

# VA Office of Inspector General

## OFFICE OF AUDITS AND EVALUATIONS



## Inspection of VA Regional Office St. Louis, Missouri

July 24, 2014  
14-01497-188

# ACRONYMS

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

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# Report Highlights: Inspection of VA Regional Office St. Louis, MO

## Why We Did This Review

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

## What We Found

Overall, VARO staff did not accurately process 31 (34 percent) of 90 disability claims reviewed. We sampled claims we considered at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Claims processing that lacks compliance with VBA procedures can result in the risk of paying inaccurate and unnecessary financial benefits.

Nineteen of 30 temporary 100 percent disability evaluations we reviewed were inaccurate, generally because VARO staff delayed ordering medical reexaminations on average for 9 months after receiving reminder notifications. VARO staff incorrectly processed 4 of 30 traumatic brain injury (TBI) claims. Staff also incorrectly processed 8 of 30 claims related to special monthly compensation (SMC) and ancillary benefits. Generally, the errors in TBI and SMC and ancillary benefits processing were due to lack of oversight to ensure these complex claims were completed and reviewed by designated staff.

VARO managers ensured Systematic Analyses of Operations were complete and

timely. However, staff delayed completion of 7 of the 30 rating reduction claims we reviewed because management placed a higher priority on other work.

## What We Recommend

We recommended the VARO Director implement the plans needed to ensure timely and appropriate action on reminder notifications for medical reexaminations, appropriate action on the 559 temporary 100 percent disability evaluations remaining from our inspection universe, staff assigned to a specialized team process TBI and SMC claims, clarify local policy by clearly defining which SMC claims require processing by a specialized team, staff comply with local policy requiring Decision Review Officers to conduct second-signature reviews of SMC claims, and prioritization of benefits reduction actions in order to minimize improper payments to veterans.

## Agency Comments

The VARO Director concurred with all recommendations and the planned corrective actions are generally responsive. However, we remain concerned that potential delays in addressing issues related to temporary 100 percent disability evaluations and benefit reductions will result in continued improper payments. We will follow up on all actions.

Handwritten signature of Linda A. Halliday in black ink.

LINDA A. HALLIDAY  
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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 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**

The following appendixes provide additional 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 St. Louis 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 effect on veterans' benefits.

#### Finding 1

#### St. Louis VARO Could Improve Disability Claims Processing Accuracy

The St. Louis 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 31 of the total 90 disability claims we sampled, resulting in 198 improper monthly payments to 11 veterans totaling approximately \$181,665.

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 the errors affecting veterans' benefits and those with the potential to affect future benefits, processed at the St. Louis VARO.

**Table 1. St. Louis VARO Disability Claims Processing Accuracy**

Type of Claim	Total Claims Reviewed	Claims Inaccurately Processed that Affected Veterans' Benefits	Claims Inaccurately Processed with the Potential To Affect Veterans' Benefits	Total Claims Inaccurately Processed
Temporary 100 Percent Disability Evaluations	30	5	14	19
TBI Claims	30	1	3	4
SMC and Ancillary Benefits	30	5	3	8
<b>Total</b>	<b>90</b>	<b>11</b>	<b>20</b>	<b>31</b>

*Source: VA OIG analysis of VBA's temporary 100 percent disability evaluations paid at least 18 months, TBI disability claims completed in the first quarter fiscal year (FY) 2014, and SMC and ancillary benefits claims completed in calendar year 2013*

**Temporary  
100 Percent  
Disability  
Evaluations**

VARO staff incorrectly processed 19 of 30 temporary 100 percent disability evaluations we reviewed. 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. VSC staff then have 30 days to process the reminder notification by establishing an appropriate control to initiate action.

Available medical evidence showed 5 of the 19 processing errors we identified affected benefits and resulted in 62 improper monthly payments to 5 veterans totaling approximately \$27,601 from April 2011 until February 2014.

Details on the 19 cases we identified with errors follows.

- Thirteen errors occurred when VARO staff delayed scheduling required VA reexaminations despite receiving reminder notifications that the reexaminations were due. In most cases, the VARO lacks the medical information needed to determine if the temporary 100 percent disability evaluations should continue.
- Two errors occurred when VARO staff did not take timely action to reduce benefits after notifying the veteran of the intent to do so. In both cases, available medical evidence showed the veteran's condition no longer supported the temporary 100 percent disability evaluation. In the first case, the veteran received approximately \$11,779 in improper payments over a 5-month period. In the second case, the veteran received approximately \$6,329 in improper payments over a 4-month period.
- Two errors occurred when Rating Veterans Service Representatives (RVSRs) used the incorrect payment code for special monthly compensation benefits. As a result, one veteran was underpaid \$3,359 over a period of 2 years and 10 months and the other was underpaid \$96 in 1 month.
- In one of the cases, an RVSR did not establish entitlement to a special monthly compensation benefit based on the evaluation of multiple disabilities, as required. As a result, the veteran was underpaid approximately \$6,038 over a period of 1 year and 6 months.

- In the final case, the error occurred when an RVSR incorrectly proposed reducing benefits for a veteran's prostate cancer although medical evidence showed the cancer was still active. Because we alerted VARO staff to the error before the reduction took place, they were able to take corrective action.

Without effective management of these temporary 100 percent disability ratings, VBA is at increased risk of paying inaccurate financial benefits. Fourteen of the total 19 errors we identified had the potential to affect veterans' benefits. We could not determine whether the evaluations would have continued in nine of these cases because the veterans' claims folders did not contain medical evidence needed to evaluate each case.

The majority of the processing inaccuracies resulted from a lack of adequate oversight to ensure staff took timely action to process reminder notifications for VA reexaminations. According to VBA policy, VARO staff have 30 days to process a reminder notification by establishing an appropriate control to initiate action. In the cases we reviewed, processing delays averaged approximately 9 months from the time the reminder notifications generated until staff took action to order the required medical reexaminations or February 2014—the month our inspection began.

Although the VARO had a workload management plan that designated staff and responsibility for processing reminder notifications, interviews with VARO staff and management indicated other claims processing activities had higher priority. VARO managers stated they focused on the priorities as directed by Central Office, which included completing rating-related cases that did not involve taking action on reminder notifications.

VARO management disagreed with 15 of the 19 errors we identified. Management stated that failure to take timely actions on reminder notifications to schedule medical examinations or to reduce benefits were workload issues and would not result in errors from quality assurance reviews. In addition, management indicated that although the VARO was responsible for ensuring timely and appropriate action on these items, workload demands hindered its ability to comply. Further, management said the timeframe for taking action was flexible based upon the specifics of each case. Although we provided VBA references that outlined the requirements to timely process reminder notifications to schedule medical reexaminations or reduce benefits, management continued to disagree with our assessments.<sup>1</sup>

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<sup>1</sup> VBA Fast Letter 08-09, "Prioritization and Processing of System-Generated Messages," April 8, 2008; Manual 21-1 Manual Rewrite (M21-1MR), Part III.iv.3.C.17, "Control of Examinations;" M21-1MR.I.2.C, "Adverse Action Proposal Period."

*Follow-Up to  
Prior VA OIG  
Inspection*

In our previous report, *Inspection of the VA Regional Office, St. Louis, Missouri* (Report No. 11-00519-172, May 20, 2011), VARO staff incorrectly processed 20 of 30 temporary 100 percent disability evaluations we reviewed. The majority of the errors occurred because VARO management had no procedures or oversight measures in place to ensure staff input suspense diaries in the electronic system to generate reminder notifications to schedule the reexaminations. In response to our recommendations, the Director agreed to follow VBA's national review plan. Further, in response to our national *Audit of 100 Percent Disability Evaluations* (Report Number 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed with our recommendations and took corrective action to automatically populate suspense diaries in the electronic record.

During our current inspection, we did not identify any errors where VARO staff did not input suspense diaries in the electronic system. Rather, the suspense diaries were generating reminder notifications, but staff were not taking timely actions to process them as required.

**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 annual 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 4 of 30 TBI claims—1 claim affected a veteran's benefits and the remaining 3 cases had the potential to affect veterans' benefits. Generally, errors in processing TBI claims were due to inadequate oversight procedures to ensure staff routed TBI cases to the designated, specialized team for review, as required by local policy. As a result, veterans did not always receive correct benefits payments. VARO management agreed with our assessments in the four cases we identified. Summaries of the four errors follow.

- An RVSR granted an incorrect effective date for migraine headaches secondary to TBI and used the date of the VA examination as the date to begin benefit payments. However, the correct effective date was July 25, 2013—the date the veteran’s TBI-related claim was received by VA. This error resulted in the veteran being underpaid by approximately \$1,053 over a 5-month period.
- In one case, an RVSR incorrectly established separate evaluations for a veteran’s TBI and coexisting mental condition although the examiner stated it was not possible to differentiate which symptoms were attributable to which condition. VBA policy requires staff to assign a single evaluation when medical examiners cannot ascribe overlapping symptoms to either a TBI-related disability or to a coexisting mental condition.
- In one case, an RVSR prematurely evaluated TBI-related migraine headaches to include dizziness using two examination reports that provided inconsistent VA examination findings. The inconsistencies in the examination findings resulted in a disparity in the disability evaluation assigned. The RVSR did not return the examination reports for clarification to the issuing clinic or health care facility as required.
- In the remaining case, an RVSR assigned a 10 percent evaluation for residual disability associated with a TBI. However, the objective evidence provided in the TBI examination showed symptoms that supported a 40 percent evaluation. Since the veteran’s combined disability evaluation was 100 percent, the error did not affect monthly benefits. However, if left uncorrected, future payments could be affected. For example, entitlement to additional special compensation may be paid when a veteran has a single disability evaluated as 100 percent disabling and also has multiple, independent disabilities that are evaluated as 60 percent or more disabling. This sort of benefit could result in an increase of \$341 in monthly benefits.

The St. Louis VARO delegated responsibility for evaluating TBI-related disability claims to staff assigned to the Special Operations team. Staff assigned to the Special Operations team process all claims requiring special handling because of their nature, such as those involving SMC, military sexual trauma, TBI, or multiple sclerosis.

Generally, VARO staff routed TBI cases to the Special Operations team as required; however, staff outside of the specialized team processed two of the TBI cases with errors. VARO management told us they relied on the staff to self-identify TBI claims and route the cases to the Special Operations team for processing. We learned through interviews that RVSRs were aware of this local requirement to route TBI claims to the Special Operations team, but they did not always comply.

*Follow-Up to  
Prior VA OIG  
Inspection*

In our previous report, *Inspection of the VA Regional Office, St. Louis, Missouri* (Report No. 11-00519-172, May 20, 2011), 14 of the 27 TBI claims reviewed contained processing errors. Generally, errors associated with TBI claims processing occurred because RVSRs used VA medical examinations that were insufficient for decision-making purposes. In response to our recommendations for improvement, the Director agreed to ensure RVSRs received additional training related to processing TBI claims. In September 2011, the OIG closed this recommendation.

During our current inspection, we identified one error resulting from staff using an insufficient examination to evaluate TBI disability claim. The corrective actions taken during the 2011 inspection were considered effective.

**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 38 United States Code §35
- Specially Adapted Housing Grant
- Special Home Adaptation Grant
- Automobile and Other Conveyance and Adaptive Equipment Allowances

VBA policy requires staff to address the issues of SMC and ancillary benefits whenever they can grant entitlement. We examined whether VARO 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.

VARO staff incorrectly processed 8 of 30 veterans' claims involving SMC and related ancillary benefits—5 of the errors affected veterans' benefits and resulted in 131 improper payments totaling approximately \$153,011 from April 2009 until February 2014. The three remaining cases had the potential to affect veterans' benefits. Generally, errors occurred because management did not enforce local policies that the Special Operations team evaluate SMC cases and that Decision Review Officers provide a second-signature review of them prior to final processing for payment. As a result, veterans received improper payments or were unaware of benefits to which they were entitled.

Summaries of the eight errors we identified within our statistical sample follow:

- An RVSR incorrectly granted service connection for blindness due to heart disease, and then granted SMC on that basis. As a result, the veteran was overpaid approximately \$108,262 over a period of more than 3 years.
- An RVSR assigned SMC for a veteran's multiple sclerosis but did not consider all disabilities associated with that diagnosis and assign additional SMC, as required. This veteran was underpaid approximately \$34,009 over 4 years and 10 months.
- A similar error occurred when an RVSR granted SMC for a veteran's spinal condition but overlooked a psychiatric disability that warranted an increase in SMC. As a result, the veteran was underpaid approximately \$7,580 over a period of 1 year and 9 months.
- An RVSR did not assign an increased level of SMC for all disabilities associated with a veteran's diabetes and peripheral neuropathy. In addition, the RVSR invited the veteran to apply for a special adapted housing grant rather than awarding the benefit outright although he was already entitled to the benefit. As a result, the veteran was underpaid \$2,178 over a period of 1 year and was not given the special adapted housing grant—a benefit worth up to \$67,555.
- In another case, an RVSR assigned the incorrect effective date to establish SMC benefits related to amyotrophic lateral sclerosis, a debilitating neurodegenerative disease. As a result, the veteran was underpaid \$981 in 1 month. VARO staff disagreed with our assessment, stating that the date used to compensate the veteran for loss of use of both hands due to the condition should have been two days prior to the date VA received the claim from the veteran. However, VA occupational

treatment records showed loss of use of both hands prior to the date the veteran submitted a claim for an increased evaluation. VBA policy requires that RVSRs use the earliest effective date ascertainable for increased evaluations of veterans' service-connected conditions.<sup>2</sup>

- Two errors occurred when RVSRs did not assign the correct hospital codes for the veterans' SMC. Generally, VARO staff must adjust SMC payments if veterans are hospitalized at VA expense. If hospital codes related to SMC are incorrect or omitted, erroneous adjustments and benefit payments to veterans may occur.
- In the last case, an RVSR used an insufficient examination report to evaluate a veteran's multiple sclerosis. VARO staff disagreed with our assessment, stating that although the VA examination could be "more descriptive," they did not find it to be inadequate. In this case, we could not determine the veteran's level of disability based on the available evidence. Per VBA policy the RVSR should have returned the insufficient examination report to the medical examiner for clarification before rating the claim.

As with TBI-related claims, the St. Louis VARO also delegated responsibility for evaluating SMC claims to staff assigned to the Special Operations team. VARO managers indicated that the VARO's SMC policy may be unclear. Specifically, they were not sure if the policy meant that the Special Operations team was to evaluate all SMC cases or just cases where veterans specifically claimed SMC. RVSRs we interviewed indicated they worked any SMC issue that developed during their review of claims and confirmed that they did not stop processing these claims to route them to the Special Operations team. Staff outside the Special Operations team evaluated four of the eight errors we identified.

VARO policy also required Decision Review Officers to conduct second-signature reviews on SMC cases for accuracy. None of the eight cases with errors had the required second-signature review by a Decision Review Officer. VARO managers conducted second-signature reviews on three of the cases, but did not identify the errors.

## Recommendations

1. We recommended the St. Louis VA Regional Office Director develop and implement a plan to ensure timely and appropriate action on reminder notifications for medical reexaminations.
2. We recommended the St. Louis VA Regional Office Director develop and implement a plan to review for accuracy the 559 temporary

<sup>2</sup> Code of Federal Regulations, Part 3 "Adjudication," Title 38, Section 3.400(o)(2).

100 percent disability evaluations remaining from our inspection universe and take appropriate actions.

3. We recommended the St. Louis VA Regional Office Director implement a plan to ensure compliance with local policy requiring staff assigned to a specialized team process traumatic brain injury and special monthly compensation claims.
4. We recommended the St. Louis VA Regional Office Director clarify local policy by clearly defining which special monthly compensation claims require processing by a specialized team.
5. We recommended the St. Louis VA Regional Office Director implement a plan to ensure staff comply with local policy requiring Decision Review Officers to conduct second-signature reviews of special monthly compensation claims.

**Management  
Comments**

The VARO Director concurred with our recommendations. VARO management acknowledged the importance of taking timely action to ensure future medical reexaminations and will evaluate and implement steps to address this issue. However, management reiterated its view that the VARO's failure to timely request medical reexaminations is neither an error nor a procedural deficiency, but rather a workload management issue. On July 1, 2014, VARO management clarified its response to the draft report and confirmed it expects to complete the review of the 559 temporary 100 percent disability claims remaining from VA OIG's inspection universe by September 30, 2014. Management also confirmed its comments related to 28 temporary 100 percent disability evaluations pending on average for 61 days are unrelated to the 559 claims OIG provided the VARO for review.

VARO had implemented a daily prioritization tracker to locate special claims such as TBI cases and route them to the Special Operations team for processing as required. Management also planned to update its workload management plan to clearly define which SMC claims require processing by a specialized team. Management provided VARO staff a copy of a VSC memorandum, dated December 23, 2005, requiring that Decision Review Officers conduct secondary reviews of SMC claims to ensure accuracy. Further, SMC training for rating staff was scheduled to occur by July 25, 2014.

**OIG Response**

The Director's planned action to review the 559 temporary 100 percent disability evaluations remaining from our inspection universe is generally responsive. However, we remain concerned that potential delay in completing this review due to workload priorities could result in continuation of unnecessary and improper benefit payments. The Director's comments and planned actions related to TBI and SMC claims are responsive to the recommendations. We will follow up on these 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 to 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.

VARO management ensured all 11 SAOs were timely completed, contained sufficient analyses using appropriate data, identified deficiencies, and made recommendations for improvements as appropriate. Because the VARO followed VBA policy when processing SAOs, we made no recommendation for improvement.

### **Follow-Up to Prior VA OIG Inspection**

In our previous report, *Inspection of the VA Regional Office, St. Louis, Missouri* (Report No. 11-00519-172, May 20, 2011), we determined that the VSC completed all 12 SAOs timely. Although, 1 of the 12 SAOs did not address all required elements, we determined VSC management generally followed VBA policy when completing SAOs. As such, we made no recommendation for improvement in this area.

### **Benefit Reductions**

VBA policy provides for the payment of 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 they are not entitled to because VAROs do not take the actions required to ensure veterans receive the correct payments for their levels of disability.

When the VARO obtains evidence that a lower disability evaluation would result in a 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 65<sup>th</sup> 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 reductions in benefits. The new policy no longer requires VARO staff to take “immediate action” to process these reductions. In lieu of merely removing this vague standard, VBA should have provided clearer guidance on prioritizing this work to ensure sound financial stewardship of these monetary benefits.

## **Finding 2**

### **VARO Lacked Oversight To Ensure Immediate Action On Benefit Reductions**

VARO staff delayed processing 7 of the 30 claims that required rating decisions to reduce or discontinue benefits. Generally, delays in processing benefit reduction cases occurred because VARO managers did not provide oversight to ensure staff processed these cases timely. As a result, VA made 57 improper payments to 7 veterans from May 2012 to March 2014. The improper payments made during this period totaled approximately \$54,193.

Of the seven cases with processing delays, an average of 8 months elapsed before staff took or should have taken the required actions. The most significant improper payment resulting from delays in reducing benefits occurred when staff received evidence that a medical condition had improved. In March 2013, VARO staff proposed reducing the veteran’s evaluation from 100 to 20 percent disabling. However, the final action to reduce benefits did not occur until December 2013—7 months beyond the date staff should have taken the action. As a result, and despite the evidence showing the medical condition had improved, VA continued to make monthly payments totaling approximately \$16,497.

Generally, delays in processing benefit reductions occurred because VARO management did not prioritize this workload. VARO managers and staff told us they did not use the VARO’s workload management plan because a national initiative had redirected available staff and resources to process the VARO’s oldest rating-related pending claims instead.

In response to a recommendation following a May 2012 Compensation Service Site Visit, VARO staff developed a plan to improve timeliness in processing work related to due process/adverse actions, including the VARO’s rating reduction workload. According to the Compensation Service Site Visit Summary, the VARO had nearly 700 due process cases pending on average for 127 days, compared with all of VBA that averaged about 109 days. Of those cases, more than 60 percent had been pending 80 days or more, and almost 66 percent had expired suspense dates. However, the VSC Manager stated the effectiveness of the action plan to address timeliness was unknown because the VARO had shifted its focus to processing rating-related work, prioritized by age of claim. VARO managers and staff told us that the focus of VARO claims processing work continued to be goals set

forth by VBA Central Office, which did not include processing rating reduction claims.

Although the VSC Manager acknowledged the VARO's expectation to take timely action on rating decisions involving benefits reduction, the VARO disagreed with our assessments in the seven cases we identified as having processing delays. Further, VSC management indicated that workload management issues were neither errors nor procedural deficiencies. As such, VSC management did not believe that errors existed in processing these benefit reductions.

In response to the VARO's non-concurrences with the seven errors we identified, we reconsidered our position but continued to find the VARO non-compliant with VBA policy. In addition to providing VBA references that showed timeliness requirements for due process periods, we pointed out the VARO's own workload management plan required staff to take weekly action on these types of claims.

Further, we reemphasized that our inspections are strictly compliance reviews, designed to identify as errors any conditions where the VAROs do not adhere to VBA policy. We concluded that providing oversight of this high-risk area of benefit reductions is within the OIG's purview and clearly necessary to ensure sound financial stewardship and minimize improper benefit payments.

### **Recommendation**

6. We recommended the St. Louis VA Regional Office Director implement a plan to ensure claims processing staff prioritize actions related to benefit reductions to minimize improper payments to veterans.

#### **Management Comments**

The VARO Director concurred with our recommendation but indicated timely actions on benefits reduction cases are dependent upon competing workload demands and adherence to a national workload prioritization strategy.

#### **OIG Response**

We appreciate the Director's agreement to take action in response to the recommendation. However, we remain concerned that balancing this workload with competing demands may not ensure that benefit reduction claims receive the priority processing required to minimize improper payments. We will follow up on management's actions during future inspections.

## Appendix A VARO Profile and Scope of Inspection

**Organization** The St. Louis VARO administers a variety of services and benefits, including compensation and pension benefits; education benefits; vocational rehabilitation and employment assistance; benefits counseling; and outreach to former prisoners of war and homeless, elderly, minority, and women veterans.

**Resources** As of February 2014, VBA reported the St. Louis VARO had a staffing level of 815 full-time employees. Of this total, the VSC had 237 employees assigned.

**Workload** As of February 2014, the VBA reported 12,373 pending compensation claims. The average number of days pending for claims was 171.4 days—56.4 days greater than VBA’s FY 2014 target of 115 days.

**Scope and Methodology** VBA has 56 VAROs and a VSC in Cheyenne, WY, that process disability claims and provide a range of services to veterans. We evaluated the St. Louis 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 fraudulent claims processing.

Our review included 30 (5 percent) of 589 temporary 100 percent disability evaluations selected from VBA’s Corporate Database. These claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of February 4, 2014. 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 559 claims remaining from our universe of 589 for its review. We reviewed 30 (37 percent) of 81 disability claims related to TBI that the VARO completed from October through December 2013. Additionally, we examined 30 of 48 veterans claims involving entitlement to SMC and ancillary benefits completed by VARO staff from January 2013 through December 2013.

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

looked at 30 (9 percent) of 326 completed claims that proposed reductions in benefits from October through December 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 VAROs 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 data were missing from key fields, included any 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, VARO 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 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 reviewed in conjunction with our inspection of the VARO did not disclose any problems with data reliability.

As reported by VBA's Systemic Technical Accuracy Review program as of February 2014, the overall claims-based accuracy of the VARO's compensation rating-related decisions was 85.7 percent. We did not test the reliability of these data. As reported by VBA's Office of Field Operations, VBA's national accuracy goal for claims-based compensation rating-related decisions was 94 percent and for issue-based compensation rating-related decisions was 97 percent.

**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

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

**Table 2. St. Louis VARO Inspection Summary**

<b>Operational Activities Inspected</b>	<b>Criteria</b>	<b>Reasonable Assurance of Compliance</b>
<b>Disability Claims Processing</b>		
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
<b>Management Controls</b>		
Systematic Analysis of Operations	Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs. (M21-4, Chapter 5)	Yes
Benefit 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)), ( <i>Compensation &amp; Pension Service Bulletin</i> , 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 23, 2014  
**From:** Director, VA Regional Office St. Louis, Missouri  
**Subj:** Inspection of the VA Regional Office, St. Louis, Missouri  
**To:** Assistant Inspector General for Audits and Evaluations (52)

1. The St. Louis VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, St. Louis, Missouri.*
2. Please refer questions to Mr. Aaron Givens, Veterans Service Manager, at 314-552-9801.

*(original signed by:)*

S. Nick Nickens, Acting Director  
St. Louis Regional Office

Attachment

## ATTACHMENT

**ST. LOUIS VA REGIONAL OFFICE  
COMMENTS ON OIG DRAFT REPORT  
DATED JUNE 6, 2014**

**Recommendation 1:** We recommend the St. Louis VA Regional Office Director develop and implement a plan to ensure timely and appropriate action on reminder notifications for medical examinations.

**St. Louis Response:** Concur

While timely action is expected, the timeframe for that action varies based upon the specifics of each case, to include balancing workload priorities. While management acknowledges the importance of timely action on future medical examinations, workload management issues are neither errors nor procedural deficiencies. We do not agree that an error exists in the processing of this end product, but will evaluate and implement steps to address this issue.

Target completion date: TBD. Completion will be determined based on national workload directives.

**Recommendation 2:** We recommend the St. Louis VA Regional Office Director develop and implement a plan to review for accuracy the 559 temporary 100% disability evaluations remaining from our inspection universe and take appropriate actions.

**St. Louis RO Response:** Concur

Temporary 100% disability evaluations will be worked according to age in accordance with Office of Field Operations guidance received February 6, 2014 as follows:

- By July 31, 2014 there will be no temporary 100% evaluations pending in the inventory that are greater than 250 days old.
- By September 30, 2014 there will be no temporary 100% evaluations pending in the inventory that are greater than 125 days old.

The St. Louis Regional Office currently has 28 temporary 100% evaluations pending. That inventory has an average days pending of 61 days.

**Addendum to VARO Response to Draft Inspection Report, July 1, 2014 email, received from St. Louis VARO Acting Director:**

In response to your request for clarification, the following is provided:

- The 28 pending cases were the 684 EPs pending in VOR at the time of our response.
- The remaining cases from the original 559 on the list provided by OIG will be reviewed by September 30, 2014.

Target Completion Date: September 30, 2014

**Recommendation 3:** We recommend the St. Louis VA Regional Office Director implement a plan to ensure compliance with local policy requiring staff assigned to a specialized team process traumatic brain injury and special monthly compensation claims.

**St. Louis RO Response:** Concur

For Traumatic Brain Injury (TBI), the VSC implemented the use of a daily prioritization summary tracker which quickly identifies special claims and their current location within the division. Claims on this tracker that are found to be outside of the special operations team will be placed in the appropriate lane.

**Recommendation 4:** We recommend the St. Louis VA Regional Office Director clarify local policy by clearly defining which special monthly compensation claims require processing by a specialized team.

**St. Louis Response:** Concur

The workload management plan of the VSC will be updated with the following information:

- RVSRs external to the Special Operations Team may only work SMC K and SMC S
- all other levels of special monthly compensation must be referred to the special operations team.

This information will be reiterated during future training on SMC Target Completion Date: July 25, 2014

**Recommendation 5:** We recommend the St. Louis VA Regional Office Director implement a plan to ensure staff comply with local policy requiring Decision Review Officers to conduct second-signature reviews of special monthly compensation claims.

**St. Louis Response:** Concur

All rating staff employees have been provided another copy the December 23, 2005 VSC Memorandum related to Decision Review Officers conducting second-signature reviews on SMC ratings for accuracy. This document will also be discussed during all future SMC rating trainings within the VSC, which will occur on or before July 25, 2014.

Target Completion Date: July 25, 2014

**Recommendation 6:** We recommend the St. Louis VA Regional Office Director implement a plan to ensure claims processing staff prioritize actions related to benefit reductions to minimize improper payments to veterans.

**St. Louis Response:** Concur

The St. Louis Regional Office is currently operating in concert with the national workload strategy. According to the Workload Management Plan, the Non Rating Team is responsible for processing all 600 EPs. The due process cases that require rating decisions are routed to the respective Express, Core or Special Operations Lane for processing to ensure better workload management. The current process is that as the respective lanes promulgate rating decisions on any cases involving proposals on potential adverse actions, the 600 end products are established in VBMS and assigned a lane.

Timely action is expected, but the timeframe for that action sometimes varies based on competing workload demands and national directives. The St. Louis RO will continue taking action on benefit reductions as timely as workload demands allow while adhering to national workload prioritization strategy.

Target Completion Date: TBD. Completion will be determined based on national workload directives.

## Appendix D **OIG Contact and Staff Acknowledgments**

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OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Nora Stokes, Director Robert Campbell Kyle Flannery Lee Giesbrecht Ambreen Husain Suzanne Love Michelle Santos-Rodriguez Lisa Van Haeren Nelvy Viguera Butler
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## **Appendix E Report Distribution**

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