

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Veterans Benefits Administration,

*Inspection of
VA Regional Office
St. Petersburg, Florida*

August 25, 2015
15-00001-436

ACRONYMS

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 the VA Regional Office, St. Petersburg, Florida

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and a Veterans Service Center in Wyoming, that provide services to veterans. We evaluated the St. Petersburg VARO to see how well it accomplishes this mission. OIG Benefits Inspectors conducted this work in January 2015.

What We Found

The St. Petersburg VARO did not consistently process two types of disability claims we reviewed. Overall, staff did not accurately process 17 of 90 disability claims (19 percent) reviewed. As a result, 54 improper monthly payments were made to 7 veterans totaling approximately \$44,900. We sampled claims that we considered at high risk of processing errors. Our results do not represent the accuracy of all claims processing at this VARO.

In our 2012 inspection report, the most frequent processing errors associated with temporary 100 percent disability evaluations occurred because management did not provide oversight to ensure staff entered suspense diaries as required. During this inspection, we did not identify similar errors. Therefore, we determined VBA's response to our previous recommendation was proactive and effective. We also reported in 2012 that TBI claims processing errors resulted from the use of insufficient medical examinations. We did not find similar issues and determined the VARO's actions in response to our previous recommendations were effective.

Staff established incorrect dates of claim in VBA's electronic systems for 4 of 30 claims. Further, staff did not correctly process 7 of 30 benefits reductions cases because management prioritized other workload higher.

What We Recommended

We recommended the Director: review the 1,717 temporary 100 percent disability evaluations pending as of October 8, 2014, and take appropriate action; provide training on establishing accurate dates of claim; improve the effectiveness of the second-signature review process for SMC; and ensure oversight and prioritization of benefits reductions cases. We also recommended the Under Secretary for Benefits direct VBA field offices to ensure timely processing of reminder notifications and prioritize benefits reductions.

Agency Comments

The Under Secretary for Benefits and VARO Director concurred with all recommendations. Management's planned actions are responsive and we will follow up as required.

A handwritten signature in black ink that reads "Brent E. Arronte".

Brent E. Arronte
Deputy 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 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 to ensure enhanced stewardship of financial benefits. We do not provide this information to require the VARO to adjust specific veterans' benefits. Processing any adjustments per this review is clearly a 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 St. Petersburg 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 Under Secretary for Benefits' comments on a draft of this report.
- Appendix D provides the St. Petersburg 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

St. Petersburg VARO Needs To Improve the Processing of Two Types of Disability Claims

The St. Petersburg VARO did not consistently process temporary 100 percent disability evaluations or entitlement to SMC and ancillary benefits. Overall, VARO staff incorrectly processed 17 of the total 90 disability claims we sampled, resulting in 54 improper monthly payments to 7 veterans totaling approximately \$44,900 at the time of our inspection in January 2015.

Table 1. St. Petersburg 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	4	4	8
TBI Claims	30	0	2	2
SMC and Ancillary Benefits	30	3	4	7
Total	90	7	10	17

Source: VA OIG analysis of the Veterans Benefits Administration’s temporary 100 percent disability evaluations paid at least 18 months, TBI disability and SMC and ancillary benefits claims completed October 1, 2013, through September 30, 2014

**Temporary
100 Percent
Disability
Evaluations**

VARO staff incorrectly processed 8 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 a 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 reduced compensation payments, Rating Veterans Service Representatives (RVSRs) must inform the beneficiary of the proposed reduction in benefits. In order to provide beneficiaries due process, VBA allows 60 days for the veteran to submit additional evidence to show that compensation payments should continue at their present level. 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 provide improved stewardship of taxpayer funds. Available evidence showed 4 of the 8 processing errors affected benefits and resulted in 12 improper monthly overpayments to 4 veterans totaling approximately \$23,800. These improper monthly benefits payments ranged from July 2014 to December 2014. Details on the errors affecting benefits follow.

- VSC staff received a reminder notification in March 2013 to review a veteran's temporary 100 percent evaluation for prostate cancer. The veteran was notified of the proposed reduction on February 25, 2014. However, after due process expired, staff did not take action to reduce the benefit until November 28, 2014. As a result, VA overpaid the veteran approximately \$8,500 over a period of 5 months. This was the most significant overpayment.

- In the second case, an RVSR proposed reducing the veteran's temporary 100 percent evaluation for prostate cancer to 20 percent disabling. The veteran was notified of the proposed reduction on April 10, 2014. After due process expired, staff did not take action to reduce the benefit until December 2, 2014. As a result, VA overpaid the veteran approximately \$7,700 over a period of 3 months.
- In another case, VSC staff received a reminder notification in September 2013 to review a veteran's temporary 100 percent evaluation for prostate cancer. The veteran was notified of the proposed reduction on April 15, 2014. After due process expired, staff did not take action to reduce the benefit until November 14, 2014. As a result, VA overpaid the veteran approximately \$5,600 over a period of 3 months.
- In the fourth case, VSC staff received a reminder notification in July 2013 to review a veteran's temporary 100 percent evaluation for prostate cancer. The veteran was notified of the proposed reduction on June 18, 2014. After due process expired, staff did not take action to reduce the benefit until September 19, 2014. As a result, VA overpaid the veteran approximately \$1,900 over a period of 1 month.

The remaining four of the eight total errors had the potential to affect veterans' benefits. Following are details on the four errors.

- In the first case, VSC staff received a reminder notification in February 2013 to evaluate a veteran's temporary 100 percent evaluation for a liver condition. Staff canceled the reminder notification on January 15, 2014, with no action taken. There was no control in place to review this temporary 100 percent disability. Until staff evaluate the veteran's condition to determine whether he continues to warrant a 100 percent evaluation, payments continue at the existing 100 percent disability rate and improper payments may occur. VSC management concurred with this error.
- In another case, VSC staff received a reminder notification in December 2013 to review a veteran's temporary 100 percent evaluation for prostate cancer. Staff did not take action until our onsite review in January 2015. Until staff evaluate the veteran's condition to determine whether he continues to warrant a 100 percent evaluation, payments continue at the existing 100 percent disability rate and improper payments may occur.
- VSC staff received a reminder notification in November 2013 to review a veteran's temporary 100 percent evaluation for bladder and prostate cancer conditions. Staff did not process the reminder notification until July 2014 and subsequently proposed reducing the

temporary evaluation in November 2014. We did not determine the potential monetary effect for this delay because the due process period had not yet expired at the time of our onsite review in January 2015.

- In the fourth case, VSC staff received a reminder notification in December 2013 to review a veteran's temporary 100 percent evaluation for prostate cancer. The veteran was notified of the proposed reduction on July 22, 2014. Staff had not taken action on the proposed reduction at the time of our review in January 2015. Because final action to reduce benefits would have occurred after our review, we did not determine the monetary impact.

Generally, errors occurred because VSC management did not prioritize management of temporary 100 percent disability claims. Management indicated and staff confirmed that VSC placed emphasis on processing other rating workloads. Without proper management of these claims, veterans may receive benefit payments in excess of their benefit entitlements. Since we reviewed 30 claims within our sample, we provided VSC management with the 1,717 claims remaining from our universe of 1,747 for review to determine if action is required.

In August 2014, in response to our *Follow-up Audit of VBA's 100 Percent Disability Evaluations* (Report No. 14-01686-185, June 6, 2014), VBA directed improvement in timeliness for follow-up actions related to temporary 100 percent disabilities. In September 2014, VBA's Southern Area Office notified the regional offices in its jurisdiction of a SharePoint application to assist the offices in identifying and prioritizing the temporary 100 percent workload. St. Petersburg VSC management then incorporated this workload into its Workload Management Plans. Guidance from VBA and the VARO's Workload Management Plans is to focus on this workload pending greater than 180 days. However, VBA policy states cases requiring reduction be processed on the 65th day following expiration of due process. In addition, staff should process reminder notifications within 30 days. Therefore, by focusing only on those cases pending greater than 180 days, direction by VBA is contrary to policy.

Supervisors we interviewed stated, and we verified, the VSC management analyst sends the temporary 100 percent SharePoint list to the supervisors requesting they process the cases as soon as possible. Their data reflect improvement in processing reminder notifications and processing reductions for temporary 100 percent disabilities. However, we could not verify the accuracy of that data because we cannot be certain any data we gather are identical to that of the VARO.

VARO management did not concur with the seven errors that we identified involving delays. Its response acknowledged that the VARO was not timely in processing the reductions stating, “The RO [Regional Office] must comply with the nationally-directed mandates involving workload management and it is not always able to dedicate the appropriate number of resources to address the instances described . . .” We disagree. It is a VBA management responsibility to address all of its workload requirements, including the actions explained above that have the potential to entail millions of dollars in improper payments. Where VBA lacks sufficient staff to properly address its management responsibilities, it should make its case for an increase in full-time equivalents through the normal budget process. Without appropriate priority for this type of work, delays in processing reductions result in unsound financial stewardship of veterans’ monetary benefits and a failure to minimize overpayments.

*Follow-Up to
Prior VA OIG
Inspection*

In our previous report, *Inspection of the VA Regional Office, St. Petersburg, Florida* (Report No. 11-04243-86, February 8, 2012), VARO staff incorrectly processed 25 of 30 temporary 100 percent disability evaluations we reviewed. The errors occurred because there was no oversight to ensure staff established suspense diaries in the electronic record. 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. As such, we made no specific recommendation for this VARO.

During this January 2015 inspection, we did not identify similar errors involving entering suspense diaries. Therefore, VBA’s response to our recommendation appears to be effective.

TBI Claims

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

In response to a recommendation in our previous 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 2 of 30 TBI claims—both inaccuracies had the potential to affect veterans' benefits. Summaries of the errors follow.

- In the first case, an RVSR prematurely denied a veteran's TBI claim without a VA medical examination to support the decision. Per VBA policy, VA will provide an examination if the evidence shows symptoms of a current disability, an in-service event, and a possible association between the symptoms and the event. Because the evidence showed trauma to the head with treatment during service and current complaints of headaches, VSC staff should have requested a medical examination. Without a VA examination, neither VARO staff nor we can determine whether the veteran would have been entitled to benefits.

VARO management non-concurred with this error. We noted a premature denial of TBI. Management responded that staff properly decided the claim and noted “. . . Although the veteran is competent to state he has headaches and there is an event in service...the veteran also has to indicate that the claimed disability or symptoms be associated with the established event in service . . .” We disagree because VBA regulations do not require the veteran to provide a link between a claimed disability and an event in service. Staff should have requested a medical examination or medical opinion because the veteran provided a competent lay statement of his disability. There was evidence of an in-service event, and there is a possible relationship between his current symptoms and the in-service event.

- In the second case, an RVSR granted service connection for a coexisting mental condition with TBI but did not properly update this action on the rating decision coded page. The error did not affect current monthly benefits. However, if left uncorrected, it could affect future benefits payments. VARO management concurred with this error.

During this onsite inspection, VSC quality staff showed us a newly created rating accuracy tracking mechanism that will assist with identifying rating deficiencies by individuals rather than by team or station. We received a demonstration of this tracking device, but due to its early stages of development, we could not assess its effectiveness. We determined VARO staff generally followed VBA policy when

processing TBI claims. Therefore, 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, St. Petersburg, Florida* (Report No. 11-04243-86, February 8, 2012), we determined processing errors associated with TBI claims resulted from the use of insufficient medical examination reports and inadequate quality oversight of evidence needed to support traumatic brain injury rating decisions. The VARO concurred with our recommendations to provide proper training focused on improving the consistency and accuracy of examination requests through quality reviews and training to ensure staff are returning insufficient medical examinations. The OIG closed these recommendations August 6, 2012, after the VARO provided documentation of the training.

During our January 2015 inspection, we did not identify errors where staff did not return an insufficient medical examination to the examiner for clarification. Therefore, we determined the VSC's actions in response to our previous recommendation have been effective.

***Special Monthly
Compensation
and Ancillary
Benefits***

As the concept of rating disabilities evolved, it was realized that for certain types of disabilities, the basic rate of compensation was not sufficient for the level of disability present. Therefore, SMC was established to recognize the severity of certain disabilities or combinations of disabilities by adding an 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 staff must consider when evaluating claims for SMC. Examples of ancillary benefits are:

- Dependents' Educational Assistance under Title 38, United States Code, Chapter 35
- Specially Adapted Housing Grant
- Special Home Adaptation Grant
- Automobile and Other Conveyance and Adaptive Equipment Allowance

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

VARO staff incorrectly processed 7 of 30 claims involving SMC and ancillary benefits—3 errors affected veterans' benefits and resulted in underpayments to veterans totaling approximately \$21,200. These errors represented 42 improper recurring monthly payments from August 2012 to December 2014. VARO management concurred with all errors we identified. Details on the errors affecting benefits follow.

- An RVSR did not grant an appropriate level of SMC for a veteran with loss of use of one elbow and one knee. As a result, VA underpaid the veteran approximately \$10,200 over a period of 28 months. This was the most significant underpayment.
- An RVSR assigned an incorrect level of SMC for a veteran with loss of use of one elbow and one knee. In addition, the RVSR used an incorrect effective date of August 23, 2013, and should have used May 31, 2013, the date medical evidence showed loss of use for both extremities. As a result, VA underpaid the veteran approximately \$6,800 over a period of 13 months.
- In another case, an RVSR assigned an incorrect effective date of November 21, 2013, for a disability with SMC. However, staff should have assigned an effective date of October 23, 2013, the date staff received the veteran's informal claim. VA considers an informal claim any type of communication or action indicating intent to apply for one or more benefits under the laws administered by the Department of Veterans Affairs. If a formal claim is received within 1 year of the date of the informal claim, VA considers the date of receipt of the informal claim as the effective

date of claim. As a result, VA underpaid the veteran approximately \$4,100 over a period of 1 month.

The remaining four of the seven total errors had potential to affect veterans' benefits. Following are details on the four errors.

- An RVSR prematurely increased the evaluation for a veteran's visual impairment and granted entitlement to SMC without a proper eye examination. Without the examination, neither VSC staff nor we could determine the correct level of the veteran's visual impairment and entitlement to SMC.
- An RVSR used incorrect SMC codes for a veteran entitled to regular and higher-level aid and attendance allowances. Although the error did not affect the veteran's current monthly benefits, the codes determine the veteran's monthly benefits payments if the veteran should become hospitalized at Government expense. As a result, VBA could reduce monthly payments incorrectly should hospitalization at Government expense occur.
- In another case, an RVSR prematurely granted loss of use of both feet and entitlement to SMC for a veteran without a VA examination. The VSC staff had previously scheduled the veteran for a VA examination. He missed the examination, but later contacted the VA and requested to be rescheduled; however, staff did not request the examination. Without a medical examination, the level of the veteran's disability and entitlement to SMC could not be determined.
- In the final case, an RVSR incorrectly granted entitlement to Dependents' Educational Assistance to a veteran who was not entitled to the benefit.

We did not notice a discernible trend or systemic issues in the SMC rating decisions that we reviewed because the errors varied. The VARO provided SMC training for staff in May 2012 and April 2013, and proposed to provide SMC training in fiscal year 2015.

However, VSC management has a policy requiring second-signature review of rating decisions involving higher levels of SMC. In the seven errors we identified, five had this additional level of review. Regardless, staff did not identify the errors we found. When asked why this occurred, interviews with management and staff provided several reasons that included production pressures, inconsistent or inadequate reviews, and working too fast to review these cases. If the second-signature review process was more effective it may have reduced the number of errors that we found. As a result, veterans did not always receive accurate benefits payments.

Recommendations

1. We recommended the St. Petersburg VA Regional Office Director conduct a review of the 1,717 temporary 100 percent disability evaluations remaining from our inspection universe as of October 8, 2014, and take appropriate action.
2. We recommended the Under Secretary for Benefits direct Veterans Benefits Administration field offices prioritize processing reminder notifications within 30 days as required.
3. We recommended the St. Petersburg VA Regional Office Director implement a plan to improve the effectiveness of the second-signature review process for special monthly compensation and ancillary benefits rating decisions.

Management Comments

The VARO Director concurred with our recommendations. The St. Petersburg VARO conducted a review of the 1,717 temporary 100 percent disability evaluations remaining as of October 8, 2014, and stated they have taken appropriate action on each of the cases as of July 6, 2015.

The St. Petersburg VARO completed training on Special Monthly Compensation and ancillary benefits to all journey-level Rating Veterans Service Representatives as of October 2014. We will also continue to provide requisite training on these issues as part of the annual mandatory training, with the next training scheduled for October 2015.

In addition, we have instructed our Quality Review Team to focus routine In-Process Reviews on these issues, to ensure comprehension and identify any further training needs. The targeted SMC In-Process Reviews are scheduled to begin on July 20, 2015. The Quality Review Team will dedicate 50 reviews per month to these types of ratings and all reviews will be tracked in the national Quality Assurance SharePoint. Errors will be analyzed and refresher training will be targeted at the employee level as well as the division level, in line with any trends discovered. These training actions and quality reviews aim to directly mitigate the concern and improve the effectiveness of the second signature review process for special monthly compensation and ancillary benefits rating decisions. The target completion date is October 31, 2016.

The Under Secretary for Benefits concurred and stated VBA has demonstrated its commitment to improving the processing of follow-up reviews for temporary 100 percent disability evaluations. Further, the Under Secretary stated VBA will continue to work to balance available

resources in order to maintain and increase its focus on timely processing of all temporary 100 percent reviews, to include achievement of the 30-day standard for processing reminder notifications. The target completion date is March 31, 2016.

OIG Response The Director's comments and actions are responsive to the recommendations.

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.

Finding 2 **St. Petersburg VARO Needs To Improve Date of Claim Accuracy**

VSC staff incorrectly established 4 of 30 dates of claim we reviewed in VBA's electronic systems of record. None of these errors affected the veterans' monthly benefits or had the potential to affect the veterans' benefits. However, incorrect dates of claim can misrepresent VBA performance measures and veterans' benefits entitlements. Details on these errors follow.

- In two cases, VSC staff used the date the veterans signed the application forms as the dates of claim instead of the earliest date stamp indicating when a VA facility received the form, as required.
- On May 30, 2014, the veteran submitted a claim for an increased evaluation for a service-connected disability. VSC staff did not address this claim. On July 17, 2014, the veteran submitted another claim for the same disability and VSC staff established this as the date of claim. However, the correct date of claim should be May 30, 2014, the earliest date VA received the veteran's claim for benefits.
- In the last case, on July 31, 2014, VSC staff completed a claim that they received on April 30, 2014. On June 12, 2014, VSC staff received an unrelated claim for additional disabilities, but did not address it. The correct date of claim should be April 30, 2014, because staff received the claim while another was still pending.

Generally, these errors occurred due to pressure to expedite processing a large volume of mail. Additionally, according to training records, the

VSC most recently conducted date of claim-related training in February 2014. Interviews with staff showed they felt they had to work as quickly as possible to process the large volume of mail and this pressure to produce resulted in the errors we found. Management we interviewed also stated that errors occurred because of employees working too quickly to process the large volume of mail.

VSC management told us it does not have a mechanism in place to measure the effectiveness of training provided. Because of using the incorrect dates of claim in the electronic systems, veterans may not have received benefits as entitled and there is an increased risk in misrepresenting the statistics of VARO performance.

Recommendation

4. We recommended the St. Petersburg VA Regional Office Director implement a plan to provide training and assess the effectiveness of that training, to ensure staff establish accurate dates of claim in the electronic systems.

Management Comments

The VARO Director concurred with our recommendation. The Quality Review Team examines date of claim establishment accuracy during quality reviews for each Veterans Service Center employee involved in claims processing, and each calendar year a Systematic Analysis of Operations (SAO) Date of Claim report is completed. We will continue these efforts to ensure accuracy of date of claim establishment, to assess the effectiveness of provided training, and identify any need for additional training. The Quality Review Team will conduct training in October 2015 to all employees on date of claim establishment and proper date stamp identification. The St. Petersburg management team will also conduct an audit of 50 claims each quarter to ensure comprehension of date of claim policy and training effectiveness. Target date for completion is October 2016.

OIG Response

The Director's comments and actions are responsive to the recommendation.

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. Such instances are attributable to VAROs not taking the actions required to ensure correct payments for the veterans' current 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 veteran does not provide additional evidence within that period, an RVSR must make a final determination to reduce or discontinue the benefit. On the 65th day following due process notification, action is required to reduce the evaluation and thereby minimize overpayments.

On April 3, 2014, VBA leadership modified its policy regarding the processing of claims requiring 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 3 St. Petersburg VARO Needs To Ensure Timely Action on Proposed Benefits Reductions

VSC staff delayed processing 7 of 30 cases involving proposed benefits reductions. Six of these errors affected veterans' benefits and one had the potential to affect a veteran's benefits. These errors occurred due to a lack of emphasis on timely processing this workload. Processing delays resulted in overpayments totaling approximately \$6,400, representing 17 improper monthly recurring payments to 5 veterans from February 2014 to December 2014. There were also underpayments totaling approximately \$1,900, representing 6 improper monthly recurring payments to 2 veterans from July 2014 to December 2014. In one case, there was both an overpayment and an underpayment. Details on the errors affecting benefits follow.

- In the first case, VSC staff sent a letter to a veteran on January 22, 2014, proposing to reduce the evaluation for his mental health condition; due process expired March 28, 2014. Staff did not take action to reduce the evaluation until September 2014. As a result, VA overpaid the veteran approximately \$2,500 over a period of 6 months. This case contained the most significant overpayment.
- VSC staff sent a letter to a veteran on September 18, 2013, proposing to reduce the evaluation for his Parkinson's disease; due process expired November 22, 2013. However, staff did not take action to reduce the evaluation until June 2014. Because of the delay, VA overpaid the veteran approximately \$1,600 over a period of 7 months. In addition, staff erroneously reduced the evaluation effective September 1, 2014, when the correct effective date was October 1, 2014. As a result, VA underpaid the veteran approximately \$229 for one month.
- In another case, VSC staff sent a letter to a veteran on April 10, 2014, proposing to reduce the evaluation for his heart condition; due process expired June 16, 2014. Staff did not take action to reduce the benefits until August 2014. As a result, VA overpaid the veteran approximately \$1,600 for a period of 2 months.
- VSC staff sent a letter to a veteran on April 14, 2014, proposing to reduce the evaluation for his mental health condition; due process expired June 18, 2014. Staff did not take action to reduce benefits until July 2014. As a result, VA overpaid the veteran approximately \$460 for a period of 1 month.
- In another case, VSC staff sent a letter to a veteran on April 29, 2014, proposing to reduce the evaluation for her right knee condition; due process expired July 3, 2014. Staff did not take action to reduce benefits until August 2014. As a result, VA overpaid the veteran approximately \$250 for a period of 1 month.
- In the final case, VSC staff sent a letter to a veteran on December 18, 2013, proposing to reduce his prostate cancer evaluation and discontinue SMC benefits due to failure to report for a medical reexamination. On December 20, 2013, the veteran notified VA of his willingness to report for reexamination. However, staff reduced the evaluation effective July 1, 2014, without a medical reexamination, as required by VBA policy. Because the veteran requested a reexamination within 30 days of the due process letter, staff should have rescheduled the examination prior to reducing the evaluation. As a result, VA underpaid the veteran approximately \$1,700 over a period of 5 months.

In the one case that had the potential to affect a veteran's benefits, VSC staff sent a letter to the veteran on January 14, 2013, proposing to reduce the evaluation for a right shoulder condition. On January 22, 2013, the VARO received the veteran's request for a hearing in response to the letter dated January 14, 2013. When a veteran submits a timely hearing request, VBA policy states benefits will continue until staff receive results from the hearing. However, on September 11, 2014, an RVSR reduced the evaluation effective December 1, 2014. We did not determine the monetary effect in this case because the final reduction occurred at the time of our file review in December 2014.

Generally, these delays occurred because VARO management did not prioritize this workload. This was confirmed during our interviews with management and staff. However, because of national changes to workload management, VSC leadership did not prioritize processing benefits reductions and concentrated instead on national priorities, including processing rating claims pending over 2 years. Both management and staff confirmed a lack of emphasis on timely following through with proposed rating reductions.

VARO management concurred with two of the seven errors that we identified and did not concur with the remaining five. For the five cases in which it disagreed, its response acknowledged that the VARO was not timely in processing the reductions stating, "The RO must comply with the nationally-directed mandates involving workload management and it is not always able to dedicate the appropriate number of resources to address the instances described. . . ."

We disagree. It is a VBA management responsibility to address all of its workload requirements, including the actions explained above that have the potential to entail millions of dollars in improper payments. Where VBA lacks sufficient staff to properly address its management responsibilities, it should make its case for an increase in full-time equivalents through the normal budget process. Without appropriate priority for this type of work, delays in processing reductions result in unsound financial stewardship of veterans' monetary benefits and a failure to minimize overpayments.

Recommendations

5. We recommended the St. Petersburg VA Regional Office Director implement a plan to ensure oversight and prioritization of benefits reductions cases.
6. We recommended the Under Secretary for Benefits direct Veterans Benefits Administration field offices to prioritize benefits reductions cases in order to minimize overpayments.

***Management
Comments***

The VARO Director concurred with our recommendations. The St. Petersburg VARO is directing a focus on completing the oldest rating related end product 600 cases with past due suspense dates. We have incorporated this effort into our local workload management plan, effective immediately. The target completion date is March 31, 2016.

The Under Secretary for Benefits concurred and stated VBA will develop a workload management plan to process benefit reduction cases more timely in FY 2016. The target completion date is October 31, 2015.

OIG Response

The Director's comments and actions are responsive to the recommendation.

Appendix A VARO Profile and Scope of Inspection

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

Resources As of December 2014, the St. Petersburg VARO reported a staffing level of 921.8 full-time employees. Of this total, the VSC had 704.9 employees assigned.

Workload As of December 2014, VBA reported the St. Petersburg VARO had 28,236 pending compensation claims pending with 18,228 (65 percent) pending greater than 125 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. In January 2015, we evaluated the St. Petersburg VARO to see how well it accomplishes this mission.

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

Our review included 30 of 1,747 temporary 100 percent disability evaluations (2 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 October 8, 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 1,717 claims remaining from our universe of 1,747 claims as of October 8, 2014, for review. We reviewed 30 of 658 disability claims related to TBI (5 percent) and 30 of 175 claims involving entitlement to SMC and ancillary benefits (17 percent) completed by VARO staff during fiscal year 2014.

We reviewed 30 of 14,920 dates of claim recorded in VBA's Corporate Database from July through September 2014 as of October 8, 2014. Additionally, we looked at 30 of 1,260 completed claims (2 percent)

that proposed reductions in benefits from July through September 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 150 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.

This report references VBA's Systematic Technical Accuracy Review data. As reported by VBA's Systematic Technical Accuracy Review program as of December 2014, the overall claims-based accuracy of the VARO's compensation rating-related decisions was 90 percent. We did not test the reliability of this data.

Inspection Standards

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

Appendix B Inspection Summary

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

Table 2. St. Petersburg 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)), (38 CFR 3.400), (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)	No
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 Under Secretary for Benefits Comments

Department of Veterans Affairs

Memorandum

Date: July 29, 2015
From: Under Secretary for Benefits (20)
Subj: OIG Draft Report - Inspection of the VA Regional Office, St. Petersburg, Florida
To: Assistant Inspector General for Audits and Evaluations (52)

1. Attached is VBA's response to recommendations 2 and 6 for the OIG Draft Report: *Inspection of the VA Regional Office, St. Petersburg, Florida*
2. Please refer questions to Christopher Denno, Lead Program Analyst

(original signed by:)
Allison A. Hickey

Attachment

Attachment

**Veterans Benefits Administration (VBA) Comments on OIG
Draft Report
Inspection of the VA Regional Office St. Petersburg, Florida**

VBA provides the following comments in response to the recommendation:

Recommendation 2: We recommended the Under Secretary for Benefits direct Veterans Benefits Administration field offices prioritize processing reminder notifications within 30 days as required.

VBA Response: Concur. VBA has demonstrated its commitment to improving the processing of follow-up review examinations for Veterans awarded temporary 100-percent disability evaluations. Since February 2014, VBA has reduced the number of temporary 100-percent reviews pending longer than 180 days by 99 percent. VBA has also improved the timeliness of temporary 100-percent reviews by 277 days since February 2014.

VBA will continue to work to balance available resources in order to maintain and increase its focus on timely processing of all temporary 100-percent reviews, to include achievement of the 30-day standard for processing reminder notifications.

Target Completion Date: March 31, 2016

Recommendation 6: We recommended the Under Secretary for Benefits direct Veterans Benefits Administration field offices to prioritize benefits reductions cases in order to minimize overpayments.

VBA Response: Concur. As VBA continues to receive and complete record numbers of disability rating claims, the result is corresponding increases in the volumes of non-rating claims (to include benefit reduction cases). VBA completed 2.7 million non-rating end products in fiscal year (FY) 2014, the highest production of non-rating work in 20 years and 50 percent more than in FY 2011. Furthermore, VBA completed almost 2.5 million non-rating end products in FY 2015 (through June 30, 2015). This represents a 21-percent improvement over the same period last year.

VBA continues to work to improve all aspects of the claims process for Veterans. Utilizing the increased funding for FTE received in 2015, VBA hired additional temporary non-rating employees. Receipt of VBA's FY 2016 request for funds to support an additional 320 non-rating FTE will allow VBA to retain these temporary employees and convert them to permanent positions. However, VBA has identified a need for 625 additional FTE to bring the non-rating workload to a steady-state inventory in FY 2017.

Within available resources, VBA will develop a workload management plan to process benefit reduction cases more timely in FY 2016.

Target completion date: October 31, 2015

Appendix D VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: July 17, 2015
From: Director, VA Regional Office St. Petersburg, Florida
Subj: Inspection of the VA Regional Office, St. Petersburg, Florida
To: Assistant Inspector General for Audits and Evaluations (52)

1. Please see the attached St. Petersburg Regional Office responses to the draft June 2015 Office of Inspector General report recommendations.
2. Please refer questions to Craig Sergott, Assistant Director, at (727) 319-5911 or VAVBASPT/RO/DIR DIR.VBASPT@va.gov.

(original signed by:)

Kerrie L. Witty, Director

Attachment

Attachment

Regional Office Responses to Office of Inspector General Recommendations (June 2015 Report)

Prepared by the St. Petersburg VA Regional Office
July 17, 2015

Recommendation 1 (p11):

We recommended the St. Petersburg VA Regional Office Director conduct a review of the 1,717 temporary 100 percent disability evaluations remaining from our inspection universe as of October 8, 2014, and take appropriate action.

Response to Recommendation 1:

RO Response:

Concur. The St. Petersburg Regional Office completed its review of the noted temporary 100 percent disability evaluations and determined that only 74 of these cases remained pending. By July 6, 2015, the St. Petersburg Regional Office reviewed and took appropriate action on each of the remaining cases.

In addition, our office continues to adhere to the VA national workload plan, which requires stations to timely address all temporary 100 percent disability evaluations within 180 days of establishment. Locally, we track these cases in a dedicated SharePoint site, which is reviewed by division level management monthly to ensure they receive proper attention and action. We request closure of this recommendation.

Recommendation 3 (p11):

We recommended the St. Petersburg VA Regional Office Director implement a plan to improve the effectiveness of the second-signature review process for special monthly compensation and ancillary benefits rating decisions.

Response to Recommendation 3:

RO Response:

Concur. The St. Petersburg Regional Office completed training on Special Monthly Compensation (SMC) and ancillary benefits to all journey-level Rating Veterans Service Representatives

(RVSRs) in October 2014. The Regional Office will also continue to provide requisite training on these issues as part of the annual mandatory training curriculum; the next related training on SMC is scheduled for October 2015.

In addition, we have instructed our Quality Review Team to focus routine In-Process Reviews (IPRs) on these issues, to ensure comprehension and identify any further training needs. The targeted SMC IPRs are scheduled to begin on July 20, 2015. The Quality Review Team will dedicate 50 reviews per month to these types of ratings. All reviews will be tracked in the national *Quality Assurance SharePoint*. Errors will be analyzed and refresher training will be targeted at the employee level as well as the division level, in line with any trends discovered. These training actions and quality reviews aim to directly mitigate the concern and improve the effectiveness of the second-signature review process for special monthly compensation and ancillary benefits rating decisions.

Target completion date: October 31, 2016

Recommendation 4 (p13):

We recommended the St. Petersburg VA Regional Office Director implement a plan to provide training and assess the effectiveness of that training, to ensure staff establish accurate dates of claim in the electronic systems.

Response to Recommendation 4:

RO Response:

Concur. Each month our Quality Review Team completes five random quality reviews for each Veterans Service Center employee involved in claims processing. During such reviews, date of claim establishment accuracy is examined. In addition, a "Date of Claim" Systematic Analysis of Operations (SAO) report is completed once per calendar year, assessing date of claim accuracy on a more general level. The most recent SAO was completed in March 2015. This report also examines associated issues and, as needed, mitigating measures, such as training. We will continue these efforts to ensure the accuracy of date of claim establishment, to assess the effectiveness of provided training specific to the issue, and to identify any need for additional training. Also, currently planned for October 2015, our Quality Review Team will conduct training to all employees on date of claim establishment and proper date stamp identification.

Each quarter, starting in October 2015, the St. Petersburg management team will also conduct an audit of 50 claims to ensure comprehension of date of claim policy and training effectiveness.

Target completion date: October 31, 2016

Recommendation 5 (p17):

We recommended the St. Petersburg VA Regional Office Director implement a plan to ensure oversight and prioritization of benefits reductions cases.

Response to Recommendation 5:

RO Response:

Concur. The St. Petersburg Regional Office is directing a focus on completing the oldest rating related end product 600 cases (benefits reduction cases), with past due suspense dates. This effort has been incorporated into our local workload management plan and is effective immediately. This will ensure that all management members are aware of the prioritization on these claims. As of July 16, our percentage of past due cases in this category is at 37 percent. With a systematic approach, we anticipate that we will be able to reduce this to 18 percent by March 31, 2016. Divisional level management will oversee the effort and track monthly progress via VETSNET Operations Reports.

Target completion date: March 31, 2016

Appendix E **OIG Contact and Staff Acknowledgments**

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Brent Arronte, <i>Director</i> Ed Akitomo Jason Boyd Yolanda Dunmore Michelle Elliott David Piña Rachel Stroup Dana Sullivan Nelvy Viguera Butler
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