

VA Office of Inspector General

OFFICE OF AUDITS & EVALUATIONS



Inspection of the VA Regional Office St. Paul, MN

January 25, 2011
10-03604-75

ACRONYMS AND ABBREVIATIONS

COVERS	Control of Veterans Records System
NOD	Notices 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	VA Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

To Report Suspected Wrongdoing in VA Programs and Operations:

Telephone: 1-800-488-8244

E-Mail: vaoighotline@va.gov

(Hotline Information: <http://www.va.gov/oig/contacts/hotline.asp>)



Report Highlights: Inspection of the VA Regional Office, St. Paul, MN

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 operations.

What We Found

The St. Paul VARO correctly processed herbicide exposure-related and traumatic brain injury disability claims. VARO management ensured Systematic Analyses of Operations were timely and complete.

Generally, VARO staff correctly processed post-traumatic stress disorder disability claims and ensured timely processing of Notices of Disagreements for appealed claims. Additionally, VARO staff corrected errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program and established correct dates of claim in the electronic record.

VARO staff should emphasize the need to improve the control and accuracy of temporary 100 percent disability evaluations processing. Overall, VARO staff did not accurately process 17 (15 percent) of the 110 disability claims that we reviewed. Controls over mail handling as well as final competency determinations processing also need strengthening.

What We Recommended

We recommended that St. Paul VARO management review all temporary 100 percent disability evaluations to determine if reevaluations are required and take appropriate actions. We recommended VARO management implement controls to ensure the staff enters reminder notifications for temporary 100 percent disability reevaluations.

We further recommended VARO management strengthen controls over mail handling procedures as well as improve the timeliness of final competency determinations processing.

Agency Comments

The Director of the St. Paul 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

TABLE OF CONTENTS

Introduction.....	1
Results and Recommendations	2
1. Disability Claims Processing	2
2. Data Integrity	5
3. Management Controls	5
4. Workload Management.....	6
5. Eligibility Determinations.....	7
Appendix A VARO Profile and Scope of Inspection	9
Appendix B VARO Director’s Comments	11
Appendix C Inspection Summary.....	14
Appendix D OIG Contact and Staff Acknowledgments.....	15
Appendix E Report Distribution	16

INTRODUCTION

Objective

The Benefits Inspection Program is part of the Office of Inspector General's (OIG) efforts 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 VA Regional Offices (VAROs). These independent inspections provide recurring oversight focused on disability compensation claims processing and performance of Veterans Service Center (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 September 2010, the OIG conducted an inspection of the St. Paul VARO. The inspection focused on five 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 80 (19 percent) of 411 disability claims related to post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and herbicide exposure that the VARO completed from April through June 2010. In addition, we reviewed 30 (15 percent) of 204 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months, generally the longest period a temporary 100 percent disability 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 St. Paul 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 disability 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 St. Paul VARO needs to improve the accuracy of disability claims processing. VARO staff incorrectly processed 17 (15 percent) of the total 110 disability claims we reviewed. We advised VARO management of the inaccuracies noted during our inspection and they initiated actions to correct them. The table below reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the St. Paul VARO.

Table

Disability Claims Processing Results				
Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Disability Evaluations	30	15	5	10
PTSD	30	2	1	1
TBI	20	0	0	0
Herbicide Exposure-Related Disabilities	30	0	0	0
Total	110	17	6	11

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 15 (50 percent) of 30 temporary 100 percent disability evaluations reviewed. Veterans Benefits Administration (VBA) policy requires a temporary 100 percent disability evaluation for a service-connected disability needing surgery or specific treatment. At the end of a mandated period of convalescence or the cessation of treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability benefits.

Based on analysis of available medical evidence, five of the 15 processing inaccuracies affected veterans' benefits—three involved overpayments totaling \$239,453 and two involved underpayments totaling \$6,204. Examples of the most significant overpayment and underpayment follow:

- A Rating Veterans Service Representative (RVSR) correctly proposed reducing a veteran's prostate cancer evaluation from 100 percent to 40 percent disabling. At the time of our inspection, VSC staff had not taken final action to reduce the veteran's benefits. As a result, VA overpaid the veteran \$181,701 over a period of 7 years and 3 months.
- An RVSR did not grant a veteran special monthly compensation. As a result, VA underpaid the veteran a total of \$3,642 over a period of 3 years and 3 months.

The remaining 10 inaccuracies had the potential to affect veterans' benefits. In these cases, VSC staff did not set in place the reminder notification needed to alert VARO staff that a VA examination needed to be scheduled or the reminder notification was set years beyond the required examination date.

We could not determine if these temporary 100 percent disability evaluations would have continued because the veterans' claims folders did not contain evidence of the medical examinations needed to reevaluate each case. The delays in scheduling the examinations ranged from 75 days to 5 years and 11 months. An average of 2 years and 3 months elapsed from the time staff should have scheduled the medical examinations until the date of our inspection—the date staff ultimately took corrective actions to obtain the necessary medical evidence.

For temporary 100 percent disability evaluations, including those where rating decisions do not change a veteran's payment amount (confirmed and continued evaluations), VSC staff must input a suspense diary 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.

The most frequent processing errors noted in five (33 percent) of the 15 cases we reviewed occurred when VARO staff did not properly establish suspense diaries for future VA examinations. According to VARO management, a local unwritten policy was in place requiring experienced staff to finalize claims needing diary actions; however, the VARO did not have sufficient oversight measures in place to ensure staff followed the local unwritten policy.

PTSD Claims

VARO staff incorrectly processed two (7 percent) of 30 PTSD claims. We did not consider the frequency of errors significant, although one error did affect a veteran's benefits. Following are summaries of the two errors.

- An RVSR prematurely granted service connection for PTSD prior to obtaining all of the necessary evidence to verify the veteran's stressful event. As a result, VA overpaid the veteran \$4,598.
- An RVSR did not properly address the issue of a veteran's competency for a service-connected mental condition evaluated as 100 percent disabling. VBA policy requires staff to consider the issue of competency whenever a mental condition is determined to be 100 percent disabling.

TBI Claims

VARO staff correctly processed all 20 TBI-related disability claims reviewed and followed VBA policy when processing these claims. We made no recommendations for improvement in this area.

**Herbicide
Exposure-Related
Claims**

In accordance with VBA policy, VARO staff correctly processed all 30 herbicide exposure-related disability claims reviewed. We made no recommendations for improvement in this area.

Recommendations

1. *We recommend the St. Paul VA Regional Office Director conduct a review of the remaining 175 temporary 100 percent disability evaluations under the regional office's jurisdiction to determine if reevaluations are required and take appropriate action.*
2. *We recommend the St. Paul VA Regional Office Director implement controls to ensure staff establish reminder notifications for temporary 100 percent disability evaluations.*

**Management
Comments**

The VARO Director concurred with our recommendations for improving disability claims processing accuracy. VSC staff reviewed 175 additional temporary 100 percent evaluations and requested medical examinations when appropriate. The Director did not believe staff should conduct a review of all temporary 100 percent evaluations regardless of the timeframe or diagnostic code.

On September 20, 2010, the Director indicated VSC management initiated process changes and follow-up procedures for claims involving future examinations. These changes included additional oversight by authorizers to ensure diaries are accurate and correctly recorded in the corporate database. Further, the VSC Quality Team will review a random sample of these types of claims to ensure quality claims processing.

OIG Response

Management comments and actions to review the remaining 175 temporary 100 percent evaluations are responsive to the recommendations. The Director indicated he did not believe staff should conduct a review of all

temporary 100 percent evaluations. This was not the intent of the recommendation, therefore, we will modify the language to recommend a review of the 175 additional temporary 100 percent evaluations, for which the Director indicated staff have completed.

2. Data Integrity

We analyzed claims folders to determine if the VARO is following VBA policy to establish dates of claim in electronic records and to timely record Notices of Disagreement (NODs) in the Veterans Appeals Control and Locator System (VACOLS). Because the VARO generally followed VBA policy when establishing effective dates and dates of claim and processing NODs, we made no recommendations for improvement.

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 110 disability claims we reviewed. As such, we made no recommendation for improvement in this area.

Dates of Claim

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 number of days to complete a claim. VARO staff established incorrect dates of claim in the electronic record for one (3 percent) of the 30 claims we selected for review.

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 an NOD is required to ensure the appeal moves through the appellate process expeditiously. VARO staff exceeded VBA's 7 day standard for two (7 percent) of 30 NODs we reviewed.

3. Management Controls

We assessed management controls to determine if VARO management adhered to VBA policy regarding correction of errors identified by VBA's Systematic Technical Accuracy Review (STAR) staff. Further, we assessed if VARO management had controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs).

***Systematic
Technical
Accuracy
Review***

The STAR Program is VBA's multifaceted quality assurance program to ensure that veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that VARO staff take corrective action on errors that STAR identifies. In general, VARO staff followed VBA policy regarding the correction of STAR errors.

VARO staff did not correct two (9 percent) of 23 errors identified by VBA's STAR Program staff from April through June 2010. In addition, VSC management erroneously reported to STAR staff that all corrective actions were completed. We did not consider the frequency of errors significant, so 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.

St. Paul VARO management followed VBA policies by ensuring all 12 required SAOs were timely and complete. The VARO followed VBA policy when processing SAOs; therefore, we made no recommendations 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. Inspection findings indicate controls over VARO Triage Team mail processing procedures need strengthening.

***Mailroom
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 St. Paul VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division. Because VARO mailroom staff processed, date stamped, and delivered all VSC mail to the Triage Team mail pick up point on a daily basis, we made no recommendations 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.

Finding Triage Team Mail Management Procedures Need Strengthening

Triage Team members did not always manage search mail according to VBA policy. For six (20 percent) of 30 pieces of search mail reviewed, staff did not properly use COVERS to ensure timely processing and adequate control of the search mail. This occurred because the station mail plan did not incorporate procedures for the Triage Team supervisor to oversee the search mail process. Consequently, RVSRs may not have all available evidence received by mail when making disability determinations. Untimely association of search mail with veterans' claims folders can result in beneficiaries potentially not receiving prompt and accurate benefit payments.

The most significant delay occurred when VARO staff did not immediately associate search mail with a claims folder. On August 16, 2010, the VARO received the final piece of evidence needed to move a veteran's claim to the next processing stage; however, staff did not place the mail on search until September 22, 2010. Because VARO staff did not place the mail on search in a timely manner, a processing delay of 37 days occurred.

Recommendation 3. *We recommend the St. Paul VA Regional Office Director amend the local mail plan to incorporate procedures for management oversight of the search mail process.*

Management Comments The VARO Director concurred with our recommendation and amended the VARO Mail Plan and Workload Management Plan. The amended plans direct the Triage Coach to perform weekly reviews of all search mail. Further, the Triage Coach will ensure staff use COVERS to ensure timely association of mail with the veterans' claims folders.

OIG Response Management comments and actions to amend the VARO Mail Plan and Workload Management Plan are responsive to the recommendations.

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 incompetency determinations by appointing a fiduciary, which is a third party that assists in managing funds for an incompetent beneficiary. 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 be timely in appointing fiduciaries.

Finding Controls over Competency Determinations Need Strengthening

VARO staff unnecessarily delayed making final decisions in six (33 percent) of the 18 incompetency determinations VARO staff completed from April through June 2010. The delays ranged from 15 to 62 days, with an average completion time of 31 days. The delays occurred because the VSC workload management plan did not contain procedures emphasizing immediate completion of claims involving competency determinations in advance of other claims requiring VSC processing actions. The risk of incompetent beneficiaries receiving benefit payments without fiduciaries assigned to manage those funds increases when the VSC staff does not complete competency determinations immediately.

VBA policy requires staff to obtain clear and convincing medical evidence that a beneficiary is incapable of managing his or her affairs prior to making a final competency decision. The policy allows the beneficiary a 65-day due process period to submit the evidence showing an ability 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 competent.

In the absence of a definition of “immediate,” we allowed 14 calendar days after the due process period to determine if VARO staff timely completed a competency decision. We considered this a reasonable period to control, prioritize, and finalize these types of cases.

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 62 days. During this period, the veteran received \$6,286 in disability payments. While the veteran was entitled to these payments, fiduciary stewardship was not in place to ensure effective funds management and the welfare of the veteran.

VARO managers stated they were aware of the VBA policy and defined “immediate” as the day after the due process period expires—the 66th day. Although the VSC workload management plan indicated these cases received special attention, the plan lacked oversight to ensure VSC staff routinely expedited these claims as a priority over other claims processing work. As a result, incompetent beneficiaries received benefits payments for extended periods despite being incapable of managing these funds effectively.

We plan to raise this issue to senior management in our FY 2010 summary report. Therefore, we make no recommendations to the VARO Director regarding this issue.

Appendix A VARO Profile and Scope of Inspection

Organization The St. Paul VARO is responsible for delivering nonmedical VA benefits and services to veterans and their families in Minnesota. 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 St. Paul VARO had a staffing level of 656 full-time employees. Of these, the VSC had 216 employees (33 percent) assigned.

Workload As of September 2010, the VARO reported 5,952 pending compensation claims. The average time to complete these claims during FY 2010 was 120.8 days—approximately 29 days better than the national target of 150 days. As reported by STAR staff, the accuracy of compensation rating related issues was 89.3 percent, slightly below the 90 percent target set by VBA.

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

Our review included 80 (19 percent) of 411 claims related to PTSD, TBI, and herbicide exposure-related disabilities that the VARO completed from April through June 2010. For temporary 100 percent disability evaluations, we selected 30 (15 percent) of 204 existing claims from VBA's Corporate Database. We provided the VARO with the 174 claims remaining from the universe of 204 to assist in implementing our first report recommendation. The 174 claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months.

We reviewed 18 available competency determinations and 23 errors identified by VBA's STAR Program during the period of April through 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 a rating decision. STAR staff review original claims, reopened claims, and claims for increased evaluation. Further, they review appellate issues that involve a myriad of veterans' disabilities claims.

Our process differs from the STAR process 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 involving temporary 100 percent disability determinations.

We selected for review 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: **January 10, 2011**

From: **Director, VA Regional Office St. Paul (335/00)**

Subj: **Response to the St. Paul Draft Inspection report 12-16-2010**

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

1. Attached are the St. Paul VARO's comments on the Report: St. Paul Inspection report 12-16-2010.
2. Questions may be referred to Shelia Jackson, Acting Veterans Service Center Manager, at (612) 970-5300.

(original signed by:)
A.L. WALLER
Director

Attachment:
VARO St. Paul Response

The St. Paul VARO is in concurrence with the findings and recommendations noted in the OIG inspection report.

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

St. Paul RO Response: Concur in part

Corrective action has been completed on all 17 of the errors for temporary 100 percent evaluations identified by the OIG.

VARO staff also reviewed and completed corrective action, if needed, on all 175 temporary 100 percent evaluation claims paid in excess of 18 months identified by the OIG. Corrective actions included setting up immediate examinations and depending on the examination results, due process for reduction.

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 St Paul Regional Office respectfully defers further action on the OIG recommendation beyond those claims identified above pending Central Office guidance.

Recommendation 2: *We recommend the St. Paul Regional Office Director implement controls to ensure staff establishes reminder notification for temporary 100 percent disability evaluations.*

St. Paul RO Response: Concur

The St. Paul VSC has initiated several process changes and follow-up procedures to ensure timely review and action is initiated on temporary 100 percent rating cases. VARO supervisory staff sent guidance to division employees regarding procedures for processing claims involving a future examination upon OIG notification. The guidance of September 23, 2010, notified the division that all future examination claims processed must be held until the following workday to ensure the examination diary and date are accurate and in the system. One day following completion of all rating claims involving a future diary, an authorizer reviews the systems to ensure the diary is accurate and exists in the corporate database. These claims are then subject to a random sample

review by the Quality Team in the Veterans Service Center (VSC) to ensure quality is maintained.

Recommendation 3: *We recommend the St. Paul VA Regional Office Director amend the local mail plan to incorporate procedures for management oversight of the search mail process.*

St. Paul RO Response: Concur

VSC amended their Mail Plan and Workload Management Plan (See Attachment B, WMP, page 3 & Attachment A, Mail Plan, page 4) to ensure proper supervisory oversight is provided for search mail. The directives incorporate a weekly review of all search mail by the Triage Coach or designee to ensure accurate COVERS usage and timely mail association.

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 Code of Federal Regulations (CFR) 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (Manual (M) 21-1 Manual Rewrite (MR) 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 Letter (FL) 08-34 and FL 08-36, Training Letter 09-01)	X	
4. Herbicide Exposure-Related Claims	Determine whether VARO staff properly processed claims for service connection for disabilities related to herbicide exposure. (38 CFR 3.309) (FL 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)	X	
Data Integrity			
5. Dates of Claim	Determine if VARO staff properly recorded the correct dates 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 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 Review	Determine if VARO staff properly corrected STAR 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. Competency Determinations	Determine if VAROs properly assessed beneficiaries’ mental capacities 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	Brent Arronte
Acknowledgments	Nora Stokes Danny Clay Kristine Abramo Robert Campbell Madeline Cantu Lee Giesbrecht Mark Ward

Appendix E Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Assistant Secretaries
Office of General Counsel
VBA Central Area Director
VARO St. Paul 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: Al Franken, Amy Klobuchar
U.S. House of Representatives: Michele Bachmann, Chip Cravaack, Keith Ellison, John Kline, Betty McCollum, Erik Paulsen, Collin Peterson, Timothy J. Walz

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.