

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



**Inspection of
VA Regional Office
Salt Lake City, Utah**

**October 8, 2014
14-01688-303**

ACRONYMS

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

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
Email: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)



Report Highlights: Inspection of VA Regional Office Salt Lake City, UT

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 Salt Lake City 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. We conducted onsite work at the VARO in April 2014.

What We Found

Overall, VARO staff did not accurately process 15 of 68 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. Of the three types of disability claims reviewed, we found VARO staff should improve processing actions related to temporary 100 percent disability evaluations. In our 2014 inspection, 12 of the 30 temporary 100 percent disability evaluations were inaccurate, primarily because staff delayed ordering medical reexaminations on average for 5 months after receiving reminder notifications. Comparatively, 16 of the 30 cases reviewed during our 2011 benefits inspection contained errors. Most of the errors from our 2011 inspection occurred when VARO staff did not enter suspense diaries in the electronic record.

Generally, VARO staff processed traumatic brain injury claims correctly—a significant improvement from the 40 percent inaccuracy rate identified during our 2011 inspection. However, two of the eight Special Monthly

Compensation (SMC) and ancillary benefits claims completed by VARO staff during calendar year 2013 contained errors. The errors were unrelated and did not constitute a systemic processing weakness.

For two consecutive benefits inspections, VARO managers ensured Systematic Analyses of Operations were complete and timely. However, staff delayed completing 4 of 30 rating reduction claims because management prioritized other rating-related work.

What We Recommended

We recommended the VARO Director implement plans needed to ensure timely action on reminder notifications for medical reexaminations and take appropriate action on the 135 temporary 100 percent disability evaluations remaining from our inspection universe. The Director should also develop a plan to prioritize actions on benefits reductions to minimize improper payments to veterans and ensure the VARO's timeliness standards for processing benefits reduction cases are consistent with VBA policy.

Agency Comments

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

Handwritten signature of Linda A. Halliday in blue ink.

LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

TABLE OF CONTENTS

Introduction.....	1
Results and Recommendations	2
I. Disability Claims Processing	2
Finding 1 Salt Lake City VARO Needs To Improve Disability Claims Processing Accuracy.....	2
Recommendations.....	8
II. Management Controls.....	10
Finding 2 VARO Lacked Oversight To Ensure Immediate Action on Benefits Reductions.....	11
Recommendations.....	12
Appendix A VARO Profile and Scope of Inspection.....	13
Appendix B Inspection Summary	15
Appendix C VARO Director’s Comments.....	16
Appendix D OIG Contact and Staff Acknowledgments	18
Appendix E Report Distribution	19

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 Salt Lake City 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 Salt Lake City VARO Needs To Improve Disability Claims Processing Accuracy

The Salt Lake City VARO did not consistently process temporary 100 percent disability evaluations or entitlement to SMC and ancillary benefits. Overall, VARO staff incorrectly processed 15 of the total 68 disability claims we sampled, resulting in 134 improper monthly payments to 5 veterans totaling approximately \$242,592.

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 Salt Lake City VARO.

Table 1. Salt Lake City 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	9	12
TBI Claims	30	0	1	1
SMC and Ancillary Benefits	8	2	0	2
Total	68	5	10	15

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 12 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.

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 12 processing errors we identified affected benefits and resulted in 54 improper monthly payments to 3 veterans totaling \$31,413. These improper payments occurred from September 2009 until April 2014. Details on the 3 cases with errors affecting veterans' benefits follow.

- In two cases, VARO staff did not timely reduce benefits after receiving medical evidence that showed the veterans' conditions no longer supported the temporary 100 percent disability evaluations. As a result, one veteran was overpaid approximately \$16,531 over a period of 7 months; the other veteran was overpaid approximately \$10,902 over a period of 6 months.
- In the third case, a Rating Veterans Service Representative (RVSR) did not establish the correct effective date for entitlement to special monthly compensation benefits. Consequently, the veteran was underpaid \$3,980 over a period of 3 years and 5 months.

Following are details on the nine errors with the potential to affect veterans' benefits.

- Four of the errors with the potential to affect veterans' benefits occurred when VARO staff delayed scheduling required VA examinations despite receiving reminder notifications that the examinations were due. Summaries of the four cases follow.
 - Because staff delayed scheduling medical reexaminations, two of the cases we sampled lacked the required medical examination reports needed to determine if the temporary 100 percent disability evaluations should continue.

- In two other cases, VARO staff delayed scheduling required medical examinations; however, the errors did not affect the veterans' overall disability evaluations at the time of our inspection in April 2014.
- An error occurred in one of the cases when an RVSR established an incorrect date for a future medical examination for a veteran's prostate cancer. In this case, the RVSR inadvertently extended the date of the examination 5 years in the future. Generally, 18 months is the longest period a temporary 100 percent disability evaluation would remain in effect before a reexamination would be required.
- In another case, an RVSR incorrectly proposed to reduce a temporary 100 percent evaluation despite medical evidence that showed continued treatment for cancer. The medical evidence continued to support the veterans' 100 percent disability evaluation. Because we alerted VARO staff to the error before the reduction took place, the error did not affect the veteran's current benefits.
- One error occurred when an RVSR did not establish a future examination for the veteran's prostate cancer, nor did the RVSR indicate the veteran's disability was permanent. Without controls in place, reminder notifications to schedule medical reexaminations do not generate in the electronic record. In such cases, the temporary 100 percent disability evaluations continue to be paid at the existing rate unless some other action brings those cases into question.
- VARO staff did not take timely action to reduce benefits after notifying the veteran of the intent to do so in October 2013. The expiration of the due process period had not elapsed, so the reduction in benefits was set to take place in the future. As such, we could not calculate the amount of the improper payments resulting from the delay at the time of our inspection.
- In the final case, an error occurred when an RVSR incorrectly granted service connection for a voiding dysfunction secondary to prostate cancer; however, the veteran's cancer was still active and evaluated as 100 percent disabling. According to VBA policy, RVSRs are required to evaluate residual disabilities, such as a voiding dysfunction, unless the cancer is active or has metastasized.

Most frequently, the processing inaccuracies resulted from inadequate oversight to ensure staff took timely action to schedule medical reexaminations after receiving reminder notifications to do so. According to VBA policy, VARO staff have 30 days to process a reminder notification by establishing an appropriate control to initiate action. In the cases we reviewed, processing delays averaged about 5 months from the time the reminder notifications generated until staff took action to order the required medical reexaminations, or April 2014—the month our inspection began. Interviews with VARO staff and management revealed other claims processing activities had higher priority.

VARO management stated it focused on priorities directed by Western Area; however, the instructions did not include taking timely action to schedule medical reexaminations after receiving reminder notifications.

Generally, VARO management disagreed with our assessments regarding 7 of the 12 errors we identified. Management considered these cases workload issues rather than errors, and pointed out that they had no monetary impact on veterans. We disagreed with the VARO's position in these seven cases, concluding that staff did not process the claims according to VBA policy. 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.

*Follow-Up to
Prior VA OIG
Inspection*

In our previous inspection report, *Inspection of the VA Regional Office, Salt Lake City, Utah* (Report No. 10-03880-142, April 13, 2011), VARO staff incorrectly processed 16 of 30 temporary 100 percent disability evaluations we reviewed. The majority of the errors resulted from staff not establishing suspense diaries in the electronic record.

The Salt Lake City VARO Director (the Director) concurred with our recommendations and indicated that management had reviewed all temporary 100 percent disability evaluation decisions processed at the VARO since February 2007. Staff also reviewed the 55 cases remaining from our prior inspection universe and determined 30 of the cases required medical reexaminations as a basis for deciding whether to continue the veterans' 100 percent disability evaluation. Management provided staff with guidance and procedures on entering suspense diaries in the electronic record to prompt scheduling the reexaminations. During our April 2014 inspection, we did not identify any errors where VARO staff did not enter suspense diaries in the electronic system. As such, we concluded the VARO's actions to address recommendations in this regard were effective.

During our 2011 inspection, we also identified 390 reminder notifications for medical reexaminations that staff had not processed. The delays occurred because supervisory staff misinterpreted the requirements for scheduling the examinations and erroneously instructed staff to discontinue reviewing the reminder notifications. In response to our recommendations, the Director required staff to review and take appropriate actions on the pending reminder notifications. VARO staff updated the workload management plan to establish the frequency for staff to conduct the reviews, as well to designate responsibility for this workload. During our April 2014 inspection, we identified four cases where staff delayed taking actions to process reminder notifications. However, VARO managers attributed those delays to inadequate staffing and competing priorities rather than erroneous instructions from supervisors advising staff not to review the notifications.

In an August 2013 Internal Controls Systematic Analysis of Operations (SAO), the VARO self-identified that the non-rating team was not adequately staffed to manage its workload, which included taking actions on pending reminder notifications. Therefore, in December 2013, VARO managers assigned two additional team members with responsibility for processing reminder notifications. Consequently, by March 2014, the VARO's average time pending for reminder notifications to order reexaminations was 37 days—exceeding VBA's 30-day processing requirement by 7 days. Although the VARO has shown some improvement in processing reminder notifications, further improvement is needed to ensure staff actually enter the reexamination requests in the electronic record. Without them, VA health care facilities cannot know to schedule the reexaminations.

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 30 TBI claims. In this case, an RVSR assigned a 40 percent evaluation for a TBI-residual disability. Objective evidence provided in the TBI examination report showed symptoms supporting a noncompensable or zero percent evaluation instead. Since the veteran's combined disability evaluations was 100 percent, the error did not affect monthly benefits. However, if left uncorrected, the error could affect future claims for benefits.

Because we identified no errors among the remaining 29 cases reviewed, we determined the VARO generally followed VBA policy in processing TBI 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, Salt, Lake City, Utah* (Report No. 10-03880-142, April 13, 2011), 12 of the 30 TBI claims reviewed contained processing errors. Generally, errors associated with TBI claims processing occurred because RVSRs used VA medical examinations

that were insufficient for decision-making purposes. In response to our recommendations for improvement, the Director agreed to ensure RVSRs received additional training related to processing TBI claims. In January 2012, the OIG closed this recommendation.

Given that we identified only one error in TBI claims processing during our April 2014 inspection, we concluded the corrective action taken in response to our 2011 VARO inspection report was 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 the activities of daily life, 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 special monthly compensation. Examples of ancillary benefits are:

- Dependents’ Educational Assistance under Chapter 35 title 38, United States Code
- Specially Adapted Housing Grant
- Special Home Adaptation Grant
- Automobile and Other Conveyance and Adaptive Equipment Allowance

VBA policy requires staff to address the issues of SMC and ancillary benefits whenever they can grant entitlement to these benefits. We 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 2 of 8 veterans' claims involving SMC and related ancillary benefits. Both errors affected veterans' benefits and resulted in 80 improper monthly payments totaling approximately \$211,179 from October 2007 to April 2014. Following are details on the two errors affecting veterans' benefits payments.

- In the first case, an RVSR incorrectly granted SMC at a rate for increased aid and attendance when the veteran did not meet VBA's evaluation requirements for this grant. VBA regulations require that a veteran have, in addition to other service-connected disabilities, an additional single disability rated at 100 percent to warrant SMC at the level in this case. As a result of the error, the veteran was overpaid approximately \$208,893 since 2007. VARO management agreed with our assessment that the veteran was not entitled to the monetary benefits that VA had paid since 2007. However, management did not believe this was an error because the error occurred on a prior rating decision.
- In the remaining case, an RVSR used an incorrect date to grant SMC for blindness with an additional 100 percent evaluation for renal failure requiring dialysis. The RVSR used the date VA received the veteran's claim; however, the VA exam report and medical records showed the veteran began dialysis nearly 6 weeks earlier. VA regulations require RVSRs to use the earliest possible date for increasing benefits. Because the date used to pay the additional benefits was incorrect, the veteran was underpaid approximately \$2,286 over a 2-month period. VARO management concurred with this error.

The two errors did not constitute a common processing weakness at the Salt Lake City VARO. As such, we made no recommendation for improvement in this area.

Recommendations

1. We recommended the Salt Lake City VA Regional Office Director develop and implement a plan to ensure staff take timely and appropriate action on reminder notifications for medical reexaminations.
2. We recommended the Salt Lake City VA Regional Office Director develop and implement a plan to review for accuracy the 135 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

***Management
Comments***

The VARO Director concurred with our recommendations. According to the Director, as of September 24, 2014, the Salt Lake City VARO did not have any reminder notifications for medical examinations pending. VARO staff responsible for processing temporary 100 percent disability evaluations are expected to receive additional training by October 31, 2014. Further, staff also completed a review of the 135 temporary 100 percent disability evaluations remaining from our inspection universe.

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 staff completed all 11 mandated SAOs timely according to the SAO schedule. All SAOs contained the required elements, included thorough analyses using appropriate data, identified weaknesses or concerns, and provided recommendations for improvement when needed.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Salt Lake City, Utah* (Report No. 10-03880-142, April 13, 2011), we determined VARO staff generally complied with VBA policy when completing SAOs. Since our April 2014 benefits inspection disclosed no issues regarding complete and timely submission of SAOs, 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 to which a veteran is entitled may change because his or her service-connected disability may improve. Improper payments associated with benefits reductions generally occur when beneficiaries receive payments to which they are not entitled because VAROs do not take the actions required to ensure correct payments for their levels of disability.

When the VARO obtains evidence that a lower disability evaluation would result in 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 must make a final determination to reduce or discontinue the benefit. On the 65th day following due process notification, action is required to reduce the evaluation and thereby minimize overpayments.

On April 3, 2014, VBA leadership modified its policy regarding the processing of claims requiring benefits reductions. The new policy no longer

includes the requirement for VARO staff to take “immediate action” to process these reductions. In lieu of merely removing the vague standard, VBA should have provided clearer guidance on prioritizing this work to ensure sound financial stewardship of these monetary benefits.

Finding 2 VARO Lacked Oversight To Ensure Immediate Action on Benefits Reductions

VARO staff delayed processing 4 of the 30 claims involving decisions to reduce or discontinue benefits. Generally, delays in processing benefits reductions occurred because VARO managers did not provide oversight to ensure staff processed these cases timely. As a result, VA made 15 improper payments to 4 veterans from April 2013 to March 2014 totaling approximately \$3,574.

The most significant improper payment occurred when staff proposed reducing a veteran’s benefits after medical evidence showed the medical condition had improved. In June 2013, VARO staff proposed reducing the veteran’s evaluation from 50 percent disabling to 20 percent. However, the final action to reduce benefits did not occur until December 2013—3 months beyond the date staff should have taken the action. As a result, the veteran received approximately \$1,392 in improper payments.

The four cases showed processing delays ranging from 1 month to 9 months. An average of 4 months elapsed before staff took the required actions. These processing delays occurred because the VARO did not place priority on this workload. VARO managers and staff told us a national initiative directed that they process the VARO’s oldest rating-related pending claims rather than rating reduction claims. Additionally, we examined the VARO’s local workload management plan and found the local timeliness standards associated with rating reductions to be out of line with the national timeliness standards. Specifically, the local workload management plan established a 110-day goal for the non-rating workload including benefits reductions, exceeding VBA’s established goal for this type of work by 35 days.

VARO management disagreed with our assessments in the four cases we identified as having processing delays. The VSC manager acknowledged the VARO’s responsibility to take timely action on rating decisions involving benefits reduction; however, he regarded the four cases we identified as workload management issues that are neither errors nor procedural deficiencies.

Recommendations

3. We recommended the Salt Lake City VA Regional Office Director implement a plan to ensure claims processing staff prioritize actions related to benefits reductions to minimize improper payments to veterans.
4. We recommended the Salt Lake City VA Regional Office Director amend the local workload management plan to ensure timeliness standards for processing benefits reduction workloads consistent with Veterans Benefits Administration policy.

Management Comments

The VARO Director concurred with our recommendations. The Director updated the VARO's workload management plan and operating procedures to specify supervisory staff and VSRs are responsible for identifying and routing benefits reduction cases for action. The workload management plan also includes an inventory target for this workload that is in line with VBA policy and agency goals. Further, the Director increased the staffing levels for the non-rating team—the team responsible for processing this workload.

OIG Response

The Director's comments and actions are responsive to the recommendations.

Appendix A VARO Profile and Scope of Inspection

Organization The Salt Lake City VARO administers a variety of services and benefits, including disability compensation; vocational rehabilitation and employment assistance; benefits counseling; and outreach to former prisoners of war, homeless, elderly, minorities, and women. The Salt Lake City VARO also has a National Call Center and a Benefits Delivery at Discharge program.

Resources As of March 2014, VBA reported the Salt Lake City VARO had a staffing level of 525 full-time employees. Of this total, the VSC had 135 employees assigned.

Workload As of March 2014, the VARO reported 11,679 pending compensation claims. On average, claims were pending 161.4 days—46.4 days more than the VBA’s FY 2014 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 services to veterans. In April 2014, we evaluated the Salt Lake City 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 indicators of fraudulent claims processing.

Our review included 30 (18 percent) of 165 temporary 100 percent disability evaluations selected from VBA’s Corporate Database. These claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of March 12, 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 135 claims remaining from our universe of 165 for its review. We reviewed 30 (21 percent) of 143 disability claims related to TBI that the VARO completed from October through December 2013. We examined 8 of the total 14 veterans’ claims involving entitlement to SMC ancillary benefits VARO staff completed from January through December 2013. Five of these cases were processed at other offices and one was outside the scope of our review.

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

Additionally, we examined 30 (25 percent) of 118 completed claims 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 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 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 98 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI, SMC and ancillary benefits, and completed claims related to benefits reductions.

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

As reported by VBA's Systemic Technical Accuracy Review program as of March 2014, the overall claims-based accuracy of the VARO's compensation rating-related decisions was 92.1 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. Salt Lake City 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
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)), (<i>Compensation & Pension Service Bulletin</i> , 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, VA Regional Office Salt Lake City, Utah
Subj: Inspection of the VA Regional Office, Salt Lake City, Utah
To: Assistant Inspector General for Audits and Evaluations (52)

1. The Salt Lake City VARO's comments are attached on the OIG Draft Report: Inspection of the VA Regional Office, Salt Lake City, Utah.
2. Please refer questions to Kimberly J. Albers, (801) 326-2332.

(original signed by:)

Jon Skelly
Director

Attachment

Salt Lake City (341)

September 24, 2014

OIG Recommendations:

Recommendation 1: *We recommended the Salt Lake City VA Regional Office Director develop and implement a plan to ensure staff take timely and appropriate action on reminder notifications for medical reexaminations*

Salt Lake City VARO Response: Concur

The Salt Lake City Regional Office (RO) will conduct additional training on 100 percent disability evaluations by October 31, 2014, for the staff that process these claims. The Salt Lake City RO will continue to process the end product 684s in response to VA Central Office's policy of notifying stations when future diary date has not been established. As of September 24, 2014, there are no write outs pending for future medical examinations.

Recommendation 2: *We recommended the Salt Lake City VA Regional Office Director develop and implement a plan to review for accuracy the 135 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.*

Salt Lake City VARO Response: Concur

The Salt Lake City RO completed the review of the remaining 135 temporary 100 percent disability evaluations on June 16, 2014.

Recommendation 3: *We recommended the Salt Lake City VA Regional Office Director implement a plan to ensure claims processing staff prioritize actions related to benefits reductions to minimize improper payments to veterans.*

Salt Lake City VARO Response: Concur

The Salt Lake City RO is following national workload directives and priorities on reducing the backlog. The Salt Lake City RO has updated appropriate Veterans Service Center SOPs and the Workload Management Plan to specify that Supervisors and VSRs are responsible for ensuring maturing EP 600s are identified and routed for action. Additionally, the Salt Lake City RO increased its staffing levels of the Non-Rating Team, which is responsible for processing these claims.

Recommendation 4: *We recommended the Salt Lake City VA Regional Office Director amend the local workload management plan to ensure timeliness standards for processing benefits reduction workloads consistent with Veterans Benefits Administration policy.*

Salt Lake City VARO Response: Concur

The Salt Lake City RO non-rating inventory is currently below its FY 2014 target established by the Veterans Benefits Administration (VBA). The FY 2014 target for pending write-out inventory for the Salt Lake City RO is 4,466; as of the end of August 2014, the pending inventory for this workload in Salt Lake City was 1,629. The Salt Lake City RO modified the Workload Management Plan to include its inventory target for these claims to ensure consistency with VBA policies and agency goal.

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 Robert Campbell Kyle Flannery Lee Giesbrecht Ambreen Husain Suzanne Love Michelle Santos-Rodriguez Lisa Van Haeren Nelvy Viguera Butler
-----------------	---

Appendix E Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Assistant Secretaries
Office of General Counsel
Veterans Benefits Administration Western Area Director
VA Regional Office Salt Lake City Director

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans
Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans
Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Orrin Hatch, Mike Lee
U.S. House of Representatives: Rob Bishop, Jason Chaffetz, Jim Matheson,
Chris Stewart

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