VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Buffalo, New York

November 10, 2014
14-02577-07

ACRONYMS

FY	Fiscal Year
DRO	Decision Review Officer
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

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

Report Highlights: Inspection of VA Regional Office, Buffalo, NY

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 Buffalo 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 June 2014.

What We Found

Overall, VARO staff did not accurately process 17 of 89 disability claims (19 percent) 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.

Eight of 30 temporary 100 percent disability evaluations we reviewed were inaccurate, generally because the VARO did not prioritize the processing of these cases to reduce benefits. This error rate has improved significantly in comparison with errors found in 17 of 30 claims reviewed in 2011. These errors resulted from staff not establishing suspense diaries in the electronic record for future VA medical reexaminations.

VARO staff incorrectly processed 3 of 30 traumatic brain injury (TBI) claims because of a lack of training on VBA rating policies. This is a significant improvement since our 2011 review where we found 8 of 11 TBI claims had processing errors. Staff also incorrectly processed 6 of 29 claims related to Special Monthly Compensation (SMC) and ancillary benefits, generally due to a lack of training.

VARO managers still did not comply with VBA policy for completing Systematic Analyses of Operations (SAOs). In 2014, we determined 6 of the 11 mandatory SAOs lacked thorough analyses or were not completed at all. Staff also delayed completing 12 of 30 rating reduction claims we reviewed because VARO management did not prioritize this work as high as other competing priorities.

What We Recommended

We recommended the Buffalo VARO Director implement plans to ensure staff prioritize benefits reductions cases and take appropriate action on the 206 temporary 100 percent disability evaluations remaining from our inspection universe. The Director should also implement plans to monitor the effectiveness of staff training and second-signature reviews of SMC cases, as well as ensure complete SAOs.

Agency Comments

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

LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

TABLE OF CONTENTS

Introduction....................1

Results and Recommendations....................2

I. Disability Claims Processing....................2

Finding 1 Buffalo VARO Needs To Improve Disability Claims Processing Accuracy....................2

Recommendations....................9

II. Management Controls....................10

Finding 2 Oversight Needed To Ensure Complete and Effective SAOs....................10

Recommendation....................12

Finding 3 Buffalo VARO Lacked Oversight To Ensure Timely Action On Benefits Reductions....................13

Recommendation....................13

Appendix A VARO Profile and Scope of Inspection....................14

Appendix B Inspection Summary....................16

Appendix C VARO Director's Comments....................17

Appendix D OIG Contact and Staff Acknowledgments....................20

Appendix E Report Distribution....................21

INTRODUCTION

Objective

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

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

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

Other Information

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

The Buffalo VARO did not consistently process temporary 100 percent disability evaluations, TBI-related claims, or entitlement to SMC and other ancillary benefits. Overall, VARO staff incorrectly processed 17 of the total 89 disability claims we sampled, resulting in 403 improper monthly payments to 12 veterans totaling approximately $208,361 at the time of our file reviews in May 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 reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Buffalo VARO.

Table 1. Buffalo 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	6	2	8
TBI Claims	30	1	2	3
SMC and Ancillary Benefits	29	5	1	6
Total	**89**	**12**	**5**	**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 from 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. 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 6 of the 8 processing errors affected the delivery of current benefits and resulted in 92 improper monthly payments to 6 veterans totaling approximately $60,654. These improper payments occurred from July 2009 to May 2014.

VARO management concurred with all eight errors we identified. Following are descriptions of these errors.

- Two errors occurred when VARO staff did not establish or maintain suspense diaries in the electronic record as required; thus, the system did not generate reminders to schedule the medical reexaminations. Both of these errors occurred prior to VBA's system modifications to automatically establish and retain suspense diaries in the electronic record.
    - One of the errors resulted in an overpayment of approximately $18,029 over a period of 4 years and 7 months.
    - We could not determine if an improper payment resulted in the second case because medical evidence was not available to determine if the temporary 100 percent evaluation should continue.

- Three errors occurred when VARO staff did not timely reduce benefits after receiving medical evidence that the veterans' conditions no longer supported eligibility for temporary 100 percent disability evaluations. As a result, the following improper payments were made.
    - One veteran was overpaid approximately $17,232 over a period of 9 months.
    - Another veteran received approximately $14,192 in overpayments for a period of 7 months.
    - In the final case, a veteran received approximately $5,641 in overpayments over a period of 3 months.
- Two errors occurred when Rating Veterans Service Representatives (RVSR) did not establish the correct effective dates for entitlement to SMC benefits. Consequently, one veteran was underpaid approximately $5,462 over a period of 1 year and 5 months, and another veteran was overpaid $96 over a 1 month period.
- In one last case, an RVSR annotated the need for an immediate VA medical reexamination to determine if the temporary 100 percent disability evaluation should continue; however, VARO staff did not schedule the required examination until about 1 year and 2 months from the date VBA identified the case for review.

Most of the processing inaccuracies occurred when VARO staff delayed finalizing benefits reductions after receiving evidence that veterans' conditions had improved. Delays averaged 6 months from the time staff should have reduced the benefits and were the result of VARO management not prioritizing this workload. VARO management stated they focused on higher priorities directed by the VA Central Office and the Eastern Area Office instead. After reviewing a statistical sample of 30 claims, we provided VARO management with 206 claims remaining from the universe of 236 for its review to determine if action is required.

It is a VBA management responsibility to address this issue, which entails millions of dollars in improper payments. Where VBA lacks sufficient staff to properly address its management responsibilities, it should make its case for an increase in full-time equivalents through the normal budget process. Without appropriate priority for this type of work, delays in processing reductions result in unsound financial stewardship of veterans' monetary benefits and a failure to minimize overpayments.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Buffalo, New York* (Report No. 11-00523-258, August 25, 2011), VARO staff incorrectly processed 17 of 30 temporary 100 percent disability evaluations we reviewed. The majority of the errors resulted from staff not establishing suspense diaries in the electronic record to remind of the need for future VA

medical 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 modify the electronic record to automatically establish and populate suspense diaries. Further, VBA agreed to review all temporary 100 percent disability evaluations and ensure each had a future exam date entered in the electronic record. During our June 2014 inspection, we identified two errors related to the VARO not establishing or maintaining suspense diaries for reexaminations; however, these two errors occurred prior to VBA's system modifications to automatically establish and retain suspense diaries.

During our May 2011 inspection, we also identified 75 reminder notifications for medical reexaminations that staff had not processed. The delays occurred because VARO staff did not follow VBA policy to timely process reminder notifications, nor did they follow the local workload management plan requiring staff to review this workload biweekly. In response to our recommendations, the Director indicated staff reviewed and took appropriate action on the pending reminder notifications. The Director also established the frequency for supervisory staff to review this workload to ensure timely processing. During our June 2014 inspection, we did not identify any errors involving delays in processing reminder notifications. As such, we concluded the VARO's corrective actions in response to our previous recommendations were 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 annual report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-167, May 18, 2011), VBA agreed to develop and implement a strategy for ensuring the accuracy of TBI claims decisions. In May 2011, VBA provided guidance to VARO Directors to implement a policy requiring a second signature on each TBI case an RVSR evaluates until the RVSR demonstrates 90 percent accuracy in TBI claims processing. The policy indicates second-signature reviewers come from the same pool of staff as those used to conduct local station quality reviews.

We determined VARO staff incorrectly processed 3 of 30 TBI claims—1 affected a veteran's benefits and the remaining 2 had the potential to affect veterans' benefits. VARO management concurred with the three errors we identified. Our inspection results supported the VARO realized a significant

improvement since our 2011 review where we found 8 of 11 TBI claims had processing errors.

Following are details on the three cases with errors.

- In two cases, RVSRs granted service connection for TBI without evidence the veterans experienced in-service brain injuries as required. In both cases, service treatment records included no documentation or references to in-service TBI events. As a result, one veteran was overpaid approximately $1,579 over a period of 9 months. The remaining error did not affect the veteran's overall disability benefits payments; however, if left uncorrected, it could result in inaccurate benefits payments for future disability claims.
- In the remaining case, an RVSR prematurely granted a separate 40 percent evaluation for TBI when there was a comorbid mental health condition previously evaluated at 10 percent based on the same symptoms of memory loss. VBA policy requires medical examiners to determine the etiology of symptoms. However, the RVSR did not return the examination reports to the issuing health care facility for clarification as required. The error did not affect the veteran's overall disability benefits payments; however, if left uncorrected, it could result in inaccurate benefits payments for future disability claims.

Generally, the errors we identified resulted from a lack of staff training on general rating policies. We reviewed training records for FY 2013 and found only Decision Review Officers (DROs) had completed training on VA medical examinations and opinions and the last time they did so was in February 2013. However, responsibility for evaluating TBI claims is not limited to DROs—of the 30 cases reviewed, RVSRs completed all but one of the TBI claims decisions. In June 2014, we confirmed the FY 2014 training plan included training on VA examinations for Veteran Service Representatives (VSRs) and RVSRs. Prior to this planned training, staff could not remember the last time the VARO provided training on this topic.

Because of a lack of training on general rating policies such as establishing compensation benefits related to in-service events, veterans may have improperly received compensation benefits for TBI injuries they did not sustain. We did not make recommendations for improvement in this area given VARO management recently expanded its training plan to include VSRs and RVSRs, as well as DROs. The June 2014 training plan covers basic rating principles such as establishing service connection for residual disabilities of in-service events, including TBI.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Buffalo, New York* (Report No. 11-00523-258, August 25, 2011), 8 of the 11 TBI claims we reviewed contained processing errors. Generally, errors associated with TBI claims processing occurred because VSC staff incorrectly interpreted

VBA policy and used VA medical examinations that were inadequate for disability evaluation purposes. In response to our recommendations for improvement, the Director indicated RVSRs received TBI refresher training in March 2011, and both RVSRs and DROs received additional training on inadequate medical examinations in June 2011. In April 2012, the OIG closed this recommendation.

During our June 2014 inspection, we did not identify errors resulting from staff using insufficient examinations to evaluate TBI disability claims. As such, we determined the corrective actions taken in response to our 2011 recommendations were 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 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 Allowances

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 6 of 29 veterans' claims involving SMC and related ancillary benefits—5 of the errors affected veterans' benefits and resulted in 302 improper payments totaling approximately $146,128 from October 2003 through May 2014. Following are details on the five errors that affected veterans' benefits payments.

- In a September 2013 rating decision, an RVSR did not recognize and correct an error from a July 2010 rating decision that failed to grant SMC at the highest level, based on the veteran's need for skilled assistance. In this case, complications of diabetes resulted in amputation of both of the veteran's feet in 2009; however, RVSRs who evaluated this claim in 2010 and again in 2013 overlooked the higher-level SMC to which the veteran was entitled since 2009. Consequently, VA underpaid the veteran approximately $63,184. This was the most significant underpayment we observed.
- In another case, an RVSR did not assign the correct level of SMC to a veteran for residuals of a stroke. This veteran was entitled to a higher level of SMC due to incontinence of bowel, separately rated at 100 percent disabling, as well as paralysis of an arm and a leg. As a result, the veteran was underpaid approximately $41,629 over a period of 1 year and 2 months.
- The three remaining errors occurred when RVSRs overlooked increases in SMC. In these cases, the veterans were entitled to SMC based on helplessness, but they also had service-connected disabilities evaluated at 50 or 100 percent disabling, which warranted even higher SMC evaluations. Summaries of these three errors follow.
  - In the first case, the veteran received SMC for loss of use of both legs, evaluated as 100 percent disabling. However, an RVSR did not notice the veteran warranted an SMC increase for a service-connected mental condition, separately evaluated as 50 percent disabling. This oversight resulted in the veteran being underpaid approximately $20,871 from the October 2003 rating decision until the time of our May 2014 file review.
  - In the second case, an RVSR conducting a review for a dependent's education benefits did not notice that a veteran was entitled to an increase in SMC. In this case, the veteran was 100 percent disabled due to the loss of use of both lower extremities and also had a mental disorder evaluated at 50 percent disabling. However, the 2010 rating decision did not assign the correct level of SMC. As a result, the veteran was underpaid approximately $10,561 from that time until our May 2014 file review.

- In one final case affecting benefits, an RVSR evaluated a veteran's service-connected Parkinson’s disease with loss of use of both legs, but did not grant increased SMC for complications of the disease. Further, the RVSR did not assign the appropriate date for an increased rating for dementia, evaluated as 100 percent disabling. These errors resulted in VA underpaying the veteran $9,882 from 2011 until our file review in May 2014.

The remaining case had the potential to affect veteran’s benefits. When assessing residual disabilities associated with a stroke, an RVSR did not develop the case for medical evidence to see if the veteran needed skilled care. Since the medical evidence was lacking, the impact on this veteran’s benefits could not be determined.

VARO managers concurred with our assessments in all six cases. Generally, errors occurred because VARO staff did not receive training on higher-level SMC. As a result, veterans received improper payments or were unaware of benefits to which they were entitled.

We confirmed VARO training records for FY 2013 and FY 2014 did not include higher-level SMC training. As a result of the lack of staff training, veterans did not always receive accurate benefits payments. We observed that VARO staff attended SMC training during our onsite inspection in June 2014; however, we could not assess the effectiveness of that training because staff completed the cases we reviewed prior to the training.

Recommendations

1. We recommended the Buffalo VA Regional Office Director develop and implement a plan to review the 206 temporary 100 percent disability evaluation claims remaining from our inspection universe and take appropriate actions.

2. We recommended the Buffalo VA Regional Office Director develop and implement a plan to monitor the effectiveness of training on higher-level Special Monthly Compensation and Ancillary Benefits.

Management Comments

The VARO Director concurred with our recommendations and indicated staff completed a review of the 206 temporary 100 percent disability evaluations remaining from our inspection universe. VARO staff completed specific training related to SMC and ancillary benefits claims in June and July 2014. Rating Quality Review specialists will conduct a 16-hour, instructor-led course on special monthly compensation for all RVSR’s during the first and second quarters of FY 2015. The VSC manager and Assistant VSC manager will monitor the improvements for compliance.

OIG Response

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

Finding 2 Oversight Needed To Ensure Complete and Effective SAOs

Six of the 11 SAOs were either incomplete or not done at all at the time of our May to June 2014 inspection. This occurred because VARO management did not provide adequate oversight to ensure SAOs contained thorough analyses, used appropriate data, and included all needed recommendations along with time frames for their implementation. As a result, VARO management may have inadequately identified existing and potential problems for corrective actions to improve VSC operations.

Following are examples of the deficiencies we identified in the SAOs we reviewed.

- The Claims Processing Timeliness SAO attributed disparities in the performance of the non-rating workload from FY 2012 to FY 2013 to a special project assigned solely to the non-rating team. The special project entailed review of 596 claims folders. The SAO discussed changes in the VARO's workload, such as an increase from 163.6 days to 335.8 days to process the non-rating workload, including benefits reduction cases. However, recommendations for improvement did not adequately address these changes or discuss the effectiveness of the VARO's Workload Management Plan. Without in-depth analysis of anomalies, such as the approximately 172-day increase in average days pending for non-rating workloads, the VSC cannot make effective recommendations, including specific time frames for implementation.
- The Division Management SAO did not use available data from VBA's Automated Standardized Performance Elements Nationwide and Talent Management System to support analyses of employee performance evaluations or station training requirements. The SAO also discussed the huge increase in average days pending for the non-rating workload. However, the recommendation to address non-rating workload team

resources only involved adding three VSRs to the team and did not include a time frame for implementation as required.

- The Internal Controls SAO did not discuss objective results of weekly Control of Veterans Records System compliance checks completed by supervisory staff. Additionally, staff did not use available data from the Veterans Service Network's Operations Reports to evaluate the VARO's Matching Programs.
- Recommendations in the Quality of Control Actions SAO did not include time frames for implementation.
- Staff did not complete SAOs regarding the Quality of Development Activity and the Quality of Compensation, Pension, and Ancillary Actions. Eastern Area Office emails to the VAROs in March and June 2012 stated these SAOs would not be required while stations implemented Quality Review Teams. This implementation was reportedly completed in March 2012. As such, VARO staff could not provide a reasonable explanation for not having completed these two mandatory SAOs in 2013 or 2014.

Deficiencies in SAOs occurred because management did not provide adequate oversight during the SAO review and approval process. Generally, the staff member responsible for reviewing the SAOs indicated he only sought to identify grammatical errors and ensure that the minimum areas were addressed within each SAO. Staff responsible for completing the SAOs stated they received no feedback on either the data they used for their analyses or the sufficiency of their recommendations. Staff also said they used SAOs from the previous year as a guide instead of referring to VBA policy to complete the SAOs. Staff could not recall when they last received training on completing SAOs.

Further, the majority of SAOs we reviewed were completed during the time period when the VSCM manager position remained vacant for 11 months. The current VSC Manager arrived on station in late February 2014 and after review, indicated the current SAOs were not effective in meeting their objectives or those of the VSC.

If VARO management had ensured proper analyses and recommendations in these SAOs, it would have had a basis for addressing deficiencies and developing a plan to prioritize the non-rating workload to the extent possible within VBA's national guidelines.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Buffalo, New York* (Report No. 11-00519-172, May 20, 2011), we determined that 5 of the 12 SAOs were incomplete. We recommended the Buffalo VARO Director develop and implement a plan for staff to address all required SAO elements. Although the SAOs reviewed during our June 2014 inspection addressed the

required elements, they did not contain thorough analyses and recommendations with time frames for implementation. As such, the corrective actions taken in response to our prior benefits inspection were not considered effective in addressing the recommendation for improvement in this area.

Recommendation

3. We recommended the Buffalo VA Regional Office Director develop and implement a plan to ensure Systematic Analysis of Operations contain thorough analyses, use appropriate data, and include all recommendations needed, along with time frames for implementation.

Management Comments

The VARO Director concurred with our recommendations. The Director developed a review checklist to assist VSC management in preparing SAOs according to VBA policy. VSC management will also receive training during the first quarter of FY 2015 on the proper preparation of SAOs.

OIG Response

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

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 VAROs do not take required actions to ensure veterans receive correct payments for their levels of disability.

When the VARO obtains evidence that a lower disability evaluation would result in reduction or discontinuance of current compensation payments, VSC staff must inform the beneficiary of the proposed benefits reduction. In order to provide beneficiaries due process, VBA allows 60 days for the veteran to submit additional evidence to show that compensation payments should continue at their present level. If the VARO does not receive additional evidence within that period, an RVSR 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 3 Buffalo VARO Lacked Oversight To Ensure Timely Action On Benefits Reductions

VARO staff delayed processing 12 of 30 claims requiring rating decisions to reduce or discontinue benefits. Generally, delays occurred because VARO managers did not provide oversight to ensure staff processed these benefits reduction cases timely. As a result, VA made 147 improper payments to 12 veterans from December 2011 to June 2014, totaling approximately $263,405.

Of the 12 cases with processing delays, an average of approximately 1 year elapsed before staff took action to reduce benefits. The most significant improper payment occurred when staff received evidence that a medical condition had improved. Specifically, in July 2011, VARO staff proposed reducing a veteran's evaluation from 100 to 20 percent disabling. However, VARO staff did not establish the required control in the electronic system to timely manage the case. Final action to reduce the veteran's benefits did not occur until May 2014—29 months beyond the date staff should have taken action. As a result, VA continued to make improper monthly payments and overpaid the veteran approximately $78,486.

VARO management agreed with our assessments in all 12 cases we found noncompliant with VBA policy. VARO management and staff indicated they attempted to follow the VARO's workload management plan, but national direction was to place higher priority on processing the VARO's oldest pending rating-related claims instead. Additionally, management agreed the VARO's workload management plan, which required staff to process benefits reduction cases by date of claim, was inconsistent with VBA policy. According to the policy, on the 65th day following due process notification, action is required to reduce evaluations and thereby minimize overpayments in cases where benefits entitlements change. 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.

Recommendation

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

Management Comments

The VARO Director concurred with our recommendations. The Director planned to update the VARO's workload management plan to include the frequency in which designated staff are required to identify and process benefits reduction cases.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

The Buffalo VARO administers a variety of services and benefits, including compensation benefits; education benefits; vocational rehabilitation and employment assistance; and outreach to former prisoners of war, homeless, minorities, and women veterans.

Resources

As of May 2014, VBA reported the Buffalo VARO had a staffing level of 408 full-time employees. Of this total, the VSC had 107 employees assigned.

Workload

As of April 2014, the VARO reported 6,722 pending compensation claims. The average number of days pending for claims was 198.5 days—83.5 days greater than 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 services to veterans. We conducted onsite work at the Buffalo VARO in June 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 of 236 temporary 100 percent disability evaluations (approximately 13 percent) 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 April 18, 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 206 claims remaining from our universe of 236 for its review. We reviewed 30 of 46 TBI-related disability claims that the VARO completed from January through March 2014. Additionally, we examined the available 29 of the total 33 veterans' claims involving entitlement to SMC and ancillary benefits that VARO staff completed from April 2013 through March 2014.

Prior to VBA consolidating Fiduciary Program Activities nationally, each VARO was required to complete 12 SAOs. However, since the Fiduciary consolidation, the VAROs are now only required to complete 11 SAOs. Therefore, we reviewed the 11 SAOs related to VARO operations. Additionally, we looked at 30 of 164 completed claims (18 percent) from January through March 2014 that proposed benefits reductions.

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 119 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 April 2014, the accuracy of the VARO's compensation rating-related decisions was 88.7 percent—5.3 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

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

Table 2. Buffalo 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
Benefit 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 Buffalo, New York

Subj: Inspection of the VA Regional Office, Buffalo, New York

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

1. The Buffalo VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Buffalo, New York.*
2. Please refer questions to VSCM, Sammie Quillin at (716) 857-3090.

(original signed by:)

Donna P. Mallia, Director
Buffalo Regional Office

Attachment

Attachment

OIG Recommendations

Recommendation 1: *We recommended the Buffalo VA Regional Office Director develop and implement a plan to review the 206 temporary 100 percent disability evaluation claims remaining from our inspection universe and take appropriate actions.*

Buffalo RO Response: Concur

All cases provided on the original manifest from the Office of Inspector General have been reviewed. Examinations have been ordered and if necessary, reductions have taken place on cases which required due process. Also, diary controls were reviewed to ensure appropriate future exam controls have been set in place.

Every Monday, a list of 800 series work items is generated with the message "VACO mandatory review of temporary total rating evaluations" and sent to each Coach for processing. Cases which have expiring diaries are sent to the Intake Processing Center for claims establishment, and are then sent to RVSRs for processing. Exams will be scheduled immediately and ratings provided when applicable. Cases that do not fall into the priority bucket list will be sent to upper management requesting approval to process.

Veterans Benefits Administration policy has consistently emphasized reducing the rating-related claim backlog; however, the guidance never dictated that this workload be neglected or delayed until it was pending more than 125 days. Rather, it is the responsibility of management to manage multiple priorities, to include the 100% temporary reviews, to ensure that this workload is completed in a timely manner. The Veterans Service Center management team is aware of this responsibility and will ensure that improvements in this area are made in the future.

Target Completion Date: Completed

Recommendation 2: *We recommended the Buffalo VA Regional Office Director develop and implement a plan to monitor the effectiveness of training on higher-level Special Monthly Compensation and Ancillary Benefits.*

Buffalo RO Response: Concur

A revision of the Standard Operating Procedures (SOP) for Special Monthly Compensation (SMC) dated May 8, 2014, designated that the Rating Quality Review Specialists (RQRS) are the Special Monthly Compensation subject matter experts who may perform second signature reviews for Special Monthly Compensation ratings. To ensure the accuracy of these complex ratings, the Veterans Service Center Manager has directed that Special Monthly Compensation ratings awarding any rate higher than "L" rate will require a second signature. In special cases, the Veterans Service Center Manager may also require two signatures for ratings that provide SMC at a rate greater than SMC (K).

Training specific to rating SMC claims was completed in June 2014. Training on Ancillary Benefits and Special Purposes was completed in July 2014. During the 1st and 2nd quarters of FY 2015, the Rating Quality Review Specialists will conduct training on the sixteen hour Special Monthly Compensation video/instructor led course for all Rating Veterans Service Representatives. The AVSCM and VSCM will monitor for compliance.

Target Completion Date: March 30, 2015

Recommendation 3: *We recommended the Buffalo VA Regional Office Director develop and implement a plan to ensure Systematic Analysis of Operations contain thorough analyses, use appropriate data, and include all recommendations needed, along with time frames for implementation.*

Buffalo RO Response: Concur

On July 16, 2014, the Eastern Area office provided guidance in an effort to improve the quality and timely completion of SAOs. In accordance with this guidance, a schedule has been prepared which requires SAOs to be submitted by the responsible person 30 calendar days prior to the date the report is due to the Office of the Director. The Buffalo Regional Office has also developed the attached "SAO Review Checklist" as a tool to assist the VSC management staff to ensure SAO reports are prepared in accordance with MR 21-4 Chapter 5 and that the report contains all of the required SAO elements. Once submitted, a maximum of three business days will be allowed for each member to review the report and make comments and/or recommendations. This will ensure that staff members responsible for completing the SAO reports receive timely and accurate feedback. Training will be conducted for all VSC Coaches and VSC management staff on the preparation of SAOs in the first quarter of FY 2015.

Target Completion Date: December 18, 2014

Recommendation 4: *We recommended the Buffalo VA Regional Office Director develop and implement a plan to ensure claims processing staff prioritize actions related to benefits reductions to minimize improper payments to veterans.*

Buffalo RO Response: Concur

RVSRs assigned to the Non-Rating Lane are responsible for the rating of cases associated with all non-rating end products (EP) (EP 600(s) and EP 290(s)).

The Monday Morning Workload Report will include two columns which will identify EP 600s pending, and EP 600 cases that are past due. Every Monday, the Coach of the Non-Rating Lane will generate a weekly list of claims that require action and will assign ready for decision cases to the RVSRs. The claims will then be assigned to VSRs on the team after the rating decisions are completed so that the award action can be promulgated. Priority claims requiring authorization action will be rated on same day of receipt. RVSRs are responsible for receiving assigned claims in COVERS daily.

These procedures will be added to the existing Workload Management Plan.

Target Completion Date: December 18, 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	Nora Stokes, Director Robert Campbell Kyle Flannery Ambreen Husain Suzanne Love Michelle Santos-Rodriguez Lisa Van Haeren Nelvy Viguera Butler

Appendix E Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Assistant Secretaries
Office of General Counsel
Veterans Benefits Administration Eastern Area Director
VA Regional Office Buffalo Director

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Kirsten E. Gillibrand, Charles Schumer
U.S. House of Representatives: Chris Collins, Richard Hanna, Brian Higgins, Dan Maffei, Bill Owens, Tom Reed, Louise Slaughter

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