VA Office of Inspector General

OFFICE OF AUDITS & EVALUATIONS

Inspection of the VA Regional Office Detroit, MI

August 19, 2010
10-02079-226

ACRONYMS AND ABBREVIATIONS

NOD	Notice of Disagreement
OIG	Office of Inspector General
PTSD	Post-Traumatic Stress Disorder
RVSR	Rating Veterans Service Representative
SAO	Systematic Analyses of Operations
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 VA Regional Office, Detroit, MI

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 Detroit VARO correctly processed disability claims related to herbicide exposure. Staff generally followed the Veterans Benefits Administration's (VBA) policy for processing post-traumatic stress disorder (PTSD) claims, establishing correct dates of claim, and completing Systematic Analyses of Operations (SAOs). Management also improved mail processing in the Triage Team and VARO mailroom. These improvements resulted in staff exceeding VBA's standard of establishing 80 percent of claims in 7-days.

Management did not timely train Rating Veterans Service Representatives (RVSR) regarding new procedures for evaluating traumatic brain injury (TBI) claims despite VBA issuing new guidance in January 2009. Also, staff needs to improve the processing of temporary 100 percent disability evaluations.

VARO staff did not accurately process claims for 25 (21 percent) of 120 claims reviewed. We identified nine additional claims processing inaccuracies attributable to claims redistributed to other VAROs to complete for workload management reasons.

Management also needs to strengthen controls over the following areas:

- Establishing mail procedures to ensure staff timely record Notices of Disagreement (NODs) for appealed claims in the Veterans Appeals Control and Locator System (VACOLS);
- Correcting errors identified by VBA's Systematic Technical Accuracy Review (STAR) Program; and
- Processing incompetency determinations.

What We Recommended

We recommended VARO management monitor its new policy regarding the processing of temporary 100 percent evaluations. We also recommended management develop and implement a plan to ensure staff take corrective action to address errors identified by VBA's STAR program.

We recommended management establish mail delivery procedures for the Appeals Team and consult with VBA to discuss establishing a standard to ensure immediate completion of final competency determinations.

Agency Comments

The Director of the Detroit VARO concurred with all recommendations except one. Specifically, the Director deferred comment to VBA's Compensation and Pension Service regarding the establishment of a standard for timely processing final competency determinations. Management's planned actions are responsive.

(original signed by:)

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 improved management of benefits processing activities and veterans' services by conducting onsite inspections at VAROs. These independent inspections provide recurring oversight focused 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; and
- 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 May 2010, the OIG conducted an inspection of the Detroit VARO. The inspection focused on 5 protocol areas examining 10 operational activities. The five protocol areas were disability claims processing, data integrity, management controls, workload management, and eligibility determinations.

We reviewed 90 (9 percent) of 991 claims related to PTSD, TBI, and disabilities related to herbicide exposure that the VARO completed during October–December 2009. In addition, we reviewed 30 (13 percent) of 232 rating decisions where VARO staff granted a temporary 100 percent evaluation for at least 18 months, generally the longest period under VA policy a temporary 100 percent evaluation may be assigned without review.

Appendix A provides details on the VARO and the scope of the inspection. Appendix B provides the Detroit VARO Director's comments on a draft of this report. Appendix C provides the criteria we used to evaluate each operational activity and a summary of our inspection results.

RESULTS AND RECOMMENDATIONS

1. Disability Claims Processing

The OIG inspection team focused on disability claims processing related to temporary 100 percent evaluations, PTSD, TBI, and disabilities related to herbicide exposure. We further considered these claims in terms of their impact upon veterans' benefits.

Finding

Detroit VARO Staff Needs to Improve Disability Claims Processing Accuracy

The Detroit VARO needs to improve the accuracy of disability claims processing. Staff incorrectly processed disability claims for 25 (21 percent) of 120 claims reviewed. Further, nine additional claims processing inaccuracies were identified and attributable to claims redistributed to other VAROs to complete for workload management reasons. VARO management concurred and initiated action to correct the inaccuracies.

Table 1 compares claims processing accuracy of the Detroit VARO with three VAROs previously inspected. We found the Detroit VARO to be comparable with two and better than one of the three VAROs previously inspected.

Table 1. Detroit VARO Claims Processing Accuracy Comparison

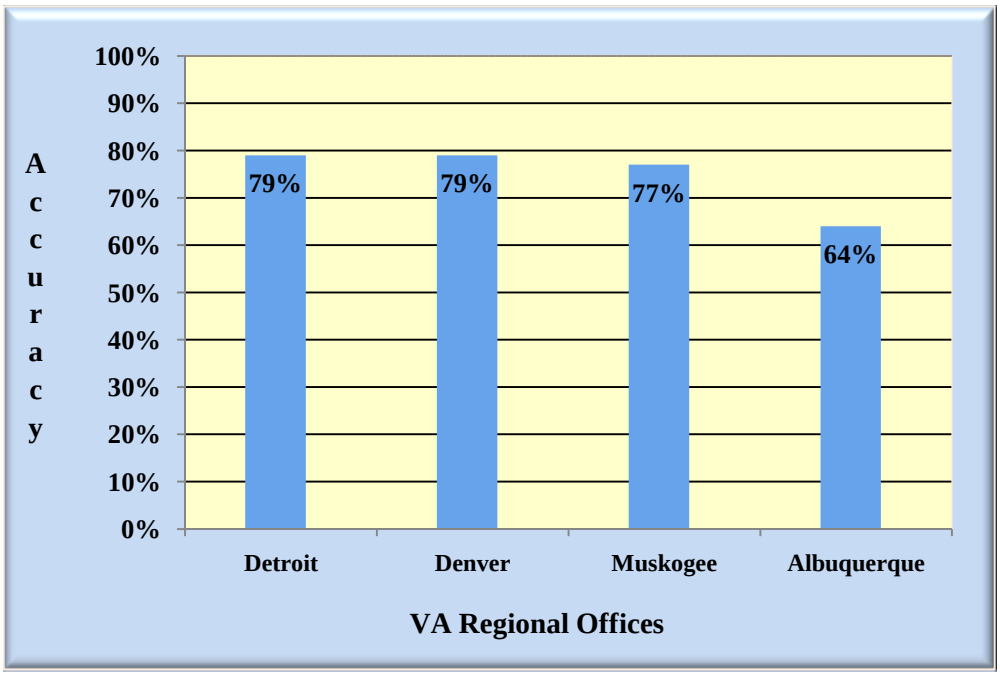

Table 2 reflects the errors affecting, and those with the potential to affect veterans' benefits processed at the Detroit VARO:

Table 2. Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Evaluations	30	27	9	18
PTSD	30	2	0	2
TBI	30	5	1	4
Disabilities Related to Herbicide Exposure	30	0	0	0
Total	**120**	**34**	**10**	**24**

Temporary 100 Percent Evaluations

VARO staff incorrectly processed 27 (90 percent) of the 30 temporary 100 percent disability evaluations. Of these 27 incorrect evaluations, however, staff at other VAROs **c**ompleted 9 (33 percent) of them as part of VBA's redistribution of workloads. 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, 9 of the total 27 processing inaccuracies affected veterans' benefits—seven involved overpayments totaling $551,295 and two involved underpayments totaling $1,344. Examples of the most significant overpayment and underpayment follow:

- A Rating Veterans Service Representative (RVSR) incorrectly granted service connection and assigned a temporary 100 percent evaluation for cancer. The veteran's claims folder did not contain medical evidence indicating a current diagnosis or treatment for cancer. As a result, VA overpaid the veteran a total of $175,558 over a period of 9 years and 10 months.
- An RVSR did not grant special monthly compensation for loss of the use of a creative organ resulting from treatment for prostate cancer. As a result, VA underpaid the veteran a total of $1,152 over a period of 12 months.

The remaining 18 inaccuracies had the potential to affect veterans' benefits. For 17 cases, staff at Detroit and other VAROs involved in the claims processing did not schedule the follow-up medical examinations needed to

determine whether the temporary 100 percent evaluation should continue. Because the veterans' claims folders did not contain the necessary medical examinations or other medical evidence, we could not determine if these temporary 100 percent evaluations would have continued. For the remaining case, VARO staff ordered the mandatory examination prior to our inspection, but 11 years and 11 months after the due date.

An average of 2 years and 9 months elapsed from the time staff should have scheduled medical exams to the date of our inspection or the date staff ultimately ordered the exams. The elapsed time ranged from 4 months to 11 years and 11 months. VARO staff initiated actions during our inspection to obtain the medical information needed to reevaluate these disabilities.

For temporary 100 percent evaluations, including those where ratings do not change the veteran's payment amount (confirmed and continued evaluations), VSC staff must input a diary in VBA's electronic system. A diary is a processing command established to maintain control of reexaminations scheduled for the future. As diaries mature, the electronic system generates reminder notifications to alert VSC staff to schedule follow-up medical examinations.

Generally, temporary 100 percent evaluation errors occurred because VSC staff did not properly record dates for future medical reexaminations in the electronic system as required. Further, eight of the Detroit VARO's inaccuracies resulted from staff not establishing diaries for confirmed and continued evaluations. As a result, veterans provided with temporary 100 percent evaluations did not always receive accurate benefits.

In July 2009, VARO management instituted local policy that required staff to review confirmed and continued decisions. This policy directed senior staff to provide oversight that could ensure employees created the diaries for future reexaminations. However, as all of the errors that resulted from the confirmed and continued evaluations occurred prior to this policy, we are unable to ascertain its effectiveness.

PTSD Claims

Detroit VARO staff incorrectly processed 2 (7 percent) of 30 PTSD claims. The two errors had the potential to affect veterans' benefits because staff prematurely denied service connection prior to obtaining all of the necessary evidence to verify the veterans' in-service stressful events. We did not consider the frequency of errors significant and as a result, determined the VARO generally followed VBA policy. We made no recommendations for improvement in this area.

TBI Claims

The Department of Defense and VBA commonly define a 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.

VARO staff incorrectly processed 5 (17 percent) of 30 TBI claims. One error affected a veteran's benefits. An RVSR incorrectly granted a separate evaluation for vertigo without a distinct diagnosis. As a result, VA overpaid the veteran a total of $3,810 for a period of 15 months.

Four of the five TBI inaccuracies had the potential to affect veterans' benefits. RVSRs incorrectly denied service connection for residual disabilities associated with TBIs for two cases. In one of those cases, the RVSR stated the evidence in the veterans claims folder did not show that an in-service event caused the TBI. However, we found the claims folder contained evidence showing that the veteran participated in combat, which concedes the in-service event. Currently, VBA policy does not require VARO staff to verify a stressful event if the claims folder contains evidence the veteran participated in combat.

RVSRs incorrectly evaluated the residual disabilities of TBIs in the two remaining cases because they used inadequate medical examinations when making their decisions. Neither VARO staff nor we can correctly ascertain all of the residuals of a TBI without adequate or complete medical examinations.

VSC staff stated they did not receive timely training after the change in TBI policy. Our analysis of the VARO's training plan confirmed RVSRs did not receive TBI training from December 2008 to September 2009. Further, despite VBA issuing new training materials and guidance in January 2009, RVSRs did not receive training on this new guidance until October 2009. Four of the five processing inaccuracies resulted from RVSRs not receiving the most current training available. Because VARO management was not timely in providing this training to RVSRs, veterans did not always receive correct benefits.

All TBI inaccuracies occurred prior to the October 2009 training event. Therefore, we made no recommendation for improvement. We will assess the effects of this training on TBI claims processing during a future inspection.

Disabilities Related to Herbicide Exposure Claims

VARO staff correctly processed all 30 herbicide related claims we selected and reviewed. As a result, we determined the VARO is generally following VBA policy regarding herbicide-related claims. We made no recommendations for improvement in this area.

Recommendations

1. *We recommend the Detroit 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 Detroit VA Regional Office Director develop and implement a plan to monitor compliance with their new policy for confirmed and continued decisions to ensure accurate processing of temporary 100 percent evaluations.*

Management Comments

The VARO Director concurred with our recommendations for improving the processing of temporary 100 percent disability determinations. Further, the Director agreed all cases reviewed required future medical examinations and re-adjudication based on the new examinations.

On May 7, 2010, all VSC staff received training on the proper procedures for updating systems, to include recording diary codes into the electronic system. The Director informed us local quality reviews will include a review of pending diaries to ensure staff follows proper procedures.

OIG Response

Management comments are responsive to the recommendations.

2. Data Integrity

In addition to specific inaccuracies identified in PTSD, TBI, herbicide disabilities, and temporary 100 percent evaluation claims processing, we identified inaccuracies with effective payment dates. Generally, the effective date of payment is the date that entitlement to a specific benefit arose.

Further, we reviewed claims folders to determine if the VARO is following VBA policy regarding the correct establishment of the date of claim in the electronic record. The date of claim is generally used to indicate when a document arrives at a specific VA facility. 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.

Effective Dates

VARO staff incorrectly processed effective dates for 4 (3 percent) of 120 claims reviewed. All four of these errors affected veterans' benefits: one involved an overpayment totaling $6,738 and three involved underpayments totaling $8,680. Details on the most significant overpayment and underpayment follow:

- An RVSR incorrectly granted service connection for prostate cancer effective April 30, 2007. The correct date was July 31, 2007, the date the VARO received the claim. As a result, the veteran was overpaid $6,738 over a period of 3 months.

- An RVSR incorrectly assigned an increased evaluation for prostate cancer effective October 27, 2004. The correct effective date for the increased disability evaluation was July 21, 2004; the earliest date private medical records showed the veteran had a diagnosis that warranted an increased evaluation. As a result, the veteran was underpaid $4,491 over a period of 3 months.

Because we found only 4 inaccuracies out of 120 claims reviewed, we determined the VARO is generally following VBA policy. As such, we made no recommendation for improvement.

Dates of Claim

VARO staff generally established the correct dates of claim in the electronic record. The date of claim designates when a VA facility receives a document. Generally, VAROs use the date of claim 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.

We reviewed 30 claims folders to determine if the VARO is following VBA policy regarding the correct establishment of the date of claim in the electronic record. Because we found only one inaccuracy, we determined the VARO is generally following VBA policy regarding dates of claim, and we made no recommendations for improvement.

Finding Controls over Recording Notices of Disagreement Need Strengthening

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 benefits decision and a desire to contest the decision. An NOD is the first step in the appeals process. The Appeals Team is responsible for the timely entering of NODs into VACOLS.

VACOLS is an application that allows VARO staff to control and track a veteran's appeal and manage the pending appeals workload. VBA policy states staff must create a VACOLS record within 7 days of receiving an NOD. Accurate and timely recording of an NOD into VACOLS is required to ensure the appeal moves through the appellate process expeditiously.

VARO staff exceeded VBA's 7-day standard for 10 (33 percent) of the 30 NODs we reviewed. It took staff an average of 26 days to record these 10 NODs into VACOLS. The most untimely action occurred when staff did not create a record for 48 days. As of April 2010, the station was not meeting the 7-day standard; however, staff recorded the disagreements into VACOLS an average of 3 days less than the 15-day national average. The

station's workload management plan did not include controls to ensure staff recorded these disagreements into VACOLS within 7 days of receipt.

Further, VSC management indicated the station's mail plan lacked instructions for delivery of Appeals Team mail. We determined the mail plan did not contain a delivery schedule or identify staff responsible for the distribution of this mail; VBA policy requires the plan to contain both of these elements.

NODs were pending completion for an average of 195 days during the period of October 2009 to April 2010. During that period, the VARO did not meet its station goal of an average of 183 days for NOD completion.

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

3. *We recommend the Detroit VA Regional Office Director amend the current mail plan to establish delivery procedures for Appeals Team mail and controls to ensure VARO staff record Notices of Disagreement in the Veterans Appeals Control and Locator System within the 7-day standard.*

Management Comments

The VARO Director concurred with our recommendation and reassigned the responsibility for establishing electronic appellate records for NODs to the Appeals Team. Management established new workload reports to account for and track appeals mail. Further, the Appeals Team supervisor is now responsible for locating and reviewing all pending appeals mail.

OIG Response

Management's comments are responsive to the recommendation.

3. Management Controls

Systematic Analysis of Operations

Detroit VARO management generally followed VBA policies by timely and accurately completing required SAOs. An SAO is a formal analysis of an organizational element or operational function of the VSC. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. For two of the 12 SAOs, minor sections of the analyses were untimely or incomplete. However, this did not have an effect on VSC operations, and we made no recommendations for improvement.

Systematic Technical Accuracy Review

The STAR Program is VBA's multi-faceted quality assurance program to ensure veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires the VARO take corrective action on errors identified by STAR.

We assessed management controls to determine if VARO management adhered to VBA policy regarding the correction of errors identified by STAR staff. VARO management needs to strengthen oversight in correcting errors identified by VBA's STAR Program staff.

Finding Errors Identified by STAR Program Not Always Corrected

VARO staff did not correct 2 (12 percent) of 17 errors identified by VBA's STAR Program staff between October–December 2009. VSC management took corrective action for the following errors we identified that had the potential to affect veterans' benefits:

- STAR instructed the VARO to correct a previous rating decision that failed to address a veteran's claimed condition. The veteran claimed service connection for a lung condition; however, the RVSR did not include this information when completing the rating decision. VARO staff erroneously notified STAR that they corrected the error identified.
- STAR instructed the VARO to send a mandatory letter describing VA's responsibility to assist a veteran with developing evidence to support a claim. VARO staff erroneously notified STAR they corrected the error; however, we found that the staff never sent the letter.

Supervisors at the Detroit VARO are responsible for ensuring the correction of errors identified by STAR. These supervisors incorrectly reported correction of the errors to a Program Support Assistant. The Program Support Assistant subsequently reported the inaccurate information to both VSC management and STAR. VSC management lacked a process to review these errors prior to relaying it to VBA's STAR Program staff. Because VARO staff did not correct these errors, veterans may not have received the correct benefits.

Recommendation

4. *We recommend the Detroit VA Regional Office Director develop and implement a plan to ensure staff take corrective action to address errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review Program.*

Management Comments

The VARO Director concurred with our recommendation and implemented a new policy requiring division management to certify that staff reviewed and corrected all errors identified by STAR program staff.

OIG Response

Management comments and actions are responsive to the recommendation.

4. Workload Management

Mail Handling Procedures

VBA policy states effective mail management is crucial to the success and control of workflow within the VSC. Detroit VARO management followed VBA policy by ensuring the accurate and timely processing of claims-related mail. VARO mailroom staff followed VBA policy regarding the processing of mail to other divisions within the VARO. In addition, the Triage Team followed policy because mail was controlled, processed, and routed to the appropriate locations within the VARO timely and accurately.

A prior OIG report, *Audit of VA Regional Office Claims-Related Mail Processing* (Report No. 08-01759-234, September 30, 2009) identified control weaknesses within the Detroit VARO Triage Team. In response, the Regional Office made improvements by increasing Triage Team staffing levels, establishing a secure room for mail processing, and assigning a different supervisor who improved oversight of the Triage Team workload.

Performance of the Triage Team improved because of changes made by Detroit's VARO management. VBA required staff to establish 80 percent of claims within 7 days. In September 2008, the VARO established 64 percent of claims within 7 days; however, one year later, the station exceeded VBA's standard as staff established 84 percent of its claims within 7 days.

5. Eligibility Determinations

VA must consider beneficiary competency in every case involving a mental health condition that is totally disabling or when evidence raises questions as to a beneficiary's mental capacity to manage his or her affairs. As part of the Public Contact Team, the Fiduciary Unit supports implementation of incompetency determinations by appointing fiduciaries, third parties that assist in managing funds, for incompetent beneficiaries. We reviewed competency determinations completed by the VSC Decision Team to ensure staff completed them accurately and timely. Delays in making these determinations ultimately affect the Fiduciary Unit's ability to appoint fiduciaries timely.

Finding Controls over Incompetency Determinations Need Strengthening

Incompetency Determinations

The VARO completed actions on 85 incompetency determinations during October–December 2009. Staff unnecessarily delayed making final decisions in 14 (47 percent) of the 30 cases we reviewed. These delays ranged from approximately 17 to 85 days. Delays occurred because management did not ensure staff followed the station's workload management plan. Unnecessary delays increase the risk of an incompetent beneficiary receiving benefits payments without a fiduciary to manage those benefits and ensure the beneficiary's welfare.

VBA policy requires staff to prepare a decision proposing a finding of incompetency after receiving clear and convincing medical evidence a beneficiary is incapable of managing his or her affairs. Prior to making a final decision, policy allows a 65-day due process period for the beneficiary to submit evidence showing an inability to manage funds and other personal affairs. At the end of the due process period, VARO staff must take immediate action to determine if the beneficiary is incompetent.

In the absence of a definition of "immediate", we allowed 14 calendar days after the due process period to determine if staff were timely in completing the competency decisions. We considered this a reasonable period to control, prioritize, and finalize these types of cases. Any delays in completing competency decisions increase the risk that incompetent beneficiaries might mishandle VA benefits.

Using our interpretation of "immediate", the most significant case we identified occurred when VARO staff unnecessarily delayed making a final incompetency decision for a veteran for approximately 3 months. During this period, the veteran received disability payments of $6,954. While the veteran was entitled to these payments, fiduciary stewardship was not in place to provide effective management of funds nor to ensure the welfare of the veteran.

Rather than follow workload management plan requirements, management appointed one employee to identify and distribute these cases to Veterans Service Representatives after the due process period had expired. The VSC workload management plan requires Veteran Service Representatives to identify assigned cases approximately 1 week prior to the expiration of the 65-day due process period. Additionally, VSC management did not establish procedures to ensure these cases received immediate processing once routed to the Decision Team for final competency determinations. As a result, incompetent beneficiaries received benefits payments for extended periods despite being incapable of managing these funds effectively.

VARO and VSC management do not agree with the OIG's 14-day definition of "immediate" because VBA has not established an official standard for making a timely competency determination. Management stated their interpretation of "immediate" fluctuates based upon the station's workload and available personnel. Although management did not agree with our definition of immediate, it did not appear that its interpretation established efficient internal controls to achieve the program's timeliness objectives as intended by existing policy.

In addition to the inaccuracies related to processing delays, we identified three instances where staff did not follow VBA policy when determining if beneficiaries were competent to handle VA funds. For two incompetency determinations, VSC staff incorrectly determined the beneficiaries were incompetent without adequate medical evidence demonstrating they could not manage their affairs. For one inaccuracy, VSC staff incorrectly determined the beneficiary incompetent without providing the mandatory 65-day due process period.

These inaccuracies resulted in $76,810 provided to fiduciaries prematurely appointed by VSC staff. We did not consider the frequency of errors significant and as a result, we made no recommendations for improvement in this area.

Recommendations

5. *We recommend the Detroit VA Regional Office Director consult with the Veterans Benefits Administration's Compensation and Pension Service to discuss establishing a standard that ensures immediate completion of final competency determinations.*

Management Comments

The VARO Director deferred comment on this recommendation. The Director stated the recommendation was outside the scope of the VARO and forwarded the recommendation to VBA's Compensation and Pension Service.

OIG Response

We are issuing a Management Advisory memorandum to the Under Secretary of Benefits. The Management Advisory will address our concerns regarding the establishment of a standard to ensure timely completion of final competency determinations.

Appendix A VARO Profile and Scope of Inspection

Organization

The Detroit VARO is responsible for delivering non-medical VA benefits and services to veterans and their families in Michigan. The VARO fulfills these responsibilities through the administration of disability compensation benefits, Veterans' and Dependents' Education and Training, Vocational Rehabilitation and Employment Assistance, Special Benefits for the Disabled, and outreach activities.

Resources

As of March 2010, the Detroit VARO had a staffing level of 227 full-time employees. Of the 227 full-time employees, 162 (71 percent) were assigned to the VSC.

Workload

As of March 2010, the VARO reported 13,737 pending compensation claims. The average time to complete these claims during FY 2010 was 216.5 days—59.3 days above the station target of 157.2 days. As reported by STAR, accuracy for compensation rating-related issues was 82.3 percent or 7.7 percent below the VBA's station target of 90 percent. Accuracy for compensation authorization-related issues was 95.9 percent or slightly below VBA's station 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 consisted of 90 (9 percent) of 991 claims related to PTSD, TBI, and herbicide exposure-related disabilities that the VARO completed during October–December 2009. In addition, we reviewed 30 (13 percent) of 232 rating decisions where VARO staff granted temporary 100 percent evaluations for at least 18 months, generally the longest period under VA policy that a temporary 100 percent evaluation may be assigned without review. We provided the VARO with the remaining 202 cases to assist in implementing our first report recommendation.

We reviewed incompetency determinations and errors identified by VBA's STAR Program completed during the period of October–December 2009. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR's measurements include a review of work associated with claims that require rating decisions. STAR staff review original and reopened claims as well as appellate issues that involve a myriad of veterans' disabilities claims.

Our process differs from the STAR Program as we review specific types of claims issues that require rating decisions, such as PTSD, TBI, and

disabilities associated with herbicide exposure. In addition, we review rating decisions and awards processing involving temporary 100 percent evaluations.

We selected for our review claim dates and NODs pending at the VARO during 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 30, 2010**

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

Subject: **Inspection of VARO Detroit, MI**

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

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

2. Questions may be referred to Rodney Cline, Management Analyst, at 313-471-3602.

(original signed by:)
LINDA C. WALKER
Director

Attachment

Comments on Draft Report
OIG Office of Audits and Evaluations
Benefits Inspection of the Detroit Regional Office

Recommendation 1. *We recommend the Detroit 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.*

VARO Response: Concur.

The Regional Office (RO) agrees that routine future examinations are needed in all cases that were reviewed. As of July 16, 2010, VA examinations had been requested for all cases, including those on the list provided at the end of the OIG visit. Some cases have already been re-adjudicated; others are pending the actual examinations. The RO will ensure that these cases are re-adjudicated immediately after examinations are held and results released.

While the OIG was on site, the RO also provided documentation to show that appropriate actions were annotated in the files to show the correct input at the time of decision and award actions. Compensation and Pension (C&P) Service guidance, systems' update notices and applicable policy were followed in addressing this issue.

Recommendation 2. *We recommend the Detroit VA Regional Office Director develop and implement a plan to monitor compliance with their new policy for confirmed and continued decisions to ensure accurate processing of temporary 100 percent evaluations.*

VARO Response: Concur

The RO agrees that there was a problem when processing final rating actions where no system award was required at time of disposition. All Service Center employees received training on May 7, 2010, addressing the system updates required when promulgating confirmed and continued actions. Training was documented in employee training records, and the training communication was provided to the OIG for reference purposes.

Employees were also shown how to input future diaries into the electronic records as an additional measure to ensure proper coding when processing awards. These inputs have been incorporated in routine work assignments as a mandatory case-review requirement during promulgation and authorization actions. Local quality reviews will include review of the pending diaries to ensure that these procedures are followed.

Recommendation 3. *We recommend the Detroit VA Regional Office Director amend the current mail plan to establish delivery procedures for Appeals Team mail and controls to ensure VARO staff record Notices of Disagreement in the Veterans Appeals Control and Locator System within the 7-day standard.*

VARO Response: Concur

On May 10, 2010, the RO implemented a process that requires daily pick up of Appeals' mail from the Triage team. The responsibility for establishing the electronic appellate records for Notices of Disagreement (NODs) has been reassigned to Appeals team employees to ensure that all mail is placed under control within 7 days. All other mail is categorized and tracked for timely completion. When dual issues exist, Triage and Appeals teams will work together to establish claims and hand-carry actions within 2-days of processing.

The Appeals team supervisor is responsible for centrally locating and reviewing pending mail in the same manner as Triage. New workload reports have been established to ensure that Appeals mail is properly accounted for and tracked.

Recommendation 4. *We recommend the Detroit VA Regional Office Director develop and implement a plan to ensure staff takes corrective action to address errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review Program.*

VARO Response: Concur

On May 10, 2010, VSC management implemented a new Systematic Technical Accuracy Review (STAR) policy that all folders for corrected STAR errors are forwarded for division manager review. Division managers will sign off on STAR review sheets as certification that an error has been reviewed and issues corrected. These sheets will be used to certify to STAR that corrections have been made. The review sheets will be maintained for 13 months for record tracking purposes.

Recommendation 5. *We recommend the Detroit VA Regional Office Director consult with the Veterans Benefits Administration's Compensation and Pension Service to discuss establishing a standard that ensures immediate completion of final competency determinations.*

VARO Response: Defer

This recommendation is outside of the scope of the Detroit Regional Office. This recommendation will be forwarded to C&P Leadership for consideration.

Appendix C Inspection Summary

10 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 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 Analysis of Operations	Determine if VARO staff properly performed formal analyses of their operations through completion of SAOs. (M21-4, Chapter 5)	X	
8. Systematic Technical Accuracy	Determine if VARO staff properly corrected STAR identified errors in accordance with VBA policy. (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	
Eligibility Determinations			
10. Incompetency Determinations	Determine if VARO staff properly assessed beneficiaries' mental capacities to manage VA benefit payments. (M21-1MR Part III, Subpart v, Chapter 9, Section A) (M21-1MR Part III. Subpart v, Chapter 9, Section B) (Fast Letter 09-08)		X

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	Brent Arronte (727) 395-2425
Acknowledgments	Danny Clay Brett Byrd Madeline Cantu Kelly Crawford Lee Giesbrecht Lisa Van Haeren

Appendix E Report Distribution

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Veterans Benefits Administration
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VBA Eastern Area Director
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