VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Togus, Maine

September 9, 2013
13-02257-294

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 Togus, ME

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 Togus VARO to see how well it accomplishes this mission.

What We Found

Overall, VARO staff did not accurately process 4 of 39 disability claims reviewed. We sampled claims we considered 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.

Generally, VARO staff processed temporary 100 percent disability evaluations correctly. However, staff incorrectly processed 2 of 9 traumatic brain injury claims. These errors occurred because staff used insufficient medical examination reports and misinterpreted VBA policy when rating the claims.

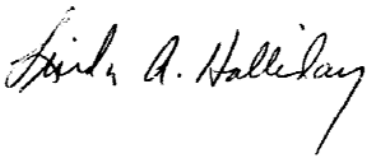
Systematic Analyses of Operations were incomplete and untimely. VARO managers lacked adequate measures to ensure staff addressed all required elements and submitted the annual analyses by the due date. Staff accurately addressed Gulf War veterans' entitlement to mental health treatment and provided adequate outreach to homeless veterans in the VARO's area of jurisdiction. However, we could not fully assess the effectiveness of these outreach activities because VBA lacked performance metrics for its Homeless Veterans Outreach Program.

What We Recommend

The VARO Director should implement a plan to ensure staff return insufficient medical examination reports to obtain the evidence required to support traumatic brain injury evaluations. The Director also needs to implement a plan to ensure staff completely and timely address all required elements of Systematic Analyses of Operations.

Agency Comments

The Director concurred with our recommendations but did not agree with 2 of the 4 claims processing errors identified. Thus, 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 May 2013, we inspected the Togus VARO. The inspection focused on the following four protocol areas—disability claims processing, management controls, eligibility determinations, and public contact. Within the five operational activities, we examined two high-risk claims processing areas of temporary 100 percent disability evaluations and traumatic brain injury (TBI) claims. We also examined three other operational activities—Systematic Analyses of Operations (SAOs), Gulf War veterans' entitlement to mental health treatment, and the Homeless Veterans Outreach Program.

We reviewed 30 (24 percent) of 127 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 9 (69 percent) of the total 13 TBI-related disability claims that VARO staff completed from January through March 2013. Four of the 13 claims folders were unavailable for review because the folders were transferred to other offices for additional claims processing actions.

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 1 Togus VARO Could Improve Disability Claims Processing Accuracy

The Togus VARO did not consistently process 100 percent disability evaluations and TBI cases accurately. Overall, VARO staff incorrectly processed 4 of the total 39 disability claims we sampled.

We sampled claims related to specific conditions we considered to be 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 93.9 percent—3.9 percentage points above VBA's FY 2013 target of 90 percent. The STAR program information was not reviewed during the scope of this inspection. The following table reflects the error affecting, and those with the potential to affect, veterans' benefits processed at the Togus VARO.

Table 1

Togus 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	1	1	2
Traumatic Brain Injury Claims	9	0	2	2
Total	**39**	**1**	**3**	**4**

Source: VAOIG analysis of VBA's temporary 100 percent disability evaluations paid at least 18 months or longer and TBI disability claims completed in the second quarter FY 2013

Temporary 100 Percent Disability Evaluations

Generally, VARO staff followed VBA policy when processing temporary 100 percent disability evaluations. 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.

VARO staff correctly processed 28 of 30 temporary 100 percent disability evaluations we reviewed. In the two cases with processing errors, VARO staff delayed scheduling medical reexaminations. An average of 4 years and 2 months elapsed from the time staff should have scheduled these medical reexaminations until the time the exams were completed. One of the processing errors affected a veteran's benefits and the other had the potential to affect benefits. Details on the two errors follow.

- In an October 2008 rating decision, a Rating Veterans Service Representative (RVSR) established service connection for a veteran's prostate cancer and requested an immediate VA examination to assess residual disabilities associated with a prostatectomy. Although VARO staff took action to begin compensation payments, they did not schedule the VA examination as requested. Consequently, the veteran received 48 improper monthly payments totaling $92,687.
- In a November 2008 rating decision, an RVSR established service connection for a veteran's prostate cancer and determined a reexamination was required in April 2009. However, staff did not enter a suspense diary in the electronic record for the reexamination as required. Without this input the system could not generate a reminder notification to alert staff to schedule the reexamination. In June 2012, VBA subsequently modified its electronic system to allow automatic population and retention of suspense diaries in the electronic record to schedule reexaminations related to confirmed and continued rating decisions.

Because VARO staff accurately processed most of the temporary 100 percent disability evaluation claims we reviewed, we make no recommendation for improvement in this area. Nonetheless, VARO managers disagreed with our assessments in the two cases we identified as having processing errors. Management stated both cases were included on a listing they received from the Eastern Area Office in January 2013. Management contended these two cases were being reviewed by the VARO as part of VBA's national review, conducted in response to a prior OIG audit discussed on the next page.

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, and then 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.

Further, during our 2013 inspection, we followed up on VBA's national review of its temporary 100 percent disability evaluation processing. In September 2011, VBA provided the Togus VARO a list of 229 cases for review. We sampled 40 of the cases and determined VARO staff accurately reported to the Eastern Area Office the actions taken, such as inputting suspense diaries or scheduling reexaminations. In comparing VBA's national review lists with data we compiled on temporary 100 percent disability evaluations, we found no cases involving prostate cancer or non-Hodgkin's lymphoma that VBA had not identified. 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, Togus, ME* (Report No. 09-03659-111, dated March 23, 2010), stated 18 of the total 30 temporary 100 percent disability evaluations we reviewed had processing errors. The majority of the errors occurred when staff did not enter suspense diaries in the electronic record, thereby removing the possibility that staff would receive reminder notifications to schedule medical reexaminations.

In response to our recommendations, the Director implemented a policy requiring an additional level of review for cases requiring future examinations to confirm staff entered the examination dates in the electronic record. The Director also agreed to review for accuracy the 27 temporary 100 percent disability evaluations remaining from our inspection universe. The OIG closed these recommendations in July 2010.

During our May 2013 inspection, only 1 of the 2 processing errors we identified involved staff not entering a suspense diary in the electronic record. As such, we concluded the corrective actions taken by VARO staff adequately addressed recommendations made in our previous inspection.

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, 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.

VARO staff incorrectly processed two of nine TBI claims we reviewed, but none of these processing errors affected veterans' benefits. In both of these cases, RVSRs prematurely evaluated TBI residuals using insufficient VA medical examination reports, instead of returning the reports to the examiners as required. The two cases involved examination reports where the examiners did not indicate whether the veterans' symptoms were associated with a TBI or a co-morbid mental condition. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without adequate or complete medical evidence.

Generally, errors associated with TBI claims processing occurred because VSC staff misinterpreted VBA policy and used their own interpretations of medical examination reports to separately evaluate TBI and co-morbid mental conditions. The majority of VSC staff felt they had this authority, even though the examiners did not state which symptoms were due to which condition as required. As a result, veterans may not have always received correct benefit decisions.

Follow-Up to Prior VA OIG Inspection

Our prior report, *Inspection of the VA Regional Office, Togus, ME* (Report No. 09-03659-111, dated March 23, 2010), stated 1 of 11 TBI claims reviewed were processed incorrectly, and we made no recommendation for improvement in this area. Comparatively, results of the May 2013 inspection showed staff incorrectly processed two of nine TBI disability claims because they misinterpreted VBA policy and used inadequate medical examinations to evaluate the claims.

Recommendation

1. We recommend the Togus VA Regional Office Director develop and implement a plan to ensure staff return insufficient medical examinations to obtain the evidence required to support traumatic brain injury evaluations.

Management Response

The VARO Director generally concurred with our recommendation and indicated that the TBI errors identified did not impact veterans' benefits. To eliminate the use of insufficient examinations when evaluating disability claims, the Veterans Service Center Manager requested TBI examinations take place prior to mental disorder examinations. By conducting TBI examinations first, the mental health provider has the opportunity to delineate psychiatric symptoms from TBI symptoms. Additionally, employees assigned to evaluate TBI disability claims have completed VBA's TBI training and VARO staff will continue to adhere to VBA's second-signature policy.

OIG Comment

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

II. Management Controls

Systematic Analysis of Operations

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of SAOs. We also considered whether VSC staff used adequate data to support 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 to 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.

Finding 2 **Oversight Is Needed To Ensure Timely and Complete Systematic Analyses of Operations**

Two of the 11 SAOs were incomplete (missing required elements) and/or untimely. This occurred because VARO management did not provide adequate oversight to ensure staff responsible for completing SAOs addressed all required elements or submitted the analyses by the due date. As a result, VARO management may not have adequately identified existing and potential problems for corrective action to improve VSC operations.

VARO management told us they were unaware that two SAOs did not address all required elements because they did not compare the completed SAOs against the required criteria. For example, the Claims Processing Timeliness SAO did not analyze or address several timeliness elements, such as claims pending over 6 months and 1 year. Further, this SAO was submitted 33 days beyond the required due date. During our inspection, VARO management initiated corrective actions to address the required missing elements; however, we were unable to assess the effectiveness of the revised SAOs.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Togus, ME* (Report No. 09-03659-111, dated March 23, 2010), we reported that VSC staff followed VBA policies by timely and accurately completing all required SAOs. Results of our current inspection indicated a downward trend in the VARO's ability to complete and submit SAOs by the due date.

Recommendation

2. We recommend the Togus VA Regional Office Director develop and implement a plan to ensure staff completely and timely address all required elements of Systematic Analyses of Operations.

Management Response

The VARO Director concurred with our recommendation. An interim due date to the Veterans Service Center Manager is now required prior to the Director's due date to ensure VARO staff complete SAOs timely. Additionally, at the start of each fiscal year, a management analyst will verify that all required elements are included in the SAO schedule.

OIG Comment

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

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, whenever an RVSR denies a Gulf War veteran service connection for any mental disorder, the RVSR also must consider whether the veteran is entitled to receive mental health treatment. RVSRs must address entitlement to mental health care in their decisions 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 Gulf War veterans' 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.

VSC staff completed 11 cases related to Gulf War veterans' entitlement to receive treatment for mental disorders from January to March 2013. Because the decisions we reviewed were accurately processed, we determined VARO staff followed VBA's policy when making mental health care treatment decisions for Gulf War veterans. Therefore, we make 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 regularly updating a resource directory of local homeless shelters, day-care facilities, and service providers. Additionally, the coordinators should attend regular meetings with local homeless service providers, community governments, and advocacy groups to provide information on VA benefits and services.

Management ensured adequate outreach to homeless veterans, shelters, and service providers by forming a committee of homeless coordinators consisting of several public contact outreach specialists. By using the committee approach, management maximized resources available to participate in community service events specific to homeless veterans in counties under the VARO's jurisdiction. Because the Togus VARO is not required to have a full-time coordinator, each member of the committee is assigned to participate in homeless outreach events one week per month in addition to their primary duties. VARO management discussed with us plans to add new homeless outreach events to the monthly schedule, including a collaborative effort with the Maine Department of Health and Human Services.

Because VARO outreach staff provided information on VA benefits and services to homeless shelters and service providers as required, we 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 Togus 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.

Resources

As of May 2013, the Togus VARO had a staffing level of 178.3 full-time employees. Of this total, the VSC had 74 employees assigned.

Workload

As of March 2013, the VARO reported 1,431 pending compensation claims. The average time to complete claims was 127.3 days—122.7 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 Togus 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 (24 percent) of 127 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 April 1, 2013. 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 9 of the total 13 TBI-related disability claims VARO staff completed from January through March 2013. Four of the 13 claims folders were unavailable for review because the folders were transferred to other offices for additional claims processing actions.

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 VAROs to adjust specific veterans' benefits. Processing any adjustments per this review is clearly a VBA program management decision.

We assessed the 11 mandatory SAOs the VARO completed in FY 2012 and FY 2013. We reviewed 11 of the 14 claims processed for Gulf War veterans from January through March 2013 to determine whether VSC staff had addressed entitlement to mental health treatment in the rating decision

documents as required. Three of the 14 claims folders were unavailable for review because the folders were transferred to other VA offices. 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 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 for our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders at the Togus VARO did not disclose any problems with data reliability.

This report references VBA's STAR data which places the overall accuracy of the VARO's compensation rating-related decisions at 93.9 percent, 3.9 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 activities inspected, applicable criteria, and whether or not we had reasonable assurance of VARO compliance.

Table 2. Togus 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 all disabilities related to in-service TBI.** (Fast Letter 08-34 and 08-36) (Training Letter 09-01)		X
Management Controls			
3. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)		X
Eligibility Determinations			
4. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War veterans' claims, considering entitlement to medical treatment for mental illness.** (38 USC 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: VAOIG
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 26, 2013

From: Director, VA Regional Office Togus, Maine

Subj: Inspection of the VA Regional Office, Togus, Maine

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

1. The Togus VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office,* Togus, Maine*.*
2. Please refer questions to Denise Benson, Veterans Service Center Manager at (207) 626-4788 ext. 5522.

(original signed by:)

SCOTT KARCZEWSKI

Attachment

Attachment

Recommendation 1: We recommend the Togus VA Regional Office Director develop and implement a plan to ensure staff returns insufficient medical examinations to obtain the evidence required to support traumatic brain injury evaluations.

Togus RO Response: Concur

While we generally concur with the findings with the Traumatic Brain Injury (TBI) rating decisions in the report, it should be noted neither TBI error called by the OIG inspection team resulted in a change of benefits to the Veterans.

In order to eliminate rating TBI cases on insufficient examinations the VSCM contacted the local VHA Exam Unit and requested all TBI Disability Benefit Questionnaires (DBQ) be conducted prior to the Mental Health DBQ. The VHA Exam Unit has accommodated this request. Having the examinations conducted in this order gives the mental health provider the opportunity to delineate the psychiatric symptoms thus preventing insufficient examinations.

Additionally, all employees rating TBI cases have completed the TBI training in TMS. The Rating Quality Review Specialists (RQRS) will continue to provide second signature reviews for all TBI cases until the RVSR has met the requisite 90 percent accuracy with 10 concurrent reviews.

Recommendation 2: We recommend the Togus VA Regional Office Director develop and implement a plan to ensure staff completely and timely address all required elements of Systematic Analyses of Operations.

Togus RO Response: Concur

It should be noted appropriate corrective action was taken while the OIG was on site. To complete SAOs timely, two due dates are set for each SAO element. The VSCM implemented a division due date set 14 days prior to the Director's due date.

To ensure all elements are included in the SAO schedule, the Director's Management Analyst will verify, prior to the start of every fiscal year, all the elements in the M21-4 correspond with the elements listed in the proposed SAO schedule.

Additional Comment: The OIG did not provide a recommendation regarding two errors they called regarding processing temporary 100 percent disability evaluations. It should be noted the Director of the Togus Regional Office does not concur with two errors the OIG inspection team called on temporary 100% evaluations. One error called was already corrected when the inspection team requested the claim folder for their review. The other error had a VA examination requested and was waiting for action to be taken by the Service Center when the OIG inspection team requested it. Both of these claims were on a list provided by Leadership and were acted upon in a timely manner. One of these claimed resulted in an overpayment to the Veteran. The errors called by the OIG for these two claims should be withdrawn. Further, it should be noted the Togus Regional Office was 100 percent compliant with completion of the list for temporary 100 percent evaluations.

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Nora Stokes, Director Kristine Abramo Robert Campbell Danny Clay Kyle Flannery Lee Giesbrecht Ambreen Husain Kerri Leggiero-Yglesias Nelvy Viguera Butler

Appendix E Report Distribution

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