VA Office of Inspector General

OFFICE OF AUDITS & EVALUATIONS

Inspection of the VA Regional Office Denver, CO

July 19, 2010
10-01530-196

ACRONYMS AND ABBREVIATIONS

AMIS	Automated Management Information System
C&P	Compensation and Pension
COVERS	Control of Veterans Records System
NOD	Notice of Disagreement
OIG	Office of Inspector General
PTSD	Post-Traumatic Stress Disorder
RVSR	Rating Veterans Service Representative
STAR	Systematic Technical Accuracy Review
SAO	Systematic Analysis of Operations
TBI	Traumatic Brain Injury
VACOLS	Veterans Appeals Control and Locator System
VARO	VA Regional Office
VAMC	VA Medical Center
VBA	Veterans Benefits Administration
VETSNET	Veterans Service Network
VSC	Veterans Service Center

Report Highlights: Inspection of VA Regional Office, Denver, CO

Why We Did This Review

The Benefits Inspection Division conducts onsite inspections at VA Regional Offices (VAROs) to review disability compensation claims processing and Veterans Service Center (VSC) operations.

What We Found

The Denver VARO correctly processed post-traumatic stress disorder (PTSD) claims. Staff generally followed the Veterans Benefits Administration's (VBA) policy for processing traumatic brain injury (TBI) and disabilities related to herbicide exposure claims.

Management ensured staff followed VBA policy to establish correct dates of claims in the electronic record and accurately complete all Systematic Analysis of Operations (SAOs). Further, in accordance with policy, staff corrected errors identified by VBA's Systematic Technical Accuracy Review (STAR) program.

VARO management needs to improve the control and accuracy of disability claims processing for temporary 100 percent disability evaluations. Overall, VARO staff did not accurately process disability claims for 25 (21 percent) of 118 claims reviewed.

Management also needs to strengthen controls over the recording of Notices of Disagreement (NODs) for appealed claims in the Veterans Appeals Control and Locator System (VACOLS) and the handling of claims mail.

We also observed an unusually large amount of mail in the Triage Team. A portion of this mail resulted from the Denver VA Medical Center (VAMC) not timely returning claims folders to the VARO after staff completed medical examinations. VARO management informed us despite their efforts to resolve this condition, excessive delays continue and have affected claims processing timeliness.

What We Recommended

We recommended VARO management ensure the staff correctly establishes future medical examination dates for temporary 100 percent evaluations. We also recommended management implement a training plan to ensure timely establishment of NODs in the electronic system.

In addition, we issued a Management Advisory to recommend the Director of the Eastern Colorado Health Care System develop procedures to ensure the prompt return of veterans' claims folders to the Denver VARO upon completion of medical examinations.

Agency Comments

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

(original signed by Sondra F. McCauley,
Deputy Assistant Inspector General for
Audits and Evaluations for:)

BELINDA J. FINN
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's) efforts to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Division contributes to the improvement and management of benefits processing activities and veterans' services by conducting onsite inspections at VAROs. The purpose of these independent inspections is to provide recurring oversight of VAROs by focusing on disability compensation claims processing and performance of VSC operations. The objectives of the inspections are to:

- Evaluate how well VAROs are accomplishing their mission of providing veterans with convenient access to high quality benefits services.
- Determine if management controls ensure compliance with VA regulations and policies; assist management in achieving program goals; and minimize the risk of fraud, waste, and other abuses.
- Identify and report systemic trends in VARO operations.

In addition to this standard coverage, inspections may examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

Scope of Inspection

During March 2010, the OIG conducted an inspection of the Denver VARO. The inspection focused on four protocol areas examining nine operational activities. The four protocol areas were disability claims processing, data integrity, management controls, and workload management.

We reviewed 88 (14 percent) of 613 claims related to PTSD, TBI, and disabilities related to herbicide exposure that the VARO completed during October–December 2009. In addition, we reviewed 30 (23 percent) of 131 rating decisions where VARO staff granted a temporary 100 percent evaluation for at least 18 months, the longest period a temporary 100 percent evaluation may be assigned without review under VA policy.

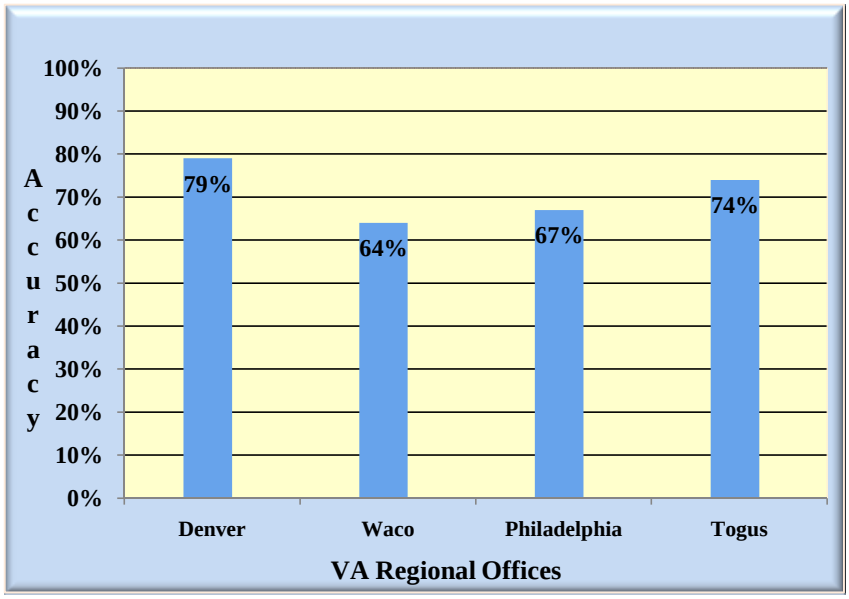
Appendix A provides additional details on the scope of the inspection. Appendix B provides the Denver VARO Director's comments. Appendix C provides a summary of the inspection results and includes the criteria used to evaluate each operational activity.

RESULTS AND RECOMMENDATIONS

1. Disability Claims Processing

VSC staff did not accurately process disability claims for 25 (21 percent) of 118 claims reviewed. Table 1 compares claims processing accuracy of the Denver VARO for the same claims issues we reviewed at three other VAROs inspected.

Table 1. VARO Claims Processing Accuracy Comparison



Finding VARO Staff Need to Improve Disability Claims Processing Accuracy

The Denver VARO needs to improve the accuracy of disability claims processing. VARO staff incorrectly processed disability claims for 25 (21 percent) of 118 claims reviewed. VARO management concurred and initiated action to correct the inaccuracies.

Table 2 reflects the errors affecting, and those with the potential to affect veterans' benefits:

Table 2. Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veteran's Benefits
Temporary 100 Percent Evaluations	30	22	7	15
PTSD	30	0	0	0
TBI	28	1	1	0
Disabilities Related to Herbicide Exposure	30	2	2	0
Total	**118**	**25**	**10**	**15**

Temporary 100 Percent Evaluations

VARO staff incorrectly processed 22 (73 percent) of the 30 temporary 100 percent disability evaluations reviewed. VBA policies provide a temporary 100 percent evaluation for service-connected disabilities requiring surgery or specific treatment. At the end of a mandated period of convalescence or cessation of treatment, VARO staff must review the veteran's medical condition to determine if they should continue the veteran's temporary evaluation.

Based on analysis of available medical evidence, seven of the processing inaccuracies affected veterans' benefits resulting in $757,672 total overpayments. The most significant overpayment occurred when a Rating Veterans Service Representative (RVSR) incorrectly granted service connection for two disabilities related to Vietnam service. Evidence in the claims folder did not reveal the veteran served in Vietnam. As a result, VA overpaid the veteran a total of $386,660 over a period of 19 years and 8 months.

VBA regulation states a disability, which has been continuously rated at any evaluation for 20 years or more, will not be reduced except upon a showing that such rating was based on fraud. If not for our review and as there was no preliminary finding of fraud in this case, benefit payments may have continued beyond 20 years, without the veteran having proper entitlement to receive them.

The remaining 15 inaccuracies had the potential to affect veterans' benefits because VARO staff did not schedule follow up medical examinations needed to determine whether the temporary 100 percent evaluation should continue. For 10 of these 15 temporary 100 percent evaluations, the elapsed days, from the date staff should have scheduled medical examinations to the

date of our inspection, averaged 1,313 days and ranged from 73 to 2,661 days. The oldest case showed staff should have scheduled a medical examination in December 2002. We cannot determine the elapsed days for the remaining five temporary 100 percent evaluations because VSC staff did not properly record routine future examination dates on the rating decision.

We could not determine if the 15 temporary 100 percent evaluations would have continued without examination results or other medical evidence, as this information was not in the veterans' claims folder at the time of our inspection. VARO staff initiated action during our inspection to obtain the needed information. Following are details of these inaccuracies, which all had the potential to affect veterans' benefits.

- For seven cases, VARO personnel did not schedule examinations to reevaluate the veterans' disabilities despite electronic notifications indicating medical examinations were required.
- For seven cases, VARO personnel did not input a required date into the proper computer application that would have generated an automatic notification to schedule a medical examination and alert staff to reevaluate whether the 100 percent evaluation should continue.
- For one case, an RVSR did not record a required date on the rating decision, thus staff were unaware a future examination was required.

VARO management and staff informed us, and we confirmed, no review process was in place to ensure staff input required dates for future medical examinations in the electronic record. As a result, veterans provided a temporary 100 percent evaluation did not always receive accurate benefits.

PTSD Claims

VARO staff correctly processed all 30 PTSD claims we selected and reviewed. As a result, we determined the VARO is following VBA policy regarding PTSD claims, and we made no recommendations for improvement.

TBI Claims

The Department of Defense and VBA commonly define a TBI as traumatically induced structural injury or physiological disruption of brain function caused by an external force. The major residual disabilities of TBI fall into three main categories: (1) physical, (2) cognitive, and (3) behavioral. VBA policies require staff to evaluate these residual disabilities.

VARO staff incorrectly processed 1 (4 percent) of 28 TBI claims. We did not consider the frequency of errors significant; however, the one error identified affected a veteran's benefits. An RVSR incorrectly granted service connection for subjective symptoms of post-traumatic headaches associated with a TBI without having a distinct diagnosis of a headache disability, such as a migraine headache. As a result, VA overpaid the veteran a total of $2,134 over a period of 11 months. Because we found only one

inaccuracy, we determined the VARO is generally following VBA policy regarding TBI claims, and we made no recommendations for improvement.

Disabilities Related to Herbicide Exposure Claims

VARO staff incorrectly processed 2 (7 percent) of 30 herbicide-related claims. We did not consider the frequency of errors significant; however, these errors affected veterans' benefits. Following is a summary of these inaccuracies found during our review of disabilities related to herbicide exposure.

- An RVSR did not properly reduce a 100 percent temporary evaluation for service-connected prostate cancer despite medical evidence indicating no residual disability remained following surgery to remove the prostate. The RVSR should have reduced the 100 percent evaluation to 0 percent and granted special monthly compensation for removal of the prostate. As a result, VA overpaid the veteran $5,532 over a period of 9 months.
- An RVSR incorrectly provided a 10 percent evaluation for service connected diabetes, a disability associated with herbicide exposure. Medical evidence in the claims folder revealed a physician prescribed medication for this condition. The RVSR should have provided a 20 percent evaluation based on the requirement for medication to control this disability. As a result, VA underpaid the veteran $1,614 over a period of 6 months.

Because we found only two inaccuracies, we determined the VARO is generally following VBA policy in the area of disabilities related to herbicide exposure, and we made no recommendations for improvement.

Recommendations

1. *We recommend the Denver VA Regional Office Director conduct a review of all temporary 100 percent evaluations under the regional office's jurisdiction to determine if reevaluations are required and take appropriate action.*
2. *We recommend the Denver VA Regional Office Director implement controls to correctly establish future examination dates for temporary 100 percent evaluations.*
3. *We recommend the Denver VA Regional Office Director implement controls to consistently monitor future examinations for temporary 100 percent evaluations.*

Management Comments

The VARO Director concurred with our recommendations for improving disability determination accuracy. The Director informed us the VSC completed reviews of 101 temporary evaluations and took action on 67 claims, the majority requiring new medical examinations. During April 2010, the Director indicated VSC management implemented a plan requiring VSC staff to print and sign documents to confirm staff correctly

established future dates in the electronic system for temporary 100 percent evaluations.

Further, supervisors will review monthly workload reports to identify temporary 100 percent evaluations that require medical examinations to ensure staff takes the appropriate action when scheduling medical examinations. In addition, the Director stated staff received refresher training regarding the proper procedures for creating future examination dates on rating decisions and recording those dates in the electronic record.

OIG Response Management comments and actions are responsive to the recommendations.

2. Data Integrity

Date of Claims VARO staff generally established the correct dates of claims in the electronic record. We reviewed 30 claims folders to determine if the VARO is following VBA policy regarding the correct establishment of the date of claims in the electronic record. The date of claims designates when a VA facility receives a document. Generally, VAROs use the date of claims as the effective date for awarding benefits. Further, VBA relies on an accurate date of claim to establish and track a key performance measure that determines the average days to complete a claim.

Because we found only one inaccuracy, we determined the VARO is generally following VBA policy regarding date of claims, and we made no recommendations for improvement.

Notices of Disagreement The VARO's Appeals Team did not always process NODs within VBA's 7-day standard. An NOD is a written communication from a claimant expressing dissatisfaction or disagreement with a decision and a desire to contest the decision. The Appeals Team is responsible for the timely entering of NODs into the Veterans Appeals Control and Locator System (VACOLS). VACOLS is an application that allows VARO staff to control and track a veteran's appeal and manage their pending appeals workload. VBA policy states VARO staff must create a VACOLS record within 7 days of receiving an NOD.

Finding **Controls over Processing Notices of Disagreement Need Strengthening**

VARO staff exceeded VBA's 7-day standard for 8 (27 percent) of 30 NODs we reviewed. It took staff an average of 40 days to record these eight NODs into VACOLS. The most untimely action occurred when VARO staff did not create a VACOLS record for 144 days. An NOD is the first step in the appeals process. Accurate and timely entering of an NOD

into VACOLS is required to ensure the appeal moves through the appellate process expeditiously.

The Denver VARO requires Claims Assistants assigned to the Triage Team to identify new NODs and forward them to the Appeals Team. Management indicated these Claims Assistants never received formal training on properly identifying an NOD, despite other employees such as Veterans Service Representatives that did receive this training. We confirmed this lack of training by interviewing staff and reviewing VARO training schedules for fiscal years 2009 and 2010.

Although staff can improve NOD recording timeliness, the office's NODs have been pending completion for an average of 148 days, 97 days better than the national average of 245 days for the period of October 2009–February 2010. In addition to potentially delaying claimant appeals, untimely VARO recording of NODs in VACOLS affects data integrity and makes it difficult for VARO and senior VBA leadership to accurately measure and monitor regional office performance. Delays in recording NODs in VACOLS also understate the total inventory of pending NODs, thus misrepresenting national performance measures.

Recommendation

4. *We recommend the Denver VA Regional Office Director develop and implement a plan to provide training on proper identification of Notices of Disagreement to Claims Assistants on the Triage Team.*

Management Comments

The Director concurred with our recommendation and on April 20, 2010, the Triage Team Coach provided training on the proper identification of Notices of Disagreements during April 2010.

OIG Response

Management comments and actions are responsive to the recommendation.

3. Management Controls

Systematic Analysis of Operations

Denver VARO management followed VBA policies by timely and accurately completing all 11 required SAOs. An SAO is a formal analysis of an organizational element or operational function of the VSC. SAOs provide an organized means for reviewing operations to identify existing or potential problems and propose corrective actions. For all SAOs where staff identified existing or potential problems, management made recommendations for improvement.

Systematic Technical Accuracy Review

VARO staff adhered to VBA policies to address errors identified by VBA's STAR program by taking corrective actions on all 16 errors identified. In addition, VARO management appropriately used information from these errors to develop a plan to train staff. STAR is one part of VBA's quality

assurance program and a key mechanism for evaluating VARO performance in processing accurate benefits claims.

4. Workload Management

Mail Handling Procedures

Triage staff did not always control and process search mail according to VBA policy. VBA defines search mail as active claims-related mail waiting to be associated with a veteran's claims folder. If claims folders are located in the file storage area, staff should not place mail in a search status. VBA's workload management system is comprised of various user plans, such as a mail plan, and computer applications to control all work throughout the disability claims process. VBA policy indicates the most important part of the workload system is oversight to ensure staff efficiently utilizes the user plans and systems available.

VBA policy states effective mail management is crucial to the success and control of workflow within the VSC. VBA's Claims Process Improvement Model Implementation Plan indicates the Triage Team is responsible for reviewing, controlling, and processing or routing all incoming mail. It is the "critical first step" for the effective coordination of other specialized teams within the VSC.

We analyzed mail-processing procedures within the Triage Team to ensure staff accurately and timely processed mail. VARO staff is required to use the Control of Veterans Records System (COVERS) to electronically track a veteran's claims folder and control search mail.

Finding Triage Team Mail Management Procedures Need Strengthening

For 7 (23 percent) of 30 pieces of search mail reviewed, staff did not properly use COVERS to ensure timely processing and accurate control of search mail. This occurred because the VARO's workload management plan did not describe specific COVERS procedures for reviewing, routing, and managing search mail. Further, staff did not retrieve search mail even though COVERS contained an electronic notice of pending search mail. COVERS provides an electronic on-screen notification of search mail awaiting pick-up when staff access an electronic record for a specific veteran. In addition, the supervisor did not always perform thorough reviews of search mail points in accordance with the workload management plan.

Because staff did not properly use COVERS to control search mail, RVSRs did not always consider all evidence available when making disability determinations. Further, not promptly associating search mail with veterans' claims folders caused delays in processing disability claims.

Following are examples of weaknesses associated with the mail user plan.

- On February 2, 2010, VARO staff received medical records from the Bethesda Naval Hospital. On February 26, 2010, an RVSR completed a rating decision for benefits; however, the RVSR did not consider these medical records when making the decision. The RVSR was unaware these medical records existed because staff did not properly place them on search in COVERS. On March 16, 2010, we identified these records during our review of search mail points—42 days after the VARO received the mail.
- On February 23, 2010, VARO staff received private medical records associated with a pending claim. The veteran's claims folder was located in a file storage area within the VARO. Instead of correctly associating the mail with the claims folder, staff incorrectly placed this mail at a search mail point. Further, staff did not place this mail on search in COVERS. On March 16, 2010, we identified these records during our review of search mail points—21 days after the VARO received the mail, thus causing a delay in processing this claim.
- VARO staff incorrectly established 190 electronic search mail indicators in COVERS. Staff should not have placed this mail on search because, according to COVERS, the files were located in the file storage area. The VARO workload management plan states if a file is located in the file storage area, staff should not place the mail on search. VSC management did not include specific guidance in the workload management plan on the use of COVERS search mail functions, thereby enabling Triage staff to create these improper COVERS search indicators.

A supervisor informed us that due to the volume of pending search mail, staff do not always perform thorough reviews of search mail points. On March 13, 2010, the VSC Triage Team reported having 1,462 pieces of pending search mail. Between October 3, 2009–March 13, 2010, Triage staff reported an average of 1,289 pieces of pending search mail at the Denver VARO. This amount of mail is approximately three times the volume we identified at previous VAROs. For example, during our inspection of the Roanoke VARO we found 504 pieces of search mail, the largest amount found at any VARO inspected prior to Denver.

VSC management acknowledged weaknesses associated with the workload management plan. These weaknesses include not having clear guidance for associating mail to claims folders, placing mail on search, and describing how staff should use the search mail functions in COVERS.

Recommendation *5. We recommend the Denver VA Regional Office Director amend the current mail user plan to include specific guidance for controlling and*

routing of search mail through use of the Control of Veterans Records Locator System.

Management Comments

The Director concurred with our recommendation and informed us the VSC is amending the current mail user plan to include specific guidance for controlling and routing search mail through the use of the Control of Veterans Records Locator System.

OIG Response

Management comments and actions are responsive to the recommendation.

5. Observation

An observation pertains to an issue that may affect benefits delivery or diminish VARO performance but is not specifically compliance-related.

Of the unusually large amount (1,462 pieces) of search mail, 476 (33 percent) pieces resulted from the claims folders temporarily located at the VA Medical Center (VAMC) pending medical examinations. Therefore, VARO staff could not associate claims-related mail with the claims folders, ultimately causing delays in claims processing.

The Director of the Eastern Colorado Health Care System Compensation & Pension (C&P) clinic, which conducts C&P medical examinations for the Denver VARO, reported the Denver VAMC had 670 claims folders located at its facility at the time of our review. The clinic Director stated procedures did not exist to ensure hospital staff promptly returned claims folders to the VARO once hospital staff completed medical examinations requested by the Denver VARO.

The clinic Director further told us the hospital staff performs a monthly review of claims folders located at the Denver VAMC to identify folders where hospital staff completed medical examinations and did not promptly return the claims folders to the Denver VARO. This review revealed an average of 25–30 claims folders unnecessarily delayed at the Denver VAMC each month. We selected 15 claims folders located at the Denver VAMC where hospital staff completed medical examinations. These folders remained at the hospital an average of 29 days after staff completed medical examinations. These delays affect VARO mail processing and ultimately cause delays in claims processing.

The Automated Management Information Systems (AMIS) 290 report showed the Denver VAMC averaged 68 days to complete medical examinations, 38 days longer than VHA's national goal of 30 days. The AMIS 290 report is a collection of statistics indicating the status of C&P examination requests for any given month.

Denver VARO management has taken the following measures in an attempt to minimize delays in receiving claims folders from the Denver VAMC:

- Notified VBA's Senior Leadership and the VAMC Director about how this issue affects VARO search mail and claims timeliness.
- Provided COVERS access to hospital staff so both VARO and VAMC staff could electronically track the location of claims folders.
- Submitted daily e-mails to VAMC staff with a list of claims files located at the VAMC with completed medical examinations.
- Endorsed a VARO supervisor's request to spend off-duty hours at the VAMC to assist with identifying claims folders where staff had completed medical examinations.

In addition, the Denver VARO initiated a contract to outsource examinations in January 2010 to assist the VAMC with decreasing the backlog of pending medical examinations. VARO management stated the contract would expire within the next few months as they were nearing the predetermined 3,000 medical examinations allotted under the contract. VARO management anticipated the expiration of this contract would likely further the backlog of medical examinations, thus perpetuating delays in associating mail with claims folders and subsequent delays in claims processing.

VARO management informed us that despite efforts to improve, excessive delays in the return of claims folders located at the VAMC have not been resolved. As a result of this observation, we are issuing a Management Advisory to the Veterans Health Administration's Under Secretary for Health.

Appendix A VARO Profile and Scope of Inspection

Organization

The Denver VARO is responsible for delivering non-medical VA benefits and services to veterans and their families in Colorado and Wyoming. It fulfills these responsibilities through the administration of compensation benefits, spina bifida and birth defect claims, vocational rehabilitation and employment assistance, guaranty and indemnity home loans, and outreach activities.

Resources

As of March 2010, the Denver VARO had a staffing level of 313 full-time employees. Of the 313 full-time employees, 163 (52 percent) were assigned to the VSC.

Workload

As of February 2010, the VARO reported 6,169 pending compensation claims. The average time to complete these claims during FY 2010 was 147.3 days—11.2 days better than the national target of 158.5 days. As reported by STAR, accuracy for compensation rating-related issues was 84.9 percent or 5.1 percent below the VBA target of 90 percent and accuracy for compensation authorization-related issues was 90.3 percent or 5.7 percent below the VBA target of 96 percent.

Scope

We reviewed selected management controls, benefits claims processing, and administrative activities to evaluate compliance with VBA policies as they related to benefits delivery and non-medical services provided to veterans and other beneficiaries. We interviewed managers and employees and reviewed veterans' claims folders.

The review of disability claims processing for PTSD, TBI, disabilities related to herbicide exposure, and errors identified by VBA's STAR covered the period October–December 2009. We did not inspect fiduciary activities because VBA has centralized all Western Area fiduciary activities at the Salt Lake City VARO.

VBA measures the accuracy of compensation and pension claims processing. STAR's measurements include a review of work associated with claims that require a rating decision. STAR staff reviews original, reopened, claims for an increased evaluation, and appellate issues that involve a myriad of disabilities veterans' claims.

Our process differs from STAR as we review specific types of claims issues that require a rating decision, such as, PTSD, TBI, and disabilities associated with herbicide exposure. In addition, we review rating decisions and awards processing that involve temporary 100 percent evaluations.

For temporary 100 percent disability evaluations, we selected for review all 131 existing claims from VBA's Corporate Database. These temporary

evaluations were not specific to the period October–December 2009 because VARO staff processed too few claims during that period; therefore, we examined all related claims processed to draw our conclusion. The 131 claims represent all instances in which VARO staff granted a temporary 100 percent evaluation for at least 18 months. From these 131, we selected a random sample of 30 claims for our review. We provided the VARO with the remaining 101 to assist with implementing recommendation number one.

For our review of claims dates and NODs, we selected claims and NODs pending within the VARO at the time of our inspection. We completed our review in accordance with the President's Council for Integrity and Efficiency's *Quality Standards for Inspections.*

Appendix B VARO Director's Comments

Department of Veterans Affairs

MEMORANDUM

Date: **July 1, 2010**

From: **Director, VA Regional Office Denver**

Subject: **Inspection of VARO Denver, CO**

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

1. Attached are Denver VARO's comments on the OIG Draft Report: Inspection of VARO Denver.

2. Please feel free to contact me at (303) 914-5800 with any questions or concerns regarding our reply.

(original signed by:)

Janice S. Jacobs
Director

Attachment

IG Recommendations:

Recommendation 1: We recommend the Denver VA Regional Office Director conduct a review of all temporary 100 percent evaluations under the regional office's jurisdiction to determine if reevaluations are required and take appropriate action.

RO Comments: Concur

The Denver Regional Office (RO) reviewed 101 cases provided by OIG. The RO took action on 67 of the files reviewed. The majority of cases required a new VA examination and a few required final rating determinations. Thirty-four of the files required no additional action.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 2: We recommend the Denver VA Regional Office Director implement controls to correctly establish future examination dates for temporary 100 percent evaluations.

RO Comments: Concur

In April 2010, the RO provided refresher training for Rating Veterans Service Representatives (RVSRs) to ensure they are entering future examination diary dates on their decisions when required. Authorizers received refresher training as well. Upon authorizing rating decisions, Authorizers will review each rating decision to identify that examination diary dates are reflected on rating decisions and entered into the system.

In April 2010, the RO additionally provided station training for processing examination write-outs pertaining to future examinations. Twice a month the Triage Coach will review VETSNET Operation Reports (VOR) for 810 series work items regarding future examinations and forward these items to the Triage Claims Assistants for claims establishment. The 310 end products (EPs) established by Claims Assistants will be subject to quality reviews by the Triage Coach. The Triage Coach will conduct reviews on Claims Assistants once per month. Moreover, 310 EPs for future examinations established in Triage are routed to four specialized Pre-determination Veterans Service Representatives (VSRs). These VSRs will review the 310 EPs for additional action and determine if an examination is necessary. If an examination is not necessary, the Pre-determination VSRs will cancel the 310 EP and annotate the folder. Upon receipt of any new examinations that reflect improvement or permanency of the 100 percent disability in question, the file will be routed to the rating board for a rating. If the medical evidence indicates the disability will

require an additional future exam (such as ongoing cancer treatment), the exam diary will be re-input. For quality purposes, RVSRs will conduct quality reviews on a sample of 310 EPs reviewed by the Specialized VSRs each month. A new Veterans Service Center Workload Management plan identifying this procedure will be implemented by July 1, 2010.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 3: We recommend the Denver VA Regional Office Director implement controls to consistently monitor future examinations for temporary 100 percent evaluations.

RO Comments: Concur

As indicated above, twice a month the Triage Coach will review VETSNET Operation Reports (VOR) for 810 series work items regarding future examinations and forward these claims to the Triage Claims Assistants for claims establishment. The 310 end products established by Claims Assistants will be subject to quality reviews by the Triage Coach. In addition to the procedures and training identified under Recommendation 2, the RO also implemented new policy effective April 2010. This new policy calls for all "confirmed and continued" rating decisions, including decisions where claimants are rated 100 percent disabled, to be reviewed by an authorizer. Previously, "confirmed and continued" ratings were cleared in VETSNET or BDN, as no award generation was typically required. This practice resulted in a high error rate as found by OIG. Due to the need for a diary to be established for routine future examinations, all "confirmed and continued" ratings will now have generated awards that will be reviewed by an authorizer to ensure the proper diary code is established. This adds a second level of review to ensure the necessary diary codes are established.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 4: We recommend the Denver VA Regional Office Director develop and implement a plan to provide training on proper identification of Notices of Disagreement to Claims Assistants on the Triage Team.

RO Comments: Concur

On April 20, 2010, the Triage Coach provided training to the Claims Assistants on the Triage team regarding the proper identification of Notices of Disagreements. Refresher training will be provided as needed.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 5: We recommend the Denver VA Regional Office Director amend the current mail user plan to include specific guidance for controlling and routing of search mail through use of the Control of Veterans Records Locator System (COVERS).

RO Comments: Concur

The Veterans Service Center mail user plan is included in the Division's Workload Management plan. The Veterans Service Center is amending the current mail user plan to include specific guidance for controlling and routing of search mail through the use of COVERS. A new Veterans Service Center Workload Management plan with the amendments to the mail user plan will be implemented by July 1, 2010.

The Veterans Benefits Administration recommends closure of this recommendation.

Appendix C Inspection Summary

Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. 100 Percent Disability Evaluations	**Determine if VARO staff properly reviewed temporary 100 percent disability evaluations**. (38 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1MR Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Post-Traumatic Stress Disorder	**Determine whether VARO staff properly processed claims for PTSD**. (38 CFR 3.304(f))	X	
3. Traumatic Brain Injury	**Determine if VARO staff properly processed claims for service connection for all residual disabilities related to an in-service TBI**. (Fast Letters 08-34 and 08-36, Training Letter 09-01)	X	
4. Disabilities Related to Herbicide Exposure	**Determine whether VARO staff properly processed claims for service connection for disabilities related to herbicide exposure (Agent Orange)**. (38 CFR 3.309) (Fast letter 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)	X	
Data Integrity			
5. Date of Claims	**Determine if VARO staff properly recorded the correct date of claims in the electronic records**. (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)	X	
6. Notices of Disagreement	**Determine whether VARO staff properly entered NODs into VACOLS**. (M21-1MR Part I, Chapter 5)		X
Management Controls			
7. Systematic Analysis of Operations	**Determine if VARO staff properly performed a formal analysis of their operations through completion of SAOs**. (M21-4, Chapter 5)	X	
8. Systematic Technical Accuracy Review	**Determine whether VARO staff properly corrected STAR errors**. (M21-4, Chapter 3, Subchapter II, 3.03)	X	
Workload Management			
9. Mail Handling Procedures	**Determine if VARO staff properly followed VBA mail handling procedures.** (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapters 1 and 4)		X

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	Brent Arronte (727) 395-2425
Acknowledgments	Danny Clay Kristine Abramo Brett Byrd Madeline Cantu Kelly Crawford Lee Giesbrecht Kerri Leggiero-Yglesias Jason Schuenemann Lisa Van Haeren

Appendix E Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Assistant Secretaries
Office of General Counsel
VBA Western Area Director
VARO Denver Director

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Michael F. Bennet, Mark Udall
U.S. House of Representatives: Mike Coffman, Diana DeGette, Doug Lamborn, Betsy Markey, Ed Perlmutter, Jared Polis, John T. Salazar.

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