VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Huntington, West Virginia

Corrected Copy: Error on page 2 corrected as of January 28, 2016.

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ACRONYMS

A&A	Aid and Attendance
FY	Fiscal Year
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
SMC	Special Monthly Compensation
TBI	Traumatic Brain Injury
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 Huntington, WV

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and a Veterans Service Center in Cheyenne, WY, that process disability claims and provide a range of services to veterans. We evaluated the Huntington VARO to see how well it accomplishes this mission. Claims processing that lacks compliance with VBA procedures can result in the risk of paying inaccurate and unnecessary financial benefits. We conducted onsite work at the VARO in May 2014.

What We Found

Overall, VARO staff did not accurately process 27 (40 percent) of 68 disability claims we reviewed. We sampled claims we considered at increased risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO.

Specifically, 16 of 30 temporary 100 percent disability evaluations were inaccurate, primarily because staff delayed reducing benefits after receiving medical evidence that veterans' disabilities had improved, or delayed scheduling required reexaminations after receiving reminder notifications. In contrast, 22 of the 30 cases reviewed during our 2011 inspection contained errors, generally because VARO staff did not enter suspense diaries in the electronic record.

Staff incorrectly processed 6 of 26 TBI claims, primarily because they misinterpreted VBA policy for rating a TBI with a coexisting mental condition. By comparison, in 2011, 3 of 5 cases we reviewed contained errors due to staff misinterpreting TBI policy and inadequate quality assurance. VARO staff also incorrectly processed 5 of 12 claims related to SMC and ancillary benefits. Generally SMC errors occurred because staff did not follow local second-signature policy.

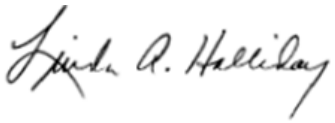
For two consecutive benefit inspections, VARO managers ensured Systematic Analyses of Operations were complete and timely. However, staff delayed completing 8 of 28 benefits reduction cases because VARO management considered other work to be a higher priority.

What We Recommended

We recommended the VARO Director develop and implement a plan to ensure staff review and take appropriate action on the 138 temporary 100 percent disability evaluations remaining from our inspection universe. The Director needs to ensure staff return insufficient medical examination reports, provide refresher training on processing TBI, and monitor training effectiveness. Further, the Director should provide training and ensure effective second-signature reviews of SMC claims, as well as develop a plan to prioritize actions on benefits reduction cases.

Agency Comments

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



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INTRODUCTION

Objective

The Benefits Inspection Program is part of the Office of Inspector General's (OIG) efforts to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Divisions contribute to improved management of benefits processing activities and veterans' services by conducting onsite inspections at VA Regional Offices (VAROs). These independent inspections provide recurring oversight focused on disability compensation claims processing and the performance of Veterans Service Center (VSC) operations. The objectives of the inspections are to:

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

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

Other Information

- Appendix A includes details on the Huntington 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 Huntington 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 effect on veterans' benefits.

Finding 1 Huntington VARO Needs To Improve Disability Claims Processing Accuracy

The Huntington VARO did not consistently process temporary 100 percent disability evaluations, TBI-related claims or entitlement to SMC and ancillary benefits. Overall, VARO staff incorrectly processed 27 of the total 68 disability claims we sampled, resulting in 201 improper payments to 16 veterans totaling $313,377, at the time of our April 2014 review.

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. The table below reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Huntington VARO.

Table 1. Huntington VARO Disability Claims Processing Accuracy for 3 High-Risk Claims Processing Areas

Type of Claim	Claims Reviewed	Claims Inaccurately Processed: Affected Veterans' Benefits	Claims Inaccurately Processed: Potential To Affect Veterans' Benefits	Claims Inaccurately Processed: Total
Temporary 100 Percent Disability Evaluations	30	9[1]	7	16
TBI Claims	26	2	4	6
SMC and Ancillary Benefits	12	5	0	5
Total	**68**	**16**	**11**	**27**

[1] Corrected figure as of January 28, 2016. Please note that the figure originally reported, "3," was a typing error and did not affect the calculated total.

Source: VA OIG analysis of the Veterans Benefits Administration's 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 16 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 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. 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 16 processing errors affected benefits and resulted in 51 improper monthly payments to 9 veterans totaling $110,855 from June 2013 to April 2014. The remaining seven errors had the potential to affect veterans' benefits. Neither we nor VARO staff could determine whether the evaluations would have continued because the veterans' claims folders did not contain the medical evidence needed to evaluate each case.

Following are descriptions of all 16 errors we identified.

- Six errors occurred when VARO staff did not take timely action to reduce benefits after notifying veterans of the intent to do so—five of the delays affected benefits. As of April 2014, an average of approximately 1 year had passed and VARO staff still had not reduced these benefits.
    - The most significant overpayment occurred when a Rating Veterans Service Representative (RVSR) delayed reducing

benefits after notifying the veteran of the intent to do so in January 2013. Available medical evidence showed the veteran's prostate cancer was no longer active and that a noncompensable evaluation was warranted. As such, the veteran's condition no longer supported a temporary 100 percent disability evaluation. In this case, the veteran continued to receive monthly payments totaling $29,908 over a period of 10 months.

- In four of the cases, delayed processing actions to reduce benefits resulted in overpayments totaling $63,749.
- In the final case, VARO staff delayed action to reduce the veteran's benefits. We are unable to calculate a monetary amount for this error as the final benefits reduction was to occur after we conducted our file review; however, this delay will result in a future monetary impact if left uncorrected.

- Six errors occurred when VARO staff delayed scheduling required VA reexaminations despite receiving reminder notifications that the reexaminations were due. An average of approximately 7 months elapsed from the time staff received the notifications until the reexaminations were scheduled. In four of the cases, the delayed scheduling resulted in overpayments totaling approximately $17,198.
- Two errors occurred when VARO staff did not take timely action to schedule hearings on proposed benefits reductions per the veterans' requests. VBA policy allows staff to extend the proposal period for a benefits reduction up to 60 days if a hearing is requested. In these two cases, the veterans requested hearings an average of about 1 year prior to our inspection, yet the hearings had not been scheduled as of April 2014.
- One error occurred when a Veterans Service Representative failed to correctly process a veteran's award and enter a future diary date in the electronic record. Consequently, a reminder notification for a required medical reexamination did not generate electronically. In this case, more than 6 years lapsed before VARO staff reviewed the veteran's claims file and took action to request the mandatory reexamination. During this period the veteran continued to receive temporary monthly benefits at the 100 percent medical disability evaluation. In this case, the VARO needs to improve its financial stewardship of taxpayer funds and ensure actions to provide benefits payments are accurately based on entitlement to those benefits.
- In the remaining case, an RVSR did not enter a date in the electronic system for a required medical reexamination to determine if a temporary 100 percent evaluation should continue for a veteran's prostate cancer. When future examination dates are omitted from the electronic record, reminder notifications alerting VARO staff to schedule examinations do not generate and the evaluations assigned continue uninterrupted.

Improved financial stewardship of taxpayer funds is also needed in the management of this claim.

The majority of the processing inaccuracies resulted from a lack of VARO management oversight to ensure staff took timely action to reduce benefits when medical evidence showed the veterans' disabilities had improved or scheduled medical reexaminations after receiving reminder notifications to do so. VARO managers and staff indicated their priority was instead on processing the oldest rating-related compensation claims. Because of the delays in processing benefits reductions and scheduling required medical reexaminations, temporary 100 percent disability evaluations continued to be paid. After concluding our review of 30 statistically-selected claims, we provided VARO management with 138 claims remaining from our universe of 168 for its review to determine if action is required.

VARO management disagreed with our assessments in all 16 of the cases we identified as errors. In its response for 14 of the 16 cases, VARO management indicated failure to take timely actions is a workload management issue, which is neither a procedural deficiency nor an error. 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.

Regarding one of the remaining two cases, VARO management disagreed because the error occurred 6 years prior; however, management did not address the cause for the error. In the last case, VARO management disagreed a reexamination was necessary because the veterans' prostate cancer was in "watchful waiting" status. However, VBA policy requires staff to request the reexamination to help determine whether to continue the veteran's temporary 100 percent disability evaluation. We found the cases noncompliant with VBA policy because VARO management did not provide adequate evidence to change our position.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Huntington, West Virginia* (Report No. 11-00522-231, July 20, 2011), VARO staff incorrectly processed 22 of 30 temporary 100 percent disability evaluations (73 percent) we reviewed. The majority of the errors occurred because staff did not enter suspense diaries in the electronic record to ensure they received reminder notifications to schedule VA medical reexaminations.

During our current May 2014 inspection, we identified only one error where staff did not enter a suspense diary in the electronic record. As such, we concluded the VARO's corrective actions in response to our 2011 inspection report were generally effective. However, we identified 14 of 16 inaccuracies involving VSC staff not following up on reminder

notifications or proposals to reduce benefits. VARO management acknowledged there was no local guidance in place on processing reminder notifications.

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 summary 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 6 of 26 TBI claims—2 affected veterans' benefits and resulted in 34 improper monthly payments totaling $18,549 from April 2012 until April 2014. Details on the errors affecting benefits follow. Both errors involved overpayments.

- The most significant overpayment occurred when a RVSR prematurely evaluated TBI residuals using an insufficient VA medical examination report. Specifically, the medical examiner did not delineate which symptoms were due to TBI and which were due to a coexisting mental condition. In cases where medical examiners cannot make such delineations, VBA policy requires that staff use the symptoms to establish a single disability evaluation. Because the RVSR did not follow the policy, the veteran was overpaid $13,528 over a period of 10 months. VARO staff did not agree that the veteran was overpaid, but did agree that a medical opinion should have been completed to clarify which symptoms were related to each disability.

- The second case affecting veterans' benefits occurred when an RVSR erroneously assigned separate evaluations for a TBI and a coexisting mental disorder, even though the medical examiners indicated the symptoms for the two conditions could not be separated. Because the RVSR did not follow VBA's policy to use the symptoms to establish a single disability evaluation, the veteran was overpaid $5,021 over a period of 2 years. VARO staff agreed the veteran was overpaid, but did

not agree with our assessment of the processing error. Instead, staff believed separate evaluations for the veteran's TBI and coexisting mental conditions were appropriate, but the TBI evaluation assigned was incorrect.

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

- In one case with the potential to impact benefits, the error occurred when an RVSR erroneously assigned separate evaluations for TBI and a coexisting mental disorder although the medical examiner indicated the symptoms for the conditions could not be separated. The RVSR did not use the symptoms to establish a single disability evaluation as required. Because the veteran had multiple service-connected disabilities, the error did not affect his overall monthly payment amount, but 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. VARO staff agreed with our assessment in this case.
- In another case with the potential to impact benefits, an RVSR continued a veteran's TBI evaluation using a VA medical examination report that included conflicting information assessing a veteran's TBI-related symptoms. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without an adequate or complete medical examination. VARO staff agreed with our assessment in this case.
- An RVSR erroneously assigned separate evaluations for TBI and a coexisting mental disorder without obtaining an opinion from the VA medical examiner on which symptoms were associated with each disability. In this case, the medical examiner did not properly complete the disability benefits questionnaire as required. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without an adequate or complete medical examination. VARO staff disagreed with our assessment in this case. Contrary to VBA policy, staff stated the medical examination report could not be rejected for not following the correct format. VARO staff also believed that since some symptoms were not reported on both the TBI and mental examinations, clarification to delineate the symptoms was not necessary.
- In the final case we identified as having the potential to impact benefits, an RVSR incorrectly evaluated a veteran's headache condition associated with TBI as 50 percent disabling. An evaluation at 50 percent level requires evidence showing very frequent, completely prostrating and prolonged attacks causing severe economic inadaptability. VA's medical examiner indicated the veteran's headache condition impacted his ability to work; however, the veteran was employed with no evidence of severe economic inadaptability to support this case. The headache condition only warranted an evaluation of 30 percent. VARO staff disagreed with our assessment, stating the 50 percent evaluation was appropriate

because the veteran worried about losing his job if his employer discovered he had a headache condition.

Generally, errors in TBI claims processing occurred because VSC staff misinterpreted VBA policy and used their own interpretations of medical examination reports to separately evaluate TBI and comorbid mental conditions. Most VARO staff interviewed said they continued to find VBA policy confusing regarding TBI claims processing. Additionally, VARO staff stated they had fulfilled VBA's second-signature requirements and no longer underwent this review process. While Quality Review Team staff tracked all errors identified in all TBI-related cases they reviewed, they did not look for trends or conduct additional training based on the errors found. VARO managers were unable to provide us with any tracking or training documentation related to TBI errors identified for the time period when they were required to fulfill these requirements. As a result of staff errors, veterans did not always receive correct benefits payments.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Huntington, West Virginia* (Report No. 11-00522-231, July 20, 2011), we identified three of five TBI processing errors attributed to incorrect staff interpretations of VBA policy and inadequate quality assurance. Specifically, RVSRs incorrectly evaluated or prematurely continued service-connected evaluations for TBI-related residuals. We recommended the Director implement a plan to monitor effectiveness of the quality review process and conduct refresher training on TBI claims processing. The Director concurred with our recommendation, provided training on proper processing of TBI claims in May 2011, and indicated he would ensure continued training so employees would understand this topic. In November 2011, the OIG closed this recommendation.

Because the results of our 2014 benefits inspection disclosed similar problems, we concluded that the corrective actions in response to our 2011 report were inadequate. Despite refresher training and implementation of a second-level review requirement for TBI claims, our current inspection still showed an unacceptable TBI claims processing error rate. The errors identified were the result of VSC staff misinterpreting VBA policy and not recognizing and returning insufficient medical examinations for clarification. Had management taken steps to ensure TBI decision-makers properly understood this topic as promised, some errors we found could have been prevented.

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 (A&A)
- 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
- Special Home Adaptation Grants
- 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, 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 12 veterans' claims involving SMC and related ancillary benefits—all of the errors affected veterans' current benefits. The errors resulted in overpayments totaling approximately $160,909 and an underpayment of approximately $3,246, representing 115 improper monthly payments paid from August 2011 until April 2014. In addition, a one-time payment of $19,817 was improperly paid for an automobile allowance. Generally, errors occurred because VARO management did not ensure staff followed the local second-signature review policy relating to higher-level SMC cases. VARO staff also stated training on SMC was inadequate. Summaries of the errors identified in processing SMC and ancillary benefits follow.

- An RVSR improperly granted a veteran service connection for dementia aggravated by a service-connected disability. Available medical records

were insufficient to support granting this benefit. Subsequently, VARO staff granted the veteran A&A based on symptoms associated with dementia. As a result, the veteran was overpaid approximately $83,074 over a period of 1 year and 7 months.

- An RVSR improperly granted SMC based on loss of use of the lower extremities, A&A, and an automobile allowance. Available medical evidence did not support entitlement to these benefits. As a result, the veteran was overpaid $17,819 over a period of 2 years and 2 months and improperly paid $19,817 to assist with purchasing an automobile.
- An RVSR improperly granted SMC based on loss of use of the lower extremities. However, available medical records did not show the veteran met VBA's criteria for loss of use of the lower extremities. As a result, the veteran was overpaid $14,326 over a period of 2 years and 3 months.
- An RVSR improperly granted A&A for a veteran's 100 percent evaluation for keratoconus and retinal degeneration. However, available medical evidence did not support the 100 percent evaluation or the need for a higher level of care. As a result, the veteran was overpaid $18,517 over a period of 1 year and 2 months.
- An RVSR improperly established an incorrect effective date for a veteran's entitlement to SMC for loss of the use of the lower extremities and entitlement to A&A. As a result, the veteran received an overpayment of $7,355 over a period of 11 months. Further, the RVSR failed to assign a higher level of SMC for an additional 50 percent disability resulting in an underpayment of approximately $3,246 over a period of 1 year and 6 months.

The VARO's local policy required second-signature review of certain higher level SMC decisions; however, none of the claims we reviewed had second signatures. Huntington VARO management indicated there were no oversight procedures in place to ensure RVSRs self-identified these claims to obtain the second-signature. Had staff followed the VARO's second-signature process for all high-level SMC cases, reviewers may have identified the errors we found.

In addition, Huntington VARO staff indicated the training they received for higher levels of SMC in March 2013 was inadequate; therefore, they were not comfortable making decisions regarding these higher-level cases. VARO employees also stated they had a lack of confidence regarding the knowledge and expertise of quality review staff.

Recommendations

1. We recommended the Huntington VA Regional Office Director develop and implement a plan to review for accuracy the 138 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

2. We recommended the Huntington VA Regional Office Director develop and implement a plan to ensure staff receive refresher training on identifying and returning insufficient medical examination reports related to traumatic brain injury claims to medical facilities for correction.

3. We recommended the Huntington VA Regional Office Director develop and implement a plan to ensure staff comply with the Veterans Benefits Administration's second-signature requirements for traumatic brain injury claims, including tracking and trending errors in processing these claims to identify local training needs.

4. We recommended the Huntington VA Regional Office Director develop and implement a plan to ensure staff comply with local second-signature requirements for processing special monthly compensation.

5. We recommended the Huntington VA Regional Office Director ensure claims processing staff receive refresher training on processing special monthly compensation and ancillary benefits.

Management Comments

The VARO Director concurred with our recommendations. The Director planned to have staff review the 138 temporary 100 percent disability evaluations remaining from our inspection universe by December 31, 2014. The Director stated training is to be scheduled for staff responsible for deciding TBI disability claims by the end of the year. Quality Review and Special Operations Team coaches will work together to identify and trend TBI errors. The Director also delegated responsibility for tracking higher level SMC claims to the Special Operations Team coach and ensured staff received SMC training in August 2014, with additional training planned in January 2015.

OIG Response

The Director's planned actions are responsive to the recommendations. We will follow up as required on these actions.

II. Management Controls

Systematic Analysis of Operations

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs). We also considered whether VSC staff used adequate data to support analyses and recommendations identified within each SAO. An SAO is a formal analysis of an organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and to propose corrective actions. VARO management must prepare annual SAO schedules designating the staff required to complete the SAOs by specific dates. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 11 SAOs annually.

Generally, VARO management ensured SAOs were submitted by the required due date, contained thorough analyses, used appropriate data, and included recommendations for improvements where appropriate. Of the 11 mandatory SAOs, we found staff did not address a required subtopic, date of claim, in the Quality of Control Actions SAO. VARO management concurred with our assessment. 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, Huntington, West Virginia* (Report No. 11-00522-231, July 20, 2011), we found VARO staff followed VBA policy for timely and accurately completing SAOs. As such, we made no recommendation for improvement in this area.

Benefits Reductions

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

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

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

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

VARO staff delayed processing 8 of 28 claims requiring rating decisions to reduce or discontinue benefits. This occurred because of a lack of VARO management oversight to ensure staff processed the benefits reductions. As a result, VA made 63 improper payments to 8 veterans from June 2013 until March 2014, totaling approximately $128,501.

For the 8 cases with processing delays, an average of almost 8 months elapsed before staff took the required actions to reduce benefits. The most significant improper payment involved VARO staff proposing to reduce a veteran's benefits after medical evidence showed the medical condition had improved. Staff proposed the reduction action in February 2013; however, the final rating decision to discontinue benefits did not occur until November 2013, which was 7 months beyond the date when the reduction action should have occurred. As a result, the veteran was overpaid approximately $20,900 in improper payments.

VARO staff disagreed with our assessments in all 8 cases we identified as processed noncompliant with VBA policy. VARO managers stated they had to follow the priorities established by the national strategy, which included reducing the inventory of VBA's oldest pending claims. Again, we disagree with this response. 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.

We continued to find the VARO noncompliant with VBA's policy to identify and route proposed benefits reductions for action on the 65th day following the due process period. We reemphasized that our inspections identify as errors any conditions where VAROs do not adhere to VBA policy. Further, we noted the VARO's own workload management plan required staff to take action on benefits reduction notices once due process had expired. We concluded that providing oversight of benefits reductions is necessary to ensure sound financial stewardship and minimize improper benefits payments.

Recommendation

6. We recommended the Huntington VA Regional Office Director implement a plan to ensure claims processing staff prioritize actions related to benefits reductions to minimize improper payments to veterans.

Management Response

The VARO Director concurred with our recommendation and updated the standard operating procedures and the workload management plan, designating staff responsible for identifying and routing non-rating workloads for action. The Director also discussed adding additional staff to the team responsible for processing benefits reduction cases.

OIG Response

The Director's planned actions are responsive to the recommendations. We will follow up as required on these actions.

Appendix A VARO Profile and Scope of Inspection

Organization

The Huntington VARO administers a variety of services and benefits, including compensation and pension benefits; vocational rehabilitation and employment assistance; benefits counseling; and outreach to homeless, elderly, minority, and women veterans.

Resources

As of April 2014, VBA reported the Huntington VARO had a staffing level of 189.9 full-time employees. Of this total, the VSC had 161.9 employees assigned.

Workload

As of April 2014, the VARO reported 6,774 pending compensation claims. The average number of days pending for claims was 235 days—120 days more than the national target of 115 days.

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. We conducted onsite work at the Huntington VARO in May 2014 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 (18 percent) of 168 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of March 24, 2014. This is generally the longest period a temporary 100 percent disability evaluation may be assigned without review, according to VBA policy. We provided VARO management with 138 claims remaining from our universe of 168 for its review. We reviewed all 26 disability claims related to TBI that the VARO completed from October through December 2013. We also examined the available 12 of 15 veterans' claims involving entitlement to SMC and ancillary benefits completed from January 2013 through December 2013.

Prior to VBA consolidating Fiduciary Program Activities nationally, each VARO was required to complete 12 SAOs. However, since the Fiduciary consolidation, VAROs are now only required to complete 11 SAOs. Therefore, we reviewed 11 SAOs related to VARO operations. Additionally, we looked at the available 28 (64 percent) of 44 completed claims proposing 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 VAROs to adjust specific veterans' benefits. Processing any adjustments per this review is clearly a VBA program management decision.

Data Reliability

We used computer-processed data from the Veterans Service Network's Operations Reports. 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 96 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI claims, SMC and ancillary benefits, and completed claims involving 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 Systematic Technical Accuracy Review program as of May 2014, the overall accuracy of the Huntington VARO's compensation rating-related decisions was 85.7 percent—8.3 percentage points below VBA's FY 2014 target of 94 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

Tables 2 reflects the operational activities inspected, applicable criteria, and whether or not we had reasonable assurance of VARO compliance.

Table 2. Huntington 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)	Yes
Benefits Reductions	Determine whether VARO staff timely and accurately processed disability evaluation reductions or terminations. (38 CFR 3.103(b)(2), 38 CFR 3.105(e), 38 CFR 3.501, M21-1MR.IV.ii.3.A.3.e, M21-1MR.I.2.B.7.a, M21-1MR.I.2.C, M21-1MR.I.ii.2.f, M21-4, Chapter 2.05(f)(4*), 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 9, 2014

From: Director, VA Regional Office Huntington, West Virginia

Subj: Inspection of the VA Regional Office, Huntington, West Virginia

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

1. The Huntington VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Huntington, West Virginia*
2. Please refer questions to Sean McLain, (304)-300-9386.

(Original signed)

Shannon Kelley
Director

Attachment

Attachment

Huntington (315) **October 09, 2014**

OIG Recommendations:

Recommendation 1*: The Huntington VA Regional Office Director develop and implement a plan to review for accuracy the 138 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.*

Huntington RO Response: Concur

Huntington will begin reviewing the accuracy of the remaining 138 temporary 100 percent disability evaluations by October 20, 2014 with a completion deadline of December 31, 2014.

Recommendation 2: *The Huntington VA Regional Office Director develop and implement a plan to ensure staff receive refresher training on identifying and returning insufficient medical examination reports related to traumatic brain injury claims to medical facilities for correction.*

Huntington RO Response: Concur

The Special Operations Lane is responsible for Traumatic Brain Injury claims decisions. The Quality Review Team, in coordination with our Training Manager, will be responsible for scheduling and implementing training for the Special Operations Lane no later than December 31, 2014. Each RVSR assigned to the Special Operations Lane in the Huntington Regional Office is required to complete the TBI TPSS training in TMS per mandate from the VSCM conference call August, 2013. In FY 2014, two new RVSRs were assigned to the Special Operations Lane and they have received the Traumatic Brain Injury training

Recommendation 3*: The Huntington VA Regional Office Director develop and implement a plan to ensure staff comply with the Veterans Benefits Administration's second-signature requirements for traumatic brain injury claims, including tracking and trending errors in processing these claims to identify local training needs.*

Huntington RO Response: Concur

The Special Operations Lane is responsible for Traumatic Brain Injury claims decisions. Rating Veterans Service Representatives (RVSRs) that are assigned to the Special Operations Lane undergo extensive training on Traumatic Brain Injury claims. Each Special Operations RVSR must complete no fewer than 10 TBI ratings at an accuracy rate of 90% or higher that require a second signature per OFO mandate dated May 31, 2011 when assigned to the Special Operations Lane. Also, as noted in recommendation 2 response, each RVSR assigned to the Special Operations Lane in the Huntington Regional Office is required to complete the TBI TPSS training in TMS. The Quality Review Lane Coach keeps a spreadsheet on all local in process reviews (IPRs) and errors noted. The QRT coach uses this to identify any trending errors, and effective immediately will identify each TBI error. The Quality Review Coach will be working with the Special Operations Lane Coach to identify trending errors for TBIs. The Special Operations Lane Coach has implemented a spreadsheet to track all Special Monthly Compensation Claim "L" or higher as of October 14, 2014.

Recommendation 4: *The Huntington VA regional Office Director develops and implements a plan to ensure staff complies with local second-signature requirements for processing special monthly compensation.*

Huntington RO Response: Concur

The Huntington Regional has a second signature requirement in place for Special Monthly Compensation cases with rating decisions at the "L" level and higher to allow for not only an additional level of quality review, but increased exposure of these complex cases to RVSRs. This was implemented during the OIG visit the week of May 5 through 9 per OIG recommendation. We will continue to track based upon the newly instituted spreadsheet as of October 14, 2014.

Recommendation 5: *The Huntington VA Regional Office Director ensure claims processing staff receive refresher training on processing special monthly compensation and ancillary benefits.*

Huntington RO Response: Concur

The RO implemented higher-level Special Monthly Compensation training on August 27, 2014. The training was conducted by the National Quality Assurance Team at the RO. The participants included Rating Quality Review Specialists, Special Operations Rating Veteran Service Representatives and Decision Review Officers.

Ancillary Benefits classroom training is scheduled for all Rating Veterans Service Representatives and Decision Review Officers in January, 2015. We have had training for some RVRSs in 4th quarter FY 14, which is included completing the TPSS Module available through TMS.

Recommendation 6: *The Huntington VA Regional Office Director implement a plan to ensure claims processing staff prioritize actions related to benefits reductions to minimize improper payments to veterans*

Huntington RO Response: Concur

The Huntington RO is following national workload directives and priorities on reducing the backlog. The Huntington RO has updated appropriate Veteran Service Center SOPs and the Workload Management Plan to specify that the Non Rating and Express Lane Supervisors and VSRs are responsible for ensuring maturing EP 800s are identified and routed for action. Additionally, the Huntington RO increased its staffing levels of the Non-Rating Team, which is responsible for processing these claims.

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Nora Stokes, Director Kristine Abramo Kelly Crawford Casey Crump Ramon Figueroa Kerri Leggiero-Yglesias Nelvy Viguera Butler Mark Ward

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