VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Benefits Administration,

Inspection of
VA Regional Office
Winston-Salem,
North Carolina

August 26, 2015
15-00452-411

ACRONYMS

OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SMC	Special Monthly Compensation
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the VA Regional Office, Winston-Salem, NC

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and a Veterans Service Center in Wyoming, that process disability claims and provide a range of services to veterans. In December 2014, we evaluated the Winston-Salem VARO to see how well it accomplishes this mission.

What We Found

Overall, 15 of the 90 claims (17 percent) reviewed contained processing inaccuracies. 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.

During our December 2014 inspection, VARO staff incorrectly processed 9 of 30 temporary 100 percent disability evaluations we sampled—showing a slight improvement from our 2012 inspection where 15 of the 30 cases were inaccurate. Additionally, inspection results from our December 2014 review showed VARO staff incorrectly processed 1 of the 30 traumatic brain injury claims we sampled. Again, this is an improvement from our 2012 review when we identified 4 of the 30 sampled cases contained errors. However, VARO staff did not accurately process 5 of the 30 sampled cases relating to Special Monthly Compensation and ancillary benefits claims.

Further, Winston-Salem VARO staff followed VBA policy and established claims in the electronic system of records using accurate dates of claims for all 30 cases we sampled. However, VARO staff delayed processing 14 of the 30 benefit reduction cases because management prioritized other workload higher.

What We Recommended

We recommended the Director review the 597 temporary 100 percent disability evaluations within the universe of claims the VARO completed as of October 8, 2014, but not reviewed as part of our sample selection and take appropriate action. The Director should develop a plan for staff to follow policies associated with reexaminations and provide refresher training on Special Monthly Compensation claims. Further, the Director should also ensure staff timely process benefits reductions to minimize improper payments to veterans.

Agency Comments

The Director of the Winston-Salem VARO did not respond to all recommendations but indicated concurrence with three of the four recommendations. However, the planned corrective actions lack the urgency required to minimize improper benefits payments. We will follow up as required.

Brent E. Arronte
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for Audits and Evaluations

TABLE OF CONTENTS

INTRODUCTION

Objective

The Benefits Inspection Program is part of the VA 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.

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

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 Winston-Salem 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 Winston-Salem 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 evaluating the accuracy in processing the following three types of disability claims and determined their effect on veterans' benefits:

- Temporary 100 percent disability evaluations
- Traumatic brain injury (TBI) claims
- Special monthly compensation (SMC) and ancillary benefits

We sampled claims related only to specific conditions that we considered at increased risk of claims processing errors. As a result, the errors identified do not represent the universe of disability claims or the overall accuracy rate at this VARO.

Finding 1 Winston-Salem VARO Needs To Improve the Processing of Two Types of Disability Claims

The Winston-Salem VARO did not consistently process two types of disability claims reviewed. Overall, VARO staff incorrectly processed 15 of the total 90 disability claims we sampled, resulting in 147 improper monthly payments to 6 veterans totaling approximately $178,878 at the time of our inspection in December 2014. Table 1 reflects processing errors identified during our review.

Table 1. Winston-Salem VARO Disability Claims Processing Accuracy for Three High-Risk Claims Processing Areas

Type of Claim	Claims Reviewed	Claims Inaccurately Processed: Affecting Veterans' Benefits	Claims Inaccurately Processed: Potential To Affect Veterans' Benefits	Claims Inaccurately Processed: Total
Temporary 100 Percent Disability Evaluations	30	1	8	9
TBI Claims	30	1	0	1
SMC and Ancillary Benefits	30	4	1	5
Total	**90**	**6**	**9**	**15**

Source: VA OIG analysis of the VBA's temporary 100 percent disability evaluations paid at least 18 months, TBI disability claims completed in the third and fourth quarters fiscal year 2014, and SMC and ancillary benefits claims completed from October 1, 2013, through September 30, 2014.

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 9 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 a 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 the appropriate control to initiate action.

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

Effective management of these temporary 100 percent disability ratings can reduce VBA's risks of paying inaccurate financial benefits and provides stewardship of taxpayer funds. Available medical evidence showed 1 of the 9 processing errors affected benefits and resulted in 5 improper monthly payments totaling approximately $8,369 over a period of 5 months.

The remaining eight errors did not affect the veterans' overall disability evaluations at the time of our inspection in December 2014. However, if left uncorrected, the errors have the potential to affect benefits. Following are details on the eight errors.

- Three errors occurred when VARO staff did not enter suspense diaries in the electronic system. As such, reminder notifications alerting VARO staff to schedule VA medical reexaminations did not generate.
- Two errors occurred when VARO staff removed reminder notifications from VBA's electronic system of records but did not schedule the required reexaminations.

- One error occurred when VARO staff incorrectly entered a suspense diary in the electronic record beyond the mandated required reexamination date—generally, no longer than 6 months. However, in this case, VARO staff extended the reexamination date for 5 years, which is inconsistent with VBA policy.
- At the time of our file review in December 2014, VARO staff had not taken action to schedule a required medical reexamination despite receiving a reminder notification to do so.
- The final error occurred when VARO staff did not take timely action to schedule a veteran's request for a personal hearing after being notified of a proposed reduction in benefits. In this case, the veteran requested a hearing in May 2013. VBA policy allows staff to extend the proposal period for benefit reductions by 30 to 60 days if a veteran requests a hearing. However, at the time of our review in December 2014, 1 year 7 months following the request, the hearing had not been scheduled. Consequently, the veteran's disability evaluation continued at the 100 percent rate despite medical evidence showing the medical condition improved and that a 20 percent evaluation was supported.

As we reviewed claims in advance of our site visit we found that VARO staff reported processing inaccuracies generally occurred because VARO management did not ensure staff took proper actions associated with medical reexaminations. Examples included failing to enter suspense diaries to ensure reminder notifications for reexaminations would generate, removing reminder notifications from the electronic record but taking no actions to schedule required examinations, or just simply delaying the actions to actually schedule the examination. As a result, veterans may receive inaccurate benefits payments. We provided VARO management with the 597 cases remaining from our universe of 627 cases related to temporary 100 percent disability evaluations for its review to determine if action is required.

VARO management did not concur with our assessments in the nine cases we identified as having errors for the following reasons:

- For five of the errors, VARO management stated the veterans' disabilities were permanent and did not require mandated reexaminations. However, VARO staff did not indicate the disabilities were permanent on the rating decisions nor did they establish dependents education benefits as required by VBA policy.
- In three of the cases, VARO staff cited workload management issues and personal hearing requests as reasons for claims processing delays. We disagree; it is a VBA management

responsibility to address issues of workload and the prioritization of cases. Delays in claims processing actions related to these types of cases results in unsound financial stewardship of veterans' monetary benefits and fail to minimize improper payments.

- In the final error, VARO staff indicated the results of a reexamination that was not scheduled timely would not affect the veterans overall combined evaluation. However, examination results showing improvement in the medical condition have the potential to impact continued entitlement to Special Monthly Compensation benefits.

The VSC manager assigned responsibility for reviewing cases we identified as having errors to Quality Review team staff. During our review and through interviews, we learned VARO staff initially concurred with our assessments of the cases we identified as having errors. Quality review staff also indicated the types of the errors we identified were similar to the types of errors identified during their local quality reviews. However, the VSC manager instructed staff to review the errors again and come up with different responses; indicating the VARO was not going to agree with the errors OIG identified even if we were correct.

We found the VSC manager's directions to quality review staff concerning. Our inspections identify conditions where VARO staff do not adhere to VBA policy and we welcome and encourage open and meaningful dialogue to discuss our assessments of cases with errors. Disagreeing for the sake of disagreeing undermines our ability to determine how well claims processing staff at the Winston-Salem VARO accomplishes its mission of delivering a range of services to veterans.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Winston‒Salem, North Carolina* (Report No. 12-00244-276, September 13, 2012) VARO staff incorrectly processed 15 of 30 temporary 100 percent disability evaluations we reviewed. The majority of the errors occurred because VARO staff did not establish suspense diaries for future examinations in the electronic records. We did not make a recommendation for improvement to the VARO because VBA had implemented a national review plan to address this issue. 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 December 2014 inspection, we identified three cases where VARO staff did not establish suspense diaries in the electronic record to ensure reminder notifications to schedule medical reexaminations would generate. We will continue to follow up during routine benefits inspections to determine if the controls VBA put in place, resulting from our prior audit of 100 percent disability evaluations, are effective.

TBI Claims

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

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

During our December 2014 inspection, we determined VARO staff incorrectly processed 1 of 30 TBI claims. In this case, an RVSR assigned a 70 percent evaluation for residual disabilities associated with TBI. However, the TBI examination showed symptoms that supported a 40 percent evaluation. As a result, VA overpaid the veteran approximately $1,510 over a period of 8 months.

VARO management disagreed with our assessment in the case we identified as having an error—yet, determined residuals of the TBI injury were over evaluated and that a mental disorder was under evaluated and by adjusting these evaluations, VARO management determined the veteran had not received improper payments. We disagree with the VARO response in this case. The scope of our review for TBI-related disability claims was limited to claims completed by VARO staff from April 2014 through September 2014. As such, the reevaluated case had no bearing on the results of our benefits inspection. Further, given that VARO management determined the case needed to be reworked is indicative that the case was in error.

Because VARO staff accurately processed 29 of the 30 TBI claims we reviewed, we determined VARO staff generally followed VBA policy. As such, we made no recommendations for improvement in this area.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Winston-Salem, North Carolina* (Report No. 12-00244-276, September 13, 2012), we identified claims processing errors related to TBI claims in 4 of the 30 cases we sampled. Generally, the errors occurred due to inadequate oversight to ensure VARO staff complied with VBA's second-signature policy. We recommended the VARO Director develop and implement a plan to ensure RVSRs comply with the VBA's second-signature requirements for TBI claims. The OIG closed this recommendation on September 5, 2013.

We did not identify any of these errors during our December 2014 inspection. As such, we determined the VARO's actions in response to our previous recommendation were effective.

Special Monthly Compensation and Ancillary Benefits

As the concept of rating disabilities evolved, it was realized that for certain types of disabilities, the basic rate of compensation was not sufficient for the level of disability present. Therefore, SMC was established to recognize the severity of certain disabilities or combinations of disabilities by adding an additional compensation to the basic rate of payment. SMC represents payments for "quality of life" issues such as the loss of an eye or limb, or the need to rely on others for 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 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 section 35, title 38, United States Code
- Specially Adapted Housing Grants
- 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 focused our review on whether VARO staff accurately processed entitlement to SMC and ancillary benefits associated with anatomical loss or loss of use of two or more extremities, or bilateral blindness with visual acuity of 5/200 or worse.

VARO staff incorrectly processed 5 of 30 veterans' claims involving SMC and ancillary benefits—4 affected veterans' benefits and resulted in underpayments totaling approximately $168,999. These errors represented 134 monthly improper payments from May 2008 until November 2014.

Details on the five errors we identified follow.

- An RVSR used an incorrect date when establishing a higher-level of SMC for a veteran who had loss of use of one foot. As a result, VA underpaid the veteran approximately $112,669 over a period of 5 years and 7 months.
- In two cases, RVSRs incorrectly denied increased levels of SMC for veterans with additional permanent disabilities independently evaluated as 50 percent disabling. Consequently, VA underpaid one veteran approximately $26,440 over a period of 2 years and 2 months, and the other veteran by approximately $6,156 over a period of 2 years and 10 months.
- In the final case affecting benefits, VARO staff incorrectly denied higher levels of SMC on three separate occasions in a single decision document-initially for additional permanent disabilities independently rated as 50 percent disabling; next for a separate evaluation due to loss of use of the lower extremities; and lastly, due to the need for increased levels of care. As a result, VA underpaid the veteran approximately $23,734 over a period of 7 months.
- In the fifth case, an RVSR incorrectly coded the veteran's SMC decision relating to hospitalization. Although current benefits were not affected, future benefits have the potential to be affected if the veteran requires hospitalization.

Generally, errors relating to SMC claims and ancillary benefits resulted from a lack of training. We confirmed through training records that RVSRs had not received formal training on SMC in the past 2 years. We also found the VARO's second-signature review policy ineffective. Local VARO policy in effect at the time of our review required second signature reviews for higher levels of SMC, yet only one of the five cases we identified as having errors, contained the required secondary review. In February 2015, Compensation Service issued a bulletin, reminding claims processing staff at 56 VAROs to follow national guidance when processing claims and that local guidance at individual VAROs should no longer be used. As such, we will limit our recommendations for improvement to training.

VARO management did not concur with our assessments in four of the five cases we identified as having errors. Given SMC and related ancillary benefits payments represent quality of life issues for veterans with severe disabilities; we are concerned corrective actions on the cases we identified as having errors may not occur.

Recommendations

1. We recommended the Winston-Salem VA Regional Office Director conduct a review of the 597 temporary 100 percent disability evaluations remaining from our universe as of October 8, 2014, and take appropriate actions.

2. We recommended the Winston-Salem VA Regional Office Director develop and implement a plan to ensure claims processing staff receive additional training on required actions relating to required medical reexaminations.

3. We recommended the Winston-Salem VA Regional Office Director implement a plan to ensure staff receive refresher training on processing higher-level special monthly compensation claims.

Management Comments

The VARO Director concurred with our recommendations. VARO management agreed to review the 597 pending temporary 100 percent evaluations. Due to agency priorities, the reviews are expected to be completed by December 31, 2015. The Director reported staff responsible for reviewing and processing medical reexaminations are expected to receive refresher training by July 31, 2015. Additionally, VARO staff responsible for evaluating claims related to SMC benefits received refresher training in January 2015 that included visual and practical applications as well as the use of the SMC calculator.

The VARO Director disagreed that management condoned "disagreeing for the sake of disagreeing" and reported errors identified by OIG were scrutinized by Quality Review staff. The Director indicated those reviews resulted in 7 of the 36 errors identified by OIG being overturned—clearly validating the need for in-depth reviews.

OIG Response

The Director's planned corrective actions are generally responsive to the recommendations; however, we encourage VARO management to expedite its review of the 597 temporary 100 percent disability evaluations that were not included in the 30 cases we sampled. As of October 8, 2014, the 597 claims represented all instances where veterans have been receiving temporary 100 percent disability evaluations for 18 months or longer. According to VBA policy, this is generally the longest period a temporary 100 percent disability evaluation may be assigned without review. Delaying the review of these claims for up to 6 months does not reflect the sound financial stewardship expected of program officials or assist in minimizing improper payments to veterans. Additionally, the review of the 597 cases is likely to result in some medical conditions being evaluated as permanent; thereby, providing entitlement to additional benefits such as education benefits for family members.

Further we acknowledge the Directors' disagreement with portions of this report. However, to reiterate, we welcome and encourage open and meaningful dialogue with VARO staff to discuss our assessments of cases we identified as having errors. As has been our practice since 2009 when OIG began conducting benefits inspections, we reconsider all errors when VARO staff provide additional information or citations. As the Director indicated, we reversed our position in 7 cases—4 of these related to the 90 cases we reviewed for the claims processing accuracy protocol. The remaining three cases related to dates of claims in our data integrity protocol.

As indicated in this report, our concern centered on the VSC managers' instructions to Quality Review staff to disagree with errors even if the error was correct. We do not know if VARO staff initially concurred or disagreed with our findings in these seven cases. However, the VSC managers' directions advising staff to disagree with our assessments even if the assessments are correct undermines our ability to determine how well the Winston-Salem VARO accomplishes its mission of delivering a range of benefits and services to veterans.

II. Data Integrity

Dates of Claim

To ensure all claims receive proper attention and timely processing, VBA policy directs staff to use the earliest date stamp shown on the claim document as the date of claim. VBA relies on accurate dates of claim to establish and track key performance measures, including the average days to complete a claim. We focused our review on whether VSC staff followed VBA policy for establishing dates of claim in the electronic record.

VSC staff established correct dates of claim for all 30 claims we reviewed. As a result, we determined the VSC is following VBA policy, and we made no recommendation for improvement in this area.

III. Management Controls

Benefits Reductions

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

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

VARO staff delayed or incorrectly processed 14 of 30 benefits reductions claims that VARO staff completed from July through September 2014. This occurred because management did not prioritize this workload. As a result, VA made 126 improper payments to 14 veterans from August 2012 to November 2014, totaling approximately $139,199.

For the 14 cases with processing delays, an average of 8 months elapsed before staff took the required actions to reduce benefits. The most significant improper payment occurred when VARO staff proposed to reduce a veteran's benefits after medical evidence showed the medical condition had improved. Staff proposed the reduction action in March 2012; however, the final rating decision to discontinue benefits did not occur until July 24, 2014—27 months beyond the date when the reduction should have occurred. As a result, the veteran was overpaid approximately $63,452 in improper payments.

VARO management did not agree with our assessments in the 14 cases we identified as having errors. The VSC manager stated while timely action is expected, the timeframe for that action is flexible based upon the specifics of each case, to include workload, and that it is clearly the intent of the VBA criteria to allow delays based on workload management issues. We disagree with this response. This is a significant concern when monthly recurring benefits are paid for medical entitlement benefits. Timely processes are needed to protect and effectively administer taxpayer funds. VBA criteria requires action on the 65th day following due process notification with the only allowance for delays based on either a hearing request from the veteran, or a need for development for more evidence. None of these 14 cases met the provisions outlined in VBA's policy that allow for an extension to complete this work.

It is a VBA management responsibility to ensure this workload is processed timely because it has the potential to entail millions of dollars in improper payments. Without ensuring this work is processed timely, delays in processing benefits reductions result in unsound financial stewardship of veterans' monetary benefits and fail to minimize improper payments. Further, where VBA lacks sufficient staff to properly address its management responsibilities, it should make its case for an increase in staff resources through the normal budget process.

Recommendation

4. We recommended the Winston-Salem VA Regional Office Director implement a plan to ensure staff timely process claims related to benefits reductions to minimize improper payments to veterans.

Management Comments

The VARO Director did not concur with our recommendation to ensure staff timely process benefits reduction cases. The Director continues to assert that workload management issues are neither errors nor procedural deficiencies and maintains that VBA policy authorizes flexibility related to the timeliness of reductions based upon the specifics of each case, to include workload. The Director further indicated that OIG misstated the VSC manager's responses to the 14 errors.

OIG Response

The VARO Director's response to the recommendation is inadequate as it does not address the recommendation to ensure staff timely process claims related to benefits reductions. These payments were clearly improper under the Improper Payments Elimination and Recovery Act of 2010, because they were "made in an incorrect amount…under statutory, contractual, administrative, or other legally applicable requirements." VBA's policy, practices, priorities, or workload do not alter this statutory definition of improper payments. Management's responsibility to prevent improper payments is not a matter of its discretion based on workload priorities as the response implies. According to Executive Order 13520, Reducing Improper Payments and Eliminating Waste in Federal Programs, "When the Federal Government makes payments to individuals and businesses as program beneficiaries, grantees, or contractors, or on behalf of program beneficiaries, it must make every effort to confirm that the right recipient is receiving the right payment for the right reason at the right time." If resources are insufficient to comply, management should work towards a solution. A first step would be to acknowledge that payment errors—i.e., improper payments—are a result of delays in processing workload related to benefits reductions.

Additionally, while examining delays associated with the 14 cases, we factored out the 130 days VBA allows to process benefits reduction cases and found it took VARO staff an average of 8 months before taking required actions to reduce the benefits. We agree VBA policy allows for extensions of the adverse action proposal period when additional development for evidence is needed or if a hearing is requested. However, in the 14 cases we reviewed, there was no evidence that additional development for evidence was needed or that hearings were requested.

We also disagree that the VSC manager's response regarding the 14 errors was misstated by OIG staff. The verbatim response from the VSC manager follows:

> *"M21-1MR, Part I, Chapter 2, Section C, Topic 9, Block d authorizes 130 days, plus time for a rating decision or administrative action plus time for any needed extension. Timely action is expected, but the timeframe for that action is flexible based upon the specifics of each case, to include workload, which is clearly the intent of this manual section. Workload management issues are neither errors nor procedural deficiencies*."

We remain insistent that VBA management has the responsibility to ensure benefits reduction cases are processed timely as it has the potential to result in millions of dollars in improper payments. Almost half of the 30 cases we sampled contained processing delays—resulting in approximately $139,199 in improper benefits payments. Our sample cases represented 3 percent of the 1,158 benefits reduction cases VARO staff completed in a 3-month period; it is not unreasonable to conclude that additional improper payments resulted from delays in processing some of those cases as well. We will continue to follow up with the Winston-Salem VARO or VBA management until all recommendations are adequately addressed.

Appendix A VARO Profile and Scope of Inspection

Organization

The Winston-Salem VARO administers a variety of services and benefits, including compensation; vocational rehabilitation and employment assistance; Benefits Delivery at Discharge; Quick Start; specially adapted housing grants; benefits counseling; public affairs; and outreach to homeless, elderly, minority, and women veterans.

Resources

As of November 2014, VBA's Office of Field Operations reported the Winston-Salem VARO had a staffing level of 697.7 full-time employees. Of this total, the VSC had 469 employees assigned.

Workload

As of November 2014, VBA reports the Winston-Salem VARO had 30,148 compensation claims pending with 13,190 (44 percent) pending greater than 125 days.[1]

Scope and Methodology

VBA has 56 VAROs and a VSC in Wyoming that process disability claims and provide a range of services to veterans. In December 2014 we evaluated the Winston-Salem VARO to see how well it accomplishes this mission.

We reviewed selected management, claims processing, and administrative activities to evaluate compliance with VBA policies regarding benefits delivery and nonmedical services provided to veterans and other beneficiaries. We interviewed managers and employees and reviewed veterans' claims folders. Prior to conducting our onsite inspection, we coordinated with VA OIG criminal investigators to provide a briefing designed to alert VARO staff to the indicators of fraud in claims processing.

Our review included 30 of 627 temporary 100 percent disability evaluations (5 percent) selected from VBA's Corporate Database. These claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of October 8, 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 597 claims remaining from our universe of 627 for its review. We reviewed 30 of 301 disability claims (10 percent) related to TBI that the VARO completed from April through September 2014. We reviewed 30 of 127 disability claims (24 percent) involving entitlement to SMC and related ancillary benefits completed by VARO staff from October 2013 through September 2014.

[1] All calculated percentages in this report have been rounded where applicable.

We reviewed 30 of the 12,041 dates of claims (1 percent) recorded in VBA's Corporate Database from July 1, 2014, through September 30, 2014, pending as of October 23, 2014. Additionally, we looked at 30 of the 1,158 completed claims (3 percent) that proposed reductions in benefits from July through September 2014.

Data Reliability

We used computer-processed data from the Veterans Service Network's Operations Reports and Awards. To test for reliability, we reviewed the data to determine whether any were missing from key fields, included calculation errors, or were outside the time frame requested. We assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Further, we compared veterans' names, file numbers, Social Security numbers, VARO numbers, dates of claim, and decision dates provided in the data received with information contained in the 150 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI claims, SMC and ancillary benefits, dates of pending claims at the VARO, and completed claims involving proposed benefits reductions.

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

This report references VBA's Systematic Technical Accuracy Review data. As reported by VBA's Systematic Technical Accuracy Review as of November 2014, the overall claims-based accuracy of the VARO's compensation rating-related decisions was 89.3 percent. We did not test the reliability of these 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. Winston-Salem VARO Inspection Summary

Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance
Disability Claims Processing		
Temporary 100 Percent Disability Evaluations	Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations. (38 CFR 3.103(b)), (38 CFR 3.105(e)), (38 CFR 3.327), (M21-1 MR Part IV, Subpart ii, Chapter 2, Section J), (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)	No
Traumatic Brain Injury Claims	Determine whether VARO staff properly processed claims for service connection for all disabilities related to in-service TBI. (FL 08-34 and 08-36), (Training Letter 09-01)	Yes
Special Monthly Compensation and Ancillary Benefits	Determine whether VARO staff properly processed SMC and correctly granted entitlement to ancillary benefits. (38 CFR 3.350, 3.352, 3.807, 3.808, 3.809, 3.809a, 4.63, and 4.64), (M21-1MR IV.ii.2.H and I)	No
Data Integrity		
Dates of Claim	Determine whether VARO staff accurately established claims in the electronic records. (38 CFR 3.1 (p) and (r)), (M21-4, Appendix A and B), (M21-1MR, III.ii.1.C.10.a), (M21-1MR, III.ii.1.B.6 and 7), (M21-1MR, III.ii.2.B.8.f), (M21-1MR, III.i.2.A.2.c) (*VBMS User Guide*), (M21-4, Chapter 4.07), (M23-1, Part 1, 1.06)	Yes
Management Controls		
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: June 3, 2015

From: Director, VA Regional Office Winston-Salem, North Carolina

Subj: Inspection of the VA Regional Office, Winston-Salem, North Carolina

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

1. The Winston-Salem Regional Office's comments on the OIG Draft Report: Inspection of the VA Regional Office, Winston-Salem, North Carolina are below.

    a. Finding 1: Winston-Salem Regional Office Needs to Improve the Processing of Two Types of Disability Claims

        i. In the Temporary 100 percent disability evaluations section, the Winston-Salem Regional Office does not concur with the last two paragraphs on page 5. Neither the Regional Office, nor the Veterans Service Center Manager (VSCM) has ever condoned "disagreeing for the sake of disagreeing." Each claim for which a Notice of Error was received was scrutinized by a member of the Quality Review Team. As a result of those reviews, seven of the original 36 errors were overturned. Four of the overturned errors were related to Temporary 100 percent disability evaluations. The number of overturned errors clearly validated the need for an in-depth review by the Winston-Salem Regional Office. This also further demonstrates our commitment to the Veteran and an accurate case review. The Winston-Salem Regional Office did concur with one of the Special Monthly Compensation errors. These actions clearly display the Winston-Salem Regional Office was focused on a full review to ensure that the accuracy of the actions taken by employees were found correct where appropriate, but also identified as an error where applicable.

        ii. Recommendations

            1. We recommended the Winston-Salem VA Regional Office Director conduct a review of the 597 temporary 100

percent disability evaluations remaining from our universe as of October 8, 2014, and take appropriate actions.

a. The Winston-Salem Regional office concurs with this finding.

b. The Winston-Salem Regional Office confirms receipt of this list of 597 claims and will work to ensure all are reviewed. Due to agency priorities for backlog claims processing, the Regional Office will complete this review by December 31, 2015.

2. We recommended the Winston-Salem VA Regional Office Director develop and implement a plan to ensure claims processing staff receive additional training on required actions relating to required medical reexaminations.

a. The Winston-Salem Regional Office concurs with this finding.

b. The Winston Salem Regional Office will conduct refresher training for Claims Assistants (CAs) in the Intake Processing Center and all Pre-Development (Pre-D) and Post-Development (Post-D) Veteran Service Representatives (VSRs). The CA training will consist of a 2-hour formal block and focus on responsibilities and steps for reviewing the items in the diaries and establishing 310 end products (EPs). Refresher training for Pre-D and Post-D VSRs will focus on preparing and scheduling examinations generated from the EP 310 and identifying indicators during final processing, respectively. Pertinent information will be disseminated through quality review meetings led by AQRSs, supervisor team huddles, and *Quality Observer* publications. All training will be completed by July 31, 2015.

3. Provide implementation plan paragraph that includes specific corrective actions and target completion dates. We recommended the Winston-Salem VA Regional Office Director implement a plan to ensure staff receives refresher training on processing higher-level special monthly compensation claims.

a. The WSRO concurs with this finding.

b. The Winston-Salem Regional Office conducted

refresher training on Special Monthly Compensation (SMC) claims for all RVSRs, DROs and QRSs from January 19 - 23, 2015. The instruction methodology encompassed both visual and practical applications, including use of the SMC calculator. The Quality Review Team (QRT) continually assesses the requirement for additional training through observance of both local and national error trends. The QRT also takes a more proactive approach and conducts individual, more specialized SMC training for RVSRs based on trends and/or staff solicitation.

b. Finding 2: VARO Lacked Oversight To Ensure Timely Action on Proposed Benefits Reductions

i. The WSRO continues to assert that workload management issues are neither errors nor procedural deficiencies and maintains that M21-1MR, Part I, Chapter 2, Section C, Topic 9, Block d authorizes 130 days, plus time for a rating decision or administrative action plus time for any needed extension. Timely action is expected, but the timeframe for that action is flexible based upon the specifics of each case, to include workload. The OIG restated this as "it is clearly the intent of the VBA criteria to allow delays based on workload management issues," which was not the intent of our rebuttal.

ii. Recommendation

1. We recommended the Winston-Salem VA Regional Office Director implement a plan to ensure staff timely process claims related to benefits reductions to minimize improper payments to veterans.

a. The WSRO does not concur with this finding based on the above explanation in section i.

2. Please refer questions to Douglas C. Chapman, VSCM 336-251-0727.

(original signed by:)

Cheryl J. Rawls
Director, Winston-Salem Regional Office

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 Nelvy Viguera Butler Robert Campbell Karen Cobb Casey Crump Ramon Figueroa Kerri Leggiero-Yglesias

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