using insufficient examinations follow.
  - The results from two veterans' TBI examinations indicated that separate examinations for headaches were needed; however, the examinations for headaches were not completed as required. We determined the existing medical evidence was insufficient to evaluate the disability claims; however, VARO staff disagreed with our assessments. Despite VBA policy requirements, staff concluded that in the absence of diagnoses for headaches, separate examinations were not necessary.
  - A veteran reported symptoms of memory loss during a VA medical examination; however, in the same examination report the medical examiner indicated the veteran did not complain of memory problems. VARO staff disagreed with our assessment, because neither the TBI examiner nor the mental health examiner provided diagnoses of TBI-related residuals. Further, the TBI examiner provided conflicting information that according to VBA policy needed to be resolved before being used to evaluate the disability claim. Despite conflicting information related to the veteran's memory, the RVSR used the examination results to deny compensation benefits for the veteran's TBI related disabilities.
  - Another veteran underwent two separate TBI examinations that provided different findings. Rather than returning the examination reports for clarification as required, the RVSR used the results to evaluate the veteran's TBI-related disabilities. VARO staff disagreed with our assessment, stating that although one examination was conducted by a medical doctor, a second examination conducted by a psychiatrist provided additional information with regard to the veteran's overall disability picture. VARO staff could not explain why two examinations were completed.

Although VARO management implemented a second-signature requirement for all TBI ratings, it did not track the accuracy of individual RVSRs to ensure they met the 90 percent accuracy requirement. All eight cases we identified with processing errors were decided by RVSRs who had been approved to rate TBI cases independently. However, VARO managers could not demonstrate the RVSRs had attained the required 90 percent accuracy

rate to do so. Further, VARO managers did not track errors identified during the local second-signature reviews and therefore could not identify trends and issues for local training.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Atlanta, Georgia* (Report No.11-00512-179, May 27, 2011), we determined 16 of 30 TBI cases reviewed contained processing errors. We attributed the errors to inadequate training. Specifically, staff had not received instruction since December 2008, despite new training materials and guidance published in January 2009. In response to our recommendations, the Director agreed to ensure RVSRs receive refresher training on TBI claims processing and implemented a requirement mandating second-signature reviews of all TBI claims. As a result, the OIG closed the recommendations in October and December 2011.

Because the results of our 2014 benefits inspection disclosed similar problems, we concluded that the corrective actions in response to our 2011 report were inadequate. Despite refresher training and implementation of a secondary review for TBI claims, this inspection still showed an unacceptable TBI claims processing error rate. The errors identified were the result of inadequate VARO management oversight to ensure staff complied with VBA's second-signature review policy. Had management ensured RVSRs met the required 90 percent accuracy rate prior to rating TBI claims independently, management may have prevented the errors. Further, had management monitored and trended the types of errors identified during the secondary reviews, it may have been able to tailor the training to address VARO-specific claims processing deficiencies.

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 9 of 30 veterans' claims involving SMC and ancillary benefits—5 errors affected veterans' benefits and resulted in 185 improper monthly payments totaling over $238,738 from November 2006 until January 2014. The remaining four cases had the potential to affect veterans' benefits—three of the errors were related to hospital codes that necessitate adjusting veterans' benefits upon hospitalization. The remaining SMC coding error did not affect the veterans' overall monthly benefit; however, if left uncorrected future benefits may be affected.

Generally, errors occurred because VARO managers did not ensure all claims processing staff received refresher training on SMC determinations. Most of the RVSRs we interviewed stated they had not received SMC training within the last year; others stated it had been several years since they received refresher training. We confirmed that VARO staff assigned to the Special Operations team received higher level/advanced training on SMC in November 2012, but SMC claims processing was not limited to that Special Operations team. Staff from the Special Operations team completed two of the cases with errors; staff assigned to teams that did not receive the SMC training were responsible for the remaining seven errors. As a result of the lack of staff training to support accurate SMC determinations, some veterans received improper benefit payments.

Details follow on the cases we identified with errors.

- The most significant overpayment occurred when an RVSR incorrectly granted a 100 percent disability evaluation for a veteran's service connected diplopia eye condition. However, the medical examination revealed the veteran's disability only warranted a 20 percent evaluation. In addition, the RVSR incorrectly granted entitlement for SMC based on blindness and multiple disabilities evaluated at 50 percent or more. The RVSR also incorrectly established ancillary benefits for an Automobile and Adaptive Equipment Allowance worth up to $19,817, along with a Special Home Adaptation Grant. As a result, the veteran was overpaid $202,447 over a period of 7 years and 2 months.
- The most significant underpayment occurred when an RVSR assigned an incorrect effective date for entitlement to SMC for a cardiovascular condition. As a result, the veteran was underpaid $23,189 over a period of 9 months.
- In four cases, RVSRs used incorrect SMC codes that did not accurately reflect the levels of impairment for the veterans' disabilities. Generally, RVSRs did not assign correct SMC codes to reflect multiple, independent disabilities, evaluated as 50 percent or more disabling. As a result, the veterans did not always receive accurate payments. VARO management agreed with our assessments in three of the four cases. In the remaining case, management stated the medical evidence provided did not show the veteran needed skilled care and, as such, determined a VA examination was not required. However, the medical evidence from the veterans private physician clearly showed the veteran needed skilled care. VBA policy requires RVSRs to consider the probative value of all medical evidence, whether it comes from a private physician or a VA examination.
- Three errors occurred when RVSRs incorrectly entered hospital codes for the veterans' SMC in the electronic record. Generally, VBA policy requires VSC staff to adjust SMC payments when veterans are hospitalized at Government expense. If left uncorrected, erroneous payments to the veterans may occur. VARO management disagreed with our assessment in these three cases because the coding errors did not affect the veterans' current monthly benefits.

Additionally, VBA policy allows the VSC manager the discretion to require a second-level review for SMC cases. The Atlanta VARO designated supervisory coaching staff to conduct second-signature reviews for all higher-level SMC claims. Staff we interviewed indicated they were aware of the VARO's second-signature review policy, but some staff lacked confidence in the quality of those reviews because some of the reviewers did not have RVSR experience. Of the nine cases we identified with errors, three had second-signature reviews conducted by coaches without RVSR

experience and five cases did not undergo second-level reviews at all. The remaining error addressed entitlement to education benefits and did not require a second-level review.

Recommendations

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

2. We recommended the Atlanta VA Regional Office Director develop and implement a plan to review for accuracy the 776 temporary 100 percent disability evaluations remaining from our inspection universe.

3. We recommended the Atlanta VA Regional Office Director provide refresher training for staff on processing traumatic brain injury claims and implement a plan to monitor the effectiveness of this training.

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

5. We recommended the Atlanta VA Regional Office Director develop and implement a plan to ensure staff receive refresher training on identifying and returning insufficient medical examination reports related to traumatic brain injury claims to medical facilities for correction.

6. We recommended the Atlanta VA Regional Office Director ensure claims processing staff receive refresher training on processing special monthly compensation and ancillary benefits.

7. We recommended the Atlanta VA Regional Office Director promote staff awareness of the second-signature review policy for processing special monthly compensation and ancillary benefits and ensure that qualified staff conduct the secondary reviews.

Management Comments

The VARO Director concurred with our recommendations. The Director designated responsibility for processing reminder notifications to schedule medical reexaminations and provided refresher training on processing the reminders on July 1, 2014. VARO staff are expected to conduct initial reviews and take required development actions on the 776 temporary 100 percent disability evaluations remaining from our inspection universe by July 31, 2014.

Refresher training on TBI claims processing is planned to take place by August 2014, with additional training slated to take place twice each year beginning in FY 2015. The effectiveness of the TBI training will be tracked and monitored based on second-signature reviews; however, regardless of individual employee accuracy, secondary reviews for all TBI cases will be conducted by staff assigned to the Quality Review Team. Additionally, refresher training on SMC cases is expected to be completed by July 31, 2014, and annually thereafter. The Director also mandated all higher level SMC cases will be second-signed by staff assigned to the Quality Review Team. The QRT team will track SMC errors to identify annual SMC training needs.

OIG Response The Director's planned actions to address the recommendations are responsive.

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.

VARO staff completed all 11 mandated SAOs timely according to the SAO schedule. All SAOs contained the required elements, included thorough analyses using appropriate data, identified weaknesses or concerns, and provided recommendations for improvement when needed.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Atlanta, Georgia* (Report No. 11-00512-179, May 27, 2011), we indicated the majority of SAOs reviewed were incomplete and/or untimely due to inadequate VARO oversight. The Director agreed to monitor the effectiveness of the VARO's newly implemented SAO policy to ensure the SAOs contained the required elements and analyses. As such, the OIG closed this recommendation in September 2011. During our January-February 2014 benefits inspection, we noted significant improvement in this area. Therefore, we made no recommendation for improvement.

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 to which they are not entitled because VAROs do not take the actions required to ensure correct payments for their levels of disability.

When the VARO obtains evidence that a lower disability evaluation would result in reduction or discontinuance of current compensation payments, VSC staff must inform the beneficiary of the proposed benefit reduction. 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 must make a final determination to reduce or discontinue the benefit. On the 65th day following due process notification, action is required to reduce the evaluation and thereby minimize overpayments.

On April 3, 2014, subsequent to our January 2014 benefits inspection, VBA leadership modified its policy regarding the processing of claims requiring benefit reductions. The new policy no longer includes the requirement for VARO staff to take "immediate action" to process these reductions. In lieu of merely removing the vague standard, VBA should have provided clearer guidance on prioritizing this work to ensure sound financial stewardship of these monetary benefits. In fact, 38 Code of Federal Regulations 3.105 (e), "Reduction in Evaluation-Compensation," on which VBA's revision of rating decisions is based, also includes a timeliness standard by requiring the effective date of a benefit reduction to be the last day of the month following 60 days from the date the payee was notified of the proposed reduction.

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

VARO staff delayed processing 16 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 90 improper overpayments to 16 veterans from November 2012 until December 2013, totaling approximately $138,364.

For the 16 cases with processing delays, an average of almost 6 months elapsed before staff took the required actions to reduce benefits. The most significant improper payment involved VARO staff proposing to reduce a veteran's benefits after medical evidence showed the medical condition had improved. Staff proposed the reduction action in October 2012; however, the final rating decision to reduce benefits was not made until September 2013, which was 9 months beyond the date it should have occurred. As a result, the veteran was overpaid approximately $26,757 in improper payments.

VARO staff disagreed with our assessments in all 16 cases we found non-compliant with VBA policy. VARO managers indicated there was no regulatory guidance regarding timeliness for reducing benefits and that they had to follow the priorities established by the national strategy, which included reducing the inventory of VBA's oldest pending claims. However, VARO management did not address the issue of compliance with VBA policy, which requires staff to identify and route proposed benefits reductions for action on the 65th day following the due process period.

We reexamined the 16 cases; however, we continued to find the VARO noncompliant with VBA's policy to route claims with proposed reductions for action following the due process period. We reemphasized that our inspections identify as errors any conditions where the VAROs do not adhere to VBA policy. Further, we noted the VARO's own workload management plan required staff to take action on benefits reduction notices once due process had expired. We concluded that providing oversight of benefits

reductions is necessary to ensure sound financial stewardship and minimize improper benefits payments.

Recommendation

8. We recommended the Atlanta 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. The Director plans to update the VARO's plan related to the benefits reduction workload by July 31, 2014.

OIG Response

The Director's planned actions to address the recommendation are responsive.

III. Review of Allegations of Deceptive Mail Management Practices

We did not substantiate allegations concerning deceptive mail management practices at the Atlanta VARO. The allegations were mailed by a complainant to various Congressional recipients for consideration. Georgia Senator Johnny Isakson's staff provided a copy of the allegations to the OIG for review and assessment shortly after we completed our inspection field work.

Allegations

In January 2014, an anonymous complainant alleged that Atlanta VARO leadership directed staff to engage in deceptive practices that misrepresented the VARO's backlog of unprocessed claims-related mail to the Undersecretary for Benefits during a July 2013 office visit. The complainant considered such practices a lack of regard and a breach of responsibility to veterans who placed their trust in the Atlanta VARO to ensure just compensation for injuries, illness, and disease incurred during military service. Specifically, the complaint alleged that VARO staff:

- Boxed and sealed unprocessed, claims-related mail for the purpose of hiding the mail from the Undersecretary for Benefits during her July 2013 visit to the regional office
- Mislabeled the boxes as "drop mail" and, as directed, advised the Under Secretary that this mail was being shipped for scanning to the Newnan, Georgia scanning facility
- Intentionally did not take the Under Secretary for Benefits into some areas of the VARO where the mail was hidden
- Unpacked and placed the mail in file cabinets, on shelves, and on the floor after the Under Secretary left the VARO

Work Performed

In March 2014, we conducted an unannounced visit to the Atlanta VARO to assess the merits of these allegations. We completed our inspection of the Atlanta VARO in February 2014, but were not made aware of the allegations until March 2014. As such, we determined a repeat visit to the Atlanta VARO was necessary for us to gain an understanding of VARO mail management, which was not included in our FY 2014 inspection protocols. To conduct our review, we conducted a complete physical inspection of all VARO workspace, including an off-site file storage area. We also interviewed VARO staff and managers responsible for the oversight and processing of mail at the Atlanta VARO.

Review Results

Based on our work, we did not substantiate the allegations of deceptive mail management practices at the Atlanta VARO. We could not attest to

conditions present during the Under Secretary for Benefits' visit in July 2013 because we were not on-site at this time. However, we found no boxes of unprocessed mail stored in file cabinets, on shelves, or on the floor. Nor did we find boxes of mail mislabeled as "drop mail." We also determined through interviews that VARO managers did not advise staff to hide mail from the view of the Undersecretary for Benefits, or prevent her access to areas where mail was allegedly hidden during her visit.

We did observe approximately 2,900 boxes of claims folders and processed mail that a contractor had returned to the VARO for storage after scanning the documents into the electronic system. VARO staff advised us they were responsible for housing the 2,900 boxes of claims folder and mail until VBA decided what to do with them. The storage of the 2,900 boxes did not appear to present safety or security concerns; however, we cautioned that VARO officials should continue to follow up with VBA on the disposition of the boxes to avoid potential security and safety concerns in the future.

Because we did not substantiate the allegations, we made no recommendation for improvement and closed our review.

Appendix A VARO Profile and Scope of Inspection

Organization

The Atlanta 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, Native American, minority, and women veterans.

Resources

As of January 11, 2014, the Atlanta VARO reported a staffing level of 763.5 full-time employees. Of this total, the VSC had 410.3 employees assigned.

Workload

As of January 2014, the VARO reported 28,746 pending compensation claims. On average, claims were pending 172 days, 57 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 services to veterans. In January and February 2014, we evaluated the Atlanta 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 (30 percent) of 806 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months or more as of December 2, 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 776 claims remaining from our universe of 806 for its review. We reviewed 30 (31 percent) of 98 TBI-related disability claims that the VARO completed from July through September 2013. We examined 30 (23 percent) of 133 veterans' claims involving entitlement to SMC and related ancillary benefits that VARO staff completed 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, the VAROs are now only required to complete 11 SAOs. Therefore, we reviewed 11 SAOs related to VARO operations. Additionally, we looked at 30 (48 percent) of 63 completed claims that proposed reductions in benefits.

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 also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Further, we compared veterans' names, file numbers, Social Security numbers, VARO numbers, dates of claim, and decision dates as provided in the data received with information contained in the 90 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI, SMC and ancillary benefits, and completed claims related to benefits reductions.

Our testing of the data disclosed that they were sufficiently reliable for our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders we reviewed did not disclose any problems with data reliability.

As reported by VBA's Systemic Technical Accuracy Review program as of January 2014, the overall accuracy of the Atlanta VARO's compensation rating-related decisions was 85.2 percent—8.8 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

Table 2 reflects the operational and administrative activities inspected, applicable criteria, and whether or not we had reasonable assurance of VARO compliance. Sampled claims are at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO.

Table 2. Atlanta 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: July 10, 2014

From: Director, VA Regional Office Atlanta, Georgia

Subj: Inspection of the VA Regional Office, Atlanta, Georgia

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

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

2. Please refer questions to Steve Furrer, Assistant Director, 404-929-5818.

(Original signed)

A. Bocchicchio
Director

Attachment

Attachment

OIG Recommendations

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

Atlanta RO Response: Concur

The Veterans Service Center (VSC) disseminated a directive dated July 1, 2014, which assigns the medical reexaminations to the Express Teams. In addition, refresher training was conducted with all members of the Express teams on July 1, 2014, to explain their role in the processing of this workload. The training covered the review and disposition of the 800 series work item and the establishment of and process for any rating end product associated with this workload. This workload will be reviewed on a weekly basis by the Assistant Veterans Service Center Manager with oversight responsibility for the Express teams to ensure timely action is being taken.

Recommendation 2: *We recommend the Atlanta VA Regional Office Director develop and implement a plan to review for accuracy the 776 temporary 100 percent disability evaluations remaining from our inspection.*

Atlanta RO Response: Concur

The VSC disseminated a directive dated July 1, 2014, which outlined the plan to complete the remaining temporary 100 percent disability evaluations from the inspection. The plan mandates that all initial reviews and required development actions will be taken by July 31, 2014, and that the claims will be completed by December 31, 2014. Weekly reports will be utilized to monitor progress against the plan and to identify any new temporary 100 percent disability evaluations for timely action.

Recommendation 3: *We recommend the Atlanta VA Regional Office Director provide refresher training for staff on processing traumatic brain injury claim and implement a plan to monitor the effectiveness of this training.*

Atlanta RO Response: Concur

The VA Office of Inspector General (VAOIG) reviewed 30 claims involving traumatic brain injury (TBI) and cited eight of the cases as containing errors. Due to its complexity, this workload is considered at a higher risk for processing errors and does not represent the overall quality of work performed at the Atlanta Regional Office (RO). The Atlanta RO only concurred with three of the eight errors cited and the office provided its rationale for non-concurrence of the remaining five, which primarily result from a different interpretation of guidance provided by Compensation Service Training Letter 09-01. The five cases in question were reviewed by a subject matter expert from Compensation Service given the difference of opinion with the findings. The Compensation Service expert concluded the Atlanta RO was correct in its interpretation and application of VBA guidance. The Atlanta RO concurs that three cases need to be corrected.

The Atlanta RO will conduct refresher training on TBI claims processing as the complexity of these claims is such that continual training is beneficial. The last instructor-led TBI class was conducted on April 29, 2014, for trainee VSRs. Refresher training will be conducted in August 2014 for VSRs and RVSRs. Beginning in FY15, TBI refresher training will be held twice each fiscal year. The effectiveness of this training will be tracked and monitored based on second signature reviews of this workload. Effective June 20, 2014, the Quality Review Team (QRT) is second-signing all TBI cases, regardless of individual employee accuracy, and maintains a spreadsheet to track the quality of the cases reviewed.

Recommendation 4: *We recommend the Atlanta VA Regional Office Director develop and implement a plan to ensure staff comply with the Veterans Benefits Administration's second-signature requirements for traumatic brain injury claims, including tracking and trending errors in processing these claims to identify local training needs.*

Atlanta RO Response: Concur

All TBI rating decisions are being reviewed and second-signed, regardless of individual employee accuracy, effective June 20, 2014. These claims are tracked to identify common errors and trends. The QRT Coach will review the tracking spreadsheet for common errors made by RVSR/DROs and provide refresher training in August 2014. The spreadsheet will monitored on an ongoing basis and trends noted will be included in the bi-annual TBI training. A VSC directive dated July 1, 2014, outlines this plan and was disseminated to all employees.

Recommendation 5: *We recommend the Atlanta VA Regional Office Director develop and implement a plan to ensure staff receive refresher training on identifying and returning insufficient medical examination reports related to traumatic brain injury claims to medical facilities for correction.*

Atlanta RO Response: Concur

The VA Office of Inspector General (VAOIG) reviewed 30 claims involving traumatic brain injury (TBI) and cited eight of the cases as containing errors. Due to its complexity, this workload is considered at a higher risk for processing errors and does not represent the overall quality of work performed at the Atlanta Regional Office (RO). The Atlanta RO only concurred with three of the eight errors cited and the office provided its rationale for non-concurrence of the remaining five, which primarily result from a different interpretation of guidance provided by Compensation Service Training Letter 09-01. The five cases in question were reviewed by a subject matter expert from Compensation Service given the difference of opinion with the findings. The Compensation Service expert concluded the Atlanta RO was correct in its interpretation and application of VBA guidance. The Atlanta RO concurs that three cases need to be corrected.

The Atlanta RO will continue to conduct training on ordering and interpreting VA examinations and just recently certified that 222 employees have conducted VA Examination/Medical Opinion Clarification training (TMS #3879541) as of June 30, 2014. The TBI 2nd Level Review Tracker will be monitored monthly to assess if there are any exam insufficiencies noted. Training on exam insufficiencies will be conducted, if warranted, during the bi-annual TBI training conducted each fiscal year.

Recommendation 6: *We recommend the Atlanta VA Regional Office Director ensure claims processing staff receive refresher training on processing special monthly compensation and ancillary benefits.*

Atlanta RO Response: Concur

VAOIG reviewed 30 claims involving Special Monthly Compensation (SMC) and Ancillary Benefits and cited nine of the cases as containing errors. Due to its complexity, this workload is considered at a higher risk for processing errors and does not represent the overall quality of work performed at the Atlanta Regional Office.

The Atlanta RO will provide refresher training on SMC cases. Refresher training for RVSRs on SMC claims will be held no later than July 31, 2014, and annually thereafter. The training will encompass not only the processing of SMC cases, but also the utilization of hospital codes and the SMC calculator.

Recommendation 7: *We recommend that Atlanta VA Regional Office Director promote staff awareness of the second-signature review policy for processing special monthly compensation and ancillary benefits and ensure that qualified staff conduct the secondary reviews.*

Atlanta RO Response: Concur

A VSC directive dated July 1, 2014, mandates that all higher level SMC cases will be second-signed by the QRT. The data from these reviews will be tracked on the In-Progress Review Tracker maintained by the QRT. Error trends identified will be included in the station's annual SMC training.

Recommendation 8: *We recommend the Atlanta VA Regional Office Director implement a plan to ensure claims processing staff prioritize actions related to benefit reductions to minimize improper payments to veterans.*

Atlanta RO Response: Concur

On April 3, 2014, VBA guidance (M21-1MR, Part 1, 2.B.7.a) was modified to no longer state 'immediate action' in regards to processing benefit reductions. The current guidance states that Supervisors and VSRs are responsible for enduring maturing EP 600s are identified and routed for action. The Atlanta RO followed all national workload directives on reducing the backlog since March 2013.

The Atlanta RO will establish an updated plan to process benefit reductions timely. The Atlanta RO's workload management plan will be updated to properly identify who has responsibility over benefit reductions and provide timeframes for action. The updated workload management plan will be implemented by July 31, 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.
Acknowledgments	Nora Stokes, Director Kristine Abramo Nelvy Viguera Butler Kelly Crawford Ramon Figueroa Kerri Leggiero-Yglesias Lisa Van Haeren Mark Ward

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