VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Phoenix, Arizona

July 17, 2012
12-00246-226

ACRONYMS AND ABBREVIATIONS

NOD	Notice of Disagreement
OIG	Office of Inspector General
QRT	Quality Review Team
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, Phoenix, Arizona

Why We Did This Review

The Veterans Benefits Administration (VBA) 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 Phoenix VARO accomplishes this mission of providing veterans with access to high-quality benefits and services.

What We Found

The VARO lacked effective controls and accuracy in processing some disability claims we sampled during our inspection. Management of temporary 100 percent disability evaluations had excessive processing errors. Inaccuracies in processing 87 percent of these claims resulted when staff did not establish controls to schedule future medical reexaminations. Without effective management of temporary ratings, VBA risked paying excessive and unnecessary financial benefits. Staff used insufficient medical examination reports and incorrectly processed 30 percent of the traumatic brain injury claims. Further, staff used incorrect effective dates in granting benefits for 20 percent of the herbicide exposure-related claims. In total, VARO staff did not correctly process 39 (47 percent) of the 83 disability claims. These results do not represent the overall accuracy of disability claims processing at this VARO as we sampled claims we considered at higher risk of processing errors.

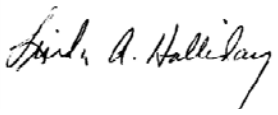
VARO staff followed VBA's policy on correcting errors identified by Systematic Technical Accuracy Review program staff. However, VARO managers did not ensure staff completed or used adequate data to support Systematic Analyses of Operations. Mail management was generally effective although Veterans Service Center management did not take action until the time of our inspection to halt staff use of manual date stamps, which VBA policy prohibits because it can result in incorrect effective dates and inaccurate benefits payments to veterans. VARO staff did provide adequate outreach to homeless veterans.

What We Recommended

We recommended the VARO Director develop and implement a plan to monitor the effectiveness of training on processing traumatic brain injury and herbicide exposure-related disability claims, and addressing Gulf War veterans' entitlement to mental health treatment. Management also needs to ensure staff complete and use adequate data to support Systematic Analyses of Operations.

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.



LINDA A. HALLIDAY
Assistant Inspector General for
Audits and Evaluations

TABLE OF CONTENTS

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. OIG Benefits Inspectors contribute 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 oversight, inspections may examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

Scope of Inspection

In March 2012, we conducted an inspection of the Phoenix VARO. The inspection focused on five protocol areas addressing eight operational activities. The five protocol areas were disability claims processing, management controls, workload management, eligibility determinations, and public contact. We did not review competency determinations as in previous inspections because the Veterans Benefits Administration (VBA) has centralized Western Area fiduciary activities at the Salt Lake City VARO.

We reviewed 53 (9 percent) of 578 disability claims related to traumatic brain injury (TBI) and herbicide exposure that VARO staff completed from October through December 2011. In addition, we reviewed 30 (7 percent) of 450 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 our 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 Benefits 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 Phoenix VARO Could Improve Disability Claims Processing Accuracy

The Phoenix VARO lacked adequate controls and accuracy in processing claims for temporary 100 percent disabilities, TBI, and herbicide exposure. VARO staff incorrectly processed 39 of the total 83 disability claims we sampled and improperly paid a total of $221,699 in veterans' benefits. VARO management agreed with our findings and began to correct the errors identified.

Because we sampled selected types of claims, our results are not representative of the full universe of disability claims processed at this VARO. As reported by VBA's Systematic Technical Accuracy Review (STAR) program as of February 2012, the overall accuracy of the Phoenix VARO's compensation rating-related decisions was 88.1 percent—1.1 percentage points above VBA's target of 87 percent.

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

Table 1

Phoenix VARO Disability Claims Processing Results				
Type	**Reviewed**	**Claims Incorrectly Processed**		
		Affecting Veterans' Benefits	**Potential To Affect Veterans' Benefits**	**Total**
Temporary 100 Percent Disability Evaluations	30	8	18	26
Traumatic Brain Injury Claims	23	1	6	7
Herbicide Exposure-Related Claims	30	6	0	6
Total	**83**	**15**	**24**	**39**

Source: VA OIG based on analysis of VBA data

Temporary 100 Percent Disability Evaluations

Management of temporary 100 percent disability evaluations had excessive processing errors. VARO staff incorrectly processed 26 of 30 temporary 100 percent disability evaluations we reviewed. That means only 13 percent of these claims were done right. VBA policy requires a temporary 100 percent disability evaluation for a service-connected disability following a veteran's surgery or when specific treatment is required. At the end of the 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 in 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.

Without effective management of these temporary ratings, VBA is at risk of paying excessive and unnecessary financial benefits. Available medical evidence showed 8 of the 26 processing errors affected veterans' benefits—all 8 involved overpayments totaling $192,165. Details on the two most significant overpayments follow.

- VARO staff did not schedule a medical reexamination to evaluate a veteran's prostate cancer. VA medical records showed the veteran had completed treatment, warranting a reduction in benefits effective August 2008. In the absence of a follow-up exam, VA continued processing monthly benefits and ultimately overpaid the veteran $123,899 over a period of 3 years and 8 months.
- VARO staff assigned a temporary 100 percent disability evaluation for prostate cancer with an incorrect effective date of December 18, 2009. However, VA treatment records provided evidence of active cancer as of September 14, 2009, the date the veteran submitted his claim to VA. In this same decision document, staff also did not grant the veteran entitlement to an additional special monthly benefit based on the loss of use of a creative organ, as required. As a result of assigning an incorrect effective date as well as not establishing the additional benefit, VA underpaid the veteran a total of $9,444 over a period of 1 year and 2 months. Ultimately, VA medical treatment records showed the veteran completed cancer treatment, warranting a reduction in benefit payments for this disability effective November 2010. However, VA continued processing monthly benefits and overpaid the veteran $37,148 over a period of 1 year and 4 months. Because of the initial underpayment in

conjunction with the overpayment, VA ultimately made a net overpayment of $27,704 to the veteran.

The remaining 18 errors in processing temporary 100 percent disability evaluations had the potential to affect veterans' benefits. Following are descriptions of these processing errors.

- In 14 cases, VSC staff did not schedule medical reexaminations to determine whether veterans' temporary 100 percent evaluations should continue. All 14 cases involved confirmed and continued rating decisions. Neither we nor VARO staff could determine if the evaluations should have continued because the veterans' claims folders did not contain the medical evidence needed to reevaluate each case.
- In four cases, VSC staff correctly processed non-disability claims related actions that did not require decision documents; however, they did not ensure suspense diaries remained in the electronic system to remind them of the need for medical reexaminations. As a result, VSC staff did not schedule reexaminations as required to provide the basis for re-rating the cases. Again, we could not determine if these temporary 100 percent evaluations should have continued because the veterans' claims folders did not contain medical evidence needed to reevaluate these cases.

For the 18 errors with the potential to affect veterans' benefits, an average of 2 years elapsed from the time staff should have scheduled medical reexaminations until the date of our inspection. The delays scheduling medical reexaminations ranged from 7 months to 5 years and 7 months.

Collectively, 22 of the 26 errors resulted from staff not establishing suspense diaries when they processed rating decisions requiring temporary 100 percent disability reexaminations. The remaining four errors occurred because VSC staff did not take final action on proposals to reduce veterans' temporary 100 percent disability evaluations. In November 2009, VBA provided guidance reminding VAROs about the need to add suspense diaries in the electronic record for confirmed and continued rating decisions. However, VARO management did not provide additional training and lacked an oversight procedure to ensure VSC staff established the suspense diaries and timely scheduled reexaminations as required.

In response to a recommendation in our national 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. The Acting Under Secretary stated the target completion date for the national review would be September 30, 2011. However, VBA did not provide each VARO with a list

of temporary 100 percent disability evaluations for review until September 2011. VBA subsequently extended the deadline to December 31, 2011, then to March 31, 2012, and then again to June 30, 2012. To assist in implementing the agreed-upon review, we provided the Phoenix VARO with 420 claims remaining from our universe of 450 temporary 100 percent disability evaluations. As of mid-June 2012, VBA was still working to complete the national review requirement.

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 7 of 23 TBI claims—one of these processing errors affected a veteran's benefits. In this case, a Rating Veterans Service Representative (RVSR) incorrectly used the same symptoms to assign evaluations for the veteran's post-traumatic stress disorder and TBI residuals, resulting in a total disability evaluation of 100 percent. VBA policy directs that staff cannot use the same symptoms to evaluate two separate disabilities, even though symptoms of cognitive impairment and mental disorders such as post-traumatic stress disorder often overlap. Staff should have ascribed the symptoms to one or the other disability to evaluate the veteran's claim, which would have resulted in an overall total disability evaluation of 90 percent. As a result, VA continued processing monthly benefits and ultimately overpaid the veteran $26,136 over a period of 2 years.

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

- In five cases, RVSRs and Decision Review Officers prematurely evaluated TBI residuals using insufficient medical examination reports. According to VBA policy, when a medical examination report 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 adequate or complete medical evidence.
- An RVSR incorrectly evaluated TBI residuals as 10 percent disabling. Medical evidence showed the TBI residuals warranted no more than a 0 percent disability, entitling the veteran to health care for the condition but not monetary compensation. Because of the veteran's multiple service-connected disabilities, this error did not affect the veteran's monthly benefits, but could affect future evaluations for additional benefits.

Generally, errors associated with TBI claims occurred because VSC staff received inadequate training on TBI regulations and policies. During FY 2011, VSC management canceled training sessions to work on a high-profile, time-sensitive national project. The last training on residuals of TBI occurred in November 2011, and three errors we identified in processing these types of claims occurred after this training. Despite the training, interviews with VSC staff revealed they were not aware medical examination reports were insufficient if they did not specifically state whether the veteran's symptoms were due to TBI or a co-morbid mental disorder. Because of using insufficient medical examination reports, veterans may not have always received correct benefits.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 6 of 30 herbicide exposure-related claims we reviewed. All of the processing errors affected veterans' benefits—five involved underpayments totaling $15,532 and one involved an overpayment totaling $3,398. Details on the most significant underpayment and the overpayment follow.

- An RVSR incorrectly evaluated ischemic heart disease as 30 percent disabling. However, available medical evidence showed the veteran warranted a 60 percent evaluation. The RVSR also assigned an incorrect effective date of December 28, 2010, the date VA received the claim. The correct effective date should have been August 31, 2010, the date of a related legislative change. 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 the legislative change, if the veteran is eligible. In this instance, eligibility existed to pay the veteran from the date of the law change because medical evidence showed a diagnosis existed at that time warranting the 60 percent evaluation. As a result of using an incorrect effective date, VA underpaid the veteran $8,153 over a period of 1 year and 6 months. We discussed the underpayment with VARO officials who agreed to take corrective action.
- An RVSR correctly granted service connection and assigned a 100 percent disability evaluation for ischemic heart disease. In the same decision, the RVSR correctly reduced the evaluation to 60 percent disabling, but used an incorrect effective date of June 10, 2011, the date of the veteran's medical reexamination. Available medical evidence showed the RVSR should have reduced the veteran's evaluation to 60 percent on April 20, 2011. As a result of the error, VA continued processing monthly benefits and ultimately overpaid the veteran $3,398 over a period of 2 months.

Generally, inaccuracies associated with herbicide exposure-related claims processing resulted from ineffective training. During FY 2011, VSC management canceled training sessions to work on a high-profile,

time-sensitive national project. The last training on herbicide exposure-related conditions occurred in November 2011 and March 2012.[1] Interviews with VSC staff revealed that despite this recent training, RVSRs did not have a clear understanding of herbicide exposure-related regulations and policies. VSC staff also revealed there was no adequate mechanism in place to measure whether the training was effective. As a result, VSC staff did not consistently properly evaluate herbicide exposure-related disabilities and veterans may not have always received correct benefits.

Recommendation

1. We recommend the Phoenix VA Regional Office Director develop and implement a plan to monitor the effectiveness of training on the proper processing of traumatic brain injury and herbicide exposure-related claims.

Management Comments

The VARO Director concurred with our recommendation. The Director stated that in April 2012 the Quality Review Teams (QRT) conducted training on the correct application of VBA's policies for evaluating TBI claims and proper processing of Herbicide exposure-related claims. The VSC provided updated training in May 2012 on both TBI and herbicide exposure-related claims emphasizing the findings from our visit. The Director indicated that in order to monitor effectiveness of all training, the QRT identifies deficiencies using local quality and in-process reviews, along with a local error tracker. The Director stated that as of May 2012, local quality review findings showed two TBI errors; however, neither error was related to co-morbid symptoms or insufficient medical examinations.

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 STAR staff. The STAR program is VBA's multifaceted quality assurance program to ensure veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that VARO staff take corrective action on errors identified by STAR.

Phoenix VARO staff did not correct 1 of 13 errors identified by STAR program staff from October through December 2011. Because VARO management generally followed VBA policy regarding corrections of STAR errors, we made no recommendation for improvement in this area

[1] RVSRs are required to complete 60 hours of training per each fiscal year—40 hours in specific areas mandated by VBA and the remaining 20 hours as determined by the VARO. Rating herbicide exposure-related claims is not VBA-mandated training.

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. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 11 SAOs annually. VARO management must publish annual SAO schedules designating the staff required to complete the SAOs by specific dates.

Finding 2 Oversight Needed To Ensure Complete SAOs

Eight of 11 SAOs were incomplete (missing required elements). VARO management did not provide adequate oversight to ensure VSC staff completed the SAOs in accordance with VBA policy. Further, although VSC managers stated they referred to VBA policy when completing the SAOs, they were unaware that recommended corrective actions in the SAOs required a time frame for completion of the actions. As a result, VARO management may not have adequately identified existing and potential problems for corrective action to improve VSC operations.

Management did not always use adequate data to support the 11 required SAOs. An example of an SAO that did not include adequate data involved mail handling. At the time of our inspection, the VARO had more than 1,400 pieces of drop mail awaiting association with veterans' claims folders. Drop mail is mail that requires no processing action upon receipt at the VARO. The SAO in question only discussed procedures for handling mail and did not include any data to analyze drop mail. If VARO staff had conducted an analysis of drop mail, they may have recommended corrective actions to reduce this large amount of pending mail.

In addition, management was unaware that SAO-recommended corrective actions required a time frame for completion of the actions. For example, the Appeals SAO recommended that the VARO identify Notices of Disagreement (NOD) in a timely manner; however, it did not provide an expected time frame for completion of this corrective action. An NOD is a written communication from a claimant expressing dissatisfaction or disagreement with a benefits decision and a desire to contest the decision. As of March 2012, VSC staff took an average of 66.5 days to record NODs—14.1 days more than the national average of 52.4 days. If VARO staff had assigned a date for completion of this SAO recommendation, they may have implemented steps to improve NOD timeliness.

Recommendation

2. We recommend the Phoenix VA Regional Office Director develop and implement a plan to ensure staff address required elements of Systematic Analyses of Operations using thorough analysis and relevant data.

Management Comments

The VARO Director concurred with our recommendation. The Director indicated VSC's Program Analysts and Assistant Veterans Service Center Managers conducted training on June 27, 2012, to all staff responsible for completing SAOs. In addition to providing them with an overview of VBA's policy on SAOs, staff were instructed to include supporting evidence, findings and recommendations, and timeframes for completion of all recommendations in SAOs. The Director stated Program Analysts updated VSC's SAO recommendation tracker to include dates for expected completion, actual completion, and interim status updates.

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 Phoenix VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Triage Team.

Mailroom staff were timely and accurate in date-stamping, processing, and delivering VSC mail to the Triage Team control point daily. However, we found the Phoenix VARO mailroom staff were actively using hand-held date stamps in violation of VBA policy. The policy required that VAROs destroy all hand-held date stamps no later than May 15, 2009, and replace them with lockable electronic stamps. Unbeknown to the VARO Director, VSC management misinterpreted this policy and allowed staff to continue using hand-held date stamps in the mailroom. We immediately informed the VARO Director of the continued use of the hand-held date stamps. Prior to our departure, we received confirmation from the Director that staff destroyed the hand-held date stamps on March 28, 2012; therefore, we made no recommendation for improvement in this area.

Triage Mail Management Procedures

We assessed the VSC's Triage Team 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.

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

4. Eligibility Determinations

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 mental health care treatment when denying service connection for mental disorders.

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

VARO staff did not properly address whether 10 of 17 Gulf War veterans were entitled to receive treatment for mental disorders. These inaccuracies occurred because VSC staff lacked understanding of VBA policy and overlooked reminder notifications to consider entitlement to mental health treatment. As a result, veterans may be unaware of their possible entitlement to treatment for mental disorders and may not get the care they need.

Interviews with VSC staff confirmed they did not always follow VBA policy to consider entitlement to mental health treatment when denying Gulf War veterans service connection for mental health disorders. In November 2011, VARO staff conducted training on mental health treatment for Gulf War veterans. VSC staff stated that, despite this recent training, they still did not have a clear understanding of VBA policy and it was easy to bypass the reminder notifications.

Recommendation

3. We recommend the Phoenix VA Regional Office Director develop and implement a plan to monitor the effectiveness of training to ensure staff follow current Veterans Benefits Administration policy regarding Gulf War veterans' entitlement to mental health treatment when denying service connection for mental disorders.

Management Comments

The VARO Director concurred with our recommendation. The Director stated that in March 2012 VSC conducted training on the correct application of VBA's policy regarding Gulf War veterans' entitlement to medical care

and treatment for mental disorders. The QRT provided additional training to all decision makers in April 2012. The Director indicated that in order to monitor effectiveness of all training, the QRT identifies deficiencies using local quality and in-process reviews. The Director stated local quality review findings for May 2012 revealed only one error regarding failure to properly address a veteran's entitlement to mental health care.

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.

Outreach to Homeless Veterans

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 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 Phoenix VARO has a full-time Homeless Veterans Outreach Coordinator. Our review confirmed that the coordinator provided outreach and contacted local homeless service providers as required by VBA policy. Therefore, we made no recommendation for improvement in this area. However, VBA needs a measurement to assess the effectiveness of this outreach.

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of January 2012, the Phoenix VARO had a staffing level of 457 full-time employees. Of this total, the VSC had almost 217 employees (47 percent) assigned.

Workload

As of February 2012, the VARO reported about 21,000 pending compensation claims. The average time to complete claims was 344.2 days—114.2 days longer than the national target of 230.

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 53 (9 percent) of 578 disability claims related to TBI and herbicide exposure that the VARO completed from October through December 2011. For temporary 100 percent disability evaluations, we selected 30 (7 percent) of 450 existing claims from VBA's Corporate Database. We provided VARO management with the 420 claims remaining from our universe of 450 for their review. These claims represented all instances in which VARO staff granted temporary 100 percent disability evaluations for at least 18 months as of January 27, 2012.

We reviewed the 11 mandatory SAOs completed in FYs 2011 and 2012. We reviewed 13 errors identified by VBA's STAR program during October through December 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 VSC. We also reviewed 17 completed claims processed for

Gulf War veterans from October through December 2011 to determine whether VSC staff addressed entitlement to mental health treatment in the rating decision documents as required. Further, we assessed the effectiveness of the VARO's homeless veterans outreach program.

Data Reliability

During our inspection, we used computer-processed data from Veterans Service Network Operations Reports and Awards. To test reliability, we reviewed the data to determine whether they were missing key fields, contained data outside of the time frame requested, included calculation errors, contained obvious duplication of records, contained alphabetic or numeric characters in incorrect fields, or contained illogical relationships among data elements. Further, we compared veterans' names, file numbers, social security numbers, station numbers, dates of claim, and decision dates provided in the data received with information contained in the 100 claims folders we reviewed.

Our testing of the data disclosed that they were sufficiently reliable for our inspection objectives. Our comparison of the data provided with information contained in the veterans' claims folders at VARO Phoenix also did not disclose any problems with data reliability.

Inspection Standards

We conducted this inspection in accordance with the Council of the Inspectors General on Integrity and Efficiency *Quality Standards for Inspection and Evaluation.* We planned and performed the inspection to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our review objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our review objectives.

Appendix B VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: June 22, 2012

From: Director, VA Regional Office Phoenix, Arizona

Subj: Inspection of the VA Regional Office, Phoenix, Arizona

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

1. The Phoenix VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Phoenix, Arizona.*

2. Questions may be referred to John Capozzi, Assistant Veterans Service Center Manager, 602-627-2843.

(original signed by:)

Sandra D. Flint

Attachment

Phoenix VA Regional Office
Response to the Office of Inspector General, Benefits Inspection

Recommendation 1:

We recommend the Phoenix VA Regional Office (VARO) Director develop and implement a plan to monitor the effectiveness of training on the proper processing of traumatic brain injury and herbicide exposure-related claims.

RO response: Concur

The VARO Director concurs with this recommendation. The VSC provided an updated training session on traumatic brain injury (TBI) for all decision makers on May 29, 2012. We also provided training on Herbicide Claims Development on May 15, 2012. Both of these training sessions included an emphasis on the findings from the OIG visit. The audio and visual training materials used for the TBI training session were recorded by LiveMeeting software. This recording is now available on the Quality Review Team's (QRT) SharePoint site. All decision makers are able to review this session as needed.

All rated TBI cases continue to require a second signature by designated Decision Review Officers (DROs). Refresher training was provided to these DROs on May 29, 2012. The findings associated with these reviews are maintained in a spreadsheet available in our station's shared computer drive, and regularly analyzed by QRT personnel to identify trends and deficiencies.

The QRT conducted team specific training for all decision makers in order to teach the correct application of 38 CFR 4.124a, TL 09-01, and the correct development and rating of herbicide related claims. Three small classroom size and team specific sessions were conducted on April 12, 18, and 26, 2012. A summary of all the material to include references, used in this training session, is available for review on the QRT SharePoint site.

The QRT is focusing on identifying deficiencies with TBI rating decisions via the completion of both local ASPEN quality reviews and "in-process reviews" (IPRs). These two types of reviews, our local error tracker, and updates to our training, are all maximizing our ability to closely monitor the effectiveness of all training provided to decision makers. Our most recent local ASPEN quality review findings (May 2012) revealed two errors associated with TBI. Neither of the TBI errors dealt with co-morbid symptomatology and insufficient examinations.

The Phoenix RO requests closure of this item.

Recommendation 2:

We recommend the Phoenix VA Regional Office Director develop and implement a plan to ensure staff address required elements of Systematic Analyses of Operations using thorough analysis and relevant data.

RO response: Concur

The VARO Director concurs with this recommendation. The VSC has taken the following steps to address the identified deficiencies in the Systematic Analyses of Operations (SAOs).

VSC Program Analysts (PA) and Assistant Veterans Service Center Managers (AVSCM) developed a formal training curriculum to train all VSC staff responsible for conducing SAOs. Training was given on June 27, 2012. The training included: SAO formatting; elements of an SAO; an overview of M21-4, Chapter 5; and other relevant topics to ensure that the SAO provides a true analysis of the topic under review. In training, the VSC staff was instructed to include supporting data (folder pull lists, mail count, VETSNET Operations Reports (VOR) data, etc.), along with the findings and recommendations when submitting drafts of their assigned SAOs. Drafts will also include a timeframe for completion for all recommendations and will be submitted to the AVSCM assigned to track, review and approve this SAO for submission to the VSCM and the Director.

The SAO Recommendation Tracker maintained by the VSC Program Analysts (PAs) has been amended to include the expected completion date, the actual completion date, and dates for any interim status updates. The AVSCM assigned to track these recommendations will follow-up with the VSC staff member to whom completion of the recommendation is assigned. This AVSCM will then close out recommendations once complete.

The Phoenix RO requests closure of this item.

Recommendation 3:

We recommend the Phoenix VA Regional Office Director develop and implement a plan to monitor the effectiveness of training to ensure staff follow current Veterans Benefits Administration policy regarding Gulf War veterans' entitlement to mental health treatment when denying service connection for mental disorders.

RO Response: Concur

The VARO Director concurs with this recommendation. The VSC provided training on the correct application of 38 U.S.C. 1702 on March 6, 14, and 22, 2012. In addition, the QRT conducted team-specific training for all decision makers on this subject on April 12, 18, and 26, 2012. A summary of all the material used in this training session, including all references, is available for review on the QRT's SharePoint site.

The QRT is also focusing on identifying deficiencies in the correct resolution of VA medical care under 38 U.S.C. 1702 by closely monitoring and analyzing local ASPEN quality reviews and IPRs. These two types of reviews and updates to our training are maximizing our ability to closely monitor the effectiveness of all training provided to decision makers in this subject. Our most recent local ASPEN quality review findings (May 2012) revealed just one error associated with the failure to properly address the issue of 38 U.S.C. 1702.

The Phoenix RO requests closure of this item.

Appendix C Inspection Summary

Table 2 reflects the operational activities inspected, applicable criteria, and whether or not we had reasonable assurance of VARO compliance.

Table 2. Phoenix VARO Inspection Summary

Eight Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. Temporary 100 Percent Disability Evaluations	**Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations.** (38 Code of Federal Regulations (CFR) 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (Manual (M)21-1 Manual Rewrite (MR) Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Traumatic Brain Injury Claims	**Determine whether VARO staff properly processed claims for service connection for all disabilities related to in-service TBI.** (Fast Letter (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. 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) (FL 08-15) (38 CFR 3.384) (38 CFR 3.2)		X
Public Contact			
8. VBA's Homeless Veterans Program	**Determine whether VARO staff provided effective outreach services.** (Public Law 107-05) (VBA Letter 20-02-34) (FL 10-11) (VBA Circular 27-91-4)(M21-1, Part VII, Chapter 6)	**X**	

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

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 Bridget Bertino Orlan Braman Madeline Cantu Michelle Elliott Lee Giesbrecht Rachel Stroup Dana Sullivan

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