VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Des Moines, Iowa

August 7, 2014
14-01501-229

ACRONYMS

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

Report Highlights: Inspection of VA Regional Office Des Moines, IA

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 Des Moines VARO to see how well it accomplishes this mission.

What We Found

Overall, VARO staff did not accurately process 13 (23 percent) of 57 disability claims reviewed. We sampled claims we considered at increased 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.

Specifically, 7 of 30 temporary 100 percent disability evaluations we reviewed were inaccurate, primarily because management did not prioritize processing claims requiring reduced evaluations. Generally, VARO staff demonstrated experience and knowledge in correctly processing complex traumatic brain injury claims. VARO staff incorrectly processed three of nine special monthly compensation (SMC) and ancillary benefits claims because specialized staff did not complete these claims as required and the VARO had no second-level review process.

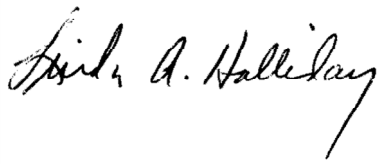
Management generally ensured Systematic Analyses of Operations were complete and timely. However, VARO staff did not timely or accurately complete 20 of 30 proposed benefits reduction cases due to VBA addressing other higher workload priorities.

What We Recommended

We recommended the VARO Director review the 131 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action. The Director should establish a second-level review process and ensure specialized staff complete complex SMC claims. The Director also should develop and implement a plan to ensure staff timely process benefits reductions.

Agency Comments

The Director of the Des Moines VARO concurred with all recommendations. We will follow up on actions as deemed necessary.



LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

TABLE OF CONTENTS

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 the 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 Des Moines 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 Des Moines VARO Could Improve Disability Claims Processing Accuracy

The Des Moines 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 13 of the total 57 disability claims we sampled, resulting in 108 improper monthly payments to 8 veterans totaling approximately $166,000.

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

Table 1. Des Moines VARO Disability Claims Processing Accuracy

Type of Claim	Claims Reviewed	Claims Inaccurately Processed: Affecting Veterans' Benefits	Claims Inaccurately Processed: Potential To Affect Veterans' Benefits	Claims Inaccurately Processed: Total
Temporary 100 Percent Disability Evaluations	30	3	4	7
TBI Claims	18	2	1	3
SMC and Ancillary Benefits	9	3	0	3
Total	**57**	**8**	**5**	**13**

Source: VA OIG analysis of the Veterans Benefits Administration's (VBA) 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 7 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.

When the VARO obtains evidence that a lower disability evaluation would result in reduced compensation payments, Rating Veterans Service Representatives (RVSRs) 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. On the 65th day following due process notification, action is required to reduce the evaluation and thereby minimize overpayments.

Without effective management of these temporary 100 percent disability ratings, VBA has an increased risk of paying inaccurate financial benefits. Available medical evidence showed 3 of the 7 processing errors we identified affected benefits and resulted in 51 improper monthly payments to 3 veterans totaling approximately $106,000. These improper payments were paid as monthly benefits to the veterans from March 2011 to March 2014. Details on the errors affecting benefits follow.

- An RVSR granted a temporary 100 percent disability evaluation for a veteran's prostate cancer on June 4, 2009, and requested a medical reexamination in October 2010. However, staff did not schedule the medical reexamination until February 2014. Based on the results of that reexamination, staff proposed reducing the veteran's temporary 100 percent disability evaluation to 20 percent disabling. Because of this delay, VA overpaid the veteran approximately $65,573 over a period of 36 months.
- An RVSR proposed reducing a veteran's temporary 100 percent disability evaluation for prostate cancer to 20 percent disabling. Staff sent a notification letter to the veteran on January 3, 2013, advising him of the proposed reduction. The due process period expired on March 9, 2013. At the time of our review in April 2014, VARO staff had not taken action on the proposed reduction. As a result, VA overpaid the veteran

approximately $24,584 over a period of 9 months. Monthly benefits continue to be paid at the 100 percent disability rate if no corrective action is taken.

- An RVSR proposed reducing a veteran's temporary 100 percent disability evaluation for prostate cancer to 20 percent disabling. Staff sent a notification letter to the veteran on April 3, 2013, advising him of the proposed reduction. The due process period expired on June 7, 2013. At the time of our review in April 2014, VARO staff had not taken action on the proposed reduction. As a result, VA overpaid the veteran approximately $16,116 over a period of 6 months. Monthly benefits continue to be paid at the 100 percent disability rate if no corrective action is taken.

The remaining four of the total seven errors had the potential to affect veterans' benefits. Following are details on the four errors:

- In one case, an RVSR proposed to reduce a veteran's temporary 100 percent disability evaluation for prostate cancer to 10 percent disabling. Staff sent a notification letter on December 27, 2012, advising him of the proposed reduction. The due process period expired on March 2, 2013. When we inspected this VARO in April 2014, staff had not taken action on the proposed reduction. This error had no effect on the veteran's current benefits payments but has the potential to affect future benefits entitlements for prostate cancer, if that condition worsens.
- An RVSR incorrectly continued a temporary 100 percent disability evaluation for a veteran's non-Hodgkin's lymphoma and requested a future reexamination in September 2014. Medical evidence showed the condition was incurable. As required by VBA policy, staff should have awarded entitlement to the additional benefit of Dependents' Educational Assistance without requesting a future reexamination.
- A veteran continued to receive a temporary 100 percent disability evaluation for prostate cancer despite an opinion by a VA medical examiner indicating he could not determine whether there was evidence of a recurrent disease. The examiner also opined that the veteran be referred to his urologist. Without sufficient medical evidence, neither VBA nor the OIG could determine whether the evaluation should continue.
- In the final case with the potential to affect benefits, staff received a reminder notification on February 4, 2014, to schedule a medical reexamination for a veteran's prostate cancer. As of our inspection in April 2014, staff had not taken action to schedule the examination. As a result, neither VBA nor the OIG could determine whether the evaluation should have continued because the veteran's claims folder did not contain sufficient medical evidence.

Generally, errors occurred because VSC management did not prioritize processing temporary 100 percent disability claims that required reduced evaluations. Delays ranged from 11 months to 14 months, and an average of 13 months elapsed from the time staff should have reduced the temporary 100 percent disability evaluations. As of March 2014, staff had not taken the required action on the three cases requiring benefits reductions. Management stated they process temporary 100 percent disability cases to the best of their ability along with their other workload priorities. Veterans may receive benefits payments in excess of their eligibility when benefits reductions are warranted but not processed. We provided VARO management with 131 claims remaining from our universe of 161 for its review to determine if action is required.

VARO management concurred with three errors we identified and neither concurred nor nonconcurred with three errors involving benefits reductions and reexamination scheduling delays. Management responded, "Workload priorities and the timeliness of processing is an issue that should be discussed between leadership at the headquarters level for both OIG and VBA." For the remaining case, VARO management did not concur with the error we identified involving a proposed reduction of prostate cancer benefits and provided no clear discussion or criteria for this decision.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Des Moines, Iowa* (Report No. 11-00511-164, May 11, 2011), VARO staff incorrectly processed 8 of 30 temporary 100 percent disability evaluations we reviewed. The most frequent processing errors occurred because staff did not establish or improperly canceled reminder notifications needed in the electronic system to alert staff to schedule future reexaminations. This happened because VARO management did not have a procedure in place requiring staff to review rating decisions that may need future reexaminations. The VARO concurred with our recommendation to implement controls to ensure staff establish suspense diaries and follow the national plan to review 100 percent disability cases. The OIG closed this recommendation on June 21, 2011, after VARO management stated it would follow the national plan to review 100 percent disability evaluation cases.

During our April 2014 inspection, we did not identify any cases where staff did not input suspense diaries in the electronic system as required. Therefore, we determined the VSC's actions in response to our previous recommendation appeared to be effective.

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.

We determined VARO staff incorrectly processed 3 of 18 TBI claims—2 affected veterans' benefits and resulted in one underpayment totaling approximately $7,468 and one overpayment totaling approximately $792. These errors represented 21 improper monthly payments from September 2012 to March 2014. Details on the two errors affecting veterans' benefits follow.

- An RVSR improperly evaluated a veteran's headaches due to a TBI. Medical evidence showed the frequency and severity of headaches warranted a higher evaluation. As a result, the veteran was underpaid approximately $7,468 over a period of 18 months.
- An RVSR granted a separate evaluation for a veteran's tinnitus due to a TBI when the veteran was already service-connected for the condition. VBA policy does not allow concurrent compensation for the same disability. As a result, the veteran was overpaid approximately $792 over a period of 3 months.

The remaining processing error had the potential to affect a veteran's benefits. An RVSR continued the evaluation for TBI residuals using medical examination reports containing conflicting information. Specifically, a mental health examiner stated the veteran did not have a TBI and therefore did not attempt to delineate current TBI-related symptoms from those due to the coexisting mental condition. The RVSR should have returned the examination for clarification per VBA policy. Neither VBA nor the OIG could determine whether the TBI evaluation should have continued without this clarification. VARO management concurred with all three processing errors.

The three TBI processing errors were unique and did not constitute a common trend, pattern, or systemic issue. Overall, VSC staff effectively processed TBI claims we reviewed. Management stated this occurred because RVSRs on the special operations team were more experienced, had taken VBA's mandatory TBI training, and had met the 90 percent accuracy requirements for processing TBI claims. Because we determined the VARO

generally followed VBA policy when processing these claims, we made no recommendation for improvement in this area.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Des Moines, Iowa* (Report No. 11-00511-164, May 11, 2011), we determined processing errors occurred because RVSRs used their own interpretations of examination reports to decide TBI claims. The VARO concurred with our recommendations to provide refresher training on the proper evaluation of TBI-related disabilities and to implement a plan for staff to return insufficient examination reports to medical facilities for clarification. The OIG closed these recommendations after the VARO provided documentation of the refresher training.

We did not identify similar errors during our April 2014 inspection. As such, we determined the VARO's actions in response to our previous recommendations appeared to be effective.

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 section 35, title 38, United States Code
- Specially Adapted Housing Grant

- Special Home Adaptation Grant
- Automobile and Other Conveyance and Adaptive Equipment Allowance

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

VARO staff incorrectly processed three of nine claims involving SMC and ancillary benefits—all three affected veterans' benefits and resulted in overpayments totaling approximately $40,600 and underpayments totaling approximately $10,900. These errors represented 36 improper monthly payments from April 2012 until March 2014. Details on these errors affecting benefits follow.

- In one case, an RVSR assigned two incorrect levels of SMC. Specifically, the RVSR granted higher levels of SMC requiring two separate 100 percent disability evaluations, which the veteran did not have as of April 2014 when we inspected the VARO. As a result, VA overpaid the veteran approximately $40,605 over a period of 14 months.
- Another veteran was denied service connection for a urinary condition, which, together with his loss of use of his lower extremities, warranted a higher evaluation for SMC. As a result, VA underpaid the veteran approximately $7,793 over a period of 15 months.
- An RVSR assigned an incorrect effective date of October 1, 2012, for entitlement to SMC based on a veteran's loss of use of his left elbow and knee. The correct effective date was March 24, 2012. As a result, VA underpaid the veteran approximately $3,080 over a period of 7 months.

Two of the three errors related to SMC occurred because VSC management did not have a second-signature review process in effect for these claims. The VSC manager stated a second-signature review process for SMC cases was not needed at the VARO since all RVSRs who were required to complete SMC claims had passed a VBA certification test. Regarding the third error, the special operations team did not process the claim. Although VBA policy states the special operations team should complete SMC claims, VARO staff informed us they did not follow this policy for all SMC claims. Staff stated that once they began working on an SMC claim, they typically would not stop processing it just to transfer it to the special operations team. In contrast, the VSC Manager stated the special operations team was required to process these cases. When VSC management did not ensure staff consistently followed claims processing policy, veterans did not always receive accurate benefit payments.

Recommendations

1. We recommend the Des Moines VA Regional Office Director conduct a review of the 131 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

2. We recommend the Des Moines VA Regional Office Director implement a plan for an additional level of review of special monthly compensation claims.

3. We recommend the Des Moines VA Regional Office Director implement a plan to ensure staff follow the policy for the special operations team to process special monthly compensation decisions.

Management Comments

The VARO Director concurred with our recommendations. VARO staff will complete a review of the remaining 131 temporary 100 percent disability evaluations by September 1, 2014. As an additional level of review, Local Quality Review staff will review all SMC cases completed during randomly selected months and provide on the spot training for any errors identified. Further, Local Quality Review staff will identify any SMC cases worked outside of the Special Operations team and notify management to ensure that the team processes these 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.

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 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.

One of the 11 SAOs was incomplete because it did not include an analysis of all required elements. The remaining 10 SAOs included thorough analyses based on appropriate data, identified deficient areas, and made recommendations for improving business operations. As a result, we determined the VARO generally followed VBA policy and we made no recommendation for improvement in this area.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Des Moines, Iowa* (Report No. 11-00511-14, May 11, 2011), we found that 1 of the 12 mandated SAOs was not completed timely per the annual schedule. We did not consider the error rate significant, so we made no recommendation for improvement in this area. During our April 2014 inspection, staff timely submitted all 11 required SAOs.

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. Such instances are attributable to VAROs not taking the actions required to ensure correct payments for the veterans' current 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 the beneficiary 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, an RVSR 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, 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 2 Des Moines VARO Lacked Oversight To Ensure Timely Action On Proposed Benefits Reductions

VARO staff incorrectly processed 20 of 30 cases involving proposed benefits reductions. These errors occurred due to a lack of priority on timely processing benefits reductions. Processing inaccuracies resulted in overpayments totaling approximately $146,733. This amount represented 105 improper monthly payments to 18 veterans from November 2012 to March 2014.

Processing Delays

Processing delays occurred in 17 of 30 claims that required rating decisions to reduce or discontinue benefits. An average of 6 months elapsed from the time staff should have taken action to reduce the evaluations for all 17 cases. In the case with the most significant overpayment, VSC staff sent a letter to the veteran on July 25, 2012, proposing reducing the evaluation for a right foot condition, and discontinuing service connection for a somatization disorder as well as entitlement to the additional benefit of Dependents' Educational Assistance. The due process period expired on September 28, 2012. However, staff did not take action to reduce the benefits until October 7, 2013. As a result, VA overpaid the veteran approximately $30,415 over a period of 15 months.

For the remaining 16 cases, processing delays ranged from 1 to 16 months. In the case with the most significant delay, VSC staff sent a letter to the veteran on June 5, 2012, proposing reducing benefits for his prostate cancer. The due process period expired on August 9, 2012. However, staff did not take action to reduce the evaluation until December 18, 2013. As a result, VA overpaid the veteran $5,386 over a period of 16 months.

Generally, these delays occurred because VBA did not assign this workload as a priority. Because of national changes to workload management, VSC leadership did not prioritize processing benefits reductions. Although the VSC's Workload Management Plan placed special emphasis on proposed benefits reductions, the VSC concentrated instead on national priorities that included processing claims pending over 2 years. Both management and staff confirmed there was no emphasis on timely following through with proposed rating reductions. Staff additionally stated benefits reductions were easy to process, they could complete an average of one to three of these cases in 1 hour, and processing these cases would have minimal impact on their other workload.

Accuracy Errors

VARO staff incorrectly reduced evaluations in 5 of 30 claims involving proposed benefits reductions; 2 of the 5 also involved processing delays. Three of these errors led to overpayments totaling approximately $26,455. Two cases had the potential to affect benefits, as the actions taken did not currently impact the veterans' payments. Following are details on the five errors.

- The most significant overpayment occurred when an RVSR proposed reducing a veteran's 100 percent disability evaluation for leukemia to 10 percent disabling, although medical evidence showed the condition warranted a 0 percent evaluation. Because a delay in processing the reduction occurred, VA overpaid the veteran approximately $19,523 over a period of 11 months.
- An RVSR incorrectly reduced a veteran's 100 percent evaluation for prostate cancer to 60 percent disabling, instead of the proposed 80 percent evaluation. VA ultimately overpaid the veteran $5,386 over a period of 16 months because of the incorrect evaluation as well as a delay in processing the reduction.
- An RVSR properly discontinued entitlement to service-related unemployability benefits effective December 1, 2013. However, staff did not properly discontinue unemployability payments until January 1, 2014. As a result, VA overpaid the veteran $1,546 over a period of 1 month.
- An RVSR proposed reducing a veteran's 100 percent disability evaluation for prostate cancer based on results from a premature medical examination. Per VBA policy, VARO staff must request a follow-up medical examination 6 months following completion of treatment. In this case, staff requested the medical examination 1 month after completion of treatment. This error has the potential to affect the veteran's benefits. Neither VBA nor the OIG can determine the correct level of disability without sufficient medical evidence.
- In the final case, an RVSR properly proposed to correct a prior decision by discontinuing a separate evaluation for hypertension and combining this disability with the veteran's renal insufficiency. However, the RVSR also incorrectly increased the overall evaluation from March 7, 2001, to September 2, 2008. Although this action did not result in incorrect payments to the veteran, it has the potential to affect future benefits if the veteran's other disabilities worsen or if a new disability is service-connected.

The five errors involving incorrectly proposed reductions were unique and did not constitute a common trend, pattern, or systemic issue. Therefore, we made no recommendation for improvement in this area.

Of the 20 total cases with errors, VARO management concurred with the 5 cases that involved inaccurate processing. Although we showed VARO management and staff VBA criteria requiring action on the 65th day following due process notification, they did not concur or nonconcur with the remaining 15 benefits reductions involving processing delays. In these cases, VARO managers noted, "Workload priorities and the timeliness of processing is an issue that should be discussed between leadership at the headquarters level for both OIG and VBA." Without appropriate priority set for this type of work, delays in processing reductions result in unsound financial stewardship of veterans' monetary benefits and failure to minimize overpayments.

Recommendation

4. We recommend the Des Moines VA Regional Office Director develop and implement a plan to ensure staff prioritize processing of benefits reductions at the expiration of due process as required.

Management Comments

The VARO Director concurred with our recommendation and developed a plan to ensure the Non-Rating team prioritizes the processing of benefits reductions.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of February 2014, the Des Moines VARO reported a staffing level of 105.4 full-time employees. Of this total, the VSC had 80.1 employees assigned.

Workload

As of February 2014, VBA reported the Des Moines VARO had 5,230 pending compensation claims. On average, claims were pending 168.1 days—53.1 days more than the national target of 115.

Scope and Methodology

VBA has 56 VAROs and a VSC in Cheyenne, WY, that process disability claims and provide a range of service to veterans. In April 2014, we evaluated the Des Moines 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 (19 percent) of 161 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented instances where VBA staff had granted temporary 100 percent disability evaluations for at least 18 months as of January 25, 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 131 claims remaining from our universe of 161 for its review. We reviewed 18 (95 percent) of 19 disability claims related to TBI that the VARO completed from October 1, 2013, through December 31, 2013. We also examined 9 of 10 veterans' claims available involving entitlement to SMC and 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 Activities consolidation, the VAROs are only required to complete 11 SAOs. Therefore, we reviewed 11 SAOs related to VARO operations. Additionally,

we looked at 30 (21 percent) of 144 completed claims involving proposed benefits reductions from October 1, 2013, through December 31, 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 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 were missing from key fields, included calculation errors, or were outside the timeframe requested. We assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Further, we compared veterans' names, file numbers, Social Security numbers, dates of claim, and decision dates as provided in the data received with information contained in the 87 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI claims, SMC and ancillary benefits, and completed claims involving proposed 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.

This report references VBA's STAR data. 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 94.3 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. Des Moines 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)	Yes
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
Proposed 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 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 17, 2014

From: Director, VA Regional Office Des Moines, Iowa

Subj: Inspection of the VA Regional Office, Des Moines, Iowa

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

1. The Des Moines VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Des Moines, Iowa.*
2. Please refer questions to Mr. Chad Christensen, Acting Veterans Service Center Manager, at (515) 323-7444.

(Original signed)

Terri A. Beer
Director

Attachment

Attachment

DES MOINES VA REGIONAL OFFICE (333)
COMMENTS ON OIG DRAFT REPORT

OIG Recommendations:

Recommendation 1: We recommend the Des Moines VA Regional Office Director conduct a review of the 131 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

Des Moines RO Response: Concur

The Des Moines Regional Office is in the process of reviewing the remaining 131 temporary 100 percent disability evaluations identified.

Target Completion Date: September 1, 2014

Recommendation 2: We recommend the Des Moines VA Regional Office Director implement a plan for an additional level of review of special monthly compensation claims.

Des Moines RO Response: Concur

Local Quality Review Specialists will conduct a review of all SMC cases completed through September 2014. The RO will continue to have Local Quality Review Specialists conduct a review of all SMC cases completed during randomly selected months twice during the fiscal year. Any errors noted will result in on the spot training.

Target Completion Date: October 31, 2014

Recommendation 3: We recommend the Des Moines VA Regional Office Director implement a plan to ensure staff follows the policy for the special operations team to process special monthly compensation decisions

Des Moines RO Response: Concur

When conducting a review of an SMC case Local Quality Review Specialists will note if the SMC case was worked outside of the Special Operations lane, if so management will be notified and any appropriate action will be taken to ensure continued processing of SMC cases by the Special Operations team.

Target Completion Date: September 30, 2014

Recommendation 4: We recommend the Des Moines VA Regional Office Director develop and implement a plan to ensure staff prioritize processing of benefits reductions at the expiration of due process as required.

Des Moines RO Response: Concur

The Des Moines Regional Office has developed a plan to ensure staff prioritize processing of benefits reductions at the expiration of due process as required. The Workload Management Plan places the responsibility for processing all 600 End Products (EP) on the Non-Rating Team. The EP 600s which require a rating decision are routed to the respective team; Express, Core, or Special Operations, based on the number and type of issues.

In order to ensure timely completion of the EP 600's which require a rating for completion, the Des Moines Regional Office will, on a monthly basis, use VETSNET Operational Reports (VOR) and Veterans Benefit Management System (VBMS) reports to identify which of the aforementioned EP 600s have had expiration of due process and route the files to the appropriate team for a rating decision. With concern to the remaining EP 600s, the timeframe for completion varies based on competing workload demands and national directives. The Des Moines Regional Office will continue to take action on the remaining EP600s as expeditiously as possible as the competing workload demands and national directives allow.

Target Completion Date: September 1, 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 Orlan Braman Daphne Brantley Brett Byrd Scott Harris Ambreen Husain David Piña Rachel Stroup Nelvy Viguera Butler Diane Wilson

Appendix E Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Assistant Secretaries
Office of General Counsel
Veterans Benefits Administration Central Area Director
VA Regional Office Des Moines Director

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Chuck Grassley, Tom Harkin
U.S. House of Representatives: Bruce L. Braley, Steve King, Tom Latham, David Loebsack

This report is available on our Web site at **www.va.gov/oig**.