VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Fargo, North Dakota

March 26, 2015
14-04622-150

ACRONYMS

FY	Fiscal Year
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SMC	Special Monthly Compensation
STAR	Systemic Technical Accuracy Review
TBI	Traumatic Brain Injury
VA	Department of Veterans Affairs
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of VA Regional Office Fargo, ND

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and a Veterans Service Center in Cheyenne, WY, that process disability claims and provide a range of services to veterans. We evaluated the Fargo VARO to see how well it accomplishes this mission. We conducted work at the VARO in October 2014.

What We Found

Overall, VARO staff did not accurately process 12 of 49 disability claims (24 percent) reviewed. We sampled 3 types of disability claims that we considered at increased risk of processing errors, temporary 100 percent disability evaluations, traumatic brain injury (TBI), and special monthly compensation (SMC) and ancillary benefits. Thus, these results do not represent the overall accuracy of disability claims processing at this VARO.

In our previous report, *Inspection of the VA Regional Office, Fargo, North Dakota* (Report No. 11-03724-73, January 25, 2012) we identified the most frequent processing errors associated with temporary 100 percent disability evaluations resulted from staff not establishing electronic controls needed to request medical reexaminations to reevaluate the severity of disabilities. During our October 2014 inspection, we did not identify similar errors. Therefore, we determined the VSC's actions in response to the national review plan have been effective.

VARO staff established correct dates of claim in the electronic record for 29 of the 30 claims we reviewed. However, staff did not timely or accurately complete 4 of 30 proposed benefits reduction cases.

What We Recommended

We recommended the Fargo VARO Director ensure staff review the 40 temporary 100 percent disability evaluations within the universe of claims that were pending at the VARO as of August 21, 2014, but not reviewed as part of our sample selection and take appropriate action. Further, the Director should ensure staff receive training regarding proper procedures for establishing permanent disability evaluations and assess the effectiveness of that training. The Director should implement a plan to ensure staff address all pending issues related to SMC and ancillary benefits.

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 VA 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.

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

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

Other Information

- Appendix A includes details on the Fargo 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 Fargo 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 evaluating the accuracy in processing the following three types of disability claims and determined their effect on veterans' benefits:

- Temporary 100 percent disability evaluations
- Traumatic brain injury (TBI) claims, and
- Special monthly compensation (SMC) and ancillary benefits.

We sampled claims related only to specific conditions that we considered at increased risk of claims processing errors. As a result, the errors identified do not represent the universe of disability claims or the overall accuracy rate at this VARO.

Finding 1 Fargo VARO Could Improve Processing of Three Types of Disability Claims

The Fargo VARO did not consistently process the three types of disability claims reviewed. Overall, VARO staff incorrectly processed 12 of the total 49 disability claims we sampled, resulting in 42 improper monthly payments to 2 veterans totaling approximately $10,144 at the time of our inspection in October 2014. Table 1 below reflects processing errors identified during our review.

Table 1. Fargo VARO Disability Claims Processing Accuracy for Three High-Risk Claims Processing Areas

Type of Claim	Claims Reviewed	Claims Inaccurately Processed: Affecting Veterans' Benefits	Claims Inaccurately Processed: Potential To Affect Veterans' Benefits	Claims Inaccurately Processed: Total
Temporary 100 Percent Disability Evaluations	30	1	5	6
TBI Claims	13	0	3	3
SMC and Ancillary Benefits	6	1	2	3
Total	**49**	**2**	**10**	**12**

Source: VA OIG analysis of the Veterans Benefits Administration's temporary 100 percent disability evaluations paid at least 18 months, TBI disability claims completed in the third quarter FY 2014, and SMC and ancillary benefits claims completed in July 2013 through June 2014

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 6 of 30 temporary 100 percent disability evaluations we reviewed. Veterans Benefits Administration (VBA) policy requires a temporary 100 percent disability evaluation for a veteran's service-connected disability following a 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 disabilities that are permanently and totally disabling, VBA policy requires VARO staff grant entitlement to Dependents' Educational Assistance. This additional benefit provides veterans' dependents with education and training opportunities.

Without effective management of these temporary 100 percent disability ratings, VBA is at an increased risk of paying inaccurate financial benefits. Available medical evidence showed 1 of 6 processing errors we identified affected a veteran's benefits and resulted in 24 improper monthly payments to this veteran totaling $7,108 from September 2012 to September 2014. Specifically, a Rating Veterans Service Representative (RVSR) did not grant service connection for bone cancer and entitlement to special monthly compensation for additional disabilities caused by the veteran's prostate cancer. In this case, VARO staff did not follow VBA policies as required. The remaining five of six total errors had the potential to affect veterans' benefits. Following are details on the five errors.

- In three cases, RVSRs incorrectly continued temporary 100 percent disability evaluations and requested future medical reexaminations although current medical evidence showed the veterans' conditions had progressed and were permanent. Instead of requesting future reexaminations in the electronic records, VSC staff should have granted entitlement to the additional benefit of Dependents' Educational Assistance as required. As a result, the veterans' dependents may not receive training and educational opportunities.
- In one case, an RVSR incorrectly continued a temporary 100 percent disability evaluation for prostate cancer without obtaining the required medical reexamination. According to VBA policy, a medical reexamination for this condition is required 6 months following treatment. Without current medical evidence, neither we nor VARO staff could determine the correct disability evaluation. As a result, there was increased risk that VA would overpay this veteran.
- VARO staff received a reminder notification to request a medical reexamination for a veteran's prostate cancer in March 2013. However, the medical reexamination did not occur until January 2014. As a result of not timely scheduling the reexamination, the veteran may have received improper monthly benefits.

Generally, processing inaccuracies occurred because VSC staff misinterpreted VBA policy related to establishing permanent 100 percent disability evaluations. Further, the VSC manager and staff stated policies for establishing a permanent 100 percent disability evaluation were unclear. VARO management concurred with five of the six errors we identified. For the remaining error, they did not agree that VBA policy required a permanent 100 percent disability evaluation for a veteran's incurable form of cancer. We disagree with this response. VBA policy clearly states that permanence of a total disability will exist when such impairment is reasonably certain to continue throughout the life of the disabled veteran.

As a result of VARO staff misunderstanding VBA policy related to establishing permanent 100 percent disability evaluations, veterans did not receive entitlement to the additional benefit of Dependents' Educational Assistance. We provided VARO management with 40 claims remaining from their universe of 70 for review to determine if action is required.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Fargo, North Dakota* (Report No. 11-03724-73, January 25, 2012) VARO staff incorrectly processed 23 of 30 temporary 100 percent disability evaluations we reviewed. The majority of the errors occurred because VARO management did not provide adequate oversight to ensure VSC staff entered suspense diaries in the electronic system to provide reminder notifications to schedule VA medical reexaminations. We did not provide a recommendation in this inspection report as VBA had implemented a national review plan to address this issue.

During our 2014 inspection, we identified one case where VSC staff did not input a suspense diary for a future VA medical reexamination in the electronic system. Therefore, we determined the VSC's action in response to the national review plan has been generally effective.

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. Additionally, VBA policy requires that employees assigned to the appeals team, the special operations team, and the quality review team complete training on TBI claims processing.

In response to a recommendation in our previous annual report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-167, May 18, 2011), VBA agreed to develop and implement a strategy for ensuring the accuracy of TBI claims 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 3 of 13 TBI claims—all 3 inaccuracies had the potential to affect veterans' benefits. Following are details explaining these errors.

- An RVSR incorrectly continued separate evaluations for a veteran's TBI and coexisting mental condition 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 the VA examiner cannot separate symptoms of TBI and a coexisting mental disorder. Because of the veteran's multiple service-connected disabilities, this error did not affect the veteran's monthly benefits. However, it has the potential to affect future benefits if the veteran's other service-connected disabilities worsen or if service connection is granted for a new disability.
- An RVSR prematurely denied a TBI claim without obtaining a VA medical examination. The veteran was in combat and his VA treatment records supported that he sustained a head injury from an explosion in service and continues to have symptoms. VARO staff did not review the VA treatment records as required. VBA policy requires staff to obtain a medical examination when the evidence of record contains an event or injury in service and associated symptoms of disability, but does not contain sufficient medical evidence to decide the claim. Without a VA medical examination, we nor VBA could not determine if the veteran would have been entitled to benefits.
- An RVSR used the incorrect SMC code for a veteran entitled to an additional aid and attendance allowance due to residuals of TBI. Although the error did not affect the veteran's current monthly benefits, this code determines the veteran's monthly benefits payments if the veteran becomes hospitalized at Government expense. As a result, VBA would reduce their monthly payments incorrectly if this error is not corrected.

VARO management nonconcurred with two of the three errors we identified. In the first case, the VSC manager did not concur with the error and stated staff properly decided the claim because the veteran did not identify VA treatment. The VSC manager stated RVSRs are not required to review VA treatment records unless the veteran identifies them. We disagree with this response. VA treatment records that affect the outcome of a veteran's claim are considered relevant evidence in VA's possession. In this case, the evidence shown in the VA treatment records warranted an examination for a combat veteran.

In the second case, the VSC manager stated that because VBA has not provided staff with adequate guidance on how to code SMC for aid and attendance due to residuals of TBI, it was not an error. We disagree with this response. VBA policy states that when a veteran entitled to the aid and attendance allowance is hospitalized, the benefits payments will be reduced to what would be payable without consideration of aid and attendance. In this case, the SMC code did not reflect what would be payable without consideration of aid and attendance if the veteran was hospitalized at Government expense.

The three TBI claims processing inaccuracies identified within our selected sample were unique and did not constitute a common trend, pattern, or systemic issue. As such, we are making no specific recommendation for this VARO.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Fargo, North Dakota* (Report No. 11-03724-73, January 25, 2012), we identified two TBI claims processing inaccuracies that were unique and did not constitute a common trend, pattern, or systemic issue. As such, we made no recommendation for improvement in this area.

Special Monthly Compensation and Ancillary Benefits

As the concept of rating disabilities evolved, it was realized that for certain types of disabilities, the basic rate of compensation was not sufficient for the level of disability present. Therefore, SMC was established to recognize the severity of certain disabilities or combinations of disabilities by adding an additional compensation to the basic rate of payment. SMC represents payments for "quality of life" issues such as the loss of an eye or limb, or the need to rely on others for daily life activities, like bathing or eating. Generally, VBA grants entitlement to SMC when the following conditions exist.

- Anatomical loss or loss of use of specific organs, sensory functions, or extremities
- Disabilities that render the veteran permanently bedridden or in need of aid and attendance
- Combinations of severe disabilities that significantly affect locomotion
- Existence of multiple, independent disabilities evaluated as 50 to 100 percent disabling
- Existence of multiple disabilities that render the veteran in need of such a degree of special skilled assistance that, without it, the veteran would be permanently confined to a skilled-care nursing home

Ancillary benefits are secondary benefits that are considered when evaluating claims for SMC. Examples of ancillary benefits are:

- Dependents' Educational Assistance under section 35, title 38, United States Code, Chapter 35
- Specially Adapted Housing Grants
- Special Home Adaptation Grants
- Automobile and Other Conveyance and Adaptive Equipment Allowance

VBA policy requires staff to address the issues of SMC and ancillary benefits whenever they can grant entitlement. We examined whether VARO staff accurately processed entitlement to SMC and ancillary benefits associated with anatomical loss, loss of use of two or more extremities, or bilateral blindness with visual acuity of 5/200 or worse.

Special Monthly Compensation Errors

VARO staff incorrectly processed three of six veterans' claims involving SMC and ancillary benefits—one error affected a veteran's benefits. In this case, an RVSR did not grant a higher level of SMC for a veteran with anatomical loss of one foot and loss of use of one hand with additional permanent disabilities evaluated at 50 percent disabling, as required. As a result, VA underpaid the veteran $3,036 from June 2008 to December 2009, spanning a period of 18 months.

Ancillary Benefit Errors

The remaining two errors had the potential to affect veterans' benefits. Following are details on those errors.

- An RVSR did not grant entitlement to an automobile and adaptive equipment allowance, a benefit currently worth up to $20,114. This error did not affect the veteran's current monetary payments because once VBA grants entitlement the veteran must apply for these benefits.
- An RVSR used the incorrect SMC code for a veteran entitled to an additional aid and attendance allowance due to residuals of TBI. Although the error did not affect the veteran's current monthly benefits, this code determines the veteran's monthly benefits payments if the veteran should become hospitalized at Government expense. As a result of this coding error, VBA would reduce monthly payments incorrectly should hospitalization at Government expense occur. This error was also identified in our TBI universe; the inaccuracy is included in both claims processing areas.

Generally, these errors occurred due to a lack of recent training. The training records from 2013 and 2014 provided by VARO staff revealed not all staff received training on higher levels of SMC and ancillary benefits during the last 2 years. According to the VSC manager and staff, training was canceled in May 2013 due to other mandatory training requirements and workload issues.

During our inspection, VARO staff received SMC training from a member of VBA's Systematic Technical Accuracy Review (STAR) staff. Two of the errors occurred in rating decisions made prior to the recent training and VARO staff stated that they do not routinely look for missed issues related to SMC and ancillary benefits since they don't frequently process these cases. We reviewed a copy of the training conducted by STAR personnel and found that it covered some of the types of errors that we identified including how to review previous decisions in order to easily identify missed issues. Interviews with VARO staff indicated they do not feel comfortable rating these complex cases. VARO management and staff informed us that the Fargo VARO does not require a second-level review on higher level SMC cases.

VBA policy allows the VSC manager the discretion to require a second-level review for SMC claims. However, the training conducted by STAR staff during our inspection recommended that, at a minimum, a peer should review higher level SMC cases and frequent refresher training be conducted due to the difficulty of these cases. As a result of this lack of training and familiarity of the processing requirements for these cases, veterans did not always receive correct SMC benefits payments and may not be aware they are entitled to ancillary benefits.

Recommendations

1. We recommended the Fargo VA Regional Office Director provide training and assess the effectiveness of that training, to ensure staff properly establish permanent disability evaluations when required.

2. We recommended the Fargo VA Regional Office Director conduct a review of the 40 temporary 100 percent disability evaluations remaining from their universe as of August 21, 2014, and take appropriate action.

3. We recommended the Fargo VA Regional Office Director implement a plan to ensure staff address all pending issues related to SMC and ancillary benefits.

Management Comments

The VARO Director concurred with our recommendations and in November 2014, discussed all errors found during the OIG inspection with staff. The Director indicated that monthly consistency studies will be conducted to ensure staff properly establish permanent evaluations. Further, employees not passing the consistency study will take required remedial training and testing. VARO staff completed their review of temporary 100 percent disability evaluations and has taken the proper actions on these cases. The Director also stated VARO staff received SMC training in October 2014 and February 2015.

OIG Response

The Director's comments and actions are responsive to the recommendations. The VARO Director provided several documents to address our recommendations. We will review each document and determine if the processes or procedures described within adequately address our recommendations. We will follow up on management's actions during future inspections.

II. Data Integrity

Dates of Claim

To ensure all claims receive proper attention and timely processing, VBA policy directs staff to use the earliest date stamp shown on the claim document as the date of claim. VBA relies on accurate dates of claim to establish and track key performance measures, including the average days to complete a claim. We focused our review on whether VSC staff followed VBA policy for establishing dates of claim in the electronic record.

VARO staff established correct dates of claim in the electronic records for 29 of the 30 claims we reviewed. In the remaining case, the date of claim was incorrectly established in an electronic record. While the VSC manager did not concur with this error, she did acknowledge the delay. When asked what corrective action would be taken to ensure the date of claim is corrected, they stated the date would be changed when the benefit payment award is processed. As a result, we determined the VARO is following VBA policy, and we made no recommendation for improvement in this area.

III. Management Controls

Benefits Reductions

VBA policy provides for compensation to veterans for conditions they incurred or aggravated during military service. The amount of monthly compensation to which a veteran is entitled may change because his or her service-connected disability may improve. Improper payments associated with benefits reductions generally occur when beneficiaries receive payments to which they are not entitled. Such instances are attributable to VAROs not taking the actions required to ensure veterans receive correct payments for their current levels of disability.

When the VARO obtains evidence that a lower disability evaluation would result in a reduction or discontinuance of current compensation payments, VSC staff must inform the beneficiary of the proposed reduction in benefits. In order to provide beneficiaries due process, VBA allows 60 days for the veteran to submit additional evidence to show that compensation payments should continue at their present level. If the veteran does not provide additional evidence within that period, an RVSR must make a final determination to reduce or discontinue the benefit. On the 65th day following due process notification, action is required to reduce the evaluation and thereby minimize overpayments.

On April 3, 2014, VBA leadership modified its policy regarding the processing of claims requiring benefits reductions. The new policy no longer includes the requirement for VARO staff to take "immediate action" to process these reductions. In lieu of merely removing the vague standard, VBA should have provided clearer guidance on prioritizing this work to ensure sound financial stewardship of these monetary benefits.

Finding 2 VARO Lacked Oversight To Ensure Timely Action on Proposed Benefits Reductions

VARO staff delayed or incorrectly processed 4 of 30 cases involving benefits reductions—2 affected veterans' benefits and 2 had the potential to affect veterans' benefits. Processing inaccuracies resulted in overpayments totaling approximately $678, representing two improper monthly payments to two veterans from July 2014 to August 2014.

Processing Delays

Processing delays occurred in 2 of 30 claims that required rating decisions to reduce benefits. In the case with the most significant overpayment, VSC staff sent a letter to the veteran on February 21, 2014, proposing to reduce the disability evaluation for the veteran's left leg condition. The due process period expired on April 28, 2014. However, staff did not take action to reduce the evaluation until May 22, 2014. As a result, VA overpaid the veteran approximately $486 over a period of 1 month. Due to generally

processing benefits reductions cases timely, we made no recommendation for improvement in this area.

The VSC manager nonconcurred with the two processing delay errors we identified. The VSC manager stated that it is clearly the intent of the VBA criteria to allow delays based on workload management issues. We disagree with this response. VBA criteria requires action on the 65th day following due process notification with the only allowance for delays based on either a hearing request from the veteran, or a need for development for more evidence. In the nonconcurred cases, neither met the provisions outlined in VBA's policy that allow for an extension to complete this work.

Accuracy Errors

VARO staff incorrectly processed 2 of 30 cases involving proposed benefits reductions. These cases had the potential to affect veterans' benefits. Details on these errors follow.

- An RVSR incorrectly reduced a disability evaluation from 100 percent to 0 percent without obtaining a VA examination as required. Without current medical evidence, neither we nor VARO staff could determine the correct disability evaluation.
- An RVSR continued the 50 percent disability evaluation for the veteran's mental health condition but incorrectly requested VARO staff schedule a future medical reexamination in 5 years. Since the VARO continued the evaluation, which had been in place for 5 years, and scheduled a medical reexamination, VARO staff are required to schedule that reexamination within 18, 24, or 30 months. As a result of incorrectly scheduling the reexamination, the veteran may receive improper monthly benefits.

Both accuracy errors identified within our selected sample were unique and did not constitute a common trend, pattern, or systemic issue. As such, we made no recommendation for improvement in this area.

Appendix A VARO Profile and Scope of Inspection

Organization

The Fargo VARO administers a variety of services and benefits, including compensation and pension benefits; vocational rehabilitation and employment assistance; specially adapted housing grants; benefits counseling; fiduciary and guardianship services; public affairs; and outreach to homeless, elderly, minority, and women veterans.

Resources

As of June 2014, the Fargo VARO reported a staffing level of 46 full-time employees. Of this total, the VSC had 37 employees assigned.

Workload

As of August 2014, VBA reported the Fargo VARO had 1,273 pending compensation claims pending with 515 (40 percent) pending greater than 125 days.

Scope and Methodology

VBA has 56 VAROs and a VSC in Cheyenne, WY, that process disability claims and provide a range of services to veterans. In September and October 2014, we evaluated the Fargo 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 coordinated with VA OIG criminal investigators to provide a briefing designed to alert VARO staff to the indicators of fraud in claims processing.

Our review included 30 of 70 temporary 100 percent disability evaluations (43 percent) 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 August 21, 2014. This is generally the longest period a temporary 100 percent disability evaluation may be assigned without review, according to VBA policy. We provided VARO management with 40 claims remaining from their universe of 70 claims as of August 21, 2014, but not reviewed as part of our sample selection and take appropriate action. We reviewed all 13 disability claims related to TBI that the VARO completed from April through June 2014. We examined all 6 veterans' claims involving entitlement to SMC and related ancillary benefits completed by VARO staff from July 2013 through June 2014.

We reviewed 30 of 735 dates of claim (4 percent) recorded in VBA's Corporate Database from July 2, 2014, through October 1, 2014, pending as of October 14, 2014. Additionally, we looked at 30 of 63 completed claims (48 percent) that proposed reductions in benefits from April through June 2014.

Data Reliability

We used computer-processed data from the Veterans Service Network's Operations Reports and Awards. To test for reliability, we reviewed the data to determine whether any data were missing from key fields, included any calculation errors, or were outside the time frame requested. We also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Further, we compared veterans' names, file numbers, Social Security numbers, VARO numbers, dates of claim, and decision dates as provided in the data received with information contained in the 109 claims folders we reviewed related to temporary 100 percent disability evaluations, TBI claims, SMC and ancillary benefits, dates of claim, and completed claims related to benefits reductions.

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 in conjunction with our inspection of the VARO did not disclose any problems with data reliability.

This report references VBA's STAR data. As reported by STAR as of August 2014, the overall claims-based accuracy of the VARO's compensation rating-related decisions was 91.8 percent. We did not test or rely upon the reliability of these 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.*

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. Fargo VARO Inspection Summary

Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance
Disability Claims Processing		
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)	No
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)	No
Special Monthly Compensation and Ancillary Benefits	Determine whether VARO staff properly processed SMC and correctly granted entitlement to ancillary benefits. (38 CFR 3.350, 3.352, 3.807, 3.808, 3.809, 3.809a, 4.63, and 4.64), (M21-1MR IV.ii.2.H and I)	No
Data Integrity		
Dates of Claim	Determine whether VARO staff accurately established claims in the electronic records. (38 CFR 3.1 (p) and (r)), (M21-4, Appendixes A and B), (M21-1MR, III.ii.1.C.10.a), (M21-1MR, III.ii.1.B.6 and 7), (M21-1MR, III.ii.2.B.8.f), (M21-1MR, III.i.2.A.2.c) (*VBMS User Guide*), (M21-4, Chapter 4.07), (M23-1, Part 1, 1.06)	Yes
Management Controls		
Benefits Reductions	Determine whether VARO staff timely and accurately processed disability evaluation reductions or terminations. (38 CFR 3.103(b)(2)), (38 CFR 3.105(e)), (38 CFR 3.501), (M21-1MR.IV.ii.3.A.3.e), (M21-1MR.I.2.B.7.a), (M21-1MR.I.2.C), (M21-1MR.I.ii.2.f), (M21-4, Chapter 2.05(f)(4)), (*Compensation & Pension Service Bulletin*, October 2010)	No

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: February 10, 2015

From: Director, VA Regional Office Fargo, North Dakota

Subj: Inspection of the VA Regional Office, Fargo, North Dakota

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

1. The Fargo VA Regional Office has reviewed the draft report for *the Inspection of the VA Regional Office, Fargo, North Dakota*.

2. Fargo concurs with the findings and recommendations. Corrective action for each recommendation is provided on attachment.

3. Please refer questions to James Brubaker, Director, at 605-333-6839 or james.brubaker@va.gov.

(original signed by:)

JAMES L. BRUBAKER, Director
Dakotas Regional Office

Attachment

Inspection of the VA Regional Office, Fargo, North Dakota
DRAFT Report Issued February 4, 2015

Recommendation 1: We recommend the Fargo VA Regional Office Director provide training and asses the effectiveness of training, to ensure staff properly establish permanent disability evaluations required.

Response: Concur with recommendation. Errors found on OIG Inspection of the Fargo VA Regional Office were discussed with all staff on 11-06-14. Monthly consistency studies also address this issue. Employees not passing consistency study take required remedial training and testing.

Recommendation 2: We recommend the Fargo VA Regional Office Director conduct review of the 40 temporary 100 percent disability evaluations remaining from their universe as of August 21, 2014, and take appropriate action.

Response: Concur with recommendation. Remaining universe of temporary 100 percent evaluations have been reviewed and findings annotated on attached list. All cases have a proper future examination, have been reduced, or granted entitlement to Chapter 35.

Recommendation 3: We recommend the Fargo VA Regional Office Director implement a plan to ensure staff address all pending issues related to SMC and ancillary benefits.

Response: Concur with recommendation. Errors found on OIG Inspection of the Fargo VA Regional Office were discussed with all staff on 11-06-14. SMC training was provided by STAR staff on 10-21-14 and by station staff on 02-05-15 (TMS#592939). Training sign in sheets attached. Additional higher level SMC is scheduled for 2-12-15 (TMS#1209944) as noted on attached FY15 Training Plan.

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	Brent Arronte, Director Orlan Braman Daphne Brantley Bridget Byrd Sandra Parsons Jason Reyes Dana Sullivan Nelvy Viguera Butler Claudia Wellborn

Appendix E Report Distribution

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