VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Huntington, West Virginia

July 20, 2011
11-00522-231

ACRONYMS AND ABBREVIATIONS

C&C	Confirmed and Continued
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

Report Highlights: Inspection of the VA Regional Office, Huntington, WV

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

Huntington VARO management ensured staff followed the Veterans Benefits Administration's policy for establishing dates of claim, processing incoming mail, and completing Systematic Analyses of Operations. Further, the average time for the VARO to complete claims was 146 days—29 days better than the national target of 175 days. VARO performance was generally effective in processing post-traumatic stress disorder claims, handling mail, and correcting errors identified through the Systematic Technical Accuracy Review program.

VARO management lacked effective controls and accuracy in processing temporary 100 percent disability evaluations, traumatic brain injury claims, and herbicide exposure-related claims. Overall, VARO staff did not accurately process 36 (38 percent) of the 95 disability claims reviewed. The VARO's recent implementation of the Quality Review and Training Team is a positive step toward addressing these deficiencies.

Although the VARO was not timely in recording Notices of Disagreement for appealed claims, it was better than the national average regarding appeals processing timeliness. Further, processing of competency determinations was not fully effective, resulting in unnecessary delays in making final decisions and improper benefits payments.

What We Recommended

We recommended Huntington VARO management monitor the effectiveness of its quality review process and provide refresher training on traumatic brain injury and herbicide exposure-related claims processing. VARO management also needs to ensure accurate processing of final competency determinations.

Agency Comments

The VARO Director concurred with our 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 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 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 April 2011, the OIG conducted an inspection of the Huntington 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 65 (17 percent) of 372 disability claims related to post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and herbicide exposure that the VARO completed from October through December 2010. In addition, we reviewed 30 (16 percent) of 185 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 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 1 VARO Staff Need to Improve Disability Claims Processing Accuracy

The Huntington VARO needs to improve the accuracy of disability claims processing. VARO staff incorrectly processed 36 (38 percent) of the total 95 disability claims we reviewed. VARO management agreed 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 Huntington 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	22	16	6
PTSD	30	2	0	2
TBI	5	3	1	2
Herbicide Exposure-Related Disabilities	30	9	4	5
Total	**95**	**36**	**21**	**15**

Source: VA OIG

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 22 (73 percent) of 30 temporary 100 percent disability evaluations we reviewed. Veterans Benefits Administration (VBA) policy requires a temporary 100 percent disability evaluation for a service-connected disability following surgery or when specific treatment is needed. At the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical

examination to help determine whether to continue the veteran's 100 percent disability evaluation.

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

Based on analysis of available medical evidence, 16 of the 22 processing inaccuracies affected veterans' benefits—14 involved overpayments totaling about $1.3 million and two involved underpayments totaling $4,173. Details on the two most significant overpayments and both underpayments follow.

- A Rating Veterans Service Representative (RVSR) incorrectly continued a temporary 100 percent evaluation for Ewing's sarcoma. Medical treatment records supported no more than a 0 percent evaluation, entitling the veteran to health care for the condition, but not monetary compensation. As a result, VA overpaid the veteran $298,527 over a period of 9 years and 10 months.
- VSC staff received a system-generated reminder notification but did not take any action to schedule a reexamination. VA did not reevaluate the disability and the 100 percent disability evaluation continued. Medical treatment records supported no more than a 30 percent disability evaluation. As a result, VA overpaid the veteran $266,124 over a period of 10 years and 4 months.
- An RVSR established an incorrect effective date for service connection for prostate cancer. As a result, VA underpaid the veteran $2,829 over a period of 1 month.
- An RVSR did not grant entitlement to an additional special monthly benefit as required, based on the loss of use of a creative organ. As a result, VA underpaid the veteran $1,344 over a period of 1 year and 2 months.

The remaining six inaccuracies had the potential to affect veterans' benefits. Following are summaries of these inaccuracies.

- In five cases, RVSRs continued the temporary 100 percent disability evaluations and annotated the need for future reexaminations. However, VSC staff did not establish suspense diaries to schedule the follow-up medical examinations.

- In one case, an RVSR granted a permanent 100 percent disability evaluation but did not consider entitlement to the additional benefit of Dependents' Educational Assistance as required by VBA policy.

An average of approximately 3 years 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 10 years and 8 months.

Eighteen of the 22 errors resulted from staff not establishing suspense diaries when they processed rating decisions requiring temporary 100 percent disability reexaminations. Sixteen of these errors involved C&C rating decisions. When processing these types of ratings, staff did not always create electronic awards for benefits. In November 2009, VBA provided guidance reminding VAROs about the need to add suspense diaries in the electronic record for C&C rating decisions. However, VARO management had no oversight procedure in place for C&C rating decisions to ensure VSC staff established suspense diaries to remind of the need for reexaminations.

We provided the VARO with 155 claims remaining from our universe of 185 temporary 100 percent disability evaluations selected for review. In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations*, (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each evaluation had a future examination date entered in the electronic record. Therefore, we made no additional recommendations for improvement in this area.

PTSD Claims

VARO staff incorrectly processed 2 (7 percent) of 30 PTSD claims we reviewed. Both errors had the potential to affect veterans' benefits. In both cases, RVSRs prematurely granted service connection for PTSD. VA medical examiners also diagnosed mood disorder without discussing the relationship between this condition and PTSD and the extent of impairment as required. According to VBA policy, when a medical examination does not address all required elements, VSC staff should return it to the healthcare facility as insufficient for rating purposes. Neither VARO staff nor we can ascertain the relationship or the extent of impairment without adequate or complete medical evidence.

Because we did not consider the frequency of errors significant, we determined the VARO generally followed VBA policy related to PTSD claims processing. Therefore, we made no recommendation for improvement in this area.

TBI Claims

The Department of Defense and VBA commonly define a TBI as traumatically induced structural injury or a physiological disruption of brain function caused by an external force. The major residual disabilities of TBI fall into three main categories—physical, cognitive, and behavioral. VBA policy requires staff to evaluate these residual disabilities.

VARO staff incorrectly processed three (60 percent) of five TBI claims. One of the errors affected a veteran's benefits. In this case, an RVSR incorrectly evaluated TBI-related residuals as 40 percent disabling. Medical evidence showed residuals warranting a 10 percent evaluation. As a result, VA overpaid the veteran $6,495 over a period of 1 year and 3 months.

The remaining two inaccuracies had the potential to affect veterans' benefits. Following are summaries of these inaccuracies.

- An RVSR prematurely continued an evaluation for TBI-related residuals. Medical evidence showed a diagnosis of cognitive disorder due to the TBI; therefore, a psychiatric examination was required. Neither VARO staff nor we can ascertain all of the residual disabilities related to a TBI without adequate or complete medical evidence.
- An RVSR incorrectly evaluated TBI-related residuals as 10 percent disabling. Medical evidence showed residuals warranting no more than a 0 percent evaluation, entitling the veteran to healthcare for the condition, but not monetary compensation. This rating did not affect the veteran's monthly benefits, but may affect future evaluations for additional benefits.

Generally, errors associated with TBI claims processing resulted from VSC staff incorrectly interpreting VBA policy and inadequate quality assurance. Interviews with VSC staff indicated prior TBI training was not fully effective and RVSRs needed refresher training. Additionally, prior to our inspection, VSC staff completed an additional level of review on two of the three inaccuracies without identifying any errors. Because of such deficiencies, veterans did not always receive correct benefit payments.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 9 (30 percent) of 30 herbicide exposure-related claims we reviewed. Four of the nine processing inaccuracies affected veterans' benefits—all four involved underpayments totaling $34,689. Details on the two most significant underpayments follow.

- An RVSR correctly granted service connection for coronary artery disease; however, both the effective date and the disability evaluation were incorrect. The effective date used was July 19, 2010; however, the actual date of claim was March 8, 2006—the date VA medical records showed the veteran underwent coronary artery bypass surgery.

According to VBA policy, this condition warranted a 100 percent evaluation for 3 months following hospital admission. Medical treatment records 3 months following surgery support no more than a 10 percent disability evaluation. Additional treatment records support an increase to a 60 percent disability evaluation effective July 19, 2010—the date the VARO received the veteran's claim for an increased evaluation. As a result, VA underpaid the veteran $19,265 over a period of 5 years.

- An RVSR incorrectly established an effective date of July 19, 2010, for an increased evaluation of diabetic nephropathy. Treatment reports from Clarksburg VA Medical Center showed entitlement to an earlier effective date of March 8, 2007. VA regulations state the date of treatment at a VA Medical Center is the date of claim for increased benefits. As a result, VA underpaid the veteran $9,328 over a period of 3 years and 4 months.

The remaining five inaccuracies had the potential to affect veterans' benefits. Following are summaries of these inaccuracies.

- An RVSR incorrectly evaluated diabetes mellitus as zero percent disabling. Medical evidence showed this condition warranted a 10 percent disability evaluation. This rating did not affect the veteran's monthly benefits, but may affect future evaluations for additional benefits.
- An RVSR incorrectly granted service connection for diabetes mellitus as zero percent disabling. VA regulations state before granting service connection for an herbicide exposure-related disability, it must reach a level of at least 10 percent disabling at any time after service. This rating did not affect the veteran's monthly benefits, but may affect future evaluations for additional benefits.
- An RVSR did not consider service connection for soft tissue carcinoma due to jet fuel exposure and prematurely denied service connection for squamous cell carcinoma without notifying the veteran. VSC staff must consider all claimed conditions and provide the veteran with proper notification of the evidence needed prior to making a determination.
- An RVSR incorrectly denied service connection for a condition worsened by service-connected diabetes.
- An RVSR did not consider service connection for hypertension related to service-connected diabetic nephropathy (that is, a kidney disease or condition) as required.

In two of the five cases summarized above, VSC staff did not request additional medical evidence from the veterans. VBA policy requires medical evidence showing the level of severity before a condition worsened and the

current level of severity. VSC staff needs this medical evidence to determine a baseline level of severity prior to granting or denying a disability.

Generally, errors associated with herbicide exposure-related claims processing resulted from lack of proper training and effective quality assurance. Interviews with VSC staff indicated a lack of understanding of herbicide exposure-related regulations and policies; our review showed their training materials conflicted with VBA policy. Prior to our inspection, VSC staff completed an additional level of review on two of the nine inaccuracies without identifying any errors. Because of these deficiencies, RVSRs did not properly evaluate herbicide exposure-related disabilities.

The VARO formed a Quality Review and Training Team in October 2010 to promote consistency in local quality reviews and provide training. The Quality Review and Training Team is a positive step towards addressing the errors associated with TBI and herbicide exposure-related claims processing. We will follow-up on this team's effort to determine their effectiveness.

Recommendation

1. We recommend the Huntington VA Regional Office Director implement a plan to monitor effectiveness of the quality review process and conduct refresher training for traumatic brain injury and herbicide exposure-related claims processing.

Management Comments

The VARO Director concurred with our recommendation. The Director stated the VARO provided training on proper processing of traumatic brain injury and herbicide exposure-related claims in May 2011.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions.

2. Data Integrity

Dates of Claim

We analyzed claims folders to determine if the VARO was following VBA policy to establish correct dates of claim in the electronic record. 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.

VARO staff established correct dates of claim in the electronic record for all 30 claims we reviewed. As a result, we determined the VARO is following VBA policy and we made no recommendation for improvement in this area.

Notices of Disagreement

We analyzed claims folders to determine if the VARO is following VBA policy to timely record Notices of Disagreement (NODs) in the Veterans Appeals Control and Locator System (VACOLS). 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 veterans' appeals 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 staff did not meet this standard for 13 (43 percent) of the 30 NODs we reviewed. Staff took an average of 10 days to record these 13 NODs in VACOLS. However, as of March 31, 2011, the VARO's NODs had been pending completion an average of 200 days, which is 65 days better than the national average of 265 days. Therefore, we made no recommendation for improvement in this area.

3. Management Controls

Systematic Technical Accuracy Review

We assessed management controls to determine whether VARO management adhered to VBA policy regarding correction of errors identified by VBA's Systematic Technical Accuracy Review (STAR) staff. 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.

Huntington VARO staff did not correct 1 (8 percent) of 12 errors identified by VBA's STAR program from October through December 2010. Because VARO management generally followed VBA policy regarding correction of STAR errors, we made no recommendation for improvement in this area.

Systematic Analysis of Operations

We assessed whether VARO management had controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs). An SAO is a formal analysis of an 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 annual SAO schedules designating the staff required to complete the SAOs by specific dates.

VARO management timely completed all 12 required SAOs. As a result, we determined the VARO is following VBA policy, and we made no recommendation for improvement in this area.

4. Workload Management

Mailroom Operations

We assessed controls over VARO mailroom operations to ensure staff timely and accurately processed incoming mail. VBA policy states staff will open, date stamp, and route all mail to the appropriate locations within 4 to 6 hours of receipt at the VARO. The Huntington VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division. Mailroom staff were timely and accurate in processing, date-stamping, and delivering VSC mail to the Triage Team control point daily. As a result, we determined the mailroom staff are following VBA policy, and we made no recommendation for improvement in this area.

Triage Mail Processing Procedures

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. VARO staff are required to use VBA's tracking system, Control of Veterans Records System, to electronically track veterans' claims folders and control search mail. VBA defines search mail as active claims-related mail waiting to be associated with veterans' claims folders. Conversely, drop mail requires no processing action upon receipt. VBA policy allows the use of a storage area, known as the Military File, to hold mail temporarily when staff are unable to identify associated claims folders in the system.

The Triage Team staff did not properly manage 3 (3 percent) of 90 pieces of mail we reviewed. As a result, we determined the Huntington VARO is generally complying with national and local mail handling policies. Therefore, we made no recommendation 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, a third party who 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 appoint fiduciaries timely.

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 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.

Until recently, VBA did not have a clear, measurable definition of "immediate" and this time frame varied from office to office. In response to our summary report for FY 2010, *Systemic Issues Reported During Inspections at VA Regional Offices,* (Report No. 11-00510-167, May 18, 2011), the Acting Under Secretary for Benefits defined "immediate" as 21 days following the expiration of the due process period.

Finding 2 Controls Over Competency Determinations Need Strengthening

Using VBA's newly defined interpretation of immediate, VARO staff unnecessarily delayed making final decisions in 3 (27 percent) of 11 competency determinations completed from October through December 2010. The delays ranged from 34 to 56 days, with an average completion time of 45 days. Delays occurred because the VSC workload management plan did not contain procedures emphasizing immediate completion of competency determinations. Interviews with VSC management indicated they are not currently prioritizing these cases. The risk of incompetent beneficiaries receiving benefits without fiduciaries assigned to manage those funds increases when staff do not complete competency determinations immediately.

The most significant case of placing funds at risk occurred when VARO staff unnecessarily delayed making a final incompetency decision for a veteran for approximately 2 months. During this period, the veteran received $6,954 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. VBA plans to implement the new 21-day policy nationwide in June 2011. Therefore, we made no recommendation to the Director of the VARO regarding this issue.

Further, VSC staff incorrectly processed 2 (18 percent) of 11 competency determinations reviewed. According to revised VBA policy, which became effective in October 2009, VARO staff should pay all current monthly benefits for existing disabilities, but should not release any retroactive benefits for these disabilities until they make a final determination on the issue of competency. In the most egregious case, on January 4, 2010, an RVSR granted a 100 percent disability evaluation and proposed incompetency. VSC staff correctly paid the veteran's monthly benefit of $2,673 beginning February 1, 2010. However, staff incorrectly released a retroactive payment of $5,346, the amount due to the veteran for the period October 22, 2009, through December 31, 2009, before finalization of the incompetency determination.

These errors were the result of a lack of understanding of the revised VBA policy. The VARO provided training in November 2009 shortly after the policy changed; however, training schedules for fiscal years 2010 and 2011 showed the VARO gave no additional training on this issue.

Recommendation

2. We recommend the Huntington VA Regional Office Director conduct refresher training and implement controls to ensure staff follow current Veterans Benefits Administration policy regarding the processing of competency determinations.

Management Comments

The VARO Director concurred with our recommendation. The Director stated the VARO provided training on proper processing of competency determinations in May 2011.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions.

Appendix A VARO Profile and Scope of Inspection

Organization

The Huntington VARO is responsible for delivering nonmedical VA benefits and services to veterans and their families. The VARO fulfills these responsibilities by administering compensation and pension benefits, vocational rehabilitation and employment assistance, and outreach activities.

Resources

As of January 2011, the Huntington VARO had a staffing level of 206 employees. As of March 2011, the VSC had 103 employees assigned.

Workload

As of March 2011, the VARO reported 6,411 pending compensation claims. The average time to complete claims was 146 days—29 days better than the national target of 175 days. As reported by STAR staff, the accuracy of compensation rating-related decisions was 87.9 percent, which was 2.1 percent below the 90 percent VBA target. The accuracy of compensation authorization-related processing was 98.8 percent—2.8 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 nonmedical services provided to veterans and other beneficiaries. We interviewed managers and employees and reviewed veterans' claims folders.

Our review included 65 (17 percent) of 372 claims related to PTSD, TBI, and herbicide exposure-related disabilities that the VARO completed from October through December 2010. For temporary 100 percent disability evaluations, we selected 30 (16 percent) of 185 existing claims from VBA's Corporate Database. We provided the VARO with the 155 claims remaining from the universe of 185. These claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months.

We also reviewed 11 competency determinations completed by the VARO during the 3-month period from October through December 2010. We reviewed 12 errors identified by VBA's STAR program during the same period. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR measurements include a review of work associated with claims that require rating decisions. STAR staff review original claims, reopened claims, and claims for increased evaluation. Further, they review appellate issues that involve a myriad of veterans' disability 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 evaluations.

For our review, we selected dates of claims, NODs, and mail pending at the VARO during the time of our inspection. We completed our review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspections.* We planned and performed the review to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our review objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our review objectives.

Appendix B VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: June 30, 2011

From: Director, VARO Huntington, WV

Subj: OIG Benefits Inspection of VARO Huntington

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

Thru: Director, VBA Southern Area

1. I would like to express appreciation to the OIG Benefits Inspection team which visited our office April 13 – 21, 2011. The team was extremely helpful, professional and collaborative.

2. All recommendations were discussed thoroughly during their visit. We concur with each recommendation. We provided employees with additional training as recommended and will continue to ensure employees properly understand these topics:

Topic	Date
Traumatic Brain Injuries	May 3, 2011
Herbicide exposure and secondary conditions	May 10, 2011
Incompetency decision and FL 09-41	May 5 & May 31, 2001
Temporary 100% actions	April 28, 2011

3. Once again, we appreciated the assistance of the inspection team. If there are additional questions, please contact me directly or Matthew Barker, Management Analyst, via email (Matthew.Barker@va.gov) or by calling (304) 399-9340.

(original signed by:)
Leanne Weldin
DIRECTOR, HUNTINGTON VARO

Appendix C Inspection Summary

Ten Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. Temporary 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 Claims	**Determine whether VARO staff properly processed claims for PTSD.** (38 CFR 3.304(f))	X	
3. Traumatic Brain Injury Claims	**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 whether 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 whether VARO staff properly entered NODs into VACOLS.** (M21-1MR, Part I, Chapter 5)		X
Management Controls			
7. Systematic Technical Accuracy Review	**Determine whether 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 whether 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 whether 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 whether 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) (FL 09-08)		X

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Dawn Provost, Director Ed Akitomo Orlan Braman Ezekiel Buchheit Madeline Cantu Michelle Elliott Lee Giesbrecht Rachel Stroup Nelvy Viguera Butler Diane Wilson

Appendix E Report Distribution

VA Distribution

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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: Joe Manchin III, John D. Rockefeller IV
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