VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

# Inspection of VA Regional Office White River Junction, Vermont

September 30, 2014
14-02889-310

# ACRONYMS

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

# Report Highlights: Inspection of VA Regional Office White River Junction, VT

## 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 White River Junction VARO to see how well it accomplishes this mission. Claims processing that lacks compliance with VBA procedures can result in the risk of paying inaccurate and unnecessary financial benefits. Office of Inspector General benefits inspectors conducted its VARO inspection work during May to June 2014.

## What We Found

Overall, VARO staff did not accurately process 11 (22 percent) of 49 disability claims reviewed. We sampled claims we considered at higher risk of processing errors, thus these results do not represent this VARO's overall disability claims processing accuracy rate.

Specifically, 6 of 30 temporary 100 percent disability evaluations we reviewed were inaccurate, generally because management did not ensure timely processing of temporary 100 percent cases requiring reduced evaluations and medical reexaminations. VARO staff incorrectly processed 1 of 10 traumatic brain injury claims. Staff also incorrectly processed 4 of 9 special monthly compensation (SMC) claims due to a lack of training and an ineffective second-level review process.

All 11 Systematic Analyses of Operations (SAOs) were either incomplete or not submitted because of a lack of management oversight to ensure staff completed the SAOs correctly. VARO staff did not timely or accurately complete 6 of 27 proposed benefits reduction cases because management did not prioritize this workload.

## What We Recommended

We recommended the VARO Director implement a plan to ensure staff timely process temporary 100 percent disability evaluations and review 33 such cases remaining from our inspection universe. The Director should provide refresher training and strengthen the additional level of review for SMC cases, ensure SAOs are complete, and implement a plan to ensure management oversight and processing of benefits reduction cases.

## Agency Comments

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

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 White River Junction 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 White River Junction VARO Could Improve Disability Claims Processing Accuracy

The White River Junction VARO did not consistently process temporary 100 percent disability evaluations, TBI-related cases, and entitlement to SMC benefits. 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. Overall, VARO staff incorrectly processed 11 of the total 49 disability claims we sampled, resulting in 66 improper monthly payments to 5 veterans totaling $164,591. The following table reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the White River Junction VARO.

**Table 1. White River Junction VARO Disability Claims Processing Accuracy for Three 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 | 0 | 6 | 6 |
| TBI Claims | 10 | 1 | 0 | 1 |
| SMC and Ancillary Benefits | 9 | 4 | 0 | 4 |
| **Total** | **49** | **5** | **6** | **11** |

*Source: VA OIG analysis of Veterans Benefits Administration's (VBA) temporary 100 percent disability evaluations paid at least 18 months, TBI disability claims completed in the second quarter fiscal year (FY) 2014, and SMC and ancillary benefits claims completed in April 2013 through March 2014*

***Temporary 100 Percent Disability Evaluations***

VARO staff incorrectly processed 6 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.

When the VARO obtains evidence that a lower disability evaluation would result in reduced compensation payments, VSC staff must inform the beneficiary of the proposed reduction in benefits. In order to provide beneficiaries due process, VBA allows 60 days for the veteran to submit additional evidence to show that compensation payments should continue at their present level. 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 is at increased risk of paying inaccurate financial benefits. We determined that VARO staff incorrectly processed 6 of 30 temporary 100 percent disability evaluations we reviewed. All of these cases had the potential to affect veterans' benefits. Details on these errors follow.

- On March 17, 2014, VSC staff proposed reducing a veteran's temporary 100 percent evaluation for prostate cancer. Staff had determined the 100 percent disability evaluation was no longer needed since the veteran's health had improved. At the time of our review in June 2014, VSC staff had not taken action to reduce the evaluation. As a result, the veteran will continue to receive incorrect monthly benefits at the 100 percent disability rate.
- VSC staff proposed to reduce a veteran's temporary 100 percent evaluation for prostate cancer to 40 percent and provided notification of the proposed reduction on February 19, 2014. At the time of our review in June 2014, VSC staff had not reduced the evaluation. Because timely action was not taken, the veteran will continue to be paid at the 100 percent disability rate, higher than what is supported by medical evidence.

- A veteran requested a personal hearing on March 13, 2013, in response to a proposed benefits reduction. At the time of our review in June 2014, the veteran was still waiting for the opportunity to provide evidence to refute the proposed reduction. Until VARO staff conduct the requested hearing, no action can be taken on the proposed reduction and monthly benefits will continue to be paid at the 100 percent disability rate.
- VSC staff received a system-generated reminder notification in April 2014 indicating the veteran needed a medical reevaluation of his prostate cancer. As of June 2014, staff had not requested the reexamination. Until VSC staff evaluate the veteran's condition to determine whether he continues to warrant a 100 percent evaluation, payments continue at the existing 100 percent disability rate and improper payments may occur.
- In April 2002, a Rating Veterans Service Representative (RVSR) confirmed and continued a temporary 100 percent evaluation for prostate cancer and established a September 2002 suspense diary. As of June 2014, VSC staff had not scheduled the medical reexamination to evaluate the veteran's prostate cancer. Until VSC staff schedule the reexamination, no action can be taken to reevaluate the veteran's condition, payments continue at the existing 100 percent disability rate and improper payments may occur.
- An RVSR prematurely assigned a temporary 100 percent evaluation when service connection for prostate cancer was granted in May 2006. From the initial rating in 2006, until our review in 2014, VSC staff never requested a medical reexamination to evaluate the veteran's prostate cancer. Until VSC staff reevaluate the veteran's condition, payments will continue at the 100 percent rate and improper payments may occur. The lack of follow-up on the claim over 8 years does not represent adequate financial stewardship for a temporary 100 percent disability evaluation.

Generally, processing inaccuracies occurred because VARO management did not ensure timely action to reduce ratings and schedule reexaminations for temporary 100 percent disability claims. Further, management advised us that Eastern Area Headquarters and VBA's Compensation Service provided instructions to not complete claims that were less than 125 days old. As a result, the VARO may continue benefits payments and overpay veterans who are no longer entitled to temporary 100 percent evaluations. We provided VARO management with 33 claims from our universe of 63 for its review to determine if action is required.

*Follow-Up to Prior VA OIG Inspection*

In our previous report, *Inspection of the VA Regional Office, White River Junction, Vermont* (Report No. 11-00518-54, January 17, 2012), we reported VARO staff incorrectly processed 15 of 30 temporary 100 percent disability evaluations we reviewed. The most frequent processing errors occurred because staff did not establish suspense diaries in the electronic system to ensure they received reminder notifications to schedule medical reexaminations to support the evaluations. We did not provide a recommendation in this inspection report as VBA had implemented a national review plan to address this issue. To assist in implementing the agreed upon review, we provided the VARO with 20 claims remaining from our universe of 50 temporary 100 percent disability evaluations.

During our June 2014 inspection, we found cases where VSC staff delayed scheduling future medical reexaminations; however, we identified no cases where staff did not establish suspense diaries in the electronic system to generate reminders to follow up on temporary 100 percent disability evaluations. As such, we made no further recommendation in this area.

***TBI Claims***

The Department of Defense and VBA commonly define a TBI as a traumatically induced structural injury or a physiological disruption of brain function caused by an external force. The major residual disabilities of TBI fall into three main categories—physical, cognitive, and behavioral. VBA policy requires staff to evaluate these residual disabilities.

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.

We determined VARO staff incorrectly processed 1 of 10 TBI claims—the inaccuracy affected a veteran's benefits. In this case, VARO staff assigned an incorrect effective date for residuals of TBI. As a result, the veteran was underpaid approximately $18,117 over a period of 16 months. Due to generally processing these TBI claims correctly, 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, White River Junction, Vermont* (Report No. 11-00518-54, January 17, 2012), we identified one TBI case for our review and found it to be correct. Since we found no error, we did not make any 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 an additional compensation to the basic rate of payment. SMC represents payments for "quality of life" issues, such as the loss of an eye or limb, the inability to naturally control bowel and bladder function, 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 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 or loss of use of two or more extremities, or bilateral blindness with visual acuity of 5/200 or worse.

VARO staff incorrectly processed four of nine claims involving SMC benefits—all four affected veterans' benefits. The errors resulted in overpayments totaling approximately $146,474, representing 50 improper monthly payments from December 2012 to May 2014. Following are descriptions of these errors.

- In three cases, RVSRs incorrectly granted higher levels of SMC requiring two separate 100 percent disability evaluations, which the veterans did

not have at the time of our review in May and June 2014. As a result, VA overpaid three veterans approximately $141,232 over a period of 45 months.

- An RVSR incorrectly granted SMC for a higher level of aid and attendance to a veteran although the veteran did not meet the eligibility requirements for this benefit. As a result, VA overpaid the veteran approximately $5,242 for a period of 5 months.

Errors related to SMC benefits were due to an ineffective second-signature review process and a lack of training. In three of the four errors we identified, staff conducted an additional level of review. However, the reviewer did not identify the errors that we found in our review. VSC management and staff acknowledged that the second-signature reviews on these cases were not thorough. Further, our review of all four errors indicated that VARO staff misinterpreted VBA policy for rating cases with higher levels of SMC.

Interviews with VARO management and staff stated that more training would be helpful in preventing these types of errors. VARO staff provided documentation showing that SMC training was last held in April 2013. As a result of the errors, veterans did not always receive accurate benefits payments. The deficiencies identified, if unaddressed, increase the risks associated with VBA's efforts to consistently process and ensure accuracy of claims processing.

## Recommendations

1. We recommended the White River Junction VA Regional Office Director implement a plan to ensure staff timely process rating reductions and medical reexamination requests for temporary 100 percent disability evaluations.
2. We recommended the White River Junction VA Regional Office Director conduct a review of the 33 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.
3. We recommended the White River Junction VA Regional Office Director provide staff with refresher training on the proper processing of special monthly compensation claims and implement a plan to assess the effectiveness of that training.
4. We recommended the White River Junction VA Regional Office Director implement a plan to strengthen the additional level of review for special monthly compensation claims.

***Management Comments***

The VARO Director concurred with our recommendations and indicated the Veterans Service Center Manager and Coach will review future exam diaries

weekly. Further, the management analyst in the Office of the Director will conduct reviews to ensure compliance with the plan already in place.

Staff completed their review of the 33 temporary 100 percent disability evaluations identified and determined 15 were completed, 7 reductions were pending, 6 were pending VA examinations, and 5 required no action as permanency had been established. The Director stated a second level review was required for all decisions involving SMC and SMC refresher training was scheduled for September 30, 2014.

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

## 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.

### Finding 2 White River Junction VARO Lacked Oversight To Ensure Complete SAOs

Nine SAOs were incomplete because recommendations lacked time frames for implementation and follow-up, and two SAOs were not submitted for approval at all. The VSC manager did not provide adequate oversight to ensure staff completed SAOs in accordance with VBA policy. Management also did not follow up on corrective actions to improve VSC operations when existing and potential problems were identified. Interviews with VARO management revealed a lack of awareness that recommendations required time frames for completion. VSC management acknowledged that more attention was needed in this area, and additional training would be beneficial. During our inspection, VARO management informed us it was developing a mechanism for tracking and implementing SAO recommendations. However, due to the early stage of development, we could not assess the effectiveness of this tool.

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

*Follow-Up to Prior VA OIG Inspection*

In our previous report, *Inspection of the VA Regional Office, White River Junction, Vermont* (Report No. 11-00518-54, January 17, 2012), we reported 5 of the 12 mandated SAOs were untimely and missing required elements and analyses. Generally, these errors occurred because management lacked oversight and adequate controls over the SAO process. We recommended that the White River Junction VARO Director develop and implement a plan to ensure that staff annually schedule all 12 mandatory SAOs and address all

required elements of each analysis. The Acting VARO Director concurred with our recommendation and amended the office Workload Management Plan. The amended plan required a Reports Tracking worksheet to centrally organize and track all mandatory SAOs. On June 27, 2012, the OIG closed this recommendation after the White River Junction VARO provided a copy of the Reports Tracking worksheet.

During our June 2014 inspection, VSC staff revealed they did not fully implement the Reports Tracking worksheet due to a general lack of understanding. For example, the worksheet required SAOs to be sent to the Director's office for review and approval; however, we found that once an SAO was sent to the Director's office, no follow-up from VSC management occurred. As a result, effective oversight and controls over the SAO process were still needed, and we saw the management of SAOs had worsened since our last inspection.

## Recommendations

5. We recommended the White River Junction VA Regional Office Director implement a plan, and assess the effectiveness of the plan, to ensure completion, and adequate and continuous oversight of Systematic Analyses of Operations requirements.
6. We recommended the White River Junction VA Regional Office Director implement a plan for training, and assess the effectiveness of the training, to ensure completion of Systematic Analyses of Operations requirements.

***Management Comments***

The VARO Director concurred with our recommendations and staff completed all past due SAOs. Further, staff implemented an SAO SharePoint site to facilitate compliance with SAO requirements. The VSC manager received SAO training while attending a leadership conference in Atlanta, GA in June 2014. Training was provided to the Coach in June 2014.

***OIG Response***

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

***Benefits Reductions***

VBA policy provides for 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 his or her service-connected disability may improve. Improper payments associated with benefit reductions generally occur when beneficiaries receive payments they are not entitled to because VAROs do not take the actions required to ensure correct payments for their levels of disability.

When the VARO obtains evidence that a lower disability evaluation would result in a reduction or discontinuance of current compensation payments, VSC staff must inform the beneficiary of the proposed reduction in benefits. In order to provide beneficiaries due process, VBA allows 60 days for the

veteran to submit additional evidence to show that compensation payments should continue at their present level. If the VARO does not receive additional evidence within that period, RVSRs must make a final determination to reduce or discontinue the benefit. On the 65th day following due process notification, action is required to reduce the evaluation in order to minimize overpayments.

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

## Finding 3 White River Junction VARO Lacked Oversight To Ensure Prompt Action On Proposed Benefits Reductions

VARO staff delayed or incorrectly processed 6 of 27 cases involving benefits reductions—4 affected veterans' benefits and 2 had the potential to affect veterans' benefits. These errors occurred due to a lack of emphasis on timely processing benefits reductions. Processing inaccuracies resulted in overpayments totaling approximately $6,812 and an underpayment of approximately $341, representing 13 improper monthly payments to 4 veterans from July 2013 to May 2014.

### *Processing Delays*

Processing delays occurred in 5 of 27 claims that required rating decisions to reduce or discontinue benefits. In the case with the most significant overpayment, VSC staff sent a letter to a veteran on January 31, 2013, proposing to reduce the disability evaluation for the veteran's prostate cancer and discontinue entitlement to SMC. The due process period expired on April 6, 2013. However, staff did not take action to reduce the evaluation until February 24, 2014. As a result of the delay, VA overpaid the veteran approximately $3,385 over a period of 10 months.

In three of the five cases, processing delays averaged four months from the time staff should have taken action to reduce benefits. In the remaining two cases, we could not define a date range for the delays. In one case, VSC staff did not release the due process letter in the same month as the proposed decision, as required by VBA policy. In the other case, the due process letter was returned as undeliverable on November 20, 2012. VSC staff did not identify a correct address as required and no action was taken to resend the due process letter until September 10, 2013. Further, VSC staff did not timely schedule a hearing for the veteran to present evidence in response to the proposed benefits reduction.

Generally, these delays occurred because VARO management had competing priorities. Although the station's Workload Management Plan

directed staff to process rating reduction cases immediately, delays occurred because the VARO did not consider these cases its first priority. VBA does not track or measure the timeliness of processing proposed rating reductions. Interviews with management confirmed that rating reductions were a lower priority as the VARO was directed by Eastern Area Headquarters to reduce the current inventory of pending disability claims. Management further stated these cases were easy and would not interfere with RVSRs reaching their daily productions goals, if they were allowed to work these cases along with the higher priority workload. As a result of the processing delays, veterans received erroneous benefits payments.

*Accuracy Errors*

VARO staff incorrectly processed 1 of 27 cases involving proposed benefits reductions. In this case, VSC staff assigned an incorrect effective date for the disability reduction. As a result, VA underpaid the veteran approximately $341 for a period of a month. The error was unique and did not constitute a common trend, pattern, or systemic issue. Therefore, we made no recommendation for improvement in this area.

## Recommendation

7. We recommended the White River Junction VA Regional Office Director implement a plan to ensure oversight and processing of benefits reduction cases.

***Management Comments***

The VARO Director concurred with our recommendation and amended the workload management plan to follow VBA policy and identify and control cases with the potential to cause over/underpayments.

***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 White River Junction VARO administers a variety of services and benefits including compensation and pension, and vocational rehabilitation and employment. Other services provided include benefits counseling, outreach services for the homeless, elderly, minority and women veterans, and public affairs.

***Resources***

As of May 2014, the White River Junction VARO reported a staffing level of 25 full-time employees. Of this total, the VSC had 22 employees assigned.

***Workload***

As of May 2014, VBA reported 738 pending compensation claims. On average claims were pending 179.8 days—64.8 days greater than the national target of 115.

***Scope and Methodology***

VBA has 56 VAROs and a VSC in Cheyenne, Wyoming, that process disability claims and provide a range of service to veterans. From May to June 2014, we evaluated the White River Junction 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 claims processing.

Our review included 30 (48 percent) of 63 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These cases represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of April 19, 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 33 claims remaining from our universe of 63 for its review. We reviewed 10 (91 percent) of 11 disability claims available related to TBI that the VARO completed from January through March 2014. We examined all 9 veterans' claims involving entitlement to SMC and related ancillary benefits that VARO staff completed from April 2013 through March 2014.

Prior to VBA consolidating Fiduciary Program Activities nationally, each VARO was required to complete 12 SAOs. However, since Fiduciary consolidation, the VAROs are now required to complete 11 SAOs. Therefore, we reviewed the 11 SAOs related to VARO operations. Additionally, we looked at 27 (79 percent) of 34 completed claims that proposed reductions in benefits from January through March 2014.

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

***Data Reliability***

We used computer-processed data from the Veterans Service Network's Operations Reports and Awards. To test for reliability, we reviewed the data to determine whether any data were missing from key fields, included any calculation errors, or were outside the time frame requested. We also assessed if 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 76 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI claims, SMC and ancillary benefits, and completed claims related to benefit 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 reviewed in conjunction with our inspection of the VARO did not disclose any problems with data reliability.

As reported by VBA's STAR program as of May 2014, the overall claims-based accuracy of the VARO's compensation rating related decisions was 86.5 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. White River Junction 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 |
| 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 24, 2014

**From:** Director, VARO White River Junction, Vermont (405/00)

**Subj:** Inspection of the VA Regional Office, White River Junction, Vermont

**To:** Linda Halliday, Assistant Inspector General for Audits and Evaluations (52)

1. During the week of June 16 - 18, 2014, OIG conducted an inspection of the Veterans Service Center operations at the White River Junction VA Regional Office. Our responses to the recommendations are incorporated in the attached report.

2. The statement on page four of the report suggesting that VARO Management did not timely process reductions due to guidance from Eastern Area and Compensation Service is misleading. Veterans Benefits Administration policy has consistently emphasized reducing the rating-related claim backlog, however guidance never dictated that this workload be neglected or delayed until it was pending more than 125 days. Rather, it was and continues to be, our responsibility to manage multiple priorities to include the workload reviewed as a part of this audit.

3. We appreciate the courtesy and cooperation your staff showed during the Inspection. If you have any questions or would like to discuss our response, please contact me at 617-303-4250.

*(original signed by:)*

Bradley G. Mayes
Director

Attachment

Attachment

**OIG Site Visit Response**

**White River Junction Veterans Affairs Regional Office**

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|---|---|
| **Recommendation I:** | The VA Regional Office should implement a plan to ensure staff timely process rating reductions and medical reexamination requests for temporary 100 percent disability evaluations. |
| **RO Response:** | Concur. Processing of future and review examinations is part of the VA Regional Office Workload Management Plan. Future and review exam diaries are reviewed weekly by the Coach and Veterans Service Center Manager. Periodic review by the Management Analyst in the Office of the Director will be instituted to ensure compliance with the plan already in place. VBA requests closure of this recommendation. |

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| **Recommendation 2:** | The VA Regional Office should conduct a review of the 33 temporary 100 percent disability evaluations remaining from the inspection universe and take appropriate action. |
| **RO Response:** | Concur. The 33 identified cases have been reviewed. Fifteen were completed, seven reductions are pending, six are pending VA examinations, and five required no action as permanency had been established. VBA requests closure of this recommendation. |

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| **Recommendation 3:** | The VA Regional Office should provide staff with refresher training on the proper processing of special monthly compensation claims and implement a plan to assess the effectiveness of that training. |
| **RO Response:** | Concur. A second level review is required for all decisions involving special monthly compensation per the attached Standard Operating Procedure effective November 2011. Refresher Training is scheduled for September 30, 2014. |

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| **Recommendation 4:** | The VA Regional Office should implement a plan to strengthen the additional level of review for special monthly compensation claims. |
| **RO Response:** | Concur. A second level review is required for all decisions involving special monthly compensation per the attached Standard Operating Procedure. VBA requests closure of this recommendation. |

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| **Recommendation 5:** | The VA Regional Office should implement a plan, and assess the effectiveness of the plan, to ensure completion, and adequate and continuous oversight of Systematic Analyses of Operations requirements. |
| **RO Response:** | Concur. The VA Regional Office has completed all past due SAOs. An SAO SharePoint site was implemented to facilitate compliance with SAO requirements. VBA requests closure of this recommendation. VBA requests closure of this recommendation. |

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| **Recommendation 6:** | The VA Regional Office should implement a plan for training, and assess the effectiveness of the training, to ensure completion of Systematic Analyses of Operations requirements. |
| **RO Response:** | Concur. The VSCM received SAO training while attending the VSCM Leadership Conference in Atlanta, GA in June 2014. Training was provided to the Coach in June 2014. An SAO SharePoint site was implemented to facilitate compliance with SAO requirements and to track recommended actions. VBA requests closure of this recommendation. |

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| **Recommendation 7:** | The VA Regional office should implement a plan to ensure oversight and processing of benefit reduction cases. |
| **RO Response:** | Concur. The attached plan was adopted by the VA Regional Office on September 19, 2014, and is being incorporated into the White River Junction Workload Management Plan. VBA requests closure of this recommendation. |

# Appendix D OIG Contact and Staff Acknowledgments

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| OIG Contact | For more information about this report, please contact the Office of Inspector General at (202) 461-4720. |
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