



Office of Inspector General

REVIEW OF COMPENSATION AND PENSION MEDICAL EXAMINATION SERVICES

*By establishing performance
measures and working together the
VBA and the VHA can improve the
completion rate of C&P medical
examinations.*

Report No. 7R1-A02-114

Date: August 6, 1997

Office of Inspector General
Washington DC 20420



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to:
Under Secretary for Health (10)
Acting Under Secretary for Benefits (20)

Review of: Compensation and Pension Medical Examination Services

1. The Office of Inspector General (OIG) conducted a review of medical examination services provided by the Department of Veterans Affairs (VA) to veterans with pending compensation and pension (C&P) disability claims. The purpose of the review was to follow-up on the status of implementation of recommendations contained in *Report of Audit, Timeliness of C&P Medical Examination Services*, dated July 11, 1994, and to identify whether additional opportunities exist to further enhance the quality and timeliness of medical examination services.
2. VA's C&P benefit programs are administered by the Veterans Benefits Administration (VBA). Veterans Health Administration (VHA) medical facilities assist the VBA by conducting medical examinations of veterans with pending C&P claims. Proper accomplishment of medical examination services is important because VBA field facilities, VA Regional Offices (VAROs), cannot properly complete actions on veterans' claims until the requested examination results are furnished. When an examination is not performed (examination request returned to VARO as incomplete), the veteran must have another examination scheduled which prolongs the processing of his/her claim and requires reprocessing by both the VBA and the VHA.
3. On July 11, 1994, OIG issued a report which found that the VBA and the VHA had an opportunity to increase the rate of examinations completed and thereby improve C&P examination services. VBA and VHA management agreed to recommended actions to jointly improve coordination and communication among VBA and VHA facilities, and veterans, and to implement better examination processing procedures. In December 1994, the Under Secretary for Benefits and the Under Secretary for Health executed a Memorandum of Understanding (MOU) on processing C&P examination requests, subsequently published as VHA Directive 10-95-023. The MOU included:

- Reaffirmation of the standard 35 calendar day average for VHA facilities to complete medical exams with monitoring requirements to ensure compliance.
 - Requiring VHA facilities, when a veteran fails to keep an initial scheduled C&P appointment, to call the veteran to reschedule a second appointment. The 35 day "time clock" would be suspended for the period between the initial missed appointment and the date of the rescheduled appointment. Exam requests are to be returned to the VARO as incomplete if the veteran fails to keep the rescheduled appointment.
 - A quality standard that no more than 3 percent of the exam reports completed each month at each VHA facility are determined by VAROs to be insufficient for rating purposes. This 3 percent requirement was also added to the VHA directors' performance standards.
4. Notwithstanding management's efforts to improve examination services, we found that the percentage of incomplete examinations had not changed significantly between the period of our prior review in Fiscal Year (FY) 1993, and FY 1996:

<u>FY 1993</u>	<u>FY 1996</u>
405,000 exam requests processed	361,000 exam requests processed
310,000 (76.5 percent) completed	282,000 (78.1 percent) completed
95,000 (23.5 percent) incomplete	79,000 (21.9 percent) incomplete

5. Our review focused on 6,238 examination requests that were returned to VAROs as incomplete during March 1996. We selected a statistical sample of 147 cases for review of veterans' C&P claims folders and pertinent VHA records. Based on the results of our review, we identified opportunities to reduce the percentage of incomplete examinations in 89 (60 percent) of the cases. We estimate that 3,777 of the 6,238 examination requests returned as incomplete during March 1996, could have been prevented by improving coordination and communication among VBA and VHA facilities and veterans, and rescheduling examinations after an initial appointment is missed.
6. During the review, we found VBA and VHA management had addressed recommendations contained in the prior OIG audit and continue to address C&P issues through joint task forces. Management had established and was monitoring the achievement of specific performance measures to improve the timeliness and quality of completed exams. As a result, during FY 1996 average timeliness for completed

examinations was reduced to 30.4 days and the percentage of insufficient examinations was 3.1 percent, nearing the 3 percent goal. However, VBA and VHA management's corrective actions in response to our previous audit were only marginally successful in reducing the percentage of incomplete examinations. While emphasis was placed on maintaining timeliness and improving quality of completed examinations, specific performance measures to prevent and reduce the percent of incomplete medical exams returned to VAROs for reprocessing had not been established.

7. Despite having no benchmarks or performance measures to improve the rate of incomplete exams, we noted that several VAROs and VHA facilities have implemented innovative procedures to enhance timeliness and quality of completed examinations and reduce the percentage of incomplete examinations. For example, by working together VBA and VHA facility directors in Oklahoma have achieved success in reducing the number of incomplete examinations to 10 percent by increasing communication and cooperation among management, staff, veterans service organizations, and veterans. By establishing and monitoring performance measures designed to achieve improvement in the rate of incomplete examinations, requiring local facility directors to work together to reduce the percentage of incomplete examinations, and requiring VHA facilities to reschedule examinations as required, the quality and timeliness of examination services provided to veterans can be further improved.

8. We recommended that:

a. The Under Secretary for Benefits and the Under Secretary for Health improve the quality and timeliness of C&P examination services by:

- (1) Establishing performance measures for their field facilities, with the objective of improving the rate of incomplete examinations.
- (2) Requiring VBA Area Directors and VISN Directors to monitor progress in reducing the percentage of incomplete examinations.
- (3) Requiring VBA and VHA facility directors to work together to reduce the percentage of incomplete examinations.

b. The Under Secretary for Health require VHA facilities to comply with requirements to reschedule examinations when veterans miss an initial appointment.

9. The Under Secretary for Health and the Acting Under Secretary for Benefits concurred in principle with the recommendations and provided acceptable implementation plans. We consider all issues resolved. However, we will follow up on the implementation of planned corrective actions.

For the Assistant Inspector General for Auditing,

(Original signed by:)

THOMAS L. CARGILL, JR.

Director, Bedford Audit Operations Division

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RESULTS AND RECOMMENDATIONS

VBA and VHA Can Reduce the Percentage of Incomplete Examinations

Our review of the Department of Veterans Affairs (VA) Veterans Benefits Administration's (VBA) and Veterans Health Administration's (VHA) Compensation and Pension (C&P) examination services showed that the percentage of incomplete examinations could be reduced and the timeliness and quality of examination services further improved. Notwithstanding management's efforts to improve examination services, the 23.5 percent rate of incomplete examinations that occurred during the period of our prior review in Fiscal Year (FY) 1993, had declined only 1.6 percent during FY 1996. Based on the results of a statistical sample, we estimate that 3,777 (60 percent) of the 6,238 examination requests returned incomplete during March 1996 could have been completed by improving coordination and communication among VBA and VHA facilities and veterans, and giving veterans a second chance by rescheduling exams when an initial appointment is missed. By establishing and monitoring performance measures designed to achieve improvement in the rate of incomplete examinations, requiring local VBA and VHA facility directors to work together to reduce the percentage of incomplete examinations, and requiring VHA facilities to reschedule examinations as required, the quality and timeliness of examination services provided to veterans can be further improved.

Background

VA's C&P benefit programs are administered by the VBA. VHA medical facilities assist the VBA by conducting medical examinations of veterans with pending C&P claims. Proper accomplishment of medical examination services is important because VBA field facilities, VA Regional Offices (VAROs), cannot properly complete actions on veterans' claims until the requested examination results are furnished. When an examination is not performed (examination request returned to VARO as incomplete), the veteran must have another examination scheduled which prolongs the processing of his/her claim and requires reprocessing by both the VBA and the VHA.

On July 11, 1994, OIG issued *Report of Audit, Timeliness of C&P Medical Examination Services*, which found that the VBA and the VHA had an opportunity to significantly increase the rate of examinations completed and thereby improve the overall timeliness of C&P examinations, reduce unnecessary delays and inconvenience to veterans, and avoid unnecessary reprocessing of pending claims. We recommended that the VBA and the VHA take joint action to increase the rate of medical examinations completed by (a) improving coordination/communication between the VBA and the VHA, (b) improving procedures for notifying veterans of their examination appointments, (c) requiring medical facilities to attempt to reschedule examinations at least once before returning

unperformed examinations to the VARO when veterans fail to report for their originally scheduled examinations, and (d) collecting and sharing better examination processing procedures developed by local VBA and VHA facilities testing innovative case management techniques. The VBA and the VHA responded that they would work together to improve timeliness and prevent "incomplete" exams (*see Appendix I, page 8 for details*).

Notwithstanding management's efforts to improve examination services, little progress had been made to reduce the percentage of incomplete examinations between the period of our prior review in FY 1993, and FY 1996:

<u>FY 1993</u>	<u>FY 1996</u>
405,000 exam requests processed	361,000 exam requests processed
310,000 (76.5 percent) completed	282,000 (78.1 percent) completed
95,000 (23.5 percent) incomplete	79,000 (21.9 percent) incomplete

During the review, we found VBA and VHA management had addressed recommendations contained in the prior OIG audit and continue to address C&P issues through joint task forces. Management had established and was monitoring the achievement of specific performance measures to improve the timeliness and quality of completed exams. As a result, during FY 1996 average timeliness for completed examinations was reduced to 30.4 days and the percentage of insufficient examinations was 3.1 percent, nearing the 3 percent goal. However, VBA and VHA management's corrective actions in response to our previous audit were only marginally successful in reducing the percentage of incomplete examinations. While emphasis was placed on maintaining timeliness and improving quality of completed examinations, specific performance measures to prevent and reduce the percent of incomplete medical exams returned to VAROs for reprocessing had not been established.

Audit Results Show 60 Percent of Examinations Not Performed Could Have Been Completed

Our review focused on 6,238 examination requests that were returned to VAROs as incomplete during March 1996. We selected a statistical sample of 147 cases for review of veterans' C&P claims folders and pertinent VHA records. Based on the results of our review, we identified opportunities to reduce the percentage of incomplete examinations in 89 (60 percent) of the cases. We estimate that 3,777 of the 6,238 examination requests returned incomplete during March 1996 could have been prevented by improving coordination and communication among VBA and VHA facilities and veterans, and enhancing compliance with the requirement to reschedule examinations after an initial appointment is missed (*see Appendix III, page 11 for details*).

We found in 48 of the cases sampled examinations could have been completed by improving communication, coordination and procedures for scheduling and notifying veterans of examinations. In 41 cases, examinations could have been completed by allowing veterans' missed appointments to be rescheduled at least once. The remaining 58 cases were generally beyond the control of VA.

Increased Communication and Coordination Among VBA, VHA and Veterans Can Result in Completed Examinations

We identified 48 cases (32.6 percent) where improved communication, coordination and procedures could have resulted in the completion of the original exam request:

- 29 cases where an incorrect address was used to notify the veteran of an appointment when the correct address was available,
- 9 cases where exam requests were sent to the wrong clinic of jurisdiction, and
- 10 cases involving a variety of situations where better communication and coordination between the VA parties and the veteran could have resulted in completed examinations and a more satisfied veteran.

For example: A VARO request for an eye examination was received at the VAMC on February 23, 1996. The VARO request did not provide the veteran's current address, although the VARO had the correct address. The VAMC scheduled the exam for March 8, 1996 and mailed notification to their address of record (an incorrect address). The VAMC correctly scheduled the exam and rescheduled a second chance examination for March 28, 1996. Again, the appointment notice was sent to an incorrect address. The exam was returned incomplete for Failure to Report to the VARO on March 28 and the veteran's claim for benefits was denied. On June 7, 1996, the veteran resubmitted his claim to the VARO, saying he had not received his examination appointment notices. The examination was rescheduled and properly conducted on July 18, 1996. Based on the examination, the VARO awarded the veteran monthly compensation totaling \$391 on November 18, 1996. If the VARO had furnished the VAMC the veteran's correct address, a 4 month delay in awarding benefits and the additional claims processing between the VARO and the VAMC could have been avoided.

Not Adhering to the Rescheduling Requirement Delays the Benefit Decision

We identified 41 cases (27.8 percent) in which the medical facilities failed to reschedule a second exam when the initial exam was missed. Failure to reschedule the exam results

in the veteran having to resubmit his/her claim, and the VARO having to resubmit an exam request. Giving the veteran a second chance notification may have prevented return of an examination request and delays in acting on benefit claims.

For example: The VARO submitted a C&P exam request to the VAMC on March 7, 1996. The VAMC appropriately scheduled the examination and notified the veteran of the appointment for March 26, 1996. The examination was returned to the VARO as Failed to Report on March 26. The VAMC did not contact the veteran or reschedule an appointment to make up for the missed exam. When the veteran called April 8, 1996 requesting to reschedule an appointment, the VAMC referred him back to the VARO to resubmit an exam request. The exam was completed June 15, 1996 resulting in an 80 day delay, and causing the VARO and VAMC to process the exam request twice before completing action on the veteran's monthly award of \$314.

VBA and VHA Facility Directors Have Reduced Incomplete Exams by Working Together

Our review of information submitted by the VAMCs on C&P exams, for the month of March 1996, showed that the Muskogee and Oklahoma City VAMCs percentages of incomplete C&P exams were among the lowest in the nation. Only 1 percent of exams in Muskogee and 10 percent in Oklahoma City were incomplete.

Facility directors from VARO Muskogee and VAMCs Muskogee and Oklahoma City have achieved success in reducing the number of incomplete examinations by increasing communication and cooperation among management, staff, veterans service organizations, and veterans. A task force consisting of staff from the three Oklahoma facilities was formed in late 1992. The task force, comprising VARO Rating Specialists, C&P Program Clerks, VAMC Medical Administration Service (MAS) personnel and physicians, opened effective lines of communication and established a spirit of cooperation that has resulted in the low number of incomplete exams. The task force members meet "face to face" once a month, and also hold a teleconference monthly. Staff members involved in the C&P exam process call each other when problems arise. The task force developed a pamphlet which explains the C&P exam process to the patient. They also developed a handbook to assist physicians performing C&P exams.

New York Facilities Established a Walk-in Clinic

In March 1997, a C&P Examination Unit was opened which is physically located at the VARO New York. The exam unit was designed to accommodate "homeless" as well as "walk-in" pension or compensation applicants and is staffed by VAMC and VARO

personnel. The veteran claimant can be scheduled for a same day appointment in the Exam Unit or for a future date at either the Exam Unit or the VAMC. The veteran is given the opportunity to speak with a VARO Case Manager and VA Health Staff before and after the examination. The veteran is also given an “expectation sheet” which explains the C&P claims procedure.

Conclusion

The review found that an estimated 3,777 (60 percent) of the 6,238 examinations not performed during March 1996 could have been completed. In our opinion, the examinations returned incomplete could have been prevented by improving coordination and communication among VBA and VHA facilities and veterans, and enhancing compliance with the requirement to reschedule examinations after an initial appointment is missed. Communication and coordination between the VAROs and VAMCs to resolve problems will allow more examinations to be completed. Communication with the veteran to explain the medical examination process will assure and hasten the completion of the C&P process. The intended perception for the veteran of “one VA” will be a reality, and VA will have benefited in the completion and timely delivery of necessary services at the lowest cost.

By establishing and monitoring performance measures designed to achieve improvement in the rate of incomplete examinations, requiring local facility directors to work together to reduce the percentage of incomplete examinations, and requiring VHA facilities to reschedule examinations as required, the quality and timeliness of examination services provided to veterans can be further improved.

Recommendations

We recommend that:

1. The Under Secretary for Benefits and the Under Secretary for Health improve the quality and timeliness of C&P examination services by:
 - a. Establishing performance measures for their field facilities, with the objective of improving the rate of incomplete examinations.
 - b. Requiring VBA Area Directors and VISN Directors to monitor progress in reducing the percentage of incomplete examinations.
 - c. Requiring VBA and VHA facility directors to work together to reduce the percentage of incomplete examinations.
2. The Under Secretary for Health require VHA facilities to comply with requirements to reschedule examinations when veterans miss an initial appointment.

Under Secretary for Health Comments

The Under Secretary concurred with the findings and in principle with the recommendations. The Under Secretary also stated that, to achieve real improvement, the C&P examination process must be reengineered. The Under Secretary has requested the Under Secretary for Benefits and the Assistant Secretary for Policy and Planning to assist the VHA in reengineering the C&P examination process.

Implementation Plan

The Under Secretary provided an implementation plan which addressed each recommendation. *(See Appendix IV on page 12 for the full text of the Under Secretary's comments).*

Office of Inspector General Comments

The implementation plan is acceptable and we consider all issues resolved. However, we will follow up on planned corrective actions.

Acting Under Secretary for Benefits Comments

The Acting Under Secretary concurred in principle with the recommendations and stated the entire C&P examination process is of great concern to the VBA. The Acting Under Secretary also stated the VBA was working with the VHA and the Office of Policy and Planning to address C&P examination processing issues.

Implementation Plan

The Acting Under Secretary for Benefits provided acceptable implementation plans for Recommendations 1a, 1b, and 1c which applied to the VBA. (*See Appendix V on page 15 for the full text of the Acting Under Secretary's comments*).

Office of Inspector General Comments

The implementation plan is acceptable and we consider all issues resolved. However, we will follow up on planned corrective actions.

BACKGROUND

Disability benefit payments are based, in part, on interpretations of medical evidence by the Veterans Benefits Administration (VBA) disability rating specialists. That evidence is developed by physicians employed or supervised by the Veterans Health Administration (VHA), in the form of compensation and pension (C&P) examinations. Examination timeliness and adequacy are significant quality of service indicators since the VBA cannot complete payment action on veterans' disability claims until examination results are received. When an examination is not performed (exam request returned to the VBA as incomplete) or is insufficient for rating purposes, the veteran must have another examination scheduled which can result in significant claim processing delays, inconvenience to veterans, and additional costs to VA.

On July 11, 1994, OIG issued *Report of Audit, Timeliness of C&P Medical Examination Services*, which found that the VBA and the VHA had an opportunity to significantly increase the rate of examinations completed and thereby improve the overall timeliness of C&P examinations, reduce unnecessary delays and inconvenience to veterans, and avoid unnecessary reprocessing of pending claims. We recommended that the VBA and the VHA take joint action to increase the rate of medical examinations completed by (a) improving coordination/communication between the VBA and the VHA, (b) improving procedures for notifying veterans of their examination appointments, (c) requiring medical facilities to attempt to reschedule examinations at least once before returning unperformed examinations to the VARO when veterans fail to report for their originally scheduled examinations, and (d) collecting and sharing better examination processing procedures developed by local VBA and VHA facilities testing innovative case management techniques.

The VBA and the VHA responded that they would work together to improve timeliness and prevent "incomplete" exams. Implementation plans included:

- Various options for notification of veterans of appointments and follow-up of missed appointments.
- Efforts to improve communication between the VBA, the VHA, and the veteran on the various portions of the C&P exam process.
- Enhancement of the Automated Medical Information Exchange (AMIE) exam process.

- Establishment of physician coordinators at VACO, medical centers and regional offices.
- Establishment of a joint VBA/VHA education and training effort on C&P examinations.

In December 1994, the Under Secretary for Benefits and the Under Secretary for Health executed a Memorandum of Understanding (MOU) on processing C&P examination requests, subsequently published as VHA Directive 10-95-023, dated March 3, 1995.

The MOU indicated that when a veteran submits a claim for C&P benefits, the VBA and the VHA have a shared set of responsibilities to ensure: (a) The veteran receives service of the highest quality; (b) The veteran is moved through the claims process as rapidly as possible and with little, if any, inconvenience; and (c) The veteran's perception shall be that he/she is dealing with one VA. The MOU's provisions included:

- Reaffirmation of the standard 35 calendar day average for VHA facilities to complete medical exams.
- Monthly reports to VBA and VHA managers listing processing times for all facilities with requirements for VAMC and VARO Directors to coordinate corrective action when a medical facility fails to meet the 35 calendar day standard for two consecutive months.
- Requiring VHA facilities, when a veteran fails to keep an initial scheduled C&P appointment, to call the veteran to reschedule a second appointment. The 35 day "time clock" would be suspended for the period between the initial missed appointment and the date of the rescheduled appointment. Exam requests are to be returned to the VARO as incomplete if the veteran fails to keep the rescheduled appointment.
- No more than 3 percent of the exam reports completed each month at each VAMC are determined by VAROs to be insufficient for rating purposes. This 3 percent requirement was also added to the VHA directors' performance standards.

The VBA and the VHA had not established benchmarks or performance measures to reduce the percentage of incomplete examinations.

OBJECTIVES, SCOPE AND METHODOLOGY

Objectives

The purpose of this review was to conduct a follow-up on the status of implementation of recommendations contained in *Report of Audit, Timeliness of C&P Medical Examination Services*, dated July 11, 1994, and identify whether additional opportunities exist to further enhance the quality and timeliness of medical exam services.

Scope and Methodology

We obtained a universe of 6,238 incomplete compensation and pension examinations (C&P) examinations for March 1996 from VHA facilities. We also performed the following:

- Reviewed the applicable VBA/VHA policy and procedures for C&P examinations.
- Discussed the scope, our review process and findings at various stages of the review with VBA, VHA, Board of Veterans Appeals, and Assistant Secretary for Management officials.
- Statistically sampled 147 of the 6,238 incomplete examinations for March 1996.
- Reviewed veterans' claims folders and pertinent VHA records for the 147 cases sampled.
- Visited three VBA Regional Offices and four VA Medical Centers to test policies and procedures.

The review was conducted in accordance with government auditing standards for qualifications, independence, and due professional care.

DETAILS OF REVIEW

Sampling Plan and Results

Review Universe

Our review universe was created from VHA facility responses to an issued OIG request for a listing of incomplete compensation and pension medical examinations for the period March 1996. Responses from 139 VHA facilities contained a universe of 6,238 incomplete exams for March 1996 (18 facilities had deleted their March 1996 incomplete exam records).

Sample Design

The sample included 147 randomly selected cases and was based on a non-stratified sampling design at a 95 percent confidence level. We validated the C&P incomplete examination data by verifying the information in the VAROs' claims folders and the VAMCs' patient data base.

Sample Results

We found in 89 (60 percent) of the 147 cases sampled, there were opportunities to reduce the number of incomplete examinations. In 48 cases, improved communication and coordination between the VAROs and VAMCs could have resulted in the completion of the original examination request. In 41 cases, returning examination requests could have been avoided by rescheduling the examination as required by VHA policy. We estimate that 3,777 (60 percent) of the 6,238 examinations returned incomplete during March 1996 could have been completed.

MEMORANDUM FROM THE UNDER SECRETARY FOR HEALTH
DATED JULY 23, 1997

Department of
Veterans Affairs

Memorandum

Date: July 24, 1997

From: Under Secretary for Health (10/105E)

Subj: *OIG Draft Report, Review of Compensation and Pension (C&P) Medical Examination Services*

To: Assistant Inspector General for Auditing (52)

1. The draft report was reviewed by appropriate Veterans Health Administration (VHA) program offices and we concur with your report findings and concur in principle with the recommendations. We recognize that providing C&P exams is one of our most basic services, one which not only directly affects veterans, but also is a direct reflection of our ability to provide high quality service to potential new VA users. Facilities and Veterans Integrated Service Networks (VISNs) have tried different approaches, with varying degrees of success, to reduce the number of insufficient and incomplete exams. We appreciate your acknowledgement of the success of our performance measures to improve the timeliness and quality of completed exams, reducing the percentage of insufficient exams to 3.1 percent, which nearly meets the stated goal of 3 percent. As your report shows, however, despite our success in reducing the percentage of insufficient exams, the C&P examination process still needs significant improvement. Based on our own efforts, several other studies and now your report, it is clear that to achieve real improvement, we must reengineer the C&P examination process.

2. We have already taken several actions to initiate this process which also respond to your recommendations. I have established a new forensic medicine strategic healthcare group (SHG) which will focus on ensuring that superior service is provided by VHA in the C&P examination process. The forensic medicine SHG will also coordinate the reengineering effort for VHA. Obviously this effort will involve a number of organizations, including the Veterans Benefits Administration (VBA). On May 20, 1997, I formally requested that both the Under Secretary for Benefits and the Assistant Secretary for Policy and Planning (008) assist VHA in reengineering the C&P examination process. The reengineering group effort is now taking form, so we cannot yet provide you with the details of the approach to be taken or when to expect implementation. We will provide this information to you when it is available. We can assure you, however, that the specifics of recommendation 1 will be addressed in the process.

3. In the meantime, we plan to explore issuing a joint VHA/VBA statement of expectations for cooperative local efforts between VHA and VBA to improve exam

2. Assistant Inspector General for Auditing (52)

completion rates. This statement would emphasize the importance of improving exam completion rates and will endorse the view that cooperation between VHA and VBA at the local level is the path to immediate improvement. In addition, we will reemphasize the already existing requirements for rescheduling exams when veterans miss an initial appointment as required in recommendation 2. This was accomplished during the July 16, 1997, Health Administration Service National Conference Call.

4. We are committed to improving our performance on C&P examinations, as it is an important component for ensuring veterans' satisfaction. Thank you for the opportunity to review this report. If you have any questions, please contact Paul C. Gibert, Jr., Director, Reports Review and Analysis Service (105E), Office of Policy, Planning and Performance, at 273.8355.

(Original signed by:)

Kenneth W. Kizer, M.D., M.P.H.

Attachment

Action Plan in Response to OIG/GAO/MI Audits/Program Evaluations/Reviews

Name of Report: *Review of Compensation and Pension (C&P) Medical Examination Services*

Project No.: None

Date of Report: Undated draft

Recommendations/ Actions	Status	Completion Date
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Recommendation 1.: The Under Secretary for Benefits and the Under Secretary for Health improve the quality and timeliness of C&P examination services by:

- a) **establishing performance measures for their field facilities, with the objective of improving the rate of incomplete examinations;**
- b) **requiring VBA Area Directors and VISN Directors to monitor progress in reducing the percentage of incomplete examinations; and,**
- c) **requiring VBA and VHA facility directors to work together to reduce the percentage of incomplete examinations.**

Concur in principle

On May 20, 1997, the Under Secretary for Health requested that the Under Secretary for Benefits and the Assistant Secretary for Policy and Planning assist VHA in the reengineering of the C&P examination process. Recommendation 1. a) through 1. c) will be addressed as part of the reengineering process. As an interim measure, a joint VBA/VHA statement emphasizing the importance of improving the process and working cooperatively in this effort will be issued to all field directors by September 30, 1997.

In process

To be determined

Recommendation 2.: The Under Secretary for Health require VHA facilities to comply with requirements to reschedule examinations when veterans miss an initial appointment.

Concur

VA policy M-1, Part I, Chapter 20 clearly states the actions to be taken to reschedule exams when veterans miss initial appointments. These requirements were restated during a Health Administration Service National Conference Call.

Completed

July 16, 1997

**MEMORANDUM FROM THE ACTING UNDER SECRETARY FOR
BENEFITS DATED JULY 25, 1997**

Department of
Veterans Affairs

Memorandum

Date: July 25, 1997
From: Acting Under Secretary for Benefits (20)
Subj: Draft Report -- Review of Compensation and Pension Medical Examination Services
To: Assistant Inspector General for Auditing (52)

1. We have received and reviewed your draft report entitled "Review of Compensation and Pension Medical Examination Services." We are pleased to respond to the recommendations which were included in your report.
2. The entire examination process is of great concern to us in the Veterans Benefits Administration. I believe this concern is reflected by the number of work groups and task teams addressing elements of the process as well as the whole work process itself. These groups include: the work of various Business Process Reengineering (BPR) teams; the C&P Examination Process Reengineering Group with VHA, VBA, and Office of Policy and Planning involvement; the Examination Process Work Group with membership from VBA, VHA, and BVA (which is concerned with examination process matters including the revision of examination worksheets, the revision of the Physician's Guide for Disability Evaluation Examinations; examination reports that are insufficient for rating purposes and those that are returned as incomplete; and the preparation of training for physicians who perform C&P exams); the AMIE Expert Panel (which considers and prioritizes suggestions for correction or enhancement of the AMIE system); the former AMIE DHCP Linkage Work Group (which reviewed current business practices and made recommendations with several options for the improvement of AMIE information exchange) and a November 1995, VHA/BVA/VBA Exam Process Focus Group.
3. The return of incomplete examinations increases our workload and exacerbates claims processing delays. For our veteran customers any preventable delays in claims processing are unacceptable. We welcome recommendations from OIG that address this concern. We will address each of your recommendations.

Recommendation 1a: Your draft report recommended that the Under Secretary for Benefits and the Under Secretary for Health improve the quality and timeliness of C&P examination services by establishing performance measures for their field facilities, with the objective of improving the rate of incomplete examinations.

We concur in principle with this recommendation. The Veterans Benefits Administration and the Office of Policy and Planning (008) have been requested to assist the Veterans Health Administration in reengineering the C&P examination process. Since the reengineering effort is now taking form, we cannot specify the details of the approach to be taken or when to expect implementation. Your recommendation will be addressed in the process and we will provide more information when it is available.

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Assistant Inspector General for Auditing (52)

In addition to developing VBA performance measures, we anticipate release of an all-station letter by September 30, 1997, in which we will share with our regional offices the reasons for success in reducing incomplete examinations at some regional offices and medical centers which were identified in the IG draft report. We will direct that the regional offices ensure that examination requests contain the most current address of record and that they are sent to the proper clinic of jurisdiction. We will also direct that examination requests provide day and night time (home and work) telephone numbers and the name of any power-of-attorney. Where necessary, we will ask that our regional offices encourage their medical facility counterparts to use the telephone to remind veterans of scheduled examinations and to reschedule examinations when there was a failure to report.

We should and will direct VBA regional offices to work on reducing the number of incomplete examinations in cooperation with VHA medical facilities. We will join with VHA in the issuance of a joint statement of expectations for cooperative local efforts between VHA and VBA to improve examination completion rates. We anticipate the joint statement will be provided to the VHA and VBA fields by September 30, 1997.

Through the use of VBA and VHA Compensation and Pension Examination Coordinators, we will direct that our regional offices continue to maintain close liaison with the medical centers to work together to improve examination quality and timeliness, including the reduction of the number of incomplete examinations. In all-station letter 97-05, we provided the regional offices with the names and telephone numbers of all the current VBA and VHA examination coordinators and urged use of the coordinators to improve liaison with the medical centers.

Recommendation 1b: Your draft report recommended that the Under Secretary for Benefits and the Under Secretary for Health improve the quality and timeliness of C&P examination services by requiring VBA Area Directors and VHA VISN Directors to monitor progress in reducing the percentage of incomplete examinations.

We concur with this recommendation. Not only will it assist veterans, but it will also reduce workload and improve the processing time for rating-related claims. We anticipate release of a joint VBA/VHA letter to the Area and VISN Directors by September 30, 1997, in which they will be informed of this requirement.

Recommendation 1c: Your draft report recommended that the Under Secretary for Benefits and the Under Secretary for Health improve the quality and timeliness of C&P examination services by requiring VBA and VHA facility directors to work together to reduce the percentage of incomplete examinations.

We concur with this recommendation for the same reasons discussed above. We anticipate release of a joint VBA/VHA letter to the Area and VISN Directors by September 30, 1997, in which they will also be informed of this requirement.

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Assistant Inspector General for Auditing (52)

Recommendation 2: Your draft report recommended that the Under Secretary for Health require VHA facilities to comply with requirements to reschedule examinations when veterans miss an initial appointment.

This is an issue solely within the jurisdiction of the Under Secretary for Health. I defer to VHA's response to this recommendation.

(Original signed by:)
Stephen L. Lemons

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