VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office New Orleans, Louisiana

July 10, 2014
14-01053-172

ACRONYMS

FY	Fiscal Year
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
SMC	Special Monthly Compensation
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VA	Veterans Affairs
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of VA Regional Office New Orleans, LA

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and a Veterans Service Center (VSC) in Cheyenne, Wyoming, that process disability claims and provide a range of services to veterans. We evaluated the New Orleans VARO to see how well it accomplishes this mission.

What We Found

Overall, VARO staff did not accurately process 42 (47 percent) of 90 disability claims reviewed. We sampled claims we considered at higher risk of processing errors, thus these results do not represent overall disability claims processing accuracy at this VARO. Claims processing that lacks compliance with VBA procedures risks paying inaccurate financial benefits.

Specifically, 15 of 30 temporary 100 percent disability evaluations were inaccurate, generally because management did not prioritize processing of claims requiring reduced evaluations. VARO staff processed 10 of 30 traumatic brain injury (TBI) claims incorrectly due to ineffective training on processing such complex cases. VARO staff also incorrectly processed 17 of 30 special monthly compensation (SMC) and ancillary benefits claims due to a lack of training and emphasis on addressing all ancillary issues.

Nine of 11 Systematic Analyses of Operations (SAOs) were incomplete due to inadequate oversight. VARO staff also did not timely or accurately complete 12 of 30 benefit reduction cases due to a lack of training and priority on addressing this workload.

What We Recommend

We recommend the VARO Director develop and implement a plan to ensure staff timely process benefit reductions, review the 329 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action, and monitor the effectiveness of training on processing TBI claims and SMC and ancillary benefits. The Director should implement a plan to ensure SAOs contain all required elements, including timeframes for implementing the recommendations. The Director should also ensure staff receive training on how to properly complete SAOs and process proposed benefit reductions.

Agency Comments

The Director of the New Orleans VARO concurred with all recommendations. Management's planned actions are responsive and we will follow up as required on all actions.

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INTRODUCTION

Objective

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

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

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

Other Information

- Appendix A includes details on the VARO and the scope of our inspection.
- Appendix B outlines criteria we used to evaluate each operational activity and a summary of our inspection results.
- Appendix C provides the New Orleans VARO Director's comments on a draft of this report.

RESULTS AND RECOMMENDATIONS

I. Disability Claims Processing

Claims Processing Accuracy

The OIG Benefits Inspection team focused on accuracy in processing temporary 100 percent disability evaluations, traumatic brain injury (TBI) claims, and special monthly compensation (SMC) and ancillary benefits. We evaluated these claims processing issues and their impact on veterans' benefits.

Finding 1 New Orleans VARO Could Improve Disability Claims Processing Accuracy

The New Orleans VARO did not consistently process temporary 100 percent disability evaluations, TBI-related cases, or entitlement to SMC and ancillary benefits. Overall, VARO staff incorrectly processed 42 of the total 90 disability claims we sampled, resulting in 238 improper monthly payments to 17 veterans totaling approximately $132,878.

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 universe of disability claims or the overall accuracy rate at this VARO. The table below reflects errors affecting, and those with the potential to affect, veterans' benefits processed at the New Orleans VARO.

Table 1. New Orleans VARO Disability Claims Processing Accuracy

Type of Claim	Reviewed	Claims Inaccurately Processed Affecting Veterans' Benefits	Claims Inaccurately Processed with Potential To Affect Veterans' Benefits	Total Claims Inaccurately Processed
Temporary 100 Percent Disability Evaluations	30	11	4	15
TBI Claims	30	2	8	10
SMC and Ancillary Benefits	30	6	11	17
Total	**90**	**19**	**23**	**42**

Source: VA OIG analysis of VBA's temporary 100 percent disability evaluations paid at least 18 months, TBI disability claims completed in the fourth quarter fiscal year (FY) 2013, and SMC and ancillary benefits claims completed in FY 2013

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 15 of 30 temporary 100 percent disability evaluations we reviewed. Veterans Benefits Administration (VBA) policy requires a temporary 100 percent disability evaluation for a veteran's service-connected disability following surgery or when specific treatment is needed. At the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

For temporary 100 percent disability evaluations, VSC staff must input suspense diaries in VBA's electronic system. A suspense diary is a processing command that establishes a date when VSC staff must schedule a medical reexamination. As a suspense diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the medical reexamination.

When the VARO obtains evidence that a lower disability evaluation would result in reduced compensation payments, Rating Veterans Service Representatives (RVSRs) must inform the beneficiary of the proposed reduction in benefits. In order to provide beneficiaries due process, VBA allows 60 days for the veteran to submit additional evidence to show that compensation payments should continue at their present level. On the 65th day following due process notification, action is required to reduce the evaluation and thereby minimize overpayments.

Without effective management of these temporary 100 percent disability ratings, VBA is at increased risk of paying inaccurate financial benefits. Available medical evidence showed 11 of the 15 processing errors we identified affected benefits and resulted in 119 improper monthly payments to 9 veterans totaling approximately $65,227. These improper payments were paid as monthly benefits to the veterans from June 2009 to January 2014. Details on the most significant overpayment and underpayment follow.

- An RVSR proposed reducing a veteran's temporary 100 percent evaluation. Staff sent a notification letter to the veteran on December 18, 2012, advising him of the proposed reduction. On February 20, 2013, the VARO received a request for a personal hearing from the veteran in response to the proposed reduction. According to VBA policy, staff should have reduced the evaluation and then scheduled the personal hearing; however, staff kept the evaluation at the same rate pending results from the hearing. As a result of the delay, VA overpaid the veteran approximately $15,284 over a period of 8 months. Monthly benefits will continue to be paid at the 100 percent disability rate if no corrective action is taken.
- An RVSR did not grant a veteran entitlement to an additional special monthly benefit based on evaluations of multiple disabilities, as required

by VBA policy. As a result, VA underpaid the veteran approximately $8,665 over a period of 26 months. Underpayments could potentially occur every month for the remainder of the veteran's life until VARO staff take the appropriate action to correct this error.

The remaining 4 of the total 15 errors had the potential to affect veterans' benefits. Neither VBA nor we could determine whether the evaluations should have continued in three of these four cases because the veterans' claims folders did not contain medical evidence needed to evaluate each case. For the remaining case, evidence showed continued entitlement; however, there was no control in place to ensure staff would schedule a medical reexamination as required. Since VBA awarded a temporary 100 percent disability evaluation, the control is necessary to gain reasonable assurance that financial stewardship over these funds is adequate.

Generally, errors occurred because VSC management did not prioritize processing the temporary 100 percent claims that required reduced evaluations. Delays ranged from 2 months to 10 months, and an average of 6 months elapsed from the time staff should have reduced the temporary 100 percent evaluations until they ultimately took action. As of January 2014, staff had not taken the required action on five cases. Management stated that instead of processing benefit reductions, they placed emphasis on processing other workloads that VBA tracks and measures for timeliness. As a result, veterans may receive benefit payments in excess of their eligibility when benefit reductions are warranted but not processed. We provided VARO management with 329 claims remaining from our universe of 359 for its review to determine if action is required.

VARO management concurred with six errors we identified and did not provide a concurrence or non-concurrence with nine errors involving delays. Management responded, "Workload priorities and the timeliness of processing is an issue that should be discussed between leadership at the headquarters level for both OIG and VBA." It is clearly within the OIG's purview to provide oversight of this high-risk area of temporary 100 percent disability evaluation processing. Management's lack of response is not helpful in addressing the errors we identify as a means of improving claims processing and ensuring accurate benefits delivery.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, New Orleans, Louisiana* (Report No. 11-00238-184, June 6, 2011), VARO staff incorrectly processed 24 of 30 temporary 100 percent disability evaluations we reviewed. The most frequent processing errors occurred because staff did not enter suspense diaries in the electronic system to ensure they received reminder notifications to schedule medical reexaminations to support the evaluations. VARO management did not provide oversight to ensure VSC staff entered the suspense diaries. The VARO concurred with our recommendation to review the 196 temporary 100 percent evaluations

remaining from our inspection universe. Also, the Director stated the VARO would follow national guidance to ensure staff enter suspense diaries into the electronic record. The OIG closed the recommendations on November 15, 2011.

During our February 2014 inspection, we identified one case from July 2007 where staff did not enter a suspense diary as required. As we only found one such error, which predated both inspections, we determined the VSC's actions in response to our previous recommendations appeared to be effective.

TBI Claims

The Department of Defense and VBA commonly define a TBI as a traumatically induced structural injury or a physiological disruption of brain function caused by an external force. The major residual disabilities of TBI fall into three main categories—physical, cognitive, and behavioral. VBA policy requires staff to evaluate these residual disabilities. Additionally, VBA policy requires that employees assigned to the appeals team, the special operations team, and the quality review team complete training on TBI claims processing.

In response to a recommendation in our report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-167, May 18, 2011), VBA agreed to develop and implement a strategy for ensuring the accuracy of TBI claims decisions. In May 2011, VBA provided guidance to VARO Directors to implement a policy requiring a second signature on each TBI case an RVSR evaluates until the RVSR demonstrates 90 percent accuracy in TBI claims processing. The policy indicates second-signature reviewers come from the same pool of staff as those used to conduct local station quality reviews.

We determined VARO staff incorrectly processed 10 of 30 TBI claims—2 affected veterans' benefits and resulted in overpayments totaling approximately $14,040. These errors represented 31 improper monthly payments from February 2012 to January 2014. Details on the two errors affecting veterans' benefits follow:

- An RVSR over-evaluated a veteran's TBI residual condition. Specifically, the medical evidence did not warrant an increased evaluation. As a result, the veteran was overpaid approximately $12,269 over a period of 23 months. This was the most significant overpayment.
- An RVSR incorrectly established separate evaluations for a veteran's TBI and a mental disorder when the VA examiner could not differentiate which symptoms were attributable to each condition. VBA policy requires staff to assign a single evaluation when the VA examiner cannot separate symptoms of TBI and a coexisting mental disorder. As a result

of using the insufficient medical examination report, the veteran was overpaid approximately $1,771 over a period of 8 months.

The remaining eight processing errors had the potential to affect veterans' benefits. In six cases, VSC staff evaluated TBI residuals using insufficient VA medical examination reports. Specifically, the examination reports contained conflicting information, were missing pertinent questions, or lacked an initial TBI diagnosis by a required medical specialist. Neither VBA nor we could determine whether the current disability evaluations were correct because the veterans' claims folders did not contain sufficient medical evidence needed to evaluate each case.

In the two remaining cases, RVSRs improperly evaluated TBI residual conditions by assigning a separate evaluation for a coexisting mental condition. In such cases, VSC staff must assign a single evaluation for both conditions that were the result of a veteran's overall mental functioning per VBA policy. These errors did not affect the veterans' current monthly benefits but have the potential to affect future benefit payments if the veterans' other service-connected disabilities worsen or if service connection is granted for new disabilities.

Generally, the TBI processing errors we identified occurred because VSC staff misinterpreted VBA policy for processing TBI claims. VARO management concurred with three errors and non-concurred with seven. For those seven, VARO management did not concur because they felt there was sufficient evidence to properly decide the claims. However, our review revealed otherwise. For example:

- An RVSR prematurely denied a TBI claim without obtaining a TBI medical examination report.
- A VA nurse practitioner provided an initial TBI diagnosis. However, policy states the diagnosis must be provided by a medical doctor.
- An RVSR used an insufficient medical examination to evaluate the severity of headaches related to a TBI. The examination was insufficient because there were pertinent questions missing from the examination, including whether the veteran had additional diagnoses such as migraine or tension headaches.

VARO staff and management confirmed they found TBI regulations complex. Based on interviews with staff and a review of VARO training records, only one RVSR received TBI-related training from March 2013 to the period of our review. In February 2014, RVSRs received training on this topic. However, we did not assess the effectiveness of that training because staff had completed the claims we reviewed prior to receiving the training. As a result of staff misinterpretations of VBA policy for processing TBI claims, veterans may not have always received correct benefits decisions.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, New Orleans, Louisiana* (Report No. 11-00238-184, June 6, 2011), we also determined errors in processing TBI claims occurred due to RVSRs prematurely evaluating TBI-related disabilities based on insufficient medical examination reports. In response to our recommendations, the VARO Director agreed to establish an additional level of review for all TBI claims prior to finalizing rating decisions. The OIG closed this recommendation based on the VARO's Quality Review Team providing second-level reviews of TBI claims processing.

Although none of the TBI errors we identified during our current inspection underwent second-level review by the Quality Review Team, we continued to identify TBI claims processing errors related to staff using insufficient medical examinations. We concluded the second-level reviews alone were not effective in reducing processing errors.

Special Monthly Compensation and Ancillary Benefits

As the concept of rating disabilities evolved, VBA realized that for certain types of disabilities, the basic rate of compensation was not sufficient for the level of disability present. Therefore, VBA established SMC to recognize the severity of certain disabilities or combinations of disabilities by adding additional compensation to the basic rate of payment. SMC represents payments for "quality of life" issues, such as the loss of an eye or limb, or the need to rely on others for daily life activities, like bathing or eating. Generally, VBA grants entitlement to SMC when the following conditions exist:

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

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

- Dependents' Educational Assistance under Title 38, United States Code, Chapter 35
- Specially Adapted Housing Grant
- Special Home Adaptation Grant

- Automobile and Other Conveyance and Adaptive Equipment Allowance

VBA policy requires staff to address the issues of SMC and ancillary benefits whenever they can grant entitlement. We focused our review on whether VARO staff accurately processed entitlement to SMC and ancillary benefits associated with anatomical loss, loss of use of two or more extremities, or bilateral blindness with visual acuity of 5/200 or worse.

VARO staff incorrectly processed 17 of 30 claims involving SMC and ancillary benefits—6 affected veterans' benefits and resulted in underpayments to veterans totaling approximately $38,996 and an overpayment totaling $14,615. These errors represented 88 improper monthly payments, processed from February 2011 until January 2014. Details on the most significant underpayment and the overpayment follow:

- An RVSR assigned an incorrect effective date for entitlement to SMC along with an incorrect level of SMC. As a result, VA underpaid the veteran approximately $20,498 over a period of 2 years and 11 months.
- An RVSR assigned an incorrect effective date for entitlement to SMC for bilateral blindness. As a result, VA overpaid the veteran $14,615 over a period of 5 months.

The remaining 11 errors had the potential to affect veterans' benefits. Summaries of those errors follow:

- Six errors involved RVSRs that failed to grant, or improperly granted, ancillary benefits.
    - In two cases, staff failed to grant entitlement to specially adapted housing, a benefit worth up to $67,555.
    - Staff incorrectly granted entitlement to both specially adapted housing and special home adaptation grants in two other cases. These grants are worth up to $13,511 each.
    - Staff, in one case, did not correctly grant entitlement to a special home adaptation grant.
    - In another case, staff failed to grant entitlement to automobile and adaptive equipment, a benefit worth up to $19,817, as well as specially adapted housing.
- Five errors involved RVSRs that incorrectly entered, or failed to enter, hospital codes for veterans' SMC into the electronic system.
    - In three cases, staff did not enter the hospital codes correctly.
    - In the remaining two cases, staff did not enter any of the hospital codes as required.

Generally, VSC staff must reduce veterans' SMC payments when they are hospitalized at government expense. Hospital codes are used to determine the correct amount to pay veterans when they are hospitalized. In the five cases we identified, the improper hospital codes could have resulted in erroneous adjustments of the veterans' payments upon hospitalization.

Errors related to SMC were generally due to a lack of training. The VARO provided training records that revealed staff received SMC training in January 2014. However, prior to that date, the last time staff received SMC training was in FY 2011. VSC staff we interviewed indicated the training was not extensive enough to cover all of the complexities associated with SMC. For example, the training did not address how to properly assign effective dates for payment when evaluating the residual disabilities of a stroke.

Errors related to ancillary benefits were generally due to a lack of emphasis for staff to conduct thorough reviews to determine applicability of any and all ancillary benefits as required. Generally, errors related to ancillary benefits occurred in prior rating decisions; however, local quality reviews only hold RVSRs accountable for errors identified in the rating decisions currently under review. The reviews may not include entitlement to unclaimed ancillary benefits. VSC management stated it hoped veterans have good representatives to help them with their claims, especially if the VARO is not notifying them of their entitlement to potential ancillary benefits.

The VARO concurred with five of the errors we identified, and partially concurred with two. VARO management did not concur with 10 errors; however, they stated they would take corrective actions to fix 9 of these errors.

Recommendations

1. We recommend the New Orleans VA Regional Office Director conduct a review of the 329 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

2. We recommend the New Orleans VA Regional Office Director implement a plan to assess the effectiveness of their recent training on processing traumatic brain injury claims and special monthly compensation benefits.

3. We recommend the New Orleans VA Regional Office Director implement a plan to emphasize that rating staff address all ancillary benefits, even if not expressly claimed, to ensure veterans receive maximum entitlement to benefits.

Management Comments

The VARO Director concurred with our recommendations and will complete the review of 329 temporary 100 percent disability evaluations by October 31, 2014. Local quality review specialists will conduct a review of all TBI and SMC cases completed through July to determine the effectiveness of recent training in these subjects. Further, VARO staff will complete the training entitled, "Ancillary Benefits and Special Purposes" by July 31, 2014.

OIG Response

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

II. Management Controls

Systematic Analysis of Operations

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs). We also considered whether VSC staff used adequate data to support analyses and recommendations identified within each SAO. An SAO is a formal analysis of an organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish annual SAO schedules designating the staff required to complete the SAOs by specific dates. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 11 SAOs annually.

Finding 2 VARO Lacked Adequate Oversight To Ensure Complete SAOs

Nine of the 11 SAOs were missing required elements such as specific timeframes for completion of recommendations. VSC management did not provide adequate guidance or recent training to ensure staff completed SAOs in accordance with VBA policy. As a result, management lacked sufficient information to adequately identify existing and potential problems needing corrective actions to improve VSC operations.

Management did not ensure staff included all required elements such as specific timeframes for completion of recommendations in the SAOs because they did not think these elements would provide additional support needed for completion of the recommendations. Management stated it last provided VSC staff with SAO training more than one year prior to our inspection, and felt the SAOs essentially contained sufficient analyses without the missing required elements. Although SAOs generally contained sufficient analyses based on appropriate data and identified deficient areas, there was a lack of VSC management guidance to ensure staff completed all SAOs as required.

The Claims Processing Timeliness SAO was an example of an incomplete SAO. As discussed above, we identified instances among the temporary 100 percent disability evaluations we reviewed where VARO staff did not take timely action to reduce benefits as appropriate. If the New Orleans VARO had completed the Claims Processing Timeliness SAO, it could have identified this problem and developed recommendations to address this issue before we did as part of our review.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, New Orleans, Louisiana* (Report No. 11-00238-184, June 6, 2011), we found that 1 of the 12 mandated SAOs was not completed timely per the annual schedule. We did not consider the error rate significant, so we made no recommendation

for improvement in this area. During our February 2014 inspection, staff timely submitted all 11 required SAOs.

Recommendations

4. We recommend the New Orleans VA Regional Office Director implement a plan to ensure Systematic Analyses of Operations contain all required elements including specific timeframes for completion of recommendations.

5. We recommend the New Orleans VA Regional Office Director ensure that staff receive training on VBA policy regarding the purpose and requirements for completing Systematic Analyses of Operations.

Management Comments

The VARO Director concurred with our recommendations. The Director indicated all SAOs were completed timely and will ensure future SAOs address each item, or will note why an item was not addressed.

OIG Response

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

Benefits Reductions

VBA policy provides for compensation to veterans for conditions they incurred or aggravated during military service. The amount of monthly compensation to which a veteran is entitled may change because his or her service-connected disability may improve. Improper payments associated with benefit reductions generally occur when beneficiaries receive payments to which they are not entitled because VAROs do not take the action required to ensure correct payments for their levels of disability.

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

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

Finding 3 VARO Lacked Oversight and Training To Ensure Correct and Immediate Action On Proposed Benefits Reductions

VARO staff incorrectly processed 12 of 30 claims involving proposed benefit reductions. These errors occurred due to a lack of emphasis on timely processing and a lack of training on procedures for reducing benefits. Processing inaccuracies resulted in overpayments totaling approximately $40,014 and underpayments totaling approximately $4,280, representing 78 improper monthly payments to 11 veterans from March 2012 to January 2014.

Processing delays occurred in 9 of 30 claims that required rating decisions to reduce or discontinue benefits. Eight of the cases showed claims processing delays ranging from 1 to 18 months. An average of 8 months elapsed from the time staff should have taken action to reduce the evaluations for these 9 cases. In the case with the most significant overpayment and delay, VSC staff sent a letter to the veteran on November 23, 2011, proposing reducing benefits for a bilateral knee condition. The due process period expired on January 27, 2012. However, staff did not take action to reduce the evaluation until September 4, 2013. As a result, VA overpaid the veteran $18,104 over a period of 20 months.

Generally, the delays occurred because VARO management did not view this workload as a priority. Because of national changes to workload management, VSC leadership did not place emphasis on processing benefit reductions in 2013. Rather, it concentrated on national priorities that included processing claims pending over 2 years old. Interviews with management and staff confirmed there was no emphasis on following through with proposed rating reductions timely.

Also, VARO staff incorrectly reduced evaluations in 4 of 30 claims we reviewed. Three of these errors led to underpayments totaling approximately $4,280 and an overpayment totaling approximately $3,323. One case had the potential to affect benefits as the incorrect reduction did not currently impact the veteran's payments. Following are details on the four errors:

- In the case of the most significant underpayment, an RVSR reduced a veteran's compensation for prostate cancer based on remission of the condition; however, the veteran provided medical evidence showing the cancer was active, thus not warranting a reduction. As a result of the error, VA underpaid the veteran approximately $3,734 over a period of 2 months.
- In one case, an RVSR did not properly consider the medical evidence and incorrectly proposed reducing a veteran's evaluation for headaches. The medical evidence showed no change in the severity of the veteran's headaches, therefore no reduction was warranted.

- In another case, an RVSR incorrectly proposed reducing a veteran's evaluation for lung cancer. The RVSR improperly used a personal interpretation of the medical evidence to determine Pulmonary Function Test results. Rather, the RVSR should have used the results provided by the examining physician.
- In the fourth case, an RVSR did not properly discontinue entitlement to SMC when the medical evidence revealed the veteran no longer met the requirement for this additional benefit.

Generally, these incorrect reductions occurred because rating staff had not received any recent training on benefit reduction procedures. A review of the VARO's training history revealed that staff had not been trained on reduction ratings since September 2011. Management scheduled training to go over reduction ratings in 2013, but canceled it due to competing requirements to work on a nationwide, priority VA project.

Of the total 12 errors we identified, VARO management concurred with 3 and partially concurred with 2 errors. Management's responses noted they were directed by VBA to not comment on delays in processing benefit reductions. Although we showed VARO management and staff VBA criteria requiring action on the 65th day following due process notification, they did not concur or non-concur with the remaining seven benefits reduction processing delays. In these cases, VARO managers noted, "Workload priorities and the timeliness of processing is an issue that should be discussed between leadership at the headquarters level for both the OIG and VBA." Prioritization of this type of work is needed to minimize overpayments and ensure sound financial stewardship of veterans' monetary benefits.

Recommendations

6. We recommend the New Orleans VA Regional Office Director develop and implement a plan to ensure staff prioritize processing of benefit reductions at the expiration of due process as required.

7. We recommend the New Orleans VA Regional Office Director provide training on the proper procedures for benefit reductions and implement a plan to assess the effectiveness of that training.

Management Comments

The VARO Director concurred with our recommendations. On May 13, 2014, VBA implemented a plan to ensure action is taken within 180 days of these items appearing on VBA's workload notification report or when future examination indicators mature. The Director indicated the New Orleans VARO will develop a plan in accordance with the national guidance by June 18, 2014. Further, training will be provided to staff regarding the implementation of this plan by June 30, 2014.

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

III. Observations

On June 20, 2014, we issued a Management Advisory Memorandum alerting the Under Secretary for Benefits that Fast Letter 13-10, "Guidance on Date of Claims Issues," could be misapplied by VAROs to manipulate dates of claims. Specifically, when staff identify a claim located in a veteran's claims folder that was not previously adjudicated, the guidance directed staff to establish the date of claim as the date the claim was discovered. As a result, VBA performed an analysis that identified the New Orleans VARO as an outlier when comparing the percent of discovered claims to the total current inventory of claims. Upon further review, VBA determined the VARO had processed 124 unadjudicated claims from a universe of 20,081 original claims.

The Under Secretary for Benefits took action to suspend the use of Fast Letter 13-10, "Guidance on Date of Claims Issues," nationwide on June 27, 2014. As a result of that action, this report does not offer a recommendation to take corrective action.

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of January 2014, the New Orleans VARO reported a staffing level of 168.8 full-time employees. Of this total, the VSC had 128.8 employees assigned.

Workload

As of January 2014, VBA reported the New Orleans VARO had 9,947 pending compensation claims. On average claims were pending 161.6 days—46.6 days more than the national target of 115.

Scope and Methodology

VBA has 56 VAROs and a VSC in Cheyenne, WY, that process disability claims and provide a range of service to veterans. In February 2014, we evaluated the New Orleans VARO to see how well it accomplishes this mission.

We reviewed selected management, claims processing, and administrative activities to evaluate compliance with VBA policies regarding benefits delivery and nonmedical services provided to veterans and other beneficiaries. We interviewed managers and employees and reviewed veterans' claims folders. Prior to conducting our onsite inspection, we coordinated with VA OIG criminal investigators to provide a briefing designed to alert VARO staff to the indicators of fraud in claims processing.

Our review included 30 (8 percent) of 359 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented instances where VBA staff had granted temporary 100 percent disability evaluations for at least 18 months as of December 12, 2013. This is generally the longest period a temporary 100 percent disability evaluation may be assigned without review, according to VBA policy. We provided VARO management with 329 claims remaining from our universe of 359 for its review. We reviewed 30 (22 percent) of 135 disability claims related to TBI that the VARO completed from July through September 2013. We also examined 30 (41 percent) of 74 veterans claims involving entitlement to SMC and ancillary benefits that VARO staff completed from October 1, 2012, through September 30, 2013.

Prior to VBA consolidating Fiduciary Activities nationally, each VARO was required to complete 12 SAOs. However, following the Fiduciary Activities consolidation, the VAROs were only required to complete 11 SAOs. Therefore, we reviewed 11 SAOs related to VARO operations. Additionally,

we looked at 30 (31 percent) of 96 completed claims involving proposed reductions in benefits from July through September 2013.

Where 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. We do not provide this information to require the VARO to adjust specific veterans' benefits. Processing any adjustments per this review is clearly a VBA program management decision.

Data Reliability

We used computer-processed data from the Veterans Service Network's Operations Reports and Awards. To test for reliability, we reviewed the data to determine whether any were missing from key fields, included calculation errors, or were outside the time frame requested. We assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Further, we compared veterans' names, file numbers, Social Security numbers, dates of claim, and decision dates as provided in the data received with information contained in the 120 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI claims, SMC and ancillary benefits, and completed claims involving proposed benefits reductions.

Our testing of the data disclosed that they were sufficiently reliable for our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders we reviewed did not disclose any problems with data reliability.

This report references VBA's STAR data. As reported by VBA's STAR program as of January 2014, the overall claims-based accuracy of the VARO's compensation rating-related decisions was 92.5 percent. We did not test the reliability of this data.

Inspection Standards

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

Appendix B Inspection Summary

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

Table 2. New Orleans VARO Inspection Summary

Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance
Disability Claims Processing		
Temporary 100 Percent Disability Evaluations	Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations. (38 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1 MR Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)	No
Traumatic Brain Injury Claims	Determine whether VARO staff properly processed claims for service connection for all disabilities related to in-service TBI. (FL 08-34 and 08-36) (Training Letter 09-01)	No
Special Monthly Compensation and Ancillary Benefits	Determine whether VARO staff properly processed SMC and correctly granted entitlement to ancillary benefits. (38 CFR 3.350, 3.352, 3.807, 3.808, 3.809, 3.809a, 4.63, and 4.64) (M21-1MR IV.ii.2.H and I)	No
Management Controls		
Systematic Analysis of Operations	Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs. (M21-4, Chapter 5)	No
Proposed Benefits Reductions	Determine whether VARO staff timely and accurately processed disability evaluation reductions or terminations. (38 CFR 3.103(b)(2), 38 CFR 3.105(e), 38 CFR 3.501, M21-1MR.IV.ii.3.A.3.e, M21-1MR.I.2.B.7.a, M21-1MR.I.2.C, M21-1MR.I.ii.2.f, M21-4, Chapter 2.05(f)(4), (*Compensation & Pension Service Bulletin*, October 2010)	No

Source: VA OIG

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

Appendix C VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: June 18, 2014

From: Director, VA Regional Office New Orleans, Louisiana

Subj: Inspection of the VA Regional Office, New Orleans, Louisiana

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

1. The New Orleans VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, New Orleans, Louisiana.*

2. Please refer questions to Mr. Steve Kelly, Veterans Service Center Manager, at (504) 619-4560.

(original signed by:)
Mark Bologna
Director

Attachment

Attachment

New Orleans (321) June 18, 2014

OIG Recommendations:

Recommendation 1: *We recommend the New Orleans VA Regional Office Director conduct a review of the 329 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.*

New Orleans RO Response: Concur

The New Orleans Regional Office has reviewed 244 of the 329 temporary 100 percent disability evaluations identified. The RO is in the process of reviewing the remaining 85 evaluations. We will continue to get a new listing of temporary 100 percent each month and will work these as received.

Target Completion Date: October 31, 2014

Recommendation 2: *We recommend the New Orleans VA Regional Office Director implement a plan to assess the effectiveness of their recent training on processing traumatic brain injury claims and special monthly compensation benefits.*

New Orleans RO Response: Concur

Local Quality Review Specialists will conduct a review of all TBI and SMC cases completed through July to determine the effectiveness of the training held on these subjects during the Fiscal Year. Any errors noted will result in on the spot training.

Target Completion Date: September 30, 2014

Recommendation 3: *We recommend the New Orleans VA Regional Office Director implement a plan to emphasize that rating staff address all ancillary benefits, even if not expressly claimed, to ensure veterans receive maximum entitlement to benefits.*

New Orleans RO Response: Concur

All rating staff will be required to complete the training entitled, “Ancillary Benefits and Special Purposes”

Target Completion Date: July 31, 2014

Recommendation 4: *We recommend the New Orleans VA Regional Office Director implement a plan to ensure Systematic Analyses of Operations contain all required elements including specific timeframes for completion of recommendations.*

New Orleans RO Response: Concur

The SAOs were completed timely. Additionally, the items identified during the audit were not material to the outcomes nor to the recommendations in the SAOs. VBA workload priorities are set at a national level. The issue of timeliness in processing particular cases (i.e., temporary 100 percent disability claims) is addressed separately in the report and in a separate recommendation. The New Orleans Regional Office concurred with the recommendation related to timely processing of temporary 100 percent disability claims. The New Orleans Regional Office will ensure future SAOs address each item, or will note why an item was not addressed.

Recommendation 5: *We recommend the New Orleans VA Regional Office Director ensure that staff received training on VBA policy regarding the purpose and requirements for completing Systematic Analyses of Operations.*

New Orleans RO Response: Concur

The New Orleans Regional Office Director provided SAO training on May 29, 2014, to staff members responsible for reviewing and completing SAOs. This training highlighted OIG's findings and provided instructions on how to integrate the feedback into the SAO process.

Recommendation 6: *We recommend the New Orleans VA Regional Office Director develop and implement a plan to ensure staff prioritize processing of benefit reductions at the expiration of due process as required.*

New Orleans RO Response: Concur

On May 13, 2014, VBA implemented a plan to ensure appropriate action is taken on all temporary 100-percent disability evaluations within 180 days of inclusion on the TRAP report or maturation of VBA's future examination indicator that is established when the Veteran is awarded a temporary 100-percent evaluation.

Since February 6, 2014, when guidance regarding this plan was issued to VBA regional offices, the inventory of pending reviews decreased by 57 percent, and the number of these reviews pending more than 180 days decreased by 65 percent (data as of April 26, 2014). The New Orleans Regional Office will develop a plan in accordance with the national guidance by June 18, 2014

Recommendation 7: *We recommend the New Orleans VA Regional Office Director provide training on the proper procedures for benefit reductions and implement a plan to assess the effectiveness of that training.*

New Orleans RO Response: Concur

The New Orleans Regional Office will conduct training on the local plan indicated in Recommendation 6 by June 30, 2014.

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Brent Arronte, Director Daphne Brantley Brett Byrd Lee Giesbrecht Scott Harris Jeffrey Myers David Piña Rachel Stroup Nelvy Viguera Butler Diane Wilson

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