VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Benefits Administration

Inspection of
the VA Regional Office
Boise, Idaho

June 21, 2017
16-04762-232

ACRONYMS

DOC	Date of Claim
DRO	Decision Review Officer
EP	End Product
FY	Fiscal Year
NWQ	National Work Queue
OIG	Office of Inspector General
PII	Personally Identifiable Information
POA	Power of Attorney
RVSR	Rating Veterans Service Representative
SAH	Specially Adapted Housing
SHA	Special Home Adaptation
SMC	Special Monthly Compensation
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center
VSCM	Veterans Service Center Manager
VSR	Veterans Service Representative

Highlights: Inspection of the VARO Boise, ID

Why We Did This Review

In October 2016, we evaluated the Department of Veterans Affairs Regional Office (VARO) in Boise, Idaho, to determine how well Veterans Service Center (VSC) staff processed disability claims, how timely and accurately they processed proposed rating reductions, how accurately they entered claims-related information, and how well VARO staff responded to special controlled correspondence.

What We Found

Claims Processing—Boise VSC staff did not consistently process one of the two types of disability claims we examined. We reviewed 30 of 144 veterans' traumatic brain injury (TBI) claims (21 percent) and found that Rating Veterans Service Representatives (RVSRs) accurately processed 29 of the 30 claims (97 percent). However, RVSRs did not always process entitlement to special monthly compensation (SMC) and ancillary benefits consistent with Veterans Benefits Administration (VBA) policy. We reviewed all 13 veterans' SMC claims and found that RVSRs incorrectly processed eight claims (62 percent). This resulted in 84 improper monthly payments made to three veterans totaling approximately $24,300. We determined this occurred because of ineffective training and a misinterpretation of VBA policy.

Proposed Rating Reductions—VSC staff generally processed proposed rating reductions accurately. However, we reviewed 30 of 89 benefits reductions cases (34 percent) and found that staff delayed or incorrectly processed 15 of these cases (50 percent). Delays occurred because the VSC Manager and Supervisory Veterans Service Representatives prioritized other workload. These delays and processing inaccuracies resulted in approximately $11,300 in overpayments and an underpayment of approximately $320, representing eight improper monthly payments from July to September 2016.

Systems Compliance—VSC staff needed to improve the accuracy of claims-related information input into the electronic systems at the time of claims establishment. We reviewed 30 of 156 newly established claims (19 percent) and found that staff did not correctly input claim and claimant information into the electronic systems in nine of 30 claims (30 percent) because of an ineffective review process and infrequent refresher training. Consequently, the potential existed for claims to be misrouted and processing to be delayed. We also found that a Claims Assistant did not update the correct Power of Attorney (POA) code in the electronic systems, which resulted in a veteran's personally identifiable information being sent to a POA who was not representing him.

Special Controlled Correspondence—VARO staff processed special controlled correspondence timely but needed to improve accuracy. We reviewed 30 of 115 special controlled correspondences (26 percent) and found that staff incorrectly processed three of these cases (10 percent) because of a lack of training and inadequate oversight. As a result, the errors affected data integrity, misrepresented VARO workload performance, and provided inaccurate information.

What We Recommended

We recommended the VARO Director provide regular refresher training for SMC; implement plans to ensure oversight of proposed rating reduction cases; strengthen the claims establishment review process; and refer the privacy violation to the VARO Privacy Officer. The VARO Director should provide refresher training on claims establishment procedures and special controlled correspondence processing.

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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INTRODUCTION

Objectives

The Benefits Inspection Program is part of the VA Office of Inspector General's efforts to ensure our nation's veterans receive timely and accurate benefits and services. We conduct onsite inspections at randomly selected VA Regional Offices (VAROs) to assess their effectiveness. In FY 2017, we looked at four mission operations: Disability Claims Processing, Management Controls, Data Integrity, and Public Contact. We further define our independent oversight inspection to identify key objectives and risks within each operation or VARO program responsibility. In FY 2017, we assessed the VARO's effectiveness in:

- Disability claims processing by determining whether Veterans Service Center (VSC) staff accurately processed traumatic brain injury (TBI) claims and claims related to special monthly compensation (SMC) and ancillary benefits
- Management controls by determining whether VSC staff timely and accurately processed proposed rating reductions
- Data integrity by determining whether VSC staff accurately input claim and claimant information into the electronic systems
- Public contact by determining whether VARO staff timely and accurately processed special controlled correspondence

When we identify potential procedural inaccuracies, we provide this information to help the VARO understand the procedural improvements it can make for enhanced stewardship of financial benefits. Errors that affect benefits have a measurable monetary impact on veterans' benefits. Errors that have the potential to affect benefits are those that either had no immediate effect on benefits or had insufficient evidence to determine the effect to benefits.

Boise VA Regional Office

As of October 2016, the Boise VARO reported a staffing level of 86 full-time employees, which is the amount authorized. Of this total, the VSC had 70 employees assigned, which is the amount authorized. In FY 2016, VBA reported the Boise VARO completed 6,728 compensation claims—averaging 4.4 issues[1] per claim.

[1] Issues under M21-1, Adjudication Procedures Manual, Part III, Subpart iv, Chapter 6, Section B, *Determining the Issues,* are disabilities and benefits.

RESULTS AND RECOMMENDATIONS

I. Disability Claims Processing

Finding 1 Boise VSC Staff Generally Processed TBI Claims Correctly But Needed To Improve Accuracy In Processing Claims Related to Special Monthly Compensation and Ancillary Benefits

The Boise Rating Veterans Service Representatives (RVSRs) generally processed TBI claims correctly. However, RVSRs did not always process entitlement to SMC and ancillary benefits consistent with VBA policy. Generally, the errors for failing to grant higher levels of SMC for veterans were due to ineffective training, and errors related to ancillary benefits were due to misinterpretation of VBA policy. For example, even after receiving training in September and October 2015, RVSRs were still confused about VA policy. Overall, RVSRs incorrectly processed nine of the total 43 disability claims we reviewed, resulting in 84 improper monthly payments to three veterans totaling approximately $24,300[2] at the time of our September 2016 review.

Table 1 reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Boise VARO. 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.

Table 1. Boise VARO Disability Claims Processing Accuracy

		Veterans' Claims Inaccurately Processed		
Type of Claim	**Reviewed**	**Affecting Veterans' Benefits**	**Potential To Affect Veterans' Benefits**	**Total**
TBI	30	0	1	1
SMC and Ancillary Benefits	13	3	5	8
Total	**43**	**3**	**6**	**9**

Source: VA OIG analysis of the Veterans Benefits Administration's TBI disability claims completed from March 1 through August 31, 2016, and SMC and ancillary benefits claims completed from September 1, 2015 through August 31, 2016.

[2] All calculations in this report have been rounded when applicable.

VBA Policy Related to TBI Claims

VBA defines a TBI event as a traumatically induced structural injury or a physiological disruption of brain function resulting from 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. RVSRs or Decision Review Officers (DROs) who have completed the required TBI training must process all decisions that address TBI as an issue. Rating decisions for TBI require two signatures until the decision-maker demonstrates an accuracy rate of 90 percent or greater, based on the VARO's review of at least 10 TBI decisions.[3]

VBA policy requires that one of the following specialists must make the initial diagnosis of TBI: physiatrists, psychiatrists, neurosurgeons, or neurologists. A generalist clinician who has successfully completed the required TBI training may conduct a TBI exam, if the diagnosis is of record and was established by one of the aforementioned specialty providers.[4]

Review of TBI Claims

We randomly selected and reviewed 30 of 144 veterans' TBI claims (21 percent) completed from March 1 through August 31, 2016, to determine whether VSC staff processed them according to VBA policy. For example, we checked to see if VSC staff obtained an initial VA medical examination, as required.

RVSRs correctly processed 29 of 30 TBI claims—the single inaccuracy had the potential to affect a veteran's benefits. Of the 30 claims we reviewed, 11 did not require medical examinations because the evidence of record did not contain an event or injury in service or associated symptoms of disability.[5] However, 19 required VA medical examinations and 18 of those exams were appropriately completed by the required medical personnel—specialists completed 16 and generalist clinicians completed two. The one claim for which the medical exam was not completed is discussed below as an inaccuracy.

In the claim with an inaccuracy, an RVSR prematurely denied a TBI claim without obtaining an initial VA medical examination, as required. The veteran claimed TBI due to service; his service treatment records noted residual symptoms due to multiple blast explosions and his VA treatment records noted continued complaints of those symptoms. VBA policy requires that staff obtain a medical examination when the evidence of record contains an event or injury in service and associated symptoms of disability but does not contain sufficient medical evidence to decide the claim.[6] Without a VA

[3] M21-1, Adjudication Procedures Manual, Part III, Subpart iv, Chapter 4, Section G, Topic 2, *TBI*
[4] M21-1, Adjudication Procedures Manual , Part III, Subpart iv, Chapter 3, Section D, Topic 2, *Examination Report Requirements*
[5] Title 38 Code of Federal Regulations Section (38 CFR) §3.159
[6] 38 CFR §3.159

medical examination, we could not determine if the veteran would have been entitled to benefits. We provided the Veterans Service Center Manager (VSCM) with the specifics of the claim and asked for a review of the claim. Because RVSRs processed 29 of the 30 TBI claims correctly, we made no recommendations for improvement in this area.

Previous OIG Inspection Results

In our previous report, *Inspection of the VA Regional Office, Boise, Idaho* (Report No. 12-03885-168, April 29, 2013), we identified two TBI claims processing errors that were unique and did not constitute a common trend, pattern, or systemic issue. Given the small sample size of five claims available for our review and the small number of errors that were unique, we made no recommendations for improvement in this area. During the current inspection, RVSRs continued to follow VBA policy in 29 of the 30 TBI claims we reviewed.

VBA Policy Related to SMC and Ancillary Benefits

VBA assigns SMC to recognize the severity of certain disabilities or combinations of disabilities by adding an additional compensation to the basic rate of payment when the basic rate is not sufficient for the level of disability present. 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.

Ancillary benefits are secondary benefits considered when evaluating claims for compensation, which include eligibility to educational,[7] automobile,[8] and housing[9] benefits. Specially Adapted Housing (SAH) and Special Home Adaptation (SHA) are two grants administered by VA to assist seriously disabled veterans in adapting housing to their special needs. An eligible veteran may receive an SAH grant of not more than 50 percent of the purchase price of a specially adapted house, up to the maximum allowable by law. An eligible veteran may receive an SHA grant toward the actual cost to adapt a house or toward the appraised market value of necessary adapted features already in a house when the veteran purchased it, up to the maximum allowable by law.

[7] Dependents' Educational Assistance under 38 CFR §3.807 provides education benefits for the spouse and children of eligible veterans.
[8] Automobiles or Other Conveyances and Adaptive Equipment under 38 CFR §3.808 provides eligible veterans funds toward the purchase of an automobile, or other special equipment or assistive devices such as power seats.
[9] SAH grants under 38 CFR §3.809 and SHA grants under 38 CFR §3.809a provide eligible veterans funds for the purchase or construction of barrier-free homes or the costs associated with the remodeling of an existing home to accommodate disabilities in accordance with Title 38 United States Code Section 2101. The maximum dollar amount allowable for SAH grants in 2016 was $73,768. The maximum dollar amount allowable for SHA grants in 2016 was $14,754.

VBA policy requires staff to address the issues of SMC and ancillary benefits whenever they can grant entitlement.[10] VBA policy also states that all rating decisions involving SMC above a specified level require a second signature.[11]

In our report, *Review of VBA's Special Monthly Compensation Housebound Benefits* (Report No. 15-02707-277, September 29, 2016), we reviewed SMC Housebound benefits. Our Benefits Inspection reports reviewed a higher level of SMC that included those payment rates related to disabilities such as loss of limbs, loss of eyesight, and paralysis. These reviews did not overlap because this review involved different types of SMC that cannot be granted simultaneously with SMC Housebound benefits.

Review of SMC and Ancillary Benefit Claims

We randomly selected and reviewed all 13 veterans' claims available involving entitlement to SMC and related ancillary benefits completed by RVSRs from September 1, 2015 through August 31, 2016. We examined whether VSC 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. We found that eight of 13 veterans' claims contained errors. Three of the eight errors affected veterans' benefits and resulted in improper payments totaling approximately $24,300. These errors represented 84 improper monthly payments from April 2009 through March 2015, and from December 2015 through September 2016. In one of these cases, the improper underpayments were still paid monthly as of September 2016 and totaled about $190 per month. Details on the errors affecting benefits follow.

- In two cases, RVSRs did not grant a higher level of SMC for veterans with additional permanent disabilities evaluated as 50 percent disabling.[12] As a result, these veterans were underpaid approximately $14,300 over a period of 80 months.

- In one case, an RVSR used an incorrect effective date to assign entitlement for a higher level of SMC. As a result, the veteran was underpaid approximately $10,000 over a period of four months.

The remaining five of eight errors had the potential to affect veterans' benefits. In all five cases, RVSRs incorrectly granted eligibility to SHA grants to veterans who were also granted, or had previously been granted, eligibility to SAH grants. According to VBA policy, eligibility only exists for an SHA grant if the claimant is not entitled to, and has not previously

[10] M21-1, Adjudication Procedures Manual, Part III, Subpart iv, Chapter 6, Section B, Topic 2, *Considering Subordinate Issues and Ancillary Benefits*
[11] M21-1, Adjudication Procedures Manual, Part III, Subpart iv, Chapter 6, Section D, Topic 7, *Signature*
[12] 38 CFR §3.350

received, an SAH grant.[13] As a result of these errors, these five veterans were eligible to receive up to $14,754 in SHA benefits when they were already eligible to receive SAH benefits. We provided the details on the errors that affected benefits, or had the potential to affect benefits, to the VSCM for appropriate action. The VSCM concurred with all of the errors we identified.

Generally, the errors for failing to grant higher levels of SMC for veterans were due to ineffective training. We interviewed VSC staff and they reported that VA policy was still confusing. For example, although DROs, Rating Quality Review Specialists, and RVSRs received training in September and October 2015, we identified two errors that failed to grant increased SMC for additional independent disabilities, after this training. In addition, quality-review staff stated that they did not have a mechanism in place to ensure comprehension of training materials, other than rating decisions produced for each claim. Based on the fact that all three impact errors related to failing to grant increased SMC, combined with staff telling us that they were confused about VA policy, we concluded that the training provided in September and October 2015 was ineffective. As a result of not following VBA policy regarding SMC, veterans did not always receive correct benefit payments.

The errors involving SHA and SAH occurred because DROs and RVSRs misinterpreted VBA policy. During our interviews, the VSCM and VSC staff stated that they did not realize RVSRs were incorrectly granting eligibility to SHA grants until we identified these errors and they reviewed the policy. The VSCM and quality-review staff did not provide training related to SAH and SHA in FY 2015 or FY 2016 because VBA did not mandate this training and the VSCM and quality review staff were not aware of deficiencies in this area. Based on our findings, on October 20, 2016, the VSC quality-review staff provided refresher training on SAH and SHA grants to decision-making staff. As a result of not following VBA policy regarding ancillary benefits, veterans had the potential to receive incorrect benefits payments in the future.

Recommendations

1. We recommended the Boise VA Regional Office Director provide refresher training for increased special monthly compensation based on additional independent disabilities and assess the effectiveness of this training.

2. We recommended the Boise VA Regional Office Director implement a plan to assess the effectiveness of the most recent refresher training for

[13] 38 CFR §3.809a

processing Specially Adapted Housing and Special Home Adaptation grants.

Management Comments

The VARO Director concurred with our findings and recommendations. The Director provided documentation of refresher training completed on January 30, 2017 for special monthly compensation. Furthermore, the VARO provided a plan that assessed the effectiveness of refresher training for special monthly compensation, as well as for Specially Adapted Housing and Special Home Adaptation Grants.

OIG Response

The VARO Director's comments and actions are responsive to the recommendations. The Director has requested closure of these report recommendations. Based on the information provided, we consider Recommendations 1 and 2 closed at this time. We will follow up as required.

II. Management Controls

Finding 2 Boise VSC Staff Generally Processed Proposed Rating Reductions Accurately But Needed Better Oversight To Ensure Timely Action

We randomly selected and reviewed 30 proposed benefit reduction cases to determine whether VSC staff accurately and timely processed them. VSC staff accurately processed 28 of the 30 proposed benefit reduction cases. However, processing delays occurred in 15 of the 30 cases that required rating decisions to reduce benefits—five of these cases affected veterans' benefits and 10 had the potential to affect benefits. Generally, processing delays occurred because the VSCM and Supervisory Veterans Service Representatives did not view this work as a priority even though the office's Workload Management Plan directed Supervisory Veterans Service Representatives to identify and prioritize these cases and have them completed within 15 days from expiration of the due process period. These delays and processing inaccuracies resulted in approximately $11,300 in overpayments and an underpayment of approximately $320, representing eight improper monthly payments from July to September 2016. In accordance with VA policy, VBA does not recover these overpayments because the delays were due to VA administrative errors.[14]

VBA Policy Related to Proposed Rating Reductions

VBA provides compensation payments to veterans for conditions they incurred or aggravated during military service.[15] The amount of monthly compensation to which a veteran is entitled may change because his or her service-connected disability may improve or worsen. Improper payments associated with benefit reductions generally occur when beneficiaries receive payments to which they are not entitled.[16] Such instances are attributable to VARO staff not taking actions to ensure that veterans receive correct payments for their current levels of disability.

When the VARO obtains evidence which demonstrates that a disability has improved and that the new evaluation would result in a reduction or discontinuance of current compensation payments, VSRs must inform the beneficiary of the proposed reduction in benefits.[17] 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.[18] If the veteran does not provide additional evidence within that period, an RVSR may make a final determination to reduce or

[14] M21-1, MR Adjudications Procedures Manual, Part III, Subpart v, Chapter 1, Section I, Topic 3, *Consideration of the Cause of Erroneous Benefits*, and 38 CFR §3.500
[15] 38 CFR §3.303
[16] Public Law 107-300
[17] 38 CFR §3.103
[18] 38 CFR §3.105

discontinue the benefit[19] beginning on the 65th day following notice of the proposed action.[20] However, due to policy modifications on April 3, 2014,[21] and again on July 5, 2015,[22] VBA policy no longer requires 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. The Boise VARO's Workload Management Plan contained local guidance directing Supervisory Veterans Service Representatives to identify and prioritize these cases and have them completed within 15 days from expiration of the due process period.

Review of Claims To Assess Accuracy

VSC staff accurately processed 28 of 30 cases involving benefit reductions. The two accuracy errors also included processing delays. Details on the errors affecting benefits follow.

- In the first case, an RVSR assigned an incorrect effective date of November 1, 2016 for the disability reductions and discontinuance of entitlement to SMC housebound benefits. According to VBA policy, the effective date in this case should have been August 1, 2016, the date of last payment because the veteran failed to report to a mandatory reexamination.[23] As a result of this processing inaccuracy, VA had overpaid the veteran approximately $1,800 over a period of one month at the time of our review.
- In the second case, an RVSR assigned an incorrect effective date of August 1, 2016, for a disability reduction based on improvement, and notified the veteran on June 2, 2016. According to VBA policy, the effective date in this case should have been September 1, 2016, the beginning of the month following the 60-day period from the date of notification to the veteran.[24] As a result of this processing inaccuracy, VA underpaid the veteran approximately $320.

We provided the details on the delays and accuracy errors that affected benefits, or had the potential to affect benefits, to the VSCM for appropriate action. As we identified only two accuracy errors, we made no recommendations for improvement in this area.

[19] *Ibid.*
[20] M21-4, Appendix B, Section II, *End Products - Compensation, Pension, and Fiduciary Operations*
[21] M21-1, MR Adjudications Procedures Manual, Part I, Chapter 2, Section B, Topic 7, *Establishing and Monitoring Controls*
[22] M21-1 Adjudications Procedures Manual, Part I, Chapter 2, Section C, Topic 2, *Responding to the Beneficiary*
[23] 38 CFR §3.655
[24] 38 CFR §3.501

Review of Claims To AssessProcessing Timeliness

We randomly selected and reviewed 30 of 89 completed cases (34 percent), from June 1 through August 31, 2016, that proposed reductions in benefits. Processing delays that required rating decisions to reduce benefits occurred in 15 of the 30 cases. We considered cases to have delays when VSC staff did not process them on the 65th day following notice of the proposed action, and the resulting effective date of reduction was impacted by at least one month.

For the 15 cases with processing delays, the delays had resulted in an average of less than one monthly overpayment at the time we began our review. In the most significant overpayment and delay, a VSR sent a letter to the veteran on February 16, 2016, proposing to reduce the disability evaluation for the veteran's soft tissue cancer and discontinue entitlement to SMC benefits. The due process period expired on April 21, 2016 without the veteran providing additional evidence. However, an RVSR and VSRs did not take final action to reduce and discontinue the benefits until June 8, 2016. As a result, VA overpaid the veteran approximately $4,500 over a period of 2 months.

In one of the 10 cases that had the potential to affect benefits, an RVSR proposed a reduction in a veteran's evaluation for coronary artery disease. Due process expired on May 25, 2016 but an RVSR and VSRs did not take final action to reduce benefits until July 12, 2016. The reduction in the veteran's benefits would have been effective October 1, 2016. As a result of an RVSR and VSRs delaying the final rating to reduce benefits, the veteran may receive future improper payments.

Generally, these processing delays occurred because the VSCM and Supervisory Veterans Service Representatives did not view this work as a priority, although the office Workload Management Plan directed Supervisory Veterans Service Representatives to identify and prioritize these cases and have them completed within 15 days from expiration of the due process period. All of the delays exceeded the local 15 day goal established by the VARO. Interviews with the VSCM, Supervisory Veterans Service Representatives, and VSC staff confirmed that rating reduction cases were considered a lower priority compared with other work being directed by VBA's Central Office. Without ensuring this work is processed timely, delays in processing proposed rating reduction cases result in unsound financial stewardship of veterans' monetary benefits and fail to minimize improper payments.

Recommendation

3. We recommended the Boise VA Regional Office Director implement a plan to ensure oversight and prioritization of proposed rating reduction cases for completion at the end of the due process time period.

Management Comments

The VARO Director concurred with our finding and recommendation, and agreed to update the VSC's Workload Management Plan to include improved oversight and prioritization of proposed rating reduction cases. However, the Director reported that, as of April 9, 2017, this work was absorbed into the National Work Queue (NWQ) for distribution, and the Workload Management Plan will be updated to reflect this change.

OIG Response

The VARO Director's comments and actions are responsive to the recommendation. The Director has requested closure of this report recommendation. Based on the information provided, we consider Recommendation 3 closed at this time. We will follow up as required.

III. Data Integrity

Finding 3 Boise VSC Staff Needed To Improve the Accuracy of Information Input Into the Electronic Systems at the Time of Claims Establishment

We randomly selected and reviewed 30 pending rating claims selected from VBA's Corporate Database to determine whether VSC staff accurately input claim and claimant information into the electronic systems at the time of claim establishment. In nine of the 30 claims reviewed, VSC staff did not enter accurate and complete information in the electronic systems. These errors were due to an ineffective review process and infrequent refresher training. Based on the fact that all nine errors were due to inaccurate or incomplete information entered into the electronic systems, combined with VSC staff telling us they rarely receive formal training, we therefore concluded that training was infrequent. As a result of an ineffective review process and infrequent training, there is the potential to misroute claims in the NWQ, delay claims processing, and expose veterans' personally identifiable information (PII) to unauthorized third parties.

VBA Policy Related to Data Integrity

VBA relies on data input into electronic systems to accurately manage and report their workload to stakeholders, and to properly route claims within their electronic workload management tool, the NWQ. The NWQ centrally manages the national claims workload by prioritizing and distributing claims across VBA's network of VAROs using rules that assign workload based on certain claimant and claim information within the electronic system.[25] Veterans Benefits Management System (VBMS) is an electronic processing system the NWQ uses to distribute work.[26] Because the NWQ relies on the accuracy of data, claims misidentified or mislabeled at the time of claims establishment can result in improper routing and therefore lead to untimely processing of claims and delays in veterans' benefits. In addition, this could lead to PII being disclosed without authorization, if not controlled by accuracy reviews at the time of establishment.

VA policy defines a privacy incident as the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations in which persons other than authorized users, and for any other than an authorized purpose, have access or potential access to PII in any usable form, whether physical or electronic. This term encompasses both suspected and confirmed incidents involving PII. VA requires anyone who identifies a PII violation to report the incident to the VARO Privacy Officer.

[25] Department of Veterans Affairs, Veterans Benefits Administration, National Work Queue, Phase 1 Playbook
[26] *Ibid.*

Initial claim routing begins at the time of claims establishment. VARO staff must input claim and claimant information into the electronic system to ensure system compliance. Table 2 reflects nine claim establishment terms.

Table 2. Claim Establishment Terms

Term	Definition
Date of Claim	Earliest date the claim or information is received in any VA facility
End Product	The end product system is the primary workload monitoring and management tool for the VSC
Claim Label	A more specific description of the claim type that a corresponding end product represents
Claimant Address	Mailing address provided by the claimant
Claimant Direct Deposit	Payment routing information provided by the claimant
Power of Attorney	An accredited representative of a service organization, agent, non-licensed individual, or attorney representative chosen by the claimant to represent him or her
Corporate Flash Indicator	Claimant-specific indicators which can represent an attribute, fact, or status that is unlikely to change
Special Issue Indicator	Claim-specific indicators and can represent a certain claim type, disability or disease, or other special notation that is only relevant to a particular claim
Claimed Issue with Classification	Specifies the claimed issue and its medical classification

Source: VA OIG presentation of definitions from VBA's M21-1 and M21-4

Systems Compliance

We randomly selected and reviewed 30 of 156 pending rating claims (19 percent) selected from VBA's Corporate Database established in August 2016, as of September 8, 2016. In nine of the 30 claims we reviewed, a VSR and Claims Assistants did not enter accurate and complete information in the electronic systems.

For example, a Claims Assistant did not update the correct Power of Attorney (POA) code in the electronic systems. VBA policy requires staff to establish the POA code in the electronic systems as soon as the claimant submits a form for representation.[27] In this case, a veteran submitted a claim for benefits and selected a veterans service organization to represent him in his claim. The system was not updated to reflect this change in POA status. Subsequently, a letter was sent to the veteran with a copy provided to an

[27] M21-1, Adjudications Procedures Manual, Part III, Subpart ii, Chapter 3, Section C, Topic 4, *Handling Power of Attorney (POA) Appointments*

unauthorized POA. As a result of not updating the system, a document that contained a veteran's PII was sent to a POA who was not representing him but would also have had access to his electronic records. We provided details on this PII violation to the VSCM for appropriate action. The VSCM stated that this violation was not referred to the Privacy Officer because he felt it was not a PII violation. However, we maintain that this was a violation since an unauthorized POA still would have had access to the veteran's folder. As this incident was not referred to the Privacy Officer, we could not determine whether there was any adverse effect to the veteran.

In another case, a Claims Assistant did not input the correct contention classification in the electronic systems. VBA policy requires staff to enter the correct contention classification when entering a claim.[28] As a result, an incorrect contention classification could affect data integrity.

Generally, the processing errors occurred because of an ineffective review process and infrequent refresher training. VSC staff stated that the claims establishment process consists of multiple steps that require completion in a specific order. They stated that VBMS does not allow checking inputs and making corrections after a step is completed. Moreover, staff stated that while claims establishment is their primary responsibility, other duties routinely interrupt the process, which adds to the difficulty of ensuring accurate information is input into the system. The VSC staff provided us with a claims establishment checklist that Claims Assistants reference when establishing rating claims in the electronic system. The Supervisory Veterans Service Representative also uses the checklist to complete quality reviews. One of the errors we found was quality reviewed by a Supervisory Veterans Service Representative who did not identify the mistake. We found the claims establishment checklist did not include claim label and claimed issue classification, which are required when the claim is established.

According to VARO training records, Claims Assistants completed claims establishment training in January 2016. However, VBA revised the training material on September 9, 2016, due to VBMS becoming the main system for establishing claims. At the time of our inspection in October 2016, Claims Assistants had not completed the revised training. As a result of an ineffective quality-review process and no refresher training since the policy was revised, there is the potential to misroute claims in the NWQ, delay claims processing, and expose veterans' PII to unauthorized third parties.

[28] M21-1, Adjudications Procedures Manual, Part III, Subpart iii, Chapter 1, Section D, Topic 2, *Utilizing Contentions and Special Issue Indicators Associated with Claimed Issues*

Recommendations

4. We recommended the Boise VA Regional Office Director strengthen the review process for claims establishment and revise the claims establishment checklist.

5. We recommended the Boise VA Regional Office Director implement a plan to provide refresher training on claims establishment procedures and monitor the effectiveness of that training.

6. We recommended the Boise VA Regional Office Director refer the personally identifiable information violation to the VA Regional Office Privacy Officer to determine proper action, if any.

Management Comments

The VARO Director concurred with our findings and recommendations, and agreed to strengthen the claims establishment review process and revise the claims establishment checklist. In addition, the VARO submitted documentation of training on claims establishment procedures that was provided on March 9, 2017. Finally, the Director referred the personally identifiable information violation to the VARO Privacy Officer who recommended no further action.

OIG Response

The VARO Director's comments and actions are responsive to the recommendations. The Director has requested closure of these report recommendations. For Recommendation 4, we requested the VARO provide the updated claims establishment checklist for review prior to closing the recommendation. We consider Recommendations 5 and 6 closed at this time based on the information provided. We will follow up as required.

IV. Public Contact

Finding 4 Boise VARO Processed Special Controlled Correspondence Timely But Needed To Improve Accuracy

We randomly selected and reviewed 30 special controlled correspondence cases to determine whether VARO staff timely and accurately processed them. The VARO responded to all 30 special controlled correspondences within 4 days after receipt−averaging approximately one day. However, VARO congressional liaison staff incorrectly processed three of the 30 special controlled correspondences we reviewed. Generally, processing errors occurred due to a lack of training and inadequate oversight by the VARO Director. As a result of not properly controlling and processing the special controlled correspondences, the errors affected data integrity, misrepresented VARO workload performance, and provided inaccurate information.

VBA Policy Related to Special Controlled Correspondence

Special controlled correspondence is mail that requires expedited processing, control, and response. Examples of special controlled correspondence include mail received from the White House, members of Congress, national headquarters of service organizations, and private attorneys. VBA policy requires the VARO Director or the VSCM to establish a specific tracking code for all special controlled correspondence.[29] Staff are required to send an acknowledgement letter within 5 business days after receipt in the VARO if they cannot provide a full response.[30]

Furthermore, according to VBA policy, all correspondence generated by VA must provide complete, accurate, and understandable information.[31] In addition, VARO staff must either file these documents in claims folders or upload them into electronic folders.[32]

Review of VARO Processing of Special Correspondence To Assess Timeliness and Accuracy

We randomly selected and reviewed 30 of 115 special controlled correspondences (26 percent) completed from June 1 through August 31, 2016. Congressional liaison staff responded to all 30 special controlled correspondence inquiries within 4 days after receipt. Of the 30 inquiries we reviewed, congressional liaison staff responded to 12 of them on the same day of receipt and the remaining 18 within 1 to 4 days. Overall, VARO's

[29] M21-4, Appendix B, Section II, *End Products - Compensation, Pension, and Fiduciary Operations*
[30] M27-1, Benefits Assistance Service Procedures, Part I, Chapter 5, Topic 3, *Acknowledging Correspondence*
[31] M27-1, Benefits Assistance Service Procedures, Part I, Chapter 5, Topic 1, *General Guidance for Processing Correspondence*
[32] M21-1, Adjudication Procedures Manual, Part III, Subpart ii, Chapter 1, Section B, Topic 2, *Handling Incoming Mail*

response time to the 30 special controlled correspondences we reviewed averaged approximately one day.

Congressional liaison staff incorrectly processed three of 30 special controlled correspondences we reviewed. Details on these errors follow.

- In the first error, the congressional liaison staff did not upload a congressional email inquiry into VBMS. VBA policy requires staff to upload these emails into veterans' electronic folders.[33] As a result, VBA staff would not be able to review any issues pertaining to this document in the veteran's electronic folder.
- In the second error, the congressional liaison staff did not use the correct date of receipt for a congressional email inquiry received at the Boise VARO. According to VBA policy, the date of receipt is defined as the date on which a claim, information or evidence was received in the Department of Veterans Affairs.[34] The VARO received the email on June 29, 2016. However, the congressional liaison staff entered an incorrect date of June 30, 2016 into the electronic data system.
- In the third error, the congressional liaison staff did not provide accurate information in response to special controlled correspondence received at the VARO, as required.[35] VARO congressional liaison staff sent an email response to congressional staff informing them that VBA had granted service connection for post-traumatic stress disorder to a veteran. However, the veteran was service-connected for major depressive disorder. As a result, the VARO's response placed the veteran at risk of receiving inaccurate information from congressional staff.

Generally, the processing errors occurred because of a lack of training and inadequate oversight by the VARO Director. During our inspection, we found that a new congressional liaison staff member had been assigned in April 2016 to handle special controlled correspondence. Interviews with the quality-review staff revealed that they did not conduct quality reviews on this type of correspondence because this work was not completed by claims processors. Moreover, interviews with the congressional liaison staff stated that there was no centralized training available for controlled correspondence. The congressional liaison staff developed an itemized checklist during our inspection; however, we have not assessed the effectiveness of this recently created job aid. Because of the three errors identified in the processing of special controlled correspondence, combined with the congressional liaison staff stating that he had not received any

[33] M21-1, Adjudication Procedures Manual, Part III, Subpart ii, Chapter 1, Section B, Topic 2, *Handling Incoming Mail*
[34] 38 CFR §3.1
[35] M27-1, Benefits Assistance Service Procedures, Part I, Chapter 5, Topic 1, *General Guidance for Processing Correspondence*

formal training, we concluded that this lack of training contributed to the errors we identified. As a result of not properly controlling and processing the special controlled correspondence, these errors affected data integrity, misrepresented VARO workload performance, and provided inaccurate information to congressional staff.

Recommendations

7. We recommended the Boise VA Regional Office Director establish a plan to provide training to congressional liaison staff on processing special controlled correspondence and monitor the effectiveness of the training.

8. We recommended the Boise VA Regional Office Director develop and implement a plan to assess the effectiveness of the special controlled correspondence checklist.

Management Comments

The VARO Director concurred with our findings and recommendations. The Director provided a list of training to be completed by the congressional staff by May 31, 2017. Furthermore, the VARO provided a plan to assess the effectiveness of the special controlled correspondence checklist.

OIG Response

The VARO Director's comments and actions are responsive to the recommendations. Based on the information provided, we consider Recommendations 7 and 8 closed at this time. We will follow up as required.

Appendix A Scope and Methodology

Scope and Methodology

In October 2016, we evaluated the Boise VARO to see how well it provides services to veterans and processes disability claims.

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. Before 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.

We randomly selected and reviewed 30 of 144 veterans' disability claims related to TBI (21 percent) that the VARO completed from March 1 through August 31, 2016. We reviewed all 13 veterans' claims available involving entitlement to SMC and related ancillary benefits completed by VARO staff from September 1, 2015 through August 31, 2016. In addition, we randomly selected and reviewed 30 of 89 completed claims (34 percent) that proposed reductions in benefits from June 1 through August 31, 2016. Furthermore, we randomly selected and reviewed 30 of 156 pending rating claims (19 percent) selected from VBA's corporate database established in August 2016, as of September 8, 2016. Finally, we randomly selected and reviewed 30 of 115 special controlled correspondences (26 percent) completed from June 1 through August 31, 2016.[36]

Data Reliability

We used computer-processed data from VBA's corporate database obtained by the Austin Data Analysis Division. 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. Furthermore, 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 133 claims folders we reviewed.

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.

[36] During the inspection, while determining our sample size of 30 claims, we determined some claims were outside of the scope of our review; therefore, we modified the universe of claims to reflect this number.

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 Management Comments

Department of Veterans Affairs Memorandum

Date: May 12, 2017

From: Director, VA Regional Office Boise, Idaho

Subj: OIG Draft Report- *Inspection of the VA Regional Office, Boise, Idaho*

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

1. The Boise VARO's comments regarding the Inspection of the VA Regional Office, Boise, Idaho are attached.

2. Please refer questions to Stephanie Pinque, Human Resources Specialist, at 208-429-2204.

(original signed by:)

KATHRYN MALIN
Director

Attachment

Attachment

Comments on Draft Report
OIG Office of Audits and Evaluations
Benefits Inspection of the Boise Regional Office

Recommendation 1: We recommended the Boise VA Regional Office Director provide refresher training for increased special monthly compensation based on additional independent disabilities, and assess the effectiveness of this training.

RO Response: Concur

The Boise VA Regional Office completed refresher training on higher levels of special monthly compensation based on additional independent disabilities on January 30, 2017 (TMS #4200879, Higher Level SMC). An internal comprehension check was completed on May 3, 2017 to assess overall effectiveness of the SMC training. Twenty out of twenty-three decision makers correctly identified the proper higher level SMC rate. Feedback on this study has been provided to all decision-makers and the Veteran Service Center Manager. SMC has been addressed on the Boise VSC's rating quality checklist.

We request closure of this recommendation based on the evidence provided above.

Recommendation 2: We recommended the Boise VA Regional Office Director implement a plan to assess the effectiveness of the most recent refresher training for processing Specially Adapted Housing and Special Home Adaptation Grants.

RO Response: Concur

After training was conducted on October 16, 2016, the Boise VSC found no Specially Adaptive Housing/Special Home Adaptation quality errors through individual quality reviews (IQRs) or individual process reviews (IPRs).

The Boise VA Regional Office has scheduled refresher training on processing Specially Adapted Housing and Special Home Adaptation Grants on May 11, 2017 (TMS #4180566), Rating for Automobile & Adaptive Equipment Allowance, (SAH/SHA). An internal comprehension check will be completed 60 days following the scheduled training. Results will be provided to the Boise Director and VSCM. Boise VSC's rating quality checklist has been modified in May 2017 with an emphasis for SAH/SHA under ancillary benefits.

We request closure of this recommendation based on the evidence provided above.

Recommendation 3: We recommended the Boise VA Regional Office Director implement a plan to ensure oversight and prioritization of proposed rating reduction cases for completion at the end of the due process time period.

RO Response: Concur

The Boise VSC updated the Workload Management Plan (WMP) on February 1, 2017. The WMP includes oversight and prioritization of proposed rating reduction (600 EPs) and was also updated for improved oversight.

On April 9, 2017 several non-rating end-products were absorbed and are now part of the National Work Queue (NWQ) distribution. Rating reduction 600 EPs are included in the daily distribution of work from NWQ. The Boise VSC now prioritizes rating reductions when received from the NWQ and managed based on time in queue (TIQ). Based on the recent changes to NWQ and non-rating work, Boise's WMP will be updated by July 1, 2017 to reflect the necessary changes.

We request closure of this recommendation based on the evidence provided above.

Recommendation 4: We recommended the Boise VA Regional Office Director strengthen the review process for claims establishment and revise the claims establishment checklist.

RO Response: Concur

Training was provided to members of the IPC staff on March 9, 2017. Individual quality discussions occur monthly. The Veteran Service Center (VSC) Intake Processing Center (IPC) Coach updated the claims establishment checklist on May 4, 2017. Additionally, new National Claim Assistant Job Performance Standards are anticipated to be released in calendar year 2017 which will include a national establishment checklist that will be used by IPC staff.

We request closure of this recommendation based on the evidence provided above.

Recommendation 5: We recommended the Boise VA Regional Office Director implement a plan to provide refresher training on claims establishment procedures and monitor the effectiveness of that training.

RO Response: Concur

A training schedule was implemented for IPC Claim Assistants on February 16, 2017. This training focuses on required training for Claim Assistants for FY 2017, to include claims establishment procedures. As noted above, quality checklist training was completed on March 9, 2017.

We request closure of this recommendation based on the evidence provided above.

Recommendation* 6*: We recommended the Boise VA Regional Office Director refer the personally identifiable information violation to the VA Regional Office Privacy Officer to determine proper action, if any.

RO Response: Concur

The Boise VA Director has made the referral to the Regional Office Privacy Officer for a possible determination. The Privacy Officer found no violation of personally identifiable information occurred and recommended no further action.

We request closure of this recommendation based on the evidence provided above.

Recommendation 7: We recommended the Boise VA Regional Office Director establish a plan to provide training to congressional liaison staff on processing special controlled correspondence and monitor the effectiveness of the training.

RO Response: Concur

The Intake Processing Team (IPC) will provide training to the congressional staff on the following subjects: Handling Incoming Mail, M21-1, Part III, Subpart ii, Chapter 1, Section B, Topic 2; Recording the Date of Receipt of Incoming Documents, M21-1, Part III, Subpart ii, Chapter 1, Section C, Topic 1; and General Guidance for Processing Correspondence, M27-1, Part I, Chapter 5. The training will be completed by May 31, 2017.

The special controlled correspondence checklist will be used in conjunction with this learning. See response to recommendation 8.

We request closure of this recommendation based on the evidence provided above.

Recommendation 8: We recommended the Boise VA Regional Office Director develop and implement a plan to assess the effectiveness of the special controlled correspondence checklist.

RO Response: Concur

The checklist has been used by the Congressional Liaison since October 2016, and will continue to be used for quality purposes. The checklist may be modified at any time, if the changes result in a positive outcome.

Beginning the third quarter of fiscal year 2017, the Boise Regional Office (RO) Quality Review Team (QRT) will review at a minimum 5 completed special controlled correspondence per month. A VOR report listing using End Product (EP) 500 series will be used for this random sample.

The random sample of 5 reviews will continue throughout each subsequent month to determine the effectiveness of the special controlled correspondence checklist. If deficiencies are identified, specific remedial training will be provided to the Congressional Liaison by the QRT or other RO subject matter experts.

If 96% quality is achieved after the initial 15 reviews, management will determine whether to continue with the random reviews. If quality is less than 96%, the reviews will continue until target quality is achieved.

We request closure of this recommendation based on the evidence provided above.

For accessibility, the format of the original memo has been modified to fit in this document.

Appendix C OIG Contact and Staff Acknowledgments

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 Michelle Elliott Elyce Girouard Nelvy Viguera Butler Claudia Wellborn

Appendix D Report Distribution

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This report is available on our website at www.va.gov/oig.