VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Indianapolis, Indiana

November 29, 2011
11-03134-32

ACRONYMS AND ABBREVIATIONS

C&C	Confirmed and Continued
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the VA Regional Office, Indianapolis, Indiana

Why We Did This Review

The Veterans Benefits Administration (VBA) has a nationwide network of 57 VA Regional Offices (VAROs) that process disability claims and provide a range of services to veterans. We conducted this inspection to evaluate how well the Indianapolis VARO accomplishes this mission.

What We Found

Indianapolis VARO staff timely processed homeless veterans' claims and effectively provided outreach efforts to homeless shelters and service providers.

The VARO lacked effective controls and accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations resulted when staff did not schedule or establish controls for future medical reexaminations. Staff incorrectly interpreted policy and used inadequate medical examinations to process traumatic brain injury claims. Errors in herbicide exposure-related disability claims occurred because quality assurance was not fully effective. Overall, VARO staff did not correctly process 33 (41 percent) of the 80 disability claims we reviewed.

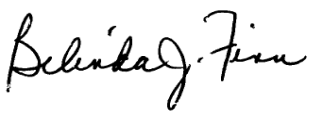
VARO management did not ensure staff timely completed all elements of Systematic Analyses of Operations, corrected errors identified by VBA's Systematic Technical Accuracy Review program staff, properly processed mail, and accurately addressed entitlement to mental health treatment for Gulf War veterans. 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 VARO management provide refresher training regarding the proper processing of traumatic brain injury claims, and implement a plan to improve effectiveness of the quality review process for herbicide exposure-related claims. Management needs to ensure staff timely complete Systematic Analyses of Operations, address errors identified by VBA's Systematic Technical Accuracy Review program, and ensure oversight and control of mail handling. Further, management needs to conduct refresher training and implement controls to ensure staff follow current VBA policy on processing competency determinations and Gulf War veterans' entitlements to mental health treatment.

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.



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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 whether 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 July 2011, the OIG conducted an inspection of the Indianapolis VARO. The inspection focused on five protocol areas examining nine operational activities. The five protocol areas were disability claims processing, management controls, workload management, eligibility determinations, and public contact.

We reviewed 50 (22 percent) of 223 disability claims related to traumatic brain injury (TBI) and herbicide exposure that the VARO completed from January through March 2011. In addition, we reviewed 30 (10 percent) of 294 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, TBI, and herbicide exposure. We evaluated claims processing accuracy and its impact on veterans' benefits.

Finding 1 Disability Claims Processing Accuracy Could Be Improved

The Indianapolis VARO lacked accuracy in disability claims processing. VARO staff incorrectly processed 33 (41 percent) of the total 80 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 Indianapolis 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	25	13	12
Traumatic Brain Injury Claims	20	4	1	3
Herbicide Exposure-Related Claims	30	4	2	2
Total	**80**	**33**	**16**	**17**

Source: VA OIG

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 25 (83 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 confirmed and continued (C&C) evaluations where rating decisions do not change veterans' payment amounts, 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.

Available medical evidence showed 13 of the 25 processing inaccuracies affected veterans' benefits—12 involved overpayments totaling about $1 million and 1 involved an underpayment totaling about $1,248. Details on the most significant overpayment and the underpayment follow.

- VARO staff did not schedule a follow-up medical examination to evaluate a veteran's non-Hodgkin's lymphoma. VA medical treatment records showed the veteran had completed treatment, warranting a reduction in benefits as of October 1999. As a result, VA overpaid the veteran $313,839 over a period of 11 years and 10 months.
- VARO staff 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 $1,248 over a period of 1 year and 1 month.

The remaining 12 inaccuracies had the potential to affect veterans' benefits. Following are summaries of these inaccuracies.

- In five cases, Rating Veteran Service Representatives (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 three cases, VSC staff did not schedule follow-up medical examinations after receiving the electronic system-generated reminder notifications.
- In two cases, RVSRs granted 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, VSC staff received medical reexamination results in September 2005. Based on the examination results, staff should have continued the 100 percent evaluation and established controls for reexamination. However, by the time of our review in July 2011, VSC staff had not taken any action. Until VSC staff obtain up-to-date medical evidence, neither VSC staff nor we can ascertain the current level of the veteran's disability.

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

For 9 of the 12 inaccuracies with potential to affect veterans' benefits, an average of approximately 4 years elapsed from the time staff should have scheduled these medical reexaminations until the date of our inspection—the date staff ultimately ordered the examinations to obtain the necessary medical evidence. The delays ranged from approximately 2 months to 16 years and 7 months.

Eleven of the 25 errors resulted from staff not establishing suspense diaries when they processed actions requiring temporary 100 percent disability reexaminations. Seven of these errors involved C&C rating decisions. 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 to ensure VSC staff established suspense diaries as reminders of the need for reexaminations.

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. As such, we are making no specific recommendation for this VARO. To assist in implementing the agreed upon review, we provided the VARO with 264 claims remaining from our universe of 294 temporary 100 percent disability evaluations.

TBI Claims

The Department of Defense and VBA commonly define a TBI as a 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 4 (20 percent) of 20 TBI claims. One of the errors affected a veteran's benefits. In this case, an RVSR incorrectly evaluated TBI residuals as 40 percent disabling. The medical examination showed TBI residuals that do not interfere with the veteran's ability to work, warranting no more than a 10 percent disability evaluation. As a result, VA overpaid the veteran $10,108 over a period of 1 year and 2 months.

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

- An RVSR incorrectly continued an evaluation for TBI residuals. According to VBA policy, when VARO staff need a current medical examination to confirm a veteran's continued entitlement to disability benefits and the veteran does not report for the medical examination, VSC staff must propose to discontinue or reduce the payment for the disability. In this case, the veteran did not report for a medical reexamination and the RVSR did not propose reducing the payment as required. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without adequate or complete medical evidence.
- In two cases, RVSRs incorrectly evaluated TBI residuals using inadequate VA medical examinations. According to VBA policy, when a medical examination does not address all required elements, VSC staff should return it to the clinic or health care facility as insufficient for rating purposes. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without an adequate or complete medical examination.

Generally, errors associated with TBI claims processing occurred because VSC staff used insufficient medical examinations to make decisions. Interviews with VSC staff indicated a combination of workload, pressure to rate cases quickly, and lack of refresher training also resulted in improper decisions. Because of such deficiencies and misinterpretation of VBA policy, RVSRs did not properly evaluate TBI-related disabilities.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 4 (13 percent) of 30 herbicide exposure-related claims we reviewed. Two of the four processing inaccuracies affected veterans' benefits—both involved underpayments totaling about $7,382. According to VA regulations, when a claimant submits a claim within 1 year of a legislative change, VA may authorize benefits from the date of legislative change, if the veteran is eligible. In both cases, eligibility existed from the date of the legislative change because medical evidence showed a diagnosis at the time of the law change. Following are summaries of these inaccuracies.

- An RVSR correctly granted service connection for Parkinson's disease; however, the effective date of November 3, 2010, was incorrect. The actual date of entitlement was August 31, 2010—the date of a related legislative change. As a result, VA underpaid the veteran $6,666 over a period of 3 months.
- An RVSR correctly granted service connection for coronary artery disease associated with herbicide exposure; however, the effective date of October 13, 2010, was incorrect. The actual date of entitlement was August 31, 2010—the date of a related legislative change. As a result, VA underpaid the veteran $716 over a period of 2 months.

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

- An RVSR did not consider service connection for skin cancer related to herbicide exposure. 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 did not consider a veteran's claim for service connection for skin cancer and asthma related to herbicide exposure. VSC staff properly notified the veteran of evidence needed prior to making the decision on the claim. However, the rating decision did not address all of the claimed contentions, as required.

Generally, errors associated with herbicide exposure-related claims processing resulted from inadequate quality assurance. Neither VARO staff nor we can ascertain why RVSRs initially made these errors. Prior to our inspection, VSC staff conducted an additional level of review on three of the four rating decisions. VSC quality review staff should have identified the errors prior to completing the decisions, but they did not. Review of local procedures and interviews with VSC management and staff revealed inconsistencies in the quality review process.

In April 2011, the VARO completed the Quality of Compensation, Pension, and Ancillary Actions Systematic Analysis of Operations (SAO) without analyses of all required elements, according to VA regulations. If management had addressed all required elements, it might have identified opportunities for improving the VARO's local quality review process. Further, the VARO has no defined policy for local quality review procedures. Because of these deficiencies, RVSRs did not properly evaluate herbicide exposure-related disabilities.

Recommendations

1. We recommend the Indianapolis VA Regional Office Director conduct refresher training and implement a plan to ensure staff follow current Veterans Benefits Administration policy regarding the processing of traumatic brain injury claims.
2. We recommend the Indianapolis VA Regional Office Director implement a plan to improve effectiveness of the quality review process for herbicide exposure-related claims.

Management Comments

The VARO Director concurred with our recommendations. In response to recommendation 1, the Director stated a Decision Review Officer conducts an additional level of review and signs all TBI claims. The Decision Review Officer also maintains an electronic log of VSC staff accuracy in processing the TBI claims. VARO staff received training on TBI claims in August 2011.

In response to recommendation 2, the Director stated VSC staff received training in October 2011 on effective dates for herbicide exposure-related disabilities. Further, VARO staff are developing a standard operating procedure for the Quality Team, which will include requirements for quality reviews and for third signatures on all herbicide exposure-related decisions under *Nehmer v. U.S. Department of Veterans Affairs*.

OIG Response

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

2. Management Controls

Systematic Technical Accuracy Review

We assessed 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 multifaceted quality assurance program to ensure that veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires VAROs to take corrective action on errors identified by STAR.

Finding 2 Oversight Needed To Ensure Correction of STAR Errors

VARO staff did not correct 4 (27 percent) of 15 errors identified by VBA's STAR program from January through March 2011. In all four instances, VSC management erroneously reported to the STAR program that it had completed all corrective actions identified. However, review of the claims folders showed three cases did not contain evidence of corrective actions and in one case VSC staff did not properly correct the identified error. All four errors affected the claimants' benefits.

Local procedures require that management review all corrective actions to address STAR errors. However, for three of the four errors we identified we found no evidence of management's review and oversight to ensure corrective action. By not accurately completing and reporting STAR error corrections, VARO management cannot provide assurance it is fulfilling requirements of VBA's National Quality Assurance program.

Recommendation

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

Management Comments

The VARO Director concurred with our recommendation. The Director stated VSC staff has created a database to track all STAR cases from the initial request for a claims folder for review, through VSC correction of the errors that STAR identifies. The VSC Manager or designee will review the database on a monthly basis.

OIG Response

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

Systematic Analysis of Operations

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs). We also considered whether VSC staff used adequate data to support the analyses and recommendations identified within each SAO. 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.

Finding 3 Oversight Needed To Ensure Timely and Complete SAOs

Seven (58 percent) of the 12 SAOs were not completed timely per the annual schedule, were incomplete (missing required elements), or were not done at all. The VSC Manager was responsible for completing the 12 annual SAOs as part of ongoing analysis of VSC operations. VARO management did not provide adequate oversight to ensure VSC staff completed the SAOs in accordance with VBA policy. As a result, VARO management may not have adequately identified existing and potential problems for corrective actions to improve VSC operations.

At the time of our inspection, 3 (25 percent) of the 12 SAOs were partially completed, 2 (17 percent) were not started, and 2 (17 percent) were both partially completed and not timely. VSC management attributed the incomplete and untimely SAOs to the VARO being a test site for new initiatives, changes in VSC management, and inexperienced staff. VSC management indicated it did not receive authorization to deviate from VBA policy regarding annual completion of SAOs. One of the SAOs that the VARO did not accurately complete involved mail handling. SAO results indicated the VARO reviewed mail once a week to locate files, which was inconsistent with VBA policy, which requires daily review. Additionally, the analysis did not identify an opportunity for improvement regarding mail placed in incorrect holding areas, or make a recommendation to decrease the approximately 2,200 pieces of pending mail.

Recommendation

4. We recommend the Indianapolis VA Regional Office Director develop and implement a plan to ensure staff complete Systematic Analyses of Operations timely and address all required elements.

Management Comments

The VARO Director concurred with our recommendation. The Director stated the VSC Manager provided SAO training in the fourth quarter of fiscal year 2011 to all management staff, and notified all personnel of their

assignments and due dates for completing SAOs during the current fiscal year. The VSC Manager established a division-level SAO schedule to ensure adequate time for one-on-one mentoring, and review and revision of all SAOs prior to submitting them to the Director's office. VSC Management Analysts will assist SAO preparers with analysis, review, and timely submission of the SAOs to the VSC Manager for approval. The Management Analysts will provide additional oversight by following up with VSC management on SAO submission and documenting approval of SAO extension requests.

OIG Response

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

3. 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 Indianapolis VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Intake Processing Center. Mailroom staff were timely and accurate in processing, date-stamping, and delivering VSC mail to the Intake Processing Center control point daily. As a result, we determined mailroom staff were following VBA policy and made no recommendation for improvement in this area.

Intake Processing Center Mail Management Procedures

VBA has embarked on a multi-year transformation of veterans' claims processing and benefits delivery. As part of this transformation, VBA is pursuing new business concepts with the goal of improving the speed, accuracy, and consistency of claims decisions rendered to veterans and their families. One of the outcomes of this initiative has been the Intake Processing Center, which combines existing VARO mail processing activities (the mailroom) with Triage sort functions in one location.

We assessed the Intake Processing Center's mail management procedures to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy. VBA policy indicates that oversight to ensure staff use available plans and systems is the most important part of workload management. It also states that effective mail management is crucial to the control of workflow within the VSC.

Search and Drop Mail

VBA policy requires that VARO staff use the Control of Veterans Records System, an electronic tracking system, to track 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.

Finding 4 Oversight Needed To Ensure Proper Control and Processing of Mail

The Intake Processing Center staff did not properly manage 23 (26 percent) of 90 pieces of search and drop mail we reviewed. Staff did not control search mail through the Control of Veterans Records System for 10 (33 percent) of 30 pieces of mail reviewed. At the time of our inspection, approximately 1,206 pieces of search mail were awaiting association with the appropriate claims folders. The most significant delay occurred when the VARO received a new claim from a veteran on June 8, 2011, and correctly placed it in the search mail holding area but without proper control. By the time of our inspection in July 2011, the VARO had established the claim in the electronic system, but had not initiated action on the claim.

Staff did not control 13 (22 percent) of 60 pieces of drop mail reviewed. At the time of our inspection, approximately 4,891 pieces of drop mail were awaiting association with the appropriate claims folders. The most significant delay occurred when the VARO received the last piece of evidence needed to complete a pending claim on March 8, 2011, and incorrectly placed it in the drop mail holding area.

The above errors resulted from inadequate oversight and lack of control of the search and drop mail holding areas. VSC management did not ensure compliance with local Standard Operating Procedures for managing search mail, and interviews with staff revealed a lack of understanding of these requirements. Errors related to drop mail occurred because management did not review the drop mail holding area to ensure staff followed proper procedures. In general, mail errors occurred because the Quality of Files Activities SAO was incomplete. If VARO staff had completed the SAO and implemented recommendations to reduce the amounts of pending search and drop mail these errors might not have occurred. Untimely association of mail with veterans' claims folders can cause delays in processing benefits claims. As a result, beneficiaries may not receive accurate and timely benefits payments.

Recommendation

5. We recommend the Indianapolis VA Regional Office Director develop and implement a plan to ensure oversight and control of mail handling according to Veterans Benefits Administration policy and local guidance.

Management Comments

The VARO Director concurred with our recommendation. The Director stated the addition of Claims Assistants to the Intake Processing Center and refresher training on mail processing has helped ensure procedures are timely followed. To improve accuracy, the Intake Processing Center Coach and Intake Analysts now check drop mail twice daily and verify that all search

mail is appropriately controlled through the Control of Veterans Records System.

OIG Response

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

4. 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 capable 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 whether the beneficiary is competent.

Until recently, VBA did not have a clear, measurable definition of "immediate," and this period varied from office to office. In response to our summary report for FY 2010, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report Number 11-00510-167, May 18, 2011), the Acting Under Secretary for Benefits defined "immediate" as 21 days following expiration of the due process period.

Finding 5 Inadequate Controls Over Competency Determinations

As measured against VBA's new definition of immediate, VARO staff unnecessarily delayed making final decisions in 9 (41 percent) of 22 competency determinations completed from January through March 2011. The delays ranged from 1 to 152 days, with an average completion time of 31 days. Delays occurred because the workload management plan did not contain oversight procedures emphasizing immediate completion of competency determinations. In addition, VSC management stated the delays occurred because of difficulties making this work a priority versus all other responsibilities. The risk of incompetent beneficiaries receiving benefits without fiduciaries assigned to manage those

funds increases when staff do not complete competency determinations timely.

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 5 months. During this period, the veteran received $39,471 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.

Further, VSC staff incorrectly processed 3 (14 percent) of 22 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 making final determinations regarding competency. In the most egregious case, on April 22, 2010, an RVSR proposed incompetency. VSC staff correctly notified the veteran of the proposed incompetency determination in a letter dated April 26, 2010. On May 25, 2010, an RVSR granted a 100 percent disability evaluation with entitlement to an additional special monthly benefit. VSC staff correctly paid the veteran's monthly benefit of $3,327 beginning June 1, 2010. However, staff incorrectly released a retroactive payment of $9,612, the amount due to the veteran for the period February 17, 2010, through May 31, 2010, 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 October 2009 shortly after the policy changed, and again in January 2010, but the training may not have been adequate given the processing errors we identified.

Recommendation

6. We recommend the Indianapolis VA Regional Office Director provide 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 management provided training to Veterans Service Representatives in July 2011 on timely processing competency determinations. To ensure timely competency determinations, the Non-Rating Team Coach monitors due process actions monthly and a Veterans Service Representative monitors and controls suspense dates weekly.

OIG Response

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

Entitlement to Medical Care and Treatment for Mental Disorders

Veterans with Gulf War military service are eligible for medical treatment for any mental disorder they develop within 2 years of the date of separation from service. According to VBA policy, whenever an RVSR denies a Gulf War veteran service connection for any mental disorder, the RVSR must consider whether the veteran is entitled to receive mental health treatment.

In February 2011, VBA updated its Rating Board Automation 2000, a computer application designed to assist RVSRs in preparing disability ratings. The application provides a pop-up notification, known as a tip master, to remind staff to consider entitlement to health care treatment when staff deny service connection for a mental disorder.

Finding 6 Gulf War Veterans Not Receiving Accurate Entitlement Decisions for Mental Health Treatment

VARO staff did not properly consider whether 4 (33 percent) of 12 Gulf War veterans were entitled to receive treatment for mental disorders. Our review included five cases VARO staff completed before the Rating Board Automation 2000 update; two (40 percent) of the five cases were not properly processed. Two (29 percent) of seven other cases VARO staff completed after the update also were not properly processed. These errors occurred because VSC staff lacked understanding of VBA policy and overlooked reminder notification prompts. As a result, veterans may be unaware of possible entitlement to treatment for mental disorders.

In all four cases, RVSRs did not follow VBA policy to consider entitlement to mental health treatment when they denied the Gulf War veterans service connection for mental disorders. Interviews with VSC management and staff confirmed RVSRs did not always adhere to the policy. RVSRs stated it was easy to ignore the reminder notification and some VSC staff stated they were unaware of the reminder notification capability. VSC staff provided refresher training on this topic in August 2010 and again during our inspection in July 2011.

Recommendation

7. We recommend the Indianapolis VA Regional Office Director develop and implement a plan to monitor the effectiveness and adequacy of training on Veterans Benefits Administration policy regarding Gulf War veterans' entitlement to mental health treatment and take corrective action as appropriate.

Management Comments

The VARO Director concurred with our recommendation. The Director stated that in July 2011 management provided refresher training to Decision Review Officers and RVSRs on Gulf War Veterans' entitlement to mental health treatment. To identify continuing problems and training opportunities, VARO staff are developing an error tracking mechanism that will be discussed in the standard operating procedure for the Quality Team.

OIG Response

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

5. Public Contact

In November 2009, VA developed a 5-year plan to end homelessness among veterans by assisting every eligible homeless veteran willing to accept service. VBA generally defines homeless as lacking a fixed, regular, and adequate nighttime residence.

Expedited Claims Processing for Homeless Veterans

VBA's national target for processing homeless veterans' claims is an average of 75 days. VBA has provided guidance that priority processing should occur for these claims.

Four (13 percent) of 30 homeless veterans' claims completed from January through March 2011 that we reviewed were processed untimely or had potential processing delays. However, as of June 30, 2011, homeless veterans' claims at the Indianapolis VARO were pending an average of 74 days, one day better than the national target. Therefore, we made no recommendation for improvement in this area.

Outreach to Homeless Shelters and Service Providers

Congress mandated at least one full-time employee oversee and coordinate programs for homeless veterans at each of the 20 VAROs that VA determined to have the largest veteran populations. VBA guidance, last updated in September 2002, directed that the coordinators at the remaining 37 VAROs be familiar with requirements for improving the effectiveness of VARO outreach to homeless veterans. These requirements include developing and updating a directory of local homeless shelters and service providers. Additionally, the coordinators should attend regular meetings with local homeless service providers, community governments, and advocacy groups to provide information on VA benefits and services.

The Indianapolis VARO has a full-time Homeless Veterans Outreach Coordinator. Our review of the VARO's homeless veterans outreach processes and contact with local homeless service providers confirmed the Indianapolis Homeless Veterans Outreach Coordinator provided effective outreach as required by VBA policy. Therefore, we made no recommendation for improvement in this area.

Appendix A VARO Profile and Scope of Inspection

Organization

The Indianapolis VARO administers a variety of services and benefits including compensation benefits, vocational rehabilitation and employment assistance, specially adapted housing grants, benefits counseling, and outreach services for homeless, elderly, minority, and women veterans.

Resources

As of March 2011, the Indianapolis VARO had a staffing level of 230 employees. In July 2011, the VSC had 166 employees assigned.

Workload

As of June 2011, the VARO reported 17,022 pending compensation claims. The average time to complete claims was 271.7 days—96.7 days more than the national target of 175 days. As reported by STAR staff, the accuracy of compensation rating-related decisions was 88.3 percent, which was 1.7 percent below VBA's 90 percent target. The accuracy of compensation authorization-related processing was 94.3 percent—1.7 percent below VBA's 96 percent target.

Scope

We reviewed selected management, 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 50 (22 percent) of 223 claims related to TBI and herbicide exposure-related disabilities that the VARO completed from January 2011 through March 2011. For temporary 100 percent disability evaluations, we selected 30 (10 percent) of 294 existing claims from VBA's Corporate Database. We provided VARO management with the 264 claims remaining from our universe of 294 for further review. These claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months.

We reviewed the 12 mandatory SAOs completed in FYs 2010 and 2011. We reviewed 15 errors identified by VBA's STAR program during January through March 2011. 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 disability claims related to TBI and herbicide exposure that require rating decisions. In addition, we review rating decisions and awards processing involving temporary 100 percent disability evaluations.

For our review, we selected mail in various processing stages in the VARO mailroom and the VSC. We also reviewed 12 completed claims processed for Gulf War veterans from January through March 2011 to determine whether VSC staff addressed entitlement to mental health treatment in the rating decision documents as required. We reviewed 22 competency determinations and 30 homeless veterans' claims completed for the same 3-month period. Further, we reviewed the effectiveness of the VARO's homeless veterans outreach program.

We completed our review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.* 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: November 8, 2011

From: Director, VA Regional Office Indianapolis, Indiana

Subj: Inspection of the VARO Indianapolis, Indiana

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

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

2. Questions may be referred to Mr. Michael Stephens, Director, at (317) 916-3400, or Ms. Ena Lima, Veterans Service Center Manager, at (317) 916-3657.

(original signed by:)

MICHAEL R. STEPHENS
Director

Attachment

Recommendation 1: We recommend the Indianapolis VA Regional Office Director conduct refresher training and implement a plan to ensure staff follow current Veterans Benefits Administration policy regarding the processing of traumatic brain injury (TBI) claims.

Indianapolis Response: Concur

- Refresher training (2.25 hours) on TBI claims was delivered to Rating Veterans Service Representatives (RVSR) and Decision Review Officers (DRO) on August 31, 2011.
- Since June 2011, a DRO reviews all TBI rating decisions, provides second signature for same, and maintains an electronic log by RVSR/DRO of TBI claims worked and their accuracy. To date, a review of 50 cases has been conducted with a 90% accuracy rate. The process of requiring a second signature review on TBI cases at the Indianapolis Regional Office is consistent with current VBA policy for the processing of TBI cases.

Recommendation 2: We recommend the Indianapolis VA Regional Office Director implement a plan to improve effectiveness of the quality review process for herbicide exposure-related claims.

Indianapolis Response: Concur

- Since two (2) of the four (4) errors found were for assignment of incorrect effective dates for newly-recognized herbicide-related conditions, training on effective dates, including application of 38 CFR 3.114 (liberalizing legislation), was conducted for RVSRs and DROs on October 19, 2011, and October 26, 2011, for a total of four (4) hours.
- A Standard Operating Procedure (SOP) for the Quality Team, which is responsible for conducting all local quality reviews monthly, is being developed and will be published within thirty (30) days. The SOP will include the process for local quality reviews, including the requirement for a third signature on rating decisions involving claims for disabilities due to herbicide exposure under *Nehmer v. U.S. Department of Veterans Affairs*.

Recommendation 3: We recommend the Indianapolis VA Regional Office Director develop and implement a plan to ensure staff take corrective action to address errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review (STAR) Program.

Indianapolis Response: Concur

The Veterans Service Center has created an Access database to track all national STAR cases. The database tracks claims files beginning at the request of the file through the error correction process. The database includes errors identified, corrective actions required, suspense dates for corrective action, and employee responsible for corrective action. This process provides an overall view of pending corrections and ensures that all corrective actions are completed timely. The Veterans Service Center Manager (VSCM) or designee will review the database on a monthly basis.

Recommendation 4: We recommend the Indianapolis VA Regional Office Director develop and implement a plan to ensure staff complete Systematic Analyses of Operations (SAO) timely and address all required elements.

Indianapolis Response: Concur

- The VSCM provided SAO training in the fourth quarter of Fiscal Year 2011 for all management staff. In addition, the internal SAO schedule allows time for feedback and one-on-one mentoring for personnel preparing SAOs.
- The VSC has established an internal SAO schedule based on the station schedule provided by the Director's Office. The schedule provides internal deadlines for the completion of SAOs to assure there is adequate time for review and revision by Division Management prior to submission to the Director's Office. All personnel responsible for preparing an SAO during the current fiscal year have been notified of their respective assignments and due dates. The failure to submit an assigned SAO timely will be considered in a preparer's performance for the fiscal year.
- The two (2) VSC Management Analysts (MA) have been assigned as the SAO stewards for the Division. The analysts will coordinate with those responsible for preparing the SAOs to assure the SAOs are submitted to the VSCM Office in a timely manner. Additionally, they will serve as Subject Matter Experts (SME) for the SAOs. As SMEs, they will be responsible for assisting SAO preparers with analysis as well as serving as the point of document review prior to submission for VSCM approval.
- The Station MAs will provide additional oversight by following up with Division Management on submission of SAOs, ensuring the quality of SAOs submitted based on thorough data analysis, and formally documenting the approval of SAO extension requests.

Recommendation 5: We recommend the Indianapolis VA Regional Office Director develop and implement a plan to ensure oversight and control of mail handling according to Veterans Benefits Administration policy and local guidance.

Indianapolis Response: Concur

- A review of the Intake Processing Center (IPC) mail operations revealed a training need for all personnel on processes for placing mail on search, the proper locations for drop file mail, and receipt of the last piece of mail for a claim. Refresher training was conducted for all Claims Assistants (CA) within the IPC.
- The addition of CAs to the IPC has helped to ensure procedures are being timely followed. The IPC Coach and Intake Analysts are checking drop mail at least twice daily to verify the accuracy of drop mail. All search mail is now placed in a basket and verified by the Coach or Intake Analyst as having appropriate Control of Veterans Records System (COVERS) coding.

Recommendation 6: We recommend the Indianapolis VA Regional Office Director provide refresher training and implement controls to ensure staff follow current Veterans Benefits Administration policy regarding the processing of competency determinations.

Indianapolis Response: Concur

- Refresher training for VSRs that generate and authorize awards was conducted on July 28, 2011, on timely processing of competency determinations.
- A VSR on the Non-Rating Team is assigned to monitor and control the suspense date of the EP 600s weekly, specifically the incompetency determinations. These files are maintained within the Team, pulled when due, hand-carried to an RVSR for rating action, and then returned to the VSR for final processing. The Non-Rating Team Coach also monitors due process actions monthly to ensure proper timelines are being followed.

Recommendation 7: We recommend the Indianapolis VA Regional Office Director develop and implement a plan to monitor the effectiveness and adequacy of training on Veterans Benefits Administration policy regarding Gulf War Veterans' entitlement to mental health treatment and take corrective action as appropriate.

Indianapolis Response: Concur

- Refresher training on entitlement to 38 U.S.C. 1702 was delivered to RVSRs and DROs in July 2011. The SOP currently being developed for the Quality team will include a mechanism for tracking national and local errors by type in order to identify continuing problem areas, trends, and training opportunities. The SOP will be published within 30 days.
- Corrected rating decisions were completed on all identified actions that did not include consideration under 38 U.S.C. 1702.

Appendix C Inspection Summary

Nine 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 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1 MR, Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Traumatic Brain Injury Claims	**Determine whether VARO staff properly processed claims for service connection for all residual disabilities related to in-service TBI.** (FLs 08-34 and 08-36, Training Letter 09-01)		X
3. Herbicide Exposure-Related Claims	**Determine whether VARO staff properly processed claims for service connection for herbicide exposure-related disabilities.** (38 CFR 3.309) (FL 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)		X
Management Controls			
4. 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
5. 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			
6. 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			
7. 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
8. Entitlement to Mental Health Treatment for Gulf War Veterans	**Determine whether VARO staff properly processed Gulf War Veterans' claims, considering entitlement to Medical Treatment for Mental Illness.** (38 United States Code 1702) (M21-1MR Part IX Subpart ii, Chapter 2)(M21-1MR Part III, Subpart v, Chapter 7) (Fast Letter 08-15) (38 CFR 3.384)(38 CFR 3.2)		X
Public Contact			
9. Homeless Veterans Outreach Program	**Determine whether VARO staff expeditiously processed homeless veterans' claims and provided effective outreach services.** (Public Law 107-05) (M21-1MR Part III Subpart ii, Chapter 1, Section B) (M21-1MR Part III Subpart iii, Chapter 2, Section I) (VBA Circular 20-91-9) (VBA Letter 20-02-34) (C&P Service Bulletins August 2009, January 2010, April 2010, May 2010)	X	

Source: VA OIG
CFR=Code of Federal Regulations, FL=Fast Letter, M=Manual, MR=Manual Rewrite

Appendix D Office of Inspector General 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 Madeline Cantu Michelle Elliott Lee Giesbrecht Rachel Stroup Nelvy Viguera Butler Diane Wilson

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