VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Providence, Rhode Island

November 13, 2014
13-03221-08

ACRONYMS

FY	Fiscal Year
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAH	Specially Adapted Housing
SHA	Special Home Adaptation
SAO	Systematic Analysis of Operations
SMC	Special Monthly Compensation
TBI	Traumatic Brain Injury
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 Providence, RI

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 Providence VARO to see how well it accomplishes this mission. Claims processing that lacks compliance with VBA procedures risks paying inaccurate financial benefits. Office of Inspector General Benefits Inspectors conducted onsite work at the VARO in June 2014.

What We Found

Overall, VARO staff did not accurately process 17 (31 percent) of 55 disability claims reviewed. We sampled claims we considered at increased risk of processing rrors, thus these results do not represent the overall accuracy of disability claims processing at this VARO.

Specifically, 8 of 30 temporary 100 percent disability evaluations we reviewed were inaccurate, primarily because management did not prioritize processing of claims requiring medical reexaminations. VARO staff processed 4 of 15 traumatic brain injury (TBI) claims incorrectly, generally by over-evaluating TBI-residual disabilities. VARO staff also incorrectly processed 5 of 10 special monthly compensation (SMC) and ancillary benefits claims due to a lack of recent training.

Management did not timely submit or complete 3 of 11 Systematic Analyses of Operations (SAOs) due to inadequate oversight. VARO staff also did not correctly process 7 of 20 benefit reduction cases due to other higher workload priorities.

What We Recommended

We recommended the Providence VARO Director review the 70 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action, as well as provide oversight to ensure staff follow VBA guidance on processing reminder notifications for medical reexaminations. The Director should also ensure staff receive refresher training on proper processing of TBI and SMC and ancillary benefits claims, and implement plans to ensure effectiveness of that training. In addition, action is needed to develop and implement a plan to ensure timely completion of the SAOs and amend, implement, and monitor the Workload Management Plan to ensure benefits reduction actions are processed timely.

Agency Comments

The Director of the Providence VARO concurred with all recommendations. Management's planned actions are responsive and we will follow up as required on these 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 the performance of Veterans Service Center (VSC) operations. The objectives of the inspections are to:

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

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

Other Information

- Appendix A includes details on the VARO and the scope of our inspection.
- Appendix B outlines criteria we used to evaluate each operational activity and a summary of our inspection results.
- Appendix C provides the Providence 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 Providence VARO Could Improve Disability Claims Processing Accuracy

The Providence VARO did not consistently process temporary 100 percent disability evaluations, TBI claims, or entitlement to SMC and ancillary benefits. Overall, VARO staff incorrectly processed 17 of the total 55 disability claims we sampled, resulting in 179 improper monthly payments to 7 veterans totaling approximately $103,000, at the time of our inspection in June 2014.

We sampled claims related only to specific conditions that we considered at increased risk of processing errors. As a result, the errors identified do not represent the universe of disability claims or the overall accuracy rate at this VARO. Table 1 below reflects errors affecting, and those with the potential to affect, veterans' benefits processed at the Providence VARO.

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

Type of Claim	Claims Reviewed	Claims Inaccurately Processed: Affecting Veterans' Benefits	Claims Inaccurately Processed: Potential To Affect Veterans' Benefits	Claims Inaccurately Processed: Total
Temporary 100 Percent Disability Evaluations	30	2	6	8
TBI Claims	15	1	3	4
SMC and Ancillary Benefits	10	4	1	5
Total	**55**	**7**	**10**	**17**

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 second quarter fiscal year (FY) 2014, and SMC and ancillary benefits claims completed April 1, 2013, through March 31, 2014

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 8 of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a veteran's service-connected disability following surgery or when specific treatment is needed. At the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

For temporary 100 percent disability evaluations, VSC staff must input suspense diaries in VBA's electronic system. A suspense diary is a processing command that establishes a date when VSC staff must schedule a medical reexamination. As a suspense diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the medical reexamination.

When the VARO obtains evidence that a lower disability evaluation would result in reduced compensation payments, Rating Veterans Service Representatives (RVSRs) must inform the beneficiary of the proposed reduction in benefits. In order to provide beneficiaries due process, VBA allows 60 days for the veteran to submit additional evidence to show that compensation payments should continue at their present level. On the 65th day following due process notification, action is required to reduce the evaluation and thereby minimize overpayments.

Effective management of these temporary 100 percent disability ratings can reduce VBA's risks of paying inaccurate financial benefits and provide improved stewardship of taxpayer funds. Available medical evidence showed 2 of the 8 processing errors affected benefits and resulted in 23 improper monthly payments to 2 veterans totaling approximately $40,000. These improper monthly benefits payments ranged from May 2013 to May 2014. Details on the errors affecting benefits follow.

- An RVSR continued a temporary 100 percent disability evaluation for a veteran's prostate cancer on June 19, 2012, and noted the need for a medical reexamination in November 2012. However, VARO staff did not request the reexamination until March 2014. Medical evidence showed the veteran's treatment for prostate cancer ended May 2012 and the condition was in remission. Additionally, the RVSR granted the veteran a special monthly benefit despite medical evidence showing entitlement was not warranted. As a result, VA overpaid the veteran approximately $35,900 over a period of 12 months. Monthly benefits payments will continue at the 100 percent disability rate if no corrective action is taken.
- Similarly, an RVSR granted a temporary 100 percent disability evaluation for a veteran's prostate cancer on March 20, 2012, and noted the need for a medical reexamination in September 2012. However, staff

did not request the reexamination until March 2014. Medical evidence dated December 2012 showed the condition was in remission. As a result, VA overpaid the veteran approximately $3,700 over a period of 11 months. Monthly benefit payments will continue at the 100 percent disability rate if no corrective action is taken.

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

- In two cases, RVSRs incorrectly continued temporary 100 percent disability evaluations and requested future medical reexaminations although current medical evidence showed the veterans' conditions had become permanent. Instead, VSC staff should have noted the conditions were permanent in the electronic record and awarded entitlement to the additional benefit of Dependents' Educational Assistance as required.
- In one case, an RVSR established the need for future reexamination of a veteran's temporary 100 percent disability evaluation. However, no control was in place to ensure staff would reevaluate the case. As a result, there was increased risk that VA would overpay this veteran.
- In another case, staff received a reminder notification to request a medical reexamination for a veteran's Non-Hodgkin's lymphoma in March 2014. However, staff had not taken action to schedule the reexamination at the time of our review in June 2014. As a result, there was increased risk that VA would overpay this veteran.
- In the fifth case, an RVSR incorrectly proposed reducing a veteran's temporary 100 percent disability evaluation for prostate cancer. However, the medical evidence showed the cancer was still active and did not warrant a reduced evaluation. This action, if taken, would inappropriately reduce the benefits the veteran should receive.
- In the last case, an RVSR granted a veteran entitlement to a special monthly benefit due to prostate cancer. However, the medical evidence did not clearly show entitlement. The RVSR should have sought clarification prior to awarding the benefit.

Generally, errors occurred because VSC management did not prioritize processing temporary 100 percent disability reexaminations. Management indicated, and VSC staff confirmed the VARO placed emphasis on processing other workloads. Further, the Workload Management Plan did not list these cases as a priority. As a result, veterans may receive benefits payments in excess of their benefits entitlements. Since we reviewed 30 claims within our sample, we provided VARO management with 70 claims remaining from our universe of 100 for its review to determine if action is required.

VARO management concurred with three of the eight errors we identified. VSC staff took corrective actions on two of the five errors with which management did not concur. In addition, for three of the five non-concurrences, VARO management indicated the findings were neither errors nor procedural deficiencies and the failure to take timely action was merely a workload management issue.

We disagree. It is a VBA management responsibility to address all of its workload requirements, including the actions explained above that have the potential to entail 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 a failure to minimize overpayments.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Providence, Rhode Island* (Report No. 11-03465-58, January 3, 2012), VARO staff incorrectly processed 20 of 30 temporary 100 percent disability evaluations we reviewed. The most frequent processing errors resulted from staff not establishing suspense diaries when they processed rating decisions requiring medical reexaminations for temporary 100 percent disability evaluations. VARO management had no oversight procedure in place to ensure staff established suspense diaries as reminders of the need for reexaminations.

In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each had a future examination date entered in the electronic record. As such, we made no specific recommendation for this VARO.

During our June 2014 inspection, we identified one case where VSC staff did not input a suspense diary for a future VA medical reexamination in the electronic system. Therefore, we determined the VSC's actions in response to our previous recommendation have been effective.

TBI Claims

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

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

We determined VARO staff incorrectly processed 4 of 15 TBI claims—1 affected a veteran's benefits. In this case, an RVSR over-evaluated a veteran's TBI residual condition, providing a 10 percent evaluation for TBI that was not warranted based on available medical evidence. As a result, the veteran was overpaid approximately $2,900, over a period of 21 months from August 2012 to May 2014.

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

- An RVSR granted a 10 percent evaluation for TBI using medical examination reports containing conflicting information. Specifically, the medical examiners noted memory loss as a symptom of both TBI and a coexisting mental health condition. The RVSR should have returned the examination for clarification per VBA policy. Neither VBA nor the OIG can determine the correct evaluation for a TBI without clarification of related symptoms.
- In another case, an RVSR assigned a 10 percent evaluation for a residual disability associated with a TBI. However, objective evidence provided in the TBI examination report showed symptoms that supported a 0 percent evaluation. Although this error did not affect current monthly benefits, it could affect future payments if left uncorrected.
- In the last case, an RVSR prematurely denied a TBI claim without a VA medical examination to support the decision. Per VBA policy, VA will provide an examination if the evidence shows symptoms from a current disability, an in-service event, and a possible association between the symptoms and the event. Because the evidence showed trauma to the head area during service, VARO staff should have requested a medical examination to evaluate residuals of a TBI. VARO management did not agree with this error, stating they did not believe the veteran suffered a head injury during service. However, the veteran's current complaints, his service treatment records, and photographic evidence of the trauma provided sufficient evidence of an in-service event with current residuals to warrant a TBI medical examination. Without a VA medical examination, we cannot determine whether the veteran would have been entitled to benefits.

Two of the four TBI processing errors we identified were due to an RVSR and a Decision Review Officer over-evaluating claims by assigning 10 percent evaluations for residuals of TBI when medical evidence showed the residuals warranted no more than 0 percent evaluations. Staff we interviewed agreed the 10 percent evaluations were not appropriate and stated they had not been trained or instructed to over-evaluate TBI residuals. In addition, management concurred with these errors and stated staff try to err in favor of the veteran. As such, we determined staff assigned the higher evaluations based on what they felt was the totality of the evidence. However, the evidence did not warrant the higher evaluations. As a result, veterans did not always receive correct benefits for TBI-related claims.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Providence, Rhode Island* (Report No. 11-03465-58, January 3, 2012), we determined processing errors occurred because staff used insufficient medical examination reports to evaluate TBI claims. We recommended the VARO Director implement a plan to ensure staff return insufficient examinations to the appropriate medical facilities. The VARO Director concurred with our recommendation and indicated the VARO hosted a joint training session with VA hospital staff in September 2011, and provided additional training to VSC staff in October and November 2011. The VARO also implemented a second-signature policy for TBI decisions. The OIG closed the recommendation after receiving evidence the VARO provided TBI training information and implemented second-signature review of TBI claims. We did not identify similar errors during our June 2014 inspection. As such, we determined the VARO's actions in response to our previous recommendation appeared to be effective.

Special Monthly Compensation and Ancillary Benefits

As the concept of rating disabilities evolved, VBA realized that for certain types of disabilities, the basic rate of compensation was not sufficient for the level of disability present. Therefore, VBA established SMC to recognize the severity of certain disabilities or combinations of disabilities by adding greater compensation to the basic rate of payment. SMC represents payments for "quality of life" issues, such as the loss of an eye or limb, or the need to rely on others for daily life activities, like bathing or eating. Generally, VBA grants entitlement to SMC when the following conditions exist.

- Anatomical loss or loss of use of specific organs, sensory functions, or extremities
- Disabilities that render the veteran permanently bedridden or in need of aid and attendance
- Combinations of severe disabilities that significantly affect locomotion
- Existence of multiple, independent disabilities that are evaluated as 50 to 100 percent disabling

- Existence of multiple disabilities that render the veteran in need of such a degree of special skilled assistance that without it, the veteran would be permanently confined to a skilled-care nursing home

Ancillary benefits are secondary benefits that are considered when evaluating claims for SMC. Examples of ancillary benefits are:

- Dependents' Educational Assistance under Title 38, United States Code, Chapter 35
- Specially Adapted Housing (SAH)
- Special Home Adaptation (SHA)
- Automobile and Other Conveyance and Adaptive Equipment Allowance

VBA policy requires staff to address the issues of SMC and ancillary benefits whenever they can grant entitlement. We focused our review on whether VARO staff accurately processed entitlement to SMC and ancillary benefits associated with anatomical loss, loss of use of two or more extremities, or bilateral blindness with visual acuity of 5/200 or worse.

VARO staff incorrectly processed 5 of 10 claims involving SMC and ancillary benefits—4 affected veterans' benefits and resulted in underpayments to 4 veterans totaling approximately $60,600. These errors represented 135 improper recurring monthly payments from June 2005 until May 2014. Details on the errors affecting benefits follow.

- In three cases, veterans warranted higher levels of SMC than assigned by RVSRs. As a result, VA underpaid one veteran approximately $42,900 over a period of 107 months, the second veteran approximately $3,100 over a period of 17 months, and the third veteran approximately $1,800 over a period of 5 months.
- In the last case, an RVSR assigned a veteran an incorrect effective date and a lower level of SMC than warranted. As a result, VA underpaid the veteran approximately $12,800 over a period of 6 months.

The remaining error had the potential to affect a veteran's benefits. In this case, an RVSR erroneously granted the veteran entitlement to both SAH and SHA benefits. According to VBA policy, the veteran only warranted entitlement to SAH.

Errors related to SMC and ancillary benefits were generally due to a lack of recent training. VARO staff provided training records from 2013 and 2014, revealing most RVSRs received no training on SMC and ancillary benefits during the previous two years.

The VARO concurred with the four errors affecting veterans' benefits that we identified. VARO management did not concur with the remaining error involving entitlement to both SAH and SHA, as it felt there would be no effect to the veteran. However, if left uncorrected, there is potential for the veteran to receive payments for both benefits. Regardless, management noted VARO staff would take corrective action. During our June 2014 inspection, the VARO's quality review team also reminded staff about VBA policies for granting entitlement to these SMC and ancillary benefits.

Recommendations

1. We recommended the Providence VA Regional Office Director conduct a review of the 70 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

2. We recommended the Providence VA Regional Office Director provide oversight to ensure staff follow Veterans Benefits Administration guidance related to processing reminder notifications for medical reexaminations.

3. We recommended the Providence VA Regional Office Director ensure staff receive refresher training on proper evaluation of traumatic brain injury and special monthly compensation and ancillary benefits claims and implement plans to ensure the effectiveness of that training.

Management Comments

The VARO Director concurred with our recommendations. The Director expects staff to complete the review of all 70 temporary 100 percent disability evaluations by the end of October. Further, the VSC implemented an updated Workload Management Plan that assigns specific responsibilities to improve oversight of processing reminder notifications related to medical reexaminations.

Staff will receive training on the proper evaluation of TBI, SMC, and ancillary benefits throughout FY 2015. The Director indicated that due to the complexity of these topics, training will be offered each quarter during the upcoming fiscal year.

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 VARO Lacked Adequate Oversight To Ensure Timely SAOs

Eight of the 11 SAOs were complete and timely submitted. However, of the three remaining SAOs, the FY 2013 Appeals and Claims Processing Timeliness SAOs were submitted untimely, and the Quality of Development Activity SAO for FY 2013 was not completed. VSC management did not provide adequate oversight of staff assigned to complete SAOs. As a result, management lacked sufficient information to adequately identify existing and potential problems needing corrective actions to improve VSC operations.

Management did not ensure staff timely submitted or completed the required SAOs because of competing priorities, such as national claims processing initiatives. Additionally, previous management vacancies contributed to a lack of control over the SAO process. Although most of the SAOs contained sufficient analyses based on appropriate data and identified deficient areas, VSC management provided inadequate oversight to ensure staff completed and timely submitted all SAOs as required.

For example, the VARO did not complete the Quality of Development Activity SAO for FY 2013. If the Providence VARO had done so, it could have identified a problem we found with VARO staff not considering all evidence when deciding TBI claims. The VARO also could have developed recommendations to address this issue before we did as part of our review.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Providence, Rhode Island* (Report No. 11-003465-58, January 3, 2012), we found that 5 of 12 mandated SAOs were not completed timely, were incomplete (missing required elements), or were both untimely and incomplete. VARO management did not provide adequate oversight to ensure VSC staff completed the SAOs according to VBA policy. As a result, VARO management may not have adequately identified existing and potential

problems for corrective actions to improve VSC operations. We recommended the Providence VARO Director develop and implement a plan to ensure staff complete SAOs timely and address all required elements. The OIG closed this recommendation after the VARO submitted an updated SAO schedule and specific guidance for writing SAOs to support implementation of the recommendation.

During our June 2014 inspection, we found VARO management did not complete or timely submit 3 of 11 required SAOs because of competing priorities and management vacancies. Because of similar findings during our previous and current inspections, we determined the VARO's actions in response to our previous recommendations have not been effective.

Recommendation

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

Management Comments

The VARO Director concurred with our recommendation and implemented a standardized SAO schedule developed by VBA's Eastern Area office to ensure timely completion of SAOs. Further, VSC management will receive training on how to conduct SAOs in October 2014.

OIG Response

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

Benefits Reductions

VBA policy provides for compensation to veterans for conditions they incurred or aggravated during military service. The amount of monthly compensation to which a veteran is entitled may change because his or her service-connected disability may improve. Improper payments associated with benefits reductions generally occur when beneficiaries receive payments to which they are not entitled. Such instances are attributable to VAROs not taking the actions required to ensure correct payments for the veterans' current levels of disability.

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

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

Finding 3 VARO Lacked Oversight To Ensure Timely Action On Proposed Benefit Reductions

VARO staff delayed or incorrectly processed 7 of 20 cases involving proposed benefits reductions due to a lack of priority on timely managing this workload. Processing delays resulted in overpayments totaling approximately $16,700, representing 29 improper monthly recurring payments to 5 veterans from February 2013 to May 2014.

Processing Delays

Processing delays occurred in 5 of 20 claims that required rating decisions to reduce or discontinue benefits. An average of 6 months elapsed from the time staff should have taken action to reduce or discontinue the evaluations for these 5 cases. In the case with the most significant overpayment, VSC staff sent a letter to the veteran on May 16, 2013, proposing to reduce the evaluation for prostate cancer and SMC. The due process period expired on July 20, 2013, without the veteran providing additional evidence to support the claim. However, staff did not reduce the benefits until January 18, 2014. As a result, VA overpaid the veteran approximately $9,000 over a period of 6 months.

In the case with the most significant delay, VSC staff sent a letter to the veteran on September 14, 2012, proposing to discontinue service connection for his heart disease. The due process period expired on November 18, 2012, without the veteran providing additional information to support the claim. However, staff did not discontinue service connection until January 2, 2014, and used an incorrect effective date to reduce the veteran's benefits. Because of the delay and the incorrect payment change date, VA overpaid the veteran approximately $2,800 over a period of 15 months.

Generally, these delays occurred because VARO management did not view this workload as a priority. Because of national changes to workload management, VSC leadership did not prioritize processing benefits reductions and concentrated instead on national priorities, including processing rating claims pending over 2 years. Additionally, the VSC manager stated he put more emphasis on staff working cases that pay veterans rather than cases that take away benefits. Both management and staff confirmed a lack of emphasis on timely following through with proposed rating reductions.

Accuracy Errors

VARO staff incorrectly reduced or discontinued evaluations in 2 of 20 claims involving proposed benefits reductions. Both cases had the potential to affect veterans' future benefits payments. Following are details on the two errors.

- An RVSR incorrectly discontinued service connection for a veteran's arthritis of the spine although medical evidence supported service connection for this condition. 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 disabilities worsen or if a new service-connected disability is claimed.
- In the second case, an RVSR prematurely reduced a veteran's benefits. Staff sent a letter to a veteran on May 30, 2013, proposing reducing the evaluation for his left knee disability. On June 17, 2013, the VARO received a request for a personal hearing from the veteran in response to the proposed reduction. Then on March 27, 2014, the RVSR reduced the evaluation for the veteran's left knee disability. According to VBA policy, because the veteran requested a hearing within 30 days of the notice of the proposed reduction, payments should continue at their current rate until staff conduct the hearing with the veteran.

These two errors were unique and did not constitute errors occurring with the frequency needed to be considered systemic concerns. Therefore, we made no recommendation for improvement in this area.

VARO management concurred with one of the total seven errors we identified. Although we showed VARO management VBA criteria (Manual 21-1 Manual Rewrite, Part I.2.B.7.a) requiring action on the 65th day following due process notification, they did not concur with the 5 benefits reduction processing delays and would not acknowledge the validity of the criteria. In these cases, VARO management indicated the findings were neither errors nor procedural deficiencies and the failure to take timely action was merely a workload management issue.

We disagree. As previously stated, it is a VBA management responsibility to address all of its workload requirements, including the actions explained above that have the potential to entail 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 a failure to minimize overpayments.

Recommendation

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

Management Comments

The VARO Director concurred with our recommendation and amended the Workload Management Plan to provide for additional oversight related to benefit reductions. Further, an RVSR was assigned to the non-rating team to control timeliness in processing benefit reductions.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of May 2014, the Providence VARO reported a staffing level of 194.8 full-time employees. Of this total, the VSC had 87.4 employees assigned.

Workload

As of May 2014, VBA reported the Providence VARO had 4,011 pending compensation claims. On average, claims were pending 107.1 days—7.9 days less 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 June 2014, we evaluated the Providence 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 (30 percent) of 100 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented instances where VBA staff had granted temporary 100 percent disability evaluations for at least 18 months as of April 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 70 claims remaining from our universe of 100 for its review. We reviewed all 15 available disability claims related to TBI that the VARO completed from January 1, 2014, through March 31, 2014. We also examined all 10 veterans' claims available involving entitlement to SMC and ancillary benefits that VARO staff completed from April 1, 2013, through March 31, 2014.

Prior to VBA consolidating Fiduciary Program Activities nationally, each VARO was required to complete 12 SAOs. However, since the Fiduciary Program Activities consolidation, the VAROs are only required to complete 11 SAOs. Therefore, we reviewed all available SAOs related to VARO operations. Additionally, we looked at 20 (65 percent) of 31 completed

claims involving proposed benefits reductions from January 1, 2014, through March 31, 2014.

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

Data Reliability

We used computer-processed data from the Veterans Service Network's Operations Reports and Awards. To test for reliability, we reviewed the data to determine whether any were missing from key fields, included calculation errors, or were outside the time frame requested. We assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Further, we compared veterans' names, file numbers, Social Security numbers, dates of claim, and decision dates provided in the data received with information contained in the 75 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI claims, SMC and ancillary benefits, and completed claims involving proposed benefits reductions.

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

This report references VBA's Systematic Technical Accuracy Review data. As reported by VBA's Systematic Technical Accuracy Review program as of May 2014, the overall claims-based accuracy of the VARO's compensation rating-related decisions was 94.1 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. Providence 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)	No
Special Monthly Compensation and Ancillary Benefits	Determine whether VARO staff properly processed SMC and correctly granted entitlement to ancillary benefits. (38 CFR 3.350, 3.352, 3.807, 3.808, 3.809, 3.809a, 4.63, and 4.64) (M21-1MR IV.ii.2.H and I)	No
Management Controls		
Systematic Analysis of Operations	Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs. (M21-4, Chapter 5)	No
Proposed Benefits Reductions	Determine whether VARO staff timely and accurately processed disability evaluation reductions or terminations. (38 CFR 3.103(b)(2), 38 CFR 3.105(e), 38 CFR 3.501, M21-1MR.IV.ii.3.A.3.e, M21-1MR.I.2.B.7.a, M21-1MR.I.2.C, M21-1MR.I.ii.2.f, M21-4, Chapter 2.05(f)(4), (*Compensation & Pension Service Bulletin*, October 2010)	No

Source: VA OIG

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

Appendix C VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: October 3, 2014

From: Director, VA Regional Office Providence, Rhode Island

Subj: Inspection of the VA Regional Office, Providence, Rhode Island

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

1. The Providence VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Providence, Rhode Island.*

2. Please refer questions to Mr. Earl Hutchinson, Director, at (401) 223-3600.

(original signed by:)

Earl J. Hutchinson
Director

Attachment

Attachment

Providence VA Regional Office Response

OIG Recommendation 1: We recommended the Providence VA Regional Office Director conduct a review of the 70 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

RO Response: Concur

The Providence Regional Office has reviewed 35 of the 70 temporary 100 percent disability evaluations identified. The RO is in the process of reviewing the remaining 35 evaluations, and expects to complete the remaining reviews by October 31, 2014. The RO also receives a listing of such cases from VBA Central Office each month, ensuring appropriate action is taken in this program area.

Target Completion Date: October 31, 2014

OIG Recommendation 2: We recommended the Providence VA Regional Office Director provide oversight to ensure staff follows Veterans Benefits Administration guidance related to processing reminder notifications for medical reexaminations.

RO Response: Concur

The Providence RO implemented an updated VSC Workload Management Plan (attached) in July 2013, which assigns specific responsibilities for and creates built in oversight of this workload. By April 2014, the RO had no past due diaries or 800 series work items pertaining to medical reevaluations. Since that time, the RO has consistently maintained controls over work items that indicate reevaluation is needed.

Completed: June 30, 2014

OIG Recommendation 3: We recommended the Providence VA Regional Office Director ensure staff receive refresher training on proper evaluation of traumatic brain injury and special monthly compensation and ancillary benefits claims and implement plans to ensure the effectiveness of that training.

RO Response: Concur

Compensation Service staff provided training on the topics of special monthly compensation and ancillary benefits during a site visit to the Providence RO in April 2014. Additional training on the proper evaluation of traumatic brain injury, special monthly compensation, and ancillary benefits will be conducted throughout FY15. Due to the complexity of these topics, either refresher or advanced training on these topics will be offered each quarter. The effectiveness of the training will be monitored by local review specifically targeting these topics using In Process Reviews (IPRs) and/or through consistency studies conducted in cooperation with Quality Assurance staff.

Target Completion Date: December 31, 2014

OIG Recommendation 4: We recommended the Providence VA Regional Office Director develop and implement a plan to ensure timely completion of Systematic Analyses of Operations.

RO Response: Concur

In order to ensure tighter controls over Systematic Analyses of Operations, a standardized schedule was developed through the Eastern Area Office and has been implemented for FY15. Training on recent

changes to M21-4 and how to conduct an SAO will be provided to VSC management staff on October 10, 2014.

Completed: October 10, 2014

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

RO Response: Concur

While a Compensation Service inspection team was on station in April 2014, the VSC amended its Workload Management Plan to reflect additional oversight in this area. An RVSR was also placed on the non-rating team in April 2014, in order to better control timeliness of decisions needed with the reduction of benefits. Additional specific local guidance regarding the reduction of under- and overpayments (VSC Directive 21-14-02- Attached) was released in May 2014.

Completed: June 30, 2014

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Brent Arronte, Director Daphne Brantley Brett Byrd Scott Harris David Piña Rachel Stroup Nelvy Viguera Butler Diane Wilson

Appendix E Report Distribution

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