

# VA Office of Inspector General

## OFFICE OF AUDITS AND EVALUATIONS



## Inspection of VA Regional Office Milwaukee, Wisconsin

August 8, 2013  
13-01445-271

## ACRONYMS AND ABBREVIATIONS

OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

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# Report Highlights: Inspection of VA Regional Office, Milwaukee, WI

## Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and 1 Veterans Service Center in Cheyenne, Wyoming, that process disability claims and provide a range of services to veterans. We evaluated the Milwaukee VARO to see how well it accomplishes this mission.

## What We Found

Overall, VARO staff did not accurately process 8 of 49 disability claims 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 VARO. Claims processing lacked consistent compliance with VBA procedures and resulted in paying inaccurate and unnecessary financial benefits.

Specifically, 6 of 30 temporary 100 percent disability evaluations we reviewed were inaccurate. Errors in processing the temporary evaluations generally occurred because VARO staff did not enter suspense diaries into the electronic record or take timely action to reduce benefits as appropriate. Additionally, staff incorrectly processed 2 of 19 traumatic brain injury claims.

VARO managers ensured Systematic Analyses of Operations were complete and timely. However, staff did not always accurately address Gulf War veterans' entitlement to mental health treatment. VARO staff provided adequate outreach to

homeless veterans in the VAROs area of jurisdiction; however, we could not fully assess the effectiveness of these outreach activities because VBA needs performance metrics for its homeless veterans outreach program.

## What We Recommend

The VARO Director should implement a plan to ensure staff review for accuracy the 294 temporary 100 percent disability evaluations we provided at the end of this inspection.

## Agency Comments

The Director concurred with our recommendation. Management's planned actions are responsive and we will follow up as required.

A handwritten signature in black ink that reads "Linda A. Halliday".

LINDA A. HALLIDAY  
Assistant Inspector General  
For Audits and Evaluations

# TABLE OF CONTENTS

Introduction.....	1
Results and Recommendations .....	2
I.    Disability Claims Processing .....	2
Finding    Milwaukee VARO Could Improve Disability Claims Processing Accuracy .....	2
Recommendation .....	6
II.    Management Controls .....	8
III.   Eligibility Determinations.....	9
IV.   Public Contact.....	10
Appendix A    VARO Profile, Scope, and Methodology of Inspection .....	11
Appendix B    Inspection Summary .....	13
Appendix C    VARO Director’s Comments.....	14
Appendix D    Office of Inspector General Contact and Staff Acknowledgments .....	16
Appendix E    Report Distribution .....	17

## 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 Divisions contribute to improved management of benefits processing activities and veterans' services by conducting onsite inspections at VA Regional Offices (VAROs). These independent inspections provide recurring oversight focused on disability compensation claims processing and performance of Veterans Service Center (VSC) operations. The objectives of the inspections are to:

- Evaluate how well VAROs are accomplishing their mission of providing veterans with access to high-quality benefits and services.
- Determine whether management controls ensure compliance with VA regulations and policies; assist management in achieving program goals; and minimize the risk of fraud, waste, and other abuses.
- Identify and report systemic trends in VARO operations.

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

### **Scope of Inspection**

In March 2013, we inspected the Milwaukee 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 two high-risk claims processing areas: temporary 100 percent disability evaluations and traumatic brain injury (TBI) claims. We also examined three operational activities: Systematic Analyses of Operations (SAOs), Gulf War veterans' entitlement to mental health treatment, and the homeless veterans outreach program.

We reviewed 30 (9 percent) of 324 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 (VBA) policy. We examined 19 of the 21 total claims related to TBI that VARO staff completed from October through December 2012. Two of the 21 completed TBI claims folders were unavailable for review.

### **Other Information**

- Appendix A includes details on the VARO and the scope of our inspection.
- Appendix B outlines criteria we used to evaluate each operational activity and a summary of our inspection results.
- Appendix C provides the VARO Director's comments on 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**

**Milwaukee VARO Could Improve Disability Claims Processing Accuracy**

The Milwaukee VARO did not consistently process temporary 100 percent disability evaluations and TBI cases accurately. Overall, VARO staff incorrectly processed 8 of the total 49 disability claims we sampled. We identified 69 improper monthly payments to 3 veterans totaling \$53,010 from February 2009 until March 2013.

We sampled claims related to specific conditions 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 (STAR) program as of March 2013, the overall accuracy of the VARO's compensation rating-related decisions was 94.9 percent—4.9 percentage points above VBA's target of 90 percent. The STAR program information was not reviewed during the scope of this inspection.

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

**Table 1**

<b>Milwaukee VARO Disability Claims Processing Accuracy</b>				
<b>Type of Claim</b>	<b>Number of Claims Reviewed</b>	<b>Claims Inaccurately Processed</b>		
		<b>Affecting Veterans' Benefits</b>	<b>Potential To Affect Veterans' Benefits</b>	<b>Total Errors</b>
<b>Temporary 100 Percent Disability Evaluations</b>	30	3	3	6
<b>Traumatic Brain Injury Claims</b>	19	0	2	2
<b>Total</b>	<b>49</b>	<b>3</b>	<b>5</b>	<b>8</b>

*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 first quarter FY 2013*

**Temporary  
100 Percent  
Disability  
Evaluations**

VARO staff incorrectly processed 6 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.

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. During this inspection, we identified three instances where suspense diaries were not established as required. A suspense diary is a processing command that establishes a date when VSC staff must schedule a medical reexamination. As a suspense diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the reexamination.

Without effective management of these temporary ratings, VBA is at risk of paying inaccurate financial benefits. Available medical evidence showed three of the six processing errors we identified affected veterans' benefits and resulted in 69 improper monthly overpayments to 3 veterans totaling \$53,010 from as early as February 2009 until March 2013. The most significant overpayment occurred when VARO staff delayed scheduling a medical reexamination for a veteran's prostate cancer. However, available medical evidence no longer supported a temporary 100 percent disability evaluation because the veteran's cancer was no longer active. As a result, VA continued processing monthly benefits and ultimately overpaid this veteran a total of \$36,142 over a period of 1 year and 5 months.

The remaining three of the six errors had the potential to affect veterans' benefits. In cases where routine future medical reexaminations were not scheduled as required, claims processing delays ranged from approximately 1 year to 2 years and 4 months. An average of approximately 1 year and 10 months elapsed from the time staff should have scheduled these medical reexaminations through the date of our inspection.

Summaries of the six total errors we identified follow.

- Three errors occurred when staff did not establish suspense diaries in the electronic record as required; thus, the system did not generate automated alert notifications to schedule medical reexaminations. However, these three errors occurred prior to VBA's system modifications to automatically establish and retain suspense diaries in the electronic record.
- Two errors occurred when staff did not take timely final action to reduce benefits after notifying the veterans of the intent to do so. On average,

approximately 2 years and 2 months elapsed from the time staff should have reduced benefits until March 2013. The delays ranged from 3 months to 4 years and 1 month.

- One error occurred when a Rating Veterans Service Representative (RVSR) cancelled the reminder notification for a routine future examination. However, the RVSR did not complete a deferred rating decision documenting the reason for cancelling the reminder notification or providing a new date to schedule the reexamination. In this case, the medical evidence showed the veteran's thyroid cancer was active and the temporary 100 percent disability evaluation was warranted.

In November 2009, VBA provided refresher guidance to VARO staff about the need to input suspense diaries to the electronic record to provide reminders to schedule medical reexaminations. However, VARO managers had no oversight procedures in place to ensure VSC staff established suspense diaries and scheduled reexaminations timely. Temporary 100 percent disability evaluations and related monthly benefits could have continued uninterrupted over the veterans' lifetimes if we had not identified the need for VARO staff to take actions to schedule reexaminations.

**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, dated 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, then to June 30, 2012, and then again to December 31, 2012. Based on the numerous delays and our continued findings, we are concerned about the lack of urgency in completing this review, which is critical to minimize the financial risk of making inaccurate benefits payments.

During our current 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 that VBA provided to the Milwaukee VARO for review and corrective action. We determined VARO staff accurately reported taking actions, such as inputting suspense diaries or scheduling 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 three cases involving prostate cancer that



VBA had not identified. We could not determine why VBA did not identify these cases; however, we will continue monitoring this situation as VBA works to complete its national review.

**Follow-Up to  
Prior VA OIG  
Inspection**

Our prior report, *Inspection of the VA Regional Office, Milwaukee, WI* (Report No. 10-03565-69, dated January 21, 2011), stated 14 of the total 30 temporary 100 percent disability evaluations we reviewed had processing errors. The majority of the errors occurred because staff did not enter suspense diaries in the electronic record to ensure they received reminder notifications to schedule VA medical reexaminations. In response to our recommendations, the VARO Director agreed to review for accuracy the 162 temporary 100 percent disability evaluations we provided at the end of the January 2011 inspection. The VARO Director also agreed to conduct refresher training and to amend quality control procedures to ensure staff entered suspense diaries in the electronic records. The OIG closed these recommendations in August 2011.

Three of the six errors we identified during this current inspection involved staff not entering suspense diaries in the electronic record. However, all of these errors occurred before VBA implemented system modifications to automatically establish and retain suspense diaries in the electronic record. During future inspections, we will continue to monitor VARO performance and the effectiveness of VBA's system modifications related to managing suspense diaries.

**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, dated May 18, 2011), VBA agreed to develop and implement a strategy for ensuring accurate TBI claims decisions. In May 2011, the then-Acting 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.

We determined VARO staff incorrectly processed 2 of 19 TBI claims—both had the potential to affect veterans' benefits. Descriptions of these two cases follow.

- In one case, VARO staff did not take final action to reduce a disability evaluation from 70 to 10 percent disabling after notifying the veteran of the intent to do so. At the time of our inspection, staff had delayed finalizing the reduction, causing the veteran to continue to receive improper payments for approximately 2 months. No overpayment was created because according to VBA policy benefits are not generally reduced retroactively, regardless of how long an RVSR takes to reduce an evaluation. Monthly benefits for a veteran with a 70 percent disability evaluation are valued at \$1,293. When the veteran's rating drops to 10 percent, the monthly benefit is reduced to \$129, for a difference of \$1,164. Without timely, proper adjustment after the veteran is notified, monthly benefit payments continue at incorrect amounts.
- In the other case, an RVSR continued a 40 percent disability evaluation for a veteran's TBI, despite medical evidence showing the condition warranted a zero percent evaluation. Although this error did not affect the veteran's overall combined monthly benefits, if left uncorrected, the error has the potential to affect future benefits.

The two TBI claims processing errors were unique and did not constitute a common trend, pattern, or systemic issue. Therefore, we determined the VARO generally followed VBA policy when processing TBI claims and we made no recommendation for improvement in this area.

**Follow-Up to  
Prior VA OIG  
Inspection**

Our prior report, *Inspection of the VA Regional Office Milwaukee, WI* (Report No.10-03565-69, dated January 21, 2011), stated 8 of the 21 TBI claims reviewed had processing errors. The majority of the errors occurred because RVSRs misinterpreted VBA policy when evaluating TBI disability claims. In response to our recommendations, the VARO Director agreed to ensure appropriate staff received TBI refresher training. The Director also planned to have TBI-related disability claims undergo an additional level of review—a policy VBA adopted approximately 9 months later. The OIG closed these recommendations in July and October 2011.

During our March 2013 inspection, we did not identify errors related to misinterpreting VBA policy on TBI claims processing. Most of the claims we reviewed contained accurate rating decisions that were consistent with the policy and contained an additional level of review, as required. We concluded the VARO's corrective actions in response to our 2011 recommendations were adequate.

**Recommendation**

1. We recommend the Milwaukee VA Regional Office develop and implement a plan to review for accuracy the 294 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate actions.

**Management  
Comments**

The VARO Director concurred with our recommendation. VARO staff reviewed the 294 temporary 100 percent disability evaluations remaining from the OIG's inspection universe and took appropriate actions.

**OIG Response**

The Director's comments and actions are responsive to the recommendation. No further follow up action is required since the Director provided a detailed spreadsheet that showed the actions taken on each of the 294 cases.

## II. Management Controls

### **Systematic Analysis of Operations**

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

VARO management ensured all SAOs contained sufficient analyses using appropriate data, identified deficiencies, and made recommendations for improvements as appropriate. The SAOS were also submitted by the required due date.

### **Follow-Up to Prior VA OIG Inspection**

In our previous report, *Inspection of the VA Regional Office Milwaukee, WI* (Report No. 10-03565-69, dated January 21, 2011), we concluded that Milwaukee VARO management followed VBA policies by timely completing all required SAOs. For all SAOs where staff identified existing or potential problems, management made recommendations for improvement. Our current inspection results further indicate VARO staff consistently used adequate data to support SAOs and recommendations and submitted them timely according to the annual schedule. As such, 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. However, the RVSR should address entitlement to mental health care in the decision when the entitlement can be granted.

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.

VARO staff did not properly address whether 3 of 30 Gulf War veterans were entitled to receive treatment for mental disorders. RVSRs should have granted entitlement to medical treatment for all three veterans as VA medical records confirmed diagnoses of a mental health disorder within 2 years of separation from military service.

All RVSRs we interviewed correctly explained the procedures for addressing entitlement to mental health care. Management reported staff received formal training in this area during FY 2012. We confirmed the two RVSRs responsible for making the three errors we identified had completed this training.

Because VARO staff completed most mental health care decisions for Gulf War veterans correctly, we determined staff generally followed VBA policy when addressing these entitlement decisions. The three errors we identified did not constitute a common trend, pattern, or systemic issue necessitating VARO-wide corrective actions. As such, we made no recommendation for improvement in this area.

## 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 services. 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 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 government, and advocacy groups to provide information on VA benefits and services.

The Milwaukee VARO is not one of the 20 VAROs designated to have a full-time coordinator to oversee its homeless veterans program. Management ensured adequate outreach to homeless veterans, shelters, and service providers by creating a committee of homeless coordinators comprised of several public contact outreach specialists. By using the committee approach, the VARO maximized resources available to participate in community service events specific to homeless veterans in counties under the VARO’s jurisdiction.

Because the VARO provided information on VA benefits and services to homeless shelters and service providers as required, we made no recommendation for improvement in this area. However, VBA needs performance measures for its homeless veterans outreach program. Without such measures, we cannot fully assess the effectiveness of its outreach activities.

## Appendix A VARO Profile, Scope, and Methodology of Inspection

**Organization** The Milwaukee 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 VARO serves as a Pension Management Center administering pension and survivor benefits programs for veterans and their dependents in Wisconsin, along with 11 other states. Additionally, it serves as a hub for Fiduciary Services, providing services for seven states, including Michigan's Upper Peninsula.

**Resources** As of March 9, 2013, the Milwaukee VARO had a staffing level of 623.9 full-time employees. Of this total, the VSC had 145.1 employees assigned.

**Workload** As of March 1, 2013, the VARO reported 6,023 pending compensation claims. The average time to complete claims was 180.9—69.1 days less than the FY 2013 national target of 250 days.

**Scope** VBA has 56 VAROs and 1 VSC in Cheyenne, Wyoming, that process disability claims and provide a range of services to veterans. We evaluated the Milwaukee VARO to see how well it accomplishes this mission.

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 (9 percent) of 324 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 January 28, 2013. We reviewed 30 claims and provided VARO management with 294 claims remaining from our universe of 324 for its review. As follow-up to our national audit, we also sampled 40 temporary 100 percent disability evaluations from the SharePoint list VBA provided to the VARO as part of its national review. We also reviewed 19 (90 percent) of 21 total TBI-related disability claims that the VARO completed from October through December 2012.

Where we identified potential procedural inaccuracies, we provide this information to help VAROs understand the procedural improvements it can make for enhanced stewardship of financial benefits. We do not provide this information to require VAROs to adjust specific veterans' benefits.

Processing any adjustments per this review is clearly a VBA program management decision.

We assessed the 11 most recent mandatory SAOs the VARO completed in FY 2012 and FY 2013. We examined 30 completed claims processed for Gulf War veterans from October through December 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 VARO's homeless veterans outreach program by reviewing its directory of homeless shelters and service providers and determining whether staff regularly attended meetings and provided information on VA benefits and services.

**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 also 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 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 the Milwaukee VARO did not disclose any problems with data reliability.

While this report references VBA's STAR data, the overall accuracy of the Milwaukee VARO's compensation rating-related decisions was 94.9 percent—4.9 percentage points above VBA's FY 2013 target of 90 percent. This data was not reviewed as part of this inspection.

**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.

<b>Table 2. Milwaukee VARO Inspection Summary</b>			
<b>Five Operational Activities Inspected</b>	<b>Criteria</b>	<b>Reasonable Assurance of Compliance</b>	
		<b>Yes</b>	<b>No</b>
<b>Disability Claims Processing</b>			
<b>1. Temporary 100 Percent Disability Evaluations</b>	<b>Determine whether VARO staff properly processed temporary 100 percent disability evaluations.</b> (38 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
<b>2. Traumatic Brain Injury Claims</b>	<b>Determine whether VARO staff properly processed claims for all disabilities related to in-service TBI.</b> (FL 08-34 and FL 08-36) (Training Letter 09-01)	X	
<b>Management Controls</b>			
<b>3. Systematic Analysis of Operations</b>	<b>Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.</b> (M21-4, Chapter 5)	X	
<b>Eligibility Determinations</b>			
<b>4 Gulf War Veterans' Entitlement to Mental Health Treatment</b>	<b>Determine whether VARO staff properly processed Gulf War veterans' claims, considering entitlement to medical treatment for mental illness.</b> (38 United States Code 1702) (38 CFR 3.384) (38 CFR 3.2) ( 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	
<b>Public Contact</b>			
<b>5. Homeless Veterans Outreach Program</b>	<b>Determine whether VARO staff provided effective outreach services.</b> (Public Law 107-95) (VBA Letter 20-02-34) (VBA Circular 27-91-4) (FL 10-11) (M21-1, Part VII, Chapter 6) (M27-1, Part II, Chapter 2)	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:** July 25, 2013  
**From:** Director, VA Regional Office Milwaukee, Wisconsin  
**Subj:** Inspection of the VA Regional Office, Milwaukee, Wisconsin  
**To:** Assistant Inspector General for Audits and Evaluations (52)

1. The Milwaukee VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Milwaukee, Wisconsin.*
2. Please refer questions to Barb Nehls, Veterans Service Center Manager, at (414) 902-5045.

*(Original signed)*

Robert Granstrom  
Director, VARO Milwaukee

Attachment

**Recommendation 1:** We recommend the Milwaukee VA Regional Office develop and implement a plan to review for accuracy the 294 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate actions.

**Milwaukee RO Response: Concur**

Milwaukee completed the review of the 294 temporary 100 percent disability evaluations remaining from the OIG inspection universe and took all appropriate actions in April 2013.

A spreadsheet detailing the actions taken was provided to OIG on April 10, 2013.

An updated spreadsheet is being provided. All cases will be tracked until appropriate actions are taken.

## **Appendix D Office of Inspector General Contact and Staff Acknowledgments**

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OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Nora Stokes, Director Kristine Abramo Robert Campbell Madeline Cantu Ramon Figueroa Kyle Flannery Lee Giesbrecht Nelvy Viguera Butler
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## **Appendix E Report Distribution**

### **VA Distribution**

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This report is available on our Web site at [www.va.gov/oig](http://www.va.gov/oig).