VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Fargo, North Dakota

January 25, 2012
11-03724-73

ACRONYMS AND ABBREVIATIONS

HVOC	Homeless Veterans Outreach Coordinator
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, Fargo, North Dakota

Why We Did This Review

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

What We Found

Fargo VARO staff followed the Veterans Benefits Administration's policy for completing Systematic Analyses of Operations and correcting errors identified through the Systematic Technical Accuracy Review program. VARO performance was generally effective in processing traumatic brain injury and herbicide exposure-related disability claims and handling mail.

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. VARO staff did not correctly process 26 (39 percent) of the 67 disability claims we sampled as part of our inspection. These results do not represent the overall accuracy of disability claims processing at this VARO.

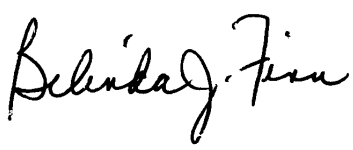
VARO management did not ensure staff accurately addressed Gulf War veterans' entitlement to mental health treatment. Processing of competency determinations was not fully effective, resulting in unnecessary delays in final decisions and improper benefits payments. A lack of management controls over receipt, development, and completion of homeless veterans' claims resulted in processing delays. Finally, the VARO did not require the Homeless Veterans Outreach Coordinator to perform duties related to homeless veterans outreach.

What We Recommended

We recommended VARO management conduct refresher training and implement controls to ensure staff follow current Veterans Benefits Administration policy on processing competency determinations and Gulf War veterans' entitlement to mental health treatment. Further, management needed to develop and implement a plan to expedite the processing of homeless veterans' claims and ensure the Homeless Veterans Outreach Coordinator performs all duties as required.

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.



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 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 September 2011, the OIG conducted an inspection of the Fargo 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 37 (31 percent) of 121 disability claims related to traumatic brain injury (TBI) and herbicide exposure that VARO staff completed from April through June 2011. In addition, we reviewed 30 (43 percent) of 69 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 Fargo VARO lacked controls and accuracy in processing temporary 100 percent evaluations and claims for TBI-related disabilities. VARO staff incorrectly processed 26 (39 percent) of the total 67 disability claims we sampled during our inspection. VARO management agreed with our findings and began to correct the inaccuracies identified.

Because we sampled claims related to specific conditions, these results do not represent the universe of disability claims processed at this VARO. As reported by Veterans Benefits Administration's (VBA) Systematic Technical Accuracy Review (STAR) program as of July 2011, the overall accuracy of the Fargo VARO's compensation rating-related decisions was 85.3 percent—4.7 percent below the 90 percent VBA target.

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

Table

Fargo VARO Disability Claims Processing Results				
Type	**Reviewed**	**Claims Incorrectly Processed**		
		Total	**Affecting Veterans' Benefits**	**Potential To Affect Veterans' Benefits**
Temporary 100 Percent Disability Evaluations	30	23	8	15
Traumatic Brain Injury Claims	7	2	0	2
Herbicide Exposure-Related Claims	30	1	1	0
Total	**67**	**26**	**9**	**17**

Source: VA OIG

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 23 (77 percent) of 30 temporary 100 percent disability evaluations we reviewed. 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 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 8 of the 23 processing inaccuracies affected veterans' benefits—7 involved overpayments totaling $697,010 and one involved an underpayment totaling $3,143. Details on the most significant overpayment and the underpayment follow.

- VARO staff assigned a temporary 100 percent evaluation for nasal lymphoma and annotated the need for an immediate reexamination. VA medical treatment records showed the veteran had completed treatment, warranting a reduction in benefits as of November 2001. As a result, VA overpaid the veteran $256,792 over a period of 9 years and 10 months.
- VARO staff assigned a temporary 100 percent evaluation with an incorrect effective date of January 29, 2010. VA medical treatment records showed active cancer warranting an increased evaluation effective December 31, 2009. As a result, VA underpaid the veteran $3,143 over a period of 1 month.

The remaining 15 inaccuracies had the potential to affect veterans' benefits. Following are summaries of these inaccuracies.

- In 10 cases, Rating Veterans 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 one case, VSC staff did not schedule a follow-up medical examination after receiving the electronic system-generated reminder notification.
- In three cases, RVSRs correctly continued temporary 100 percent disability evaluations for active cancer. According to VBA policy, the veterans with these disabilities each required a medical reexamination 6 months following completion of treatment. However, in all three cases

the RVSRs incorrectly annotated the need for reexaminations five years in the future, which did not provide for adequate follow-up and reevaluation as required.

- In one case, an RVSR incorrectly annotated the need for future reexamination of a veteran diagnosed with incurable chronic lymphocytic leukemia. In making this decision, the RVSR also did not consider entitlement to the additional benefit of Dependents' Educational Assistance as required by VBA policy.

For 13 of the 15 inaccuracies with potential to affect veterans' benefits, an average of approximately 1 year and 3 months elapsed from the time staff should have scheduled these medical reexaminations until the date of our inspection. The delays ranged from approximately 2 months to 6 years and 1 month.

Seventeen of the 23 errors resulted from staff not establishing suspense diaries when they processed rating decisions requiring temporary 100 percent disability reexaminations. Eleven of these errors involved confirmed and continued rating decisions. In November 2009, VBA provided guidance to the VAROs about the need to enter suspense diaries in the electronic record as reminders to schedule reexaminations for confirmed and continued rating decisions. However, VARO management had no oversight procedure in place to ensure VSC staff established the suspense diaries as required.

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 39 claims remaining from our universe of 69 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 two (29 percent) of seven TBI claims. Both of these processing inaccuracies had the potential to affect veterans' benefits. Following are summaries of these inaccuracies.

- An RVSR incorrectly continued a 10 percent disability evaluation for TBI residuals. Medical evidence showed a mild TBI with no residuals

warranting no more than a 0 percent disability evaluation. Because of the veteran's multiple service-connected disabilities, this error did not affect the veteran's monthly benefits, but may affect future evaluations for additional benefits.

- An RVSR incorrectly continued a 10 percent disability evaluation for TBI residuals using an inadequate VA medical examination. According to VBA policy, when a medical examination does not address all required elements, VSC staff should return it to the issuing 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.

The two TBI claims processing inaccuracies were unique and did not constitute a common trend, pattern, or systemic issue. As such, we made no recommendation for improvement in this area.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed one (3 percent) of 30 herbicide exposure-related claims we reviewed. In this case, 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 $480 over a period of 5 months.

Because we found only one inaccuracy, we determined the VARO generally followed VBA policy for processing herbicide exposure-related claims. Therefore, we made no recommendation for improvement in this area.

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

Fargo VARO staff adhered to VBA policy by taking corrective action on all 10 cases with errors identified by VBA's STAR program from April through June 2011. Therefore, 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). 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. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 11 SAOs annually.

VARO management timely completed all 11 required SAOs. The completed SAOs contained thorough analyses using appropriate data, identified areas for improvement, and made recommendations. For example, one SAO revealed VSC staff were not properly updating the Modern Award Processing application, which was designed to assist VARO staff in tracking and recording development actions for claims processing. Management recommended refresher training for VARO staff in Modern Award Processing compliance. As a result, we determined the VARO was following VBA policy and made no recommendation for improvement in this area.

3. Workload Management

Mailroom Operations

We assessed controls over 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 Fargo VARO does not have its own mailroom. Instead, the VA Medical Center mailroom, located on the same VA campus, receives all incoming mail for the VARO. VSC staff are responsible for retrieving and processing this mail on a daily basis. Staff were timely and accurate in processing, date-stamping, and delivering VSC mail. As a result, we determined the VARO was following VBA policy and made no recommendation for improvement in this area.

Mail Management Procedures

We assessed the VSC'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.

VSC staff did not properly manage one (2 percent) of 60 pieces of mail we reviewed. As a result, we determined the Fargo VARO was generally compliant with national and local mail-handling policies. Therefore, we made no recommendation for improvement in this area.

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 that staff 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 60-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. Effective July 2011, VBA defines "immediate" as 21 days.

Finding 2 Inadequate Controls Over Competency Determinations

As measured against VBA's definition of immediate, VARO staff unnecessarily delayed making final decisions in 11 (61 percent) of 18 competency determinations completed from April through June 2011. The delays ranged from 13 to 132 days, with an average completion time of 49 days. Delays occurred because the workload management plan did not contain oversight procedures emphasizing immediate completion of competency determinations. 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 4 months. During this period, the veteran received $5,332 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 (17 percent) of 18 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 December 1, 2010, an RVSR granted entitlement to an additional monthly benefit based on the claimant's

need for daily assistance from another person to perform routine activities. In the same rating decision the RVSR proposed incompetency. VSC staff correctly paid the widow's monthly benefit of $1,056 beginning December 1, 2010. However, staff incorrectly released a retroactive payment of $3,168, the amount due to the widow for the period August 19, 2010, through November 30, 2010, before determining whether she was competent to manage the funds.

These errors were the result of a lack of understanding of the revised VBA policy on processing competency determinations. The VARO provided training in May 2011 and again during our inspection in September 2011. Training VSC staff on this issue is a positive step toward addressing the errors identified.

Recommendations

1. We recommend the Fargo VA Regional Office Director implement controls to ensure staff follow current Veterans Benefits Administration policy regarding the processing of competency determinations.
2. We recommend the Fargo VA Regional Office Director develop and implement a plan to monitor the effectiveness and adequacy of the training provided in September 2011 regarding proper processing of competency determinations, and take appropriate action as needed.

Management Comments

The VARO Director concurred with our recommendations. In response to recommendation 1, the Director indicated VARO Fargo updated the workload management plan to ensure staff review competency determinations on a weekly basis. Additionally, VSC staff will incorporate the findings in the annual SAO on Claims Processing Timeliness. In response to recommendation 2, the Director stated the VARO conducted refresher training on October 6, 2011, on processing competency determinations.

OIG Response

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

Entitlement to Medical Care and Treatment for Mental Disorders

Gulf War veterans are eligible for medical treatment for any mental disorder they develop within 2 years of the date of separation from military service. According to VBA, 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 Gulf War veterans' entitlement to health care treatment when staff deny service connection for a mental disorder.

Finding 3 Gulf War Veterans Not Receiving Accurate Entitlement Decisions for Mental Health Treatment

In both cases we reviewed, VARO staff did not properly consider whether Gulf War veterans were entitled to receive treatment for mental disorders. These errors occurred because VSC staff lacked understanding of VBA policy and overlooked reminder notification prompts to consider entitlement to mental health treatment. As a result, veterans may be unaware of possible entitlement to treatment for mental disorders.

Interviews with VSC management and staff confirmed RVSRs did not always follow VBA policy to consider entitlement to mental health treatment when they denied the Gulf War veterans service connection for mental disorders. RVSRs stated it was easy to ignore the reminder notifications and some VSC staff stated they were unaware of the reminder notification capability. VARO staff did not receive refresher training on this topic during FY 2011.

Recommendation

3. We recommend the Fargo VA Regional Office Director conduct refresher training and implement a plan to ensure staff follow current policy regarding Gulf War veterans' entitlement to mental health treatment.

Management Comments

The VARO Director concurred with our recommendation. The Director indicated the VARO received refresher training on October 6, 2011, on entitlement to mental health treatment for Gulf War veterans. The Director stated quality reviewers have found no deficiencies since the training.

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 homelessness as lacking a fixed, regular, and adequate nighttime residence. VBA provided guidance to all VAROs that claims submitted by homeless veterans should receive priority processing.

Expedited Claims Processing for Homeless Veterans

At the time of our inspection, VBA determined its national performance measure for processing homeless veterans' claims based on the average days the claims were pending. VBA's national target was for the claims to be pending no more than an average of 75 days.

Finding 4 Inadequate Controls for Homeless Veterans' Claims Processing

At the time of our inspection, the Fargo VARO had three homeless veterans' claims pending an average of 143 days—exceeding VBA's 75-day national target by 68 days. Our review determined one claim no longer met the criteria for expedited claims processing due to the veteran's incarceration. In addition, one claim had been pending at another VARO before receipt at the Fargo VARO. We adjusted the average time pending for the claims based on this information. We found that the claims had actually been pending at the Fargo VARO an average of 146 days—exceeding VBA's national target by 71 days. This measure only reflected the average time elapsed from claims receipt at the VARO until the current date. It did not reflect how long it took VARO staff to make determinations on the claims and inform the veterans.

The Fargo VARO assigned processing of homeless veterans' claims to the Homeless Veterans Outreach Coordinator (HVOC). Our inspection showed VARO staff members other than the HVOC were processing these claims. The two delayed claims had been pending for 119 and 172 days. These delays occurred because management did not ensure the HVOC monitored receipt, development, and completion of homeless veterans' claims timely as required by local policy. As a result, two homeless veterans were not afforded priority claims processing as required.

Recommendation

4. We recommend the Fargo VA Regional Office Director develop and implement a plan to expedite the processing of homeless veterans' claims.

Management's Comment

The VARO Director concurred with our recommendation. The Director stated the Fargo VARO implemented a plan for review of homeless claims on a weekly basis. Further, the Director indicated the average days to complete a homeless claim improved during the first quarter of FY 2012.

OIG Response

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

Outreach to Homeless Shelters and Service Providers

Congress mandated that at least one full-time employee oversee and coordinate homeless veterans programs 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 Fargo VARO is not one of the 20 VAROs required to have a full-time coordinator dedicated to address homeless veterans' needs. As such, VARO management assigned one employee to perform the function of the HVOC as a collateral duty, including expediting the processing of homeless veterans' claims.

Finding 5 No Consistent Homeless Veterans Outreach Program

Our inspection showed VARO management did not ensure the HVOC performed duties related to homeless veterans outreach, such as developing and regularly updating a local resource directory, providing information about VA benefits, and attending community events and meetings specific to homeless veterans, as required by VBA policy. As a result, VARO management had no assurance homeless shelters and service providers received information from the VARO regarding benefits and services available to homeless veterans.

During a June 2009 site visit, VBA Compensation and Pension Service officials determined the Fargo VARO did not perform outreach during that fiscal year and needed to improve its efforts to assist homeless veterans. In response to those findings the VARO staff attended outreach events in September, October, and November 2009. Our inspection showed VARO staff did not attend outreach functions again until May, June, and October 2010. VARO staff did not participate in four outreach events subsequently held in the Fargo area between November 2010 and September 2011.

We contacted representatives at 10 (17 percent) of 59 homeless shelters and service providers listed in the outreach services directory VSC staff provided. Only two providers indicated familiarity with the VARO's HVOC. VSC staff confirmed they did not routinely contact homeless service providers or provide those facilities with outreach information. Further, our interview with the Veterans Health Administration's Homeless Program Supervisor revealed VA Medical Center staff, rather than the HVOC, had developed the outreach services directory. The HVOC did not maintain contact with Veterans Health Administration staff, who stated they were not familiar with the HVOC.

Recommendation

5. We recommend the Fargo VA Regional Office Director develop and implement a plan to ensure the Homeless Veterans Outreach Coordinator performs all duties as required.

Management's Comments

The VARO Director concurred with our recommendation. The Director indicated VARO Fargo appointed a new coordinator as an additional duty. Further, the Director stated VARO Fargo, in conjunction with the VA Health Care coordinator, is developing an outreach plan, which will be finalized by February 1, 2012.

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 Fargo 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 June 2011, the Fargo VARO had a staffing level of 51 full-time employees. Of this total, in July 2011, the VSC had 43 employees (84 percent) assigned.

Workload

As of July 2011, the VARO reported 1,345 pending compensation claims. The average time to complete these claims was 125.7 days—49.3 days less than the national target of 175.

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 37 (31 percent) of 121 disability claims related to TBI and herbicide exposure that the VARO completed from April through June 2011. For temporary 100 percent disability evaluations, we selected 30 (43 percent) of 69 existing claims from VBA's Corporate Database. We provided VARO management with 39 claims remaining from our universe of 69 for further review. These claims represented all instances in which VARO staff granted temporary 100 percent disability evaluations for at least 18 months or longer as of August 2, 2011.

We reviewed the 11 mandatory SAOs completed in FYs 2010 and 2011. We reviewed 10 cases with errors identified by VBA's STAR program during April through June 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 VSC. We also reviewed two completed claims processed for Gulf War veterans

from April through June 2011 to determine whether VSC staff addressed entitlement to mental health treatment in the rating decision documents as required. We reviewed 18 competency determinations and 1 homeless veteran's claim completed for the same 3-month period. Further, we reviewed three homeless veterans' claims pending at the time of our inspection and assessed 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 Inspections 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: January 9, 2012

From: Director, VA Regional Office

Subj: Inspection of the VA Regional Office, Fargo, North Dakota

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

1. Attached are the Fargo VARO's comments on the OIG Draft Report: Inspection of the VA Regional Office, Fargo, North Dakota.

2. Questions may be referred to Mr. James L. Brubaker, Director, at 605-333-6839, or Ms. Paula Conard, Veterans Service Center Manager, at 701-451-4601.

(original signed by:)

James Brubaker
Director Dakotas Regional Office

Attachment

VARO Director's Comments

Finding 1 Disability Claims Processing Accuracy Could Be Improved

Recommendation: 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 39 claims remaining from our universe of 69 temporary 100 percent disability evaluations.

Response: In response to OIG report "Audit of 100 Percent Evaluations" dated January 24, 2011, VBA developed a national plan to review temporary 100 percent evaluation cases, which was accepted by OIG. Therefore, the Regional Office will follow the national review plan. To date, Fargo has reviewed 65 cases under the national plan and found 80 percent of the cases reviewed did not require any future examinations. Of the remaining 20 percent, review action has been undertaken on all of these cases.

Finding 2 Inadequate Controls Over Competency Determinations

Recommendation: 1) We recommend the Fargo VA Regional Office Director implement controls to ensure staff follow current Veterans Benefits Administration policy regarding the processing of competency determinations.

Response: Concur. The Fargo VA Regional Office has incorporated controls into its Workload Management Plan to review competency determinations on a weekly basis. A copy of the Workload Management Plan is attached. Findings will be incorporated into the annual Systematic Analysis of Operations (SAO) on Claims Processing Timeliness.

Recommendation: 2) We recommend the Fargo VA Regional Office Director develop and implement a plan to monitor the effectiveness and adequacy of the training provided in September 2011 regarding proper processing of competency determinations, and take appropriate action as needed.

Response: Concur. Corrective actions have been taken on all the exceptions noted by OIG. On October 6, 2011, the Fargo VA Regional Office conducted refresher training on processing competency determinations. VOR data for first quarter of FY12 show one competency claim processed in 8 days, which is well within the 21 day standard for immediate processing. Additionally, there are two competency claims currently pending, and both are within the standard.

We request closure of these recommendations based on ongoing VSC actions taken to monitor progress in this area.

Finding 3 Gulf War Veterans Not Receiving Accurate Entitlement Decisions for Mental Health Treatment

Recommendation: We recommend the Fargo VA Regional Office Director conduct refresher training and implement a plan to ensure staff follow current policy regarding Gulf War veterans' entitlement to mental health treatment.

Response: Concur. On October 6, 2011, the Fargo VA Regional Office conducted refresher training on entitlement to mental health treatment for Gulf War veterans' pursuant to 38 USC 1702. Both the FAQ dated November 14, 2008, and M21-1MR, IX.ii.2.5.c from February 3, 2011, was specifically reviewed. No deficiencies have been found on the 150 local quality reviews conducted since the training. Additionally, Quality Review Specialist positions have been posted and a Quality Review Team (QRT) is being implemented in conjunction with the 2012 Transformation Initiative.

We request closure of this recommendation based on ongoing VSC actions taken to monitor progress in this area.

Finding 4 Inadequate Controls for Homeless Veterans' Claims Processing

Recommendation: We recommend the Fargo VA Regional Office Director develop and implement a plan to expedite the processing of homeless veterans' claims.

Response: Concur. The Fargo VA Regional Office implemented a plan for weekly review of homeless claims by the Homeless Veterans Outreach Coordinator and Supervisor. The Average Days to Complete (ADC) for homeless claims for the first quarter of FY12 is 40.8 days (4 claims completed). This is a 64.6-day improvement from the 105.4 ADC in FY11 (9 claims completed).

We request closure of this recommendation based on ongoing VSC actions taken to monitor progress in this area.

Finding 5 No Consistent Homeless Veterans Outreach Program

Recommendation: We recommend the Fargo VA Regional Office Director develop and implement a plan to ensure the Homeless Veterans Outreach Coordinator performs all duties as required.

Response: Concur. A full time coordinator is not warranted as less than ten homeless veterans claims were processed in North Dakota last fiscal year. The Fargo VA Regional Office has appointed a new Homeless Veterans Outreach Coordinator as an ancillary duty. An outreach plan is being developed in coordination with the Fargo VA Health Care Center Homeless Coordinator. By February 1, 2012, the outreach plan will be finalized.

We request closure of this recommendation based on ongoing VSC actions taken to monitor progress in this area.

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 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. Traumatic Brain Injury Claims	**Determine whether VARO staff properly processed claims for service connection for all disabilities related to in-service TBI.** (FL 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. Gulf War Veterans' Entitlement to Mental Health Treatment	**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) (Compensation and Pension Service Bulletins August 2009, January 2010, April 2010, May 2010)		X

CFR=Code of Federal Regulations, FL=Fast Letter, M=Manual, MR=Manual Re-write

Source: VA OIG

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.
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