VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Muskogee, Oklahoma

September 3, 2013
12-04326-275

ACRONYMS AND ABBREVIATIONS

DRO	Decision Review Officer
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 Muskogee, OK

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 Muskogee VARO to see how well it accomplishes this mission.

What We Found

Overall, VARO staff did not accurately process 25 (42 percent) of 60 disability claims we reviewed. We sampled claims we consider to be at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Claims processing lacked consistent compliance with VBA procedures and resulted in paying inaccurate and unnecessary financial benefits.

Specifically, 12 of 30 temporary 100 percent disability evaluations we reviewed were inaccurate; however, we identified no systemic trend associated with these processing errors. Additionally, staff misinterpreted VBA policy and inaccurately processed 13 of 30 traumatic brain injury claims.

VARO management ensured Systematic Analyses of Operations were complete and timely, but did not ensure staff properly addressed Gulf War veterans' entitlement to mental health treatment. VARO staff provided adequate outreach to homeless veterans; however, we could not fully assess the effectiveness of VBA's outreach activities because VBA needs performance measures for its homeless veterans outreach program.

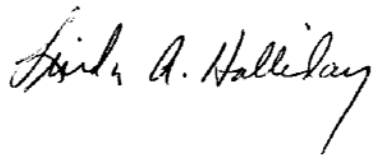
What We Recommend

The VARO Director should:

- Develop a plan to review the 304 temporary 100 percent disability evaluations remaining from our inspection universe.
- Provide and monitor the effectiveness of training on processing traumatic brain injury claims.
- Implement a plan to ensure accurate second-signature reviews of traumatic brain injury claims.
- Ensure staff address Gulf War veterans' entitlement to mental health treatment.

Agency Comments

The Director concurred with our recommendations, although VARO staff did not agree with 6 of 13 traumatic brain injury claims processing errors we identified. 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 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 April 2013, we inspected the Muskogee 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 of 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 334 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 also examined 30 (73 percent) of 41 disability claims related to TBI that VARO staff completed during the period October through December 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 their impact on veterans' benefits.

Finding 1

Muskogee VARO Could Improve Disability Claims Processing Accuracy

The Muskogee VARO did not consistently process temporary 100 percent disability evaluations and TBI cases accurately. Overall, VARO staff incorrectly processed 25 of the total 60 disability claims we sampled, resulting in 95 improper monthly payments to 5 veterans totaling $150,129 from April 2010 until March 2013.

We sampled claims related to specific conditions that we considered at higher risk of processing errors. As a result, the errors we identified do not represent the universe of disability claims or the overall claims processing accuracy rate at this VARO. As reported by VBA's Systematic Technical Accuracy Review (STAR) program as of February 2013, the overall accuracy of the VARO's compensation rating-related decisions was 89.9 percent—0.1 percentage points below VBA's target of 90 percent. We did not review this program information 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 Muskogee VARO.

Table 1

Muskogee 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	8	12
Traumatic Brain Injury Claims	30	1	12	13
Total	**60**	**5**	**20**	**25**

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 12 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. 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 medical reexamination.

VBA policy requires a 65-day due process period after a veteran is notified of a proposed adverse action, such as a reduction in a temporary 100 percent evaluation. At the end of the due process period, immediate action should be taken as appropriate to reduce the evaluation and thereby minimize overpayments.

Without effective management of these temporary 100 percent disability ratings, VBA is at increased risk of paying inaccurate financial benefits. Available medical evidence showed that 4 of the 12 processing errors we identified affected veterans' monthly benefits and resulted in 75 improper monthly payments totaling $139,657 from April 2010 until March 2013. Three errors involved overpayments totaling $137,140 and one error involved an underpayment totaling $2,517. The remaining 8 of the total 12 errors had the potential to affect veterans' benefits. Details on the most significant overpayment and the underpayment follow.

- A Rating Veterans Service Representative (RVSR) incorrectly continued a temporary 100 percent disability evaluation of a veteran's prostate cancer. Medical evidence showed the veteran had completed treatment warranting a reduction in benefits as of April 2010. However, VA continued processing monthly benefits and overpaid the veteran $86,499 over a period of 2 years and 11 months.
- An RVSR did not grant a veteran entitlement to an additional special monthly benefit based on multiple 100 percent disability evaluations as required. As a result, the veteran was underpaid $2,517 over a period of 7 months.

VARO staff did not schedule medical reexaminations as required for some of the errors identified. In six cases, we found scheduling delays ranging from approximately 1 year to 7 years and 3 months.

Summaries of the total 12 errors we identified follow.

- Three errors occurred when staff did not schedule routine medical reexaminations after receiving system-generated reminder notifications to do so.
- Two errors occurred when RVSRs incorrectly reduced veterans' benefits.
- Two errors occurred when RVSRs incorrectly continued the veterans' 100 percent disability evaluations for prostate cancer although medical evidence warranted reductions in the disability benefits.
- One error occurred when an RVSR continued a veteran's temporary 100 percent evaluation; however, the rating decision did not indicate whether a future examination was required. The rating decision also did not state whether the veteran's temporary 100 percent disability evaluation would be considered a permanent condition that did not require medical re-examination.
- One error occurred when staff did not establish a suspense diary in the electronic record, thereby removing the possibility that staff would receive a reminder notification to schedule a medical reexamination as required.
- One error occurred when an RVSR did not provide a veteran due process as required before reducing benefits.
- One error occurred when an RVSR did not consider entitlement to Dependents' Educational Assistance. Evidence in the claims folder showed the veteran's disabilities were permanently and totally disabling, warranting receipt of the additional benefit.
- One error occurred when an RVSR did not grant a veteran entitlement to an additional special monthly benefit based on multiple 100 percent disability evaluations.

In response to a recommendation in our national report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), VBA updated the electronic system to automatically establish diaries for confirmed and continued rating decisions when a future medical reexamination is required. VBA confirmed the update was successful in June 2011. One of the 12 errors we found occurred prior to this update. After the update, we did not identify any errors involving establishment of diaries for confirmed and continued rating decisions.

In November 2011, Muskogee VSC management implemented a local checklist to assist staff in processing routine medical reexaminations after receiving system-generated reminder notifications. The checklist referenced VBA policy and provided specific step-by-step requirements. Three of the 12 errors we found occurred prior to implementation of this checklist. We

did not identify any errors involving staff not scheduling routine medical reexaminations when the system alerted them to do so following implementation of the checklist.

Our review showed the reasons for the remaining eight errors varied. VSC management and staff interviewed could not explain why RVSRs made these errors and attributed them to human error. Because we did not identify a systemic trend associated with processing these evaluations, we made no recommendation for improvement in this area.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Muskogee, OK* (Report No. 10-00936-158, dated May 21, 2010), we reported that inaccuracies in processing 16 of 30 temporary 100 percent disability evaluation errors occurred because VARO staff did not have an understanding of the computer system's capabilities. Specifically, VARO managers stated they assumed VBA's electronic system eliminated the need for staff to input future exam diaries and therefore they did not provide oversight of this process.

As corrective action, the Director of the Muskogee VARO implemented a plan requiring that VSC staff print and sign documents to confirm that dates in the electronic system were correct. After plan implementation, we did not identify any error involving confirmed and continued rating decisions. Additionally, the Director concurred with our recommendation to review the temporary 100 percent disability evaluations remaining from our sample universe to determine if reevaluations were required and to take appropriate action. The OIG closed this recommendation in September 2010, based on the VARO Director's report that VSC staff took corrective action on all cases identified during our inspection.

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. To date, our national

audit recommendation for VBA to review all temporary 100 percent disability evaluations remains open. We do not intend to close this recommendation until our inspection results show a significant decrease in the types of errors identified during our national audit.

During our 2013 inspection, we followed up on VBA's national review of its temporary 100 percent disability evaluation processing. We sampled 40 cases from the list of cases needing corrective actions that VBA provided to the Muskogee VARO for review. We determined VARO staff accurately reported taking actions in 39 of 40 cases we reviewed. In 1 of the 40 cases, staff incorrectly reported the veteran was no longer evaluated at 100 percent for prostate cancer. However, the electronic system showed the veteran continued to receive a temporary 100 percent disability evaluation for the condition. Further, in comparing VBA's national review lists with our data on temporary 100 percent disability evaluations, we found seven cases 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, dated May 18, 2011), VBA agreed to develop and implement a strategy for ensuring accurate TBI claims rating decisions. In May 2011, VBA 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.

VARO staff incorrectly processed 13 of 30 TBI claims we reviewed. One of the processing errors affected a veteran's benefits and resulted in 20 improper monthly payments totaling $10,472. In this case, an RVSR incorrectly established separate evaluations for a veteran's TBI and post-traumatic stress disorder although the examiner stated it was not possible to differentiate which symptoms were attributable to each condition. VBA policy requires staff to assign a single evaluation when medical examiners state symptoms of TBI and a coexisting mental condition cannot be clearly separated. As a result of the processing error, VA overpaid the veteran over a period of 1 year and 8 months from July 2011 until March 2013.

The remaining 12 processing errors had the potential to affect veterans' benefits. Following are descriptions of these errors.

- In 10 cases, RVSRs used insufficient VA medical examination reports to evaluate the veterans' disabilities. The RVSRs did not return these insufficient examination reports for clarification to the issuing clinics or health care facilities as required. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without an adequate or complete medical examination.
- In one case, an RVSR denied service connection for a combat veteran even though the veteran had been diagnosed with a TBI associated with combat service. According to VBA policy, when a veteran claims that a condition occurred due to combat, and has a current disability associated with such combat, service connection is warranted.
- In another case, an RVSR incorrectly established separate evaluations for a veteran's TBI and coexisting mental conditions although the examiner stated it was not possible to differentiate which symptoms were attributable to which condition. This error did not affect the veteran's monthly benefits, but may affect future evaluations.

Generally, errors in TBI claims processing resulted from staff misinterpreting VA policy. Interviews with VSC staff revealed that although they were aware that a cognitive disorder is a mental disorder, the VARO's common practice was to evaluate this disorder using TBI evaluation criteria, rather than using the specific criteria for mental disorders as required by VBA training letter 09-01, dated January 21, 2009. For this reason, the Muskogee VARO did not concur with 5 of the 13 TBI processing errors we identified during our inspection.

The Muskogee VARO also did not concur with a TBI processing error we identified in a sixth case, but for a slightly different reason. VSC staff incorrectly assigned a 40 percent evaluation for TBI-related residuals based on a symptom that the VA examiner had attributed to neither a TBI nor a coexisting mental disorder. VSC staff believed that if a VA examiner associates one or more symptoms to a mental disorder, then staff can assume all remaining symptoms shown on that examination are related to TBI. However, VBA policy requires the examiner to distinguish among symptoms of a coexisting mental disorder and residuals of TBI, and to state if the symptoms cannot be delineated. As a result of these misinterpretations of VA policy, veterans may not have always received correct benefits.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Muskogee, OK* (Report No. 10-00936-158, dated May 21, 2010), we stated 8 of 30 TBI processing errors generally occurred because VARO staff had not received training following VBA's issuance of new training materials and guidance on TBI claims processing. The Director of the Muskogee VA Regional

Office concurred with our recommendation and agreed to provide refresher training to ensure staff properly and accurately processed TBI claims. The OIG closed this recommendation in September 2010 based on documentation showing this TBI training was completed in March 2010. Although additional training was provided in June 2012, we continued to identify TBI processing errors during our current inspection due to VSC staff misinterpreting VBA policy. As a result, we concluded the refresher training has not effectively reduced processing errors.

Recommendations

1. We recommend the Muskogee VA Regional Office Director conduct a review of the 304 temporary 100 percent disability evaluations remaining from the data we used to perform the inspection and take appropriate action.
2. We recommend the Muskogee VA Regional Office Director provide refresher training on processing traumatic brain injury claims and implement a plan to monitor the effectiveness of the training.
3. We recommend the Muskogee VA Regional Office Director develop and implement a plan to ensure accurate second-signature reviews of traumatic brain injury claims.

Management Response

The VARO Director concurred with our recommendations and indicated staff will complete a review of 304 temporary 100 percent disability evaluations by September 9, 2013. The Quality Review Team will use data from a locally created spreadsheet to identify common TBI claims processing errors and provide training as appropriate. In addition, VBA mandated that all RVSRs and Decision Review Officers complete 22 hours of TBI claims processing training by November 2013.

The Director concurred with our recommendations, although VARO staff did not agree with 6 of 13 traumatic brain injury claims processing errors we identified. The Director indicated there are no regulations or guidance that supports the requirement for medical examiners to explicitly attribute every noted symptom on an examination report to a TBI. However, we note that on VBA's Disability Benefits Questionnaire, physicians are asked, "Does the veteran have a TBI?" If the answer is yes, the physician is directed to differentiate which symptoms are attributable to each diagnosis. We believe this question clearly directs physicians to attribute symptoms to a TBI.

OIG Response

The Director's actions and comments 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.

VARO staff completed all 11 mandated SAOs timely according to the SAO schedule. All SAOs contained the required elements, included thorough analyses using appropriate data, identified weaknesses or concerns, and provided recommendations for improvement when needed. As such, we made no recommendation for improvement in this area.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Muskogee, OK* (Report No. 10-00936-158, May 21, 2010), we reported VARO management followed VBA policies by timely and accurately completing all required SAOs. During our 2013 inspection, we found VSC management and staff continued to complete SAOs timely using thorough analyses and appropriate data. 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 prior VBA policy in effect for a portion of the claims we sampled, whenever an RVSR denied a Gulf War veteran service connection for any mental disorder, the RVSR had to also consider whether the veteran was entitled to receive mental health treatment. This policy required RVSRs to deny entitlement when there was no medical evidence of a mental disorder that developed within 2 years of separation from military service even when the benefit had not been claimed by the veteran.

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.

In February 2011, VBA updated its Rating Board Automation 2000, a computer application designed to assist RVSRs in preparing disability ratings. The application provides a pop-up notification known as a tip master to remind staff to consider Gulf War veterans' entitlement to mental health 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 Accurate Entitlement Decisions for Mental Health Treatment**

Based on the prior policy, VSC staff did not properly address whether 9 (39 percent) of 23 Gulf War veterans were entitled to receive treatment for mental disorders. Generally, these inaccuracies occurred because staff overlooked reminder notifications to consider entitlement to mental health treatment. As a result, veterans may be unaware of the possible entitlement and may not get the care they need.

Summaries of the nine errors we identified follow.

- Four errors occurred when RVSRs overlooked the pop-up notification reminder and subsequently did not consider entitlement to mental health treatment. In three of these cases, entitlement was warranted.
- Three errors occurred when RVSRs did not consider entitlement to mental health treatment. In one of these cases, entitlement was warranted.

- Two errors occurred when RVSRs incorrectly denied the veterans entitlement to mental health treatment.

Applying the new policy continued to show inaccuracies in addressing entitlement to mental health treatment in 6 of 23 cases we reviewed.

Generally, these errors occurred because RVSRs overlooked the pop-up notification reminding them to consider entitlement to mental health treatment. Interviews with RVSRs revealed sufficient understanding of VBA's policy and receipt of recent training in this area. However, RVSRs stated the pop-up notification was easy to ignore.

Recommendation

4. We recommend the Muskogee VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives correctly address Gulf War veterans' entitlement to mental health treatment as required.

Management Response

The VARO Director concurred with our recommendation and indicated VARO staff use the Veterans Benefits Management System (Rating) (VBMS-R). The Director indicated this system automatically requires RVSRs to consider entitlement to mental health treatment for Gulf War Veterans. The Director concluded that this enhancement should ensure this issue is addressed appropriately.

OIG Response

The Director's actions and comments are responsive to the recommendation. However, we did not test this system during our inspection as it had not been deployed to all staff. We will test VBMS during a future inspection to determine if system enhancements improve the accuracy of considering entitlement to mental health treatment for Gulf War Veterans.

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 20 VAROs that VA determined to serve 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 nearby homeless service providers, local government, and advocacy groups to provide information on VA benefits and services.

The Muskogee VARO has a part-time Homeless Veterans Outreach Coordinator. Our review confirmed that the coordinator was familiar with requirements for improving the effectiveness of VARO outreach to homeless veterans. The coordinator had established collaborative partnerships with local homeless outreach facilities to provide information on VA benefits and services. As such, we made no recommendation for improvement in this area. However, without established performance measures, we could not fully assess VBA's outreach efforts. VBA needs a measurement to assess the effectiveness of its homeless veterans outreach program.

Appendix A VARO Profile and Scope of Inspection

Organization

The Muskogee VARO administers a variety of services and benefits, including compensation benefits; vocational rehabilitation and employment assistance; specially adapted housing grants; benefits counseling; and outreach to homeless, elderly, minority, and women veterans. The Muskogee VARO also houses an Education Regional Processing Office and the National Education Call Center.

Resources

As of January 2013, the Muskogee VARO reported a staffing level of 1,385 full-time employees. Of this total, the VSC had 206.6 employees assigned.

Workload

As of February 2013, the Muskogee VARO reported 13,158 pending compensation claims. The average time to complete claims was 235.5 days—14.5 days better than the national target of 250.

Scope

VBA has 56 VAROs and 1 VSC that process disability claims and provide a range of services to veterans. We evaluated the Muskogee 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 334 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 16, 2013. We provided VARO management with 304 claims remaining from our universe of 334 for its review. As follow-up to our January 2011 audit, we 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 30 (73 percent) of 41 TBI-related disability claims that the VARO completed from October through December 2012.

Where we identify 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 the VAROs to adjust specific veterans' benefits. Processing any adjustments affecting entitlement to benefits per this review is clearly a VBA management decision.

We assessed the 11 mandatory SAOs the VARO completed in FY 2012 and FY 2013. We examined 23 completed claims processed for Gulf War veterans from October through December 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 83 claims folders we reviewed related to temporary 100 percent evaluations, TBI, and Gulf War veterans' entitlement to mental health treatment.

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

While this report references VBA's Systematic Technical Accuracy Review data, the overall accuracy of the VARO's compensation rating-related decisions was 89.9 percent—0.1 percentage points below 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 and those instances where our review of claims found no evidence provide 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. Muskogee 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 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1 MR Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Traumatic Brain Injury Claims	**Determine whether VARO staff properly processed claims for service connection for all disabilities related to in-service TBI.** (FL 08-34 and 08-36) (Training Letter 09-01)		X
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	**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) (FL10-11) (M21-1, Part VII, Chapter 6) (M27-1, Part II, Chapter 2)	X	

Source: VA OIG
Note: 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: August 12, 2013

From: C. Jason McClellan, Director, VA Regional Office Muskogee, Oklahoma

Subj: Inspection of the VA Regional Office, Muskogee, Oklahoma

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

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

2. Please refer questions to Linda LoPinto (918) 781-7500.

(original signed by:)

C. JASON McCLELLAN
Director

Attachment

IG Recommendations:

Recommendation 1: Develop a plan to review the 304 temporary 100 percent disability evaluations remaining from our inspection universe.

RO Comments: Concur

The review of these cases began on August 9, 2013, with all review action to be completed by September 9, 2013.

Recommendation 2: Provide and monitor the effectiveness of training on processing traumatic brain injury claims.

RO Comments: Concur

The Muskogee RO utilizes a tracking spreadsheet to monitor the quality of completed TBI claims. The Quality Review Team (QRT) Coach will review the tracking spreadsheet for common errors made by Rating Veterans Service Representatives (RVSR) and Decision Review Officers (DRO) and provide training in August 2013. The spreadsheet will continue to be reviewed for monitoring purposes on a quarterly basis and training provided as appropriate.

On August 5, 2013, VBA Compensation Service mandated all RVSRs and DROs complete VBA's Training Performance and Support System (TPSS) module for rating traumatic brain injury (TBI) by November 12, 2013. This module consists of 22 hours strictly devoted to rating TBI. The training will be completed by the assigned date.

Recommendation 3: Implement a plan to ensure accurate second-signature reviews of traumatic brain injury claims.

RO Comments: Concur in-part

VAOIG reviewed 30 claims involving TBI and cited 13 of the cases as containing errors, all of which had a second signature review. The Muskogee RO did not concur with six of 13 errors cited and the office provided its rationale for non-concurrence. The six cases in question were sent for review by VBA Quality Assurance Staff for a second-level review given the difference of opinion with the findings. Their response dated June 24, 2013, supported Muskogee's non-concurrence and stated the examinations were sufficient for rating purposes based on existing policy and guidance. A copy of the VBA Quality Assurance Staff's report was provided to VAOIG on June 26, 2013. There are no regulations or guidance that supported the requirement VAOIG was citing that examiners must explicitly attribute every noted symptom on examination to TBI by excluding attribution to other conditions. The Muskogee RO concurs in-part based on the fact there is a mix of cases we agree need to be corrected (seven cases), and some that have been shown to be correct by VA Central Office (six cases). There are no regulations or guidance to support the VAOIG's interpretation with respect to the six errors in question.

QRT will review a sample of second signature cases each month to ensure we are consistently interpreting TBI rating practices.

The Muskogee RO utilizes a tracking spreadsheet to monitor the quality of completed TBI claims. As stated above, the QRT Coach will review the tracking spreadsheet for common errors made by RVSR/DRO's and provide training in August 2013. The spreadsheet will continue to be reviewed for monitoring purposes on a quarterly basis and training provided as appropriate.

Recommendation 4: Ensure staff addresses Gulf War veterans' entitlement to mental health treatment.

RO Comments: Concur

The Muskogee RO has been using Veterans Benefits Management System (Rating) (VBMS-R) since April 8, 2013. VBMS-R requires RVSRs to consider entitlement to mental health treatment for Gulf War Veterans by automatically placing it as an issue. The RVSR must delete the issue if entitlement is not warranted. We believe this enhancement will ensure RVSRs address this issue appropriately.

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 Vinay Chadha Michelle Elliott Scott Harris Lee Giesbrecht Rachel Stroup Dana Sullivan Nelvy Viguera Butler

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