VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office St. Paul, Minnesota

September 9, 2013
13-01550-286

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

Report Highlights: Inspection of VA Regional Office St. Paul, MN

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 St. Paul VARO to see how well it accomplishes this mission.

What We Found

Overall, VARO staff did not accurately process 14 (23 percent) of 60 disability claims 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 lacks consistent compliance with VBA procedures and is resulting in paying inaccurate and unnecessary financial benefits.

Specifically, 5 of 30 temporary 100 percent disability evaluations we reviewed were inaccurate, generally because VARO staff did not establish controls to request future medical reexaminations. Further, VARO staff incorrectly processed 9 of 30 traumatic brain injury claims. These errors occurred primarily due to ineffective training on processing complex traumatic brain injury claims.

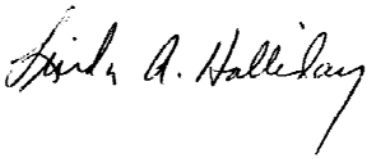
Management generally ensured Systematic Analyses of Operations were complete and timely. However, VARO staff did not always properly grant Gulf War veterans entitlement to mental health treatment. VARO staff provided adequate outreach to homeless veterans. Due to a lack of performance measures, we could not fully assess the effectiveness of the VARO's homeless veterans outreach program.

What We Recommend

We recommend the VARO Director develop and implement a plan to review the 299 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action. The Director should also provide refresher training on processing traumatic brain injury claims and monitor the effectiveness of that training.

Agency Comments

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



LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

The Benefits Inspection Program is part of the Office of Inspector General's (OIG) efforts to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection 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

We inspected the St. Paul VARO in April and May 2013. 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 329 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 30 (73 percent) of 41 disability claims related to TBI that VARO staff completed from 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 the delivery of veterans' benefits.

Finding 1 The St. Paul VARO Could Improve Disability Claims Processing Accuracy

The St. Paul VARO did not consistently process temporary 100 percent disability evaluations and TBI cases accurately. Overall, VARO staff incorrectly processed 14 of the total 60 disability claims we sampled. Claims processing lacks consistent compliance with VBA procedures and is resulting in paying inaccurate and unnecessary financial benefits. We identified 44 improper monthly payments to 2 veterans totaling $14,068 from October 2009 to April 2013.

We sampled claims related 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 or the overall processing accuracy rate at this VARO. As reported by VBA's Systematic Technical Accuracy Review (STAR) program as of March 2013, overall accuracy of the VARO's compensation rating-related decisions was 93.7 percent—3.7 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 St. Paul VARO.

Table 1

St. Paul VARO Disability Claims Processing Accuracy

Type of Claim	Number of Claims Reviewed	Claims Inaccurately Processed		
		Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits	Total Errors
Temporary 100 Percent Disability Evaluations	30	2	3	5
Traumatic Brain Injury Claims	30	0	9	9
Total	**60**	**2**	**12**	**14**

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 5 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, VSC staff must input suspense diaries in VBA's electronic system. 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 for VSC staff to schedule the medical reexamination.

Without effective management of these temporary 100 percent disability ratings, VBA is at increased risk of paying inaccurate financial benefits. Available evidence showed that two of the five processing errors we identified affected veterans' benefits. The errors resulted in 44 improper monthly payments to 2 veterans totaling $14,068 from October 2009 through April 2013. Details on the two errors follow.

- A Rating Veterans Service Representative (RVSR) did not grant a veteran entitlement to an additional special monthly benefit based on evaluations of multiple disabilities, as required by VBA policy. As a result, VA underpaid the veteran $13,972 over a period of 3 years and 7 months.
- A Decision Review Officer correctly granted a veteran entitlement to an additional special monthly benefit. However, the effective date of October 26, 2010, was incorrect because the date used to calculate benefits was not the date of entitlement. The actual date of entitlement to benefits was November 29, 2010. As a result, VA overpaid the veteran $96 over a period of 1 month.

The remaining three errors had the potential to affect veterans' benefits. These errors occurred when VSC staff did not establish suspense diaries as required, thereby removing the possibility staff would receive reminder notifications to schedule medical reexaminations. Two of these errors involved medical reexaminations required within 2 months of staff finalizing decisions. The medical reexaminations were delayed by approximately 1 year and 1 month in one case, and by 2 years and 6 months in the other. In such cases, VBA policy requires that VAROs use local procedures to maintain control of future medical reexaminations.

In September 2010, after learning of these types of errors through our prior inspection, VARO management established local diary procedures to ensure

the reexaminations were scheduled. This corrective action appears effective because we did not identify similar errors after its implementation. The reasons for the remaining errors varied; we did not identify a systemic trend related to processing temporary 100 percent disability evaluations. Therefore, 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, St. Paul, MN* (Report No. 10-03604-75, dated January 25, 2011), we stated errors in processing temporary 100 percent evaluations generally occurred because VARO staff did not establish suspense diaries in the electronic system to provide reminder notifications to schedule medical reexaminations.

The Director of the St. Paul VARO concurred with our recommendation to conduct a review of the remaining 175 temporary 100 percent disability evaluations identified during our inspection. VARO management reported staff reviewed the 175 evaluations and requested medical reexaminations when appropriate. The OIG closed the recommendation in June 2011.

The Director of the St. Paul VARO also concurred with our recommendation to implement controls to ensure staff establish reminder notifications to schedule reexaminations for temporary 100 percent disability evaluations. Effective September 2010, the VSC implemented process changes that included additional oversight to ensure staff properly recorded diaries in the electronic system. The OIG closed the recommendation in June 2011. VSC actions appear to be effective because we did not find similar errors.

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 evaluation had a future examination date entered in the electronic record. Our report stated, "If VBA does not take timely corrective action, they will overpay veterans a projected $1.1 billion over the next 5 years." The then-Acting Under Secretary for Benefits stated in response to our audit report that the target completion date for the national review would be September 30, 2011.

However, VBA did not provide each VARO with a list of temporary 100 percent disability evaluations for review until September 2011. VBA subsequently extended the national review deadline to December 31, 2011, then to June 30, 2012, and then again to December 31, 2012. Based on VBA's numerous delays, 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 onsite May 2013 inspection, we followed up on VBA's national review of its temporary 100 percent disability evaluation processing. We examined 40 (13 percent) of 311 temporary 100 percent disability

evaluations on VBA's SharePoint lists of cases for review. We determined VARO staff accurately reported corrective actions, such as reducing temporary 100 percent evaluations or establishing permanent evaluations, on all 40 cases we reviewed. However, in comparing VBA's national review list with our data on temporary 100 percent disability evaluations, we found two 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 the accuracy of TBI claims decisions. In May 2011, VBA provided guidance to all VARO Directors to implement a policy requiring a second signature on each TBI case an RVSR evaluates until the RVSR demonstrates 90 percent accuracy in TBI claims processing. The policy indicates second-signature reviewers come from the same pool of staff as those used to conduct local station quality reviews.

VARO staff incorrectly processed 9 of 30 TBI claims—all 9 claims had the potential to affect veterans' benefits. Following are descriptions of these errors.

- In four cases, RVSRs used inadequate VA medical examination reports to evaluate the veterans' disabilities. Two of these errors involved medical reports where the examiners did not indicate whether the veterans' symptoms were associated with a TBI or a coexisting mental condition. The RVSRs did not return these insufficient medical examination reports to the issuing health care facilities as required by VBA policy. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without adequate or complete medical evidence.
- In two cases, RVSRs improperly evaluated TBIs separately from coexisting mental conditions. The RVSRs were required to assign a single evaluation for each veteran's overall impaired functioning due to both medical conditions.
- In two cases, RVSRs improperly evaluated residuals of TBI. These errors did not affect the veterans' ongoing monthly benefits, but have the potential to affect future benefits in the event of additional compensable disabilities.

- In one case, an RVSR prematurely denied service connection for TBI without requesting a TBI examination for a combat veteran.

Generally, errors associated with TBI claims processing resulted from ineffective training on evaluating complex TBI claims. VSC management and staff reported TBI claims are difficult to evaluate. The VARO held TBI training in April 2012. However, staff subsequently reported the complex policies for rating TBI claims were still confusing because they did not frequently rate these types of cases. Staff indicated they need training that focuses on more complex TBI scenarios. As a result of the TBI claims processing errors, veterans may not always receive correct benefit decisions.

Recommendations

1. We recommend the St. Paul VA Regional Office Director conduct a review of the 299 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.
2. We recommend the St. Paul VA Regional Office Director provide refresher training on processing traumatic brain injury claims and develop and implement a plan to monitor the effectiveness of that training.

Management Comments

The VARO Director concurred with our recommendations. The Director indicated VARO staff will complete a review of all temporary 100 percent disability evaluations remaining from our universe by October 2013. Further, all RVSRs, Ratings Quality Service Representatives (RQSRs), and Decision Review Officers (DROs) will complete the TBI training.

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 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.

Staff completed the 11 SAOs we reviewed on time. One of the SAOs did not include an analysis of all required elements. The remaining 10 SAOs included thorough analyses based on appropriate data, identified deficient areas, and made recommendations for improving 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 effect prior to December 2012, 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 veteran had not claimed the benefit.

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 Entitlement Decisions for Mental Health Treatment**

VARO staff did not properly address whether 19 of 30 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 their entitlement to treatment for mental disorders and may not get the care they need.

Summaries of the 19 errors we identified follow.

- In 10 cases, RVSRs denied service connection for mental disorders on current disability decisions but did not consider entitlement to treatment.
- In five cases, RVSRs addressed entitlement to treatment and informed the veterans but did not document the decisions in the electronic record.
- In four cases, RVSRs did not address entitlement to treatment for mental disorders on current disability decisions after previous decisions did not address the issue.

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 only have to address this entitlement when a veteran's mental health benefit can be granted based on diagnosis of a mental disorder that developed within 2 years of separation from military service. In 12 claims

completed prior to the policy change, we identified processing errors where veterans were not entitled to mental health treatment and RVSRs did not properly address the issue in the formal decision. Because these veterans did not have diagnosed mental disorders within 2 years of separation from military service, the modified policy would not require RVSRs to address entitlement to treatment in these cases.

Veterans were entitled to mental health treatment in the remaining seven cases we identified with processing errors. These errors generally occurred because VSC staff overlooked reminder notifications to consider entitlement to treatment. Staff we interviewed knew the criteria for establishing entitlement to treatment and when to address the issue. However, staff stated that since the pop-up notification was easy to ignore, they would forget to address this issue.

According to VSC management, the VARO implemented the Veterans Benefits Management System, a web-based, electronic claims processing solution complemented by improved business processes in April 2013, after the scope of our review. VSC staff demonstrated that this new system requires RVSRs to consider entitlement to mental health treatment whenever they deny service connection for a mental illness. Because this new system prevents staff from completing these claims without considering entitlement to mental health treatment, 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 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, local governments, and advocacy groups to provide information on VA benefits and services.

The St. Paul VARO had two part-time Homeless Veterans Outreach Coordinators. Interviews with local homeless shelter representatives, VA Medical Center staff, and a local Veterans' Service Officer confirmed the coordinators were proactive in providing outreach services to homeless veterans. Our review further confirmed that VARO staff participated in regular outreach events, during which they explained VA benefits. Because we determined the coordinators provided outreach services to homeless veterans as required, we made no recommendation for improvement in this area. However, without established performance measures we could not fully assess the effectiveness of the VARO's homeless veterans outreach efforts. VBA needs a measurement to assess the effectiveness of this program.

Appendix A VARO Profile and Scope of Inspection

Organization

The St. Paul VARO administers a variety of services and benefits, including compensation and pension benefits; home loan guaranty; vocational rehabilitation and employment assistance; specially adapted housing grants; benefits counseling; and outreach to homeless, elderly, minority, and women veterans.

Resources

As of March 2013, VBA reported the St. Paul VARO had a staffing level of 723.7 full-time employees. Of this total, the VSC had 184.3 employees assigned.

Workload

As of March 2013, the St. Paul VARO reported 5,027 pending compensation claims. The average time to complete claims was 97.8 days, 52.2 days less than the national target of 250.

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 St. Paul 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. Prior to conducting our onsite inspection, we contacted VA OIG criminal investigators to provide a briefing designed to alert VARO staff to the indicators of fraudulent claims processing.

Our review included 30 (9 percent) of 329 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 March 1, 2013. We provided VARO management with 299 claims remaining from our universe of 329 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 procedural inaccuracies, we provide this information to help the VARO understand the procedural improvements it can make for enhanced stewardship of financial benefits. We do not provide this information to require the VARO to adjust specific veterans' benefits. Processing any adjustments per this review is clearly a VBA program management decision.

We assessed the 11 mandatory SAOs the VARO completed in FYs 2012 and 2013. We examined 30 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 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 reviewed as part of our inspection of the St. Paul VARO did not disclose any problems with data reliability.

This report references VBA's STAR data. As reported by STAR, the overall accuracy of the VARO's compensation rating-related decisions was 93.7 percent—3.7 percentage points above VBA's FY 2013 target of 90 percent. We did not test the reliability of this data.

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 and administrative activities inspected, applicable criteria, and whether or not we had reasonable assurance of VARO compliance.

Table 2. St. Paul 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 disabilities related to in-service TBI. (FL 08-34 and 08-36) (Training Letter 09-01)**		X
Management and Administrative 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 107-95) (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: August 16, 2013

From: Director, VA Regional Office St. Paul, Minnesota

Subj: Inspection of the VA Regional Office, St. Paul, Minnesota

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

1. Attached are the St. Paul VARO's comments on the OIG Draft Report: *Inspection of the VA Regional Office, St. Paul, Minnesota.*

2. Questions may be referred to Ms. Jessica Gillette, Veterans Service Center Manager at 612-970-5300.

(original signed by:)

ANTIONE WALLER
Director

Attachment

Attachment

Recommendation 1: We recommend the St. Paul VA Regional Office Director conduct a review of the 299 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

Response: Concur.

The St. Paul VSC has assigned personnel and initiated a review of the remaining 100 percent disability evaluations. Appropriate action will be taken, as necessary. Reviews will be completed by October 15, 2013.

We request closure of this recommendation due to the existing plan for completion of review and the actions taken to monitor effectiveness in this area.

Recommendation 2: We recommend the St. Paul VA Regional Office Director provide refresher training on processing traumatic brain injury claims and develop and implement a plan to monitor the effectiveness of that training.

Response: Concur.

In–person training on rating TBI claims was provided to all RVSRs, DROs, and RQRSs on June 20, 2013. The training focused primarily on the higher level concepts of rating TBI claims and the specific errors identified during the OIG review.

All RVSRs and DROs in the St. Paul VSC will be required to complete the TBI Training Performance Support System (TPSS) module during FY2013. As of August 2013, 76% of the identified employees have completed the training. To receive credit for completing the TPSS module, employees are required to rate two TBI claims. All TBI ratings are reviewed and second signed by a RQRS to ensure accuracy.

We request closure of this recommendation due to the training and process changes taken to monitor effectiveness in this area.

Appendix D Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Brent Arronte, Director Ed Akitomo Daphne Brantley Brett Byrd Lee Giesbrecht Scott Harris Jeff Myers David Piña Nelvy Viguera Butler Diane Wilson

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