

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



# Veterans Benefits Administration

*Inspection of  
the VA Regional Office  
Phoenix, Arizona*

August 17, 2017  
17-00515-299

# ACRONYMS

FY	Fiscal Year
NWQ	National Work Queue
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SMC	Special Monthly Compensation
SVSR	Supervisory Veterans Service Representative
TBI	Traumatic Brain Injury
VA	Department of Veterans Affairs
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center
VSCM	Veterans Service Center Manager
VSR	Veterans Service Representative

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# Highlights: Inspection of the VARO Phoenix, AZ

## Why We Did This Review

In January and February 2017, we evaluated the Department of Veterans Affairs Regional Office (VARO) in Phoenix, Arizona, to assess whether Veterans Service Center (VSC) staff (i) accurately processed disability claims; (ii) timely and accurately processed proposed rating reductions; (iii) accurately entered claims-related information; and (iv) timely and accurately responded to special controlled correspondence.

## What We Found

**Claims Processing**—Phoenix VSC staff did not consistently process one of the two types of disability claims we examined. We reviewed 30 of 1,105 veterans' traumatic brain injury claims (3 percent) and found that Rating Veterans Service Representatives (RVSR) accurately processed 29 of 30 claims. However, RVSRs did not always process entitlement to special monthly compensation (SMC) and ancillary benefits consistent with Veterans Benefits Administration (VBA) policy. We reviewed 30 of 108 veterans' SMC claims (28 percent) and found that RVSRs incorrectly processed three claims. This resulted in 73 improper monthly payments made to three veterans, totaling approximately \$44,700. We determined this occurred because of a lack of effective oversight.

**Proposed Rating Reductions**—VSC staff generally processed proposed rating reductions accurately but they needed to prioritize this workload to ensure timely

action. We reviewed 30 of 497 benefits reduction cases (6 percent) and found that RVSRs delayed or incorrectly processed 11 cases that resulted in approximately \$15,500 in overpayments and \$2,400 in underpayments. The delays were due to prioritization of other workloads.

**Systems Compliance**—VSC staff needed to improve the accuracy of claims-related data input into the electronic systems at the time of claims establishment. We reviewed 30 of 1,158 newly established claims (3 percent) and found that Claims Assistants (claims assistants) and a Veterans Service Representative did not correctly enter claim and claimant information into the electronic systems in 15 of 30 claims due to ineffective operational oversight. Consequently, the potential existed for claims to be misrouted and processing to be delayed.

**Special Controlled Correspondence**—VSC staff generally processed special controlled correspondence timely but needed to improve the accuracy of processing. We reviewed 30 of 431 special controlled correspondences (7 percent) and found that congressional liaisons at the Phoenix VSC incorrectly processed 11 cases due to a lack of training.

As a result, veterans' electronic files were incomplete and VBA staff may not have been aware of all required information in the electronic folders.

## What We Recommended

We recommended the VARO Director implement plans to improve oversight of SMC decisions, place higher priority on

rating reductions, ensure data entered at the time of claims establishment are accurate, and provide training for 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.

A handwritten signature in blue ink that reads "Larry M. Reinkemeyer". The signature is written in a cursive style with a large initial "L".

**LARRY M. REINKEMEYER**  
Assistant Inspector General  
for Audits and Evaluations

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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 (VARO) to assess their effectiveness. In FY 2017, we looked at four mission operations—Disability Claims Processing, Management Controls, Data Integrity, and Public Contact. Our inspections help identify risks within each operation or VARO program responsibility. In FY 2017, our objectives are assessing 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 VSC 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 on benefits.

### Phoenix VA Regional Office

As of December 2016, the Phoenix VARO reported a staffing level of 597 full-time employees; it was authorized 619. Of this total, the VSC reported 273 employees assigned; it was authorized 264. In FY 2016, the Veterans Benefits Administration (VBA) reported the Phoenix VARO completed 27,321 compensation claims—averaging 4.5 issues<sup>1</sup> per claim.

<sup>1</sup> Under M21-1 Adjudication Procedures Manual, Part III, Subpart iv, Chapter 6, Section B, *Determining the Issues*, “issues” are disabilities and benefits.

## RESULTS AND RECOMMENDATIONS

### I. Disability Claims Processing

#### Finding 1 **Phoenix VSC Staff Generally Processed TBI Claims Correctly But Needed To Improve Accuracy in Processing SMC and Ancillary Benefits**

Rating Veterans Service Representatives (RVSR) generally processed TBI claims correctly. However, they did not always process entitlement to SMC and ancillary benefits consistent with VBA policy. Generally, the errors for SMC were due to ineffective operational oversight of VBA's second signature review process. Overall, RVSRs correctly processed 56 of the 60 disability claims we reviewed (93 percent). The four errors we identified resulted in 73 improper monthly payments to three veterans, totaling approximately \$44,700<sup>2</sup> as of January 2017.

Table 1 reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Phoenix VARO. We sampled claims related only to specific conditions that we considered at higher risk of processing errors. As a result, the errors identified do not represent the overall accuracy rate at this VARO.

**Table 1. Phoenix 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	30	3	0	3
<b>Total</b>	<b>60</b>	<b>3</b>	<b>1</b>	<b>4</b>

*Source: VA OIG analysis of the VBA's TBI disability claims completed from May 1 through October 31, 2016, and SMC and ancillary benefits claims completed from November 1, 2015 through October 31, 2016.*

<sup>2</sup> 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/emotional.<sup>3</sup> VBA policy requires staff to evaluate these residual disabilities. RVSRs or Decision Review Officers 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 has demonstrated an accuracy rate of 90 percent or greater, based on the VARO’s review of at least 10 TBI decisions.<sup>4</sup>

VBA policy requires that one of the following specialists must make the initial diagnosis of TBI: physiatrists, psychiatrists, neurosurgeons, or neurologists.<sup>5</sup> 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.<sup>6</sup>

**Review of  
TBI Claims**

We randomly selected and reviewed 30 of 1,105 veterans’ TBI claims (3 percent) completed from May 1 through October 31, 2016 to determine whether VSC staff processed them according to Federal regulations. For example, we checked to see if VSC staff obtained an initial VA medical examination, as required.<sup>7</sup>

RVSRs correctly processed 29 of 30 TBI claims (97 percent)—the single inaccuracy had the potential to affect a veteran’s benefits. Of the 30 claims we reviewed, four did not require a medical examination because the evidence of record did not contain an event or injury in service or associated symptoms of disability.<sup>8</sup> However, 26 of the claims required VA medical examinations and 23 of those exams were appropriately completed by the required medical personnel—specialists completed 18 and generalist clinicians completed five. Three veterans did not appear for their scheduled VA examinations.

Our review of initial TBI examinations found no improper diagnoses of TBI. The Veterans Service Center Manager (VSCM) concurred with the one error we identified, which involved an RVSR improperly awarding separate compensable evaluations for TBI and a co-existing mental health condition. In this case, a medical examiner could not determine which occupational and social impairments were due to TBI or the co-existing mental health condition. According to VBA policy, the RVSR should have

<sup>3</sup> M21-1 Adjudication Procedures Manual, Part III, Subpart iv, Chapter 4, Section G, Topic 2, *TBI*.

<sup>4</sup> *Ibid.*

<sup>5</sup> Chapter 3, Section D, Topic 2, *Examination Report Requirements*.

<sup>6</sup> *Ibid.*

<sup>7</sup> Title 38 Code of Federal Regulations Section (38 CFR) §3.159(c)(4).

<sup>8</sup> *Ibid.*

assigned a single evaluation that provides for a higher evaluation based on overall impaired functioning due to both TBI and the mental health condition.<sup>9</sup> This error did not affect the veteran's benefits payment but could affect future payments if his current service-connected disabilities worsen and are increased, or if new disabilities are compensated at some future date.

Because RVSRs processed 29 of the 30 TBI claims correctly, we made no recommendations for improvement in this area.

**VBA Policy  
Related to  
Special  
Monthly  
Compensation  
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 whenever 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 that are considered when evaluating claims for compensation, which include eligibility for educational,<sup>10</sup> automobile,<sup>11</sup> and housing benefits.<sup>12</sup>

VBA policy requires staff to address the issues of SMC and ancillary benefits whenever they can grant entitlement.<sup>13</sup> VBA policy also states that all rating decisions involving SMC above a specified level require a second signature.<sup>14</sup>

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 eye sight, and paralysis. These reviews did not overlap because our earlier inspection involved different types of SMC that cannot be granted simultaneously with SMC housebound benefits.

<sup>9</sup> M21-1 Adjudication Procedures Manual, Part III, Subpart iv, Chapter 4, Section G, Topic 2, *TBI*.

<sup>10</sup> Dependents' Educational Assistance under Title 38 Code of Federal Regulations Section 3.807, provides education benefits for the spouse and children of eligible veterans.

<sup>11</sup> Automobiles or Other Conveyances and Adaptive Equipment under Title 38 Code of Federal Regulations Section 3.808, provides eligible veterans payments toward the purchase of an automobile, or other special equipment or assistive devices such as power seats.

<sup>12</sup> Specially Adapted Housing (SAH) Grants under Title 38 Code of Federal Regulations Section 3.809 and Special Home Adaptation (SHA) Grants under Title 38 Code of Federal Regulations Section 3.809a, provide eligible veterans the purchase or construction of barrier-free homes or remodeling 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.

<sup>13</sup> M21-1 Adjudication Procedures Manual, Part III, Subpart iv, Chapter 6, Section B, Topic 2, *Considering Issues Within Scope of a Claim*.

<sup>14</sup> Section D, Topic 7, *Signature*.

**Review of  
SMC and  
Ancillary  
Benefit  
Claims**

We randomly selected and reviewed 30 of 108 veterans' claims (28 percent) involving entitlement to SMC and related ancillary benefits completed from November 1, 2015 through October 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 three of 30 veterans' claims contained errors (10 percent)—all three errors affected veterans' benefits and resulted in improper payments totaling approximately \$44,700. These errors represented 73 improper monthly payments from December 2012 through January 2017. The VSCM concurred with the errors we identified. Summaries of the errors affecting benefits follow.

- In the first claim, an RVSR assigned an incorrect effective date for SMC. As a result, the veteran was underpaid approximately \$28,700 over a period of 9 months. This was the most significant improper payment we identified.
- In the remaining two claims, RVSRs did not grant a higher level of SMC when entitlement was warranted. As a result, these veterans were underpaid approximately \$16,000 over a period of 64 months.

Generally, the errors occurred due to ineffective operational oversight with respect to the second signature review policy. In the 30 veterans' claims reviewed, three did not have the required second signature (10 percent). Interviews with VSC staff revealed they were aware when second signature reviews were required for grants of SMC. Of the three veterans' cases with errors, one did not have a required second signature. While the other two errors did have second signatures, the decision-makers who performed the additional review did not mitigate the potential for errors. Although the VSCM could not explain why the reviewers did not identify errors, there was a willingness to explore alternatives to improve outcomes—such as a third signature review or increased accountability measures. As a result of ineffective oversight, some veterans received incorrect benefits payments.

**Previous OIG  
Inspection  
Results**

In our previous report, *Inspection of the VA Regional Office, Phoenix, Arizona* (Report No. 15-01381-437, September 17, 2015), we identified six errors involving SMC evaluations out of the 30 claims we reviewed. We determined that errors occurred due to a lack of regular training. We recommended the Phoenix VARO Director ensure frequent refresher training for processing higher levels of special monthly compensation and ancillary benefits claims. The VARO Director concurred with our recommendation and stated that refresher training would be completed. Because we found fewer errors involving SMC in the current inspection, we concluded that the VARO's response to our original recommendation was effective.

## Recommendations

1. We recommended the Phoenix VA Regional Office Director implement a plan to ensure Rating Veterans Service Representatives follow second signature policy requirements for special monthly compensation rating decisions and perform an effective review.
2. We recommended the Phoenix VA Regional Office Director implement a plan to improve the second signature review process for special monthly compensation rating decisions.

### **Management Comments**

The VARO Director concurred with our findings and recommendations. The Director indicated that reminders on the proper second signature policy requirements would be presented to all employees by the Quality Review Team at a training update on July 20, 2017. In addition, the Quality Review Team will provide monthly training reminders on the importance of SMC second signature requirements. Furthermore, the Director stated that the training manager and the Quality Review Team coach will track the effectiveness of training by monitoring local and national error rates. The target completion date was July 20, 2017.

### **OIG Response**

The VARO Director's comments and actions are responsive to the recommendations. We will follow up as required.

## II. Management Controls

### Finding 2

### Phoenix VSC Staff Generally Processed Proposed Rating Reductions Accurately But This Workload Needed Higher Priority

Veterans Service Representatives (VSR) and RVSRs generally processed proposed rating reductions accurately. However, VARO management, including Supervisory Veterans Service Representatives (SVSR), the VSCM, and the Director, needed to prioritize this workload higher to ensure timely action. We randomly selected and reviewed 30 proposed benefits reduction cases to determine whether they were accurately and timely processed by VSC staff. Overall, RVSRs delayed or incorrectly processed 11 of the 30 cases we reviewed (37 percent). Two cases involved inaccurate processing and nine cases involved delays. All 11 of these cases affected veterans' benefits and resulted in overpayments totaling approximately \$15,500 and an underpayment of about \$2,400—representing 23 improper monthly payments from July to December 2016. Per VBA policy, VBA does not recover these overpayments because the delays were due to VA administrative errors.<sup>15</sup> These processing delays occurred because of VARO management (including SVSRs, the VSCM, and the Director) not prioritizing these cases to ensure action would be taken on the date the due process notice period expired.

### VBA Policy Related to Proposed Rating Reductions

VBA provides compensation payments to veterans for conditions they incurred or aggravated during military service.<sup>16</sup> 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.<sup>17</sup> Such instances are attributable to VSC staff not taking actions to ensure veterans receive correct payments for their current levels of disability.

When the VARO obtains evidence that demonstrates a disability has improved and 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.<sup>18</sup> 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.<sup>19</sup> If the veteran does not provide additional evidence within that period, an RVSR may make a final determination to reduce or

<sup>15</sup> M21-1 MR Adjudications Procedures Manual, Part III, Subpart v, Chapter 1, Section I, Topic 3, *Handling Cases Involving Administrative Errors*, and 38 CFR §3.500.

<sup>16</sup> 38 CFR §3.303.

<sup>17</sup> Public Law 107-300.

<sup>18</sup> 38 CFR §3.103.

<sup>19</sup> 38 CFR §3.105.

discontinue the benefit<sup>20</sup> beginning on the 65<sup>th</sup> day following notice of the proposed action.<sup>21</sup>

On April 3, 2014,<sup>22</sup> and again on July 5, 2015,<sup>23</sup> VBA leadership modified its policy regarding the processing of benefits reductions. The current policy no longer includes the requirement for VSC staff to take “immediate action” to process these reductions. VBA noted this change was made to avoid implying the next action on a proposed reduction must be immediate. VBA policy also no longer includes a measurable standard for VSC staff to make final determinations to reduce benefits following expiration of the due process period. 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 and to ensure all workload is processed timely.

**Review of  
Claims  
To Assess  
Accuracy**

We randomly selected and reviewed 30 of 497 cases (6 percent) completed from August 1 through October 31, 2016 when benefits were proposed to be reduced by rating decisions. RVSRs accurately processed 28 of the 30 cases we reviewed (93 percent). Details on the two errors affecting benefits follow.

- In the first case, an RVSR incorrectly reduced an incarcerated veteran’s post-traumatic stress disorder from 30 percent disabling to 0 percent without an examination. According to VBA policy, there must be documented evidence in the veteran’s record that shows VSC staff not only made substantial attempts to schedule and conduct a medical re-examination but also exhausted all efforts in their attempts.<sup>24</sup> In this case, the evidence did not show these procedures had been followed prior to the reduction of the veteran’s benefits. As a result, the veteran’s dependent was underpaid approximately \$2,400 over a period of 5 months.
- In the second case, the due process letter sent to the veteran included an incorrect effective date for the reduction of benefits. An RVSR reduced the evaluation effective December 1, 2016. Had the due process letter contained accurate information, the correct effective date would have been October 1, 2016. As a result, the veteran was overpaid approximately \$550 over 2 months.

<sup>20</sup> *Ibid.*

<sup>21</sup> M21-4, Appendix B, Section II, End Products - Compensation, Pension, and Fiduciary Operations.

<sup>22</sup> M21-1MR Adjudications Procedures Manual, Part I, Chapter 2, Section B, Topic 7, *Establishing and Monitoring Controls.*

<sup>23</sup> M21-1 Adjudications Procedures Manual, Part I, Chapter 2, Section C, Topic 2, *Responding to the Beneficiary.*

<sup>24</sup> Part III, Subpart iv, Chapter 3, Section A, Topic 9, *Special Issue Claims and Other Types of Examination Requests.*

Since we did not identify a systemic trend, we made no recommendations for improvement in this area.

**Review of  
Claims  
To Assess  
Processing  
Timeliness**

Processing delays involving required rating decisions to reduce benefits occurred in nine of the 30 claims (30 percent). We considered cases to have delays when RVSRs did not process them on the 65<sup>th</sup> day following notice of the proposed action and the resulting effective date of reduction was affected by at least one month. For the nine cases with processing delays, the delays had resulted in an average of almost two monthly overpayments as of January 2017.

The most significant improper payment occurred when an RVSR proposed to reduce a veteran's evaluation for colon cancer from 100 percent disabling to 0 percent based on medical evidence showing improvement. The due process expired on June 6, 2016 without the veteran having provided evidence showing the reduction should not occur. However, an RVSR did not take final action to reduce benefits payments until September 26, 2016. As a result, VA overpaid the veteran approximately \$7,300 over a period of 3 months.

The VSCM agreed with the accuracy errors cited but did not agree with the nine delay errors we identified, noting that VBA policy does not provide a specific time frame for completion of the final rating decision to reduce benefits. However, prior to the policy change in April 2014, VBA policy had required that maturing due process cases were to be processed immediately on the 65<sup>th</sup> day to minimize overpayments. An interview with VBA Compensation Service staff noted the policy was changed as it was generally felt that workload management decisions were under the purview of VARO management and VBA's Office of Field Operations. While current policy does not include a specific time frame to process rating reductions, Phoenix VSRs, RVSRs, and SVSRs did agree that had VSRs and RVSRs taken final action on the date due process expired, approximately \$15,000 would not have been overpaid to veterans for medical conditions that were shown to have improved.

Generally, these processing delays occurred because VARO management, including SVSRs, the VSCM, and the Director, did not prioritize these cases high enough to ensure action would be taken on the date the due process period expired. Interviews with SVSRs and 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 result in unsound financial stewardship of veterans' monetary benefits and failure to minimize improper payments.

**Previous OIG  
Inspection  
Results**

In our previous report, *Inspection of the VA Regional Office, Phoenix, Arizona* (Report No. 15-01381-437, September 17, 2015), we identified nine errors involving proposed rating reductions out of the 30 claims

reviewed. We determined the delays were generally due to a lack of emphasis on the timely processing of this workload. We recommended the VARO Director implement a written plan to ensure oversight and prioritization of benefits reduction cases and related hearings. The Director concurred with our recommendation and, in response, updated the facility's local plan on July 1, 2015 to reduce the inventory of benefits reduction cases by the end of FY 2015. As a result of this response, the recommendation was closed. However, since our last inspection, the VSCM changed and current staff were unaware of this plan—they could not state whether it had been implemented.

### Recommendation

3. We recommended the Phoenix VA Regional Director implement a plan to prioritize 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. The Director reported that since April 9, 2017 all regional offices receive a daily distribution of due process work that is either priority or the oldest pending claims. Furthermore, VBA will continue to monitor the End Product (EP)<sup>25</sup> timeliness and make prioritization adjustments as necessary.

#### OIG Response

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

<sup>25</sup> Per M21-1 Adjudications Procedures Manual, Appendix B, Section I, *End Products – General Principles*, the EP system is the primary workload monitoring and management tool for the Veterans Service Center (VSC).

### III. Data Integrity

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

Claims assistants and a VSR needed to improve the accuracy of claim and claimant information entered into the electronic systems at the time of claims establishment. We randomly selected and reviewed 30 pending rating claims from VBA's corporate database to determine whether VSC staff accurately input claim and claimant information into the electronic systems when establishing the claims. In 15 of the 30 claims we reviewed, claims assistants and a VSR did not enter accurate and complete information in the electronic systems when the claims were established. These errors occurred due to a lack of effective oversight. Inaccurate data at the time of claims establishment could result in misrouting in the National Work Queue (NWQ), delayed processing, or misrepresentation of the VARO's workload and performance data.

#### **VBA Policy Related to Data Integrity**

VBA relies on data input into electronic systems to accurately manage and report its workload to stakeholders and to properly route claims within its 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 systems.<sup>26</sup> The Veterans Benefits Management System is an electronic processing system the NWQ uses to distribute work.<sup>27</sup> 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, delays in veterans' benefits, or misrepresentation of VARO workload and performance data. In addition, if not controlled by accuracy reviews at the time of establishment, personally identifiable information could be disclosed without authorization.

Initial claims routing begins at the time of claims establishment. Claims assistants or VSRs must input claim and claimant information into the electronic systems to ensure compliance.

<sup>26</sup> Department of Veterans Affairs, Veterans Benefits Administration, National Work Queue, Phase 1 Playbook

<sup>27</sup> *Ibid.*

Table 2 reflects nine claim establishment terms used by VSC staff when they establish a claim in the electronic record.

**Table 2. Claim Establishment Terms**

<b>Term</b>	<b>Definition</b>
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 definition from VBA's M21-1 and M21-4*

### **Systems Compliance**

We randomly selected and reviewed 30 of 1,158 claims (3 percent) established in October 2016 that were pending as of November 7, 2016. In 15 of the 30 claims (50 percent), claims assistants and a VSR did not enter accurate and complete information in the electronic systems at the time of claims establishment. For three of the 15 errors, claims assistants or VSRs eventually corrected claim and claimant information.

In seven of the 15 claims, claims assistants and a VSR did not establish correct contentions and contention classifications—this was the most frequent establishment error type we found. For example, in two claims, veterans claimed increased evaluations for service-connected medical conditions. However, claims assistants incorrectly established those claims as “Administrative” issues, rather than the proper medical classifications. VBA policy states that contention classification and medical fields are

required components when entering a contention.<sup>28</sup> Selection of the appropriate contention classification will drive the selection of medical exams once exam automation functionality has been implemented. Furthermore, if the contention classification is incorrectly selected, it will send the incorrect data to the examiner and may cause the scheduling request to be returned with clarification requests. This return could potentially lead to processing delays for claims.

The VSCM concurred with one of the 15 errors but did not concur with the remaining 14. However, the VSCM provided no criteria to dispute our finding that the claims were not established by claims assistants or VSRs according to VBA policies. The VSCM stated that the standard should be to ensure incorrect or missing information is remedied prior to completion of the claim, as opposed to ensuring the information is correct or complete at the time of establishment.

Furthermore, the VSCM stated that the OIG adopted an unreasonable standard not reflected in guidance. However, this contention is incorrect, as multiple VBA policies require claims to be established with accurate information and state that adherence to all systems usage and systems compliance guidance is mandatory.<sup>29</sup> In addition, management must ensure that prescribed procedures are followed through supervisory functions, including quality reviews, training, supervisory reviews, and staff visits. Input deficiencies often require additional, avoidable handling of claims and rework, which degrades the VARO's ability to provide veterans with benefits and services in an accurate and timely manner.<sup>30</sup>

Generally, the processing errors occurred due to ineffective oversight of the claims establishment process. The VSCM, an SVSR, and VSC staff attributed the claims establishment errors to claims assistants and VSRs working too quickly, as well as inattention to detail. The VSC had no requirement that oversight be performed at the time claims are established. A quality reviewer stated that oversight was performed randomly the month following claims establishment. Therefore, the quality reviewer was unable to determine whether claims assistants or VSRs initially established claims incorrectly.

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<sup>28</sup> 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*.

<sup>29</sup> M21-1 Adjudications Procedures Manual, Part III, Subpart iii, Chapter 1, Section D, *Record Maintenance During the Development Process*; M21-4 Adjudications Procedures Manual, Appendix B, Section I, *End Products – General Principles*; M21-4 Adjudications Procedures Manual, Appendix C, *Index of Claim Attributes*.

<sup>30</sup> M21-4 Adjudications Procedures Manual, Chapter 2, Subchapter I, section 2.02 *Quality of Data Input*.

In addition, the checklists used by quality reviewers did not fully reflect every establishment action completed. For example, the checklist did not include quality assurance reviews to ensure Power of Attorney access to electronic documents. Staff stated, and the VSCM agreed, that an updated checklist would be helpful. As a result of ineffective oversight, there was the potential to misroute claims in the NWQ, delay claims processing, and misrepresent the VARO's workload and performance data.

## **Recommendations**

4. We recommended the Phoenix VA Regional Office Director implement a plan to ensure data input at the time of claims establishment is accurate.
5. We recommended the Phoenix VA Regional Office Director implement a plan to update the checklist used to evaluate quality at the time of claims establishment.

### ***Management Comments***

The VARO Director concurred with our findings and recommendations. The Director stated that the VSC established a quality review program to ensure that data input at the time of claims establishment is reviewed. The target completion date was July 1, 2017.

The Director also indicated that the Quality Review Team will update the checklist used to evaluate quality at the time of claims establishment and that training will be provided by September 1, 2017.

### ***OIG Response***

The VARO Director's comments and actions are responsive to the recommendations. We will follow up as required.

## IV. Public Contact

### Finding 4 Phoenix VSC Staff Generally Responded to Special Controlled Correspondence Timely but Needed To Improve Accuracy

Congressional liaisons generally responded to special controlled correspondence timely. However, improvements needed to be made to ensure accuracy. We randomly selected and reviewed 30 special controlled correspondence cases to determine whether VSC staff timely and accurately processed them. Congressional liaisons responded to all 30 of the correspondences, averaging 3 business days after receipt. However, 11 of the 30 cases we reviewed (37 percent) were processed inaccurately or contained delays, including two cases that had untimely responses. Generally, the errors occurred because the congressional liaisons did not receive training on the proper procedures for processing correspondence. Furthermore, the VSC's guidance for processing these types of correspondence was outdated. As a result of inaccurate processing, the electronic files were incomplete and VBA staff may not have been aware of all required information in the electronic folders.

#### 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.<sup>31</sup> Employees are required to send an acknowledgement letter within 5 business days after receipt of special controlled correspondence in the VARO.<sup>32</sup>

Furthermore, according to VBA policy, all correspondence generated by VA must provide complete, accurate, and understandable information.<sup>33</sup> In addition, VSC staff must file these documents either in a claims folder or upload them into an electronic folder.<sup>34</sup>

<sup>31</sup> M21-4, Appendix B, Section II, *End Products - Compensation, Pension, and Fiduciary Operations*.

<sup>32</sup> M27-1 Benefits Assistance Service Procedures, Part I, Chapter 5, Topic 3, *Acknowledging Correspondence*.

<sup>33</sup> Topic 1, *General Guidance for Processing Correspondence*.

<sup>34</sup> M27-1 Benefits Assistance Service Procedures, Part I, Chapter 5, Topic 5, *Handling Various Types of Correspondence*.

**Review of VARO  
Processing of  
Special  
Controlled  
Correspondence  
To Assess  
Timeliness**

Congressional liaisons generally responded to special controlled correspondence timely. We randomly selected and reviewed 30 of 431 special controlled correspondences (7 percent) completed from August 1 through October 31, 2016. Congressional liaisons responded to all 30 of the correspondences, averaging 3 business days after receipt. Congressional liaisons also responded to 28 of 30 special controlled correspondences within 5 business days after receipt. In one case, it took a congressional liaison 30 business days to respond and, in another case, a congressional liaison responded in 6 business days. The VSCM concurred with the delay errors we identified. Since we did not identify a systemic trend, we made no recommendations for improvement in this area.

**Review of  
VARO  
Processing of  
Special Controlled  
Correspondence  
To Assess  
Accuracy**

Congressional liaisons incorrectly processed 11 of the 30 special controlled correspondence inquiries reviewed (37 percent). In nine of the cases, congressional liaisons did not upload all of the required documents, such as privacy consent documents, congressional inquiries, or final responses to the veterans' electronic claims folders. Therefore, VBA management and staff could not review issues pertaining to timeliness and accuracy of these documents in the veterans' electronic claims folders. The VSCM concurred with the errors we identified.

Generally, inaccurate processing occurred due to a lack of training and outdated local guidance. Interviews with VSC staff revealed there was no formal training relating to special controlled correspondence. Staff members assigned to review and respond to special controlled correspondence only received on-the-job training and were not familiar with current procedures relating to the proper handling of special controlled correspondence. In addition, the local procedures for processing special controlled correspondence, dating back to April 2012, did not reflect current VBA procedures, such as the requirement to upload documents to the electronic claims folders. An SVSR told us that a review of all local procedures related to public contact began in the first quarter of FY 2017.

## **Recommendations**

6. We recommended the Phoenix VA Regional Office Director provide training to congressional liaisons on special controlled correspondence to ensure all documents are included in the electronic record in accordance with current Veterans Benefits Administration guidance.
7. We recommended the Phoenix VA Regional Office Director update the office's local procedures relating to special controlled correspondence in accordance with current Veterans Benefits Administration procedures.

**Management  
Comments**

The VARO Director concurred with our findings and recommendations. The Director stated that refresher training for congressional liaisons was conducted on March 15, 2017. Furthermore, the Director reported that a

standard operating procedure for special controlled correspondence was being created, with a target completion date of August 1, 2017.

**OIG  
Response**

The VARO Director's comments and actions are responsive to the recommendations. We will follow up as required.

## Appendix A Scope and Methodology

### **Scope and Methodology**

In January and February 2017, we evaluated the Phoenix 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 1,105 veterans' claims (3 percent) related to TBI that VSC decision-makers rated from May 1 through October 31, 2016. We randomly selected and reviewed 30 of 108 veterans' claims (28 percent) involving entitlement to SMC and related ancillary benefits rated by VSC decision-makers from November 1, 2015 through October 31, 2016. In addition, we randomly selected and reviewed 30 of 497 proposed rating reductions (6 percent) completed by VSRs and RVSRs from August 1 through October 31, 2016.

We randomly selected and reviewed for systems compliance 30 of 1,158 claims (3 percent) that VSC staff established in the electronic records in October 2016. In addition, we randomly selected and reviewed 30 of 431 special controlled correspondence inquiries (7 percent) that congressional liaisons completed from August 1 through October 31, 2016.<sup>35</sup>

### **Data Reliability**

We used computer-processed data from the Corporate Data Warehouse. 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 150 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.

<sup>35</sup> While determining our sample size of 30 claims, we identified some claims that were outside of the scope of our review; therefore, we removed these claims from the universe of claims.

***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: June 28, 2017

From: Director, VA Regional Office Phoenix

Subj: Phoenix VARO OIG Benefits Inspection–Response to Recommendations

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

1. The Phoenix VARO's responses to recommendations contained in the OIG Draft Report: Inspection of the Phoenix VARO.
2. Please refer questions to the Director's Office at 602-627-2740.

*(Original signed by:)*

CHRIS NORTON  
Director

Attachment

Phoenix VA Regional Office  
Response to OIG Site Visit

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

OIG Recommendations

Recommendation #1 - We recommend the Phoenix VA Regional Office Director implement a plan to ensure Rating Veterans Service Representatives follow second signature policy requirements for special monthly compensation rating decisions and perform an effective review.

Phoenix RO Response: Concur

Action: Reminders on proper second signature policy requirements will be presented to all employees via Quality Review Update Training on July 20, 2017.

The Quality Review team will provide monthly training reminders on the importance of SMC second signature requirements for continual reinforcement.

*Target Completion Date: July 20, 2017*

Recommendation #2 - We recommend the Phoenix VA Regional Office Director implement a plan to improve the second signature review process for special monthly compensation rating decisions.

Phoenix RO Response: Concur

Action: The VSC will hold SMC refresher training on July 20, 2017. The Training Manager and Quality Review Team Coach will continue to track the effectiveness of the training by monitoring local and national error rates. This training will be tracked in the Talent Management System (TMS).

*Target Completion Date: July 20, 2017*

Recommendation #3 - We recommend the Phoenix VA Regional Office Director implement a plan to prioritize proposed rating reduction cases for completion at the end of the due process time period.

Phoenix RO Response: Concur

Response: VBA provides oversight and prioritization of proposed rating reduction cases at the national level. As of April 9, 2017, all Regional Offices receive a daily distribution of actionable due process work that is either priority - homeless, terminally ill, etc. - or our oldest pending claims. Nationally, Regional Offices are held to a standard that all work must be completed on a claim that is distributed to them within five days. Regional and District Office leadership, as well as the Office of Field Operations, routinely monitor stations performance related to the five day Time In Queue (TIQ) standard. Since NWQ began managing distribution of EP600s (due process EPs), timeliness of these claims improved by 30 days.

VBA will continue to monitor the improvements in EP600 timeliness and make prioritization adjustments as necessary. VBA requests closure of this recommendation.

Recommendation #4 - We recommend the Phoenix VA Regional Office Director implement a plan to ensure data input at the time of claims establishment is accurate.

Phoenix RO Response: Concur

Action: The VSC has established a Quality Review program to ensure that data input at the time of claims establishment is reviewed. Each month the VSC completes quality reviews on 5 randomly-selected claims processed by CAs. The VSC completes each month's quality reviews by the 15th of the following month.

FYTD, the VSC has completed 436 quality reviews on CAs with an overall accuracy rate of 98.62%. Effective July 1, 2017, the Quality Review Team will do the quality review for the CAs.

*Target Completion Date: July 1, 2017*

Recommendation #5 - We recommend the Phoenix VA Regional Office Director implement a plan to update the checklist used to evaluate quality at the time of claims establishment.

Phoenix RO Response: Concur

Action: The Quality Review Team will update the current checklist by August 15, 2017. Training will be provided by September 1, 2017. This training will be tracked in the Talent Management System (TMS).

*Target Completion Date: September 1, 2017.*

Recommendation #6 – We recommend the Phoenix VA Regional Office Director provide training to congressional liaisons on special controlled correspondence to ensure all documents are included in the electronic record in accordance with current Veterans Benefits Administration guidance.

Phoenix RO Response: Concur

Action: The Phoenix RO conducted refresher training for the congressional liaisons on March 15, 2017, on controlled correspondence. This training can be tracked in the Talent Management System.

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

Recommendation #7 – We recommend the Phoenix VA Regional Office Director update the office's local procedures relating to special controlled correspondence in accordance with current Veterans Benefits Administration procedures.

Phoenix RO Response: Concur

Action: A Special Controlled Correspondence Standard Operating Procedure is being created.

*Target Completion Date: August 1, 2017*

<p><i>For accessibility, the format of the original memo has been modified to fit in this document.</i></p>
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## **Appendix C      OIG Contact and Staff Acknowledgments**

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Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Dana Sullivan, Director Daphne Brantley Brett Byrd Theresa Golson Raymond Jurkiewicz David Piña Michael Stack
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## Appendix D Report Distribution

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This report is available on our website at [www.va.gov/oig](http://www.va.gov/oig).