VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Chicago, Illinois

September 25, 2014
14-02357-270

ACRONYMS

FY	Fiscal Year
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAH	Specially Adapted Housing
SHA	Special Home Adaptation
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
VSR	Veterans Service Representative

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Report Highlights: Inspection of VA Regional Office Chicago, IL

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and a Veterans Service Center (VSC) in Cheyenne, WY, that process disability claims and provide a range of services to veterans. We evaluated the Chicago VARO to determine how well it accomplishes this mission. Claims processing that lacks compliance with VBA procedures risks paying inaccurate financial benefits. The Office of Inspector General's Benefits Inspectors conducted onsite work at the VARO in May 2014.

What We Found

Overall, VARO staff did not accurately process 35 (39 percent) of 89 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.

Specifically, 19 of 30 temporary 100 percent disability evaluations we reviewed were inaccurate, primarily because management did not prioritize processing of claims requiring reexaminations. VARO staff demonstrated experience and knowledge in correctly processing complex traumatic brain injury claims. VARO staff incorrectly processed 16 of 31 special monthly compensation (SMC) and ancillary benefits claims due to a lack of recent effective training.

Management did not complete 5 of 11 Systematic Analyses of Operations (SAOs) due to inadequate oversight. VARO staff also did not timely complete 15 of 30 benefit reduction cases due to addressing other higher workload priorities.

What We Recommended

We recommended the Chicago VARO Director review the 581 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action, as well as provide oversight to ensure staff follow VBA guidance for establishing suspense diaries and processing reminder notifications. The Director should ensure staff receive refresher training on proper processing of SMC and ancillary benefits and implement a plan to ensure effectiveness of the training. The Director should develop and implement a plan to ensure completion of all SAOs. Finally, he should amend, implement, and monitor the Workload Management Plan to ensure staff take timely action on processing proposed benefits reductions.

Agency Comments

The Director of the Chicago VARO concurred with all recommendations. Management's planned actions are responsive and we will follow up as required on all actions.

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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 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

- 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 Chicago 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 Chicago VARO Could Improve Disability Claims Processing Accuracy

The Chicago VARO did not consistently process temporary 100 percent disability evaluations or entitlement to SMC and ancillary benefits. VARO staff correctly processed all 28 TBI claims we reviewed. We attributed the high accuracy rate to experienced staff and implementation of VBA's second-level review policy for TBI claims.

Overall, VARO staff incorrectly processed 35 of the total 89 disability claims we sampled, resulting in 172 improper monthly payments to 11 veterans totaling approximately $187,000, at the time of our inspection in May 2014. We sampled claims related only to specific conditions 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 Chicago VARO.

Table 1. Chicago VARO Disability Claims Processing Accuracy For 3 High-Risk Claims Processing Areas

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	16	19
TBI Claims	28	0	0	0
SMC and Ancillary Benefits	31	8	8	16
Total	**89**	**11**	**24**	**35**

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 19 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.

Effective management of these temporary 100 percent disability ratings can reduce VBA's risks of paying inaccurate financial benefits. Available medical evidence showed 3 of the 19 processing errors affected benefits and resulted in 55 improper monthly recurring payments to 3 veterans totaling approximately $61,800. These improper monthly benefits payments ranged from May 2011 to April 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 10, 2010, and requested a medical reexamination in October 2012. However, VARO staff had not scheduled the reexamination at the time of our review in May 2014. Medical evidence from October 2012 showed the veteran's disability improved; therefore, it warranted a reduced evaluation. As a result, VA overpaid the veteran approximately $35,500 over a period of 13 months. Monthly benefits payments continue at the 100 percent disability rate if no corrective action is taken.
- In another case, an RVSR proposed reducing a veteran's temporary 100 percent disability evaluation for prostate cancer to 40 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 May 2014, VARO staff

had still not taken action on the proposed reduction. As a result, VA overpaid the veteran approximately $14,700 over a period of 7 months. Monthly benefit payments continue at the 100 percent disability rate if no corrective action is taken.

- An RVSR did not address a veteran's entitlement to an additional level of compensation due to multiple disabilities, as required. As a result, VA underpaid the veteran approximately $11,600 over a period of 35 months.

The remaining 16 of the total 19 errors had the potential to affect veterans' benefits. Following are details on the 16 errors:

- In 13 cases, RVSRs established the need for future reexaminations of the veterans' temporary 100 percent disability evaluations. The electronic system generated reminder notifications to alert staff to schedule the medical reexaminations; however, staff had not yet scheduled the reexaminations. We could not determine if these temporary 100 percent disability evaluations would have continued because the veterans' claims folders did not contain the medical evidence needed to re-evaluate each case. As a result, there is increased risk that VA overpaid these veterans.
- RVSRs established the need for future reexaminations of the veterans' temporary 100 percent disabilities in the remaining three cases. However, at the time of our May 2014 review, staff had not scheduled the reexaminations and no electronic system controls were in place to ensure staff would schedule the reexaminations as required. As a result, there is increased risk that VA was continuing to overpay these veterans without appropriate medical support.

Generally, errors occurred because VSC management did not prioritize processing temporary 100 percent disability claims. Their Workload Management Plan did not list these cases as one of the workload priorities. Management stated and VSC staff confirmed they placed emphasis on processing other workloads that VBA tracks and measures for timeliness. As a result, veterans may receive benefits payments in excess of their benefits entitlements. We provided VARO management with 581 claims remaining from our universe of 611 for its review to determine if action is required.

VARO management concurred with one error we identified and neither concurred nor nonconcurred with 16 errors that involved delays in benefit reductions and reexamination scheduling. In response, management stated, "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."

We disagree. It is a VBA management responsibility to address this issue, which entails millions of dollars in improper payments. Where VBA lacks sufficient staff to properly address its management responsibilities, it should

make its case for an increase in full-time equivalents through the normal budget process. VARO management did not concur with the two remaining errors that resulted when staff did not address reminder notifications to schedule reexaminations. However, management confirmed it would take corrective actions on both cases.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Chicago, Illinois* (Report No. 11-00521-183, June 2, 2011), VARO staff incorrectly processed 13 of 30 temporary 100 percent disability evaluations we reviewed. The most frequent processing errors occurred when staff did not follow VBA policy on reminder notifications to schedule reexaminations. The OIG recommended the VARO Director establish mechanisms to ensure staff control claims requiring medical reexaminations within 60 days of final processing actions, review all pending reminder notifications to determine if medical reexaminations are required and take appropriate action, and implement oversight to ensure staff follow VBA guidance and the local Workload Management Plan for reviewing reminder notifications. The OIG closed these recommendations after VARO management stated it would follow the national plan to review temporary 100 percent disability evaluation cases and implement compliance reviews of reminder notification management.

During our May 2014 inspection, we identified cases where VSC staff did not input suspense diaries for future VA medical reexaminations in the electronic system or follow VBA guidance on managing reminder notifications. Therefore, we determined the VSC's actions in response to our previous recommendations have not been 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.

During this inspection, VARO staff correctly processed all 28 TBI claims we reviewed. We attributed the high accuracy rate to experienced staff, effective communication, implementation of the second-signature policy, and the practice of requesting specific information at the beginning of the VA medical examination process. Staff we interviewed stated they processed TBI claims daily and had at least 3 years of experience. Staff also said they requested specific TBI information at the beginning of the examination process so VA examiners were aware of the medical information required for TBI evaluations. Management indicated communication between RVSRs and quality review staff contributed to their success in processing TBI claims. We determined the VARO staff followed VBA policy when processing these claims. Therefore, 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, Chicago, Illinois* (Report No. 11-00521-183, June 2, 2011), we determined processing errors occurred because staff misinterpreted VBA policy and used insufficient VA medical examinations for rating decisions. VARO staff conducted TBI training during our inspection in response to errors we identified. We recommended the VARO Director develop and implement plans to evaluate the effectiveness of the March 2011 training and improve accuracy and oversight of TBI claims processing. The OIG closed these recommendations after the VARO provided information regarding feedback from the training and documentation of second-signature reviews of TBI claims. We did not identify any errors during our May 2014 inspection. As such, we determined the VARO's corrective 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 Title 38, United States Code, Chapter 35
- Specially Adapted Housing (SAH)
- Special Home Adaptation (SHA)
- 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 16 of 31 claims involving SMC and ancillary benefits—8 affected veterans' benefits and resulted in overpayments to veterans totaling approximately $109,000 and underpayments totaling approximately $16,000. These errors represented 117 improper monthly recurring payments from August 1999 until April 2014. Details on the errors affecting benefits follow:

- An RVSR incorrectly increased the evaluation of a veteran's bilateral eye condition and granted entitlement to Dependents' Educational Assistance. As a result, the veteran was overpaid approximately $101,000 over a period of 40 months.
- In another case, an RVSR assigned a lower level of SMC than warranted for a veteran. As a result, VA underpaid the veteran approximately $11,600 over a period of 26 months.
- VARO staff assigned a higher level of SMC than warranted and incorrectly processed payments to a veteran. As a result, VA overpaid the veteran approximately $8,000 over a period of 41 months.
- A veteran warranted a higher level of SMC than assigned by the RVSR. As a result, VA underpaid the veteran approximately $2,400 over a period of 6 months.
- In two cases, RVSRs assigned veterans incorrect effective dates for increased SMC. As a result, VA underpaid one veteran approximately $1,000 for a period of 1 month and another veteran approximately $690 for a period of 1 month.

- An RVSR assigned an earlier effective date than was warranted for increased SMC. As a result, VA overpaid the veteran approximately $410 for a period of 1 month.
- In the last case, an RVSR did not grant a higher level of SMC for a veteran when warranted. As a result, VA underpaid the veteran approximately $270 for a period of 1 month.

The remaining eight errors had the potential to affect veterans' benefits. Summaries of these errors follow.

- Five errors involved RVSRs that failed to grant, or improperly granted, ancillary benefits.
  - In two cases, staff failed to grant entitlement to automobile and adaptive equipment, a benefit worth up to $19,817. In one of these cases, an RVSR also failed to grant entitlement to SHA, a benefit worth up to $13,511.
  - Staff incorrectly granted entitlement to both SAH and SHA in two other cases. VA regulations preclude entitlement to SAH when the veteran is also entitled to SHA.
  - In one case, an RVSR granted entitlement to SAH, a benefit worth up to $67,555, when the veteran did not meet the eligibility requirements. The RVSR also failed to grant SHA although the veteran was eligible.
- Two errors involved RVSRs that incorrectly entered, or failed to enter, hospital codes for veterans' SMC into the electronic system. Generally, VSC staff must reduce veterans' SMC payments when they are hospitalized at Government expense. Staff use hospital codes to determine the correct amount to pay hospitalized veterans. In these two cases, the improper hospital codes could have resulted in erroneous adjustments of the veterans' payments upon hospitalization.
- In the final case, an RVSR denied a veteran entitlement to SMC at a higher rate without informing the veteran what was necessary to grant the benefit. Without the veteran receiving required claims assistance, the RVSR improperly denied SMC, and additional evidence the veteran may have been able to provide could have led to a different decision.

Errors related to SMC and ancillary benefits were generally due to both a lack of recent and effective training. VARO staff provided records revealing they last received training for SMC and ancillary benefits in 2011 and 2012. Furthermore, VSC staff we interviewed indicated the training for SMC and ancillary benefits was basic and brief, lasting just a few hours. Staff stated that future training on the topics of SMC and ancillary benefits should dedicate more time to this complex subject.

The VARO concurred with 14 of the errors we identified and did not concur with two errors. Although VARO management did not concur with the two errors, it agreed processing of these two cases was not compliant with policy and VARO staff would take corrective action.

Recommendations

1. We recommended the Chicago VA Regional Office Director conduct a review of the 581 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

2. We recommended the Chicago VA Regional Office Director provide oversight to ensure staff follow Veterans Benefits Administration guidance for establishing suspense diaries and processing reminder notifications.

3. We recommended the Chicago VA Regional Office Director ensure staff receive refresher training on the proper processing of special monthly compensation and ancillary benefits and implement a plan to ensure the effectiveness of the training.

Management Comments

The VARO Director concurred with our recommendations and indicated staff completed reviews of 554 of the 581 temporary 100 percent disability evaluations identified. The Director expects staff to complete reviews of the remaining cases by October 15, 2014.

Veterans Service Representatives (VSRs) will receive training regarding the proper procedures for suspense diaries and processing reminder notifications. VSRs will review the 100 oldest cases each week and take necessary actions. Staff will provide a weekly report to the VSC Manager for review to ensure cases are processed as reported. Staff will also receive training on Special Monthly Compensation and Ancillary Benefits. The Quality Review Team will conduct a special review of these cases during November 2014 and provide a follow-up training plan on its findings, as well as on-the-spot training as the review progresses.

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 VARO Lacked Adequate Oversight To Ensure Complete SAOs

Six SAOs were complete and submitted timely. However, VARO management did not provide the remaining 5 of the 11 SAOs for our review due to inadequate oversight over the SAO process. As a result of not completing all required SAOs, management lacked sufficient information to adequately identify existing and potential problems needing corrective actions to improve VSC operations.

Management did not provide four of the five SAOs for our review because the Director's staff had not finalized them. We were unable to review the fifth SAO because the manager assigned to this SAO did not complete it prior to retiring, and management did not realize this until we requested the SAO for review. We notified the VARO of our inspection and requested the SAOs on April 21, 2014. We arrived at the VARO on May 19, 2014. However, management still did not provide us with the five SAOs needed for review. A lack of management oversight of the SAO process resulted in the remaining five required SAOs being incomplete.

For example, we were unable to review the Internal Controls SAO. As discussed in our review of temporary 100 percent disability evaluations, we identified instances where VARO staff did not take timely actions to minimize overpayments. If the Chicago VARO had completed the Internal Controls SAO, it could have identified this problem and developed recommendations to address this issue before we did as part of our review.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Chicago, Illinois* (Report No. 11-00521-183, June 2, 2011), we found that 7 of the 12 mandated SAOs were not completed timely, were missing required elements, or were not done at all. VARO management did not provide adequate oversight to ensure VSC staff completed the SAOs according to VBA policy. As a result, VARO management may not have adequately

identified existing and potential problems for corrective actions to improve VSC operations. We recommended the Chicago VARO Director develop and implement a plan to ensure staff complete SAOs timely and address all required elements. The OIG closed this recommendation on February 27, 2012, after the VARO submitted SAO standard operating procedures to support its implementation of the recommendation.

During our May 2014 inspection, staff completed and timely submitted 6 of the 11 required SAOs. VARO management did not complete the remaining five SAOs because it did not provide adequate oversight. In our previous inspection, we found SAOs that were not completed and made recommendations for improvement. Because of similar findings during our previous and current inspections, we determined the VARO's actions in response to our previous recommendations have not been effective.

Recommendation

4. We recommended the Chicago VA Regional Office Director develop and implement a plan to ensure completion of all Systematic Analyses of Operations.

Management Comments

The Chicago VARO will continue to enforce its existing schedule and plan for Systematic Analyses of Operations. While one of the five SAOs was not completed timely due to personnel retirement, the other four were drafted and submitted. Management was actively engaged in the VARO's established SAO process, which includes edits and changes between the division and the Director's Office. The VARO did not provide draft versions to the OIG team while it was onsite, as SAOs are considered complete only after the Director's Office has approved them.

OIG Response

The Director's comments and actions are responsive to the recommendation. 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. 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 veteran does not provide 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 3 VARO Lacked Oversight To Ensure Timely Action On Proposed Benefit Reductions

VARO staff delayed processing 15 of 30 cases involving proposed benefits reductions due to a lack of priority on timely managing this workload. Processing delays resulted in overpayments totaling approximately $152,000, representing 113 improper monthly recurring payments to 15 veterans from July 2012 to March 2014.

In the case with the most significant overpayment, VSC staff sent a letter to the veteran on August 23, 2012, proposing reducing the evaluation for prostate cancer. The due process period expired on October 27, 2012, without the veteran providing additional evidence to support the claim. However, staff did not reduce the benefits until November 25, 2013. As a result, VA overpaid the veteran approximately $39,000 over a period of 14 months.

An average of 8 months elapsed from the time staff should have taken action to reduce the evaluations for these 15 cases. In the case with the most significant delay, VSC staff sent a letter to the veteran on February 22, 2012, proposing reducing the evaluation for his prostate cancer from 100 to 60 percent disabling. The due process period expired on April 27, 2012, without the veteran providing additional information to support the claim. However, staff did not reduce the evaluation until November 14, 2013. Additionally, the proposed evaluation of 60 percent disabling was incorrect as medical evidence warranted a 40 percent evaluation. Because of the delay and the incorrect evaluation, VA overpaid the veteran approximately $28,000 over a period of 19 months.

Generally, these delays occurred because VARO management did not view this workload as a priority. Because of national changes to workload management, VSC leadership did not prioritize processing benefits reductions and concentrated instead on national priorities including processing rating claims pending over 2 years. Additionally, we noted the

VSC's Workload Management Plan did not reflect current guidance to process benefit reductions. Both management and staff confirmed there was no emphasis on timely following through with proposed rating reductions.

VARO management concurred with 9 of the total 15 errors we identified. Although we showed VARO management and staff VBA criteria (Manual 21-1 Manual Rewrite, PartI.2.B.7.a) requiring action on the 65th day following due process notification, they neither concurred nor nonconcurred with the remaining 6 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."

We disagree. It is a VBA management responsibility to address this issue, which entails millions of dollars in improper payments. Where VBA lacks sufficient staff to properly address its management responsibilities, it should make its case for an increase in full-time equivalents through the normal budget process. Without appropriate priority for this type of work, delays in processing reductions result in unsound financial stewardship of veterans' monetary benefits and fail to minimize overpayments.

Recommendation

5. We recommended the Chicago VA Regional Office Director amend, implement, and monitor the local Workload Management Plan to ensure staff take timely action on claims requiring rating decisions for reduction of benefits.

Management Comments

The VARO Director concurred with our recommendation and implemented a procedure for VSRs to add electronic controls to any rating-related or non-rating-related work product. These electronic controls enable employees and supervisors to identify work items that need rating decisions for possible 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 Chicago 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 April 2014, the Chicago VARO reported a staffing level of 186.8 full-time employees. Of this total, the VSC had 154.9 employees assigned.

Workload

As of April 2014, VBA reported the Chicago VARO had 8,938 pending compensation claims. On average, claims were pending 144.7 days to 29.7 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 May 2014, we evaluated the Chicago 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 611 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 March 24, 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 581 claims remaining from our universe of 611 for its review. We reviewed all 28 available disability claims related to TBI completed by the VARO in the first quarter of FY 2014 (October 1, 2013 through December 31, 2013). We also examined all 31 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 all available SAOs related to VARO operations. Additionally, we looked at 30 (14 percent) of 221 completed claims

involving proposed benefits reductions from the first quarter of FY 2014 (October 1, 2013, through December 31, 2013).

Where we identify potential procedural inaccuracies, we provide this information to help the VARO understand the process improvements it can make to ensure 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 time frame requested. We assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Further, we compared veterans' names, file numbers, Social Security numbers, 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 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 Systematic Technical Accuracy Review data. As reported by VBA's Systematic Technical Accuracy Review program as of April 2014, the overall claims-based accuracy of the VARO's compensation rating-related decisions was 89.8 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. Chicago 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)	No
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: September 8, 2014

From: Director, VA Regional Office Chicago, Illinois

Subj: Inspection of the VA Regional Office, Chicago, Illinois

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

1. The Chicago VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Chicago, Illinois.*
2. Please refer questions to Ms. Tanya Fisher, Assistant Veterans Service Center Manager, at (312) 980-4401.

(original signed by:)

Suzanne DeNeau-Galley
Acting Director

Attachment

Attachment

Chicago (328)

September 8, 2014

OIG Recommendations:

Recommendation 1: *We recommended the Chicago VA Regional Office Director conduct a review of the 581 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.*

Chicago RO Response: Concur

The Chicago Regional Office has reviewed 554 of the 581 temporary 100 percent disability evaluations identified. The RO is in the process of reviewing the remaining 27 evaluations. We expect to complete those reviews by October 15, 2014. We will continue to get a new listing of temporary 100 percent cases each month, and will work these as received.

Target Completion Date: October 15, 2014

Recommendation 2: We recommended the Chicago VA Regional Office Director provide oversight to ensure that staff follow Veterans Benefits Administration guidance for establishing suspense diaries and processing reminder notifications.

Chicago RO Response: Concur

The Chicago Regional Office will conduct training on proper procedures for suspense diaries and processing reminder notifications. Chicago VSRs will review the 100 oldest 810s each week, and take the necessary action (including establishing an EP 310, if appropriate). A report on the number of 810s worked each week will be provided to the VSC Manager's office every Friday by the Express Lane Coaches. The AVSCM(s) will also review the completed/cancelled message work items in VOR each week, to verify that the 810s are being processed as reported.

Target Completion Date: November 1, 2014

Recommendation 3: We recommended the Chicago VA Regional Office Director ensure that staff receives refresher training on the proper processing of special monthly compensation and ancillary benefits and implement a plan to ensure the effectiveness of the training.

Chicago RO Response: Concur

Training sessions for Special Monthly Compensation and Ancillary Benefits are scheduled for October 1, 2014, October 2, 2014 and October 7, 2014. The Quality Review Team will conduct a special review of these cases during November 2014 and provide a follow up training plan on their findings, as well as provide on-the-spot training as the review progresses.

Target Completion Date: December 15, 2014

Recommendation 4: We recommend the Chicago VA Regional Office Director develop and implement a plan to ensure completion of all Systematic Analyses of Operations.

Chicago RO Response: Concur

The Chicago VA Regional Office will continue to enforce its existing schedule and plan for Systematic Analyses of Operations. While one of the five was not completed timely due to personnel retirement, the other four were drafted and submitted, and were actively engaged in the RO's established SAO process, which includes edits and changes between the division and the Director's Office. The RO did not provide draft versions to the OIG while on site, as SAOs are considered complete only when they have been approved by the Office of the Director. We recommend closure of this recommendation, as the Chicago VARO received positive feedback on the SAOs reviewed by the OIG, which illustrates that the current process provides a quality product.

Recommendation 5: We recommended the Chicago VA Regional Office Director amend, implement, and monitor the local Workload Management Plan to ensure that staff take timely action on claims requiring rating decisions for reduction of benefits.

Chicago RO Response: Concur

In February 2014, the Veterans Service Center implemented a procedure for VSRs to add "RO Special Issue 1" to any rating-related EP 600, and "RO Special Issue 2" to any non-rating-related EP 600. This special issue designation enables employees and supervisors to quickly identify EP 600s which need rating decisions for possible reductions via the daily Tableau report. Cases established prior to the February date will have the appropriate flashes added by September 30, 2014.

Target Completion Date: September 30, 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 Daphne Brantley Brett Byrd Scott Harris Jeffrey Myers David Piña Rachel Stroup Nelvy Viguera Butler Diane Wilson

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