VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Benefits Administration,

Inspection of
VA Regional Office
Honolulu, Hawaii

September 17, 2015
15-01996-503

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

Report Highlights: Inspection of the VA Regional Office, Honolulu, Hawaii

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and a Veterans Service Center in Wyoming, that process disability claims and provide services to veterans. We evaluated the Honolulu VARO to see how well it accomplishes this mission. OIG Benefits Inspectors conducted this work in April 2015.

What We Found

The Honolulu VARO did not consistently process the three types of disability claims we reviewed. Overall, staff did not accurately process 20 of the 69 disability claims (29 percent) we reviewed. As a result, 181 improper monthly payments were made to 7 veterans totaling approximately $135,085. We sampled claims we considered at increased risk of processing errors. These results do not represent the accuracy of all disability claims processing at this VARO.

We found staff incorrectly processed 5 of 30 temporary 100 percent disability evaluations. In our 2012 inspection report, the most frequent errors associated with temporary 100 percent disability evaluations occurred because management did not have a mechanism in place to ensure staff timely scheduled reexaminations. During this 2015 inspection, we did not identify similar errors. Therefore, since there has been significant improvement, we made no recommendation in this area. Staff did not accurately process 8 of 30 traumatic brain injury (TBI) claims, 7 of 9 special monthly compensation (SMC) claims, or timely complete 14 of 30 benefits reductions cases we reviewed. However, we found that all 30 Honolulu dates of claim we reviewed contained no errors.

During our April 2015 inspection, we followed-up on our review of alleged data manipulation. We reviewed 30 of 208 claims from our initial review and found action was required for 1 of the 30 claims. We determined the VARO was generally compliant with our recommendation.

What We Recommended

We recommended the Director provide training on TBI and SMC claims and assess the effectiveness of that training. The Director should also strengthen the review process for higher levels of SMC and ancillary benefits claims, and implement a plan to ensure oversight and prioritization of benefits reduction cases.

Agency Comments

The VARO Director concurred with our recommendations. Management's planned actions are responsive.

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

TABLE OF CONTENTS

INTRODUCTION

Objective

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

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

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

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

Other Information

- Appendix A includes details on the Honolulu 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 Honolulu VARO Director's comments on a draft of this report.

RESULTS AND RECOMMENDATIONS

I. Disability Claims Processing

Claims Processing Accuracy

The OIG Benefits Inspection team focused on evaluating the accuracy in processing the following three types of disability claims and determined their effect on veterans' benefits:

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

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

Finding 1 Honolulu VARO Needs To Improve the Processing of Three Types of Disability Claims

The Honolulu VARO did not consistently process the three types of disability claims we reviewed. Overall, VARO staff incorrectly processed 20 of the total 69 disability claims we sampled, resulting in 181 improper monthly payments to 7 veterans totaling approximately $135,085 at the time of our inspection in April 2015. Table 1 reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Honolulu VARO.

Table 1. Honolulu 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	0	5	5
TBI Claims	30	2	6	8
SMC and Ancillary Benefits	9	5	2	7
Total	**69**	**7**	**13**	**20**

Source: VA OIG analysis of VBA's temporary 100 percent disability evaluations paid at least 18 months, TBI disability, and SMC and ancillary benefits claims completed January 1, 2014, through December 31, 2014.

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 5 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.

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

Effective management of these temporary 100 percent disability ratings can reduce VBA's risks of paying inaccurate financial benefits and provide improved stewardship of taxpayer funds. Available medical evidence showed the five errors we identified had the potential to affect veterans' benefits. Details on the errors follow:

- In three cases, VARO staff did not timely reduce the veterans' temporary 100 percent evaluations despite available medical evidence showing improvement in the conditions. At the time of our review in March 2015, staff had not taken action on two of these cases. In the third case, due process expired December 24, 2014; however, VARO staff did not take action to reduce the benefit until January 13, 2015. We could not determine overpayment amounts for these three cases because final benefits reductions would not have occurred at the time of our review in March 2015. Therefore, there is potential for the veterans to have been overpaid.
- In two cases, RVSRs incorrectly continued temporary 100 percent disability evaluations and requested future medical reexaminations even though the veterans' conditions were permanent. Instead of requesting future medical reexaminations, the RVSRs should have evaluated the disabilities as permanent and granted entitlement to the additional benefit of Dependents' Educational Assistance, as required. As a result, the veterans' dependents might not receive training and educational opportunities.

Generally, errors occurred because VSC management did not prioritize benefit reductions related to temporary 100 percent disability claims. Management and staff indicated the VSC placed emphasis on other rating related workload. As a result, veterans may receive benefits payments in excess of their entitlement. We provided VARO management with 49 claims remaining from their universe of 79 claims 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, Honolulu, Hawaii* (Report No. 12-00151-123, March 26, 2012), VARO staff incorrectly processed 26 of 30 temporary 100 percent disability evaluations we reviewed. Twenty of the errors occurred because there was no mechanism in place to ensure staff timely scheduled medical reexaminations for temporary 100 percent disabilities. We made no specific recommendation because, in response to 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 medical reexamination date entered in the electronic record.

During our April 2015 inspection, we did not find any cases where staff delayed scheduling medical reexaminations. Management told us that VARO staff has focused on timely scheduling medical reexaminations. Since there has been significant improvement, we made no recommendation in this area.

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 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 8 of 30 TBI claims—2 affected veterans' benefits and resulted in 38 improper payments totaling approximately $26,077 from August 2013 until March 2015. Summaries of the errors follow:

- An RVSR incorrectly assigned separate evaluations for a veteran's TBI and coexisting mental condition, which increased the veteran's combined disability evaluation to 100 percent, and entitled the veteran to the additional benefit of Dependents' Educational Assistance. VBA policy requires staff to assign a single evaluation when the VA examiner cannot separate the symptoms of a TBI and a coexisting mental disorder. As a result, the veteran was overpaid approximately $21,725 over a period of 19 months and incorrectly received Dependents' Educational benefits.
- An RVSR incorrectly assigned a 40 percent evaluation for a veteran's TBI based on symptoms related to the coexisting mental condition. Objective evidence in the TBI examination report showed that the TBI symptoms supported a 10 percent evaluation. As a result of the incorrect evaluation, the veteran was overpaid approximately $4,352 over a period of 19 months.

The remaining six of the total eight errors had the potential to affect veterans' benefits. Following are details on these six errors.

- In two cases, RVSRs assigned 10 percent evaluations for residual disabilities associated with TBI. However, objective evidence provided in the TBI examination reports showed symptoms that supported 0 percent evaluations. Although the errors did not affect current monthly benefits, if left uncorrected, they could affect future benefits payments.
- In two cases, RVSRs prematurely granted separate evaluations for TBI and coexisting mental conditions without a medical examiner distinguishing which overlapping symptoms were attributable to TBI and the coexisting mental conditions. Without the required evidence, neither VARO staff, nor we can determine the correct evaluations for TBI and the coexisting mental conditions.
- An RVSR incorrectly increased a veteran's TBI evaluation from 10 percent to 40 percent disabling based on symptoms related to the coexisting mental condition. Objective evidence provided in the TBI examination report showed that the TBI symptoms supported a 0 percent evaluation. Because the veteran's 10 percent evaluation for TBI had been in place for five or more years, and improvement or recovery can be anticipated based on medical evidence, the TBI evaluation would continue as 10 percent disabling, pending the

results of a routine future medical reexamination, as required by VBA policy. 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 based on an insufficient VA examination. The veteran was involved in a motorcycle accident during service and treated for a concussion with complaints of memory loss and headaches. On the initial VA TBI examination, the examiner did not diagnosis TBI; however, a specialist did not review the examination. VBA policy states that only a physiatrist, a neurologist, or a psychiatrist can determine there is no diagnosis of TBI. Without the required evidence, neither VARO staff, nor we, can determine if the veteran would have been entitled to benefits.

Generally, the errors we identified were the result of ineffective TBI training. We received records showing that RVSRs last completed TBI training at the VARO in June, July, and August 2014; however, five decision makers had not had training since fiscal year 2013. During our interviews, VARO management and staff stated that they do not measure the effectiveness of the training. Additionally, members of the quality review team revealed that they had not identified local trends related to TBI claims, and they were not aware of deficiencies in this area. In addition, staff we interviewed said they continued to find VBA policy confusing regarding evaluations of TBI and co-morbid mental conditions. Five of the eight errors occurred after staff had completed TBI training. If the Honolulu VARO had assessed the effectiveness of the TBI training, management might have prevented those TBI errors. As a result, veterans did not always receive accurate benefit payments.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Honolulu, Hawaii* (Report No. 12-00151-123, March 26, 2012), we identified two TBI claims available for our review that VARO staff correctly processed. As a result, we determined the Honolulu VARO was in compliance with VBA's policy to process TBI claims. Therefore, we made no recommendation for improvement in this area.

Special Monthly Compensation and Ancillary Benefits

As the concept of rating disabilities evolved, it was realized that for certain types of disabilities, the basic rate of compensation was not sufficient for the level of disability present. Therefore, SMC was established to recognize the severity of certain disabilities or combinations of disabilities by adding an additional compensation to the basic rate of payment. SMC represents payments for "quality of life" issues such as the loss of an eye or limb, or the need to rely on

others for daily life activities, like bathing or eating. Generally, VBA grants entitlement to SMC when the following conditions exist.

- Anatomical loss or loss of use of specific organs, sensory functions, or extremities
- Disabilities that render the veteran permanently bedridden or in need of aid and attendance
- Combinations of severe disabilities that significantly affect locomotion
- Existence of multiple, independent disabilities that are evaluated as 50 to 100 percent disabling
- Existence of multiple disabilities that render the veteran in need of such a degree of special skilled assistance that without it, the veteran would be permanently confined to a skilled-care nursing home

Ancillary benefits are secondary benefits that are considered when evaluating claims for SMC. Examples of ancillary benefits are:

- Dependents' Educational Assistance Under Title 38, United States Code, chapter 35
- Specially Adapted Housing Grants
- Special Home Adaptation Grants
- Automobile and Other Conveyance and Adaptive Equipment Allowance

VBA policy requires staff to address the issues of SMC and ancillary benefits whenever they can grant entitlement. We 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 7 of 9 claims involving SMC and ancillary benefits—5 errors affected veterans' benefits and resulted in 143 improper payments to veterans totaling approximately $109,008. These errors represented improper recurring monthly payments from March 2007 to March 2015. Details on the errors affecting benefits follow.

- In three cases, VARO staff did not grant a higher level of SMC for veterans with loss of use of two extremities and additional permanent disabilities evaluated as 50 percent disabling.[1] As a result, these veterans were underpaid a total of approximately $9,779 over a period of 49 months.
- In another case, VARO staff did not assign the appropriate level of SMC for a veteran with bilateral blindness. Additionally, in this case, VARO staff failed to grant aid and attendance when the medical evidence showed the veteran required it for his blindness. As a result, VA underpaid the veteran approximately $94,670 over a period of 77 months. This was the most significant underpayment.
- In the last case, VARO staff incorrectly granted a higher level of SMC for additional disabilities evaluated as 50 percent disabling. VARO staff also assigned a higher level of SMC for the veteran's permanent 100 percent evaluation for prostate cancer.[2] As a result, VA overpaid the veteran approximately $4,558 over a period of 17 months.

The remaining two of the seven total errors had potential to affect veterans' benefits. Following are details on the two errors.

- VARO staff incorrectly granted entitlement to the Special Home Adaptation Grant, which is a benefit worth up to $14,093. In this case, VARO staff previously granted entitlement to the Specially Adapted Housing Grant, which is a benefit worth up to $70,465, in fiscal year 2014. According to VBA policy, veterans are entitled to the Special Home Adaptation Grant only if they are not entitled to the Specially Adapted Housing Grant. As a result, the veteran may receive improper benefits. In addition, VARO staff did not separately evaluate all of the veteran's Amyotrophic Lateral Sclerosis residuals, as required. As a result, neither VARO staff, nor we, can determine the correct SMC rate until VARO staff properly evaluate the veteran's residuals.
- In the final case, an RVSR assigned an incorrect SMC code to determine the veteran's disability benefits payments while he is

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

[2] VBA policy does not allow a higher level of SMC for additional independent permanent disabilities totaling 50 percent, or more, when the veteran is receiving SMC for an additional independent permanent disability evaluated at 100 percent.

hospitalized at Government expense. As a result, the veteran may receive improper payments if he becomes hospitalized at Government expense.

Generally, the errors occurred due to a lack of regular training and an ineffective signature review policy. According to VARO training records, VARO staff completed SMC refresher training during December 2014, January 2015, and February 2015. Six of the seven errors we found occurred before staff had completed this training. Previously, VARO staff completed "Introduction to SMC" training in 2011. The VSC manager explained that VARO staff did not receive frequent SMC training because staff had other training requirements to meet. Despite this last training, interviews with VARO staff revealed that they were still unclear about the SMC policies. Additionally, all of the VARO management and staff we interviewed agreed that they do not see higher levels of SMC cases regularly, which makes them difficult to process. VSC management acknowledged that VARO staff needed additional SMC training, and they have requested that VBA's Systematic Technical Accuracy Review staff conduct SMC training for the station. According to the VSC Manager, this training was to be conducted in May 2015.

On October 10, 2012, the Honolulu Director created a local policy delegating the VSC manager to provide a third signature on cases involving higher levels of SMC, but did not mention who should provide a second signature on these cases. During our interviews with VSC management and staff, they thought the station's policy was for the VSC manager to provide a second signature on these cases. VARO staff provided a copy of a local checklist showing that cases involving higher levels of SMC required a second signature, and there is no mention of a third signature requirement for these cases. VARO staff stated that they sent cases involving higher levels of SMC directly to the VSC manager for review, and they did not think this policy was effective because the VSC manager did not have experience processing these cases. VARO staff believed that the accuracy of cases involving higher levels of SMC would improve if someone with expertise processing these cases was assigned to review them. On April 3, 2015, VBA implemented a policy requiring a second signature on all cases involving higher levels of SMC and does not require that the VSC manager provide the signature. As a result, of this lack of training and ineffective review process for higher level SMC cases, veterans did not always receive correct benefits payments.

Recommendations

1. We recommended the Honolulu VA Regional Office Director provide training on traumatic brain injury claims and assess the effectiveness of that training.

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

3. We recommended the Honolulu VA Regional Office Director strengthen the review process for higher levels of special monthly compensation and ancillary benefits claims.

Management Comments

The VARO Director concurred with our recommendations related to traumatic brain injury claims. The Honolulu VARO has scheduled training for Traumatic Brain Injury claims for September 2, 2015. Further, the VSC standard operating procedure (SOP) requiring TBI second signature review was updated on August 25, 2015. The Director stated the updated SOP provides specific requirements for training and enhanced quality review procedures. Additional requirements include quarterly trend analysis using the TBI Tracker to target specific training needs.

The Director also concurred with our recommendations related to special monthly compensation and ancillary benefits claims. The Honolulu VARO has scheduled and completed training for processing higher levels of special monthly compensation and ancillary benefits training as of July 14, 2015, and August 4, 2015. Additional training is scheduled for September 23, 2015. Further, the VSC implemented a Standard Operating Procedure (SOP) for rating and management of cases involving higher levels of SMC. The SOP provides for training, enhanced quality review procedures, a comprehensive review and signatory process on all cases involving higher levels of SMC, and a SMC Tracker for quarterly trend analysis.

OIG Response

The Director's comments and actions are responsive to the recommendations. The VARO Director provided several documents to address our recommendations. We will follow up on management's actions during future inspections.

II. Data Integrity

Dates of Claim

To ensure all claims receive proper attention and timely processing, VBA policy directs staff to use the earliest date stamp shown on the claim document as the date of claim. VBA relies on accurate dates of claim to establish and track key performance measures, including the average days to complete a claim.

We focused our review on whether VSC staff followed VBA policy for establishing dates of claim in the electronic record. We found that all 30 cases contained no errors that affected benefits or had the potential to affect benefits. As a result, we determined the VSC is following VBA policy and we made no recommendation for improvement in this area.

III. Management Controls

Benefits Reductions

VBA policy provides for compensation to veterans for conditions they incurred or aggravated during military service. The amount of monthly compensation to which a veteran is entitled may change because his or her service-connected disability may improve. Improper payments associated with benefits reductions generally occur when beneficiaries receive payments to which they are not entitled. Such instances are attributable to VARO staff not taking the actions required to ensure veterans receive correct payments for their 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 the beneficiary due process, VBA allows 60 days for the veteran to submit additional evidence to show that compensation payments should continue at their present level. If the veteran does not provide additional evidence within that period, an RVSR must make a final determination to reduce or discontinue the benefit. On the 65th day following due process notification, action is required to reduce the evaluation and thereby minimize overpayments.

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

Finding 2 Honolulu VARO Lacked Oversight To Ensure Timely Action on Proposed Benefits Reductions

VSC staff delayed processing or incorrectly processed 14 of 30 cases involving benefits reductions—all 14 affected veterans' benefits. These processing inaccuracies resulted in overpayments totaling approximately $124,375, and one underpayment totaling approximately $347, representing 84 improper monthly payments to 14 veterans from March 2013 to March 2015.

Processing Delays

Processing delays occurred in 13 of 30 claims that required rating decisions to reduce benefits. In the case with the most significant overpayment and delay, VARO staff sent a letter to the veteran on October 22, 2012, proposing to reduce the disability evaluation for the

veteran's prostate cancer. The due process period expired on December 26, 2012. However, staff did not take action to reduce the evaluation until November 6, 2014. As a result, VA overpaid the veteran approximately $34,007 over a period of 23 months**.** Details on the other errors affecting benefits follow:

- VARO staff proposed to reduce a veteran's evaluation for metastatic melanoma. Due process expired on November 28, 2013; however, on November 28, 2014, VARO staff incorrectly continued the evaluation. As a result, the veteran's reduction has been delayed by 13 months and has led to an overpayment of approximately $29,688, at the time of our review.
- VARO staff proposed to reduce a veteran's mental health condition evaluation. Due process expired on November 29, 2012, but no action was taken to reduce the benefits until October 31, 2014. As a result, the veteran's reduction was delayed by 23 months and led to an overpayment of approximately $20,074.
- VARO staff proposed to reduce a veteran's evaluation for prostate cancer. Due process expired on August 11, 2014, but no action was taken to reduce the benefits until December 3, 2014. As a result, the veteran's reduction was delayed by 4 months and led to an overpayment of approximately $11,176.
- VARO staff proposed to reduce a veteran's evaluation for prostate cancer and discontinue entitlement to SMC. Due process expired on June 23, 2014, but no action was taken to reduce and discontinue the benefits until November 17, 2014. As a result, the veteran's reduction and discontinuance were delayed by 5 months and led to an overpayment of approximately $8,426.
- VARO staff proposed to reduce a veteran's evaluation for prostate cancer and discontinue entitlement to SMC. Due process expired on June 4, 2014, but no action was taken to reduce and discontinue the benefits until November 25, 2014. As a result, the veteran's reduction and discontinuance were delayed by 5 months and led to an overpayment of approximately $7,557.
- VARO staff proposed to reduce a veteran's evaluation for a mental health condition. Due process expired on September 22, 2014, but no action was taken to reduce the benefits until December 3, 2014. As a result, the veteran's reduction was delayed by 3 months and led to an overpayment of approximately $4,066.
- VARO staff proposed to reduce a veteran's evaluation for cancer. Due process expired on October 24, 2014, but no action was taken to reduce the benefits until November 7, 2014. As a result, the

veteran's reduction was delayed by 1 month and led to an overpayment of approximately $2,936.

- VARO staff proposed to reduce a veteran's evaluation for prostate cancer. Due process expired on October 8, 2014, but no action was taken to reduce the benefits until December 3, 2014. As a result, the veteran's reduction was delayed by 2 months and led to an overpayment of approximately $2,711.
- VARO staff proposed to reduce a veteran's evaluation for prostate cancer. Due process expired on October 8, 2014, but no action was taken to reduce the benefits until November 24, 2014. As a result, the veteran's reduction was delayed by 1 month and led to an overpayment of approximately $1,848.
- VARO staff proposed to reduce a veteran's evaluation for a mental health condition and discontinue entitlement to SMC. Due process expired on November 28, 2014, but no action was taken to reduce and discontinue the benefits until December 2, 2014. As a result, the veteran's reduction and discontinuance were delayed by 1 month and led to an overpayment of approximately $1,582.
- VARO staff proposed to reduce a veteran's evaluation for a left wrist neurological condition. Due process expired on October 27, 2014, but no action was taken to reduce the benefits until November 20, 2014. As a result, the veteran's reduction was delayed by 1 month and led to an overpayment of approximately $196.
- In the final case, VARO staff proposed to reduce a veteran's evaluation for a lumbar spine condition. An untimely hearing request was received on September 9, 2014. The hearing was conducted on October 22, 2014. Due process expired on September 15, 2014, but no action was taken to reduce the benefits until October 23, 2014, after the hearing. As a result, the veteran's reduction was delayed by 1 month and led to an overpayment of approximately $130.

Generally, these processing delays and errors occurred because VARO management did not view this work as a priority even though the station's Workload Management Plan directed staff to review rating reduction cases weekly. Interviews with management and staff confirmed that rating reductions were considered a lower priority compared to other work. As a result of the processing delays, veterans received erroneous benefits payments.

Accuracy Errors

VARO staff incorrectly processed 2 of the 30 cases involving benefits reductions, 1 of which included a processing delay. In one case,

VARO staff assigned an incorrect effective date for the disability reduction. As a result of this processing inaccuracy, VA underpaid the veteran approximately $347 for a period of one month. In the second case, VARO staff incorrectly continued the 100 percent disability evaluation for a veteran's cancer without medical evidence of active disease when staff should have reduced the evaluation to 0 percent disabling. As a result of this processing inaccuracy, the reduction was delayed by 13 months at the time of our review. The overpayment amount of this processing inaccuracy is reported in our processing delays. As we identified only two accuracy errors and did not identify a common trend, pattern, or systemic issue, we make no recommendation for improvement in this area.

Recommendation

4. We recommended the Honolulu VA Regional Office Director implement a plan to ensure oversight and prioritization of benefits reduction cases.

Management Comments

The VARO Director concurred with our recommendation. The Honolulu VARO implemented a plan to ensure oversight and prioritization of benefit reduction cases.

The plan requires the Coach of the Non-Rating team to generate a Veterans Operations Report Pending Full Detail report daily to identify all pending EP 600 cases. Rating cases will be assigned daily based on DOC priority and time in cycle, and Awards/Authorizations cases will be processed daily. The Non-Rating Coach will also ensure a daily assignment of a minimum of 5 rating cases daily to one dedicated RVSR.

The anticipated completion date for completing and clearing all backlogged cases is October 1, 2015. The Director stated once the backlog is cleared, and all reduction cases are in a current status, the Non-Rating Coach will ensure all EP 600 cases are reviewed and assigned weekly for rating when due process expires. Further, daily reporting will be monitored and tracked on the EP reduction spreadsheet maintained and updated daily on a shared drive.

OIG Response

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

IV. Hotline Follow-up

In our *Review of Alleged Data Manipulation at VA Regional Office Honolulu, HI* (Report No. 15-00880-157, March 26, 2015), we substantiated the allegation that a supervisor inappropriately removed controls in the electronic record used to track and identify claims related to verifying the status of veterans' dependents without taking proper actions in 143 claims. Those actions to remove claims from the electronic record misrepresented the VARO's claims inventory and timeliness measures, and impaired its ability to measure and manage its workloads. As such, we recommended that the Honolulu Director take immediate action to correct all improper actions taken by that supervisor, ensure staff receive training on the proper procedures for processing dependency questionnaires, and to confer with other officials to determine appropriate administrative action against the supervisor.

In response to our recommendations, the Director stated that VARO staff took corrective actions on all cases improperly processed and received training related to processing dependency claims and due process. In addition, the supervisor that took the improper actions resigned from his position. During our April 2015 inspection, we reviewed 30 of the total 208 claims from our initial review to see if VARO staff took corrective actions. One of the 30 cases we reviewed required additional action. This file was located at another VA facility and not available to us at the time of our initial review. The VSC manager told us this file was being scanned and was therefore not available to VARO staff at the time of their review. The file is now available electronically, and the VARO has initiated action to remove the veteran's dependents, as required. Therefore, we determined the VARO was generally compliant with our recommendation.

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of April 2015, the Honolulu VARO reported a staffing level of 97 full-time employees. Of this total, the VSC had 65 employees assigned.

Workload

As of March 2015, VBA reported the Honolulu VARO had 2,654 compensation claims pending with 939 (35 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 April 2015, we evaluated the Honolulu 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 79 temporary 100 percent disability evaluations (38 percent) selected from VBA's Corporate Database. These claims represented instances where VBA staff had granted temporary 100 percent disability evaluations for at least 18 months as of February 2, 2015. 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 49 claims remaining from our universe of 79 for review. We reviewed 30 of 71 disability claims related to TBI (42 percent) and all 9 claims involving entitlement to SMC and ancillary benefits completed by VARO staff during 2014.

We reviewed 30 of 1500 dates of claim recorded in VBA's Corporate Database from October through December 2014 as of February 2, 2015. Additionally, we looked at 30 of 206 completed

claims (15 percent) that proposed reductions in benefits from October through December 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 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 provided in the data received with information contained in the 129 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI claims, SMC and ancillary benefits, dates of claims, 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 program as of April 2015, the overall claims-based accuracy of the VARO's compensation rating-related decisions was 90.4 percent. We did not test the reliability of this data.

Inspection Standards

We conducted this inspection in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.*

Appendix B Inspection Summary

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

Table 2. Honolulu 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)), (38 CFR 3.400), (M21-4, Appendix A and B), (M21-1MR.III.ii.1.C.10.a), (M21-1MR.III.ii.1.B.6 and 7), (M21-1MR.III.ii.2.B.8.f), (M21-1MR, III.i.2.A.2.c), (*VBMS User Guide*), (M21-4, Chapter 4.07), (M23-1, Part 1, 1.06)	Yes
Management Controls		
Benefits Reductions	Determine whether VARO staff timely and accurately processed disability evaluation reductions or terminations. (38 CFR 3.103(b)(2), (38 CFR 3.105(e)), (38 CFR 3.501), (M21-1MR.IV.ii.3.A.3.e), (M21-1MR.I.2.B.7.a), (M21-1MR.I.2.C), (M21-1MR.I.ii.2.f), (M21-4,Chapter 2.05(f)(4)), (*Compensation & Pension Service Bulletin*, October 2010)	No

Source: VA OIG

CFR=Code of Federal Regulations, FL=Fast Letter, M=Manual, MR=Manual Rewrite

Appendix C VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: August 27, 2015

From: Director, VARO Honolulu (459/00)

Subj: Draft Report, Inspection of the VA Regional Office, Honolulu, HI

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

1. During the week of April 20-24, 2015, OIG conducted an inspection of the Veterans Service Center operations at the Honolulu VA Regional Office.

2. Specific responses to each OIG recommendation of the subject report are provided in the attachment to this memorandum.

3. We appreciate the courtesy and cooperation your staff showed during the inspection. If you have any questions or would like to discuss our response, please contact Nessie A. Shores, Acting VSCM at 808-433-0160.

(original signed by:)

Karen M. Gooden, Director

Attachment
cc: Pacific District Director's Office

Attachment

Honolulu VA Regional Office OIG Reponses

Recommendation 1:

We recommended the Honolulu VA Regional Office Director provide training on traumatic brain injury claims and assess the effectiveness of that training.

RO Response:

Concur. The Honolulu Regional Office has scheduled additional training for Traumatic Brain Injury (TBI) claims for September 2, 2015, utilizing the TMS course, "Rating Traumatic Brain Injuries" (TMS #1209939), which will be instructor led by the Quality Review Rating Specialists.

The VSC standard operating procedure (SOP) requiring TBI second signature review has been recently updated on August 25, 2015. This updated SOP provides specific requirements for semi-annual training, as well as enhanced quality review procedures that are specifically focused to cases involving traumatic brain injuries. Additional requirements include quarterly trend analysis with utilization of the TBI Tracker. This data will be used to target specific training needs in relation to training needs of the rating staff within the VSC.

Recommendation 2:

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

RO Response:

Concur. The Honolulu Regional Office has scheduled and completed additional training for processing higher levels of special monthly compensation (SMC) and ancillary benefits training. This training included the courses:

a. Introduction to SMC (TMS#592939) completed July 14, 2015

b. Higher Level SMC (TMS#3939100) completed August 4, 2015
c. An additional training is scheduled for September 23, 2015 which will provide an enhancement to TMS Course #3939100, by utilizing case specific examples provided and applying them for a demonstration of in the proper use of the SMC calculator.

The VSC recently developed and implemented a Standard Operating Procedure (SOP) for rating and management of cases involving higher levels of SMC. This procedure provides specific requirements for semi-annual training, as well as enhanced quality review procedures that are specifically focused to cases involving higher levels of SMC. Additional requirements include quarterly trend analysis with utilization of the SMC Tracker. This data will be used to target specific training needs in relation to training needs of the rating staff within the VSC.

Recommendation 3:

We recommended the Honolulu VA Regional Office Director strengthen the review process for higher levels of special monthly compensation and ancillary benefits claims.

RO Response:

Concur. The Veteran Service Center (VSC) recently developed and implemented a Standard Operating Procedure (SOP) for rating and management of cases involving higher levels of SMC. This procedure provides specific requirements for semi-annual training, as well as enhanced quality review procedures that are specifically focused to cases involving higher levels of SMC. This SOP provides for a comprehensive review and signatory process on all cases involving higher levels of SMC. All cases reviewed will be documented utilizing the SMC Tracker.

Recommendation 4:

We recommended the Honolulu VA Regional Office Director implement a plan to ensure oversight and prioritization of benefits reduction cases.

RO Response:

Concur. The following plan was implemented to ensure oversight and prioritization of benefit reduction cases.

The Coach of Non-Rating team will generate the Veterans Operations Report (VOR) Pending Full Detail report daily to identify all pending EP 600 cases requiring action as identified below:

- Rating: Cases will be assigned daily based on DOC priority and time in cycle.
- Awards/Authorization: All cases in this category will be processed daily.

There are 94 cases pending completion of rating action in relation to proposed reductions. Of these, 62 are backlogged and require immediate intervention to ensure a finalized rating action is completed as soon as possible.

Utilizing the VOR report cited above, the Non-Rating Coach will ensure a daily assignment of a minimum of 5 rating cases daily to one dedicated RVSR. All cases assigned will be completed daily. This daily assignment will continue until such time as all backlogged cases are completed and cleared (anticipated completion date is October 1, 2015).

Once this backlog is cleared and all reduction cases are in a current status, the Non-Rating Coach will ensure all EP 600 cases are reviewed weekly, and applicable cases assigned out weekly for rating when due process expires.

Daily reporting will be monitored and tracked on the EP 600 reduction spreadsheet maintained and updated daily on a shared drive.

The Non-Rating Coach will submit daily progress reports to the Veterans Service Center Manager of the backlog reduction progress, as well as upcoming pending EP 600 reduction cases, to include the total number of reduction cases pending, number of cases attributed to backlog, number of cases pending promulgation and/or authorization, number of cases cleared the day prior, and the average number of days pending.

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Brent Arronte, *Director* Jason Boyd Orlan Braman Bridget Byrd David Piña Dana Sullivan Nelvy Viguera Butler Claudia Wellborn

Appendix E Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Assistant Secretaries
Office of General Counsel
Veterans Benefits Administration Pacific District Director
VA Regional Office Honolulu Director

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Mazie K. Hirono, Brian Schatz
U.S. House of Representatives: Tulsi Gabbard, Mark Takai

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