VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Department of Veterans Affairs

Review of

Alleged Data Manipulation at the Los Angeles VA Regional Office

September 18, 2014
14-03736-273

ACRONYMS

FY	Fiscal Year
OIG	Office of Inspector General
VA	Veterans Affairs
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VSR	Veterans Service Representative

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EXECUTIVE SUMMARY

On June 24, 2014, the Office of Inspector General received an anonymous allegation that Los Angeles VA Regional Office (VARO) management instructed staff to manipulate data to meet a Veterans Benefits Administration (VBA) claims processing timeliness goal. This allegation involved claims assigned to Veterans Service Representatives (VSRs) for processing on May 2, 2014. The complainant alleged that management told staff to update VBA's electronic system to make it appear that VARO staff properly requested documentation to support veterans' claims, although no actions were actually taken to obtain the required evidence.

We did not substantiate the allegation that management instructed staff to input incorrect data in VBA's electronic system. We determined VARO management provided written instructions to the assigned VSRs on initiating development of evidence to process 183 claims. However, we found that one of the seven VSRs assigned this workload had made entries in VBA's electronic system to reflect documentation had been requested to support veterans' claims, although the employee took no actions to obtain the required evidence. This VSR acknowledged manipulating data for claims, stating this was done to comply with verbal instructions from management.

Based on our review, we concluded one employee misunderstood management's instructions and made improper entries in VBA's electronic system. Since the errors were the result of one individual, we did not consider this a systemic issue. However, given the nature and seriousness of the employee's claims processing errors, we recommended that the VARO Director take action to correct the fourteen errors the employee introduced in the electronic records on the claims processed. We also recommended the Director ensure monitoring of all employees' work to ensure that all future work is performed in accordance with VBA policy.

LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

RESULTS AND RECOMMENDATIONS

Allegation

Did Los Angeles VARO management instruct staff to falsify records to make it appear that documentation to support veterans' claims was properly requested?

On June 24, 2014, the Office of Inspector General received an anonymous allegation that Los Angeles VA Regional Office (VARO) management instructed staff to manipulate data to meet a Veterans Benefits Administration (VBA) claims processing timeliness goal. Specifically, the complainant alleged that management told staff to update VBA's electronic system to make it appear that VARO staff properly requested documentation to support veterans' claims, although no actions were actually taken to obtain the required evidence.

What We Did

We conducted an unannounced site visit to the Los Angeles VARO to assess the merits of the allegation. We obtained and reviewed the emails sent, which provided instructions on initiating development of 183 pending claims as of May 2, 2014. We interviewed seven Veterans Service Representatives (VSRs) responsible for developing these claims. We interviewed VARO management responsible for providing the guidance. Further, we examined the 183 pending cases to determine whether staff took appropriate actions to gather the supporting evidence needed.

What We Found

We found no evidence that Los Angeles VARO management instructed the VSRs to manipulate data to meet claims processing timeliness goals. A VARO team supervisor assigned 183 claims to seven VSRs to complete initial development for evidence on May 2, 2014. These claims represented the number of cases management requested the team to complete that day in order to assist with meeting production goals. We were able to obtain the email sent to VSRs on May 2, 2014, and determined that it did not instruct them to manipulate claims processing data. During our interviews, six of the VSRs denied receiving verbal instructions to make entries in the electronic record of the need to gather specific evidence to support veterans' claims, but not to take actions to obtain the evidence.

However, one VSR made entries in VBA's electronic system to make it appear as though documentation had been requested to support veterans' claims although no corresponding actions were taken to obtain the required evidence. When questioned, this VSR acknowledged manipulating the data for the referenced claims, and was unaware of any plan to follow up on these claims. The VSR further noted that management had indicated the most important task was to make the system entries. Manipulating the data in this manner falsified the elapsed time between when the claim was established and when VARO staff actually initiated work on the claim by requesting the

necessary evidence. This also showed the VARO acted more timely in processing claims than it actually had.

Managers who provided the guidance to process this specific assignment of claims denied instructing staff to manipulate data. Further, one manager conceded staff could have misinterpreted the instructions given the emphasis placed on entering the actions in the electronic record.

Our review of the 183 cases in the electronic record showed that 14 (8 percent) had improper entries. These entries made it appear as though evidence had been requested to support the pending claims, although no such actions had been taken. The VSR responsible for the 14 entries was the same employee who had discussed receiving instructions to manipulate the data for these cases processed on May 2, 2014.

Based on our interviews and examination of the 183 cases processed, we did not substantiate the allegation that management directed the entry of false information. We concluded that one VSR misunderstood management's instructions and improperly entered data in the electronic records regarding initiation of claims development. Such data manipulation was limited to errors in 14 claims by one VSR. Thus, we did not consider this a systemic issue.

Given the nature and seriousness of the employee's claims processing error, we believe immediate action is needed to review and correct as appropriate all entries the employee made in the electronic system on claims processed in response to management's direction. Further, moving forward, monitoring of all employees' work performance is critical to ensure that all future work is carried out in accordance with VBA and management policy.

Recommendations

1. We recommended the Los Angeles VA Regional Office Director take action to review and correct all entries the employee made in the electronic system on the 14 claims we identified.
2. We recommended the Los Angeles VA Regional Office Director ensure monitoring of all employees' work for the future to ensure that all work is performed in accordance with VBA policy.

Management Comments

The VARO Director concurred with our recommendations and took corrective action on all 14 claims we identified as inappropriately processed. Further, staff were provided additional training and quality reviews to ensure accurate processing of these claims.

OIG Response

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

Government Standards

We conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation* except those assessing internal controls.

Appendix A Management Comments

Department of Veterans Affairs

Memorandum

Date: September 2, 2014

From: Director, VA Regional Office Los Angeles, California

Subj: Review of Alleged Data Manipulation at the Los Angeles VARO, Los Angeles, California

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

1. The Los Angeles Regional Office (LARO) submits the following comments in response to the OIG's Draft Report. The LARO Director and staff concur with the findings and each recommendation. Seven of the 14 irregularities were corrected in conjunction with the out briefing of the OIG visit. The other seven were corrected when we were made aware of their identity by the OIG team. Other actions include:

- We have worked with the employee who had misinterpreted the guidance from management.
- We have taken steps to ensure accurate processing and have applied additional training and Quality Review Team (QRT) review procedures.
- Supervisory staff have initiated spot reviews of work being completed by team members at every touch point.
- Additional huddles are conducted to ensure accurate understanding of guidance that is provided by management.
- Our QRT maintains a list of new guidance and procedures to perform a quick reference cross-check for comprehension of guidance and procedures.
- Errors found by the QRT in the performance of their reviews are treated as training and immediate feedback opportunities for employees.

2. Thank you for your attention to this issue and the opportunity to review the draft report. Feel free to contact me at 310.235.7696 should you have any questions.

Sincerely,

(original signed by:)

ROBERT W. McKENRICK
Director

Appendix B 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 Brett Byrd David Pina Rachel Stroup Dana Sullivan

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