

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Veterans Benefits Administration

*Inspection of
the VA Regional Office
Philadelphia, Pennsylvania*

August 24, 2017
17-01276-300

ACRONYMS

DOC	Date of Claim
DRO	Decision Review Officer
FY	Fiscal Year
NWQ	National Work Queue
OIG	Office of Inspector General
QRT	Quality Review Team
RQRS	Rating Quality Review Specialist
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

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Highlights: Inspection of the VARO Philadelphia, PA

Why We Did This Review

In February and March 2017, we evaluated the Department of Veterans Affairs Regional Office (VARO) in Philadelphia, Pennsylvania, to determine how well Veterans Service Center (VSC) staff processed veterans' disability claims, how timely and accurately they processed proposed rating reductions, how accurately they entered claims-related information, and how well they responded to special controlled correspondence.

What We Found

Claims Processing—Philadelphia VSC staff did not consistently process one of the two types of disability claims we selected for review. We reviewed 30 of 1,320 veterans' traumatic brain injury claims (2 percent) and found that Rating Veterans Service Representatives (RVSR) accurately processed 27 of 30 claims. This represented a significant improvement from our 2013 inspection when staff incorrectly processed seven of the 30 claims we sampled. However, RVSRs did not always process entitlement to special monthly compensation (SMC) and ancillary benefits consistent with Veterans Benefits Administration policy.

We reviewed 30 of 147 veterans' claims involving entitlement to SMC and related ancillary benefits (20 percent) and found that RVSRs incorrectly processed 13. This resulted in 189 improper monthly payments made to 10 veterans totaling approximately \$123,000. We determined this occurred because of an ineffective second signature review process.

Proposed Rating Reductions—VSC staff generally processed proposed rating reductions accurately. However, we reviewed 30 of 174 benefits reductions (17 percent) and found that staff delayed or incorrectly processed 10. Delays occurred because the Veterans Service Center Manager and Supervisory Veterans Service Representatives placed higher priority on other workload.

Systems Compliance—VSC staff needed to improve the accuracy of information input into the electronic systems at the time of claims establishment. We reviewed 30 of 2,089 newly established claims and found that staff did not correctly input claim and claimant information into the electronic systems in 15 of 30 claims because of a lack of training and staff rushing to establish claims.

Special Controlled Correspondence—VSC staff processed special controlled correspondence timely but needed to improve accuracy. We reviewed 30 of 1,746 special controlled correspondences and found that staff incorrectly processed 13 of 30 because of a lack of training and inadequate oversight by VSC management.

What We Recommended

We recommended the VARO Director develop and implement a plan to assess the accuracy of secondary reviews involving higher level SMC; ensure oversight of proposed rating reduction cases; monitor the effectiveness of claims establishment training; and develop a plan to monitor the effectiveness of training and reviews of special controlled correspondence.

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" and "R".

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 independent inspection identified and reviewed risks within each operation or VARO program responsibility. In FY 2017, our inspections 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 to benefits.

Philadelphia VA Regional Office

As of February 2017, the Philadelphia VARO reported a staffing level of 949 full-time employees, which is 24 below the amount authorized. Of this total, the VSC had 319 employees assigned, which is four below the amount authorized. In February 2017, the Veterans Benefits Administration (VBA) reported that the Philadelphia VARO completed 11,057 compensation claims—averaging 3.8 issues¹ per claim.

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

Philadelphia 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 an ineffective second signature review process. We found that 11 of the decisions contained errors which were not identified by the second signature review process. Overall, RVSRs incorrectly processed 16 of the 60 veterans’ disability claims we reviewed (27 percent), resulting in 189 improper monthly payments to nine veterans totaling approximately \$123,000² as of February 2017.

Table 1 reflects the errors affecting, and those with the potential to affect, veterans’ benefits processed at the Philadelphia 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 overall accuracy rate at this VARO.

Table 1. Philadelphia 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	3	3
SMC and Ancillary Benefits	30	10	3	13
Total	60	10	6	16

Source: VA OIG analysis of the veterans’ TBI disability claims completed from July 1 through December 31 2016, and veterans’ SMC and ancillary benefits claims completed from January 1, through December 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 (DRO) 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.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 the 1,320 veterans’ TBI claims (2 percent) completed from July 1 through December 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 27 of 30 TBI claims—all three errors had the potential to affect veterans’ benefits. Of those claims, 25 required VA examinations. The required medical personnel completed 22 of these examinations—specialists completed 17 and certified generalist clinicians completed five. Two examinations were not completed by the required medical personnel; they are discussed below as inaccuracies. One examination was not completed because the veteran did not attend the scheduled examination. The remaining five cases did not require VA examinations because the evidence of record did not contain an event or injury in service or associated symptoms of disability.⁵ Summaries of the errors follow.

- An RVSR incorrectly assigned separate evaluations for a veteran’s TBI and coexisting mental condition. VBA policy requires staff to assign a single evaluation when the VA examiner cannot separate symptoms of TBI and a coexisting mental disorder. In addition, the TBI examination was performed by a generalist clinician who had not completed the required TBI training. Furthermore, the rating decision required two signatures as the RVSR had not demonstrated the required accuracy rate for TBI decisions. This error did not affect the veteran’s monthly

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

⁴ *Ibid.*, Chapter 3, Section D, Topic 2, *Examination Report Requirements*.

⁵ Title 38 Code of Federal Regulations Section (38 CFR) §3.159.

benefits; however, it has the potential to affect future benefits if the veteran's other service-connected disabilities worsen or if service connection is granted for a new disability.

- An RVSR incorrectly assigned separate evaluations for a veteran's TBI and coexisting mental condition. VBA policy requires staff to assign a single evaluation when the VA examiner cannot separate symptoms of TBI and a coexisting mental disorder. This error did not affect the veteran's monthly benefits; however, it has the potential to affect future benefits if the veteran's other service-connected disabilities worsen or if service connection is granted for a new disability.
- An RVSR incorrectly evaluated the veteran's TBI based on results of an examination performed by a generalist clinician who had not completed the required TBI training. Neither VARO staff nor we could determine the correct evaluation for TBI without an examination completed by a certified generalist clinician.

We provided the Veterans Service Center Manager (VSCM) with the specifics of the claims and asked for reviews of the claims. Given that RVSRs correctly processed 27 of the 30 cases and that the inaccuracies did not constitute a common trend, pattern, or systemic issue, we determined that staff generally followed VBA policy when processing TBI claims. Therefore, we made no recommendations for improvement in this area.

*Previous
OIG
Inspection
Results*

In our previous report, *Inspection of the VA Regional Office, Philadelphia, Pennsylvania* (Report No. 12-03475-169, April 9, 2013), we found that VARO staff incorrectly processed seven of the 30 TBI claims we reviewed. Generally, those errors occurred because the VARO lacked adequate oversight to ensure VSC staff complied with VBA's second signature policy. Moreover, RVSRs used insufficient examination reports that lack medical evidence when making disability decisions.

We recommended the VARO Director develop and implement a plan to ensure staff compliance with VBA's second signature requirements for processing TBI claims and to return insufficient medical examination reports to health care facilities, to obtain the required evidence needed to support TBI claims. The VARO Director concurred with our recommendations and stated that management finalized procedures for ensuring implementation of VBA's policy requiring second level review of TBI disability claims. Moreover, VARO management assigned responsibility for TBI disability claims processing to the special operations lane. RVSRs reviewed incoming TBI examinations, identified insufficient reports, and returned them to VA facilities for clarification, when required.

During our February and March 2017 inspection, we found one claim missing the required two signatures and we did not find TBI examinations missing the required medical evidence. Given the significant improvement

demonstrated by VARO staff when processing TBI claims, we concluded the VARO's action in response to our prior recommendations was effective.

**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 for educational,⁶ automobile,⁷ and housing⁸ 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 total maximum allowable by law.

VBA policy requires staff to address the issues of SMC and ancillary benefits whenever they can grant entitlement.⁹ VBA policy also states that all rating decisions involving SMC above a specified level require a second signature.¹⁰

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 report reviewed a higher level of SMC benefit claims 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

⁶ Dependents' Educational Assistance 38 CFR Section §3.807, provides education benefits for the spouse and children of eligible veterans.

⁷ 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.

⁸ Specially Adapted Housing (SAH) Grants under 38 CFR §3.809 and Special Home Adaptation (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.

⁹ M21-1 Adjudication Procedures Manual, Part III, Subpart iv, Chapter 6, Section B, Topic 2, *Considering Subordinate Issues and Ancillary Benefits*.

¹⁰ *Ibid.*, Section D, Topic 7, *Signature*.

types of SMC that cannot be granted simultaneously with SMC housebound benefits.

**Review of
SMC and
Ancillary
Benefit
Claims**

We randomly selected and reviewed 30 of the 147 veterans' SMC claims (20 percent) completed by VSC staff from January 1 through December 31, 2016. We examined whether VSC staff accurately processed entitlement to SMC and ancillary benefits associated with anatomical loss or loss of use of two or more extremities, or bilateral blindness with visual acuity of 5/200 or worse. We found that RVSRs incorrectly processed 13 of the 30 veterans' claims involving SMC and ancillary benefits—10 errors affected veterans' benefits and resulted in improper payments to veterans totaling approximately \$123,000. These errors represented 189 improper monthly payments from November 2011 to February 2017. In four claims the improper payments were still paid monthly, as of November 2016, and amounted to about \$4,400 per month. The VSCM concurred with all the errors we identified.

The 10 errors that affected veterans' benefits involved RVSRs assigning incorrect effective dates for SMC, incorrect levels of loss of use,¹¹ and incorrect levels of SMC¹² for the special aid and attendance benefit¹³ and for veterans with additional independent disabilities.¹⁴ In one of the 10 claims, which involved the most significant improper payment we identified, an RVSR incorrectly assigned a higher level of SMC based on loss of use of both feet and aid and attendance. However, aid and attendance could not be justified because the veteran did not have a separate total disability, as required.¹⁵ Furthermore, the SMC calculator was not used to determine the appropriate level of SMC in this claim, as required.¹⁶ As a result, the veteran was overpaid approximately \$41,400 over a period of 12 months.

The three remaining errors had the potential to affect veterans' benefits. In one of the three claims involving the most significant potential impact, an RVSR assigned incorrect SMC codes for a veteran. VBA policy requires staff to reduce some SMC benefits if a veteran receives hospital care at VA

¹¹ Generally, loss of use is defined as the remaining effective function of an extremity. M21-1 Adjudication Procedures Manual, Part IV, Subpart ii, Chapter 2, Section H, Topic 1, *General Information on SMC*.

¹² SMC is additional payment above the basic levels of compensation for various types of anatomical losses or levels of impairment due solely to service-connection disabilities. M21-1 Adjudication Procedures Manual, Part III, Subpart ii, Chapter 2, Section G, Topic 1, *General Information on SMC*.

¹³ A veteran receiving the maximum SMC rate who is in need of regular aid and attendance is entitled to an additional allowance during periods he or she is not hospitalized at United States Government expense. 38 CFR §3.350.

¹⁴ 38 CFR §3.350.

¹⁵ M21-1 Adjudications Procedures Manual, Part IV, Subpart ii, Chapter 2, Section H, Topic 8, *Entitlement to SMC Based on the Need for A&A*.

¹⁶ *Ibid.*, Topic 1, *General Information on SMC*.

expense.¹⁷ As a result, the veteran may receive improper payments if ever hospitalized at Government expense.

Generally, the errors were due to the VSCs' ineffective second signature review process. In the majority of errors, a Supervisory Veterans Service Representative, DROs, and an RQRS completed a second level of review, also known as a second signature review. A second signature review is a control to ensure the accuracy of this complicated process.

Eleven of the decisions contained errors that were not identified by the second signature review process. The VSCM and quality review staff stated that they believed the second signature review process did not identify the errors because the Supervisory Veterans Service Representative was no longer proficient in the rating activity. Also, the DROs did not take the time to review entire decisions made by RVSRs because they rushed to complete their additional appeals workload. A Supervisory Veterans Service Representative and DROs second signed 10 of the 11 inaccuracies we found. Moreover, the supervisor who second signed the inaccuracies we identified was not aware of the requirements for granting higher levels of SMC based on separate 100 percent disability evaluations. As a result, veterans either did not receive correct benefits payments or could receive incorrect benefits payments in the future.

Recommendation

1. We recommended the Philadelphia VA Regional Office Director develop and implement a plan to assess the accuracy of secondary reviews involving higher-level Special Monthly Compensation and ancillary benefits.

Management Comments

The VARO Director concurred with our recommendation. The Director stated that the VA Regional Office provided training on higher level SMC and ancillary benefits for supervisors and RVSRs in February 2017. The Director also reported that the VA Regional Office would conduct a quarterly assessment on accuracy and report the findings at the Director's Quarterly Review.

OIG Response

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

¹⁷ M21-1 Adjudications Procedures Manual, Part IV, Subpart ii, Chapter 2, Section H, Topic 3, *Hospital Adjustments under 38 CFR 3.552*.

II. Management Controls

Finding 2

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

We randomly selected and reviewed 30 proposed benefits reductions cases to determine whether they were accurately and timely processed by VSC staff. VSC staff accurately processed 29 of 30 cases involving benefits reductions. However, processing delays occurred in nine of the 30 claims that required rating decisions to reduce benefits and one case had an accuracy error—all 10 cases affected veterans' benefits. Generally, processing delays occurred because the VSCM and Supervisory Veterans Service Representatives did not view this work as a priority, even though the Workload Management Plan directed the Supervisory Veterans Service Representative to provide a weekly report to identify and prioritize cases and ensure that the VSRs were processing the oldest claims. These delays and the processing inaccuracy resulted in approximately \$139,000 in overpayments and an underpayment of approximately \$4,700, representing 112 improper monthly payments from March 2015 to February 2017. In accordance with VA policy, VBA does not recover these overpayments because the delays were due to VA administrative errors.¹⁸

VBA Policy Related to Proposed Rating Reductions

VBA provides compensation to veterans for conditions they incurred or aggravated during military service.¹⁹ 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 benefits reductions generally occur when beneficiaries receive payments to which they are not entitled.²⁰ Such instances are attributable to VSC staff not taking the 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.²¹ 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.²² If the veteran does not provide additional evidence within that period, an RVSR must make a final determination to reduce or

¹⁸ M21-1, Adjudications Procedures Manual, Part III, Subpart v, Chapter 1, Section 1, Topic 3, *Considerations of the Cause of Erroneous Benefits*, and 38 CFR §3.500.

¹⁹ 38 CFR §3.303.

²⁰ Public Law 107-300.

²¹ 38 CFR §3.103.

²² 38 CFR §3.105.

discontinue the benefit²³ beginning on the 65th day following notice of the proposed action.²⁴ However, due to policy modifications on April 3, 2014,²⁵ and again on July 5, 2015,²⁶ 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.

**Review of
Claims
To Assess
Accuracy**

VSC staff accurately processed 29 of 30 cases involving benefit reductions. In the one accuracy error, an RVSR failed to increase the evaluation of a skin condition from 0 to 10 percent disabling, effective February 18, 2015, as proposed. As a result, the veteran was underpaid approximately \$4,700 over a period of four months. We provided the details of this error to the VSCM for appropriate action. Because we identified only one accuracy error, we made no recommendations for improvement in this area.

**Review of
Claims
To Assess
Processing
Timeliness**

We randomly selected and reviewed 30 of 174 completed claims (17 percent) from October 1 through December 31, 2016 that proposed reductions in benefits. Processing delays occurred in nine of the 30 claims. 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 affected by at least one month. For the nine cases with processing delays, the delays had resulted in an average of 12 monthly overpayments at the time we began our review.

In the most significant overpayment and delay, a VSR had sent a letter to the veteran on March 3, 2015 proposing to reduce the disability evaluation for the veteran’s coronary artery disease and to discontinue entitlement to individual unemployability and Chapter 35 Dependents’ Educational Assistance, based on improvement. The due process period expired on May 7, 2015 without the veteran providing additional evidence to support the claim. However, an RVSR did not take final action to reduce and discontinue the benefits until October 1, 2016. As a result, VA overpaid the veteran approximately \$46,200 over a period of 17 months.

Generally, processing delays occurred because the VSCM and Supervisory Veterans Service Representatives did not view this work as a priority at the expiration of the due process period. Interviews with the VSCM, Supervisory Veterans Service Representatives, and VSC staff confirmed that

²³ *Ibid.*

²⁴ M21-4, Appendix B, Section II, *End Products - Compensation, Pension, and Fiduciary Operations.*

²⁵ M21-1MR Adjudications Procedures Manual, Part I, Chapter 2, Section B, Topic 7, *Establishing and Monitoring Controls.*

²⁶ M21-1 Adjudications Procedures Manual, Part I, Chapter 2, Section C, Topic 2, *Responding to the Beneficiary.*

proposed rating reduction cases were considered a lower priority compared with other work being directed by VBA's Central Office. The VSC's Workload Management Plan directed the Supervisory Veterans Service Representatives to provide a weekly report to identify and prioritize cases and ensure that the VSRs were processing the oldest claims. Since the plan included other claims, they were prioritized higher than proposed rating reductions, if they were older. Delays in processing proposed rating reduction cases result in unsound financial stewardship of veterans' monetary benefits and fail to minimize improper payments.

Recommendation

2. We recommended the Philadelphia VA Regional Office Director implement a plan to ensure prioritization of proposed rating reduction cases for completion at the expiration of the due process time period.

Management Comments

The VARO Director concurred with our finding and recommendation. The Director reported that, as of April 9, 2017, all regional offices receive a daily distribution of VARO actionable due process work. Furthermore, regional offices are held to a standard that all work must be completed within five days, and VBA will continue to monitor the end product 600 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 2 closed at this time. We will follow up as required.

III. Data Integrity

Finding 3

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

We reviewed 30 pending rating claims selected from VBA's corporate database to determine whether VSC claims establishment staff accurately input claim and claimant information into the electronic systems at the time of claim establishment. In 15 of the 30 claims reviewed, a VSR and Claims Assistants did not enter accurate and complete information in the electronic systems. Generally, inaccuracies involving contention classification, special issue, and claim label errors occurred because of a lack of training and rushing to process claims workload. Based on errors we found with inaccurate and incomplete information, combined with Claims Assistants telling us they wanted and needed more formal training, we concluded that there was a lack of training. Other errors included incorrect dates of claim and an incorrect end product, but these were not systemic issues. These errors affect data integrity and could impair the VARO's ability to manage its workload or delay claims decisions.

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 the National Work Queue (NWQ)—VBA's electronic workload management tool. 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.²⁷ Veterans Benefits Management System (VBMS) is an electronic processing system the NWQ uses to distribute work.²⁸ 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 the untimely processing of claims.

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.

²⁷ Department of Veterans Affairs, Veterans Benefits Administration, National Work Queue, Phase 1 Playbook.

²⁸ *Ibid.*

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

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	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 2,089 pending rating claims (1 percent) from VBA’s corporate database established in December 2016, as of January 12, 2017. In 15 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 input the correct contention classification in the electronic systems. VBA policy requires staff to enter the correct contention classification when entering a claim.²⁹ Inaccurate contention classifications could affect data integrity and misrepresent VARO performance for pending workload.

²⁹ 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.*

In another case, a Claims Assistant did not input a special issue in the electronic systems. VBA policy requires staff to identify and input special issues into the electronic record when applicable.³⁰ Omission of a special issue could lead to incorrect and delayed routing in the NWQ, affect data integrity, and misrepresent VARO performance for pending workload.

Generally, the errors occurred because of a lack of training and rushing to process claims workload. During our interviews, Supervisory Veterans Service Representatives and VSC staff stated that one of the reasons for selecting the wrong contention classification was because the Claims Assistants were previously told to use the incorrect classification. They also stated that employees were rushing and selecting the first contention classification in VBMS that appeared correct, rather than looking further for the actual correct classification. Furthermore, Claims Assistants stated that there are many special issues that could have been missed in VBMS because staff were rushing during claims establishment. Claims Assistants also stated that there was confusion in determining the correct claim label and a Supervisory Veterans Service Representative stated that training was needed in this area. Claims Assistants reported that they would like more frequent and formal training.

In response to the errors, on February 24, 2017, a Supervisory Veterans Service Representative sent an email to staff to clarify the correct contention classifications and provided the VBA Contention Classification reference. As well, on March 9, 2017, VSC staff completed claims establishment training, specifically on contention classification, special issue, and claim label. As a result of a lack of training and rushing to process claims workload, there is the potential to misroute claims in the NWQ or delay claims processing.

Recommendation

3. We recommended the Philadelphia VA Regional Office Director implement a plan to assess the effectiveness of the most recent claims establishment training.

Management Comments

The VARO Director concurred with our finding and recommendation. The Director stated that the VA Regional Office has developed a tracker to identify training needs based on error trends and will complete a quarterly assessment to gauge the effectiveness of that training.

OIG Response

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

³⁰ M21-4 Manual, Appendix C, Section III, *Special Issues*.

IV. Public Contact

Finding 4 Philadelphia VARO Needed To Improve Accurate Processing of Special Controlled Correspondence

Philadelphia VSC congressional liaison staff responded to special controlled correspondence timely. However, improvements needed to be made to ensure accuracy. We randomly selected and reviewed 30 special controlled correspondence inquiries concerning compensation benefits to determine whether staff timely and accurately processed them. VSC congressional liaison staff responded to all 30 of the correspondences within five business days after receipt. However, 13 of the 30 cases we reviewed contained inaccuracies and two contained multiple inaccuracies. Ten cases involved lack of tracking control through completion and five cases involved inaccurate processing.

Generally, the processing errors were due to a lack of training and inadequate oversight by Supervisory Veterans Service Representatives. Based on the errors we found with inaccurate and incomplete information, combined with VSC staff reporting they had no formal training, we concluded that there was a lack of training. 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 to Congressional staff.

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 correspondence.³¹ Staff are required to send an acknowledgement letter within five business days after receipt in the VARO if they cannot provide a full response.³²

Moreover, according to VBA policy, all correspondence generated by VA must provide complete, accurate, and understandable information.³³ In addition, VARO staff must either file these documents in a claims folder or upload them into electronic folders.³⁴

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

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

³³ *Ibid.*, Topic 1, *General Guidance for Processing Correspondence*.

³⁴ *Ibid.*, Topic 5, *Handling Various Types of Correspondence*.

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

We randomly selected and reviewed 30 of 1,746 special controlled correspondence cases (2 percent) completed from October 1 through December 31, 2016 to determine whether VSC staff timely and accurately processed them. VSC congressional liaison staff responded to all special controlled correspondence timely, within five business days after receipt. However, VSC congressional liaison staff incorrectly processed 13 of the 30 special controlled correspondence inquiries. Two cases contained multiple errors. In 10 cases, VSC congressional liaison staff did not maintain tracking control through completion of all required actions.

The inability to maintain control could affect data integrity and could impair the VARO's ability to manage its workload. In four cases, VSC congressional liaison staff did not provide the veteran and Congressional staff with accurate and complete responses. Therefore, the Congressional staff members were provided with inaccurate information and the veterans were at risk of being misinformed. Finally, in one case, VSC congressional liaison staff did not upload to the veteran's electronic claims folder all of the required documents, such as the privacy consent document and the congressional inquiry. Therefore, VBA employees would not be able to review issues pertaining to timeliness and accuracy of these documents in the veteran's electronic claims folder. The VSCM concurred with the errors we identified.

Generally, inaccurate processing occurred because of a lack of training and inadequate oversight by Supervisory Veterans Service Representatives. Interviews with Supervisory Veterans Service Representatives and VSC staff revealed that there was no formal training for special controlled correspondence. Congressional liaison staff members assigned to review and respond to special controlled correspondence only received on-the-job training that included templates for the responses. In addition, VSC congressional liaison staff were unaware of a quality review process on special controlled correspondence. A Supervisory Veterans Service Representative told us that spot checks were conducted in lieu of quality reviews but this activity was not recorded for tracking and trend analysis.

Supervisory Veterans Service Representatives and staff handling special controlled correspondence at the time of our interviews knew that the tracking code should remain pending until all actions have been completed. The errors found in this area were completed by VSC staff who no longer process special controlled correspondence; therefore, we made no recommendations in this area.

Recommendations

4. We recommended the Philadelphia VA Regional Office Director provide training on special controlled correspondence to ensure accurate and

complete responses to the veteran and Congressional staff, and monitor the effectiveness of the training.

5. We recommended the Philadelphia VA Regional Office Director improve oversight of special controlled correspondence.

**Management
Comments**

The VARO Director concurred with our findings and recommendations. The Director stated that the VA Regional Office conducted training in February 2017 on special controlled correspondence; they will monitor the accuracy and completeness of these responses on a weekly basis. Furthermore, the Director stated that the VA Regional Office has designated staff on the Public Contact team to expedite actions on special controlled correspondence; they will monitor and report areas of concern to the Director's Office weekly.

**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 February and March 2017, we evaluated the Philadelphia 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 sampled 30 of 1,320 veterans' disability claims related to TBI (2 percent) that the VARO completed from July 1 through December 31, 2016. We randomly sampled 30 of 147 veterans' claims involving entitlement to SMC and related ancillary benefits (20 percent) completed by VARO staff from January 1 through December 31, 2016. In addition, we randomly sampled 30 of 174 completed claims that proposed reductions in benefits (17 percent) from October 1 through December 31, 2016. Furthermore, we randomly sampled 30 of 2,089 pending rating claims (1 percent) selected from VBA's corporate database established in December 2016, as of January 12, 2017. Finally, we randomly sampled 30 of 1,746 special controlled correspondences (2 percent) completed from October 1 through December 31, 2016.³⁵

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 150 claims folders we reviewed related to TBI claims, SMC and ancillary benefits, completed claims related to benefits reductions, pending claims for systems compliance, and special controlled correspondence.

Our testing of the data disclosed that they were sufficiently reliable for our inspection objectives. Our comparison of the data with information

³⁵ 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 removed these claims from the universe of claims.

contained in the veterans' claims folders reviewed in conjunction with our inspection of the VARO did not disclose any problems with data reliability.

***Inspection
Standards***

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

Appendix B Management Comments

Department of Veterans Affairs Memorandum

Date: June 23, 2017

From: Director, VA Regional Office Philadelphia, Pennsylvania

Subj: Draft Report, Inspection of VA Regional Office Philadelphia, PA (Project Number 2017-01276-SD-0062)

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

1. The Philadelphia VARO's comments are attached on the Draft Report, Inspection of VA Regional Office Philadelphia, PA (Project Number 2017-01276-SD-0062)
2. Please refer questions to Diana Rubens, 215-381-3001

(Original signed by:)

DIANA RUBENS
Director

Enclosure

Enclosure

Veterans Benefits Administration (VBA)
Comments on Office of Inspector General (OIG) Draft Report
Inspection of the VA Regional Office, Philadelphia PA

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

OIG Recommendation 1: We recommended the Philadelphia VA Regional Office Director develop and implement a plan to assess the accuracy of secondary reviews involving higher level Special Monthly Compensation and ancillary benefits.

Philadelphia RO Response: Concur. The Philadelphia Regional Office has provided additional training for Supervisors on February 21, 2017, on higher level SMC and ancillary benefits, in addition to training provided to RVSRs in February 2017. The station will conduct an assessment quarterly on accuracy and report findings at the Director's Quarterly Review.

We request closure of this recommendation.

OIG Recommendation 2: We recommended the Philadelphia VA Regional Office Director implement a plan to ensure prioritization of proposed rating reduction cases for completion at the expiration of the due process time period.

Philadelphia RO Response: Concur. 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.

OIG Recommendation 3: We recommended the Philadelphia VA Regional Office Director implement a plan to assess the effectiveness of the most recent claims establishment training.

Philadelphia RO Response: Concur. The Philadelphia Regional office has developed a tracker to help identify training needs based on the error trends of personnel involved in claims establishment. A quarterly assessment will occur to gauge the effectiveness of establishment training based on error trends.

We request closure of this recommendation.

OIG Recommendation 4: We recommended the Philadelphia VA Regional Office Director provide training on special controlled correspondence to ensure accurate and complete responses to the veteran and Congressional staff, and monitor the effectiveness of the training.

Philadelphia RO Response: Concur. The Philadelphia Regional Office in February 2017 has conducted training to personnel assigned to specially controlled correspondence as well as added additional staffing. The VSC will monitor on a weekly basis the accuracy and completeness of responses to Veterans and Congressional staff.

We request closure of this recommendation.

OIG Recommendation 5: We recommended the Philadelphia VA Regional Office Director improve oversight of special controlled correspondence.

Philadelphia RO Response: Concur. The Philadelphia Regional Office has designated staff on the Public Contact team that will expedite actions on special controlled correspondence. The VSC will monitor weekly and report areas of concern to the Director's Office

We request closure of this recommendation.

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.
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Acknowledgments	Dana Sullivan, Director Jason Boyd Orlan Braman Lauralee Cook Dana Fuller Elyce Girouard Rachel Stroup Claudia Wellborn Herman Woo
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Appendix D Report Distribution

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Glenn W. Thompson

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