VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Columbia, South Carolina

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ACRONYMS

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

Report Highlights: Inspection of VA Regional Office Columbia, SC

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and a Veterans Service Center (VSC) in Cheyenne, Wyoming, that process disability claims and provide a range of services to veterans. We evaluated the Columbia VARO to see how well it accomplishes this mission. OIG benefits inspectors conducted on-site work at the VARO in March 2014.

What We Found

Overall, VARO staff did not accurately process 36 (40 percent) of 89 disability claims reviewed. We sampled claims we considered at higher risk of processing errors, thus these results do not represent this VARO's overall disability claims processing accuracy rate. Claims processing that lacks compliance with VBA procedures can risk paying inaccurate financial benefits.

Specifically, 22 of 29 temporary 100 percent disability evaluations reviewed were inaccurate, generally because staff did not timely process reminder notifications for medical reexaminations. Staff incorrectly processed 10 of 30 traumatic brain injury (TBI) claims, primarily by using insufficient medical examination reports. VARO staff also incorrectly processed 4 of 30 special monthly compensation (SMC) claims due to a lack of training.

Three of 11 Systematic Analyses of Operations (SAOs) were incomplete because management did not provide adequate training to ensure staff completed the SAOs correctly. VARO staff did not timely or accurately complete 18 of 30 proposed benefits reduction cases because management did not prioritize this work.

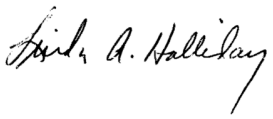
VSC management considered benefit reduction delays procedural deficiencies, not errors. Management stated the delays occurred because VBA leadership directed the VARO to focus on other national priorities. Moreover, management indicated it had the discretion to grant staff extensions to complete this work, though we found the extensions unmerited given the financial risks associated with potential overpayments.

What We Recommended

We recommended the VARO Director implement a plan to ensure staff take timely action on reminder notifications and take appropriate action on the 658 temporary 100 percent disability evaluations remaining from our inspection universe. The Director should ensure staff receive training on properly completing TBI claims, SMC benefits, and SAOs, and implement a plan to ensure prompt action on rating reductions.

Agency Comments

The Columbia VARO Director concurred with all recommendations. We will follow up on these actions as deemed appropriate. We have addressed the Director's technical comments as appropriate throughout this report.



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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 (VSC) operations. The objectives of the inspections are to:

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

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

Other Information

The following appendixes provide additional 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 Columbia 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 impact on veterans' benefits.

Finding 1 Columbia VARO Needs To Improve Disability Claims Processing Accuracy

The Columbia VARO did not consistently process temporary 100 percent disability evaluations, TBI-related cases, or entitlements to SMC benefits. Overall, VARO staff incorrectly processed 36 of the total 89 disability claims we sampled, resulting in 189 improper monthly payments to 11 veterans totaling $267,108.

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 Columbia VARO.

Table 1. Columbia VARO Disability Claims Processing Accuracy

Type of Claim	Reviewed	Claims Inaccurately Processed That Affected Veterans' Benefits	Claims Inaccurately Processed With the Potential To Affect Veterans' Benefits	Total Claims Inaccurately Processed
Temporary 100 Percent Disability Evaluations	29	6	16	22
TBI Claims	30	1	9	10
SMC and Ancillary Benefits	30	4	0	4
Total	**89**	11	25	**36**

Source: VA OIG analysis of VBA's temporary 100 percent disability evaluations paid at least 18 months, TBI disability claims completed in the first quarter fiscal year (FY) 2014, and SMC and ancillary benefits claims completed in calendar year 2013

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 22 of 29 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a veteran's service-connected disability following surgery or when specific treatment is needed. At the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

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

Without effective management of these temporary 100 percent disability ratings, VBA is at increased risk of paying inaccurate financial benefits. Available medical evidence showed 6 of the 22 processing errors we identified affected benefits and resulted in 75 improper monthly payments to 6 veterans totaling approximately $146,722. These improper payments occurred from December 2010 to February 2014. Following are descriptions of these errors:

- In October 2010, VARO staff received a system-generated reminder notification to request a medical reexamination to reevaluate a veteran's prostate cancer. VARO staff scheduled the reexamination in January 2014 and received the medical report in February 2014. As of March 2014, VARO staff had not completed this claim. As a result, VA overpaid this veteran $68,935 spanning a period of 35 months.
- VARO staff did not propose to reduce a veteran's temporary 100 percent evaluation for Non-Hodgkin's lymphoma when a January 29, 2013 reexamination report showed that the veteran's condition was in remission. As a result, VA overpaid the veteran $43,487 spanning a period of 18 months.
- A Rating Veterans Service Representative (RVSR) granted service connection for a veteran's disability and did not accurately evaluate the severity of the disability. As a result, VA overpaid the veteran $22,104 spanning a period of 15 months.
- On April 30, 2013, VSC staff proposed to reduce a veteran's temporary 100 percent evaluation for prostate cancer. As of March 2014, VSC staff had not reduced the evaluation and the veteran continued to receive monthly benefits at the 100 percent disability rate. As a result, VA has overpaid the veteran $7,439 spanning a period of 5 months.

- An RVSR granted service connection for prostate cancer on January 21, 2011. However, evidence in the claims folder showed the correct date for service connection was December 21, 2010. As a result, VA underpaid the veteran approximately $2,823 over a period of 1 month.
- VSC staff received a system-generated reminder notification on August 8, 2013, indicating the veteran needed a reevaluation for his prostate cancer condition. As of March 2014, VSC staff had not requested the medical reexamination. As a result, VA overpaid the veteran $1,935 over a period of 1 month.

The remaining 16 of the total 22 errors had the potential to affect veterans' benefits. We could not determine whether the evaluations would have continued because the veterans' claims folders did not contain the medical evidence needed to evaluate each case. Twelve of the 16 errors occurred when VSC staff received reminder notifications but did not schedule medical reexaminations as required. Without current medical evidence, neither we nor VARO staff could determine the correct disability evaluations. Details follow on the remaining four cases:

- On June 25, 2013, VSC staff received a timely request from a veteran for a personal hearing in response to a proposed benefits reduction. As of March 2014, staff had not scheduled a hearing because this work was not considered a priority. As a result of the delay, the veteran had waited 8 months to provide evidence to refute the proposed benefits reduction. Until VARO staff complete the requested hearing, no action can be taken to reevaluate the claim, and monthly benefits will continue to be paid at the 100 percent disability rate.
- On October 18, 2013, VSC staff received a medical reexamination report required to reevaluate a veteran's prostate cancer. As of March 2014, VARO staff had taken no action to reevaluate the claim based on the update on the veteran's condition. Until staff reevaluate the claim to determine whether the veteran continues to warrant a 100 percent disability evaluation, payments will continue at the existing rate and improper payments may occur.
- On September 6, 2013, an RVSR proposed reducing a veteran's temporary 100 percent evaluation for residuals of prostate cancer to 60 percent disabling. As of March 2014, VARO staff had taken no action on the proposed reduction and the veteran was still receiving monthly benefits at the 100 percent disability rate. These improper payments will continue until VSC staff take timely action to reduce the benefits as appropriate.
- An RVSR incorrectly granted a temporary 100 percent disability evaluation for chronic lymphocytic leukemia although this condition warranted a permanent 100 percent evaluation. As a result, the veteran

did not receive entitlement to the additional benefit of Dependents' Educational Assistance, as required by VBA policy.

Generally, processing inaccuracies occurred because VARO management did not have the resources to cover all priorities to ensure timely action on these cases. An average of 11 months elapsed from the time staff should have scheduled these medical reexaminations until February 1, 2014. The initial responses to the processing inaccuracies received from VARO staff noted, "… the delay in final processing is a result of directions from higher authority…" to complete specific cases. In fact, management indicated VBA had directed that all RVSRs devote their time to eliminating claims from the backlog for the remainder of the fiscal year. As a result, the VARO may have continued benefits payments and overpaid veterans who were no longer entitled to temporary 100 percent evaluations. We provided VARO management with 658 cases remaining from our universe of 687 for its review to determine if action is required.

VSC subject matter experts reviewed the 22 errors we identified and management initially concurred with 19. Management later rescinded the initial response and nonconcurred with 11 errors. When asked why the office changed its response, VSC officials replied that the VSC Manager did not have the opportunity to review and approve the initial response.

Eight of the 11 nonconcurrences involved delays in establishing controls to schedule future medical reexaminations. Management informed us that there was no timeframe for establishing a control to prompt future action to schedule a medical reexamination. Management stated that timeliness in such matters is relative to workload, prioritization of workload, and staffing. Nonetheless, VBA policy states that staff have 30 days to schedule a reexamination after receiving a reminder notification.

The remaining three nonconcurrences involved delays in processing proposed benefits reductions. VSC management explained, "The Columbia VARO processes all aspects of the non-rating workload as timely as possible with consideration to all directed reviews, national initiatives, and the time and resources required to accomplish all responsibilities under the non-rating umbrella." VSC management indicated that per VBA policy, it can grant staff extensions to complete this work if certain circumstances exist, such as time to develop a claim for additional evidence or to schedule a hearing for a claimant. However, none of the three instances identified involved the types of circumstances that would merit extensions to complete proposed benefits reductions.

The processing delays we identified are not without consequence. Failure to prioritize this work has resulted in, and will continue to result in, inaccurate and unnecessary benefits payments if left unaddressed. Financial stewardship of the benefits delivery is important and necessary to ensure

accountability and to use entitlement authority properly and in compliance with policies and procedures.

Follow Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Columbia, South Carolina* (Report No. 11-00236-257, August 24, 2011), we indicated that VARO staff incorrectly processed 21 of 30 temporary 100 percent disability evaluations we reviewed. Most of the processing inaccuracies occurred because staff did not enter suspense diaries in the electronic system to ensure they received reminder notifications to schedule medical reexaminations. VARO management lacked an oversight procedure in place to ensure VSC staff established suspense diaries as reminders of the need for reexaminations. We did not provide a recommendation in this inspection report as VBA had implemented a national review plan to address this issue. To assist in implementing the agreed upon review, we provided the VARO with 397 cases remaining from the universe of 427 temporary 100 percent disability evaluations identified.

During this inspection, we found cases where VSC staff delayed scheduling future medical reexaminations; however, we identified no cases where staff did not input suspense diaries in the electronic system to generate reminders to follow up on temporary 100 percent disability evaluations. As such, we made no further recommendation in this area.

TBI Claims

The Department of Defense and VBA commonly define a TBI as a traumatically induced structural injury or a physiological disruption of brain function caused by an external force. The major residual disabilities of TBI fall into three main categories—physical, cognitive, and behavioral. VBA policy requires staff to evaluate these residual disabilities. Additionally, VBA policy requires that 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 report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-167, May 18, 2011), VBA agreed to develop and implement a strategy for ensuring the accuracy of TBI claims decisions. In May 2011, VBA provided guidance to VARO Directors to implement a policy requiring a second signature on each TBI case an RVSR evaluates until the RVSR demonstrates 90 percent accuracy in TBI claims processing. The policy indicates second-signature reviewers come from the same pool of staff as those used to conduct local station quality reviews.

VARO staff incorrectly processed 10 of 30 TBI claims we reviewed. In one case that affected a veteran's monthly benefits, an RVSR incorrectly assigned separate evaluations for TBI-related headaches. Assigning two evaluations based on the same symptomology is a violation of VBA policy. As a result of the inaccuracy, VA overpaid the veteran approximately

$3,990 spanning a period of 17 months. These improper payments occurred from September 2012 to February 2014.

The remaining nine inaccuracies had the potential to affect veterans' benefits. Following are descriptions of these errors:

- In seven cases, VSC staff used insufficient VA medical examination reports to evaluate veterans' disabilities. Staff did not return these insufficient examination reports to the issuing clinics or healthcare facilities, as required by VBA policy. Neither VSC staff nor we can ascertain all of the residual disabilities of TBI without adequate or complete medical examination reports.
- In one case, an RVSR incorrectly evaluated TBI residuals using symptoms the medical examiner attributed to a coexisting mental condition instead of only those symptoms related to the TBI. In addition, VSC staff used an insufficient TBI medical examination report to evaluate the veteran's headaches instead of returning it for correction, as required by VBA policy. Because of the veteran's multiple service-connected disabilities, the inaccuracies did not affect the veteran's monthly benefits. However, they had the potential to affect future benefits if the veteran's other service-connected disabilities worsen or if service connection is granted for a new disability.
- In one case, an RVSR incorrectly granted service connection for residuals of a TBI when the veteran's service records did not contain a verified in-service event, as required by VBA policy. Because of the veteran's multiple service-connected disabilities, this error did not affect the veteran's monthly benefits. However, it has the potential to affect future benefits if the veteran's other service-connected disabilities worsen or if service connection is granted for a new disability.

Generally, the TBI processing errors we identified occurred because VSC staff misinterpreted VBA policy for processing TBI claims. Interviews with management and staff revealed they used their own interpretations of the policy to decide these claims. Some staff incorrectly believed they had the authority to separately evaluate TBI and coexisting mental disorders when VA examiners did not differentiate which symptoms were attributable to each condition as required. A review of the VARO's training records showed the last training on processing TBI claims occurred between July and October 2012. As a result of these issues, veterans with these disability claims may not have always received accurate benefits.

The Columbia VARO did not concur with 1 of the 10 TBI errors we identified. In this case, an RVSR used an insufficient medical examination report and over-evaluated a veteran's TBI residuals with headaches. Additionally, the RVSR did not request a separate medical examination for headaches, as required. Management agreed the veteran's TBI was over-

evaluated, but did not concur that the evaluation should be reduced as it would not affect the veteran's current monthly benefits. Had VARO staff requested a separate examination for headaches, the result could have increased the veteran's monthly benefits. As a result, VBA lacks assurance that the veteran may not be receiving the highest overall evaluation for this disability.

Follow Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Columbia, South Carolina* (Report No. 11-00236-257, August 24, 2011), we determined that errors in processing TBI claims occurred due to inadequate quality assurance. In response to our recommendation, the VARO Director agreed to provide training on proper TBI claims processing. Further, the Director said that TBI claims would require a second signature by an RVSR, and a third signature by VSC management or a member of the VARO's quality review team. The OIG closed this recommendation based on a review of the VARO's policy and training documents.

Interviews with VSC staff revealed that the additional levels of review of TBI-related claims were effective and had improved the overall quality of TBI evaluations. However, VARO management discontinued the local third-signature policy based on their assessment that staff had demonstrated adequate proficiency to evaluate TBI claims. Yet, the national second-signature policy remained in force at the VARO. Additionally, based on our previous inspection, VSC management developed a flowchart for RVSRs outlining the required steps that needed to be taken to process TBI claims. On April 9, 2014, VSC management provided the OIG with the revised flowchart, indicating that changes had been made based on findings from our current inspection. VSC management stated the flowchart would help assist RVSRs in processing TBI claims. We did not test the results of TBI claims processed after implementation of the flowchart and cannot make an assessment as to its effectiveness in assisting RVSRs process TBI claims.

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, the inability to naturally control bowel and bladder functions, 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 section 35, title 38, United States Code
- Specially Adapted Housing Grant
- Special Home Adaptation Grant
- Automobile and Other Conveyance and Adaptive Equipment Allowance

VBA policy requires staff to address the issues of SMC and ancillary benefits whenever they can grant entitlement to these benefits. We focused our review on whether VARO staff accurately processed entitlement to SMC and ancillary benefits associated with anatomical loss, loss of use of two or more extremities, or bilateral blindness with visual acuity of 5/200 or worse.

VARO staff incorrectly processed 4 of 30 claims involving SMC and ancillary benefits—all 4 affected veterans' benefits. The errors resulted in underpayments totaling approximately $99,321 and an overpayment of approximately $17,075, representing 97 improper monthly payments paid from July 2010 to February 2014.

In the case of the overpayment, an RVSR incorrectly assigned entitlement to SMC for bilateral blindness. As a result, VA overpaid the veteran approximately $17,075 over 14 months.

The remaining three errors resulted in underpayments to veterans. Details of those errors follow:

- An RVSR did not grant aid and attendance for a veteran's loss of use of both legs, along with a total loss of control of bowel and bladder functions, as required by VBA policy. As a result, VA underpaid the veteran approximately $88,875 over a period of 3 years and 7 months.
- An RVSR did not grant SMC for a veteran's additional permanent disability independently evaluated at 50 percent disabling, as required by VBA policy. As a result, the veteran was underpaid approximately $9,132 over a period of 2 years and 11 months. The RVSR also did not grant entitlement to automobile and adaptive equipment, a benefit worth

up to $19,817, as well as special home adaptation, a benefit worth up to $13,511.

- An RVSR did not grant a higher level of SMC for a veteran's additional permanent disability independently evaluated at 100 percent disabling, as required by VBA policy. As a result, the veteran was underpaid $1,314 over a period of 5 months.

Errors related to SMC and ancillary benefits were due to a lack of training. VARO training records for FY 2013 did not include SMC training, and management and staff stated they needed additional instruction. As a result of the lack of staff training, veterans did not always receive accurate benefits payments. The training deficiencies identified, if left unaddressed, increase the risks to VBA efforts to consistently and accurately process SMC and ancillary benefits claims.

Recommendations

1. We recommended the Columbia 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 Columbia VA Regional Office Director conduct a review of the 658 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

3. We recommended the Columbia VA Regional Office Director ensure staff receive training on the proper processing of traumatic brain injury claims and implement a plan to assess the effectiveness of that training.

4. We recommended the Columbia VA Regional Office Director ensure staff receive training on the proper processing of special monthly compensation and ancillary benefit claims and implement a plan to assess the effectiveness of that training.

Management Comments

The Director concurred with our recommendations and the VSC will develop a process to improve timeliness of medical reexaminations. The VSC began reviewing the temporary 100 percent disability evaluations remaining from our inspection universe and expects to complete this review by the end of September 2014. VSC staff will receive training on TBI claims, SMC, and ancillary benefits with an anticipated completion date of October 2014. A mechanism to assess the effectiveness of this training will be determined upon completion of the training.

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 propose corrective actions. VARO management must prepare annual SAO schedules designating the staff required to complete the SAOs by specific dates. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 11 SAOs annually.

Finding 2 Columbia VARO Lacked Adequate Oversight To Ensure Complete SAOs

Three of the 11 SAOs were incomplete (missing required elements). VSC management did not provide adequate training to ensure staff completed the SAOs in accordance with VBA policy. As a result, management may not have adequately identified existing and potential problems for corrective actions to improve VSC operations.

Management did not ensure all required SAO elements were included because they did not provide adequate oversight or training of VSC staff tasked with completing the SAOs. VSC management stated that although they provided staff with VBA policy and a copy of previously completed SAOs, they did not provide training or a checklist to ensure all SAO elements were addressed. Further, the Compensation Service site visit team completed a review of the VARO's SAOs in February 2014; however, the team did not identify any weaknesses associated with the SAO process.

The Claims Processing Timeliness SAO was an example of an incomplete SAO. We identified multiple instances among proposed benefits reduction cases we reviewed where VARO staff did not take timely action to reduce payments as appropriate. If the Columbia VARO had completed the Claims Processing Timeliness SAO, it could have detected this problem earlier and developed recommendations to resolve it before we did as part of our inspection.

Recommendation

5. We recommend the Columbia VA Regional Office Director ensure that staff receive training on VBA policy regarding the purpose and requirements for completing Systematic Analyses of Operations.

Management Comments

The VARO Director concurred with our recommendation and anticipates completion of SAO training by July 31, 2014.

OIG Response

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

Benefits Reductions

VBA policy provides for compensation to veterans for conditions they incurred or aggravated during military service. The amount of monthly compensation to which a veteran is entitled may change because his or her service-connected disability may improve. Improper payments associated with benefits reductions generally occur when beneficiaries receive payments to which they are not entitled 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 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 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 in order to minimize overpayments.

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

Finding 3 Columbia VARO Needs To Ensure Prompt Action On Proposed Benefits Reductions

VARO staff delayed or incorrectly processed 18 of 30 cases involving benefits reductions—14 affected veterans' benefits and 4 had the potential to affect veterans' benefits. These errors occurred due to a lack of emphasis on timely processing benefits reductions. Processing inaccuracies resulted in overpayments totaling approximately $83,745, representing 90 improper monthly payments to 14 veterans from April 2013 to February 2014.

Processing Delays

Processing delays occurred in 16 of 30 claims that required rating decisions to reduce or discontinue benefits. In the case with the most significant overpayment, VSC staff sent a letter to a veteran on December 10, 2012, proposing to reduce the disability evaluation for the veteran's prostate

condition. The due process period expired on February 13, 2013. However, staff did not take action to reduce the evaluation until November 25, 2013. As a result of the delay, VA overpaid the veteran $16,164 spanning a period of 9 months.

In 14 of 16 cases, processing delays averaged 6 months from the time staff should have taken action to reduce the benefits for the 14 cases. In the remaining two cases, we could not define a date range for the delays because one case involved VSC staff not scheduling an immediate medical reexamination, and the other case involved not timely scheduling a hearing for the veteran to present evidence in response to the proposal to reduce his benefits.

Although the VARO's Workload Management Plan directed staff to focus on processing rating reduction cases, delays occurred because the VARO did not consider these cases its first priority. The VSC Manager noted that rating reductions were not a top priority as VBA leadership redirected attention to completing other work related to national initiatives. Further, interviews with staff noted that these cases were easy to process and that, on average, they could complete two to four rating reductions in just 1 hour. As a result of the processing delays, veterans received erroneous benefits payments.

Accuracy Errors

VARO staff incorrectly processed 2 of 30 cases involving proposed benefits reductions. The errors involved VSC staff incorrectly reducing a disability evaluation and establishing an incorrect medical reexamination date; however, these errors did not impact the veterans' current benefits but have the potential to affect future benefits. Both errors were unique and did not constitute a common trend, pattern, or systemic issue. Therefore, we made no recommendation for improvement in this area.

VARO management nonconcurred with 13 of the processing delays we identified, stating that "… only outcome-related deficiencies found under the review are recorded as errors. Procedural deficiencies generally do not rise to the level of errors." Further, management stated that the VARO had prioritized work according to national "surge initiatives." VSC management indicated that VBA policy allowed them to grant staff extensions to complete this work if certain circumstances existed, such as time to develop a claim for additional evidence or schedule a hearing for a veteran. In the nonconcurred cases that included processing delays, none met the provisions outlined in VBA's policy that allow for an extension to complete this work.

The processing delays we identified were not merely procedural deficiencies. As demonstrated, failure to prioritize this work has resulted in, and will continue to result in, inaccurate and unnecessary benefits payments if left unaddressed. The amount of the inaccurate payments continues to increase as recurring benefit payments are processed automatically each month.

Recommendation

6. We recommended the Columbia VA Regional Office Director develop and implement a plan to ensure prompt action on benefits reduction cases.

Management Comments

The VARO Director concurred with our recommendation and will develop a workload process to improve the processing of benefits reduction cases.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of February 2014, the Columbia VARO reported a staffing level of 585.5 full-time employees. Of this total, the VSC had 237.5 employees assigned.

Workload

As of February 2014, VBA reported 16,715 pending compensation claims. On average claims were pending 180.7 days—65.7 days more than the national target of 115.

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 Columbia VARO to see how well it accomplishes this mission.

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

Our review included 29 (4 percent) of 687 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These cases represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of January 21, 2014. This is generally the longest period a temporary 100 percent disability evaluation may be assigned without review, according to VBA policy. We provided VARO management with 658 claims remaining from our universe of 687 for its review. We reviewed 30 (40 percent) of 75 disability claims related to TBI that the VARO completed from October through December 2013. We examined 30 (29 percent) of 104 veterans' claims available involving entitlement to SMC and related ancillary benefits that VARO staff completed from January 1, 2013, through December 31, 2013.

Prior to VBA consolidating Fiduciary Activities nationally, each VARO was required to complete 12 SAOs. However, since the Fiduciary consolidation, VAROs are now required to complete 11 SAOs. Therefore, we reviewed 11 SAOs related to VARO operations. Additionally, we looked at

30 (12 percent) of 247 completed claims that proposed reductions in benefits from October through December 2013.

Where we identify potential procedural inaccuracies, we provide this information to help the VARO understand the procedural improvements it can make for enhanced stewardship of financial benefits. We do not provide this information to require the VARO to adjust specific veterans' benefits. Processing any adjustments per this review is 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 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 119 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI claims, 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 STAR program as of February 2014, the overall claims-based accuracy of the VARO's compensation rating-related decisions was 95 percent. We did not test the reliability of this data.

Inspection Standards

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

Appendix B Inspection Summary

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

Table 2. Columbia 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, 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)	No
Benefits Reductions	Determine whether VARO staff timely and accurately processed disability evaluation reductions or terminations. (38 CFR 3.103(b)(2), 38 CFR 3.105(e), 38 CFR 3.501, M21-1MR.IV.ii.3.A.3.e, M21-1MR.I.2.B.7.a, M21-1MR.I.2.C, M21-1MR.I.ii.2.f, M21-4, Chapter 2.05(f)(4), Compensation & Pension Bulletin October 2010)	No

Source: VA OIG

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

Appendix C VARO Director's Comments

Department of Veterans Affairs **Memorandum**

Date: July 1, 2014

From: Director, VA Regional Office Columbia, South Carolina

Subj: Inspection of the VA Regional Office, Columbia, South Carolina

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

1. The Columbia VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Columbia, South Carolina.*
2. Please note we have inserted comments within the body of the draft to clarify or refute specific statements within the report while I have concurred with the recommendations. I take exception to any reference to a "lack of management oversight" as our RO management is well aware of the entire workload while your staff reviewed a small subset of the work. RO management addresses all of the competing priorities appropriately with the resources available.
3. Please contact me or VSCM James Ard at 803-647-2351 if any additional questions.

(Original signed)
Leanne Weldin
Director

Attachment

Attachment

VARO Columbia OIG SITE VISIT
March 24-27, 2014
RO Response *(draft)*

Recommendation 1	We recommend the Columbia VA Regional Office Director develop and implement a plan to ensure timely and appropriate action on reminder notifications for medical reexaminations.
RO Response	Concur
Status *Anticipated completion:* July 31, 2014	VSC will develop a workload management process to improve the timeliness of medical re-examinations. This process will be submitted to the Director's office NLT EOM July 2014.
Recommendation 2	We recommend the Columbia VA Regional Office Director conduct a review of the 658 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.
RO Response	Concur
Status *Anticipated completion:* September 30, 2014	Prior to the receipt of the draft report, the Columbia VSC has distributed the list of temporary 100 percent evaluations to the segmented lanes. Instructions include the completion of 4 reviews daily for each team. Given the number of temporary 100 percent evaluations requiring review and in an attempt to balance all other VSC workload priorities, it is estimated that the reviews will be completed end of FY14.
Recommendation 3	We recommend the Columbia VA Regional Office Director ensure staff receive training on the proper processing of traumatic brain injury claims and implement a plan to assess the effectiveness of that training.
RO Response	Concur
Status *Anticipated completion:* October 2014	Training was conducted in FY12 and FY 13 IAW the NTC guidelines. The local TBI flow chart was revised and incorporated the suggestions and recommendations provided by the VAOIG site visit staff. Columbia VARO will request Compensation Service provide formal TBI training to all claims processors and quality review specialists. Our request will be submitted NLT July 15, 2014. Pending the outcome of our request, local training will be scheduled if necessary. The mechanism to assess the effectiveness of training will be determined pending the completion of either National or local training.

Recommendation 4	We recommend the Columbia VA Regional Office Director ensure staff receive training on the proper processing of special monthly compensation and ancillary benefit claims and implement a plan to assess the effectiveness of that training.
RO Response	Concur
Status *Anticipated completion:* October 2014	Columbia VARO will request Compensation Service provide formal SMC and ancillary benefits training to all claims processors and quality review specialists. Our request will be submitted NLT July 15, 2014. Pending the outcome of our request, local training will be scheduled if necessary. The mechanism to assess the effectiveness of training will be determined pending the completion of either National or local training.
Recommendation 5	We recommend the Columbia VA Regional Office Director ensure that staff receive training on VBA policy regarding the purpose and requirements for completing Systematic Analyses of Operations.
RO Response	Concur
Status *Anticipated completion:* July 31, 2014	While we do not agree with the OIG's methodology or the compliance deficiency with VBA policy regarding completion of SAOs, we concur with the recommendation for training to further strengthen the quality of our SAOs. Training has been scheduled for July 2014 for all VSC managers and MAs. The class will cover the requirements of the M21-4 and a newly developed checklist will be reviewed and distributed at that time.
Recommendation 6	We recommend the Columbia VA Regional Office Director develop and implement a plan to ensure prompt action on benefits reduction cases.
RO Response	Concur
Status *Anticipated completion:* July 31, 2014	VSC will develop a workload management process to improve the processing of benefits reduction cases. This process will be submitted to the Director's office NLT EOM July 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	Brent Arronte, Director Ed Akitomo Orlan Braman Bridget Byrd Vinay Chadha Michelle Elliott Scott Harris Dana Sullivan Nelvy Viguera Butler

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