VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Benefits Administration,

Inspection of
VA Regional Office
Los Angeles, California

Corrected Copy: Errors on Reports Highlights page, page 5, and page 13 corrected as of January 28, 2016.

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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, Los Angeles, CA

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and a Veterans Service Center (VSC) in Cheyenne, WY, that process disability claims and provide a range of services to veterans. We evaluated the Los Angeles VARO to see how well it accomplishes this mission. Office of Inspector General Benefits Inspectors conducted work at the VARO in February 2015. Concurrent with performing this review, we reviewed an anonymous allegation that VARO staff inappropriately shredded veterans' disability claims. Given the seriousness of the allegation, we issued a separate report on these specific findings.

What We Found

The Los Angeles VARO did not consistently process the three types of disability claims we reviewed. Overall, staff incorrectly processed 24 of the total 90 disability claims reviewed. As a result, 336[1] improper monthly payments were made to 14 veterans totaling approximately $485,116[2]. We sampled claims that we considered at increased risk of processing errors. Thus, these results do not represent the overall accuracy of disability claims processing at this VARO.

We found staff incorrectly processed 13 of 30 temporary 100 percent disability evaluations. In our 2012 inspection report, the most frequent processing errors associated with temporary 100 percent disability evaluations occurred because staff did not establish suspense diaries as required. During our February2015 inspection, we did not identify similar errors. Staff did not accurately process 7 of 30 Traumatic Brain Injury (TBI) claims, 4 of 30 Special Monthly Compensation (SMC) claims, or timely complete 3 of 30 benefits reductions cases we reviewed. Further, VARO staff established incorrect dates of claim in VBA's electronic system for 2 of 30 claims because management prioritized other workload higher.

What We Recommended

We recommended the Los Angeles VARO Director review the remaining 522 temporary 100 percent disability evaluations within the universe of claims at the VARO as of December 2014, and take appropriate action. The Director should ensure oversight and prioritization of temporary 100 percent disability evaluations and benefit reduction cases. The Director should provide training on SMC claims. Further, the Director should provide training on TBI claims, assess the effectiveness of that training and ensure staff is in compliance with VBA's second-signature policy when processing TBI claims.

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[1] Corrected figure as of January 28, 2016. Please note that the figure originally reported, "347," was a typing error and did not affect any calculated totals.

[2] Corrected amount as of January 28, 2016. Please note that the amount originally reported, "499,976," was a typing error and did not affect any calculated totals.

Agency Comments

The VARO Director concurred with our recommendations. Management's planned actions are responsive and we will follow up as required.

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TABLE OF CONTENTS

Introduction..4

Results and Recommendations 5

I. Disability Claims Processing 5

Finding 1 Los Angeles VARO Needs To Improve the Processing of Three Types of Disability Claims 5

Recommendations...14

II. Data Integrity..16

III. Management Controls 17

Finding 2 Los Angeles VARO Lacked Oversight To Ensure Timely Action on Proposed Benefits Reductions 17

Recommendation 18

Appendix A VARO Profile and Scope of Inspection...20

Appendix B Inspection Summary...22

Appendix C VARO Director's Comments..23

Appendix D OIG Contact and Staff Acknowledgments..28

Appendix E Report Distribution 29

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 Los Angeles 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 Los Angeles 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, and
- 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 Los Angeles VARO Needs To Improve the Processing of Three Types of Disability Claims

The Los Angeles VARO did not consistently process temporary 100 percent disability evaluations, TBI-related cases, or entitlement to SMC and ancillary benefits. Overall, VARO staff incorrectly processed 24 of the total 90 disability claims we sampled resulting in 336[3] improper monthly payments to 14 veterans totaling approximately $485,116[4] at the time of our review.

Table 1. Los Angeles 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	8	5	13
TBI Claims	30	2	5	7

[3] Corrected figure as of January 28, 2016. Please note that the figure originally reported, "347," was a typing error and did not affect any calculated totals.

[4] Corrected amount as of January 28, 2016. Please note that the amount originally reported, "499,976," was a typing error and did not affect any calculated totals.

SMC and Ancillary Benefits	30	4	0	4
Total	**90**	**14**	**10**	**24**

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

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 13 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 provide improved stewardship of taxpayer funds. Available evidence showed 8 of 13 processing errors affected benefits and resulted in 250 improper monthly payments to 8 veterans totaling approximately $452,406. These improper monthly benefit payments occurred from December 2005 to January 2015. Details on the errors affecting benefits follow.

- In six cases, RVSRs did not timely reduce the veterans' temporary 100 percent disability evaluations despite available medical

evidence showing improvement in their conditions. These delays resulted in 132 improper monthly benefits payments to 6 veterans and totaled approximately $321,990 from January 2008 to January 2015. One of these processing inaccuracies was also identified during our May 2012 inspection. Because VARO management did not take corrective action to reduce the veteran's temporary 100 percent disability evaluation at that time, this veteran has continued to receive benefits payments at the 100 percent disability rate. Monthly benefits payments will continue at the 100 percent disability rate until VARO management takes corrective action. VSC management concurred with all six errors.

- In another case, the available medical evidence showed improvement in the veteran's medical condition; therefore, a letter was sent to inform him of the proposed reduction in monthly benefits. The letter incorrectly showed there would be no change in his compensation payments, and a corrected letter had not been sent at the time of our review. Additionally, an RVSR did not grant entitlement to SMC as required to a veteran with a temporary 100 percent disability evaluation and separate disabilities evaluated as 60 percent disabling, which resulted in an underpayment. Even though the total underpayment amount was taken into consideration, the veteran still received 109 improper benefits payments totaling approximately $129,501 from December 2005 to January 2015. VSC management concurred with this error.
- In the last case, an RVSR did not grant entitlement to SMC for loss of use of a creative organ associated with prostate cancer as required. As a result, the veteran was underpaid approximately $915, which resulted in 9 improper benefits payments from April 2014 to January 2015. VSC management concurred with this error.

The remaining 5 of 13 total errors had the potential to affect veterans' benefits. Following are details on these five errors.

- In two cases, the medical reexaminations needed to reassess the veterans' service-connected disabilities had not been completed at the time of our January 2015 review. As a result of staff not requesting medical reexaminations timely, these veterans may have received improper monthly payments. VSC management concurred with these errors.
- In one case, an RVSR confirmed and continued a temporary 100 percent evaluation for lymphoma and established a June 2003 suspense diary. As of January 2015, VSC staff had not scheduled the medical reexamination to evaluate the veteran's lymphoma. A

medical reexamination may have shown improvement, however, this evaluation has been in effect since April 1991—20 years; therefore, it is now protected and cannot be reduced. VSC management concurred with this error.

- In another case, an RVSR proposed to reduce a veteran's temporary 100 percent disability evaluation based on medical evidence showing improvement. VARO staff received a timely request for a hearing. VBA policy requires a hearing be scheduled within a reasonable amount of time from the date the request was received. As of January 2015, nearly 9 months had passed and VARO staff still had not scheduled the hearing as required. VSC management concurred with this error.
- In the remaining case, an RVSR incorrectly continued the veteran's temporary 100 percent disability evaluation for prostate cancer despite medical evidence showing the condition had increased in severity and was permanent. Instead of requesting future reexaminations in the electronic record, VSC staff should have noted the condition was permanent and granted entitlement to the additional benefit, Dependents' Educational Assistance, as required. VSC management concurred with this error.

Generally, errors occurred because VSC management did not prioritize temporary 100 percent disability claims. VARO management placed emphasis on processing other workloads despite the local Workload Management Plan instructing staff to finalize all non-rating cases within 7 work days of receipt on the team. Management stated and VSC staff confirmed temporary 100 percent disability evaluation claims do not have the same priority as other rating workloads. As a result, veterans may receive benefit payments in excess of their entitlement. Since our sample included 30 claims, we provided VSC management with 522 claims remaining from their universe of 552 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, Los Angeles, California* (Report No. 12-00245-176, May 10, 2012), VARO staff incorrectly processed 29 of 30 temporary 100 percent disability evaluations we reviewed. The majority of the errors resulted from VARO staff not establishing suspense diaries in the electronic record to ensure they would receive reminder notifications to schedule required VA reexaminations. In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each had a future examination date

entered in the electronic record. As such, we made no specific recommendation for this VARO.

During this inspection, we did not identify similar errors involving suspense diaries. However, 7 of the 13 processing errors we identified were also included on the national review list we provided to the VARO in February 2012. Therefore, we find the actions taken by VSC staff in response to addressing pending temporary 100 percent disability claims as part of the national review plan ineffective.

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.

VARO staff incorrectly processed 7 of 30 TBI claims—2 affected veterans' benefits and resulted in 35 improper payments totaling $9,323 from December 2011 to January 2014. Both errors occurred when RVSRs assigned incorrect effective dates for service connection for TBI. Consequently, one veteran was overpaid approximately $6,380 over a period of 12 months, and another veteran was underpaid $2,943 over a period of 23 months.

The remaining five errors had the potential to affect veterans' benefits. Following are details on those errors.

- An RVSR incorrectly assigned separate evaluations for a veteran's TBI and coexisting mental condition. VBA policy requires staff to assign a single evaluation when the VA examiner cannot separate symptoms of TBI and a coexisting mental disorder. This error did not affect the veteran's monthly benefits; however, 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.

- An RVSR prematurely denied a TBI claim without obtaining required service treatment records. VBA policy requires staff to obtain relevant service treatment records prior to deciding a claim. Without service treatment records, we could not determine if the veteran would have been entitled to benefits.
- An RVSR prematurely denied a TBI claim without obtaining a VA medical examination. The veteran claimed TBI due to service and his service treatment records noted residual symptoms due to a blast explosion. VBA policy requires 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, we could not determine if the veteran would have been entitled to benefits.
- An RVSR prematurely granted separate evaluations for a veteran's TBI and coexisting mental condition without a medical examiner distinguishing which overlapping symptoms were attributable to TBI and his coexisting mental condition. Without the required evidence, neither VARO staff nor we can determine the correct evaluation for TBI and the coexisting mental condition.
- An RVSR incorrectly assigned a single evaluation for a veteran's TBI and coexisting mental condition. VARO management disagreed with this error stating that the RVSR correctly evaluated TBI and the coexisting mental condition because the VA examiner did not distinguish all the overlapping symptoms. However, the VA examiner did distinguish the overlapping symptoms of the veteran's TBI and coexisting mental condition. VBA policy states to assign a separate evaluation for each condition if the symptoms are clearly separable. This error did not affect the veteran's monthly benefits; however, 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.

Generally, the errors we identified were the result of a lack of training and management oversight. According to VARO training records, no TBI training occurred in fiscal year 2014 when the cases we reviewed were completed. Although VARO staff completed TBI training in January 2015, we could not assess the effectiveness of that recent training. Further, management and staff stated that the VARO does not have a process to measure the effectiveness of training. Additionally,

four of the six cases we identified with processing errors did not receive a second-level review, as required by VBA policy. VARO staff also processed two of those cases outside of the specialized team assigned to process TBI claims, as required by the local Workload Management Plan. Had management ensured RVSRs followed the TBI processing requirements, they may have prevented the errors in those cases. As a result of this lack of training and management oversight, veterans may not always receive correct benefits payments.

Follow-Up to Prior VA OIG Inspection

In our previous report, Inspection of the *VA Regional Office, Los Angeles, California* (Report No. 12-00245-176, May 10, 2012), we determined 17 of 30 TBI cases reviewed contained processing errors. We attributed the errors to staff not returning insufficient medical examination reports to the issuing clinics or health care facilities to ensure they addressed all required elements. In response to our recommendation, the Director conducted training and agreed to develop and implement a plan to ensure VSC staff return insufficient TBI medical examination reports. The Director also stated that the quality review team supervisor would track all TBI errors and coordinate with the VARO Training Manager for additional training based on trend analysis. Further, the Director stated that RVSRs and Decision Review Officers were required to meet a 100 percent accuracy rate over a review of 10 cases in order to obtain single-signature authority with claims involving TBI examinations. As a result, the OIG closed the recommendation in January 2013.

During this 2015 inspection, we identified one case where VSC staff did not return an insufficient medical examination report to the issuing clinic. As such, we made no recommendation for improvement in this area. However, we continued to see a high error rate associated with TBI claims processing. Management noted that the quality review team had not been tracking all TBI errors and coordinating with the VARO Training Manager for additional training based on trend analysis since February 2013. Further, the VSC Manager was unsure when the requirement ended for RVSRs and Decision Review Officers to meet a 100 percent accuracy rate over 10 cases in order to obtain single-signature authority with claims involving TBI examinations. If management had maintained adequate oversight and trended the types of errors identified during a second-signature review, training may have occurred to address TBI-specific claims processing deficiencies.

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, the inability to naturally control bowel and bladder functions, 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 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 Grant
- Special Home Adaptation Grant
- 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 4 of 30 veterans' claims involving SMC and ancillary benefits. All four inaccuracies affected veterans' payments. These inaccuracies resulted in 51[5] improper payments totaling approximately $23,386[6] to 4 veterans, from June 2013[7] until January 2015. Details on these errors follow.

- VARO staff did not grant SMC for loss of use of one foot, as required, when objective medical evidence revealed the veteran did not have functional use of his foot. Specifically, the evidence showed the veteran did not have the strength to walk without the use of a suitable prosthetic appliance. As a result, the veteran was underpaid approximately $20,063 over a period of 25 months. This was the most significant underpayment.
- VARO staff did not grant SMC at the highest level, based on the veteran's need for skilled assistance. As a result, the veteran was underpaid approximately $9,454 over a period of 9 months.
- In another case, VARO staff did not grant a higher level of SMC for a veteran with loss of use of both feet and an additional permanent disability evaluated at 100 percent disabling.[8] As a result, the veteran was underpaid approximately $7,088 over a period of 19 months.
- In the final case, VARO staff did not grant a higher level of SMC for a veteran with loss of use of both feet and additional permanent disabilities evaluated as 50 percent disabling.[9] As a result, the veteran was underpaid approximately $1,642 over a period of 9 months.

Generally, these errors occurred due to a lack of training. We received records showing that SMC training for higher levels was last conducted at the VARO in April 2014; however, only five employees attended this

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[5] Corrected figure as of January 28, 2016. Please note that the figure originally reported, "62," was a typing error and did not affect any calculated totals.

[6] Corrected amount as of January 28, 2016. Please note that the amount originally reported, "38,247," was a typing error and did not affect any calculated totals.

[7] Corrected date as of January 28, 2016. Please note that the date originally reported, "December 2012," was a typing error.

[8] VBA policy requires an increase in SMC to the next full level if the veteran has loss of use of both feet and an additional independent permanent 100 percent disability.

[9] VBA policy requires an increase in SMC to the next intermediate level if the veteran has loss of use of both feet and additional independent permanent disabilities totaling 50 percent or more.

training. During our interviews, VARO management and staff stated that higher-level SMC cases were complex and difficult. Further, three of the four errors we found received a second-signature review. Interviews with members of the quality review team revealed that they had not identified local trends related to higher levels of SMC. VSC management explained that recent training for all employees had not been provided as they were not aware of deficiencies in this area. As a result of the lack of training, veterans received incorrect benefits payments.

Recommendations

1. We recommended the Los Angeles VA Regional Office Director conduct a review of the 522 temporary 100 percent disability evaluations remaining from our inspection universe as of December 2014, and take appropriate actions.
2. We recommended the Los Angeles VA Regional Office Director implement a plan to ensure oversight and prioritization of temporary 100 percent disability evaluations.
3. We recommended the Los Angeles VA Regional Office Director implement a plan to monitor the effectiveness of training on traumatic brain injury claims.
4. We recommended the Los Angeles VA Regional Office Director implement a plan to ensure staff comply with Veterans Benefits Administration's second-signature requirements for traumatic brain injury claims, and the local procedures for processing traumatic brain injury claims.
5. We recommended the Los Angeles VA Regional Office Director provide training on higher levels of special monthly compensation for all staff members responsible for evaluating or providing second-signature reviews for these cases.

Management Comments

The VARO Director concurred with our recommendations. The Los Angeles VARO is reviewing the cases identified by OIG for necessary action and will complete by the end of FY 15. The Director stated the review is being conducted and tracked by one Rating Quality Review Specialist. The VARO implemented a plan in March 2015 within the station's Workload Management Plan to review monthly any cases with EP 684s/EP 810s requiring a rating.

The Quality Review Team will conduct and track In Process Reviews on TBI second signature cases beginning in September 2015. The Director stated quarterly reports will be provided to the director's office, and results will be used to tailor individual employee training

needs. The QRT sends quarterly reminders of 2nd signature for TBI. One QRT member reviews all TBI ratings for consistency, validates accuracy, and ensures ten accurate ratings prior to release from second signature. TBI training is planned for all RQRSs, DROs, and RVSRs in October 2015 and the survey at the end of the course will be a means to validate the training.

The QRT sends quarterly reminders to all RVSRs regarding the requirements of second signature for higher levels of SMC above S and K, and will conduct local IPR on special monthly compensation claims. Further, training will be conducted for all RVSRs on September 22, 2015.

OIG Response

The Director's comments and actions are responsive to the recommendations. We will follow up on management's actions during future inspections.

II. Data Integrity

Dates of Claim

VBA relies on accurate dates of claim to establish and track key performance measures, including the average days to complete a 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. We focused our review on whether VSC staff followed VBA policy for establishing dates of claim in the electronic record.

VARO staff incorrectly established 2 of 30 dates of claim we reviewed in VBA's electronic systems of record. These errors did not affect or have the potential to affect veterans' monthly benefits. However, incorrect dates of claim can misrepresent VBA performance measures and veterans' benefit entitlements. Details on these errors follow.

- In the first case, VARO staff incorrectly established the date of claim as July 15, 2014, for a veteran's new claim. Review of the evidence shows the claim was actually received on May 31, 2013, a difference of 410 days.
- In the remaining case, a veteran's claim for service connection was established using August 13, 2014, as the date of claim. However, the evidence shows the claim was received at the VARO on January 15, 2014—a difference of 210 days.

Because VARO staff accurately recorded dates of claims for 28 of 30 claims we reviewed, we concluded staff generally followed VBA policy when establishing claims in the electronic systems of records. As such, we made no recommendation for improvement in this area. However, the amount of time these two veterans had been waiting to receive benefits decisions was considered significant. Further, recording incorrect dates of claims in the electronic record reduces the data integrity-associated timeliness metrics for pending claims workload. VARO management concurred with both errors.

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 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 benefits reduction. In order to provide 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. 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 — Los Angeles VARO Lacked Oversight To Ensure Timely Action on Proposed Benefits Reductions

VARO staff delayed processing 3 of 30 cases involving benefits reductions—all 3 affected veterans' benefits. Processing delays resulted in overpayments totaling approximately $30,238, representing 13 improper monthly payments to 3 veterans from December 2013, through November 2014. Details on these errors follow.

- In the first case, VSC staff sent a letter to the veteran on June 20, 2013, proposing to reduce the evaluation for prostate cancer. The due process period expired on August 24, 2013. In this case, the veteran provided additional evidence in support of his claim prior to the expiration of due process, which extended the due process deadline to September 22, 2013. However, VSC staff did

not take action to reduce the benefits until August 4, 2014. As a result, VA overpaid the veteran approximately $26,147 over a period of 11 months. This is the most significant overpayment.

- In the second case, VSC staff sent a letter to the veteran on April 16, 2014, proposing to reduce the evaluation for thyroid cancer. The due process period expired on June 20, 2014. VSC staff did not take action to reduce the benefits until July 7, 2014. As a result, VA overpaid the veteran approximately $2,759.
- In the remaining case, VSC staff sent a letter to the veteran on April 21, 2014, proposing to discontinue entitlement to Individual Unemployability and, subsequently, educational benefits. The due process period expired on June 25, 2014. VSC staff did not take action to discontinue the benefits until July 7, 2014. As a result, VA overpaid the veteran approximately $1,333.

Generally, these processing delays occurred because VARO management did not view this work as a priority and the station's Workload Management Plans did not address the review of benefits reduction cases. Interviews with management and staff confirmed that these cases were a lower priority compared with other work directed by VBA's Central Office. As a result of the processing delays, veterans received erroneous benefits payments.

VARO management concurred with the most significant processing delay, but nonconcurred with the remaining two, even though the facts of all three processing delays were objectively identical. In the two nonconcurrences, VARO management stated that the delays were not unreasonable, and that it is clearly the intent of the VBA manual to allow flexibility for workload management issues in the time frame for action following due process notification. Management also stated that since the due process period expired near the end of the month in both cases, there was no evidence that suggests there was a lack of control. We disagree with this response. VBA criteria states VARO staff must take immediate action at the end of the due process period. The only allowances for delays are based on either a hearing request from the veteran or a need for development for more evidence. In these cases, none met the provisions outlined in VBA's policy.

Recommendation

6. We recommended the Los Angeles VA Regional Office Director implement a plan to ensure oversight and prioritization of benefit reduction cases.

Management Comments

The VARO Director concurred with our recommendation and has taken the following actions: assignment of RVSRs to review EP 600 reductions; trained VSRs to create a suspense for all EP 600s where rating related reductions are required; the VSC Management Analyst to run weekly VOR reports for EP 600s and provide the list to the responsible Coach for action; and the Non-Rating Coach will distribute EP 600s for rating reductions to RVSRs tasked to work these cases. Further, the Director stated the LARO will take workload management actions to ensure EP 600s are identified and tracked for end-of-month completion.

OIG Response

The Director's comments and actions are responsive to the recommendation. We will follow up on management's actions during future inspections.

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of January 2015, the Los Angeles VARO reported a staffing level of 282.8 full-time employees. Of this total, the VSC had 216.6 employees.

Workload

As of December 2014, VBA reported the Los Angeles VARO had 13,946 pending compensation claims with 9,009 (65 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 January and February 2015, we evaluated the Los Angeles 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 552 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 December 5, 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 522 claims remaining from its universe of 552 claims as of December 5, 2014, for review. We reviewed 30 of 413 disability claims related to TBI (7 percent) and 30 of 50 claims involving entitlement to SMC and ancillary benefits (60 percent) completed by VARO staff during fiscal year 2014.

We reviewed 30 of 5,367 dates of claim recorded in VBA's Corporate Database from July through September 2014 as of October 8, 2014. Additionally, we looked at 30 of 312 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 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, dates of pending claims at the VARO, and completed claims related to 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 January 2015, the overall claims-based accuracy of the VARO's compensation rating-related decisions was 90 percent. We did not test the reliability of these data.

Other OIG Reports

On January 20, 2015, the Office of Inspector General (OIG) received an anonymous allegation that staff at the Los Angeles VA Regional Office (VARO) were shredding large quantities of mail related to veterans' disability compensation claims. The complainant also alleged that supervisors were instructing staff to shred these documents.

In our interim report, *Review of Alleged Shredding of Claims-Related Evidence at the VA Regional Office, Los Angeles, California* (Report No. 15-04652-448), we substantiated the allegation that Los Angeles VARO staff were shredding claims-related mail without properly processing the claims, as required. However, we could not confirm that VARO supervisors were instructing staff to shred claims-related mail.

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. Los Angeles VARO Inspection Summary

Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance
Disability Claims Processing		
Temporary 100 Percent Disability Evaluations	Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations. (38 CFR 3.103(b)), (38 CFR 3.105(e)), (38 CFR 3.327), (M21-1 MR Part IV, Subpart ii, Chapter 2, Section J), (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)	No
Traumatic Brain Injury Claims	Determine whether VARO staff properly processed claims for service connection for all disabilities related to in-service TBI. (FL 08-34 and 08-36), (Training Letter 09-01)	No
Special Monthly Compensation and Ancillary Benefits	Determine whether VARO staff properly processed SMC and correctly granted entitlement to ancillary benefits. (38 CFR 3.350, 3.352, 3.807, 3.808, 3.809, 3.809a, 4.63, and 4.64), (M21-1MR IV.ii.2.H and I)	No
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: August 27, 2015

From: Director, VA Regional Office Los Angeles, California

Subj: Inspection of the VA Regional Office, Los Angeles, California

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

1. See attachment

2. Please refer questions to Emmett O'Meara, Acting Assistant Director, at (310) 235-7038.

(original signed by:)

Robert W. McKenrick

Attachment

The Los Angeles VA Regional Office (LARO) is committed to providing excellent service to Veterans and all claimants. Management utilizes the Office of Inspector General (OIG) Team interactions while on station, as well as the OIG's inspection findings to drive reassessments of where and how to make necessary improvements in work efforts. Review of the 2012 OIG Benefits Inspection shows that LARO has made marked improvements in several key areas from this last benefits inspection.

A visual comparison to the 2012 OIG benefits inspection demonstrates LARO's improvements for Temporary 100% Disability Evaluations and Traumatic Brain Injury (TBI).

Los Angeles VARO Disability Claims Processing Results 2012					
		Claims Incorrectly Processed			
Type	**Reviewed**	**Total**	**Affecting Veterans' Benefits**	**Potential To Affect Veterans' Benefits**	**Accuracy**
Temporary 100 Percent Disability Evaluations	30	29	12	17	3%
Traumatic Brain Injury Claims	30	17	0	17	43%

Los Angeles VARO Disability Claims Processing Results 2015					
		Claims Incorrectly Processed			
Type	**Reviewed**	**Total**	**Affecting Veterans' Benefits**	**Potential To Affect Veterans' Benefits**	**Accuracy**
Temporary 100 Percent Disability Evaluations	30	13	8	5	56%
Traumatic Brain Injury Claims	30	7	2	5	76%

Recommendation 1: "We recommend the Los Angeles VA Regional Office Director conduct a review of the 522 temporary 100 percent disability evaluations remaining from our inspection universe as of December 2014, and take appropriate actions."

Response 1: LARO concurs with this recommendation and is reviewing the cases identified by OIG for necessary action.

- The review began in the fourth quarter of FY15 and will be complete by end of FY15.
- The review is being conducted by one Rating Quality Review Specialist (RQRS) and tracked on a spreadsheet to document accuracy and/or errors

Recommendation 2: "We recommend the Los Angeles VA Regional Office Director implement a plan to ensure oversight and prioritization of temporary 100 percent disability evaluations."

Response 2: LARO concurs with this recommendation and implemented a plan in March 2015 within the station's Workload Management Plan.

- EP 684s/EP 810s are run through Vetsnet Operation Report (VOR) monthly and reviewed to identify any cases requiring a rating.
- These cases are then processed and reviewed by Express team members for control and subsequent completion.

Recommendation 3: "We recommend the Los Angeles VA Regional Office Director implement a plan to monitor the effectiveness of training on traumatic brain injury claims."

Response 3: LARO concurs with this recommendation. Beginning in September 2015, Quality Review Team (QRT) staff will conduct In Process Reviews (IPR) on TBI second signature cases. These reviews are tracked on a national IPR SharePoint. They will be tracked locally as well on a master TBI IPR spreadsheet. Quarterly reports will be provided to the director's office. Results will be used to tailor training individual employee training needs, as warranted.

Recommendation 4: "We recommend the Los Angeles VA Regional Office Director implement a plan to ensure staff comply with Veterans Benefits Administration's second-signature requirements for traumatic brain injury claims, and the local procedures for processing traumatic brain injury claims."

Response 4: LARO concurs with this recommendation and the following has been implemented since the OIG visit in February 2015:

- QRT sends quarterly reminders to all Rating Veteran Service Representatives (RVSR) regarding the requirements of 2nd signature for TBI. The last reminder was sent August 13, 2015.
- One QRT member is assigned to Special Operations and reviews all TBI ratings for consistency. The member validates accuracy and ensures ten accurate ratings are complete prior to release from second signature.
- These are tracked on a spreadsheet and saved in a local QRT folder.
- A memo is signed by an Assistant Veteran Service Center Manager (AVSCM) for release from second signature TBI and provided to the coach of the employee.
- The TBI spreadsheet is reviewed by the QRT coach bi-monthly.
- The employees who are released from second signature requirements will be provided consistency studies in order to

assess their skill retention. RQRSs, Decision Review Officers (DRO) and the RVSRs released will participate in the study.

- TBI training is planned for all the RQRSs, DROs and RVSRs in October 2015 (TMS#1209939). The survey at the end of the course will be a means to validate the training and will be reviewed with the Training Manager upon completion. The last training was completed in January 2015, as noted by OIG in the report.
- TBI training is planned for all VSRs in October 2015 (TMS#68864). This is for development purposes. The survey at the end of the course will be a means to validate the training and will be reviewed with the Training Manager upon completion.

Recommendation 5: "We recommend the Los Angeles VA Regional Office Director provide training on higher levels of special monthly compensation for all staff members responsible for evaluating or providing second-signature reviews for these cases."

Response 5: LARO concurs with this recommendation.

- QRT sends quarterly reminders to all RVSRs regarding the requirements of second signature for higher levels of SMC above S and K. The last reminder was sent August 13, 2015.
- QRT will conduct local IPR on special monthly compensation claims, for which they provide second signatures. These reviews are tracked on a national IPR SharePoint.
- Training will be conducted for all RVSRs on September 22, 2015 (TMS# 3939100).
- The IPR spreadsheet and IPR SharePoint is reviewed by the QRT coach bi-monthly to track team and individual training requirements.

Recommendation 6: "We recommend the Los Angeles VA Regional Office Director implement a plan to ensure oversight and prioritization of benefit reduction cases."

Response 6: LARO concurs with this recommendation.

Of the three cases cited by OIG states that resulted in overpayments to Veterans, one resulted in eleven months of overpayments to the Veteran while the remaining two were processed within 20 calendar days resulting in an overpayment of one month to each Veteran. None of the overpayments created a debt or hardship for the Veterans. The LARO is well aware of the requirements to be good stewards of taxpayer funds in the execution of our mission to Veterans and is committed to honoring both responsibilities with available resources and in a timely manner. The LARO has taken the following actions:

- Assigned RVSRs to review EP 600 reductions.
- All VSRs are trained to create a suspense for all EP 600s where rating related reductions are required. The suspense is noted as "Predetermination Notice-Rating issue."
- The Management Analyst for the VSC runs VOR weekly for EP 600s and provides the list to the responsible Coach for action.
- The Non-Rating Coach triages the 600s for rating reductions to distribute to the RVSRs tasked to work these cases.
- LARO will take workload management actions to ensure that the cesting of EP 600s are identified and tracked for end-of-month completion.

The LARO requests closure of this recommendation.

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	Dana Sullivan, Director Jason Boyd Orlan Braman Daphne Brantley Bridget Byrd Dana Sullivan Nelvy Viguera Butler Claudia Wellborn

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