VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Benefits Administration

Inspection of
VA Regional Office
Phoenix, Arizona

September 17, 2015
15-01381-437

ACRONYMS

OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
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

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Report Highlights: Inspection of the VA Regional Office, Phoenix, Arizona

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 services to veterans. We evaluated the Phoenix VARO to see how well it accomplishes this mission. Office of Inspector General Benefits Inspectors conducted this work in March 2015.

What We Found

The Phoenix VARO did not consistently process one of the three types of disability claims we reviewed. Overall, staff did not accurately process 10 of 90 disability claims reviewed. As a result, 71 improper monthly payments were made to 4 veterans totaling approximately $35,500. We sampled claims that we considered at increased risk of processing errors. These results do not represent the accuracy of all disability claims processing at this VARO.

Staff correctly processed 28 of 30 temporary 100 percent disability evaluations we reviewed. In our 2012 inspection report, the most frequent processing errors associated with temporary 100 percent disability evaluations occurred because management did not have an oversight process to ensure staff entered suspense diaries as required. During this inspection, we did not identify similar errors. Therefore, we determined VBA's response to our previous recommendation was effective. Staff also accurately processed 28 of 30 traumatic brain injury claims we reviewed.

Phoenix VARO staff incorrectly processed 6 of 30 Special monthly compensation (SMC) claims, but followed VBA's policy for establishing dates of claim in the 30 claims we reviewed. VARO staff did not correctly process or delayed processing 9 of 30 benefits reductions cases because management prioritized other workload higher.

What We Recommended

We recommended the Director review the 325 temporary 100 percent disability evaluations within the universe of claims at the VARO as of December 17, 2014, and take appropriate action. The Director should ensure refresher training for processing higher levels of SMC and ancillary benefits claims. We also recommended the Director implement a written plan to ensure oversight and prioritization of benefits reduction cases and related hearings.

Agency Comments

The VARO Director concurred with our recommendations and their planned actions are responsive.

Brent E. Arronte
Deputy Assistant Inspector General
for Audits and Evaluations

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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.

We provide this information to help the VARO make procedural improvements 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 Phoenix 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 Phoenix 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 Phoenix VARO Needs To Improve the Processing of One Type of Disability Claim

The Phoenix VARO did not consistently process entitlement to SMC and ancillary benefits. Overall, VARO staff incorrectly processed 10 of the total 90 disability claims we sampled, resulting in 71 improper monthly payments to 4 veterans totaling approximately $35,500 at the time of our inspection. Table 1 reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Phoenix VARO.

Table 1. Phoenix 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	1	2
TBI Claims	30	0	2	2
SMC and Ancillary Benefits	30	3	3	6
Total	**90**	**4**	**6**	**10**

Source: VA OIG analysis of the VBA's temporary 100 percent disability evaluations paid at least 18 months, TBI disability and SMC and ancillary benefits claims completed in fiscal year 2014.

Temporary 100 Percent Disability Evaluations

VARO staff correctly processed 28 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. 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.

Effective management of these temporary 100 percent disability ratings can reduce VBA's risks of paying inaccurate financial benefits and provide improved stewardship of taxpayer funds. Available evidence showed one of the two processing errors affected benefits and resulted in five improper monthly overpayments to a veteran totaling approximately $10,900. These improper monthly benefits payments ranged from September 2014 to February 2015. Details on the error affecting benefits follow.

VSC staff received a reminder notification in August 2013 to review a veteran's temporary 100 percent evaluation for Non-Hodgkin's lymphoma. The veteran was notified of the proposed reduction on April 16, 2014. However, after due process expired, staff did not take action to reduce the benefit until March 18, 2015—after receiving our notification of the error. VARO management concurred with this error.

The second error could potentially affect a veteran's benefits. Following are details on the error.

A VA examiner noted that the veteran's prostate cancer would require continuous hormonal treatment with no completion date. The RVSR confirmed and continued the temporary 100 percent evaluation. The RSVR also noted an August 2015 reexamination date; instead, the RSVR should have granted entitlement to Dependents' Educational Assistance benefits. If left uncorrected, the veteran will not receive entitlement to the additional benefit, and may be required to attend unnecessary medical reexaminations. VARO management concurred with this error.

Based on our inspection and the accuracy rate for temporary 100 percent evaluations, we found that the Phoenix VARO has been proactive in its efforts to prioritize these cases. Our interviews with management and staff showed the VARO has realigned these cases to one processing team. This team reviews reminder notifications, requests reexaminations, and processes the rating decisions. With aggressive controls and management of the temporary 100 percent evaluations, the VARO is generally compliant in this area. Therefore, we made no recommendation for improvement. Since we reviewed 30 claims within our sample, we provided VSC management with the 325 claims remaining from our universe of 355 for review to determine if action is required.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Phoenix, Arizona* (Report No. 12-00246-226, July 17, 2012), VARO staff incorrectly processed 26 of 30 temporary 100 percent disability evaluations we reviewed. Twenty-two errors occurred because there was no oversight to ensure staff established suspense diaries in the electronic record. Four errors resulted from delayed action on proposed reductions. In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each had a future examination date entered in the electronic record. We made no specific recommendation for this VARO.

During our March 2015 inspection, we did not find any cases in which staff did not establish suspense diaries in the electronic record. There was one case similar to the 2012 delay errors. As the VARO was generally compliant during the current inspection, VBA's response to our recommendation appears to have been effective.

TBI Claims

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

In response to a recommendation in our previous 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 correctly processed 28 of 30 TBI claims—the two inaccuracies identified had the potential to affect veterans' benefits. VARO management concurred with both errors. Summaries of the errors follow.

- In the first case, an RVSR incorrectly assigned a 10 percent evaluation for a veteran's TBI based on subjective symptoms that included headaches and tinnitus. However, the RVSR also granted separate evaluations for these two disabilities. VBA policy requires staff to avoid evaluating the same disability under various diagnoses. Because of the veteran's multiple service-connected disabilities, this error does not currently affect the veteran's monthly benefits. However, if left uncorrected, it has the potential to affect future benefits if the veteran's other service-connected disabilities worsen, or if service connection is granted for a new disability.
- In the second case, an RVSR prematurely denied a combat veteran's TBI claim without obtaining a VA medical examination. The veteran claimed TBI due to service and his service treatment records noted unconsciousness due to a blast explosion. VBA policy requires that staff obtain a medical examination when the evidence of record contains an event or injury in service and associated symptoms of disability, but does not contain sufficient medical evidence to decide the claim. Without a VA medical

examination, neither VARO staff nor we could determine whether the veteran would have been entitled to benefits.

During this inspection, interviews with management and staff and a review of training records showed VARO staff had received TBI training, which helped staff correctly process TBI claims. In addition, the VARO's Quality Review Team provided second-signature review of TBI rating decisions and monitored these cases to identify trends. We also noted that the quality review staff engaged and maintained effective communication with the RVSRs. The team sends weekly emails with information on rating issues to staff and have an "open door" policy to help answer TBI-related questions. We determined VARO staff generally followed VBA policy when processing TBI claims. Therefore, we made no recommendation for improvement in this area.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Phoenix, Arizona* (Report No. 12-00246-226, July 17, 2012), we found 7 of 23 TBI claims were processed incorrectly. The errors generally occurred because staff received inadequate training on TBI regulations and policies. The VARO concurred with our recommendation to develop and implement a plan to monitor the effectiveness of training on the proper processing of TBI claims. The OIG closed this recommendation on February 12, 2013, after the VARO provided documentation showing that the station implemented a review procedure for completed TBI rating decisions. The purpose of the review was to monitor the effectiveness of training and to address any noted deficiencies. Given the significant improvement demonstrated by VARO staff when processing TBI claims, we conclude the VARO's action in response to our prior recommendation was 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 that are evaluated as 50 to 100 percent disabling
- Existence of multiple disabilities that render the veteran in need of such a degree of special skilled assistance that without it, the veteran would be permanently confined to a skilled-care nursing home

Ancillary benefits are secondary benefits that staff must consider when evaluating claims for SMC. Examples of ancillary benefits are:

- Dependents' Educational Assistance Under Title 38, United States Code, Chapter 35
- 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, 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 30 claims involving SMC and ancillary benefits—3 errors affected veterans' benefits and resulted in improper payments to veterans totaling approximately $24,600. These errors represented 66 improper recurring monthly payments from January 2013 to February 2015. In one case, there was both an overpayment and an underpayment. VARO management concurred with all errors we identified. Details on the errors affecting benefits follow:

- An RVSR incorrectly granted SMC based on bilateral blindness. As a result, VA overpaid the veteran approximately $12,800 over a period of 11 months. In the same case, the RVSR assigned an incorrect effective date for the veteran's increase in disability for his visual impairment. As a result, the same veteran was underpaid approximately $500 over a period of 5 months.
- In another case, an RVSR did not award the appropriate level of SMC for a veteran with bilateral above knee amputations and

additional permanent disabilities rated at 50 percent or more disabling. As a result, VA underpaid the veteran approximately $6,700 over a period of 25 months. This was the most significant underpayment.

- An RVSR assigned an incorrect level of SMC for a veteran with loss of use of both lower extremities and additional permanent disabilities evaluated at 50 percent or more disabling. As a result, VA underpaid the veteran approximately $4,600 over a period of 25 months.

The remaining three errors had the potential to affect veterans' benefits. Details on the three errors follow.

- An RVSR prematurely increased the evaluation for a veteran's visual impairment and granted entitlement to SMC using an insufficient medical examination. The RVSR should have returned the examination report for clarification. The RVSR incorrectly granted the Specially Adapted Housing benefit for blindness when the veteran was not entitled to this benefit. Without a sufficient medical examination report, neither VSC staff nor we could determine the correct level of the veteran's visual impairment or entitlement to SMC.
- In another case, an RVSR did not grant entitlement to the Specially Adapted Housing grant although the veteran met the criteria on May 14, 2013. As a result, the veteran, who died on December 27, 2014, did not receive notice of his entitlement to a benefit worth up to $67,555.
- In the final case, an RVSR assigned a level of SMC for a veteran with loss of use of both hands but did not grant entitlement to the auto allowance benefit. As a result, the veteran did not receive notice of his entitlement to a benefit that provides up to $19,817 toward the purchase of an automobile or other conveyance.

Generally, the errors occurred due to a lack of regular training. According to VARO training records, higher levels of SMC training was provided in November 2014 and March 2015. Previously, SMC training was completed in January 2013. Our review consisted of cases processed prior to the training held in November 2014 and March 2015. The VSC manager acknowledged the complexity of SMC and said that additional training is necessary. Staff interviewed stated that the recent training was effective. They also indicated refresher training is helpful, because it helps staff remember the complex issues involved with SMC.

Two of the six errors we found were due to staff failing to award higher levels of SMC, and two were due to staff failing to award ancillary benefits. In these cases, RVSRs must infer entitlement, meaning they must remember to award the benefit even when the veteran did not specifically claim it. RVSRs stated additional issues with SMC are easy to overlook due to the complexity and infrequency of the claims.

Based on interviews, we determined the most recent SMC training provided in fiscal year 2015 was effective as staff are aware of requirements for the intermediate evaluations and ancillary benefits. Additionally, staff that made errors within our sample also completed rating decisions within the sample that were error-free. Thus, we believe RVSRs simply overlooked awarding the benefits. As a result, veterans did not always receive correct SMC benefits payments and may not be aware of entitlement to ancillary benefits.

Recommendations

1. We recommended the Phoenix VA Regional Office Director conduct a review of the 325 temporary 100 percent disability evaluations remaining from their inspection universe as of December 17, 2014, and take appropriate action.

2. We recommended the Phoenix VA Regional Office Director ensure frequent refresher training for processing higher levels of special monthly compensation and ancillary benefits claims.

Management Comments

The VARO Director concurred with our recommendations and stated the RO has reviewed all 325 temporary 100 percent disability evaluations that OIG identified. The Director also stated the VARO reviewed controls to ensure that appropriate suspense diaries were set for future controls.

Additionally, staff from the Compensation Service Quality Review and Consistency team will provide SMC training to VARO Quality Review Team during the week of July 20-24, 2015. Subsequently, staff from the Quality Review Team will provide monthly SMC and ancillary benefits training to all RVSRs and Decision Review Officers from August through December 2015.

OIG Response

The Director's comments and actions are responsive to the recommendations.

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. Such instances are attributable to VAROs not taking the actions required to ensure correct payments for the veterans' current levels of disability.

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

On April 3, 2014, VBA leadership modified its policy regarding the processing of claims requiring benefits reductions. The new policy no longer includes the requirement for VARO staff to take "immediate action" to process these reductions. Instead 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 Phoenix VARO Needs To Ensure Timely Action on Proposed Benefits Reductions

VSC staff delayed processing or incorrectly processed 9 of 30 cases involving proposed benefits reductions. There were eight processing delays affecting veterans' benefits and one processing inaccuracy that had the potential to affect a veteran's benefits. The delays generally were due to a lack of emphasis on the timely processing of this workload. These processing delays resulted in overpayments totaling approximately $124,000 representing 89 improper monthly recurring

payments to 8 veterans from June 2013 to February 2015. Details on the errors affecting benefits follow:

- In the first case, VSC staff sent a letter to a veteran on January 24, 2013, proposing to reduce the evaluation for his leukemia; due process expired April 1, 2013. Staff did not take action to reduce the evaluation until September 2014. As a result, VA overpaid the veteran approximately $46,000 over a period of 18 months. This case contained the most significant overpayment and delay.
- VSC staff sent a letter to a veteran on April 25, 2013, proposing to reduce the evaluation for his prostate cancer; due process expired July 1, 2013. However, staff did not take action to reduce the evaluation until September 2014. As a result, VA overpaid the veteran approximately $41,300 over a period of 15 months.
- In another case, VSC staff sent a letter to a veteran on June 17, 2013, proposing to reduce the evaluation for her TBI; due process expired August 21, 2013. Staff did not take action to reduce the benefits until August 2014. As a result, VA overpaid the veteran approximately $13,900 over a period of 12 months.
- VSC staff sent a letter to a veteran on January 23, 2014, proposing to reduce the evaluation for his prostate cancer; due process expired March 31, 2014. However, staff did not take action to reduce the evaluation until August 2014. As a result, VA overpaid the veteran approximately $9,400 over a period of 5 months.
- In another case, VSC staff sent a letter to a veteran on November 26, 2013, proposing to reduce the combined evaluation for his service-connected conditions. The veteran submitted a hearing request on January 6, 2014, more than 30 days after the letter notifying him of the proposed reduction, and due process expired January 30, 2014. VSC staff established an electronic system control for a hearing and removed the control for the proposed reduction. According to VBA policy, staff should have taken the reduction action at the expiration of due process, as the hearing request was not timely, and scheduled the hearing later. At the time of our review, staff had not taken final reduction action nor held the hearing. As a result, VA overpaid the veteran approximately $6,100 over a period of 10 months.
- VSC staff sent a letter to a veteran on June 21, 2013, proposing to reduce the evaluations for some of his service-connected conditions; due process expired August 26, 2013. The veteran submitted a hearing request on June 13, 2013. VSC staff removed the control for the proposed reduction on September 9, 2014.

According to VBA policy, the hearing request suspends reduction action only if the veteran submits the request within 30 days of the notice of the proposed reduction. Since the veteran submitted his hearing request prior to receiving notification of the proposed decision, staff should have reduced the evaluations upon expiration of due process. However, at the time of our onsite review in March 2015, staff had not taken action to reduce the veteran's benefits, and there was no control in place for the proposed reduction. As a result, VA overpaid the veteran approximately $3,600 over a period of 15 months.

- In another case, VSC staff sent a letter to a veteran on June 11, 2013, proposing to reduce the evaluation for her Meniere's disease; due process expired August 15, 2013. However, staff did not take action to reduce the evaluation until September 2014. As a result, VA overpaid the veteran approximately $3,000 over a period of 13 months.
- In the final case, VSC staff sent a letter to a veteran on August 4, 2014, proposing to reduce the evaluation for his depressive disorder; due process expired October 8, 2014. However, at the time of our review, staff had not taken action to reduce the veteran's benefits. As a result, VA overpaid the veteran approximately $390 over a period of 1 month.

In the one case that had the potential to affect a veteran's benefits, VSC staff sent a letter to the veteran on June 6, 2014, proposing to reduce the evaluation for his mental condition. On June 12, 2014, the veteran stated his willingness to report for an examination and asked that staff schedule it between October and December 2014. Staff requested an examination on August 13, 2014, but did not indicate the veteran's availability dates, and the veteran did not report for the scheduled examination. On September 30, 2014, VSC staff erroneously cleared the electronic system control for the proposed reduction. At the time of our review, staff had not rescheduled the veteran's examination, and there was no control in place for the proposed reduction. The veteran will continue to be paid at the current rate until staff conduct a VA examination and make a final rating decision.

During our review of the 30 completed cases involving proposed benefits reductions, we found 7 veterans who timely requested hearings, within 30 days of the letters proposing to reduce or discontinue their evaluations. The oldest hearing request was March 21, 2013, and the most recent was July 1, 2014. When veterans submit timely hearing requests, VBA policy states benefits will continue until staff receive results from the hearings. We did not

consider the final reductions delayed because the veterans timely requested hearings; however, at the time of our review, staff had not held these hearings.

Generally, the processing delays occurred because VSC management did not prioritize this workload, which we confirmed during our interviews with management and staff. Because of national changes to workload management, VSC leadership did not prioritize processing benefits reductions and concentrated instead on the national priority, processing rating claims pending over 125 days. According to VSC management, since the benefits reductions associated with the delayed hearings were not a priority, these hearings also were not a priority. Both management and staff confirmed a lack of emphasis on timely following through with proposed rating reductions and related hearings.

Recommendation

3. We recommended the Phoenix VA Regional Office Director implement a written plan to ensure oversight and prioritization of benefits reduction cases and related hearings.

Management Comments

The VARO Director concurred with our recommendation and updated a plan on July 1, 2015, to reduce the current EP 600 series by the end of the fiscal year. A non-rating coach will oversee this workload and will prioritize the oldest pending reductions and related hearings daily.

OIG Response

The Director's comments and actions are responsive to the recommendation.

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of March 2015, the Phoenix VARO reported a staffing level of 485 full-time employees. Of this total, the VSC had 262.4 employees assigned.

Workload

As of February 2015, VBA reported the Phoenix VARO had 9,626 compensation claims pending with 4,883 (51 percent) pending greater than 125 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. In March 2015, we evaluated the Phoenix 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 355 temporary 100 percent disability evaluations (8 percent) selected from VBA's Corporate Database. These claims represented instances in which VBA staff had granted temporary 100 percent disability evaluations for at least 18 months as of December 17, 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 325 claims remaining from our universe of 355 claims as of December 17, 2014, for review. We reviewed 30 of 444 disability claims related to TBI (7 percent) and 30 of 41 claims involving entitlement to SMC and ancillary benefits (73 percent) completed by VARO staff during fiscal year 2014.

We reviewed 30 of 3,448 dates of claim recorded in VBA's Corporate Database from July through September 2014, as of December 17, 2014. Additionally, we looked at 30 of 296 completed claims (10 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 we reviewed did not disclose any problems with data reliability.

This report references VBA's Systematic Technical Accuracy Review data. As reported by VBA's Systematic Technical Accuracy Review program as of February 2015, the overall claims-based accuracy of the VARO's compensation rating-related decisions was 91.5 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. Phoenix 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)	Yes
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)), (38 CFR 3.400), (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: September 2, 2015

From: Director, VA Regional Office, Phoenix, Arizona

Subj: Phoenix VARO OIG Benefits Inspection- Response to Recommendations

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

1. The Phoenix VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Phoenix, Arizona*
2. Please refer questions to the Director's Office at 602-627-2740.

/s/

Duane A. Honeycutt

Acting Director

Attachment

Phoenix VA Regional Office

Responses to OIG Site Visit

The following comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation #1 - We recommended the Director review the 325 temporary 100 percent disability evaluations within the universe of claims at the VARO as of December 17, 2014, and take appropriate action.

Regional Office Response, September 2015: The Phoenix RO concurs with this recommendation. The RO has reviewed all 325 temporary 100 percent disability evaluations that OIG identified. In addition, controls were reviewed to ensure that appropriate suspense diaries were set for future reviews.

As of September 2, 2015, there are only 21 items pending from the original listing provided by OIG. Appropriate development and administrative actions have been initiated for these items. The Express Coach and Non-Rating Coach share responsibility over these items and the Assistant Veterans Service Center Manager closely monitors their progress. The VARO will complete this review and corrective actions by December 31, 2015.

The RO adheres to the national priority of this workload and has no routine future examination work items pending over 180 days. The RO is prepared to make adjustments based on workload and staffing in order to prioritize these reviews efficiently.

The Phoenix RO requests closure of this item.

Recommendation #2 - We recommended the Phoenix VA Regional Office Director ensure frequent refresher training for processing higher levels of special monthly compensation (SMC) and ancillary benefits claims.

Regional Office Response, July 2015: The Phoenix RO concurs with this recommendation. Members of Compensation Service Quality Review and Consistency staff will provide on-site SMC training to the Quality Review Team (QRT) during the week of July 20-24, 2015. From August through December 2015, the QRT members will provide monthly SMC and ancillary benefits training to all Rating Veterans Service Representatives and Decision Review Officers.

The Phoenix RO requests closure of this item.

Recommendation #3 - We recommended the Phoenix VA Regional Office Director implement a written plan to ensure oversight and prioritization of benefits reduction cases and related hearings.

Regional Office Response, July 2015: The Phoenix RO concurs with this recommendation. In order to prioritize benefit reduction actions and related hearings, a plan was implemented at the beginning of FY15 and updated July 1, 2015 which will reduce the current EP 600 series average days pending of 71.6 days to 65 days, by the end of the fiscal year.

The Non-Rating Coach is responsible for distributing the daily workload and overseeing timeliness of employee actions. The oldest pending reductions and related hearings are prioritized daily. The Assistant Veterans Service Center Manager closely monitors the progress and will make adjustments based on workload and staffing.

The Phoenix RO requests closure of this item.

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Brent Arronte, *Director* Ed Akitomo Michelle Elliott David Piña Rachel Stroup Dana Sullivan Nelvy Viguera Butler

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