VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Portland, Oregon

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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
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of VA Regional Office Portland, OR

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 Portland 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 April to May 2014.

What We Found

Overall, VARO staff did not accurately process 24 (29 percent) of 84 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, 10 of 30 temporary 100 percent disability evaluations we reviewed were inaccurate, generally because management did not prioritize processing of such cases requiring reduced evaluations. VARO staff incorrectly processed 3 of 30 traumatic brain injury claims; however, these inaccuracies did not constitute a systemic issue. VARO staff also incorrectly processed 11 of 24 special monthly compensation (SMC) claims due to a lack of training and no second-level review policy.

All 11 Systematic Analyses of Operations (SAOs) were incomplete because management did not provide adequate oversight to ensure staff completed the SAOs correctly. VARO staff did not timely process 10 of 30 proposed benefits reduction cases that averaged 5-month delays and resulted in overpayment of benefits to veterans. The processing delays occurred because management did not provide oversight and prioritize this workload.

What We Recommended

We recommended the VARO Director develop and implement a plan to ensure staff timely process temporary 100 percent disability evaluation cases requiring reductions, and review the 364 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action. The Director should assess the effectiveness of SMC training, ensure SAOs are complete, and implement a plan to ensure management oversight and prioritization of benefits reduction cases. We recommended the Under Secretary for Benefits implement a national plan for an additional level of review of SMC and ancillary benefits claims.

Agency Comments

The Under Secretary for Benefits and the Director of the Portland 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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TABLE OF CONTENTS

INTRODUCTION

Objective

The Benefits Inspection Program is part of the Office of Inspector General's (OIG) efforts to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Divisions contribute to improved management of benefits processing activities and veterans' services by conducting onsite inspections at VA Regional Offices (VAROs). These independent inspections provide recurring oversight focused on disability compensation claims processing and 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 Under Secretary for Benefits comments on a draft of this report.
- Appendix D provides the Portland 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 Portland VARO Needs To Improve Disability Claims Processing Accuracy

The Portland VARO did not consistently process temporary 100 percent disability evaluations, TBI-related cases, or entitlements to SMC and ancillary 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 24 of the total 84 disability claims we sampled, resulting in 287 improper monthly payments to 15 veterans totaling approximately $306,833. The following table reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Portland VARO.

Table 1. Portland 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	9	1	10
TBI Claims	30	0	3	3
SMC and Ancillary Benefits	24	6	5	11
Total	**84**	**15**	**9**	**24**

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 10 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. 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. Available medical evidence showed 9 of the 10 processing errors we identified affected benefits and resulted in 62 improper monthly payments to 9 veterans totaling approximately $132,649 in overpayments. These improper payments occurred from June 2013 to April 2014. Following are descriptions of these errors identified during our review in April to May 2014.

- On January 24, 2013, VSC staff proposed reducing a veteran's temporary 100 percent evaluation for bladder cancer. At the time of our review, VSC staff had not reduced the evaluation and the veteran continued to receive monthly benefits at the 100 percent disability rate. As a result, VA overpaid the veteran about $25,461 spanning a period of 10 months.
- VSC staff proposed reducing a veteran's temporary 100 percent evaluation for prostate cancer on January 28, 2013. VSC staff had not reduced the evaluation and the veteran continued receiving monthly benefits at the 100 percent disability rate. As a result, VA overpaid the veteran approximately $20,358 over a period of 9 months.
- VSC staff proposed a reduction in a veteran's temporary 100 percent evaluation for prostate cancer on April 26, 2013. VSC staff had not

reduced the evaluation and the veteran continued receiving monthly benefits at the 100 percent disability rate. As a result, VA overpaid the veteran about $19,189 spanning a period of 7 months.

- Although VSC staff proposed reducing a veteran's temporary 100 percent evaluation for prostate cancer on January 29, 2013, staff had not reduced the evaluation at the time of our review. As a result, the veteran continued receiving monthly benefits at the 100 percent disability rate and VA overpaid the veteran approximately $18,888 for a period of 9 months.
- VSC staff had not taken action to reduce a temporary 100 percent evaluation for prostate cancer as proposed on March 15, 2013. The veteran continued receiving monthly benefits at the 100 percent disability rate. As a result, VA overpaid the veteran approximately $13,291 spanning a period of 8 months.
- VSC staff received notice of a veteran's hospitalization on October 9, 2012, for prostate cancer but did not establish a suspense diary in the electronic record. As such, staff removed the possibility of receiving reminder notifications to schedule a medical reexamination. As a result, VA overpaid the veteran about $12,278 over a period of 6 months.
- On July 23, 2013, VSC staff proposed reducing a veteran's temporary 100 percent evaluation for prostate cancer. VSC staff had not reduced the evaluation, and the veteran continued receiving monthly benefits at the 100 percent disability rate. As a result, VA overpaid the veteran approximately $10,503 for a period of 4 months.
- Although VSC staff proposed reducing a veteran's temporary 100 percent evaluation for prostate cancer on April 5, 2013, the evaluation had not been reduced and the veteran continued receiving monthly benefits at the 100 percent disability rate. As a result, VA overpaid the veteran approximately $9,270 spanning a period of 7 months.
- On September 9, 2013, VSC staff proposed to reduce a veteran's temporary 100 percent evaluation for prostate cancer. VSC staff had not reduced the evaluation at the time of our April to May 2014 review, and the veteran continued to receive monthly benefits at the 100 percent disability rate. As a result, VA overpaid the veteran approximately $3,411 spanning a period of 2 months.

The remaining case had the potential to affect a veteran's benefits. On April 2, 2014, VSC staff received a timely request from the veteran for a personal hearing in response to a proposed benefits reduction. At the time of our inspection later that month, staff had not scheduled a hearing because this work was not considered a priority. As a result, the veteran was still waiting for the opportunity to provide evidence to refute the proposed

benefits reduction. Until VARO staff conduct the requested hearing, no action can be taken to reevaluate the claim, and monthly benefits will continue to be paid at the 100 percent disability rate.

Generally, processing inaccuracies occurred because VARO management addressed other priorities instead of temporary 100 percent disability claims that required reduced evaluations. Delays ranged from 2 months to 10 months. An average of 7 months elapsed from the time staff should have reduced the temporary 100 percent disability evaluations until April 2014. The VSC manager stated that instead of processing these temporary 100 percent disability claims, VARO focus was on processing other workloads that VBA tracks and measures for timeliness. As a result, veterans may receive benefits payments in excess of the amounts warranted for their levels of disability. We provided VARO management with 364 claims remaining from our universe of 394 for its review to determine if action is required.

VARO management did not concur with the errors we identified. Management responded:

> *Although this Regional Office understands its responsibilities to take actions to reduce benefits when appropriate, our inability to execute these in a timely manner is a workload issue, and not a quality error that would be cited by Compensation Service's Quality Assurance staff.*

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.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Portland, Oregon* (Report No. 11-00070-93, February 22, 2011), we reported VARO staff incorrectly processed 16 of 30 temporary 100 percent disability evaluations we reviewed. The most frequent processing errors occurred because staff did not enter suspense diaries in the electronic system to ensure they received reminder notifications to schedule medical reexaminations to support the evaluations. VARO management did not provide oversight to ensure VSC staff entered the suspense diaries. The Director concurred with our recommendation to review the 183 temporary 100 percent evaluations remaining from our inspection universe. Also, the Director stated the VARO would implement a procedure to require a review of all confirmed and continued temporary 100 percent evaluations to ensure staff properly

recorded future medical examinations dates in the electronic record. The OIG closed the recommendations on August 9, 2011.

During our inspection in April to May 2014, we identified one case where VSC staff delayed scheduling a future medical reexamination; however, we identified no cases where staff did not input 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 and we recognize the improvement realized in the management of these claims.

TBI Claims

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

In response to a recommendation in our annual report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-167, May 18, 2011), VBA agreed to develop and implement a strategy for ensuring the accuracy of TBI claims decisions. In May 2011, VBA provided guidance to VARO Directors to implement a policy requiring a second signature on each TBI case an Rating Veterans Service Representative (RVSR) evaluates until the RVSR demonstrates 90 percent accuracy in TBI claims processing. The policy indicates second-signature reviewers come from the same pool of staff as those used to conduct local station quality reviews.

We determined VARO staff incorrectly processed 3 of 30 TBI claims—all 3 inaccuracies had the potential to affect veterans' benefits.

Following are descriptions of these errors.

- An RVSR granted service connection for headaches secondary to a TBI that a veteran sustained in service, but denied service connection for the claimed TBI. VBA policy requires that service connection for a primary condition be established prior to assigning any other disabilities shown to be due to that condition. Because of the veteran's multiple service-connected disabilities, this inaccuracy did not affect the veteran's monthly benefits. However, it could potentially affect future benefits if the veteran's other service-connected disabilities worsen or if service connection is granted for a new disability.
- VARO staff prematurely denied TBI without providing a veteran adequate notice under the Veterans Claims Assistance Act. On

November 26, 2013, staff informed the veteran that she had 30 days to submit additional evidence. However, the decision was made on December 7, 2013, prior to expiration of the 30-day period.

- An RVSR incorrectly assigned a 10 percent evaluation for a veteran's TBI based on memory loss. However, the medical examiner associated the memory loss with the veteran's mental condition. In addition, VARO staff did not schedule the veteran for a separate examination for his residual headaches as VBA policy required. Because of the veteran's multiple service-connected disabilities, this error did not affect the veteran's monthly benefits. However, it has the potential to affect future benefits if the veteran's other service-connected disabilities worsen or if service connection is granted for a new disability.

The three TBI claims processing inaccuracies identified within our selected sample were unique and did not constitute a common trend, pattern, or systemic issue. As such, 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, Portland, Oregon* (Report No. 11-00070-93, February 22, 2011), we reported VARO staff incorrectly processed 7 of 30 TBI claims we reviewed. The most frequent processing errors occurred due to staff misinterpreting VBA policy and using insufficient medical examinations to evaluate TBI-related residuals. In response to our recommendations, the VARO Director agreed to provide training on how to identify and return insufficient medical examinations. The OIG closed these recommendations based on a review of the training documents that were submitted by the VARO.

During our inspection in April to May 2014, we found one error in TBI-related claims where staff used an insufficient medical examination. As such, we determined the VARO's actions in response to our previous recommendations appeared to be effective, and we made no further recommendation 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, the inability to naturally control bowel and bladder functions, 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 examined 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 11 of 24 claims involving SMC and ancillary benefits—6 of the 11 affected veterans' benefits. The errors resulted in underpayments totaling approximately $101,567 and overpayments totaling approximately $72,617, representing 225 improper monthly payments from June 1999 to April 2014. Following are descriptions of these errors.

- An RVSR did not grant a higher level of SMC for a veteran's additional permanent disability independently evaluated at 50 percent disabling for loss of use of both legs preventing natural knee action, as required by VBA policy. As a result, the veteran was underpaid approximately $50,095 from June 1999 to May 2013 spanning a period of 167 months. Further, the RVSR incorrectly assigned a higher level of SMC requiring two separate 100 percent disability evaluations, which the veteran did not have at the time of our review. As a result, VA overpaid the veteran approximately $31,997 from May 2013 to April 2014 spanning a period of 11 months.
- An incorrect effective date was continued for a veteran's entitlement to SMC for aid and attendance for loss of use of both legs, along with a total

loss of control of bowel and bladder functions. Further, the RVSR assigned an incorrect effective date for the grant of SMC at the highest level. As a result, VA underpaid the veteran approximately $44,380 over a period of 14 months.

- In one case, an RVSR incorrectly assigned a higher level of SMC requiring two separate 100 percent disability evaluations, which a veteran did not have at the time of our review. As a result, VA overpaid the veteran approximately $32,602 for a period of 10 months.
- Although allowed by VBA policy, an RVSR did not grant a higher level of SMC for a veteran's loss of use of three extremities and an additional permanent disability independently evaluated at 50 percent disabling. Further, the RVSR assigned an incorrect effective date and the wrong SMC codes to determine the veteran's disability benefits payments. As a result, VA underpaid the veteran approximately $7,092 spanning a period of 6 months.
- An RVSR continued entitlement to SMC requiring two separate 100 percent disability evaluations, which a veteran did not have at the time of our review. The RVSR nonetheless incorrectly granted entitlement to SMC based on a higher level of care. As a result, VA overpaid the veteran about $6,260 over a period of 6 months.
- In the final case, an RVSR incorrectly assigned a higher level of SMC requiring two separate 100 percent disability evaluations, which a veteran did not have at the time of our review. As a result, VA overpaid the veteran approximately $1,759 spanning a period of 11 months.

The remaining five errors had the potential to affect veterans' benefits. Summaries of those errors follow.

- In two cases, RVSRs granted higher levels of SMC requiring two separate 100 percent disability evaluations, which the veterans did not have at the time of our review. Subsequently, the RVSRs used incorrect SMC codes to determine the veterans' disability benefits payments. Although these errors did not affect the veterans' current monthly benefits, they may affect future monthly benefits. For example, if the veterans become hospitalized at Government expense, their monthly payments would be reduced to an incorrect SMC rate.
- An RVSR did not grant the highest level of SMC, based on medical evidence and used the incorrect SMC codes to determine a veteran's disability benefits payments. Although this error did not affect the veteran's current monthly benefits, it can affect future monthly benefits. For example, if the veteran becomes hospitalized at Government expense, his monthly payment would be reduced to an incorrect SMC rate.

- An RVSR did not grant a veteran entitlement to specially adapted housing, a benefit worth up to $67,555. The RVSR also did not grant entitlement to an automobile and adaptive equipment allowance, a benefit currently worth up to $19,817. This error did not affect the veteran's monetary payments because once entitlement is granted the veteran must apply for these benefits.
- In the final case, an RVSR provisionally decided a veteran's entitlement to SMC. However, VARO staff did not ensure existing required controls were functioning as needed to track and finalize the claim. As a result, the veteran's claim had the potential to never receive a final decision with appeal rights if we had not identified it during our April to May 2014 review.

Errors related to SMC and ancillary benefits were generally due to a lack of training. VARO training records showed that staff received higher-level SMC training in January 2014. However, prior to that date, the last time staff received SMC training was in December 2011. We could not assess the adequacy of the January 2014 training because VSC staff completed the cases we reviewed before this date. Further, VBA policy allows the VSC manager the discretion to require a second-level review for SMC claims. In the 11 errors that we identified, VARO staff did not conduct second-signature reviews because VSC management did not have a second-signature review policy in place for SMC cases. RVSRs we interviewed stated that a second-signature review would increase the accuracy of these difficult and infrequent cases.

Recommendations

1. We recommended the Portland VA Regional Office Director implement a plan to ensure staff timely process rating reductions for temporary 100 percent disability evaluations.
2. We recommended the Portland VA Regional Office Director conduct a review of the 364 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.
3. We recommended the Portland VA Regional Office Director assess the effectiveness of training for special monthly compensation and ancillary benefits claims.
4. We recommended the Under Secretary for Benefits implement a national plan for an additional level of review for special monthly compensation and ancillary benefits claims.

Management Comments

The VARO Director concurred with our recommendations and is following VBA national policy to identify and assign to the VARO of jurisdiction any temporary 100 percent disability evaluation lacking a diary to ensure future action. The VARO of jurisdiction then has 125 days to resolve the cases.

Staff will begin reviewing the remaining 364 temporary 100 percent disability evaluations after September 30, 2014, and expects to complete the review of these evaluations by December 31, 2014.

The challenge in processing higher-level special monthly compensation cases is the infrequency with which RVSRs work these types of cases. On June 23, 2014, the VARO implemented a second-signature procedure for cases that involve higher-levels of special monthly compensation to allow for an additional layer of quality review and increased exposure of these rare and complex cases to RVSRs.

The Under Secretary for Benefits concurred to review their process to determine what action is most appropriate. If an additional level of review is the right policy, VBA will implement national guidance requiring an additional level of review for SMC and ancillary benefits related to SMC.

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 Portland VARO Lacked Adequate Oversight To Ensure Complete SAOs

All 11 SAOs were incomplete due to missing required elements and because recommendations lacked time frames for implementation and follow-up. The VSC manager did not provide adequate oversight to ensure staff completed SAOs in accordance with VBA policy. As a result, management did not implement corrective actions to improve VSC operations when existing and potential problems were identified. Interviews with the VSC manager revealed he was aware the SAOs were incomplete, and he acknowledged the "VSC needs to do a better job in this area." He also stated " … once the SAOs are routed to the Director's office, they are out of my control." During our inspection, VARO management informed us they were 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 is an example of an incomplete SAO. During our inspection in April to May 2014, we identified multiple instances among the proposed benefits reduction cases reviewed where VARO staff did not take timely action to reduce payments as appropriate. If the Portland VARO had completed the Claims Processing Timeliness SAO, it may have detected this problem earlier and developed recommendations to resolve it 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, Portland, Oregon* (Report No. 11-00070-93, February 22, 2011), we determined 4 of the 11 SAOs were either incomplete or were untimely submitted. Specifically, 3 of the 11 SAOs were untimely. The Director of the Portland VARO concurred with our recommendation to develop and implement a plan to ensure staff complete SAOs timely and address all required elements. The Director also established a stricter deadline schedule for completing SAOs.

The OIG closed this recommendation on August 9, 2011, after a copy of this schedule was received.

During our inspection in April to May 2014, we did not find any SAOs that were untimely submitted. We concluded the VARO's corrective actions in response to our 2011 recommendation were generally adequate. As such, we made no recommendation for improving SAO timeliness.

Recommendation

5. We recommended the Portland VA Regional Office Director implement a plan, and assess the effectiveness of the plan, to ensure adequate and continuous oversight of completing Systematic Analyses of Operations.

Management Comments

The VARO Director concurred with our recommendation and on April 24, 2014, implemented an electronic SAO routing policy. Electronically signed SAOs are now deposited into a shared network folder by management who then email the Director's Office for review. Staff forward the emails through the review process and ultimately back to management, which creates an audit trail and eliminates the possibility of lost SAO files.

Divisions are now required to transfer approved recommendations to an SAO recommendation tracking spreadsheet. Discussions regarding implementation or extensions to deadlines for addressing recommendations, now take place during biweekly meetings with the Director. The SAO master schedule and the SAO itself are updated to indicate they are completed, to include implementation of all recommendations.

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 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 Portland VARO Lacked Oversight To Ensure Prompt Action on Proposed Benefits Reductions

VARO staff delayed processing 10 of 30 cases involving benefits reductions—all 10 affected veterans' benefits. These errors occurred due to a lack of emphasis on timely processing benefits reductions. Processing delays resulted in overpayments totaling approximately $74,157, representing 49 improper monthly payments to 10 veterans from February 2013 to April 2014.

In the case with the most significant overpayment, VSC staff sent a letter to a veteran on July 6, 2012, proposing to reduce the disability evaluation for his prostate condition. In response to the letter, the veteran submitted additional medical information for this condition. The VARO requested and obtained a medical opinion on November 9, 2012, which did not justify rescinding the proposed action. However, staff did not take action to reduce the evaluation until October 17, 2013. As a result of the delay, VA overpaid the veteran approximately $22,966 spanning a period of 11 months.

The 10 cases showed processing delays ranging from 1 to 12 months. An average of 5 months elapsed from the time staff should have taken action to reduce the benefits for the 10 cases.

These processing delays occurred because VARO management did not view this workload as a priority, although the station's Workload Management Plan directed staff to review rating reduction cases weekly. Interviews with management and staff confirmed that rating reductions were not a priority as the VARO directed its attention to reducing the inventory of pending claims. In addition to not prioritizing the rating reduction cases, management did not provide oversight to ensure staff processed these cases in a timely manner. As a result of the processing delays, veterans received erroneous benefits payments.

VARO management nonconcurred with nine of the processing delays we identified, stating that:

Although this Regional Office understands its responsibilities to take actions to reduce benefits when appropriate, our inability to execute these in a timely manner is a workload issue, and not a quality error that would be cited by Compensation Service's Quality Assurance staff.

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

6. We recommended the Portland VA Regional Office Director implement a plan to ensure oversight and prioritization of benefits reduction cases.

Management Comments

The Director concurred with our recommendation and on June 4, 2014, modified the VARO's Workload Management Plan to include weekly reviews of work products within all teams.

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 Portland VARO administers a variety of services and benefits, including compensation benefits; vocational rehabilitation and employment assistance; public affairs; and outreach to homeless, elderly, minority, and women veterans.

Resources

As of April 2014, the Portland VARO reported a staffing level of 212.5 full-time employees. Of this total, the VSC had 171.2 employees assigned.

Workload

As of April 2014, VBA reported 9,768 pending compensation claims. On average, claims were pending 157 days—42 days more than the national target of 115.

Scope and Methodology

VBA has 56 VAROs and a VSC in Cheyenne, WY, that process disability claims and provide a range of service to veterans. In April to May 2014, we evaluated the Portland 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 (8 percent) of 394 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 February 28, 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 364 claims remaining from our universe of 394 for its review. We reviewed 30 (60 percent) of 50 disability claims related to TBI that the VARO completed from October through December 2013. We examined 24 (96 percent) of 25 veterans' claims available involving entitlement to SMC and related 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 consolidation, VAROs are now required to complete 11 SAOs. Therefore, we reviewed 11 SAOs related to VARO operations. Additionally, we looked at 30 (47 percent) of 64 completed claims that proposed reductions in benefits from October through December 2013.

Where we identify potential procedural inaccuracies, we provide this information to help the VARO understand the procedural improvements it can make for enhanced stewardship of financial benefits. We do not provide this information to require the VARO to adjust specific veterans' benefits. Processing any adjustments per this review is 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 any 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, VARO numbers, dates of claim, and decision dates as provided in the data received with information contained in the 114 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI claims, 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 STAR program as of April 2014, the overall claims-based accuracy of the VARO's compensation rating-related decisions was 93.7 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. Portland 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 Under Secretary for Benefits Comments

Department of Veterans Affairs

Memorandum

Date: September 19, 2014

From: Under Secretary for Benefits (20)

Subj: OIG Draft Report - Inspection of the VA Regional Office, Portland, Oregon

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

1. Attached is VBA's response to recommendation 4 for the OIG Draft Report: *Inspection of the VA Regional Office, Portland, Oregon.*
2. Questions may be referred to Christopher Denno, Program Analyst, at (202) 461-9125.

Allison A. Hickey

Attachment

Attachment

Veterans Benefits Administration (VBA)
Comments on OIG Draft Report
Inspection of the VA Regional Office Portland, Oregon

VBA provides the following comments in response to the recommendation:

Recommendation 4: We recommended the Under Secretary for Benefits implement a national plan for an additional level of review for special monthly compensation and ancillary benefits claims.

VBA Response: Concur in principle. VBA will review the process and determine what action is most appropriate. If it is determined that an additional level of review is the right policy, VBA will develop and implement national guidance requiring an additional level of review for higher levels of special monthly compensation (SMC) that will include the ancillary benefits related to SMC. Target Completion Date: December 31, 2014.

Appendix D VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: September 8, 2014

From: Director, VA Regional Office Portland, Oregon

Subj: Inspection of the VA Regional Office, Portland, Oregon

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

1. The Portland VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Portland, Oregon.*
2. Please refer questions to Kevin Kalama, (503) 412-4595.

(original signed by:)

Chris Marshall
Director

Attachment

Attachment

September 8, 2014

Portland (348)

OIG Recommendations:

Recommendation 1: *We recommended the Portland VA Regional Office Director implement a plan to ensure staff timely process rating reductions for temporary 100 percent disability evaluations.*

Portland RO Response: Concur

VBA implemented a procedure in which an EP 684 is created in Central Office for any temporary 100 percent case that lacks a future diary. The RO of jurisdiction is then assigned to resolve the EP 684 within 125 days.

Recommendation 2: *We recommended the Portland VA Regional Office Director conduct a review of the 364 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.*

Portland RO Response: Concur

We will begin our review after September 30, 2014, and expect to be completed by December 31, 2014.

Recommendation 3: *We recommended the Portland VA Regional Office Director assess the effectiveness of training for special monthly compensation and ancillary benefits claims.*

Portland RO Response: Concur

The training is adequate for its purposes. The challenge with higher-level special monthly compensation cases (which this OIG site inspection targeted), is the infrequency with which raters happen upon them. On June 23, 2014, the RO implemented a second-signature procedure for special monthly compensation cases with rating decisions at the R1 and R2 levels to allow for not only an additional layer of quality review, but increased exposure of these rare and complex cases to raters.

Recommendation 5: *We recommended the Portland VA Regional Office Director implement a plan, and assess the effectiveness of the plan, to ensure adequate and continuous oversight of completing Systematic Analyses of Operations.*

Portland RO Response: Concur

On April 24, 2014, the RO implemented an electronic SAO routing policy. Electronically signed SAOs are now deposited into a shared network folder by the Division Chiefs who then email to the Director's Office providing a hyperlink to the document for staff review and electronic signature by the Director. This email is forwarded through the review process and ultimately back to the Division, thus creating an audit trail and eliminating the possibility of lost SAO files.

Divisions are now required to transfer approved recommendations to an SAO recommendation tracking spreadsheet. Discussion of SAO recommendation implementation or deadline extension now takes place during biweekly Division Chief meetings with the Director. The SAO master schedule and the SAO document itself are updated to indicate completion upon receipt of correspondence from the Division Chief that all recommendations have been implemented.

Recommendation 6: *We recommended the Portland VA Regional Office Director implement a plan to ensure oversight and prioritization of benefits reduction cases.*

Portland RO Response: Concur

On June 4, 2014, the RO modified its Workload Management Plan to include weekly reviews of EP 600 cases within all Lanes of the Division, rather than in just the Non-Rating Lane.

Appendix E 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 Ed Akitomo Orlan Braman Bridget Byrd Vinay Chadha Michelle Elliott Scott Harris Dana Sullivan Nelvy Viguera Butler

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