VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Denver, Colorado

April 24, 2013
12-04525-170

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

Report Highlights: Inspection of VA Regional Office Denver, Colorado

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 evaluated the Denver VARO to see how well it accomplishes this mission.

What We Found

Overall, VARO staff did not accurately process 20 (33 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. Claims processing that lacks compliance with VBA procedures can result in the risk of paying inaccurate and unnecessary financial benefits.

Specifically, 16 of the 30 temporary 100 percent disability evaluations we reviewed were inaccurate. Generally, errors in processing the temporary evaluations occurred because staff did not establish controls to ensure scheduling of future medical reexaminations to reevaluate these cases. This occurred due to incorrect guidance and ineffective training. In addition, VARO staff inaccurately processed 4 of 30 traumatic brain injury claims.

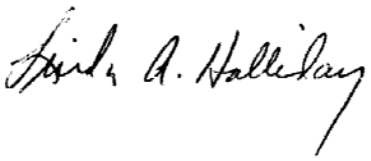
VARO managers generally ensured staff completed Systematic Analyses of Operations and addressed Gulf War veterans' entitlement to mental health treatment as required. Denver VARO staff provided adequate outreach to homeless veterans; however, VBA needs a performance measure to assess its homeless veterans outreach program.

What We Recommend

We recommend the VARO Director develop and implement a plan to provide the guidance and training needed to comply with VBA policy on scheduling routine future medical reexaminations.

Agency Comments

The VARO Director concurred with our recommendation. 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 November 2012, we inspected the Denver VARO. The inspection focused on the following four protocol areas: disability claims processing, management controls, eligibility determinations, and public contact. Within these areas, we examined five operational activities: temporary 100 percent disability evaluations, traumatic brain injury (TBI) claims, systematic analysis of operations (SAOs), Gulf War veterans' entitlement to mental health treatment, and homeless veterans outreach program.

We reviewed 30 (8 percent) of 361 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months. This is generally the longest period a temporary 100 percent disability evaluation may be assigned without review, according to Veterans Benefits Administration's (VBA) policy. We examined 30 (68 percent) of 44 disability claims related to TBI that VARO staff completed during the period 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 Denver VARO Could Improve Disability Claims Processing Accuracy

The Denver VARO did not consistently process temporary 100 percent disability evaluations and TBI cases accurately. Overall, VARO staff incorrectly processed 20 of the total 60 disability claims we sampled, resulting in 399 improper payments to 11 veterans totaling $547,354 from August 1999 until the time of our inspection.

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 VARO. As reported by VBA's Systematic Technical Accuracy Review program as of September 2012, the overall accuracy of the VARO's compensation rating-related decisions was 92.1 percent—5.1 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 Denver VARO.

Table 1

Denver 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	9	7	16
Traumatic Brain Injury Claims	30	2	2	4
Total	**60**	**11**	**9**	**20**

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

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 16 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 a veteran needs specific treatment. 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 that 9 of the 16 processing errors we identified affected veterans' monthly benefits and resulted in 385 improper payments totaling $542,948. Eight errors involved overpayments totaling $519,209 and one error involved an underpayment totaling $23,739. Details on the most significant overpayment and underpayment follow.

- A Rating Veterans Service Representative (RVSR) incorrectly evaluated a veteran's brain tumor as 100 percent disabling. In two subsequent disability decisions, RVSRs incorrectly continued the 100 percent disability evaluation. Medical evidence showed the tumor was benign, warranting a 60 percent disability evaluation. As a result, VA processed monthly benefits and ultimately overpaid the veteran $234,599 over a period of 13 years and 3 months.
- VARO staff did not grant a veteran entitlement to an additional special monthly benefit based on evaluations of multiple disabilities, as required. As a result, VA underpaid the veteran a total of $23,739 over a period of 6 years and 3 months.

The remaining 7 of the 16 errors had the potential to affect veterans' benefits. Generally, these errors involved VSC staff not:

- Inputting suspense diaries as required.
- Scheduling a medical reexamination after receiving a system-generated reminder notification to do so.

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 medical reexamination.

Eleven of the 16 errors resulted from staff not inputting suspense diaries, or taking appropriate action on reminder notifications to reexamine veterans for temporary 100 percent evaluations. VSC staff had not received training on

system-generated reminder notifications since November 2011. In July 2012, VSC management provided guidance instructing VSC staff to input system-generated reminder notifications 5 years from the date of the rating decision, and to control the routine future medical reexamination with the incorrect date of claim. Interviews with VSC staff revealed they did not clearly understand the procedures for addressing the notifications. Further, VSC staff were unaware of VBA policy for maintaining control of medical reexaminations to be scheduled 60 days or less in the future. 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 VA Regional Office, Denver, Colorado*, (Report No. 10-01530-196, July 19, 2010), we reported inaccuracies in processing temporary 100 percent disability evaluations occurred because staff did not input required dates in the electronic system to initiate system-generated reminder notifications. In addition, staff did not schedule examinations to reevaluate veterans' temporary 100 percent disabilities, despite reminder notifications that the examinations were due. The Director of the Denver VARO agreed to provide training and strengthen controls to ensure staff correctly established reminders and scheduled future medical examinations. The OIG closed this recommendation in January 2011, based on a new VARO policy requiring staff to generate awards on all confirmed and continued ratings, and implementing new procedures for processing system-generated reminder notifications. In addition, we received documentation that Veterans Service Representatives and RVSRs attended refresher training in April 2010.

VARO staff implemented new procedures for processing system-generated reminder notifications and provided refresher training in FYs 2011 and 2012. However, our November 2012 inspection disclosed that, despite the training and due to conflicting guidance from management, VSC staff has continued to process a significant number of temporary 100 percent disability evaluations incorrectly.

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 then 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 has since extended the national

review deadline to December 31, 2012, and is still working to complete this requirement. 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 Denver VARO for review. We determined VARO staff accurately reported actions, such as scheduling reexaminations, on all 40 cases we reviewed. However, in comparing VBA's national review lists with the 30 temporary 100 percent disability evaluations we reviewed, we found 6 additional cases that VBA had not identified for reasons we could not determine. 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.

VSC staff incorrectly processed 4 of 30 TBI claims. The four TBI claims processing errors were unique and did not constitute a common trend, pattern, or systemic issue. Two of the processing errors affected veterans' benefits and resulted in 14 improper payments totaling $4,406. Details on these overpayments follow:

- VARO staff correctly proposed reducing a veteran's 40 percent evaluation for TBI to 10 percent on April 5, 2012. By the time of our inspection in November 2012, VSC staff had not reduced the TBI evaluation as required by VBA policy. As a result, VA continued processing monthly benefits and overpaid the veteran $2,216 over a period of 2 months.
- An RVSR incorrectly granted service connection for TBI in the absence of a verified in-service event. The VA medical examination linked the TBI to an event that occurred when the veteran was no longer in service. As a result, VA processed monthly benefits and overpaid the veteran $2,190 over a period of 1 year.

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

- An RVSR incorrectly evaluated TBI residuals at 10 percent using symptoms the medical examiner attributed to the veteran's service-connected mental condition, not the TBI residuals. Because of

the veteran's multiple service-connected disabilities, this error did not affect monthly benefits but may affect future evaluations.

- An RVSR incorrectly completed a disability decision when a veteran reported that he was returning to military service and did not show up for a scheduled TBI examination. VBA policy does not allow for payment of compensation benefits while a veteran is serving on active duty. Because VSC staff did not confirm the veteran's military status at the time of the decision, we could not determine if the evaluations should have continued.

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 decisions. In May 2011, the Under Secretary for Benefits provided guidance to 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. During our inspection, we found no errors related to the second-signature review policy. As such, we made no recommendation for improvement in this area.

Recommendation

1. We recommend the Denver VA Regional Office Director develop and implement a plan to ensure compliance with Veterans Benefits Administration policy on scheduling medical reexaminations for temporary 100 percent disabilities.

Management Comments

The VARO Director concurred with our recommendation and in April 2013 amended the Workload Management Plan to assign responsibility for reviewing the appropriate work products to the Express Team.

OIG Response

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

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.

All 11 SAOs reviewed were timely completed. One of the 11 SAOs did not include an analysis of all required elements. The remaining 10 SAOs included thorough analyses using 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 policy in place during the scope of our inspection, whenever an RVSR denied a Gulf War veteran service connection for any mental disorder, the RVSR had to consider whether the veteran was entitled to receive mental health treatment. This policy required RVSRs to deny entitlement when there was no evidence a mental disorder had developed within 2 years of separation from military service.

In December 2012, VBA modified its policy to state that RVSRs no longer have to address Gulf War veterans' entitlement to mental health care in all cases. RVSRs must consider this entitlement when a veteran's mental health benefit can be granted based on diagnosis of a mental disorder within 2 years of separation from military service. Because this policy modification became effective after we concluded our inspection of the Denver VARO, we cannot determine whether the change might 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, local governments, and advocacy groups to provide information on VA benefits and services.

The Denver VARO is not one of the 20 VAROs required to have a full-time coordinator. The Denver VARO has four employees who perform homeless veterans outreach duties. The employees maintain two directories of local homeless shelters and service providers. Collaborative relationships exist among these employees, the Community Resource and Referral Center representative, the Denver VA Medical Center, the Denver Police Department, and other local homeless outreach facilities throughout the State of Colorado. However, VBA needs a measurement to assess the effectiveness of its homeless veterans outreach efforts.

Appendix A VARO Profile and Scope of Inspection

Organization

The Denver 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 Denver VARO also has a Regional Loan Center.

Resources

As of September 2012, the Denver VARO had a staffing level of 344.7 full-time employees. Of this total, the VSC had 211.2 employees assigned.

Workload

As of September 2012, the VARO reported 12,495 pending compensation claims. The average time to complete claims was 230.4 days—0.4 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.

Our review included 30 (8 percent) of 361 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 September 19, 2012. We provided VARO management with the remaining claims from our universe of 361 for its review. We reviewed 30 (68 percent) of 44 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 actions it can take 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 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.

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, included any calculation errors, or were outside the time frame requested. We assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or 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 90 claims folders we reviewed.

Our testing of the data disclosed that they were sufficiently reliable to meet our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders at VARO Denver 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. Denver VARO Inspection Summary

Five Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		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: April 4, 2013

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

Subj: Response to Draft Report, Inspection of the VA Regional Office Denver, Colorado

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

Thru: Director, Western Area

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

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

(Original signed)

William J. Kane
Director

Attachment

The Denver VARO concurs with the Findings and Recommendations of the OIG draft report of the November 2012, Inspection of the VA Regional Office, Denver, CO. The following response to the Recommendation is provided.

Recommendation: We recommend the Denver VA Regional Office Director develop and implement a plan to ensure compliance with Veterans Benefits Administration policy on scheduling medical reexaminations for temporary 100 percent evaluations.

Response: Concur. The Denver RO has assigned EP 810 series work items and EP 684 reviews to the Express Team. Assignment of these reviews will be incorporated in the April 2013 version of the station's Workload Management Plan.

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 Nelvy Viguera Butler

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