VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Philadelphia, Pennsylvania

April 9, 2013
12-03475-169

ACRONYMS AND ABBREVIATIONS

HVOC	Homeless Veterans Outreach Coordinator
OIG	Office of Inspector General
QRT	Quality Review Team
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

Report Highlights: Inspection of VA Regional Office, Philadelphia, PA

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and 1 Veterans Service Center nationwide that process disability claims and provide a range of services to veterans. We conducted this inspection to evaluate how well the Philadelphia VARO accomplishes this mission.

What We Found

Overall, VARO staff did not accurately process 22 (37 percent) of 60 disability claims we reviewed. We sampled claims we consider at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Where claims processing lacks compliance with VBA procedures, VBA risks paying inaccurate and unnecessary financial benefits.

Specifically, 50 percent of the 30 temporary 100 percent disability evaluations we reviewed were inaccurate because of lack of effective management and oversight to ensure staff took timely actions to reduce veterans' benefits as appropriate. Further, staff did not follow VBA or local policy for scheduling future medical reexaminations. VARO staff inaccurately processed 7 of 30 traumatic brain injury claims because they did not always comply with second signature requirements and used insufficient medical examination reports to evaluate these claims.

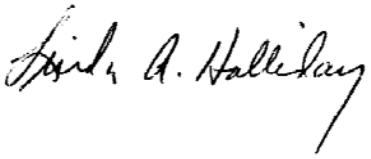
VARO managers generally ensured staff completed Systematic Analyses of Operations as required. However, staff did not always advise Gulf War veterans they were entitled to mental health treatment at VA facilities. Managers also did not ensure staff updated the homeless veterans outreach directory, nor did staff contact all homeless facilities in their jurisdiction.

What We Recommend

We recommend the VARO Director develop and implement plans to ensure timely benefits reduction actions, provide refresher training on scheduling future medical reexaminations, and ensure staff follow second signature requirements and return insufficient medical examination reports for traumatic brain injury claims. Also, controls are needed to ensure staff update the resource directory and contact all homeless facilities in their jurisdiction.

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

Scope of Inspection

In August 2012, the OIG conducted an inspection of the Philadelphia VARO. The inspection focused on four protocol areas examining five operational activities. The four protocol areas were disability claims processing, management controls, eligibility determinations, and public contact.

We reviewed 30 (4 percent) of 800 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 without review, according to Veterans Benefits Administration (VBA) policy. We examined 30 (54 percent) of 56 disability claims related to traumatic brain injury (TBI) that VARO staff completed from April through June 2012.

Other Information

- Appendix A provides details on the VARO 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

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

Finding 1 Philadelphia VARO Could Improve Disability Claims Processing Accuracy

Claims Processing Accuracy

The Philadelphia VARO did not always process temporary 100 percent disability evaluations and TBI cases accurately. Overall, VARO staff incorrectly processed 22 of the total 60 disability claims we sampled, resulting in 83 improper monthly payments to 4 veterans totaling $194,130.

We sampled claims related to two 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 VARO. As reported by VBA's Systematic Technical Accuracy Review program as of July 2012, the overall accuracy of the VARO's compensation rating-related decisions was 85.2 percent—1.8 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 Philadelphia VARO.

Table 1

Philadelphia VARO 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	30	4	11	15
Traumatic Brain Injury Claims	30	0	7	7
Total	**60**	**4**	**18**	**22**

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

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 15 of 30 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 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.

Without effective management of these temporary ratings, VBA is at increased risk of paying inaccurate financial benefits. Available medical evidence showed 4 of the 15 processing errors affected veterans' benefits and resulted in 83 improper monthly payments to these 4 veterans totaling $194,130. Details on the overpayments follow.

- For one case, a Rating Veterans Service Representative (RVSR) incorrectly continued a 100 percent disability evaluation of a veteran's cancer condition, although medical evidence showed the cancer was in remission. As a result, VA continued processing monthly benefits and ultimately overpaid the veteran $133,181 over a period of 3 years and 9 months. This was the most significant overpayment we identified.
- In three instances, VARO staff did not take final action to reduce claims benefits after informing veterans of proposed reductions. Medical evidence showed the veterans' disabilities no longer warranted the 100 percent disability evaluations previously assigned. As a result, VA continued processing monthly benefits and ultimately overpaid these veterans a total of $60,949.

The remaining 11 of the 15 errors had the potential to affect veterans' benefits. In most cases, we could not determine whether the evaluations would have continued because the veterans' claims folders did not contain the medical examinations reports needed to evaluate each case. Where examination reports were unavailable, we determined these errors occurred because VSC staff did not schedule reexaminations as required.

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.

In cases where routine future medical reexaminations were not scheduled as required, claims processing delays ranged from 1 year and 1 month to 4 years and 2 months. An average of 2 years and 3 months elapsed from the time staff should have scheduled these medical examinations through the date of our inspection.

Moreover, 5 of the 15 total errors resulted from a lack of management oversight to ensure timely staff action to discontinue veterans' temporary 100 percent disability evaluations. VA policy requires that staff notify veterans of proposed reductions to their benefits and allow 60 days for veterans to provide evidence refuting these decisions. This policy states staff should take final action on the claims at the end of the 60-day period. Furthermore, local policy states management must closely monitor these cases to ensure staff takes appropriate follow-up action. Despite the policy requirements, VARO management indicated that other nationally mandated priorities hindered staff in taking timely action to reduce benefits. As a result of the lack of timely action, veterans may be at risk of receiving inaccurate benefits payments.

Follow Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Philadelphia*, (Report No. 09-03846-93, March 4, 2010), we indicated inaccuracies in processing temporary 100 percent disability evaluations occurred because staff did not properly record dates in the electronic system as required to ensure automatic reminders to schedule future medical examinations. The Director of the Philadelphia VARO at that time agreed to strengthen controls to ensure proper scheduling of the medical reexaminations needed to support determinations of whether to continue temporary 100 percent disability evaluations. OIG closed this recommendation on July 27, 2010, based on a new VARO policy requiring staff to print a copy of the computer screen identifying the dates of future examinations and file these documents in the claims folders.

While managers stated the above policy was still in effect, they lacked oversight to ensure staff consistently applied this policy. Two of 30 cases we reviewed during our August 2012 inspection included processing errors where claims folders did not contain copies of the computer screens identifying future examination dates as required.

Actions Taken In Response to Prior Audit Report

We assessed whether VARO management accurately reported actions taken on temporary 100 percent disability claims identified by VBA. 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. 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. At the time of our inspection, VBA was still working to complete this national review requirement and extended the national review deadline again 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 our 2012 inspection, we followed up on VBA's national review of its temporary 100 percent disability evaluation processing. We sampled 40 cases from the lists of cases needing corrective actions that VBA provided to the Philadelphia VARO for review. We determined VARO staff accurately reported actions, such as inputting suspense diaries or taking actions to schedule reexaminations, on all 40 cases we reviewed. However, in comparing VBA's national review lists with our data on temporary 100 percent disability evaluations, we found 7 cases related to temporary evaluations involving prostate cancer or non-Hodgkin's lymphoma that VBA had not identified. We will continue monitoring this situation as VBA works to complete its national review.

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.

From our inspection, we determined VARO staff incorrectly processed 7 of 30 TBI claims—these processing errors had the potential to affect veterans' benefits. Generally, these errors occurred because the VARO lacked adequate oversight to ensure VSC staff complied with VBA's second signature policy. Specifically, six of the seven inaccurate rating decisions had an additional level of review; however, peers rather than staff from the Quality Review Team (QRT) conducted the reviews. Those peers reviewed six of the seven rating decision; however, they did not identify the errors we found.

Had QRT staff reviewed these cases, they may have determined that RVSRs used insufficient medical examination reports when making disability decisions—a repeat OIG finding in this area. 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 and obtain the medical evidence needed to support a TBI claims decision. Where RVSRs rated cases based on insufficient medical examination reports, veterans may be at increased risk of not receiving correct disability payments.

Follow Up To Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Philadelphia,* (Report No. 09-03846-93, March 4, 2010), we also indicated TBI processing errors occurred because RVSRs incorrectly used inadequate examinations to evaluate claims and did not fully assess all residual disabilities associated with TBIs. We recommended the Philadelphia VA Regional Office Director coordinate with VA medical staff responsible for completing TBI examinations to ensure examiners use the most current examination worksheets. During our August 2012 inspection, we did not find similar conditions as VA medical staff were using current medical examination worksheets.

Recommendations

1. We recommend the Philadelphia VA Regional Office Director develop and implement a plan to ensure compliance with Veterans Benefits Administration policy regarding timely benefits reduction actions.
2. We recommend the Philadelphia VA Regional Office Director provide refresher training to ensure staff establish suspense diaries for temporary 100 percent disability reevaluations.
3. We recommend the Philadelphia VA Regional Office Director develop and implement a plan to ensure staff return insufficient medical examination reports to health care facilities to obtain the required evidence needed to support traumatic brain injury claims.
4. We recommend the Philadelphia VA Regional Office Director develop and implement a plan to ensure staff compliance with Veterans Benefits Administration second signature requirements for processing traumatic brain injury claims.

Management Comments

The VARO Director concurred with our recommendations. The Director updated the VARO's workload management plan to include oversight procedures for supervisors to ensure staff take timely actions to correct future benefits. In March 2013, VARO staff received additional training on establishing suspense diaries for temporary 100 percent disability evaluations.

In October 2012, as part of its organizational transformation, VARO management assigned responsibility for TBI disability claims processing to the Special Operations Lane. RVSRs assigned to evaluate TBI disability claims review all incoming examination report to identify insufficient reports and return them to VA facilities for clarification. In January 2013, during a

quarterly partnership meeting between VARO and Veterans Health Administration officials, the importance of ensuring complete Disability Benefits Questionnaires for TBI claims was discussed. In February 2013, management formalized procedures for ensuring implementation of VBA's policy requiring second-level review of TBI disability claims.

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

II. Management Controls

Systematic Analysis of Operations

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs). We also considered whether VSC staff used adequate data to support the analyses and recommendations identified within each SAO. An SAO is a formal analysis of an organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish annual SAO schedules designating the staff required to complete the SAOs by specific dates. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 11 SAOs annually.

One of the 11 SAOs did not include an analysis of 3 required elements. The remaining 10 SAOs included thorough analyses based on appropriate data, identified deficient areas, and made recommendations for improvement of business operations. As a result, we determined the VARO generally followed VBA policy and we made no recommendation for improvement in this area.

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 a Gulf War veteran's 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 2 Gulf War Veterans Did Not Always Receive Entitlement Decisions for Mental Health Treatment

VARO staff did not properly address whether 8 of 30 Gulf War veterans were entitled to receive treatment for mental disorders. These inaccuracies generally occurred because supervisory reviews, conducted prior to the March 2012 establishment of the QRT, lacked emphasis on ensuring that these entitlements were consistently addressed. Additionally, VSC staff 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. Following are summaries of the eight errors observed.

- Five errors occurred when RVSRs did not address veterans' entitlement to treatment for mental disorders on current claims decisions after previous decisions also did not address the issue. In these cases, the pop-up notifications did not generate.
- In two instances, RVSRs did not address veterans' entitlement to mental health treatment in current disability decisions, although pop-up notifications generated to remind them to do so.
- In one case, an RVSR correctly addressed the entitlement and informed the veteran, but did not document the decision in the electronic record. When the RVSR does not update the electronic record, VA treating facilities cannot determine whether the veteran is entitled to the benefit.

The VSC provided training sessions on this topic in 2011, early 2012, and most recently in August 2012. RVSRs we interviewed were able to explain the correct process for addressing Gulf War veterans' entitlement to mental health care. Nonetheless, according to management, previous supervisory

reviews of RVSR claims decisions probably were not as thorough as those the newly formed QRT team conducted after its establishment in March 2012. The VSC manager agreed with this assessment and expected that RVSRs will eventually stop making this mistake as the QRT continues to hold staff accountable through quality reviews.

Additionally, the majority of the RVSRs and management we interviewed thought the pop-up notification was not effective because it was easy to ignore. Some staff felt it was also a problem because it only appeared when the current rating decision denied a mental health condition. There was no pop-up notification if a previous decision neglected to consider a Gulf War veteran's entitlement to mental health treatment.

In December 2012, VBA modified its policy that required RVSR staff to address entitlement to health care treatment in all cases that involved Gulf War veterans. Given that the new policy change became effective after we concluded our inspection of the Philadelphia VARO, we cannot speculate if the change would have affected the number of errors we identified. Therefore, we make no recommendation for improvement.

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

Finding 3 Oversight Needed To Ensure Homeless Outreach Activities are Completed

The Philadelphia VARO is 1 of the 20 VAROs required to have a full-time coordinator. The VARO's Homeless Veterans Outreach Coordinator (HVOC) had not created an updated resource directory or contacted local homeless shelters and service providers as required. This occurred because VARO management did not have a procedure or process in place to monitor and ensure that the HVOC completed these required duties. As a result, VARO management had no assurance that homeless shelters and service providers were aware of available VA benefits and services when assisting homeless veterans.

The VARO provided us a shelter resource directory that staff informed us was last updated 7 years ago and was no longer in use. VARO management was unaware the resource directory was outdated and the HVOC had not contacted homeless shelters and service providers within the VARO's jurisdiction. During our inspection, the VSC manager informed us that in the future the VARO would update the directory and send out mailings to all homeless facilities informing them of the current HVOC's name and telephone number. The VSC manager informed us the HVOC would also follow up with telephone calls.

Our review confirmed the HVOC maintained liaisons with the VA Medical Centers' homeless coordinators and local Veterans Multi-Service Center staff. This Center is a nonprofit organization that provides permanent and transitional housing, job placement assistance, and legal counseling referrals. Although the HVOC had a collaborative partnership with this Center, the HVOC did not regularly contact other shelters and homeless service

providers within the VARO's jurisdiction. Had VARO managers put in place controls to monitor outreach efforts, they would have been aware that local homeless shelters and service providers had not received information on VA benefits and services available to homeless veterans. VBA also needs a measurement to assess the effectiveness of its homeless veterans outreach efforts.

Recommendation

5. We recommend the Philadelphia VA Regional Office Director develop and implement a plan to ensure staff update the resource directory and regularly provide outreach to homeless shelters and service providers.

Management Comments

The VARO Director concurred with our recommendation. In September 2012, VARO staff updated the directory of homeless shelters and service providers within the VARO's jurisdiction. In October 2012, VARO staff contacted these shelters and service providers by mail to communicate information of homeless veterans' benefits and service. Management also designated staff responsible for ensuring that update of the homeless resource directory and outreach to shelters and service providers occur annually.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

The Philadelphia VARO administers a variety of services and benefits, including compensation and pension benefits; vocational rehabilitation and employment assistance; specially adapted housing grants; benefits counseling; and outreach to homeless, elderly, minority, and women veterans. The Philadelphia VARO also has a National Call Center and Pension Management Center.

Resources

As of July 2012, the Philadelphia VARO had a staffing level of 940.6 full-time employees. Of this total, the VSC had 245 employees assigned.

Workload

As of July 2012, the VARO reported 15,615 pending compensation claims. The average time to complete claims was 287.5 days—57.5 days more 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. Prior to conducting our on-site inspection, we coordinated with VA-OIG criminal investigators to provide a briefing designed to alert VARO staff of the indicators of fraud related to claims processing.

Our review included 30 (4 percent) of 800 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of July 6, 2012. We provided VARO management with 770 claims remaining from our universe of 800 for its review. We reviewed 30 (54 percent) of 56 disability claims related to TBI that the VARO completed from April through June 2012. 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 program management decision.

We assessed the 11 mandatory SAOs the VARO completed in FY 2012. We sampled 40 temporary 100 percent disability evaluations from the SharePoint list VBA had provided to the VARO for review. We examined 30 completed claims processed for Gulf War veterans from April through June 2012 to determine whether VSC staff had 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 by

reviewing its directory of homeless shelters and service providers and determining whether staff regularly attend meetings and disseminate information on VA benefits and services.

Data Reliability

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

Table 2. Philadelphia VARO Inspection Summary

Five Operational Activities Inspected	Criteria	Reasonable Assurance of	
		Yes	No
Disability 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
Management Controls			
3. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)	X	
Eligibility Determinations			
4. 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			
5. Homeless Veterans Outreach Program	**Determine whether VARO 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 Rewrite

Appendix C VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: February 22, 2013

From: Director, VA Regional Office Philadelphia, Pennsylvania

Subj: Inspection of the VA Regional Office, Philadelphia, Pennsylvania

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

1. The Philadelphia VA Regional Office (RO) comments are attached on the OIG Draft Report, *Inspection of the VA Regional Office, Philadelphia, Pennsylvania.* The attached contains the RO's response to the recommended action items from the inspection team.

2. Please refer questions to me at (215) 381-3001.

(original signed by:)

Robert McKenrick

Attachment

Recommendation 1: We recommend the Philadelphia VA Regional Office Director develop and implement a plan to ensure compliance with Veterans Benefits Administration policy regarding timely benefits reduction actions.

RO response: Concur.

The Workload Management Plan, last updated February 11, 2013, includes oversight for monitoring and processing claims involving proposed disability evaluation reduction, ensuring that prompt action is taken to minimize potential overpayments. This plan requires the Coach to run a pending full detail report for EP 690 and 693 on the 1st and 15th of each month to ensure that a corresponding non-rating EP is also pending and that prompt action is being taken to minimize potential overpayments. Refresher training for EP 690 and 693 will be conducted on March 12, 2013.

Recommendation 2: We recommend the Philadelphia VA Regional Office Director provide refresher training to ensure staff establish suspense diaries for temporary 100 percent.

RO response: Concur.

The Philadelphia Veterans Service Center (VSC) conducted refresher training on this topic on March 4, 2013.

Recommendation 3: We recommend the Philadelphia VA Regional Office Director develop and implement a plan to ensure staff return insufficient medical examination reports to health care facilities to obtain the required evidence needed to support traumatic brain injury claims.

RO response: Concur.

In October 2012, the Philadelphia RO transformed into VBA's Organizational Model. All traumatic brain injury claims are worked in the Special Operations Lane. Rating Veterans Service Representatives (RVSR) closely review all incoming examination results for sufficiency and all examination results found to be insufficient for rating purposes are returned to the healthcare facility providing the examination results. The Philadelphia RO conducts quarterly meetings with our VHA partners, discussing the importance of fully completing the Disability Benefits Questionnaire. TBI exams were addressed at the January 31, 2013 meeting.

Recommendation 4: We recommend the Philadelphia VA Regional Director develop and implement a plan to ensure staff compliance with Veterans Benefits Administration second signature requirements for processing traumatic brain injury claims.

RO response: Concur.

VBA implemented a policy requiring two signatures on rating decisions involving TBI until sufficient accuracy is proven on the part of the RVSR. The Philadelphia RO has implemented this policy. A local policy was implemented in February 2013 that formalizes the process within the VSC. The Special Operations Coach maintains and closely monitors the accuracy of RVSRs with single signature authority to rate TBI claims.

Recommendation 5: We recommend the Philadelphia VA Regional Office Director develop and implement a plan to ensure staff update the resource directory and regularly provide outreach to homeless shelters and service providers.

RO response: Concur.

The Philadelphia RO updated the resource directory on homeless shelters and service providers within its jurisdiction on September 20, 2012. The RO will continue to update this resource directory annually. Letters were sent to all homeless facilities on October 5, 2012. The Public Contact Team Coach will ensure that the resource directory is updated each September and letters are sent out to all providers at that time. In addition, the Homeless Veterans Outreach Coordinator (HVOC) will continue to utilize the Internet for resource information on homeless facilities and services. In addition to the activities noted above, the HVOC will continue to provide outreach to homeless shelters and service providers in our area ensuring that Veterans receive the benefits and assistance they deserve.

The following ongoing activities will continue: the HVOC will continue to serve on the committee for the Community Homelessness Assessment Local Education and Networking Group (CHALENG) that brings homeless service providers together to exchange information and discuss benefits and services. The goal is to work towards solutions to end homelessness among Veterans. This meeting is often hosted by the Philadelphia Regional Office. The HVOC will continue to work closely with VAMC staff who work with homeless Veterans. The HVOC will continue to recruit service providers to participate at Philadelphia Stand Down events as well as participating in the annual Point in Time (PIT) count.

The HVOC will continue to work closely with the Veterans Multi-Service Center and will remain stationed one day a week at the facility. He works on a regular basis with other grant and per diem recipients to include Impact Services, Fresh Start, Safe Haven, and Mary Walker House. These locations house and provide services to the majority of homeless Veterans in the Philadelphia Area.

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 Kristine Abramo Madeline Cantu Danny Clay Kelly Crawford Lee Giesbrecht Kerri Leggiero-Yglesias Suzanne Murray Nelvy Viguera Butler Mark Ward

Appendix E Report Distribution

VA Distribution

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Veterans Benefits Administration
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Veterans Benefits Administration Eastern Area Director
VA Regional Office Philadelphia Director

Non-VA Distribution

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Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Robert P. Casey, Jr.; Pat Toomey
U.S. House of Representatives: Lou Barletta, Robert Brady, Mathew Cartwright, Charlie Dent, Mike Doyle, Chaka Fattah, Mike Fitzpatrick, Jim Gerlach, Mike Kelly, Tom Marino, Patrick Meehan, Tim Murphy, Scott Perry, Joe Pitts, Keith Rothfus, Allyson Y. Schwartz, Bill Shuster, Glenn 'GT' Thompson

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