VA Office of Inspector General

OFFICE OF AUDITS & EVALUATIONS

Inspection of the Veterans Service Center Cheyenne, WY

July 19, 2010
10-02080-197

ACRONYMS AND ABBREVIATIONS

NOD	Notice of Disagreement
OIG	Office of Inspector General
PTSD	Post-Traumatic Stress Disorder
RVSR	Rating Veterans Service Representative
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VACOLS	Veterans Appeals Control and Locator System
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the Veterans Service Center, Cheyenne, WY

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. The Cheyenne VSC is a satellite office under the jurisdiction of the Denver VARO Director. As part of our recurring oversight of VSC operations, and at the request of the Denver VARO Assistant Director, we performed a separate inspection of this facility.

What We Found

The Cheyenne VSC correctly processed herbicide exposure claims and generally followed the Veterans Benefits Administration's (VBA) policy for processing post-traumatic stress disorder (PTSD) claims.

VSC staff properly established the correct dates of claim in the electronic record, accurately corrected errors identified by VBA's Systematic Technical Accuracy Review (STAR), and generally adhered to policy for recording Notices of Disagreement (NOD) in the Veterans Appeals Control and Locator System (VACOLS).

VSC management needs to improve the control and rating decision accuracy for the processing of temporary 100 percent disability evaluations and improve the accuracy of processing traumatic brain injury (TBI) claims. Overall, VSC staff did not accurately process disability claims for 12 (18 percent) of the 65 specific claims reviewed.

Management also needs to strengthen controls over mail handling by ensuring mailroom staff deliver mail to the VSC on the date received.

What We Recommended

We recommended the Denver VARO Director ensure the staff correctly establishes future medical examination dates for all temporary 100 percent evaluations and implement a plan to ensure staff correct errors identified during local quality reviews.

In addition, we recommended the Director update mail handling procedures to ensure accurate and timely processing of incoming mail.

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

TABLE OF CONTENTS

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 the 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

In March 2010, the OIG conducted an inspection of the Cheyenne VSC. The inspection focused on four protocol areas examining eight operational activities. The four protocol areas were disability claims processing, data integrity, management controls, and workload management.

We reviewed all 58 claims related to PTSD, TBI, and disabilities related to herbicide exposure that the VSC completed during October–December 2009. In addition, we reviewed all seven decisions requiring a rating decision where VSC staff granted a temporary 100 percent evaluation for at least 18 months, the longest period under VA policy a temporary 100 percent evaluation could be assigned without review.

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.

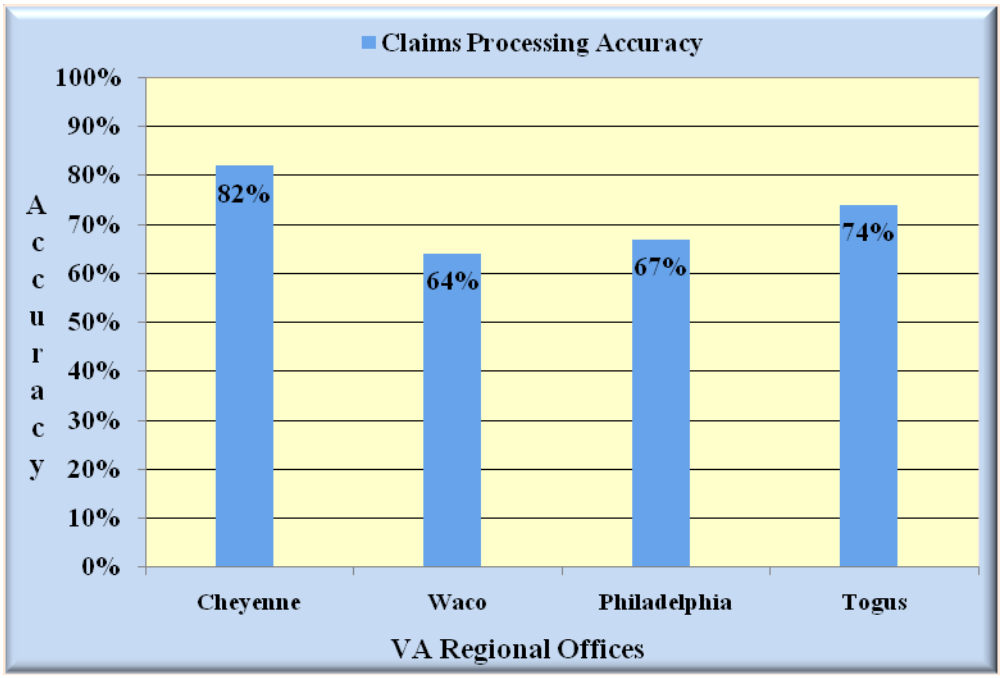
RESULTS AND RECOMMENDATIONS

1. Disability Claims Processing

VSC staff did not accurately process disability claims for 12 (18 percent) of 65 claims reviewed. In addition, VSC management needs to improve the control and accuracy of disability claims processing for temporary 100 percent disability evaluations and improve accuracy for processing traumatic brain injury (TBI) claims.

Table 1 compares our review results on claims processing accuracy at the Cheyenne VSC for these types of claims with results from the previous three VAROs inspected. Although the volume of claims processed at all VAROs differ for several reasons, the activities within each VSC are comparable.

Table 1. VARO Claim Processing Accuracy Comparison



Finding VSC Staff Need to Improve Disability Claims Processing Accuracy

The Cheyenne VSC needs to improve the accuracy of disability claims processing. VSC staff incorrectly processed disability claims for 12 (18 percent) of 65 claims reviewed. VSC management concurred and initiated action to correct the inaccuracies.

Table 2 reflects the errors affecting veterans' benefits and those potentially affecting veterans' benefits:

Table 2. Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Evaluations	7	7	2	5
PTSD	34	3	0	3
TBI	7	2	1	1
Disabilities Related To Herbicide Exposure	17	0	0	0
Total	**65**	**12**	**3**	**9**

Temporary 100 Percent Evaluations

VSC staff incorrectly processed all seven temporary 100 percent disability evaluations. VBA policies authorize 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, VSC staff must review the veteran's medical condition to determine if the individual should continue the temporary evaluation.

Based on analysis of available medical evidence, two of the processing inaccuracies affected veterans' benefits resulting in $190,458 in overpayments. Following are details of the two temporary 100 percent evaluation cases.

- A Rating Veterans Service Representative (RVSR) incorrectly granted service connection for two disabilities based on a veteran's claimed service in Vietnam. Evidence in the claims folder did not indicate the veteran served in Vietnam. The RVSR assigned a 100 percent evaluation for one of the disabilities. As a result, VA had overpaid the veteran $160,758 over a period of 7 years and 9 months by the time of our inspection.
- In May 2007, an RVSR properly indicated that a future medical examination was required for a veteran's prostate cancer. However, VSC staff never requested the medical examination. As of November 2008, VA medical treatment reports revealed the veteran no longer had an active malignancy. As a result, VA overpaid the veteran $29,700 over a period of 11 months by the time of our inspection.

The remaining five temporary 100 percent evaluation inaccuracies had the potential to affect veterans' benefits. VSC staff did not schedule medical examinations needed to determine whether the temporary 100 percent

evaluations should continue. For these five temporary 100 percent evaluations, the elapsed time (from the date staff should have scheduled medical examinations to the date of our inspection) averaged 1,169 days and ranged from 73 to 2,964 days. The worst case required staff to schedule a medical examination in February 2002; however, the examination was not scheduled. Without a follow up examination, benefits continue to be paid.

We could not determine if the temporary evaluations would have continued without the results of medical examinations or other medical evidence. This information was not in the veterans' claims folders at the time of our inspection. Following is a summary of the temporary 100 percent evaluation cases having the potential to affect veterans' benefits.

- For three cases, VSC personnel did not input a required date into the computer application that would have generated an automatic notification for staff to schedule a medical examination and reevaluate whether the 100 percent evaluation should continue.
- For one case, VSC personnel did not schedule a medical examination to reevaluate the veteran's disability despite an electronic notification indicating a medical examination was required.
- For another case, an RVSR did not record a required date on the rating decision, thus staff were unaware a future medical examination was required.

For the errors we identified that occurred prior to October 2009, Senior Veterans Service Representatives informed us they did not have procedures to ensure staff input required dates for future medical examinations in the electronic records. In October of 2009, the Cheyenne VSC began requiring that staff generate documentation that could help Senior Veterans Service Representatives ensure staff properly input these dates into the electronic records. Five errors identified during our inspection occurred prior to the implementation of this procedure.

PTSD Claims

VSC staff incorrectly processed 3 (9 percent) of 34 PTSD claims—a rate of error we did not consider significant given the complexity of the claims processed. Following are details of the three cases, all of which had the potential to affect veterans' benefits.

- An RVSR incorrectly granted service connection for PTSD without having required information from the examining physician linking the PTSD diagnosis to the veteran's stressful event in service.
- An RVSR prematurely denied service connection for PTSD prior to obtaining all of the necessary evidence to verify the veteran's stressful event. The veteran provided sufficient information, such as the date,

place, name of assigned military unit, and a description of the stressful event. Based on this information, the RVSR should have requested additional evidence to corroborate the veteran's claim.

- An RVSR properly noted the veteran's PTSD would likely improve and indicated a future medical examination was required. VSC staff did not input a required date into a computer application. This action would have generated an automatic notification to schedule an examination to reevaluate the veteran's PTSD.

Because we found only three inaccuracies, we determined the VSC is generally following VBA policy in this area and we made no recommendations for improvement.

TBI Claims

The Department of Defense and VBA commonly define TBI as a 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.

VSC staff incorrectly processed two (29 percent) of seven TBI claims. These seven claims represented all TBI claims completed by the Cheyenne VSC during October–December 2009. Staff did not properly evaluate all residual disabilities related to the in-service TBIs. This occurred because RVSRs used inadequate medical examinations to make determinations for the residual disabilities.

In one case, inaccurate processing affected a veteran's benefits. An RVSR incorrectly provided a 10 percent evaluation for residual disabilities associated with a TBI. Medical evidence in the claims folder indicated the RVSR should have assigned a 40 percent evaluation. The error occurred because the RVSR used an inadequate medical examination although a corrected medical examination was in the claims folder. The RVSR stated that she did not identify it due to pressures associated with meeting production standards. As a result, the veteran was underpaid a total of $5,122 over a period of 13 months.

In the other case, the inaccuracy could potentially affect a veteran's benefits. It occurred because the RVSR evaluated residuals of an in-service TBI using an inadequate medical examination. The RVSR stated that he did not schedule another examination because of pressures associated with meeting production standards. Further, the RVSR was concerned with the amount of time it would take the VA Medical Center to provide a corrected medical examination report.

A Decision Review Officer identified this error during a local quality review. The error remained despite the Decision Review Officer informing the RVSR to correct it. VSC management did not have a procedure to ensure staff corrected errors identified during local quality reviews. As a result, veterans did not always receive accurate benefits.

Disabilities Related to Herbicide Exposure Claims

VSC staff correctly processed all 17 disabilities related to the herbicide exposure claims we reviewed. We determined the VSC was following VBA policy in this area and therefore 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 Cheyenne Veterans Service Center's jurisdiction to determine if reevaluations are required and take appropriate action.*
2. *We recommend the Denver VA Regional Office Director establish written policies for the Cheyenne Veterans Service Center to ensure the proper scheduling of future examinations for all continued temporary 100 percent evaluations.*
3. *We recommend the Denver VA Regional Office Director develop and implement a plan for Cheyenne Veterans Service Center staff that ensures the correction of errors identified during local quality reviews.*
4. *We recommend the Denver VA Regional Office Director develop and implement a plan for Cheyenne Veterans Service Center staff that ensures Rating Veterans Service Representatives return medical examinations determined to be inadequate for rating purposes.*

Management Comments

The VARO Director concurred with our recommendations for improving disability determination accuracy. The Director informed us the VSC completed reviews of 13 temporary evaluations and took action on 12 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.

Effective June 2010, VSC management implemented a new policy requiring errors identified during local quality reviews be corrected and returned to the training coordinators to ensure staff takes corrective action on all errors identified. During June 2010, 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 Claim VSC staff followed VBA policy to establish the dates of claim in the electronic records for 30 files reviewed. The dates of claim recorded in the electronic records directly correspond with the dates of receipt stamp located on the claims. VAROs use the date of claim as the effective date for awarding benefits.

Incorrect Effective Dates.

Generally, the effective date of payment is the date VA receives a claim or the date an entitlement to a specific benefit begins. We found that RVSRs incorrectly assigned effective dates for 4 (6 percent) of 65 disability claims we reviewed. All four errors affected veterans' benefits—two involved overpayments totaling $7,812 and two involved underpayments totaling $8,463. Details on the most significant underpayment and overpayment related to the incorrect effective dates follow.

- An RVSR incorrectly assigned a May 18, 2009, effective date for an increased PTSD evaluation, 4 months after the actual date the veteran filed the claim. As a result, VA underpaid the veteran a total of $7,036 over a period of 4 months.
- An RVSR assigned an incorrect effective date of February 10, 2007, for service-connected prostate cancer. The correct date was May 7, 2007, the date the VSC received the claim. As a result, the veteran was overpaid $7,689 over a period of 3 months.

Because we did not deem the frequency of errors as significant, we determined the Cheyenne VSC is generally following VBA policy in this area. As a result, we are not offering recommendations for improvement.

Notices of Disagreement Claims Assistants generally established NODs in VACOLS 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 it. This written communication is the first step in the appeals process. Accurate and timely updating of VACOLS is required to ensure an appeal moves through the appellate process expeditiously. VACOLS is an application that allows VSC staff to control and track a veteran's appeal and manage the pending appeals workload.

We determined staff did not establish 2 (7 percent) of the 30 NODs within VBA's 7-day standard. We did not consider the frequency of errors significant and concluded the VSC was generally following VBA policy in

this area of data integrity. Thus, we are not offering recommendations for improvement.

3. Management Controls

Systematic Technical Accuracy Review

VSC staff took appropriate corrective action in addressing the only two errors identified by VBA's STAR program staff regarding incorrect effective dates for benefit payments. STAR is one part of VBA's quality assurance program and a key mechanism for evaluating VARO performance in processing accurate benefits claims. As a result, we determined the VSC was following VBA policy in this area of management controls. Thus, we are not offering recommendations for improvement.

4. Workload Management

Mail Handling Procedures

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 with other specialized teams, such as the Pre-Determination and Post-Determination teams, within the VSC.

The Cheyenne VSC does not have its own mailroom. The Cheyenne VA Medical Center, which is co-located with the VSC, receives all incoming mail and delivers it to the VSC.

VBA policy requires early pickup or delivery at the U.S. Post Office to ensure the first mail of the day will reach the VSC at or near the opening hour of the office. Policy states all mail will be date stamped with the date it arrived at the VA facility. VBA policy also requires the VSC to review and update mail handling procedures annually. We analyzed mail processing procedures within the mailroom and the Triage Team to ensure staff accurately and timely processed mail.

Finding Controls Over Mail Handling Need Strengthening

VSC management did not ensure the VA Medical Center mailroom staff delivered incoming mail to the VSC on the date received. VARO and VSC management were unaware of the mail delivery requirements because management had not updated mail handling procedures since July 2008. As a result of mail processing delays, beneficiaries did not always receive accurate benefit payments.

Instead of date stamping mail the day it arrived, Triage staff received and date stamped incoming mail the day after it arrived at the VA Medical

Center. A Claims Assistant appointed in 2007 was unaware of this until we identified it during our inspection. Management and staff could not tell us how long this improper procedure had been in place.

Generally, benefit payments are the first of the month following the claim receipt date. For example, if VSC staff properly date stamp a claim received on January 31, the benefits would be payable on February 1. However, when VSC staff improperly date stamp the claim on February 1, VSC staff unintentionally underpay beneficiaries 1 month of benefits.

Analysis of 16 claims marked as received by the Triage Team on February 1, 2010, and March 1, 2010, revealed VBA could potentially underpay those 16 claimants by 1 month due to inaccurate mail date stamping. We could not determine if actual underpayments occurred since the claims were pending at the time of our inspection.

Management informed us they had not reviewed and updated the VSC mail handling procedures since July 2008, which we confirmed. These procedures did not include provisions to address local issues, such as pick-up and delivery times, specific to the flow of mail from the U.S. Post Office through its delivery to the Triage Team.

Recommendations

5. *We recommend the Denver VA Regional Office Director coordinate with the Cheyenne VA Medical Center to ensure staff delivers mail to the Cheyenne Veterans Service Center on the same day it arrives at the mailroom.*
6. *We recommend the Denver VA Regional Office Director update the current mail handling procedures for the Cheyenne Veterans Service Center to establish explicit delivery procedures for all types of mail.*

Management Comments

The VARO Director concurred with our recommendations for improving mail handling procedures at the Cheyenne VSC. The VARO Director informed us management established a separate P.O. Box number for delivery of mail directly to the Cheyenne VSC. Further, VSC management began amending the Mail Plan to establish specific guidelines for mail delivery procedures. The Director stated management should complete the amended plan by August 2010.

OIG Response

Management comments and actions are responsive to the recommendations.

Appendix A VSC Profile and Scope of Inspection

Organization

The Cheyenne VSC is responsible for delivering non-medical VA benefits and services to veterans and their families in Wyoming. The VSC fulfills these responsibilities through the administration of compensation benefits, benefits counseling, and outreach activities.

Resources

As of February 2010, the Cheyenne VSC had a staffing level of 21 full-time employees.

Workload

As of February 2010, the VSC reported 922 pending compensation claims. The average time to complete these claims during fiscal year 2010 was 155.9 days—2.6 days better than the national target of 158.5 days. As of December 2009, accuracy for compensation rating-related issues, as reported by STAR, was 85.4 percent or 4.6 percent below the VBA target of 90 percent. Accuracy for compensation authorization-related issues, as reported by STAR, was 90.9 percent or 5.1 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 program covered the period October–December 2009. We did not conduct a review of Systematic Analysis of Operations for the Cheyenne office because the Denver VARO incorporated analyses of Cheyenne's operations into their annual Systematic Analysis of Operations program. 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 review original, reopened, claims for increased evaluations, and appellate issues that involve a myriad of veterans' disabilities claims.

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

For temporary 100 percent disability evaluations, we selected all 16 existing claims from VBA's Corporate Database. These temporary evaluations were not specific to the period October–December 2009 because VSC staff would

have processed too few claims for us to provide an objective summary of this work. The 16 claims represented all instances in which VSC staff granted temporary 100 percent evaluations for 18 months or longer. We could not review 9 of the 16 claims folders because they were not located at the Cheyenne VSC during our visit. We provided the VSC with the claim numbers for these nine claims, to assist with implementing our 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 the Veterans Service Center, Cheyenne, WY**

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

1. Attached are the Denver VARO's comments on the OIG Draft Report: Inspection of the Veterans Service Center, Cheyenne, WY.

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 Cheyenne Veterans Service Center's jurisdiction to determine if reevaluations are required and take appropriate action.

RO Comments: Concur

The Cheyenne Veterans Service Center (VSC) reviewed 13 cases of temporary 100 percent evaluations as provided by OIG. Six cases were reviewed during the OIG visit. Seven cases were off station during the course of the visit. These seven cases were subsequently reviewed June 8, 2010. Cheyenne took action on 12 of the13 cases reviewed, and determined one of the cases required no additional action due to a permanent 100% evaluation previously assigned. There are two remaining cases yet to be reviewed which are currently in route from Station 376.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 2: We recommend the Denver VA Regional Office Director establish written policies for the Cheyenne Veterans Service Center to ensure the proper scheduling of future examinations for all continued temporary 100 percent evaluations.

RO Comments: Concur

The Cheyenne VSC changed procedures in April 2010. 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. Refresher training for both Veterans Service Representatives (VSRs) and Rating VSRs (RVSRs) was provided in June 2010.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 3: We recommend the Denver VA Regional Office Director develop and implement a plan for Cheyenne Veterans Service Center staff that ensures the correction of errors identified during local quality reviews.

RO Comments: Concur

The Cheyenne VSC has implemented a plan effective June 2010 requiring errors identified during local quality review, be corrected and returned to the respective training coordinators within three days for VSRs and five days for RVSRs. The timeliness element under the new VSR standards specifies three days for any corrective actions. Currently, there is no measurement under the national performance standards for RVSRs for corrective actions. Therefore, Cheyenne implemented the local five-day policy for RVSRs.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 4: We recommend the Denver VA Regional Office Director develop and implement a plan for Cheyenne Veterans Service Center staff that ensures Rating Veterans Service Representatives return medical examinations determined to be inadequate for rating purposes.

RO Comments: Concur

OIG findings indicate the Cheyenne VSC staff incorrectly processed two of seven traumatic brain Injury (TBI) claims due to RVSRs using inadequate medical examinations to make determinations for the residual disabilities. The Cheyenne VSC implemented a policy in June 2010 requiring all rating decisions for TBI claims be reviewed and second signed by a Decision Review Officer (DRO).

Effective in June 2010, any examination that a RVSR determines to be inadequate will additionally be reviewed by our C&P Liaison who is a DRO. Once the DRO reviews the examination, it will be routed back to the C&P unit of the appropriate VAMC for correction. Moreover, a DRO will provide training on inadequate exams to Cheyenne RVSRs on July 7, 2010.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 5: We recommend the Denver VA Regional Office Director coordinate with the Cheyenne VA Medical Center to ensure staff delivers mail to the Cheyenne Veterans Service Center on the same day it arrives at the mailroom.

RO Comments: Concur

All mail for the Cheyenne VSC is routed through the mailroom of the Cheyenne VA Medical Center (VAMC). The VAMC mailroom personnel

pick up mail from the local post office at 3:00 pm daily. Formerly, the mail for the Cheyenne VSC was handled under the same PO Box number as the Cheyenne VAMC. At this time, we have decided to establish a separate PO Box number for the Cheyenne VSC. The Cheyenne VAMC mailroom staff will pick up the mail for both PO Boxes and deliver the Cheyenne VSC mail to the Cheyenne VSC on the same day they pick it up. The Cheyenne VSC will then date stamp the mail on the day it is received. The VSC is in the process of changing the address on its letterhead to reflect the new PO Box address. Establishment of the PO Box with accompanying procedures should be complete by July 15, 2010.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 6: We recommend the Denver VA Regional Office Director update the current mail handling procedures for the Cheyenne Veterans Service Center to establish explicit delivery procedures for all types of mail.

RO Comments: Concur

The Cheyenne VSC will amend the current Mail Workflow plan (dated July 2008) to establish new specific guidelines for mail delivery procedures. The amended Mail Workflow plan will be completed in August 2010.

Appendix C Inspection Summary

Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Disability 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 whether VARO staff properly processed 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 Claim	**Determine if VARO staff properly recorded the correct date of claim in the electronic records**. (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)	X	
6. Notices of Disagreement	**Determine if VARO staff properly entered NODs into VACOLS**. (M21-1MR Part I, Chapter 5)	X	
Management Controls			
7. Systematic Technical Accuracy Review	**Determine if VARO staff properly corrected STAR errors**. (M21-4, Chapter 3, Subchapter II, 3.03)	X	
Workload Management			
8. 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	Kristine Abramo Brett Byrd Madeline Cantu Danny Clay Kelly Crawford Lee Giesbrecht Kerri Leggiero-Yglesias Lisa Van Haeren Robert Campbell

Appendix E Report Distribution

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U.S. Senate: John Barrasso, Michael B. Enzi
U.S. House of Representatives: Cynthia M. Lummis

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