

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Inspection of VA Regional Office Louisville, Kentucky

July 28, 2015
15-01193-433

ACRONYMS

FY	Fiscal Year
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SMC	Special Monthly Compensation
TBI	Traumatic Brain Injury
VA	Department of 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 Louisville, KY

Why We Did This Review

The Veterans Benefits Administration has 56 VA Regional Offices (VAROs) and a Veterans Service Center in Wyoming that process disability claims and provide a range of services to veterans. In February 2015, we evaluated the Louisville VARO to see how well it accomplishes this mission. We sampled claims we considered at increased risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO.

What We Found

The Louisville VARO did not consistently process two types of disability claims we reviewed according to VBA policy. Overall, 11 of the 85 disability claims (13 percent) reviewed contained errors that resulted in improper payments of approximately \$151,305. During this inspection, VARO staff incorrectly processed 7 of 30 temporary 100 percent disability evaluations we sampled; however, all 30 traumatic brain injury claims were processed accurately.

Considering inspection results from our 2011 inspection—significant improvement in both claims processing areas is noted. During the 2011 benefits inspection, 25 of the 30 temporary 100 percent disability evaluations and 6 of the 20 TBI claims reviewed contained errors. VARO staff also incorrectly processed 4 of the 25 disability claims related to Special Monthly Compensation (SMC) and ancillary benefits.

VARO staff accurately established claims in the electronic record using correct dates of claim in the 30 claims we reviewed.

However, VARO staff delayed processing 11 of the 30 benefits reduction cases because management prioritized other workload higher. Effective management of these rating actions can reduce the risk of improper payments and provide better stewardship of taxpayer funds.

What We Recommended

We recommended the VARO Director implement a plan to ensure staff follow policies associated with medical reexaminations as well as review and take appropriate actions on the 345 temporary 100 percent disability evaluations remaining from the inspection universe. Further, the Director should implement plans to evaluate the effectiveness of training and accuracy of secondary reviews for SMC claims and ensure staff timely process benefits reductions to minimize improper payments to veterans.

Agency Comments

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

GARY K. ABE
Acting Assistant Inspector General
for Audits and Evaluations

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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.

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 Veterans Benefits Administration (VBA) program management decision.

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 Louisville 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 Louisville 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 evaluating the accuracy in processing the following three types of disability claims and determined their effect on veterans’ benefits:

- Temporary 100 percent disability evaluations
- Traumatic brain injury (TBI) claims
- Special monthly compensation (SMC) and ancillary benefits

We sampled claims related only to specific conditions that we considered at increased risk of claims processing errors. As a result, the errors identified do not represent the universe of disability claims or the overall accuracy rate at this VARO.

Finding 1

Louisville VARO Needs to Improve the Processing of Two Types of Disability Claims

The Louisville VARO did not consistently process two of the three types of disability claims reviewed. Overall, VARO staff incorrectly processed 11 of the total 85 disability claims we sampled, resulting in 240 improper monthly payments to 8 veterans totaling approximately \$151,305 at the time of our inspection in February 2015. Table 1 reflects processing errors identified during our review.

Table 1. Louisville VARO Disability Claims Processing Accuracy for Three High-Risk Claims Processing Areas

Type of Claim	Claims Reviewed	Claims Inaccurately Processed: Affecting Veterans’ Benefits	Claims Inaccurately Processed: Potential To Affect Veterans’ Benefits	Claims Inaccurately Processed: Total
Temporary 100 Percent Disability Evaluations	30	5	2	7
TBI Claims	30	0	0	0
SMC and Ancillary Benefits	25	3	1	4
Total	85	8	3	11

Source: VA OIG analysis of the VBA temporary 100 percent disability evaluations paid at least 18 months, TBI disability claims completed in the 3rd and 4th quarters of fiscal year (FY) 2014, and SMC and ancillary benefits claims completed in FY 2014

**Temporary
100 Percent
Disability
Evaluations**

VARO staff incorrectly processed 7 of 30 temporary 100 percent disability evaluations we reviewed. VBA's 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 the appropriate control to initiate action.

When the VARO obtains evidence that a lower disability evaluation would result in a reduction or discontinuance of current 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. If the VARO does not receive additional evidence within that period, RVSRs will 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.

Effective management of these temporary 100 percent disability ratings can reduce VBA's risks of paying inaccurate financial benefits and provides stewardship of taxpayer funds. Available medical evidence at the time we reviewed claims prior to the on site visit showed five of the seven processing errors affected benefits—the two remaining errors had the potential to affect veterans' benefits. The errors affecting benefits resulted in 67 improper monthly payments to 5 veterans totaling approximately \$109,853 from May 2013 to November 2014. Details on the errors affecting benefits follow:

- In November 2012, an RVSR established temporary 100 percent disability evaluation benefits for a veterans' aortic aneurism and directed VARO staff to request an immediate review examination. However, VARO staff delayed requesting the examination until August 2014. Medical evidence showed the disability had improved but only supported a 0 percent evaluation. As a result of the delay in scheduling the reexamination, the veteran was overpaid approximately \$44,910 over a period of 1 year 7 months.

- One error occurred when an RVSR continued a temporary 100 percent disability evaluation for a veteran's bladder cancer in April 2012 and noted the need for a medical reexamination. Although VARO staff received a reminder notification in October 2012, action to schedule reexamination did not occur until December 2014. Medical evidence showed the condition warranted a 60 percent evaluation. Because of the delay, VA overpaid the veteran approximately \$35,538 over a period of 1 year 7 months.
- In a November 2012 rating decision, an RVSR granted a temporary 100 percent disability evaluation for prostate cancer and directed staff to request a required medical reexamination; however, VARO staff delayed scheduling the reexamination until December 2013. Medical evidence showed the veteran warranted a 60 percent evaluation and was no longer entitled to additional SMC benefits. As a result, the veteran was overpaid approximately \$20,745 over a period of 1 year 2 months.
- In a May 2013 rating decision and based on medical evidence, an RVSR proposed to reduce a veterans' temporary 100 percent evaluation to 20 percent and discontinue entitlement to SMC. As of the date of our review, VARO staff had not taken action to reduce the benefits despite notifying the veteran of the intent to do so. Consequently, the veteran was overpaid approximately \$4,428 over a period of 1 year 1 month.
- The fifth error occurred when VARO staff delayed requesting a required medical reexamination after receiving a reminder notification to do so. Medical evidence showed the veteran's prostate cancer was no longer active and only supported a 40 percent evaluation. As a result, the veteran was overpaid approximately \$4,232 over a period of 2 months.

The remaining two of the seven total errors we identified did not affect the veterans' overall disability evaluations at the time of our inspection in February 2015. However, if left uncorrected, the errors have the potential to affect benefits. Following are details on the two errors.

- In one case, an RVSR directed staff to request an examination in June of 2008; however, at the time of our inspection in February 2015, staff had not scheduled the examination as required by VBA policy. VARO staff did not establish or maintain a suspense diary in the electronic record as required; thus, the system did not generate a reminder notification to schedule the medical reexamination. Neither VBA nor the OIG can determine the correct evaluation for the veteran's temporary 100 percent disability until VSC staff schedule the review examination.
- The final error occurred when VARO staff did not take timely action to schedule a personal hearing for a veteran after receiving a notification proposing to reduce benefits. In this case, the veteran had requested a personal hearing in April 2014. VBA policy allows staff to extend the proposal period for benefit reductions by 30 to 60 days if a veteran

requests a hearing. However, at the time of our review in February 2015, VARO staff had not scheduled the hearing as requested.

Generally, errors occurred because VARO staff did not take timely actions to schedule medical reexaminations, reduce benefits, or schedule personal hearings. As a result, veterans may receive inaccurate benefits payments. We provided VARO management with the 345 cases remaining from our universe of 375 cases related to temporary 100 percent disability evaluations for its review to determine if action is required.

VARO management disagreed with six of the seven errors indicating their timeframe to take action is flexible based on the specifics of each case; to include workload, which are neither procedural deficiencies nor errors. Management also stated they did not assign sufficient staff to timely process these claims due to competing priorities.

We disagree with VARO management responses. First, it is a VBA management responsibility to process this workload timely. Without appropriate priority for this type of work, delays in claims processing result in unsound financial stewardship of veterans' monetary benefits and fail to minimize improper payments. Where VBA lacks sufficient staff to address its management responsibilities, it should make its case for increase in full-time equivalents through the normal budget process.

Second, we disagree that VARO management has a flexible timeframe, based on workload, to take actions and that these types of workload issues are neither procedural deficiencies nor errors. As indicated in this report, VBA policy provides specific timeframes for processing reminder notifications for medical reexamination and for scheduling hearings. Further, as reported in our national report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), we projected \$1.1 billion in improper payments over 5 years would result from untimely reexaminations related to 100 percent disability evaluations.

*Follow-Up to
Prior VA OIG
Inspection*

In our previous report, *Inspection of the VA Regional Office, Louisville, Kentucky* (Report No. 11-00520-174, May 24, 2011), VARO staff incorrectly processed 25 of 30 temporary 100 percent disability evaluations we reviewed. The most frequent processing errors resulted from staff not establishing suspense diaries when they processed rating decisions requiring medical reexaminations for temporary 100 percent disability evaluations. In response to our recommendation, the VARO Director agreed to conduct refresher training and implement controls to ensure staff established suspense diaries to request the medical reexaminations as required. In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure

each had a future examination date entered in the electronic record. To assist in implementing the agreed-upon review, we provided the VARO with 201 claims remaining from our universe of 231 temporary 100 percent disability evaluations.

Additionally, in June 2014, in a follow-up report, we concluded VBA did not take sufficient action to ensure each temporary 100 percent disability evaluation had a future exam date. We estimated that VBA paid over 3,100 veterans almost \$85 million in benefit payments without adequate medical evidence since January 2012.¹ VBA reviewed our findings and reported coding errors prevented its TRAP report from identifying these veterans.²

During this 2015 inspection the VARO showed significant improvements in this area. The majority of errors identified occurred because VARO staff delayed taking action to schedule reexaminations. We identified one error related to the VARO not establishing or maintaining suspense diaries for reexaminations. We could not determine why this case was not identified on VBA's TRAP report; despite the required future reexamination date had been missing from the electronic record for more than 6 years. We will continue to follow up on future inspections to ensure cases missing required future examinations are identified by VBA's TRAP report.

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.

¹ *Follow-up Audit of VBA's 100 Percent Disability Evaluations* (Report No. 14-01686-185 June 6, 2014)

² The TRAP report identifies temporary 100 percent disability evaluations that do not include a future exam date in VBA's electronic records

During this 2015, inspection, we found VARO staff correctly processed all 30 TBI claims we reviewed. Since fiscal year 2013, only three other VAROs have demonstrated this level of accuracy when processing TBI related disability claims. VARO management and staff attributed the high accuracy rate for processing TBI claims to improved communication between RVSRs and the VAROs internal quality review staff as well as improved in-process quality reviews.³

Based on the results of our 30-case file review, interviews with RVSRs and internal quality review staff, we agree the accuracy of TBI claims are closely related to the communication between staff processing the cases and internal quality reviewers, to include the improved in-process quality reviews of these claims.

*Follow-Up to
Prior VA OIG
Inspection*

In our previous report, *Inspection of the VA Regional Office, Louisville, Kentucky* (Report No. 11-00520-174, May 24, 2011), we determined 6 of the 20 TBI cases reviewed contained errors. Generally, the errors occurred because staff incorrectly interpreted VBA policy. In addition, insufficient TBI examinations reports and inadequate training affected the accuracy in rating TBI disability claims. We recommended and the VARO agreed to conduct refresher training and develop and implement a plan to improve the quality review process. We did not identify any of these types of errors during our current February 2015 inspection. As such, we determined the VARO's actions in response to our previous recommendation were 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

³ In-process reviews are reviews designed to correct deficiencies throughout the claims process prior to promulgation and identify training opportunities.

- 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 section 35, title 38, United States Code
- Specially Adapted Housing Grants
- Special Home Adaptation Grants
- 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 assessed 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 4 of 25 claims involving SMC and ancillary benefits—3 affected veterans' benefits and resulted in underpayments totaling approximately \$41,452. These errors represented 173 improper monthly payments from February 2006 until November 2014. VARO management concurred with our assessments in the four cases we identified with errors.

In all three of the cases that affected benefits, RVSRs incorrectly denied higher levels of SMC to veterans who had additional, permanent disabilities that were independently evaluated as 50 percent or more disabling. In such cases, VBA policy requires RVSRs to grant additional special monthly compensation benefits. Consequently, three veterans were underpaid approximately:

- \$20,473 over a period of 8 years and 10 months
- \$11,839 over a period of 4 years and 2 months
- \$9,140 over a period of 1 year and 5 months

The remaining error had the potential to affect a veteran's benefits. In this case, the RVSR incorrectly coded the veteran's SMC decision relating to hospitalization. Although current benefits were not affected, future benefits may be affected if the veteran requires hospitalization.

Generally, errors related to SMC and ancillary benefits were due to ineffective training and second-signature review policy. Staff we interviewed reported a general need for training on higher-level SMC,

including use of the SMC calculator. We confirmed VARO staff had not received higher-level SMC training since March 2013 and that formal training on this topic was not planned for FY 2014. Additionally, VARO management and staff were inconsistent as to whether or not a second-signature policy existed for SMC cases. Further, none of the four cases we identified as having errors had undergone a secondary review.

In February 2015, Systematic Technical Accuracy Review staff provided classroom training for VARO staff that included examples highlighting the functionality of the SMC calculator. Additionally, VBA implemented a national policy that required two signatures on all cases of higher-level SMC.⁴ We were unable to assess the effectiveness of the on-site SMC training or the required secondary reviews because VARO staff had completed the cases we sampled in FY 2014 prior to the on-site SMC training and the policy change.

Recommendations

1. We recommended the Louisville VA Regional Office Director develop and implement a plan to ensure staff follows policies and procedures associated with scheduling medical reexaminations.
2. We recommended the Louisville VA Regional Office Director conduct a review of the 345 temporary 100 percent disability evaluations remaining from our inspection universe as of December 10, 2014, and take appropriate action.
3. We recommended the Louisville VA Regional Office Director develop and implement a plan to assess the effectiveness of higher-level Special Monthly Compensation training.
4. We recommended the Louisville VA Regional Office Director develop and implement a plan to assess the accuracy of secondary reviews involving higher-level Special Monthly Compensation and ancillary benefits.

Management Comments

The VARO Director concurred with our recommendations and designated the Express Team supervisor oversight responsibility to ensure staff follow policies and procedures associated with scheduling medical reexaminations. The VARO Director also indicated training on Routine Future Examinations is planned to occur in early FY 2016 and that the Quality and Training Committee will further evaluate the training needs based on accuracy and error trends. The Director also agreed to have staff review the

⁴ This policy applies to SMC at a rate greater than “L.” The rate would include conditions evaluated as more severe than those requiring daily aid and attendance, such as bilateral amputations above the knee.

345 temporary 100 percent disability evaluations remaining from our inspection universe by December 31, 2015.

The Director also reported that staff from VBA's Systematic Technical Accuracy Review, provided training for VARO staff that included examples highlighting the functionality of the SMC Calculator. Additionally, the VARO Director indicated local QRT staff provide training to staff in June 2015 that emphasized second signature requirement for higher level SMC cases. Further, the QRT supervisor is required to conduct monthly reviews on 5 percent of the secondary reviews involving higher-level SMC and ancillary benefits.

The Director also noted that VBA's Office of Field Operations regularly provides listings to all VAROs of any claims requiring medical reexaminations and the Louisville VARO is now current on these types of claims. The Director further stated OIG's findings consisted of historical cases and do not reflect the VARO's current workload processing.

**OIG
Response**

The Director's planned actions are responsive to the recommendations. However, we encourage VARO management to expedite its review of the 345 temporary 100 percent disability evaluations that were not included in the 30 cases we sampled. As of December 10, 2014, the 345 claims represented all instances where veterans have been receiving temporary 100 percent disability evaluations for 18 months or longer. According to VBA policy, this is generally the longest period a temporary 100 percent disability evaluation may be assigned without a review examination.

Delaying the review of these claims for up to 6 months does not reflect the sound financial stewardship expected of program officials or assist in minimizing improper payments to veterans. Additionally, the review of the 345 cases is likely to result in some medical conditions being evaluated as permanent; thereby, providing entitlement to additional benefits such as education and healthcare benefits for family members.

We also disagree that our findings consisted of historical cases. While the improper payments being made dated back several years the sample cases we reviewed were representative of temporary 100 percent evaluations that existed at the VARO as of December 2014. Again, as indicated in this report, this is generally the longest period a temporary 100 percent disability evaluation may be assigned without a review examination. We will follow up as required on the corrective actions as required.

II. Data Integrity

Dates of Claim

To ensure all claims receive proper attention and timely processing, VBA policy directs staff to use the earliest date stamp shown on the claim document as the date of claim. VBA relies on accurate dates of claim to establish and track key performance measures, including the average days to complete a claim. We focused our review on whether VSC staff followed VBA policy for establishing dates of claim in the electronic record.

VSC staff established correct dates of claim for all 30 claims we reviewed. As a result, we determined the VSC is following VBA policy, and we made no recommendation for improvement in this area.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Louisville, Kentucky* (Report No. 11-00520-174, May 24, 2011), VARO staff established the correct dates of claim in the electronic record for all 30 claims we reviewed.

III. Management Controls

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 benefits reductions generally occur when beneficiaries receive payments to which they are not entitled because VAROs do not take the actions required to ensure 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 benefits reduction. In order to provide the beneficiary 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 will 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 benefits reductions. The new policy no longer includes 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 2

Louisville VARO Lacked Oversight To Ensure Timely Action on Benefits Reductions

VARO staff delayed processing 11 of 30 benefits reductions claims that VARO staff completed from July through September 2014. This occurred because management did not prioritize this workload. As a result, VA made 149 improper payments to 11 veterans from January 2013 to December 2014, totaling approximately \$93,393.

For the 11 cases with processing delays, an average of 1 year and 2 months elapsed before staff took the required actions to reduce benefits. The most significant improper payment occurred when VARO staff proposed to reduce a veteran’s benefits after medical evidence showed the medical condition had improved. Staff proposed the reduction action in July 2012; however, the final rating decision to reduce benefits did not occur until July 2014, with the final reduction in payments effective October 2014—1 year and 9 months beyond the date when the reduction action should have occurred. As a result, the veteran received approximately \$54,165 in improper payments.

VARO management did not agree with our assessments in the 11 cases we identified as having errors. Although the VARO workload management plan included steps for oversight of rating-related benefits reductions cases, management did not follow the plan. Management told us it prioritized other workload considered by VBA to be a higher priority, and also cited a lack of staff to work these claims timely to be a cause for the delays.

We disagree with VARO management's response. It is a VBA management responsibility to ensure this workload is processed timely because it has the potential to entail millions of dollars in improper payments. Without ensuring this work is processed timely, delays in processing benefits reductions result in unsound financial stewardship of veterans' monetary benefits and fail to minimize improper payments. Further, where VBA lacks sufficient staff to address its management responsibilities, it should make its case for an increase in staff resources through the normal budget process.

Recommendation

5. We recommended the Louisville VA Regional Office Director implement a plan to ensure staff timely process claims related to benefits reductions to minimize improper payments to veterans.

Management Comments

The VARO Director concurred with our recommendation. The Director plans to provide additional resources to the team that processes benefits reductions cases in FY 2015. Reportedly, the additional resources would enable VARO staff to timely process benefits reductions cases and to minimize improper payments. However, the Director stipulated that the planned actions are subject to competing mandates from VBA Central Office.

OIG Response

The VARO Director's planned actions are responsive to the recommendation. However, we are concerned that the planned corrective actions can be set aside in lieu of other workload deemed to be a higher priority by VBA Central Office. As indicted in this report, we reviewed a sample of 30 benefits reductions cases that VARO staff completed in one quarter in FY 2014.

The sampled cases represented 15 percent of similar cases completed by VARO staff from July through September 2014. Delays in processing 11 of the 30 benefits reduction cases we sampled averaged 1 year and 2 months and resulted in over \$93,000 in improper payments. It is reasonable to conclude that similar delays and improper benefits payments existed in the remaining 166 cases staff completed during the same 3-month period.

Management's responsibility to prevent improper payments is not a matter of its discretion based on workload priorities as the VARO responses to Notification of Errors implied. According to Executive Order 13520,

Reducing Improper Payments and Eliminating Waste in Federal Programs, “When the Federal Government makes payments to individuals and businesses as program beneficiaries, grantees, or contractors, or on behalf of program beneficiaries, it must make every effort to confirm that the right recipient is receiving the right payment for the right reason at the right time.”

If resources are insufficient to comply, management should work towards a solution. A first step would be to acknowledge that payment errors—i.e., improper payments—are a result of delays in processing workload related to benefits reductions. We will follow up as required on all actions.

Appendix A VARO Profile and Scope of Inspection

Organization	The Louisville VARO administers a variety of services and benefits, including compensation, vocational rehabilitation and employment assistance, housing grants, and outreach services for homeless, elderly, minority, and women veterans.
Resources	As of January 2015, the Louisville VARO reported a staffing level of 376.6 full-time employees. Of this total, the VSC had 192.7 employees assigned.
Workload	As of January 2015, VBA reported the Louisville VARO had 9,096 pending compensation claims pending with 5,774 (63 percent) pending greater than 125 days. ⁵
Scope and Methodology	<p>VBA has 56 VAROs and a VSC in Wyoming that process disability claims and provide a range of services to veterans. In February 2015, we evaluated the Louisville VARO to see how well it accomplishes this mission.</p> <p>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.</p> <p>Our review included 30 of 375 temporary 100 percent disability evaluations (8 percent) 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 10, 2014. This is generally the longest period a temporary 100 percent disability evaluation may be assigned without review, according to VBA policy.</p> <p>We provided VARO management with 345 claims remaining from their universe of 375 claims as of December 10, 2014 for review. We reviewed 30 disability claims related to TBI that the VARO completed from April 1, 2014, through September 30, 2014. We also examined all 25 veterans' claims available involving entitlement to SMC and ancillary benefits that VARO staff completed from October 1, 2013, through September 30, 2014.</p> <p>We sampled and reviewed 30 of 3,404 dates of claims (less than 1 percent) pending at the VARO during the period July 1, 2014, through September 30, 2014. Additionally, we looked at 30 of the 196 available</p>

⁵ All calculated percentages in this report have been rounded where applicable.

completed claims (15 percent) involving proposed benefits reductions from July 1, 2014, through September 30, 2014.

**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, VARO numbers, dates of claim, and decision dates provided in the data received with information contained in the 145 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI claims, SMC and ancillary benefits, dates of pending claims at the VARO, 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.

As reported by VBA's Systematic Technical Accuracy Review program as of January 2015, the overall claims-based accuracy of the VARO's compensation rating-related decisions was 89.2 percent. We did not test the reliability of these 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. Louisville 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)	Yes
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
Data Integrity		
Dates of Claim	Determine whether VARO staff accurately established claims in the electronic records. (38 CFR 3.1 (p) and (r)), (M21-4, Appendix A and B), (M21-1MR, III.ii.1.C.10.a), (M21-1MR, III.ii.1.B.6 and 7), (M21-1MR, III.ii.2.B.8.f), (M21-1MR, III.i.2.A.2.c) (<i>VBMS User Guide</i>), (M21-4, Chapter 4.07), (M23-1, Part 1, 1.06)	Yes
Management Controls		
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)), (<i>Compensation & 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: July 2, 2015
From: Director, VA Regional Office Louisville (327/00)
Subj: Inspection of the VA Regional Office, Louisville, KY
To: Assistant Inspector General for Audits and Evaluations (52)

1. Attached are the Louisville VARO comments on the OIG Draft Report: Inspection of VARO Louisville.
2. Questions may be referred to Mr. David J. Davis, Director, at 502-566-4500, or Mrs. Laura Kuerzi-Rodgers, Veterans Service Center Manager, at 502-566-4301.

(original signed by:)
DAVID J. DAVIS
Director

Attachment

VARO LOUISVILLE
Benefits Inspection Division Visit

Recommendation 1. *The Louisville VA Regional Office Director develop and implement a plan to ensure staff follows policies and procedures associated with scheduling medical reexaminations.*

VARO Response: Concur.

The VARO will establish the Express team coach to be the point of contact and overseer of this workload. The VARO will provide a training class on Routine Future Exams in the First Quarter of FY2016. The IPR and IQR process will check for accuracy and error trends on this workload and the findings will be provided to the Quality and Training Committee (QTC) for further evaluation of training needs. Furthermore, Office of Field Operations (OFO) regularly provides listings to all VAROs of any claims requiring medical reexaminations and the VARO is now current on these claim types. The OIG review and findings consisted of historical cases and are not a reflection of our current workload processing.

Recommendation 2. *The Louisville VA Regional Office Director conduct a review of the 345 temporary 100 percent disability evaluations remaining from our inspection universe as of December 10, 2014, and take appropriate action.*

VARO Response: Concur.

The VARO will appoint a Rating Veterans Service Representative (RVSR) to review the 345 temporary 100 percent disability evaluations remaining from the inspection universe as of December 10, 2014, and take appropriate action. The review will be completed by December 31, 2015. The VARO does believe the recommendation is redundant as the VARO follows the national plan VBA developed in response to OIG report "Audit of 100 Percent Evaluations" dated January 24, 2011, which was accepted by OIG.

Recommendation 3. *The Louisville VA Regional Office Director develop and implement a plan to assess the effectiveness of higher-level Special Monthly Compensation training.*

VARO Response: Concur.

In February 2015, Systematic Technical Accuracy Review (STAR) staff provided classroom training for VARO staff that included examples highlighting the functionality of the SMC Calculator. Local Training was provided by the Quality Review Team (QRT) on June 16, 2015, with emphasis given to the second signature requirement for all higher level SMC.

The In Process Reviews (IPRs) conducted by QRT capture the effectiveness of the SMC training. The results of the IPRs are presented to the QTC monthly. These findings are used to determine the types of training the VARO needs.

Recommendation 4. *The Louisville VA Regional Office Director develop and implement a plan to assess the accuracy of secondary reviews involving higher-level Special Monthly Compensation and ancillary benefits.*

VARO Response: Concur.

The VARO will have the QRT Coach perform a monthly review on 5% of the secondary reviews involving Higher-level SMC and ancillary benefits. The findings will be communicated to the QTC monthly to identify additional training needs. Additionally, the accuracy of claims, including higher-level SMC and Ancillary benefits, is handled on a national level through STAR.

Recommendation 5. *The Louisville VA Regional Office Director implement a plan to ensure staff timely process claims related to benefits reductions to minimize improper payments to veterans.*

VARO Response: Concur.

The VARO currently has a plan to add additional resources to the Non-Rating Team in the FY2016. The Non-Rating Team handles the benefit reduction claims. The additional hiring was approved by OFO in FY2015. Subject to any competing mandates by CO, the additional staffing will allow the VARO to timely process this workload and minimize improper payments to veterans.

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	Nora Stokes, Director Kristine Abramo Robert Campbell Karen Cobb Casey Crump Ramon Figueroa Lee Giesbrecht Kerri Leggiero-Yglesias

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