VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Benefits Administration

Inspection of
VA Regional Office
San Diego, California

September 9, 2015
15-00399-410

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, San Diego, CA

Why We Did This Review

The Veterans Benefits Administration 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 San Diego VARO to see how well it accomplishes this mission. 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.

What We Found

The San Diego VARO did not accurately process two of the three types of disability claims we reviewed. Overall, 23 of the 90 disability claims (26 percent) we reviewed contained processing inaccuracies that resulted in approximately $111,271 in improper payments paid from April 2012, until October 2014. During this inspection, VARO staff incorrectly processed 10 of 30 temporary 100 percent disability evaluations we sampled.

These results show improvement from our previous inspection in 2012 where 23 of the 30 cases sampled contained processing errors. Results from our current inspection also showed staff accurately processed 28 of the 30 traumatic brain injury (TBI) claims we sampled—a significant improvement from our 2012 inspection, where 9 of the 19 cases we reviewed contained errors. However, VARO staff did not accurately process 11 of the 30 claims for Special Monthly Compensation (SMC) and ancillary benefits that VARO staff completed.

VARO staff established the correct dates of claim for 30 cases we reviewed in the electronic record. However, VARO staff did not correctly process 7 of 30 benefits reduction cases due to other workload prioritized higher.

What We Recommended

We recommended the San Diego VARO Director implement plans to ensure staff take timely actions to request medical reexaminations, review the 388 temporary 100 percent disability evaluations remaining from our inspection universe, ensure staff receive refresher training on SMC and ancillary benefits, and take steps to strengthen the VARO's second-signature review process. The Director should also ensure staff prioritize benefits reductions to minimize improper payments to veterans.

Agency Comments

The Director of the San Diego VARO concurred with all recommendations. However, the Director's planned corrective actions do not adequately address the recommendations. We will follow up as required.

BRENT E. ARRONTE
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for Audits and Evaluations

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INTRODUCTION

Objective

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

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

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 San Diego 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 San Diego 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 higher 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.

Finding 1 San Diego VARO Needs To Improve the Processing of Two Types of Disability Claims

The San Diego VARO did not consistently process temporary 100 percent disability evaluations or entitlement to SMC and ancillary benefits accurately. Overall, VARO staff incorrectly processed 23 of the total 90 disability claims (26 percent) we sampled. As a result, 12 veterans received 202 improper monthly payments totaling approximately $111,271.

Table 1. San Diego 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	5	5	10
TBI Claims	30	0	2	2
SMC and Ancillary Benefits	30	7	4	11
Total	**90**	**12**	**11**	**23**

Source: VA OIG analysis of VBA's temporary 100 percent disability evaluations paid at least 18 months; TBI disability claims completed from April 1, 2014 through September 30, 2014; and SMC and ancillary benefits claims completed from October 1, 2013, through September30, 2014

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 10 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 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.

Without effective management of these temporary 100 percent disability ratings, VBA is at an increased risk of paying inaccurate financial benefits. Available medical evidence showed 5 of the 10 processing errors we identified affected veterans' benefits and resulted in 103 improper monthly payments to 5 veterans totaling approximately $82,308 from April 2012 to October 2014. Details on the errors affecting benefits follow.

- VARO staff failed to take timely action to reduce benefits despite medical evidence in the veteran's claim file that showed the veteran's condition no longer supported the temporary 100 percent disability evaluation. As a result, the veteran was overpaid approximately $33,024 over a period of 1 year. This was the most significant overpayment.
- A Rating Veterans Service Representative (RVSR) incorrectly evaluated a veteran's total knee replacement (prosthesis) as 100 percent disabling for longer than the required 1 year and 1 month entitlement, as required. As a result, the veteran was overpaid approximately $26,223 over a period of 1 year and 2 months.
- Two errors occurred when RVSRs incorrectly established higher levels of SMC based on temporary 100 percent disability evaluations of prostate cancer. As a result, the veterans were overpaid approximately $10,897 over a period of 2 years and 6 months and approximately $4,391 over a period of 2 years, respectively.

- An RVSR did not establish service connection for bone cancer and entitlement to SMC for additional disabilities caused by the veteran's prostate cancer. As a result, the veteran was underpaid approximately $7,773 over period of 1 year and 11 months. This was the only underpayment we identified in our sample.

The remaining five errors had the potential to affect veterans' benefits. The errors did not affect the veterans' overall disability evaluations at the time of our inspection in October 2014. Following are details on the five errors.

- Four errors occurred when VARO staff delayed scheduling required VA reexaminations despite receiving reminder notifications that the reexaminations were due.
- An RVSR established an incorrect date for a medical reexamination for a veteran's Hodgkin's disease in July 2018—approximately 5 years into the future. Generally, 18 months is the longest period a temporary 100 percent disability evaluation would remain in effect before a reexamination would be required. Although VA treatment records showed the temporary 100 percent disability evaluation should be continued; however, the reexamination date of July 2018, exceeded VBA's required examination date by several years.

The majority of the processing inaccuracies resulted from inadequate VARO management oversight to ensure staff took timely action to schedule medical reexaminations despite receiving reminder notifications to do so. We reviewed claims in advance of our site visit and found that VARO staff had delayed requesting reexaminations on average for 5 months. Until VARO staff obtain the medical evidence needed to reevaluate each case, the temporary 100 percent disability evaluations continue uninterrupted. We provided VARO management with 388 claims remaining from our universe of 418 after completing our sample review of 30 claims for its review to determine whether similar action is required.

Interviews with VARO management revealed other claims processing activities had higher priority. VARO management stated it focused on rating disability compensation claims. VBA's Central Office and Western Area office instructed the VARO to focus on a specific workload; however, the instructions did not include taking timely action to schedule medical reexaminations after receiving reminder notifications.

VARO management concurred with our assessment in 6 of the 10 cases. Management did not concur with the remaining four cases; citing failure to take timely actions on the temporary 100 percent disability evaluations were workload management issues. In addition, management indicated that although it has a local policy and is responsible for ensuring that timely and appropriate action is taken, workload demands have impacted the ability to do so.

We disagree. It is a VBA management responsibility to address this issue, which entails millions of dollars in improper payments. Where VBA lacks sufficient staff to properly address its management responsibilities, it should make its case for an increase in full-time equivalents through the normal budget process. Without appropriate priority for this type of work, delays scheduling required medical reexaminations may 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, San Diego, California* (Report No. 12-00242-177, May 10, 2012), VARO staff incorrectly processed 23 of 30 temporary 100 percent disability evaluations we reviewed. The majority of the errors occurred because management did not provide adequate oversight to ensure VSC staff entered suspense diaries in the electronic record to schedule VA medical reexaminations.

During this current inspection, we did not identify any errors where staff did not establish suspense diaries for reexaminations of temporary 100 percent disability evaluations. Rather, the suspense diaries were generating reminder notifications, but staff were not taking timely action to schedule the medical reexaminations after receiving the reminder notifications to do so. Therefore, we determined 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 to 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.

VARO staff generally processed TBI claims correctly; however, 2 of the 30 cases reviewed were processed incorrectly.

Because these veterans had multiple service-connected disabilities, these inaccuracies did not affect the veterans' monthly benefits. However, it could potentially affect future benefits if the veterans' service-connected disabilities worsen or if service connection is granted for a new disability. Details on the two errors follow. .

- An RVSR established a 40 percent evaluation for TBI based on objective testing of mild impairment of memory. However, the veteran is currently receiving benefits for a coexisting mental disorder based on the same symptomatology. The RVSR should have returned the examination for clarification per VBA policy. Neither VBA nor the OIG can determine the correct evaluation for a TBI without clarification of related symptoms. VARO management agreed with our assessment in this case.
- An RVSR erroneously assigned separate evaluations for TBI and coexisting mental disorders. On the examination the medical examiner indicated the symptoms could not be delineated as they were co-occurring. The RVSR did not use the symptoms to establish a single disability evaluation as required. VARO management agreed both evaluations applied the symptom of memory loss. However, management disagreed that this was a processing error. VARO management believed the error was harmless and should be classified as an evidentiary error as it does not affect the overall evaluation. We disagree. In this case, the medical examiner indicated the symptoms could not be delineated, as such, VBA policy required that the RVSR assign one evaluation either to the TBI or the mental disorder—but not both. VBA policy requires staff to avoid evaluating the same disability under various diagnoses.

Given VARO staff correctly processed 28 of the 30 cases; we determined staff generally followed VBA policy when processing TBI−related disability 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, San Diego, California (Report No. 12-00242-177, May 10, 2012), VARO staff incorrectly processed 9 of the 19 TBI claims we reviewed, generally because staff used insufficient VA medical examinations for rating decisions. We recommended the VARO Director implement a plan to ensure staff return insufficient medical examination reports to the VA health care facilities to obtain the evidence needed to support decisions on TBI claims. In September 2012, OIG closed this recommendation.

We did not identify any similar errors during this inspection. 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 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 VBA 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, which allow veterans with certain disabilities such as amputations or paralysis to purchase or renovate a barrier-free home
- Special Home Adaptation Grants, which help blinded veterans or those with upper-extremity handicaps to renovate a home
- Automobile and Other Conveyance and Adaptive Equipment Allowance

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

VARO staff incorrectly processed 11 of 30 veterans' claims involving SMC and ancillary benefits. Seven errors affected veterans' benefits and resulted in 99 improper payments totaling approximately $28,963.[1] The improper payments occurred from September 2012, until October 2014. Generally, errors occurred because of ineffective training and lack of a strong second-signature review process. VARO management concurred with all errors we identified.

Details on the seven errors affecting benefits follow.

- One of the errors affecting benefits occurred when an RVSR incorrectly granted an SMC increase because of the veteran's prostate cancer. This prostate cancer was a temporary evaluation, subject to a future examination. VA regulations require that 50 and 100 percent disabilities for the SMC increase be permanent, not temporary, evaluations. As a result, the veteran was overpaid approximately $10,571 over a period of 1 year and 8 months.
- Six of these errors occurred when RVSRs overlooked increases in SMC. In these cases, veterans were entitled to SMC based on needing help with daily activities, such as bathing or eating, but they also had service-connected disabilities evaluated at 50 or 100 percent disabling, which warranted even higher SMC evaluations.
    - In the largest underpayment, an RVSR established SMC for loss of use of both feet but did not grant an increase in SMC for coronary artery disease, permanently rated at 100 percent disabling. As a result, the veteran was underpaid approximately $6,226 over a period of 1 year and 5 months.

[1] Due to rounding, the amounts in the errors will not add up to $28,963.

- An RVSR established SMC at a level appropriate for the veteran's loss of use of both feet, but overlooked his service-connected hearing loss and tinnitus. The rating should have been effective February 1, 2013; as a result, the veteran was underpaid approximately $3,645 over a period of 1 year and 8 months.
- An RVSR increased a veteran's SMC to meet his need for personal care, but overlooked a previous rating error that failed to grant an increase for other disabilities. That previous rating evaluated the veteran for loss of use of both feet and bowel incontinence, rated at 60 percent. As a result, the veteran was underpaid approximately $3,074 over a period of 1 year and 5 months.
- Two errors occurred when RVSRs evaluated veterans with amyotrophic lateral sclerosis. In one case, an RVSR overlooked a mistake on a previous rating that did not grant increased SMC for additional disabilities more than 50 percent disabling. This veteran had respiratory complications and was underpaid approximately $2,696 for 10 months. In the other, an RVSR did not evaluate a veteran's amyotrophic lateral sclerosis related arm weakness. This veteran was underpaid approximately $1,651 over a period of 9 months.
- An RVSR did not increase a veteran's SMC when evaluating multiple sclerosis and its complications, in this case bowel and bladder involvement. As a result, this veteran was underpaid approximately $1,101 over a period of 6 months.

Four of the total 11 errors had the potential to affect veterans' benefits. Details on these errors follow.

- Two errors involved hospitalization rates for veterans with SMC. VBA policy requires staff to reduce some SMC benefits if a veteran receives hospital care at VA expense. Because the SMC codes were incorrect, these veterans would receive inaccurate payments if hospitalized.
- VARO staff failed to grant entitlement to Specially Adapted Housing, a benefit valued at $67,555 in FY 2014. This error did not affect the veteran's monetary payments because once VBA grants entitlement; veterans must apply for these benefits.
- VARO staff failed to grant entitlement to a Special Home Adaptation Grant—in FY 2014, this was valued at $13,511. This error did not affect the veteran's monetary payments because once VBA grants entitlement; veterans must apply for these benefits.

Generally, VARO staff told us they believed the errors occurred due to a lack of effective training. We confirmed RVSRs last attended higher−level SMC training in May 2014; however, they indicated the training did not meet their needs because it did not include hands-on practice, useful feedback, or opportunities to ask the instructor questions.

We also confirmed the VARO's local policy required that the Special Operations Team manager conduct a second-signature review on all higher-level SMC cases. However, 6 of the 11 cases containing errors had the required secondary review, but the manager conducting the review had not attended SMC training for the past two years. We also learned the manager who provided the secondary reviews had served as an RVSR for about 18 months before becoming the Special Operations Team manager in January 2013. The Special Operations manager told us he did not have time to thoroughly review a case that might take staff several hours to complete and that he trusted his staff to be the subject-matter experts on SMC cases. Consequently, we concluded the Special Operations manager's lack of training in this area undermined the second-signature review process because he did not conduct a thorough review of the cases and did not recognize the errors.

Because VARO management did not ensure staff responsible for the secondary review process maintained the skill set needed to conduct a robust review of the cases, veterans did not always receive correct SMC benefits payments and may not be aware they are entitled to ancillary benefits.

Recommendations

1. We recommended the San Diego VA Regional Office Director develop and implement a plan to ensure staff take timely actions on reminder notifications to request medical reexaminations.

2. We recommended the San Diego VA Regional Office Director conduct a review of the 388 temporary 100 percent disability evaluations remaining from our inspection universe as of October 17, 2014, and take appropriate action.

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

4. We recommended the San Diego VA Regional Office Director develop and implement a plan to increase the effectiveness of the

station's second-signature process for cases with special monthly compensation and ancillary benefits.

Management Comments

The VARO Director concurred with our recommendations and indicated procedures for reviewing reminders for scheduling medical reexaminations are incorporated in the workload management plan and a current local policy. The Director also reported action had been taken on 388 temporary 100 percent disability evaluations OIG provided. VARO staff received SMC refresher training in January 2015 that included practical exercises which confirmed staff had not been using the SMC calculator as intended. Additional training related to ancillary benefits is planned for August 2015. The VARO Director also stated the current VSC policy adequately outlined the VARO's second signature policy for SMC cases and that staff were reminded to follow the guidance.

OIG Response

The Director's responses do not adequately address the recommendations. Specifically, at the time of our review, the VARO already had a local policy requiring staff to take timely actions related to scheduling medical reexaminations but failed to do so—citing workload demands as the reason. With specificity, we will follow up to determine if the corrective actions reported by the Director ensure staff take timely actions to schedule medical reexaminations for temporary 100 percent disability evaluations. Similarly, we found the VARO's local policy for secondary reviews of SMC cases lacking. As such, it is unclear how reiterating the same policy will increase the effectiveness of the secondary reviews.

II. Data Integrity

Dates of Claim

To ensure all claims receive proper attention and timely processing, VBA policy directs staff 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.

VARO staff established claims in the electronic records for all 30 claims we reviewed using correct dates of claims. As such, we made no recommendation for improvement in this area.

III. Management Controls

Benefits Reductions

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

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

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

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

VARO staff delayed processing 6 of 30 cases involving benefits reductions—5 affected veterans' benefits and 1 had the potential to affect veterans' benefits. These delays occurred due to a lack of emphasis on timely processing benefits reductions. As a result, VA made 24 improper payments to 5 veterans from November 2013, to October 2014, totaling approximately $7,853.

Delayed Processing Actions

For the six cases with processing delays, an average of 4 months elapsed before staff took the required actions to reduce benefits. The most significant improper payment involved VSC staff proposing to reduce a veteran's benefits in June 2013; however, the final rating decision to reduce benefits did not occur until August 2014, almost 1 year later. As a result, the veteran received approximately $4,627 in improper payments.

VARO management did not agree with the six processing delays we identified. The VSC manager stated failure to take timely action on these reductions was a workload management issue, and not an error. We disagree with this response. 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. In these cases, neither met the provisions outlined in VBA's policy that allow an extension to complete this work.

Generally, these delays occurred because VARO management did not consider benefits reduction cases a priority. Management stated it was directed by VBA's Central Office and the Office of Field Operations to reduce the current inventory of older pending disability claims. VARO management indicated it did not have the resources to meet the production goals and timely process other workload like rating reductions. Because of the processing delays, veterans received erroneous benefits payments.

It is a VBA management responsibility to address this issue, which entails millions of dollars in improper payments. Where VBA lacks sufficient staff to address properly its management responsibilities, it should make its case for an increase in full-time equivalents through the normal budget process. We concluded that providing oversight of benefits reductions is necessary to ensure sound financial stewardship and minimize improper benefits payments.

Accuracy

VARO staff incorrectly processed 1 of 30 cases involving proposed benefits reductions. In this case, VSC staff sent a letter notifying the

veteran of a proposed action to reduce his disability evaluation as required, which also included the new compensation award amount. However, the notification letter included incorrect information that overstated the veteran's future award amount. VBA policy requires VARO staff to correct the deficiency and provide another due process notification period—ultimately delaying the final reduction in benefits. At the time of this inspection, the final reduction had not taken place so the veteran's current benefits were not affected. However, if left uncorrected, the veteran's benefits may be inappropriately reduced without receiving proper due process. The VSC manager agreed with the accuracy error we identified.

Recommendation

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

Management Comments

The VARO Director concurred with our recommendation but reiterated his position that delayed actions to process benefits reduction cases are not accuracy errors. The Director indicated supervisory staff monitor electronic work controls related to these types of cases and that training for staff was planned to occur in July 2015.

OIG Response

The Director's planned corrective action is not responsive to the recommendation because it does not specify how management will ensure staff prioritize actions related to benefits reductions cases. As we indicated in this report, financial stewardship is a VBA management responsibility to address this issue of improper payments. Where VBA lacks sufficient resources to carry out its responsibilities, it should make its case for increased staffing through the normal budgetary process.

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of November 2014, the San Diego VARO reported a staffing level of 581.9 full-time employees. Of this total, the VSC had 361.5 employees assigned.

Workload

As of September 2014, VBA reported the San Diego VARO had 17,135 pending compensation claims with 5,609 (33 percent) pending greater than 125 days.[2] VBA's Systematic Technical Accuracy Review reported the 12-month claim-based accuracy rate for compensation rating-related issues was 85.2 percent, which is 8.8 percentage points below the FY 2014 national target of 94.0 percent.

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 San Diego 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 418 temporary 100 percent disability evaluations (7 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 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 388 claims remaining from our universe of 418 claims as of October 17, 2014 for review. We reviewed 30 of 389 disability claims related to TBI (8 percent) that the VARO completed from April 1, 2014, through September 30, 2014. We examined 30 of

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

74 veterans' claims involving entitlement to SMC and related ancillary benefits (41 percent) completed by VARO staff from October 1, 2013, through September 30, 2014.

We reviewed 30 of 7,618 dates of claims (0.4 percent) pending at the VARO during the period from July 1, 2014, through September 30, 2014. Additionally, we looked at 30 of 592 completed claims involving proposed benefits reductions (5 percent) from July 1, 2014, through September 30, 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 data were missing from key fields, included any calculation errors, or were outside the time frame requested. We also 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 150 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI claims, SMC and ancillary benefits, completed claims related to benefits reductions, and dates of claims.

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.

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. San Diego 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 dates of claim 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 15, 2015

From: Director, VA Regional Office San Diego

Subj: San Diego VARO OIG Benefits Inspection – Response to Recommendations

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

1. The San Diego VARO's responses to recommendations contained in the OIG Draft Report: Inspection of the San Diego Regional Office, San Diego, CA.

2. Please refer questions to Jan Trausch at 619-400-5410.

(original signed by:)

Patrick C. Prieb
Director

Attachment

OIG Site Visit Response
San Diego Veterans Affairs Regional Office

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

OIG Recommendations

Recommendation 1. We recommended the San Diego VA Regional Office Director develop and implement a plan to ensure staff take timely actions on reminder notifications to request medical reexaminations.

RO Response: Concur. The San Diego VSC Express Team Coaches distribute current listings of EP 810's for needed action within 30 days of when the EP was generated. If an EP 310 is established for scheduling of an examination, the Coaches ensure timely action is taken. The process for working EP 810's, specifically for review examinations, is incorporated in the VSC Workload Management Plan and local VSC Policy 21-15-08, Review Examination Processing. The San Diego RO requests closure of this item.

Recommendation 2. We recommended the San Diego VA Regional Office Director conduct a review of the 388 temporary 100 percent disability evaluations remaining from our inspection universe as of October 17, 2014, and take appropriate action.

RO Response: Concur. Action has been taken on the additional list of 388 temporary 100 percent disability evaluations. The San Diego RO requests closure of this item.

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

RO Response: Concur. Training was completed for all RVSR's, DRO's, and RQRS's on *Intro to SMC, Higher Level of SMC, and Ancillary Benefits* on January 8th and 27th, 2015. Effectiveness of training was measured by in-class practical exercises which allowed the employees to engage in the proper use of the SMC calculator and pop-up messages. Feedback from the employees during the training was positive as it appeared that employees were not accurately using the SMC calculator as intended. *Ancillary Benefits* training is scheduled for all VSR's for August 4th, 5th, and 25th, 2015. The San Diego RO requests closure of this item.

Recommendation 4. We recommended the San Diego VA Regional Office Director develop and implement a plan to increase the effectiveness of the station's second-signature process for cases with special monthly compensation and ancillary benefits.

RO Response: Concur. The current VSC Policy 21-15-15 adequately outlines the second signature process for SMC and ancillary benefits. Additional training provided in January 2015 reiterated the existing 2nd signature requirements of VSC Policy 21-15-15. Periodic ongoing notices are sent to employees reminding them of the need to follow second signature guidance, and ensure accuracy of SMC criteria. The San Diego RO requests closure of this item.

Recommendation 5. We recommended the San Diego VA Regional Office Director implement a plan to ensure claims processing staff prioritize actions related to benefits reductions to minimize improper payments to veterans.

RO Response: Concur. The San Diego VARO concedes there were processing delays in 6 of 30 cases. Processing delays, however, are not considered accuracy errors for VA purposes. Coaches of all Teams monitor EP 600's for needed action. Follow-up training is scheduled for all VSR's on July 14th and July 15th, 2015, which will cover correct assignment of the needed claim label (as stated in Compensation Bulletin of February 2015) to ensure EP 600 workload is identified more easily for needed action; particularly those requiring rating review, i.e. "Predetermination - Rating Issue". The San Diego 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	Nora Stokes, Director Nelvy Viguera Butler Kelly Crawford Kyle Flannery Suzanne Love Michelle Santos-Rodriguez Lisa Van Haeren Mark Ward

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