VA Office of Inspector General

OFFICE OF AUDITS & EVALUATIONS

# Inspection of the VA Regional Office Milwaukee, WI

January 21, 2011
10-03565-69

# ACRONYMS AND ABBREVIATIONS

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

# Report Highlights: Inspection of the VA Regional Office, Milwaukee, WI

## 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 Milwaukee VARO correctly processed post-traumatic stress disorder (PTSD) disability claims and generally followed the Veterans Benefits Administration's (VBA) policy for processing claims related to herbicide exposure. Management ensured staff generally followed VBA's policy for establishing dates of claim in the electronic record and processing mail within the VARO mailroom and Triage. Further, all Systematic Analyses of Operations (SAOs) were timely and complete and staff corrected all errors identified by VBA's Systematic Technical Accuracy Review (STAR) program.

VARO management needs to improve the control and accuracy of processing of temporary 100 percent evaluations and traumatic brain injury (TBI) claims. Overall, VARO staff did not accurately process 24 (22 percent) of the 111 disability claims reviewed.

Management also needs to strengthen controls over recording Notices of Disagreement (NODs) for appealed claims and ensure accurate processing of final competency determinations.

## What We Recommended

We recommended that Milwaukee VARO management review all temporary 100 percent evaluations to determine if reevaluations are required and take appropriate actions. Management needs to implement controls to ensure VSC staff establish suspense diaries to request medical examinations for temporary 100 percent disability reevaluations. Further, we recommended management provide refresher training on the proper procedures for processing TBI claims and implement a plan to have an additional level of review prior to finalizing TBI decisions.

Additionally, we recommended Milwaukee VARO management strengthen controls to ensure timely establishment of NODs in the Veterans Appeals Control and Locator System (VACOLS), and develop and implement a plan to ensure staff review up-to-date medical evidence in all cases involving court declarations of incompetency.

## Agency Comments

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

*(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 efforts of the Office of Inspector General (OIG) to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Division contributes to 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 and 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 August 2010, the OIG conducted an inspection of the Milwaukee 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 81 (19 percent) of 435 disability claims related to PTSD, TBI, and herbicide exposure that the VARO completed during April to June 2010. In addition, we reviewed 30 (16 percent) of 182 rating decisions where VARO staff granted temporary 100 percent evaluations for at least 18 months, generally the longest period a temporary 100 percent evaluation may be assigned under VA policy without review.

Appendix A provides details on the VARO and the scope of the inspection. Appendix B provides the Milwaukee VARO Director's comments on a draft of this report. Appendix C provides 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 herbicide exposure. We evaluated claims processing accuracy and its impact on veterans' benefits.

**Finding** **VARO Staff Need to Improve Disability Claims Processing Accuracy**

The Milwaukee VARO needs to improve the processing accuracy of temporary 100 percent disability evaluations and TBI claims. VARO staff incorrectly processed 24 (22 percent) of the total 111 disability claims reviewed. VARO management concurred with our findings and initiated action to correct the inaccuracies identified.

The following table reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Milwaukee VARO.

***Table***

**Disability Claims Processing Results**

| Type | Reviewed | Claims Incorrectly Processed | | |
|---|---|---|---|---|
| | | Total | Affecting Veterans' Benefits | Potential To Affect Veterans' Benefits |
| **Temporary 100 Percent Evaluations** | 30 | 14 | 4 | 10 |
| **PTSD** | 30 | 0 | 0 | 0 |
| **TBI** | 21 | 8 | 1 | 7 |
| **Disabilities Related to Herbicide Exposure** | 30 | 2 | 0 | 2 |
| **Total** | **111** | **24** | **5** | **19** |

***Temporary 100 Percent Evaluations***

VARO staff incorrectly processed 14 (47 percent) of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent evaluation for a service-connected disability needing surgery or specific treatment. At the end of a mandated period of convalescence or cessation of treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

Based on analysis of available medical evidence, 4 of the 14 processing inaccuracies affected veterans' benefits. They all involved overpayments

totaling approximately $100,824. In the case of the most significant overpayment, a Rating Veterans Service Representative (RVSR) correctly proposed reducing a veteran's bladder cancer evaluation from 100 to 10 percent. However, at the time of our inspection, the VSC staff had not taken the final action to reduce the veteran's benefits. As a result, VA overpaid the veteran $82,430 over a period of 3 years and 6 months.

The remaining 10 inaccuracies had the potential to affect veterans' benefits. All 10 involved rating decisions that established the need for future reexaminations of temporary 100 percent disabilities. However, VSC staff did not schedule the follow-up medical examinations needed to determine whether the temporary 100 percent evaluations should continue.

We could not determine if the 10 temporary 100 percent disability determinations would have continued because the veterans' claims folders did not contain evidence of the medical examinations needed to reevaluate each case. An average of approximately 2 years and 8 months elapsed from the time staff should have scheduled these medical examinations until the date of our inspection—the date staff ultimately ordered the examinations to obtain the necessary medical evidence. The delays ranged from approximately 3 months to 8 years and 8 months.

For temporary 100 percent evaluations, including those where rating decisions do not change a veteran's payment amount (confirmed and continued evaluations), VSC staff must input suspense diaries in VBA's electronic system. A diary is a processing command that establishes a date when VSC staff must schedule reexaminations. As diaries mature, the electronic system generates reminder notifications to alert VSC staff to schedule the reexaminations.

Eight of the 14 temporary 100 percent errors resulted from staff not establishing diaries for confirmed and continued evaluations. VSC management stated, and we verified, that the office had no procedure in place requiring senior staff to review implementation of confirmed and continued rating decisions. As such, oversight did not occur to ensure staff properly established diaries for these decisions.

***PTSD Claims***

VARO staff correctly processed all 30 PTSD claims reviewed. Therefore, we made no recommendations for improvement in this area.

***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 policy requires staff to evaluate these residual disabilities.

VARO staff incorrectly processed 8 (38 percent) of 21 TBI claims. In the case of the inaccuracy that affected a veteran's benefits, an RVSR incorrectly increased the evaluation for service-connected post-traumatic headaches from 10 to 30 percent disabling without a medical diagnosis of migraine headaches. As a result, VA overpaid the veteran $3,681 over a period of 1 year and 5 months.

Following are details on the remaining seven TBI inaccuracies that had the potential to affect veterans' benefits:

- In two cases, RVSRs incorrectly granted service connection for residual TBI-related disabilities to veterans who were also service-connected for PTSD. In both cases, the medical examinations did not specifically state, as required, whether the veterans' complaints and symptoms of mild memory loss were due to either TBI or PTSD.
- In two cases, RVSRs prematurely evaluated residual TBI-related disabilities using inadequate medical examinations. Neither VARO staff nor we can ascertain all of the residual disabilities related to a TBI without adequate or complete medical evidence.
- In one case, an RVSR incorrectly granted service connection for a disability associated with a TBI without medical evidence providing a link between the diagnosis and the TBI. This rating did not affect the veteran's current 80 percent disability evaluation, but may affect future evaluations for additional benefits.
- In one case, an RVSR incorrectly continued separate evaluations for TBI-related disabilities and vertigo based on a medical examination. This rating did not affect the veteran's current 90 percent disability evaluation, but may affect future evaluations for additional benefits.
- In one case, an RVSR did not assign a separate evaluation for migraine headaches despite a distinct diagnosis in the VA medical examination. This rating did not affect the veteran's current disability evaluation, but may affect future evaluations for additional benefits.

Generally, errors associated with TBI claims processing occurred because VSC staff interpreted VBA policy incorrectly. Interviews with VARO staff indicated that TBI regulations and policies were difficult to understand. Although RVSRs are required to return inadequate examinations, our inspection revealed four RVSRs made decisions using the results of inadequate examinations. These RVSRs incorrectly established or denied service connection for conditions associated with TBI. As a result, veterans did not always receive correct healthcare entitlements or benefits payments.

**Herbicide Exposure-Related Claims**

VARO staff incorrectly processed 2 (7 percent) of 30 herbicide exposure-related claims reviewed. We did not consider the frequency of errors significant; however, these errors could potentially affect veterans' benefits. Following is a summary of the inaccuracies we identified regarding herbicide exposure-related disability claims.

- An RVSR granted service connection for diffuse large B cell lymphoma associated with herbicide exposure. The medical evidence also showed a diagnosis of diabetes mellitus type II, an herbicide exposure-related disability. However, VSC staff took no action to notify the veteran of potential entitlement to service connection for this condition. This rating did not affect the veteran's current 100 percent disability evaluation, but may affect future evaluations for additional benefits.
- An RVSR granted service connection for diabetes associated with herbicide exposure. The VA medical examination and VA treatment reports showed a diagnosis of glaucoma, a known complication of diabetes. However, VARO staff did not request an eye examination. Neither VARO staff nor we can determine service connection for conditions that are known complications of diabetes mellitus without adequate medical evidence.

Because the VARO had only two inaccuracies, we made no recommendations for improvement.

**Recommendations**

1. *We recommend the Milwaukee 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 Milwaukee VA Regional Office Director implement controls and conduct refresher training to ensure staff establish suspense diaries for temporary 100 percent disability reevaluations.*
3. *We recommend the Milwaukee VA Regional Office Director conduct refresher training to ensure Rating Veterans Service Representatives properly evaluate disabilities related to traumatic brain injuries.*
4. *We recommend the Milwaukee VA Regional Office Director establish an additional level of review for all traumatic brain injury rating decisions prior to finalizing the decision to ensure accurate benefit payments.*

**Management Comments**

The VARO Director concurred with our recommendations for improving disability claims processing accuracy. VSC staff reviewed an additional 162 cases identified by the OIG and determined 94 did not have controls in place to ensure staff scheduled future examinations. The Director reported all Veterans Service Representatives (VSRs) received additional guidance on the proper procedures for establishing suspense diary controls for future

examinations. The Director amended the VSC's quality control procedures to provide oversight to ensure the establishment of suspense diaries.

Further, the VARO Director stated that in October 2010, VSRs received training on the establishment of suspense diaries and RVSRs received training regarding the proper procedures for evaluating TBI-related claims. In September and October 2010, VARO staff provided training to the VA Medical Center on requirements for a sufficient TBI-related medical examination. The VARO Director also amended the VSC's quality control procedures to require a second accuracy review for all TBI-related claims.

The Director countered that not all temporary 100 percent disability claims, regardless of timeframe or diagnostic code, warranted review. In an additional comment, the Director pointed out our report states the VARO needs to improve the accuracy of disability claims processing, but revealed no errors in PTSD claims and an insignificant number of errors in herbicide-related claims. Because of this, he believed our report needs to indicate that only 100 percent disability claims pending 18 months or more and TBI claims need improvement.

***OIG Response*** Management's comments and actions are responsive to the recommendations. The Director indicated that he did not believe a review of all temporary 100 percent disability evaluations regardless of diagnostic code or timeframe was necessary; however, that was not the intent of our recommendation. To help the VARO further identify problems and take corrective actions, we proposed the VARO review the 162 additional temporary 100 percent evaluations that we did not include in our sample. The Director reported that VARO staff completed the review of all 162 claims so no further action is needed to respond to Recommendation 1.

With respect to the Director's additional comment regarding language in our report, it should be noted that we had documented on our Report Highlights page that the VARO correctly processed PTSD claims and generally followed VBA's policy for processing herbicide-related claims. Further, we said in Report Highlights that management needs to improve accuracy of processing temporary 100 percent evaluations and TBI claims. We agree with the Director about clarifying in the report body the actual disability claims processing areas that need improvement. As such, we revised the report as appropriate to reflect better the overall claims processing accuracy of the VARO.

## 2. Data Integrity

We analyzed claims folders to determine if the VARO is following VBA policy to establish effective dates and dates of claim in electronic records and to timely record NODs in VACOLS.

***Effective Dates***

Generally, an effective date indicates when entitlement to a specific benefit arose. VARO staff followed VBA policy and correctly established an effective date for all 111 disability claims we reviewed. As such, we made no recommendation for improvement in this area.

***Dates of Claim***

In addition to establishing the time frame for benefits entitlement, VBA generally uses a date of claim to indicate when a document arrives at a VA facility. VBA relies on accurate dates of claim to establish and track key performance measures, including the average days to complete a claim.

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

***Notices of Disagreement***

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. VACOLS is a computer 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 NODs is required to ensure appeals move through the appellate process expeditiously. VARO management needs to strengthen controls over recording NODs in VACOLS.

## Finding Controls over Recording Notices of Disagreement Need Strengthening

The VARO's Appeals Team did not consistently record NODs in VACOLS within VBA's 7-day standard. VARO staff exceeded VBA's 7-day standard for 16 (53 percent) of the 30 NODs we reviewed. It took staff an average of 14 days to record these 16 NODs in VACOLS. The most untimely action occurred when staff did not create a record for 28 days. The delays occurred because the Milwaukee VARO workload management plan and local procedures did not incorporate provisions to ensure prompt control of NODs in VACOLS. The Appeals Team staff also was not aware of the national standard regarding Appeals Control Time. VSC staff's untimely recording of NODs in VACOLS affects data integrity and misrepresents VARO performance.

As of August 2010, the VARO averaged 13 days to control NODs, exceeding the VBA goal by 6 days. Although staff can improve appeal

control time, the VARO's NODs have been pending completion an average of 126 days, 82 days better than the national average of 208 days.

Data integrity issues make it difficult for VARO and senior VBA leadership to accurately measure and monitor VARO performance. Further, VBA's National Call Centers rely upon VACOLS information to provide accurate customer service to veterans. Unnecessary delays in controlling NODs affect national performance measures for NOD inventory and timeliness.

***Recommendation***

5. *We recommend the Milwaukee VA Regional Office Director develop and implement a plan to ensure staff record Notices of Disagreement in the Veterans Appeals Control and Locator System within 7 days as required by VBA policy.*

***Management Comments***

The VARO Director concurred with our recommendation. The Director informed us that on September 8, 2010, management provided guidance to claims assistants instructing them on the proper procedures for daily recording NODs. Further, according to the guidance, claims assistants shall provide supervisors any NOD pending longer than 7 days. The Director reported that since our inspection, NOD timeliness had improved and was better than VBA's 7-day standard.

The Director also provided an additional comment regarding what we determined to be the root cause for NOD processing inaccuracies. Specifically, he indicated the VARO Workload Management Plan directs claims assistants to enter NODs within 2 days of receipt. Because of this, he stated the report incorrectly identified the root cause as a management oversight issue versus a local resource utilization issue.

***OIG Response***

Management's action to provide guidance is responsive to the recommendation. We are encouraged by the Director's report that NOD timeliness has improved since our review. With respect to the root cause for NOD delays, we believe that proper resource utilization is part of management oversight, not a separate issue. Although the Workload Management Plan directs the claims assistants to enter NODs within 2 days, it does not provide for management oversight to ensure this occurs.

## 3. Management Controls

We assessed management controls to determine if VARO management adhered to VBA policy regarding correction of errors identified by VBA's STAR staff. Further, we assessed controls to determine if VARO management completed timely SAOs, which address necessary elements and operational functions of the VSC.

***Systematic Technical Accuracy Review***

The STAR program is VBA's multi-faceted quality assurance program to ensure that veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that the VARO take corrective action on errors that STAR identifies. VARO staff adhered to VBA policy by taking corrective action on all 13 errors identified by VBA's STAR program from April to June 2010. Therefore, we made no recommendations for improvement in this area.

***Systematic Analysis of Operations***

An SAO is a formal analysis of a VSC organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish an annual SAO schedule designating the staff required to complete the SAOs by specific dates. Milwaukee VARO management followed VBA policies by timely completing all 12 required SAOs. For all SAOs where staff identified existing or potential problems, management made recommendations for improvement. Therefore, we made no recommendations for improvement in this area.

## 4. Workload Management

We assessed controls over VARO mailroom operations to ensure staff timely and accurately processed incoming mail. Further, we assessed the VSC's Triage Team mail processing procedures to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy.

***Mail Room Operations***

VBA policy states staff will open, date stamp, and route all mail to the appropriate locations within 4–6 hours of receipt at the VARO. The Milwaukee VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division. Staff were timely and accurate in processing, date stamping, and delivering VSC mail to the Triage Team control point at least twice daily. As a result, we determined the VARO Support Services mailroom is following VBA policy. Therefore, we made no recommendations for improvement in this area.

***Triage Mail Processing Procedures***

VARO staff are required to use VBA's tracking system, Control of Veterans Records System (COVERS), to electronically track veterans' claims folders and control search mail. VBA defines search mail as active claims-related mail waiting to be associated with a veteran's claims folder. Further, if claims folders are located in the file storage area, staff should not place mail on search.

The Triage Team is responsible for reviewing, controlling, and processing or routing all incoming mail for the VSC. The Triage team incorrectly processed 1 (3 percent) of 30 pieces of search mail we reviewed. As a result, we determined the Triage Team is generally following the station's mail

handling procedures. Therefore, we made no recommendations for improvement in this area.

## 5. Eligibility Determinations

***Competency 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. The Fiduciary Unit supports implementation of competency determinations by appointing a fiduciary, which is a third party that assists in managing funds for an incompetent beneficiary. We reviewed competency determinations made at the VARO to ensure staff completed them accurately and timely. Delays in making these determinations ultimately affect the Fiduciary Unit's ability to be timely in appointing fiduciaries. The VARO was timely in processing all 19 competency determinations reviewed.

### Finding Controls over Competency Determinations Need Strengthening

VARO staff incorrectly processed 4 (21 percent) of 19 competency determinations. This occurred because VSC staff misinterpreted VBA policy and did not obtain required medical evidence to support a court's determination of a veterans' incompetency. As a result, VSC staff prematurely deemed veterans incompetent without medical evidence demonstrating they were unable to handle their financial affairs.

VBA policy states that when a court finds a veteran incompetent, the VARO must obtain additional medical evidence to support the court's incompetency determination. VBA policy requires review of all medical evidence relating to incompetency prior to making a final competency determination. Judicial findings of a court with respect to the competency of a veteran are not binding upon VBA decisions. They are compelling evidence, but not a sole source of evidence.

In all four cases, VARO staff incorrectly determined the veterans were incompetent and appointed fiduciaries based solely upon court decrees of incompetency. VARO staff did not request additional medical evidence before determining the veterans' inability to manage their personal affairs, nor did they complete formal decisions before appointing the fiduciaries.

***Recommendation***

6. *We recommend that the Milwaukee VA Regional Office Director implement controls to ensure staff obtain and review current medical evidence in all cases involving court declarations of incompetency.*

***Management Comments***

The VARO Director concurred with our recommendation. On September 16, 2010, the Director provided guidance to all employees on how to process court declarations of incompetency. On October 19, 2010, fiduciary and post-decision employees received training on how to apply regulations regarding court-appointed fiduciaries. Further, the Director amended VSC's quality control procedures to provide oversight to ensure review of medical evidence in court declarations of incompetency.

The Director provided an additional comment regarding the scope of our review of competency determinations. Specifically, the Director remarked that our draft report did not contain information on timeliness in processing competency determinations. He believed that incorporating such information would provide a true measure of the VARO's performance.

***OIG Response***

Management's actions to provide training and guidance are responsive to the recommendations. With respect to the Director's additional comment, we agree that the report should contain information regarding the timeliness of competency determinations. Therefore, based on our inspection results, we added a statement indicating that the VARO was timely in processing all 19 competency determinations reviewed.

# Appendix A VARO Profile and Scope of Inspection

***Organization***

The Milwaukee VARO is responsible for delivering non-medical VA benefits and services to veterans and their families in Wisconsin. The VARO fulfills these responsibilities by administering compensation and pension benefits, vocational rehabilitation and employment assistance, and outreach activities.

***Resources***

As of June 2010, the Milwaukee VARO had a staffing level of 562 full-time employees. As of August 2010, 143 employees (25 percent) were assigned to the VSC.

***Workload***

As of August 2010, the VARO reported 6,643 pending compensation claims. The average time to complete claims during FY 2010 was 144.2 days—7 days less than the national target of 151.2 days. As reported by STAR, accuracy of compensation rating-related issues was 92 percent—2 percent above the 90 percent VBA target, and accuracy of compensation authorization-related issues was 99 percent—3 percent above the 96 percent VBA target.

***Scope***

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

Our review included 81 (19 percent) of 435 claims related to PTSD, TBI, and herbicide exposure-related disabilities that the VARO completed during April–June 2010. For temporary 100 percent disability evaluations, we selected 30 (16 percent) of 182 existing claims from VBA's Corporate Database. We provided the VARO with the 162 claims to assist in implementing our recommendation.

The 182 claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months. Because VARO staff processed too few temporary 100 percent evaluations during April–June 2010 for us to review and draw conclusions, we selected a sample from the universe of 182 existing claims.

We reviewed 19 available competency determinations and 13 errors identified by VBA's STAR Program during the period of April–June, 2010. 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 claims, reopened claims, and claims for increased evaluations.

Further, they review 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 herbicide exposure-related disabilities that require rating decisions. In addition, we review rating decisions and awards processing involving temporary 100 percent disability determinations.

We selected and reviewed dates of claim 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:** December 27, 2010

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

**Subj:** Inspection of the VARO Milwaukee, WI

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

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

2. Questions may be referred to Chris Norton, Veterans Service Center Manager, at (414) 902-5045.

*(original signed by:)*

Robert Granstrom
Director, VARO Milwaukee

Attachment

The Milwaukee VARO is in general concurrence with the findings and recommendations noted in the inspection report. However, we believe that some of the language in the draft presents an inaccurate picture of the overall performance of the Milwaukee RO as well as the root cause of the recommendations. Specifically, the RO would like to respectfully suggest the following changes:

1. On page 2 of the report, language suggests that the "Milwaukee Regional Office needs to improve the accuracy of disability claims processing", and notes a 22 percent error rate overall for the number of claims reviewed. Given that a) the scope of claims reviewed was limited to very specific types of claims, and b) no errors were noted in claims for PTSD and an insignificant number of errors were noted in association with herbicide exposure, the above language should be amended to reflect that

   "The Milwaukee VARO needs to improve the processing accuracy for claims for traumatic brain injury (TBI) and Temporary 100 percent evaluations pending greater than 18 months".

   We believe that this change would better reflect the overall claims processing accuracy of the regional office as well as the specific findings of the OIG claims review.

2. Page 7 of the report states that delays in NOD processing

   "occurred because the Milwaukee VARO workload management plan and loca**l** procedures did not incorporate provisions to ensure prompt control of NODs in VACOLS"

   We direct your attention to page 9 of the station Workload Management Plan, which directs that CAs are to input NODs within two days of receipt. While we concur with OIG's findings regarding the untimely input of NODs, we believe that the draft report incorrectly identifies the root cause as a managerial oversight vs. local resource utilization issue.

3. The OIG Scope of Inspection indicates that incompetency determinations will be reviewed for timely processing. However, the body of the draft report contains no metrics regarding timeliness. Suggest that timeliness data be incorporated into the report to provide a true measure of Regional Office performance and meet the parameters of the Scope of Inspection.

**Recommendation 1:** *We recommend the Milwaukee 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.*

**Milwaukee RO Response: Concur in part**

On November 8, 2010, the Milwaukee Regional Office completed review and action on the remaining 162 cases identified by the OIG involving temporary 100 percent disability evaluations pending greater than 18 months. Of those cases reviewed, 94 did not properly have future examination controls set due to either human error or systems (IT) constraints.

While we concur that numerous anomalies were identified among those cases reviewed (that is, those with a temporary 100 percent evaluation in effect for longer than 18 months), we do not concur that this warrants review of all claims in which a temporary 100 percent evaluation is in effect regardless of timeframe or diagnostic code.

It is our understanding that VBA Central Office is formulating a response to a similar recommendation, with specific review to be targeted towards disability-specific problem areas and limited to the three most commonly identified diagnostic codes. The Milwaukee Regional Office respectfully defers further action on the OIG recommendation beyond those claims identified above pending Central Office guidance.

**Recommendation 2:** *We recommend the Milwaukee VA Regional Office Director implement controls and conduct refresher training to ensure staff establish suspense diaries for temporary 100 percent reevaluations.*

**Milwaukee RO Response: Concur**

An email was sent to all VSRs on the Post-determination team on August 31, 2010 reminding them of diary procedures and potential system errors. VSRs were instructed to review all work to ensure any future diary is properly reflected in the systems. Additional guidance to include manual references was provided on September 15, 2010, and a training session was conducted on October 19, 2010 to clarify any questions or concerns.

Authorizers have been instructed to review for diaries prior to the authorization of any award. In addition, reviewing for proper diary procedures has been incorporated and emphasized during local SQC review. Finally, future examination quality will be addressed in the yearly Systematic Review of Operations on the Quality of Authorization Actions.

**Recommendation 3:** *We recommend the Milwaukee VA Regional Office Director conduct refresher training to ensure Rating Veterans Service Representatives properly evaluate disabilities related to traumatic brain injuries.*

**Milwaukee RO Response: Concur**

Training for all RVSRs on traumatic brain injuries was conducted on October 13th, 2010 and incorporated both C&P training materials and the actual errors noted by OIG.

In addition, training was provided for VAMC staff during the months of September and October 2010 to ensure that VA exam results are sufficient for rating.

Additional training on traumatic brain injuries was conducted by C&P training staff on December 1, 2010.

**Recommendation 4:** *We recommend the Milwaukee VA Regional Office Director establish an additional level of review for all traumatic brain injury decisions prior to finalizing the decision to ensure accurate benefit payments.*

**Milwaukee RO Response: Concur**

A Delegation of Authority adding a second signature requirement for all RVSRs making a determination any TBI claim was completed on September 9, 2010.

**Recommendation 5:** *We recommend the Milwaukee VA Regional Office Director implement a plan to ensure staff record Notices of Disagreement in the Veterans Appeals Control and Locator System within 7 days as required by VBA policy.*

**Milwaukee RO Response: Concur**

As noted previously, the station Workload Management Plan contains guidance that all NODs are to be established in VACOLS within two days of receipt. Guidance instructing Claims Assistants to establish all NODs daily was provided by email on September 8, 2010. Claims Assistants have been instructed to bring any new NOD pending establishment greater than seven days to their supervisor's attention to determine the cause for the discrepancy. The average control time to establish a NOD for the past three months has been less than five days, below the established goal of seven days.

**Recommendation 6:** *We recommend that the Milwaukee VA Regional Office Director implement controls to ensure staff obtain and review current medical evidence in all cases involving court declarations of incompetency.*

**Milwaukee RO Response: Concur**

All employees were informed of the pertinent manual references regarding court declarations of incompetency on September 16, 2010. Training was provided to Post-determination and Fiduciary employees on October 19, 2010.

A review for sufficient medical evidence in court declarations of incompetency will be incorporated into all local quality reviews. In addition, a random sample of court appointed fiduciaries will be reviewed for compliance and incorporated into the annual Systematic Analysis of Operations for Fiduciary Program Management.

# Appendix C Inspection Summary

| 10 Operational Activities Inspected | Criteria | Reasonable Assurance of Compliance | |
|---|---|---|---|
| | | Yes | No |
| **Claims Processing** | | | |
| **1. 100 Percent Disability Evaluations** | **Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations**. (38 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1MR, 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 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 record.** (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 in accordance with VBA policy.** (M21-4, Chapter 3, Subchapter II, 3.03) | X | |
| **8. Systematic Analysis of Operations** | **Determine if VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5) | 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. Competency Determinations** | **Determine if VAROs properly assessed beneficiaries' mental capacity to handle 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 | Dawn Provost |
| Acknowledgments | Diane Wilson<br>Ed Akitomo<br>Brent Arronte<br>Orlan Braman<br>Robert Campbell<br>Madeline Cantu<br>Michelle Elliott<br>Lee Giesbrecht<br>Rachel Stroup<br>Lisa Van Haeren |

# Appendix E Report Distribution

## VA Distribution

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Veterans Benefits Administration
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Office of General Counsel
VBA Central Area Director
VARO Milwaukee 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: Herb Kohl, Ron Johnson
U.S. House of Representatives: Tammy Baldwin, Ron Kind, Gwen Moore, Thomas Petri, Paul Ryan, James F. Sensenbrenner

This report will be available in the near future on the OIG's Web site at **http://www.va.gov/oig/publications/reports-list.asp**. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.