VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Seattle, Washington

September 24, 2014
14-01502-259

ACRONYMS

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

Report Highlights: Inspection of VA Regional Office Seattle, WA

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and a Veterans Service Center in Cheyenne, WY, that process disability claims and provide a range of services to veterans. We evaluated the Seattle VARO to see how well it accomplishes this mission. Office of Inspector General benefits inspectors conducted onsite work at this VARO in March 2014.

What We Found

Overall, VARO staff did not accurately process 22 (24 percent) of 90 disability claims reviewed. We sampled claims we considered at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Claims processing that lacks compliance with VBA procedures can result in the risk of paying inaccurate and unnecessary financial benefits.

Specifically, 15 of 30 temporary 100 percent disability evaluations reviewed were inaccurate. Errors related to temporary 100 percent disability evaluations primarily occurred because staff did not timely process reminder notifications for medical reexaminations. Generally, VARO staff accurately processed traumatic brain injury claims. However, VARO staff incorrectly processed 6 of 30 special monthly compensation and ancillary benefits claims due to lack of oversight and training.

VARO managers ensured Systemic Analyses of Operations were complete and timely and contained the analyses and recommendations needed to address deficiencies. However, because VARO management required staff to address other work considered to be a higher priority, they delayed completing 11 of 30 benefits reduction cases. Taking timely and appropriate actions on benefits reductions is necessary to ensure financial stewardship and minimize improper benefits payments.

What We Recommend

We recommend the VARO Director develop and implement plans to ensure staff take timely action on reminder notifications for medical reexaminations; review and take appropriate action on the 576 temporary 100 percent disability evaluations remaining from our inspection universe; ensure effective training and modify the local secondary review policy for processing special monthly compensation and ancillary benefits; and develop a plan to prioritize actions on benefits reduction cases.

Agency Comments

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

LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

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

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

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

Other Information

- Appendix A includes details on the VARO and the scope of our inspection.
- Appendix B outlines criteria we used to evaluate each operational activity and a summary of our inspection results.
- Appendix C provides the Seattle VARO Director's comments on a draft of this report.

RESULTS AND RECOMMENDATIONS

I. Disability Claims Processing

Claims Processing Accuracy

The OIG Benefits Inspection team focused on accuracy in processing temporary 100 percent disability evaluations, traumatic brain injury (TBI) claims, and special monthly compensation (SMC) and ancillary benefits. We evaluated these claims processing issues and their effect on veterans' benefits.

Finding 1 Seattle VARO Needs To Improve Disability Claims Processing Accuracy

The Seattle VARO did not consistently process temporary 100 percent disability evaluations and entitlement to SMC and ancillary benefits. However, the VARO generally processed TBI claims accurately. Overall, VARO staff incorrectly processed 22 of the total 90 disability claims we sampled, resulting in 128 improper monthly payments to 9 veterans totaling $168,455.

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. Table 1 reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Seattle VARO.

Table 1. Seattle VARO Disability Claims Processing Accuracy

Type of Claim	Claims Reviewed	Claims Inaccurately Processed: Affected Veterans' Benefits	Claims Inaccurately Processed: Potential To Affect Veterans' Benefits	Claims Inaccurately Processed: Total
Temporary 100 Percent Disability Evaluations	30	3	12	15
TBI Claims	30	0	1	1
SMC and Ancillary Benefits	30	6	0	6
Total	**90**	**9**	**13**	**22**

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 15 of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a 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 3 of the 15 processing errors we identified affected veterans' benefits and resulted in 16 improper monthly payments to 3 veterans totaling $30,688. These improper payments occurred from August 2013 until March 2014. Following are descriptions of these errors.

- The most significant overpayment occurred when VARO staff did not take action to reduce benefits after receiving medical evidence that showed a veteran's condition had improved. Results from a March 2013 medical reexamination showed residual disabilities associated with prostate cancer supported a 40 percent evaluation. However, VARO staff did not take action to notify the veteran of the proposed reduction until January 2014—almost 10 months after the reexamination was completed. As a result, the veteran was overpaid $14,155 over a period of 6 months.
- In a March 2013 rating decision, a Rating Veterans Service Representative (RVSR) proposed reducing a temporary 100 percent disability evaluation after receiving medical evidence that the veteran's prostate cancer condition had improved. However, a final rating decision to reduce the benefits did not occur until February 2014. Consequently, VA overpaid the veteran by $13,054 spanning approximately 7 months.
- In a February 2010 VA rating decision, an RVSR established the need for a reexamination to take place in October 2011. However, the examination was not conducted until January 2012. Delays associated with the delayed examination resulted in the veteran receiving $3,480 in benefits payments that were unsupported by medical evidence over a period of 3 months.

The remaining 12 of the total 15 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. Neither we nor VBA can determine evaluations when claims folders lack the medical examination reports needed to evaluate each case. Details follow on these 12 cases.

- Seven errors occurred when VARO staff delayed scheduling required VA reexaminations despite receiving reminder notifications to do so. VBA policy requires that within a 30-day time period, VARO staff input controls in the electronic system to ensure the reexaminations are scheduled. However, on average, 9 months elapsed from the time staff scheduled or should have scheduled these medical examinations until March 2014.
- Three errors occurred when VARO staff did not take timely action to address veterans' requests for hearings in response to proposals to reduce their benefits. VBA policy states VARO staff will extend the due process period of 30 days to 60 days in such cases if hearings are requested. In all three cases, VARO staff exceeded the allowed extension period, and the hearings had not yet taken place at the time of our March 2014 inspection. In one of the three cases, the veteran requested the hearing more than 1 year and 10 months prior to our inspection, yet no hearing and no final reduction of benefits had occurred.
- The remaining errors occurred when VARO staff needed future reexaminations to determine if temporary 100 percent disability evaluations for two veterans' prostate cancer should continue. Reexaminations to assess residual disabilities associated with prostate cancer are required 6 months following cessation of treatment. However, in these two cases the reexaminations were not scheduled to take place until 5 years in the future.

The majority of the processing inaccuracies resulted from a lack of oversight to ensure staff took timely action to process reminder notifications for VA reexaminations. VBA policy allows VARO staff 30 days to process reminder notifications. We determined the VARO had 1,218 reminder notifications pending at the time of our March 2014 inspection. These pending reminder notifications ranged from about 1 month to 2 years and 4 months, and averaged approximately 5 months. Both VARO staff and management indicated their priority was to work on rating-related compensation cases as part of VBA's national initiatives rather than process reminder notifications to order reexaminations.

The second most frequent type of error occurred when VARO staff delayed scheduling hearings or finalizing benefits reductions associated with temporary 100 percent disability evaluations after receiving evidence that

veterans' conditions had improved. Again, VARO staff and management indicated that priority had not been placed on processing these workloads items.

VARO management disagreed with 13 of the 15 errors we identified as noncompliant with VBA policy. Management indicated failure to take timely action is a workload issue that quality assurance staff would not identify as an error. Management acknowledged the VARO's responsibility to ensure staff take timely and appropriate action on work items, but indicated workload demands had impacted their ability to do so. Regardless of competing priorities, timely processing of these benefits reductions is required to ensure financial stewardship in VBA's Compensation Program.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Seattle, WA* (Report No. 11-00515-266, September 8, 2011), VARO staff incorrectly processed 17 (57 percent) of 30 temporary 100 percent disability evaluations we reviewed. The most frequent errors occurred because staff did not enter suspense diaries in the electronic record to ensure they received reminder notifications to schedule VA medical reexaminations.

During our March 2014 inspection, we did not identify any errors where staff did not enter suspense diaries in the electronic record. The suspense diaries were generating reminder notifications; however, VARO staff were not taking timely action to request reexaminations from VA medical facilities.

TBI Claims

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

In response to a recommendation in our annual 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.

Generally, VARO staff accurately processed TBI disability claims. Of the 30 claims reviewed, only 1 of the cases contained an error. Specifically, a medical examiner did not complete a required examination to assess a

veteran's headaches. Nonetheless, an RVSR used the insufficient TBI examination results to rate the veteran's TBI-related headaches. Had VARO staff requested a separate examination for headaches, the results could have increased the veteran's monthly benefits. Without the separate exam, VBA lacks assurance that the veteran received the highest overall evaluation for this disability.

VARO management did not concur with the error we found. Management stated that the OIG was technically correct that an additional examination should have been conducted, but determined the headache condition was adequately evaluated as part of the TBI examination. VBA policy requires that an additional examination be completed in order to accurately evaluate the veteran's residual headache condition. Neither we nor VARO staff we can ascertain all the residual disabilities of a TBI without an adequate or complete medical examination.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Seattle, WA,* (Report No. 11-00515-266, September 8, 2011), we determined TBI claims processing errors occurred because TBI training did not ensure RVSRs had the skills needed to make accurate disability determinations. We recommended the director develop and implement a plan to assess the effectiveness and adequacy of RVSR training on processing TBI claims. The Director concurred with our recommendation and provided additional TBI training to all RVSRs and Decision Review Officers. Additionally, VARO management indicated staff would follow the second-signature guidance mandated by VBA for reviewing TBI claims. Further, the Director indicated TBI training would be an ongoing concentration, along with assessing the effectiveness and adequacy of the training. In January 2012, the OIG closed this recommendation.

Based on this TBI information and the fact that we identified only one TBI claims processing error during our March 2014 inspection, we concluded the corrective actions taken in response to our 2011 VARO inspection were adequate. As such, we made no recommendation for improvement in this area.

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 (A&A)
- 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 special monthly compensation. Examples of ancillary benefits are:

- Dependents' Educational Assistance under 38 USC Chapter 35
- Specially Adapted Housing Grant
- Special Home Adaptation Grant
- Automobile and Other Conveyance and Adaptive Equipment Allowances

VBA policy requires staff to address the issues of SMC and ancillary benefits whenever they can grant entitlement to these benefits. We examined 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 6 of 30 veteran's claims involving SMC and related ancillary benefits—all of the errors affected veterans' benefits and resulted in 112 improper monthly payments to veterans totaling over $137,767 from October 2010 to March 2014. As a result, veterans received improper payments or were unaware of benefits to which they were entitled.

Summaries of the six errors identified in processing SMC and ancillary benefits follow.

- In one case, an RVSR incorrectly established SMC based on a need for A&A to assist with activities of daily living. The RVSR granted this entitlement based on all of the veteran's disabilities. However, VBA policy prohibits staff from using the same disability in multiple ways to establish additional SMC benefits. As a result, we determined VA overpaid the veteran $71,975 over a period of 2 years and 1 month. VARO management disagreed with our assessment stating staff applied reasonable doubt and the evidence as a whole was sufficient to show a need for A&A. We continued to find the case to be in error because the

inaccuracy had nothing to do with reasonable doubt—more so, the error resulted from staff applying the rating criteria incorrectly.

- An error occurred when an RVSR incorrectly granted A&A benefits based on the veteran's service-connected coronary artery disease. When service-related disabilities render a veteran permanently bedridden or in need of A&A, VBA policy requires staff to establish the need for an SMC benefit. However, medical evidence showed the need for A&A was due to residuals of a cerebrovascular accident (stroke)—a disability that was not related to military service. As a result, the veteran was overpaid $44,767 over a period of 1 year and 4 months. VARO management disagreed with our assessment in this case. Management stated that although the evidence did not support granting A&A, the condition was a known complication of one of the veteran's other service-connected disabilities. As such, additional development should have been done. We continued to find staff did not comply with VBA policy because we did not identify evidence linking residual disabilities of the stroke to military service or to any of the veteran's other service-connected disabilities.
- An RVSR established SMC for a veteran's bilateral eye condition but did not assign the correct level of SMC when the veteran had other disabilities evaluated at 50 percent or more disabling. As a result, the veteran was underpaid $10,688 over a period of 3 years and 5 months.
- An RVSR did not correctly establish a higher level of SMC or the need for A&A based on the veteran's bilateral blindness. As a result, the veteran was underpaid $6,290 over 1 year and 2 months.
- Another error occurred when an RVSR established SMC for a veteran's loss of use of the lower extremities but did not assign the correct SMC level based on an additional disability evaluated as 100 percent disabling. As a result, the veteran was underpaid $2,408 over a period of 7 months.
- An RVSR established SMC for a veteran's loss of use of the lower extremities. However, the RVSR did not increase SMC for other related disabilities as required. As a result, the veteran was underpaid $1,639 over a period of 9 months.

Generally, errors related to SMC and ancillary benefits occurred because VARO managers did not have a mechanism in place to determine effectiveness of the SMC training provided or a venue for staff to ask clarifying questions about the training. Although we identified these SMC training weaknesses, VARO managers were unaware that staff found the training confusing. We reviewed VARO training records and confirmed training for higher level SMC evaluations last occurred in January 2013. However, the majority of the staff we interviewed stated the training was not thorough and inadequately explained the rules for granting higher SMC rates.

Staff also believed the training would have been more beneficial had trainers used real case examples.

Additionally, we identified weaknesses in the VARO's local secondary review policy for SMC cases above an established threshold or degree of disability. VBA policy allows VSC managers the discretion to require second-level reviews for SMC cases. The Seattle VSC manager designated staff to conduct secondary reviews for higher level SMC cases. Generally, ratings requiring secondary reviews involve SMC for anatomical loss, or loss of use, of both feet, one hand, and one foot; blindness in both eyes with visual acuity of 5/200, or less; or being permanently bedridden or so helpless as to need regular aid and attendance.

We concluded VARO managers may have prevented the types of errors we found if there had been a mechanism in place to determine the effectiveness of SMC training or a venue for staff to ask clarifying questions about the training material or scenarios. Additionally, we determined the VSC manager could strengthen the secondary-review policy by lowering the SMC threshold for requiring second-level reviews.

Recommendations

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

2. We recommend the Seattle VA Regional Office Director implement a plan to review for accuracy the 576 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate actions.

3. We recommend the Seattle VA Regional Office Director develop and implement a plan to ensure staff receive refresher training on processing claims related to special monthly compensation and ancillary benefits and implement a plan to monitor the effectiveness of that training.

4. We recommend the Seattle VA Regional Office Director amend its secondary-review policy by reducing the special monthly compensation threshold for requiring second-signature reviews as a means of ensuring accuracy in processing these complex claims.

Management Comments

The VARO Director concurred with our recommendations. In July 2014, the Director updated the VARO's workload management plan to address and prioritize the processing of reminder notifications to ensure staff schedule medical reexaminations. VARO staff also completed a review of the 576 temporary 100 percent disability evaluations remaining from our inspection universe and took appropriate actions. Refresher training on SMC

cases is expected to be administered at a later date, to include a local consistency study to gauge the effectiveness of the training. Additionally, Quality Review staff will conduct an additional level of review of all SMC cases completed during selected months and provide training on the errors identified.

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

II. Management Controls

Systematic Analysis of Operations

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs). We also considered whether VSC staff used adequate data to support analyses and recommendations identified within each SAO. An SAO is a formal analysis of an organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and to propose corrective actions. VARO management must 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.

VARO management ensured staff completed all 11 mandated SAOs timely. SAOs also contained sufficient analyses using appropriate data and included recommendations for improvements where appropriate.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Seattle, Washington* (Report No. 11-00515-266, September 8, 2011), we indicated VARO staff generally followed VBA policy and timely and accurately completed the mandated SAOs. During this March 2014 inspection, we also determined VARO staff effectively completed SAOs. As such, we made no recommendation for improvement in this area.

Benefits Reductions

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

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

On April 3, 2014, VBA leadership modified its policy regarding the processing of claims requiring reductions in benefits. 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. Timely actions are fundamentally necessary to ensure proper use of resources.

Finding 2 Seattle VARO Lacked Oversight to Ensure Immediate Action On Benefits Reductions

VARO staff delayed processing 11 of the 30 claims that required rating decisions to reduce or discontinue benefits. Generally, delays in processing benefits reduction cases occurred because VARO managers did not provide oversight to ensure staff processed these cases timely. As a result, VA made 102 improper overpayments to 11 veterans from November 2012 to March 2014 totaling approximately $171,783.

Of the 11 cases with processing delays, an average of approximately 10 months elapsed before staff reduced benefits. The most significant improper payment occurred when staff proposed reducing benefits after medical evidence showed the veteran's condition had improved. VARO staff proposed the reduction in June 2012; however, the final action to reduce benefits did not occur until December 2013, approximately 16 months beyond the date the reduction should have occurred. As a result, the veteran received approximately $37,055 in improper payments.

VARO management disagreed with our assessments in all 11 cases we found noncompliant with VBA policy. In its response, VARO management stated the failure to take timely action on a reduction is a workload management issue, which is neither a procedural deficiency nor an error. Management acknowledged the VARO's responsibility for ensuring staff take timely and appropriate actions on benefits reductions but indicated workload priorities impacted their ability to do so. Specifically, the VSC manager told us staff were focused on reducing VBA's oldest rating-related claims in accordance with priorities of the national strategy, which started in April 2013. Staff said VARO managers did not allow them to resume processing non-rating-related claims until September 2013. At the time of our March 2014 inspection, staff and managers indicated they were processing the oldest pending non-rating-related claims, including proposed benefit reductions, which were between 900 and 1,000 days old.

Despite management's disagreement, we continued to find the VARO noncompliant with VBA's policy to identify and route proposed benefits reductions for action on the 65th day following the due process period. We explained that our inspections identify as errors any conditions where VAROs do not adhere to VBA policy. We concluded that providing oversight of this high-risk area of benefits reductions to ensure sound financial stewardship, maximize the effective use of resources, and minimize

improper benefits payments is clearly necessary and within the OIG's purview.

Recommendation

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

Management Response The VARO Director concurred with our recommendation. In July 2014, the Director updated the VARO's workload management plan to address the prioritization of benefit reduction case.

OIG Response The Director's comments and actions are responsive to the recommendation.

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of February 2014, the Seattle VARO reported a staffing level of 576.1 full-time employees. Of this total, the VSC had 242.3 employees assigned.

Workload

As of February 2014, the VBA reported 24,756 pending compensation claims. On average, claims were pending 148.5 days—33.5 days more than the national target of 115 days.

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 March 2014, we evaluated the Seattle 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 (5 percent) of 606 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented all instances in which VBA staff had granted temporary 100 percent disability evaluations for at least 18 months or more as of February 10, 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 576 claims remaining from our universe of 606 for its review. We reviewed 30 (13 percent) of 225 TBI-related disability claims that the VARO completed from October 1, 2013, through December 31, 2013. We examined 30 (36 percent) of 84 veterans' claims involving entitlement to SMC and related ancillary benefits that VARO staff completed from January 2013 through December 2013.

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

Additionally, we examined 30 (18 percent) of 167 claims completed from October 2013 to December 2013 that proposed reductions in benefits.

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

Data Reliability

We used computer-processed data from the Veterans Service Network's Operations Reports. 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 120 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI claims, SMC and ancillary benefits, and completed claims involving benefits reductions.

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

As reported by VBA's Systematic Technical Accuracy Review program as of March 2014, the overall accuracy of the VARO's compensation rating-related decisions was 91.5─2.5 percentage points below VBA's FY 2014 target of 94 percent. We did not test the reliability of this data.

Inspection Standards

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

Appendix B Inspection Summary

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

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

Source: VA OIG

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

Appendix C VARO Director's Comments

(Comments received via email)

From: CHI, JANE L., VBASEAT **On Behalf Of** VAVBASEA/RO/DIR

Sent: Thursday, August 21, 2014 3:25 PM

To: Stokes, Nora D. (OIG); Figueroa, Ray (OIG)

Cc: VAVBAPHO/WAREA; Thomas, Angela, VBAPHNX; VAVBASEA/RO/DIR

Subject: Seattle Response: Inspection of the Seattle VA Regional Office

Importance: High

The Seattle Regional Office respectfully provides the attached Response to the OIG's Draft Inspection Report.

Patrick C. Prieb,
Director

(File Attached to Email)

SEATTLE VA REGIONAL OFFICE (346)

COMMENTS ON OIG DRAFT REPORT

OIG Recommendations:

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

Seattle Regional Office (RO) Response: Concur

Action: Since end of March 2014, there were 1131 Future Physical Examination work items and as of this response, there are 686 pending, which represents a 61 percent reduction. In addition to the reemphasized focus on these work items, effective July 9, 2014, the Workload Management Plan was updated to address 800 series work items, and processing prioritization.

Target Completion Date: Completed.

Recommendation #2: We recommend the Seattle VA Regional Office Director implement a plan to review for accuracy the 576 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate actions.

Seattle RO Response: Concur

Response: The Seattle RO has reviewed all 576 temporary 100 percent disability evaluations identified and ensured the next appropriate action has been taken.

Target Completion Date: Completed.

Recommendation #3: We recommend the Seattle VA Regional Office Director develop and implement a plan to ensure staff receive refresher training on processing claims related to special monthly compensation and ancillary benefits and implement a plan to monitor the effectiveness of that training.

Seattle RO Response: Concur

Proposed: Refresher training for special monthly compensation and ancillary benefits will be given to RVSRs with a local consistency study to be administered at a later date to gauge the effectiveness of the refresher training.

Anticipated Completion Date: November 30, 2014

Recommendation #4: We recommend the Seattle VA Regional Office Director amend its secondary-review policy by reducing the special monthly compensation threshold for requiring second-signature reviews as a means of ensuring accuracy in processing these complex claims.

Seattle RO Response: Concur

Response: As an additional level of review, local Quality Review staff will conduct reviews of all SMC cases completed during selected months throughout the year and provide on the spot training for any errors identified.

Anticipated Completion Date: December 31, 2014

Recommendation #5: We recommend the Seattle Regional Office Director implement a plan to ensure claims processing staff prioritize actions related to benefits reductions to minimize improper payments to veterans.

Seattle RO Response: Concur

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

As of July 9, 2014, the updated Workload Management Plan addresses the prioritization for EP600s.

Anticipated Completion Date: Completed.

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Nora Stokes, Director Kristine Abramo Kelly Crawford Casey Crump Ramon Figueroa Lee Giesbrecht Kerri Leggiero-Yglesias Nelvy Viguera Butler Mark Ward

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