VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of Veterans Service Center Cheyenne, Wyoming

February 21, 2013
12-03477-118

ACRONYMS AND ABBREVIATIONS

OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center
WMP	Workload Management Plan

Report Highlights: Inspection of Veterans Service Center, Cheyenne, Wyoming

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. The Cheyenne Veterans Service Center (VSC) is under the jurisdiction of the Denver VARO Director. We evaluated the Cheyenne VSC to see how well it accomplishes the VBA mission.

What We Found

Overall, VSC staff did not accurately process 20 (67 percent) of 30 disability claims we reviewed. We sampled claims we consider to be at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VSC. Where claims processing lacks compliance with VBA procedures, VBA risks paying inaccurate and unnecessary financial benefits.

Specifically, 79 percent of the 24 temporary 100 percent disability evaluations we reviewed were inaccurate because staff did not take action to schedule follow-up medical examinations after receiving system-generated reminder notifications. An error in processing one of six traumatic brain injury claims we reviewed occurred because staff used an insufficient exam report as a basis for the rating decision. Allowing suspense dates to lapse due to competing priorities resulted in additional delays in processing claims pending over 1 year.

VSC managers did not ensure staff accurately completed Systematic Analyses of Operations or addressed Gulf War veterans' entitlement to mental health treatment. VSC staff provided adequate outreach to homeless veterans. However, VBA needs a measure to assess its homeless veterans outreach program.

What We Recommend

We recommend the Denver VARO Director develop and implement controls to ensure VSC staff timely schedule routine future medical reexaminations upon receipt of electronic system-generated reminder notifications. The Director should reinforce controls for review of claims pending over 365 days to avoid processing delays. Management also needs to implement plans to make certain VSC staff complete Systematic Analyses of Operations and address Gulf War veterans' entitlement 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.

Linda A. Halliday

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

Scope of Inspection

In September 2012, we inspected the Cheyenne VSC. The inspection focused on four protocol areas examining six operational activities. The four protocol areas were disability claims processing, management controls, eligibility determinations, and public contact.

We reviewed 24 of 36 rating decisions where VSC 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 without review, according to Veterans Benefits Administration (VBA) policy. We examined six of eight disability claims related to traumatic brain injury (TBI) that VSC staff completed during the period April through June 2012. In addition, we analyzed the 10 oldest completed claims available at the time of our inspection.

Other Information

Appendix A provides details on the VSC and the scope of our inspection. Appendix B provides criteria we used to evaluate each operational activity and a summary of our inspection results. Appendix C provides the VARO Director's comments on a draft of this report.

RESULTS AND RECOMMENDATIONS

I. Disability Claims Processing

Claims Processing Accuracy and Timeliness

The OIG Benefits Inspection team focused on accuracy in processing temporary 100 percent disability evaluations and TBI claims. We also assessed timeliness in processing the oldest completed disability claims at the VSC. We evaluated these claims processing issues and assessed their impact on veterans' benefits.

Finding 1 Cheyenne VSC Needs To Improve Disability Claims Processing Accuracy

Claims Processing Accuracy

The Cheyenne VSC did not always process temporary 100 percent disability evaluations and TBI cases accurately. Overall, VSC staff incorrectly processed 20 of the total 30 disability claims we sampled and provided $502,644 in improper benefit payments.

We sampled claims related only to specific conditions that we considered at higher risk of processing errors. As a result, the errors identified do not represent the universe of disability claims processed at this VSC. As reported by VBA's Systematic Technical Accuracy Review program as of August 2012, the overall accuracy of the VSC compensation rating-related decisions was 82.5 percent—4.5 percentage points below 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 Cheyenne VSC.

Table 1

Cheyenne VSC Disability Claims Processing Accuracy

Type of Claim	Reviewed	Claims Inaccurately Processed		
		Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits	Total
Temporary 100 Percent Disability Evaluations	24	8	11	19
Traumatic Brain Injury Claims	6	0	1	1
Total	**30**	**8**	**12**	**20**

Source: VA OIG analysis of VBA's temporary 100 percent disability evaluations paid at least 18 months and TBI disability claims completed during third quarter FY 2012.

Temporary 100 Percent Disability Evaluations

VSC staff incorrectly processed 19 of 24 temporary 100 percent disability evaluations we reviewed. 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 a mandated period of convalescence or treatment, VBA staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

Without effective management of these temporary ratings, VBA is at increased risk of paying inaccurate financial benefits. Available medical evidence showed that 8 of the 19 processing errors we identified affected veterans' benefits. These errors involved 6 overpayments totaling $499,104 and 2 underpayments totaling $3,540. Details on the processing procedure errors follow.

- VSC staff incorrectly reinstated service connection for a temporary 100 percent disability based on a veteran's claimed service in the Republic of Vietnam. Evidence in the file at the time of our review did not show the veteran served in Vietnam, as required. Prior to our follow-up inspection in September 2012, VSC staff reinstated the service connection even though evidence continued to show the veteran had not served in the Republic of Vietnam. As a result, VA continued processing monthly benefits and ultimately overpaid the veteran $255,944 over a period of 10 years and 3 months.
- A Rating Veterans Service Representative (RVSR) did not grant entitlement to an additional special monthly benefit based on loss of use of a creative organ, as required. In addition, VSC staff did not schedule a follow-up medical examination after receiving a system-generated reminder notification. As a result, VA needed to correct the veteran's monthly benefit payment. As a result, VA underpaid the veteran a total of $1,944 over a period of 1 year and 8 months.

The remaining 11 of the total 19 errors had the potential to affect veterans' benefits. Generally, these errors resulted from a lack of management oversight to ensure staff took action to schedule follow-up medical examinations on temporary 100 percent disability evaluations after receiving system-generated reminder notifications.

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.

Ten of the total 19 errors resulted from staff not taking action to schedule follow-up medical examinations regarding temporary 100 percent disability evaluations after receiving system-generated reminder notifications. Interviews with VSC staff revealed they were not taking action to schedule medical reexaminations upon receipt of the system-generated reminder notifications, even though the Workload Management Plan (WMP) outlined requirements to do so. VSC staff revealed they did not clearly understand the proper steps to take once they received a reminder notification. At the time of our inspection, the Cheyenne VSC had 197 overdue electronic reminder notifications for routine future medical examinations—the oldest pending 894 days. As a result, veterans may be at increased risk of receiving inaccurate benefits payments.

Follow Up to Prior VA OIG Inspection

In our previous report, *Inspection of the Veterans Service Center, Cheyenne, Wyoming* (Report No. 10-02080-197, July 19, 2010), we stated errors in processing temporary 100 percent evaluations generally occurred because VSC staff did not schedule medical reexaminations needed to determine whether the temporary evaluations should continue. The Director of the Denver VARO concurred with our recommendation to conduct a review of all temporary 100 percent evaluations under the Cheyenne VSC's jurisdiction to determine if reevaluations were required and take appropriate action.

Further, the Director of the Denver VA Regional Office concurred with our recommendation to ensure proper scheduling of future examinations for all confirmed and continued temporary 100 percent evaluations. OIG closed this recommendation in November 2010 after the VSC stated it changed procedures to ensure controls for scheduling reexaminations on all confirmed and continued ratings. The VSC also provided refresher training for both Veterans Service Representatives and RVSRs in June 2010. We found during our 2012 inspection that VSC staff continued to process a significant number of temporary 100 percent disability evaluations incorrectly; however, these errors occurred because staff did not take action upon reminder notification to schedule the reexaminations as required.

Actions Taken in Response to Prior Audit Report

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 had a future examination date entered in the electronic record. Our report stated, "If VBA does not take timely corrective action, they will overpay veterans a projected $1.1 billion over the next 5 years." The then Acting Under Secretary for Benefits stated in response to our audit report that 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 national review deadline to December 31, 2011, and then again to June 30, 2012. VBA is still working to complete this national review requirement and has extended the national review deadline to December 31, 2012. We are concerned about the lack of urgency in completing this review, which is critical to minimize the financial risks of making inaccurate benefits payments.

During this inspection, we followed up on VBA's national review of its temporary 100 percent disability evaluation processing. VSC staff accurately reported corrective actions taken on all 38 cases we sampled from VBA's list. Therefore, we made no recommendation for improvement in this area.

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.

In response to a recommendation in our annual report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-167, May 18, 2011), VBA agreed to develop and implement a strategy for ensuring the accuracy of TBI claims decisions. In May 2011, the Under Secretary for Benefits provided guidance to all VARO Directors to implement a policy requiring a second signature on each TBI case an RVSR evaluates until the RVSR demonstrates 90 percent accuracy in TBI claims processing. The policy indicates second signature reviewers come from the same pool of staff as those used to conduct local station quality reviews.

VSC staff incorrectly processed one of six TBI claims—this type of processing error did not affect the veteran's benefits. However, in this case, VSC staff prematurely evaluated TBI residuals using insufficient medical examination reports. Although required, the medical examiner did not indicate whether the veteran's symptoms were associated with residuals of a TBI or a coexisting mental condition. 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 VSC staff nor we can ascertain all of the residual disabilities of a TBI without adequate or complete medical evidence. The Cheyenne VSC has a unique relationship with the co-located VA Medical Center that, according to VSC management, has resulted in a decrease in the number of inadequate TBI medical examinations. RVSRs and physicians meet routinely to discuss questions related to TBI Disability Benefits Questionnaires, TBI symptoms, and examinations.

The one TBI claims processing error we identified based on an inadequate medical examination report occurred prior to the creation of this collaborative partnership. We determined the VSC generally followed VBA policy for processing TBI claims because the five remaining TBI claims were sufficient for rating purposes, showing a clear delineation between TBI residuals and co-morbid mental conditions. As such, we made no recommendation for improvement in this area.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of Veterans Service Center Cheyenne, Wyoming* (Report Number 10-02080-197, Issued July 19, 2010), we identified two of seven TBI processing errors where VSC staff inaccurately processed TBI claims because they relied upon inadequate medical examinations. The Director of the Denver VARO concurred with these errors and implemented a local policy requiring that all TBI rating decisions be reviewed and second-signed by a Decision Review Officer. OIG closed this recommendation in November 2010, based on documents showing implementation of the local TBI second signature policy. During this inspection, we found the Cheyenne VSC was compliant in this area.

Recommendation

1. We recommend the Denver VA Regional Office Director develop and implement controls to ensure Cheyenne Veterans Service Center staff timely schedule routine future medical reexaminations upon receipt of electronic system-generated reminder notifications.

Management Comments

The VARO Director concurred with our recommendation and revised the WMP to reflect changes in claims processing and align responsibility and oversight for routine future medical exams.

OIG Response

The Director's comments and actions are responsive to the recommendation.

Finding 2 Improvement Needed To Ensure Timely Claims Processing

Claims Processing Timeliness

VBA policy requires constant monitoring of the claims process to ensure staff promptly control, completely develop, and timely decide claims. It also requires VAROs to establish local processing timeliness goals in their WMP. Workload management is a coordinated system used to control how claims and other workloads move through VBA's adjudicative process. The WMP should provide for timely claims review throughout the adjudicative process and help prevent inefficient practices and delays.

VBA established national performance standards for measuring cycle times among the claims processing phases. Table 2 provides a description of each phase and the expected cycle times.

Table 2

VBA's Claims Processing Phases and National Performance Measures		
Phases	**Definitions**	**Cycle Times**
Control Time	Time from date of claim receipt at the VARO until establishment in the electronic record	7 days
Development Initiation	Time from the date a claim is established until staff initiate requests for evidence	20 days
Evidence Gathering	Time from initial requests for evidence until the claim is ready for a decision	83 days
Decision Completion	Time from when a claim is ready for a decision until a decision is complete	15 days
Award Generation	Time from when a decision is complete until an award for payment is generated	5 days
Award Authorization	Time from when an award for payment is generated until the award payment is authorized	2 days

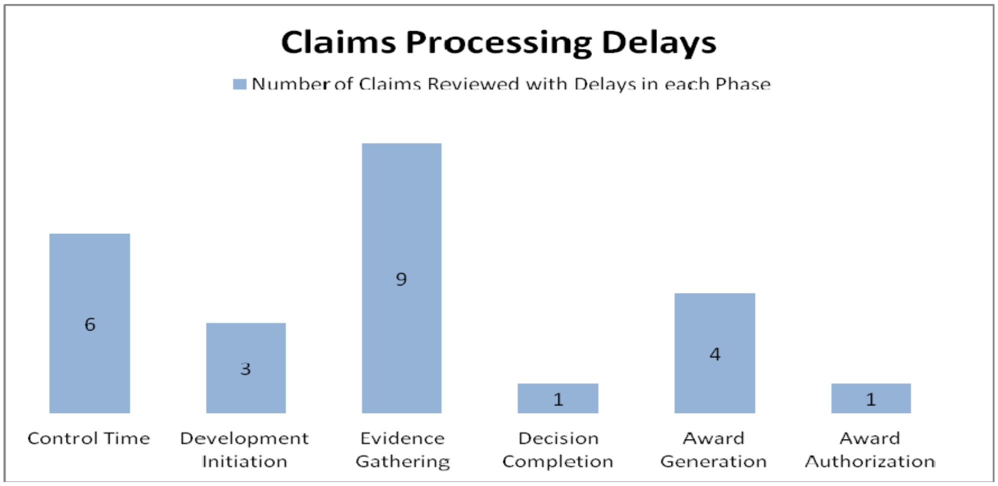
Source: VBA's Office of Performance Analysis and Integrity as of August 2012

According to the current version of the Secretary of Department of Veterans Affair's *Strategic Plan FY 2011–2015*, VA's goal is to ensure that by 2015 a veteran does not have to wait more than 125 days for a claim decision. Currently, as noted on the station's National Performance Standards, the FY 2012 target is to complete decisions in an average of 230 days. VBA policy further requires that VSC management personally review claims pending more than 1 year. If it is not feasible to review the claims, as an alternative, managers must review a monthly report prepared by designated staff.

As of August 31, 2012, the VSC's average time to complete claims was 165 days—65 days less than the FY 2012 national target. However, the VSC performed worse than the national targets in the following phases: development initiation by 53.5 days, decision completion by 30.7 days, and award generation by 2.5 days. We reviewed the 10 oldest disability claims completed from April through June 2012 and available at the time of our inspection. We sampled these claims from the total 59 claims that took over 365 days to complete. We determined these claims required 546 to 910 days to complete. Our review disclosed significant delays in development initiation and evidence gathering to support claims adjudication.

Figure 1 indicates the frequency of delays across the various claims processing phases for the 10 oldest claims reviewed.

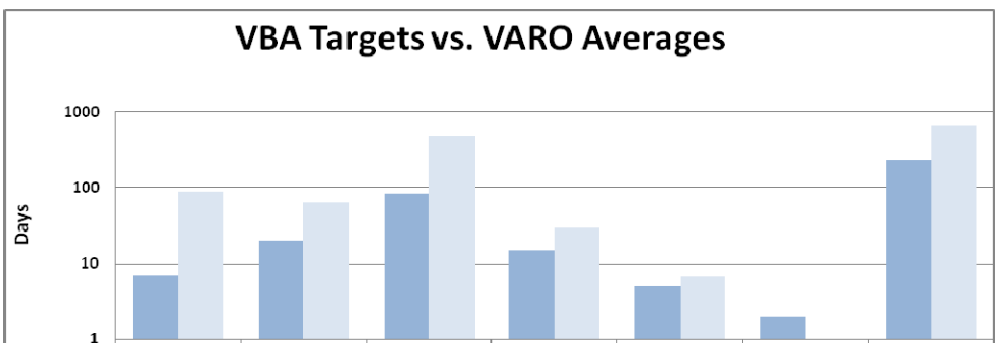
Figure 1



Source: VA OIG analysis of VBA's disability claims files

Further, Figure 2 compares VBA's national targets (cycle times for each phase) with the VSC staff's average performance in processing the 10 claims we reviewed. The total average cycle time for these 10 claims was 652 days—about 3 times the national target. The greatest delays were in the control time and evidence gathering phases. Cheyenne VSC staff were exclusively responsible for processing 6 of the 10 claims that had avoidable delays. Three of the 4 remaining cases experienced processing delays at the Cheyenne VSC as well as other VAROs. One case incurred avoidable delays at another VARO; however, once received on station, VSC staff timely completed all subsequent claims processing actions.

Figure 2



	Control Time	Development Initiation	Evidence Gathering	Decision Completion	Award Generation	Award Authorization	Total Days
Target	7	20	83	15	5	2	230
Avg	87	64	480	30	7	0	652

Source: VA OIG analysis of VBA's disability claims files completed from April through June 2012

Generally, delays in claims processing were due to non-compliance with VBA policy. VSC management stated they allowed suspense dates to lapse in order to shift resources to meet national production goals. Managers stated that competing national priorities also hindered their ability to ensure timely processing of cases over 365 days old. In addition, at the time of our inspection, the Cheyenne VSC was working claims for the Honolulu VARO. The avoidable delays involved Cheyenne VSC staff not:

- Establishing claims timely in the electronic record due to lost or misplaced veterans' claims files
- Initiating timely development for evidence after claims were established
- Following up timely on requests for evidence to support veterans' claims
- Developing veterans claims correctly, and
- Completing claims timely once they were determined to be ready for decisions

The Cheyenne VSC WMP requires a weekly review of claims that have been ready for decisions for more than 30 days, and a bi-weekly review of claims pending over 365 days. However, VSC management did not always conduct these reviews as required. Additionally, the WMP did not include local measures to ensure staff completed timely reviews throughout all claims processing phases. Had VSC managers followed provisions in the WMP and ensured it included all required elements, they may have been able to prevent the avoidable delays we identified. Because of the processing delays, veterans did not receive timely benefits decisions.

Recommendations

2. We recommend the Denver VA Regional Office Director develop and implement a Workload Management Plan that includes claims processing cycle time goals for the Cheyenne Veterans Service Center.
3. We recommend the Denver VA Regional Office Director reinforce controls to ensure Cheyenne Veterans Service Center managers follow the Veterans Benefits Administration's policy and Workload Management Plan for all claims pending more than 1 year.

Management Comments

The VARO Director concurred with our recommendations and revised the Workload Management Plan to align claims processing with the new Organizational Model and Segmented Lanes. The revision includes processing requirements for employees to meet cycle times. Further, supervisors will reinforce controls to ensure staff comply with VBA policy and the Workload Management Plan.

OIG Response

The Director's comments and actions are responsive to the recommendations.

II. Management Controls

Systematic Analysis of Operations

We assessed whether VSC 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. VSC management must publish annual SAO schedules designating the staff required to complete the SAOs by specific dates.

Finding 3 Oversight Needed To Ensure Complete SAOs

Ten of 11 SAOs were incomplete (missing required elements). In addition, 3 of the 10 incomplete SAOs used insufficient data for analysis. VSC management did not provide adequate oversight to ensure staff completed the SAOs in accordance with VBA policy. As a result, management may not have adequately identified existing and potential problems for corrective action to improve VSC operations.

Management did not ensure SAOs were complete, as required. VSC managers stated they did not ensure all required elements were included because SAOs and associated recommendations were not a priority. For example, the Internal Controls SAO did not include a thorough review of controls to minimize compensation benefits overpayments. At the time of our review, we found 197 overdue electronic reminder notifications to schedule routine future examinations; the oldest notification had been pending 894 days. If VSC managers had adequately addressed this area of review, they may have implemented corrective measures to control these cases and minimize potential overpayments.

Recommendation

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

Management Comments

The VARO Director concurred with our recommendation and will ensure VSC supervisors and managers receive training on addressing deficiencies in Systematic Analysis of Operations, including the use of proper and relevant supporting data. The training will be completed no later than March 2013.

OIG Response

The Director’s comments and actions are responsive to the recommendation.

III. Eligibility Determinations

Entitlement to Medical 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 a mental disorder. This pop-up notification does not generate if a previous decision did not address entitlement to mental health services and a mental condition is not part of the current claim.

Finding 4 — Gulf War Veterans Did Not Always Receive Entitlement Decisions for Mental Health Treatment

VSC staff did not properly address whether 6 of 10 Gulf War veterans were entitled to receive treatment for mental disorders. These inaccuracies generally occurred because VSC staff lacked understanding of VBA policy and overlooked reminder notifications to consider entitlement to mental health treatment. As a result, the six veterans may be unaware of their possible entitlement to treatment for mental disorders and may not get the care they need. Following are details on the six processing errors observed.

- Four errors occurred when RVSRs did not address veterans' entitlement to mental health treatment when the RVSRs made decisions to deny service connection for mental disorders.
- Two processing errors occurred when RVSRs considered but denied entitlement to mental health treatment when the evidence in the claims folder did not show the veterans served in the Southwest Asia Theater of operations. Service in this area is not a requirement to receive entitlement to mental health treatment, according to VBA policy.

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. VSC staff stated they did not have a clear understanding of VBA policy and had received inconsistent guidance from VBA staff prior to formal training in November 2011.

Further, RVSRs stated it was easy to bypass the reminder notifications. Two RVSRs we interviewed felt the pop-up notification was not effective because it was easy to ignore, while some of the RVSRs and management we interviewed were not aware of this system prompt.

Recommendations

5. We recommend the Denver VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives correctly address Gulf War veterans' entitlement to mental health treatment as required.
6. We recommend the Denver 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 recommendations. During our on-site inspection, VSC staff received training on the proper procedures for processing Gulf War veterans' entitlement to mental health treatment when denying service connection for mental disorders.

OIG Response

The Director's comments and actions are responsive to the recommendations.

IV. Public Contact

Outreach to Homeless Veterans

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.

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, local governments, and advocacy groups to provide information on VA benefits and services.

The Cheyenne VSC has a part-time Homeless Veterans Outreach Coordinator. The coordinator was familiar with requirements for improving the effectiveness of VSC outreach to homeless veterans. The coordinator had collaborative partnerships with local homeless outreach facilities to provide information on VA benefits and services. Therefore, we made no recommendation for improvement in this area. However, VBA needs a measurement to assess the effectiveness of its homeless veterans outreach efforts.

Appendix A VSC Profile and Scope of Inspection

Organization The Cheyenne VSC administers a variety of services and benefits, including compensation benefits; benefits counseling; and outreach to homeless, elderly, minority, and women veterans.

Resources As of June 2012, the Cheyenne VSC had a staffing level of 25 full-time employees.

Workload As of August 2012, the Cheyenne VSC reported about 1,100 pending compensation claims. The average time to complete claims was 165 days—65 days less 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 24 (67 percent) of 36 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented instances in which VSC staff had granted temporary 100 percent disability evaluations for at least 18 months as of July 10, 2012. We provided VSC management with 12 claims remaining from our universe of 36 for its review. We reviewed six (75 percent) of eight TBI-related disability claims that the VSC completed from April through June 2012. In addition, we analyzed the 10 oldest completed claims available for review from that same period. Where we identify potential procedural inaccuracies, this information is provided to help the VARO understand the procedural improvements it can make and to improve the overall stewardship of financial benefits. This information is not provided to require the VAROs to adjust specific veterans' benefits. Processing any adjustments per this review is clearly a VBA management decision.

We assessed the 11 mandatory SAOs the VSC completed in FYs 2011 and 2012. We sampled 38 temporary 100 percent disability evaluations from the SharePoint list VBA had provided to the VARO for review. We examined 10 completed claims processed for Gulf War veterans from April through June 2012 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 VSC's homeless veterans outreach program.

Data Reliability We used computer-processed data from the Veterans Service Network's Operations Reports and Awards. To test for reliability, we reviewed the data to determine whether any data were missing from key fields, contained data outside of the time frame requested, included any 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 as provided in the data received with information contained in the claims folders we reviewed.

Our testing of the data disclosed that they were sufficiently reliable for our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders at the Cheyenne VSC 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's *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 inspection objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our inspection objectives.

Appendix B Inspection Summary

Table 3 reflects the operational activities inspected, applicable criteria, and whether or not we had reasonable assurance of VSC compliance.

Table 3. Cheyenne VSC Inspection Summary			
Six Operational Activities Inspected	**Criteria**	**Reasonable Assurance of Compliance**	
		Yes	**No**
Disability Claims Processing			
1. Temporary 100 Percent Disability Evaluations	**Determine whether VSC 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) (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 VSC 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. Claims Processing Timeliness	**Determine whether VSC staff unnecessarily delayed processing disability claims.** (Manual (M) 21-4, Chapter 2) (Fast Letter (FL) 12-04 and 10-23) (M21-1Manual Re-write(MR))		X
Management Controls			
4. Systematic Analysis of Operations	**Determine whether VSC staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)		X
Eligibility Determinations			
5. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VSC 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			
6. Homeless Veterans Outreach Program	**Determine whether VSC staff provided effective outreach services.** (Public Law 107-05) (VBA Letter 20-02-34) (VBA Circular 27-91-4) (FL 10-11) (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 C VARO Director's Comments

Department of Veterans Affairs **Memorandum**

Date: January 28, 2013

From: Director, VA Regional Office Denver, Colorado (399/00)

Subj: Inspection of the Veterans Service Center, Cheyenne, Wyoming

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

1. The Denver VARO concurs with all Findings and Recommendations. VARO Director's comments are attached on the OIG Draft Report: *Inspection of the Veterans Service Center, Cheyenne, Wyoming.*

2. Please refer questions to me at 303-914-5800.

(original signed by:)

WILLIAM J. KANE

Attachment

Denver VARO concurs with all Findings and Recommendations. The following comments on the Recommendations are provided.

Recommendation #1: *We recommend the Denver VA Regional Office Director develop and implement controls to ensure Cheyenne Veterans Service Center staff timely schedule routine future medical reexaminations upon receipt of electronic system-generated reminder notifications.*

Response: Concur. The Cheyenne workload management plan includes oversight for monitoring routine future medical examinations. The current workload management plan is being revised to reflect changes in claims processing to align with the new Organizational Model and Segmented Lanes. A revision will be implemented in the workload management plan to specifically assign responsibility and oversight for routine future medical exams. This revision will be made no later than February 28, 2013.

Recommendation #2: *We recommend the Denver VA Regional Office Director develop and implement a Workload Management Plan that includes claims processing cycle time goals for the Cheyenne Veterans Service Center.*

Response: Concur. The current workload management plan is being revised to reflect changes in claims processing to align with the new Organizational Model and Segmented Lanes. The revision will provide detailed processing requirements for employees in each lane to meet cycle time goals. The revision to the workload management plan will be made no later than February 28, 2013.

It should be noted that, although individual cycle times were not met, Cheyenne successfully met overall timeliness goals for claims completion and days pending. The sum of the individual cycle time goals is 132 days; however, the goal for completing claims in Fiscal Year 2012 was 230 days and the goal for average days pending was 180 days. Cheyenne completed claims in 163.2 days with an average days pending of 109.2 days.

***Recommendation* #3**: We recommend the Denver VA Regional Office Director reinforce controls to ensure Cheyenne Veterans Service Center managers follow the Veterans Benefits Administration's policy and Workload Management Plan for all claims pending more than 1 year.

Response: Concur. The Cheyenne VSC supervisors will work to ensure that Veterans Benefits Administration's policy and the Workload Management Plan for all claims that are pending more than one year, are followed. This action item is complete and is requested to be closed.

Recommendation #4: *We recommend the Denver VA Regional Office Director develop and implement a plan to ensure staff prioritize Systematic Analyses of Operations and corresponding recommendations and address all required elements using thorough analysis and relevant data.*

Response: Concur. The VSC supervisors and management analyst will be required to attend formal training to address identified deficiencies in Systematic Analyses of Operations (SAO's). Training will include an overview of M21-4, Chapter 5, and the proper use of relevant supporting data and analysis. This training will be scheduled and completed no later than March 30, 2013.

Recommendation #5: *We recommend the Denver VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives correctly address Gulf War veterans' entitlement to mental health treatment as required.*

Response: Concur. Training was provided during the IG Visit. No further action is necessary as the requirement under 1702 is no longer effective. Per VSCM Conference Call December 2012:

"Congress' intent in enacting Section 1702 was to ensure that certain Veterans have access to health care for mental illness regardless of whether VBA has awarded service connection for such illness. It is a health care eligibility statute and should, therefore, be implemented by VHA's health care eligibility offices." This action item is complete and is requested to be closed.

Recommendation #6: *We recommend the Denver 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.*

Response: Concur. Training was provided during the IG Visit. No further action is necessary as the requirement under 1702 is no longer effective. Per VSCM Conference Call December 2012:

"Congress' intent in enacting Section 1702 was to ensure that certain Veterans have access to health care for mental illness regardless of whether VBA has awarded service connection for such illness. It is a health care eligibility statute and should, therefore, be implemented by VHA's health care eligibility offices." This action item is complete and is requested to be closed.

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	Brent Arronte, Director Bridget Bertino Orlan Braman Madeline Cantu Michelle Elliott Lee Giesbrecht Rachel Stroup Dana Sullivan

Appendix E Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Assistant Secretaries
Office of General Counsel
Veterans Benefits Administration Western Area Director
VA Regional Office Denver Director

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: John Barrasso, Michael B. Enzi
U.S. House of Representatives: Cynthia M. Lummis

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig. This report will remain on the OIG Web site for at least 2 fiscal years.