VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Louisville, Kentucky

May 24, 2011
11-00520-174

ACRONYMS AND ABBREVIATIONS

C&C	Confirmed and Continued
COVERS	Control of Veterans Records System
NOD	Notice of Disagreement
OIG	Office of Inspector General
PTI	Permanent Transfer In
PTSD	Post-Traumatic Stress Disorder
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
TTO	Temporary Transferred Out
VACOLS	Veterans Appeals Control and Locator System
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the VA Regional Office, Louisville, Kentucky

Why We Did This Review

The Benefits Inspection Division conducts onsite inspections at VA Regional Offices (VAROs) to review disability compensation claims processing and Veterans Service Center operations.

What We Found

Louisville VARO management ensured staff followed Veterans Benefits Administration's policy for correctly establishing dates of claims and processing incoming mail. Further, the average time for the VARO to complete claims was 114.8 days, 60.2 days better than the national target of 175 days. VARO performance was generally effective in processing post-traumatic stress disorder and herbicide exposure-related disability claims, establishing correct effective dates, timely completing Systematic Analyses of Operations, and correcting errors identified by the Systematic Technical Accuracy Review program.

VARO management lacked effective controls and accuracy in processing temporary 100 percent disability evaluations and traumatic brain injury claims. Overall, VARO staff did not accurately process 34 (31 percent) of the 110 disability claims reviewed. Further, in the Triage Team mail management was not fully effective.

Although VARO staff were not timely in recording Notices of Disagreement for appealed claims, they were better than the national average for appeals processing timeliness. Further, processing of competency determinations was not always accurate; however, VARO management's recent training of Veterans Service Center staff is a positive step toward addressing this deficiency.

What We Recommended

We recommended Louisville VARO management implement controls to ensure the Veterans Service Center staff establishes suspense diaries to request the medical reexaminations for temporary 100 percent disability reevaluations as required. Management should provide refresher training and implement a plan to improve quality review of traumatic brain injury claims.

VARO management needs to implement a plan to ensure oversight and control of mail handling. Finally, VARO management also needs to implement a plan to monitor effectiveness and adequacy of the training on proper processing of competency determinations.

Agency Comments

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

(original signed by:)

BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

The Benefits Inspection Program is part of the efforts of the Office of Inspector General (OIG) to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Division contributes 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 if 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 standard coverage, inspections may examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

Scope of Inspection

In February 2011, the OIG conducted an inspection of the Louisville VARO. The inspection focused on 5 protocol areas examining 10 operational activities. The five protocol areas were disability claims processing, data integrity, management controls, workload management, and eligibility determinations.

We reviewed 80 (15 percent) of 548 disability claims related to post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and herbicide exposure that the VARO completed from October through December 2010. In addition, we reviewed 30 (13 percent) of 231 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months, generally the longest period a temporary 100 percent disability evaluation may be assigned under VA policy without review.

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

RESULTS AND RECOMMENDATIONS

1. Disability Claims Processing

The OIG inspection team focused on disability claims processing related to temporary 100 percent disability evaluations, PTSD, TBI, and herbicide exposure. We evaluated claims processing accuracy and its impact on veterans' benefits.

Finding 1 VARO Staff Need to Improve Disability Claims Processing Accuracy

The Louisville VARO needs to improve the accuracy of disability claims processing. VARO staff incorrectly processed 34 (31 percent) of the total 110 disability claims reviewed. VARO management agreed with our findings and initiated action to correct the inaccuracies identified.

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

Table

Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Disability Evaluations	30	25	9	16
PTSD	30	2	1	1
TBI	20	6	0	6
Herbicide Exposure-Related Disabilities	30	1	1	0
Total	**110**	**34**	**11**	**23**

Source: VA OIG

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 25 (83 percent) of 30 temporary 100 percent disability evaluations we reviewed. Veterans Benefits Administration (VBA) policy requires a temporary 100 percent disability evaluation for a service-connected disability following surgery or when specific treatment is needed. At the end of a mandated period of

convalescence or cessation of treatment, VARO staff may request a follow-up medical examination to help determine whether to continue a veteran's 100 percent disability evaluations.

For temporary 100 percent disability evaluations, including those where rating decisions do not change a veteran's payment amount (confirmed and continued evaluations), VSC staff must input suspense diaries to VBA's electronic system. A suspense diary is a processing command that establishes a date when VSC staff must schedule a reexamination. As a suspense diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the reexamination.

Based on analysis of available medical evidence, 9 of the 25 processing inaccuracies affected veterans' benefits—all 9 involved overpayments totaling $596,484. Two examples of the most significant overpayments follow.

- VARO staff did not schedule a follow-up examination to evaluate a veteran's prostate cancer. Treatment reports from the Lexington VA Medical Center warranted a reduction in benefits as of January 1, 2005. As a result, VA overpaid the veteran $152,884 over a period of 6 years and 2 months.
- VARO staff did not schedule a follow-up examination to evaluate a veteran's prostate cancer. Medical evidence in the claims folder warranted a reduction in benefits as of March 1, 2007. As a result, VA overpaid the veteran $114,480 over a period of 4 years and 4 months.

The remaining 16 inaccuracies had the potential to affect veterans' benefits. Following are summaries of these inaccuracies.

- In ten cases, VSC staff did not schedule the follow-up medical examinations needed to determine whether the temporary 100 percent disability evaluations should continue.
- In four cases, VSC staff correctly established suspense diaries to request reexaminations. However, at the time of our inspection the staff had taken no action to schedule the follow-up medical examinations.
- In one case, an RVSR continued a temporary 100 percent disability evaluation and annotated the need for future reexamination. However, VSC staff did not establish a suspense diary to schedule the follow-up medical examination.
- In one case, an RVSR continued a temporary 100 percent disability evaluation and annotated an incorrect reexamination date.

An average of approximately 2 years and 4 months elapsed from the time staff should have scheduled these medical examinations until the date of our inspection—the date staff ultimately ordered the examinations to obtain the necessary medical evidence. The delays ranged from approximately 1 month to 6 years and 2 months.

Twenty of the 25 errors resulted from staff not establishing suspense diaries when processing rating decisions requiring temporary 100 percent disability reexaminations. Thirteen of these errors involved confirmed and continued (C&C) rating decisions. When processing these types of ratings, the staff does not always create an electronic award for benefits. In November 2009, VBA provided guidance reminding VAROs about the need to add a suspense diary in the electronic record for C&C rating decisions. VARO management had no procedure in place requiring that VSC staff review the C&C rating decisions to ensure VSR's properly established suspense diaries in VBA's electronic system to generate reminder notifications to schedule reexaminations.

PTSD Claims

VARO staff incorrectly processed 2 (7 percent) of 30 PTSD claims we reviewed. One of the errors affected a veteran's benefits. Following are summaries of these inaccuracies.

- An RVSR continued the evaluation of a veteran's service-connected PTSD and granted entitlement to special monthly compensation based on multiple disabilities. However, according to VBA policy the veteran was not entitled to special monthly compensation. As a result, VA overpaid the veteran $9,546 over a period of 2 years and 6 months.
- An RVSR did not grant service connection for an associated mental disorder diagnosed through a veteran's examination for PTSD. Granting service connection for an additional mental disorder would not change the overall assigned evaluation but may affect future evaluations for additional benefits.

Because we did not consider the frequency of errors significant, we determined the VARO generally followed VBA policy related to PTSD claims. Therefore, we made no recommendations for improvement in this area.

TBI Claims

The Department of Defense and VBA commonly define a TBI as traumatically induced structural injury or 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.

VARO staff incorrectly processed 6 (30 percent) of 20 TBI claims. All of these processing inaccuracies had the potential to affect veterans' benefits. For all six claims, RVSRs prematurely granted service connection for TBI-related residuals based on inadequate VA medical examinations. According to VBA policy, when a medical examination report does not address all required elements, VSC staff should return it to the issuing clinic or healthcare facility as insufficient for rating purposes. Neither VARO staff nor we can ascertain all of the residual disabilities related to a TBI without adequate or complete medical evidence.

Generally, errors associated with TBI claims processing occurred because VSC staff incorrectly interpreted VBA policy. In addition, insufficient TBI examination reports and inadequate training negatively affected accuracy in rating TBI disability claims. As a result, RVSRs did not properly evaluate TBI-related residuals.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 1 (3 percent) of 30 herbicide exposure-related claims we reviewed. In this case, an RVSR incorrectly evaluated residuals of prostate cancer as 20 percent disabling. Medical evidence showed residuals warranting a 40 percent evaluation. As a result, VA underpaid the veteran $1,888 over a period of 7 months.

Because we found only one inaccuracy, we determined the VARO generally followed VBA policy related to herbicide exposure-related claims. Therefore, we made no recommendations for improvement in this area.

Recommendations

1. We recommend the Louisville VA Regional Office Director conduct refresher training and implement controls to ensure staff establish suspense diaries for temporary 100 percent disability reevaluations.
2. We recommend the Louisville VA Regional Office Director conduct refresher training and develop and implement a plan to improve the quality review process for traumatic brain injury claims.

Management Comments

The VARO Director concurred with our recommendations. The Director stated in May 2011 the VARO will provide training to Veterans Service Representatives on establishing suspense diaries and will conduct monthly reviews to ensure compliance. Additionally, the VARO provided refresher training to RVSRs on proper processing of temporary 100 percent disability evaluations and TBI-related claims. The Director stated the VSC Exam Coordinator will work closely with the VA Medical Centers to ensure TBI medical examinations are sufficient for rating purposes.

OIG Response

Management's actions are responsive to the recommendations. We will follow up as required on all actions.

A draft of this inspection report included an additional recommendation that the VA Regional Office Director review the remaining temporary 100 percent disability evaluations identified but not included in our inspection sample to determine if reevaluations are required and take appropriate action. We have removed the recommendation from this individual VARO inspection report since the Acting Under Secretary for Benefits has already concurred with a corresponding recommendation in our national report, "Veterans Benefits Administration: Audit of 100 Percent Disability Evaluations," (Report Number 09-03359-71, January 24, 2011).

The Acting Under Secretary for Benefits has agreed to review all temporary 100 percent disability evaluations and ensure each evaluation has a future exam date entered in the electronic record. The Acting Under Secretary explained that VBA's national review plan entails use of three medical diagnostic codes to comprise a sample for testing whether future examination dates are established in the electronic record. Those diagnostic codes relate to Non-Hodgkin's Lymphoma, Malignant Neoplasms of the Genitourinary System, and Post-traumatic Stress Disorder. Further, the Acting Under Secretary stated, "the remainder of the cases will be identified through a batch process, and VBA will establish the appropriate future diary controls electronically."

While the Acting Under Secretary for Benefits' national review plan differs from the approach we previously recommended in a draft of this VARO inspection report, we believe the intent is the same. Removing the recommendation from our draft inspection report will allow VBA time to implement its national plan for reviewing all temporary 100 percent disability evaluations to correct processing errors. The target completion date is September 30, 2011, as the Acting Under Secretary for Benefits previously indicated.

We have requested from VBA's Office of Field Operations a copy of both VBA's national review plan for sample testing using the diagnostic codes specified above, as well as a documented explanation of its batch process for identifying the remaining cases and establishing appropriate future diary controls electronically. We will use such information to monitor implementation progress and gauge effectiveness of VBA's national review plan approach as we move forward in conducting our individual VARO inspections. Based on the magnitude of errors and associated financial risks we have identified in temporary 100 percent disability evaluation processing to date, we have an ongoing responsibility to exercise continued oversight in this area.

2. Data Integrity

Effective Dates

We analyzed claims folders to determine if the VARO was following VBA policy to establish correct effective dates in the electronic record. Generally, an effective date indicates when entitlement to a specific benefit arose. VARO staff incorrectly established an effective date for 1 (1 percent) of 110 disability claims we reviewed. The incorrect effective date did not affect the veteran's benefits.

Because we found only one inaccuracy, we determined the VARO is generally following VBA policy regarding effective dates. Therefore, we made no recommendations for improvement in this area.

Dates of Claim

We analyzed claims folders to determine if the VARO was following VBA policy to establish correct dates of claim in the electronic record. In addition to establishing a timeframe for benefits entitlement, VBA generally uses a date of claim to indicate when a document arrives at a VA facility. VBA relies on accurate dates of claim to establish and track key performance measures, including the average days to complete a claim.

VARO staff established the correct dates of claim in the electronic record for all 30 claims we reviewed. As a result, we determined the VARO is following VBA policy and we made no recommendations for improvement in this area.

Notices of Disagreement

We analyzed claims folders to determine if the VARO is following VBA policy to timely record Notices of Disagreement (NODs) in the Veterans Appeals Control and Locator System (VACOLS). An NOD is a written communication from a claimant expressing dissatisfaction or disagreement with a benefits decision and a desire to contest the decision. An NOD is the first step in the appeals process. VACOLS is a computer application that allows VARO staff to control and track a veteran's appeal and manage the pending appeals workload. VBA policy states staff must create a VACOLS record within 7 days of receiving an NOD. Accurate and timely recording of NODs is required to ensure appeals move through the appellate process expeditiously.

VARO staff did not meet this standard for 5 (17 percent) of the 30 NODs we reviewed. Staff took an average of 12 days to record these five disagreements in VACOLS. However, as of January 31, 2011, the VARO's NODs have been pending completion an average of 123 days, which is 126 days below the national average of 249 days. Therefore, we made no recommendations for improvement in this area.

3. Management Controls

Systematic Technical Accuracy Review

We assessed management controls to determine if VARO management adhered to VBA policy regarding correction of errors identified by VBA's Systematic Technical Accuracy Review (STAR) staff. The STAR program is VBA's multi-faceted quality assurance program to ensure veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires the VARO take corrective action on errors that STAR identifies.

VARO staff did not correct 1 (5 percent) of 19 errors identified by VBA's STAR program from July through September 2010. VARO management reported to STAR staff it had completed the corrective action needed. However, our review of the claims folder showed VSC staff had done nothing to address the error. The error had no impact on the claimant's benefit. Because Louisville VARO management generally followed VBA policy regarding correction of STAR errors, we made no recommendations for improvement in this area.

Systematic Analysis of Operations

We assessed controls to determine whether VARO management had controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs). An SAO is a formal analysis of a VSC 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.

One (8 percent) of the 12 SAOs was incomplete at the time of our inspection. The Appeals SAO was incomplete because VSC management did not review all required areas. VARO management generally followed VBA policy regarding SAOs so we made no recommendations for improvement in this area.

4. Workload Management

Mailroom Operations

We assessed controls over VARO mailroom operations to ensure staff timely and accurately processed incoming mail. VBA policy states staff will open, date stamp, and route all mail to the appropriate locations within 4–6 hours of receipt at the VARO. The Louisville VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the VSC's Triage Team. The mailroom staff was timely and accurate in processing, date stamping, and delivering VSC mail to the Triage Team control point daily. As a result, we determined the mailroom is following VBA policy and made no recommendations for improvement in this area.

Triage Mail Processing Procedures

We assessed the VSC's Triage Team mail processing procedures to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy. The VARO staff is required to use VBA's tracking system, Control of Veterans Records System (COVERS), to electronically track veterans' claims folders and control search mail. VBA defines search mail as active claims-related mail waiting to be associated with a veteran's claims folder. Conversely, drop mail requires no processing action upon receipt. VBA policy allows the use of a storage area, known as the Military File, to hold mail temporarily when the staff is not able to identify an associated claims folder in the system.

VBA policy defines permanent transfer in (PTI) mail as search mail received in Triage for claims folders located in other regional offices or Federal records storage centers. Additionally, temporary transferred out (TTO) mail is search mail for claims folders provided by the VARO to another VA facility for a limited length of time. VARO staff must control the mail using a specific function in COVERS.

Finding 2 Triage Team Mail Management Procedures Need Strengthening

The Triage Team staff did not properly manage 24 (19 percent) of 129 pieces of mail, we reviewed. The most significant errors occurred when staff did not control through COVERS 23 (77 percent) of 30 pieces of PTI/TTO mail reviewed. At the time of our inspection, approximately 1,000 pieces of PTI/TTO mail were pending. The most egregious error occurred when the VARO received a claim on August 6, 2010. Although the Triage Team staff requested the claims folder from a Federal records storage facility, they did not control the mail in COVERS. Additionally, the Triage Team staff did not set-up a control mechanism, known as an end product in the electronic record, which would track the claim as required.

The above errors occurred because VARO management misinterpreted the definition of search mail. VARO management also did not incorporate procedures for the proper processing of PTI/TTO mail in its local mail plan. As a result, untimely association of mail with veterans' claims folders can cause delays in processing benefits claims and beneficiaries may not receive accurate and timely benefits payments.

Recommendation

3. We recommend the Louisville VA Regional Office Director develop and implement a plan to ensure control of Triage Team permanent transfer in and temporary transfer out mail.

Management Comments

The VARO Director concurred with our recommendation. The Director stated the VSC has a distinct location for storing mail that needs to be associated with claims folders that have been temporarily transferred off

station. The VSC staff checks this location for mail when the corresponding claims folders are returned to the VARO. The Director stated that based on our findings, the VSC tightened controls over this mail to ensure it is timely associated with related claims folders upon receipt at the VARO.

OIG Response Management's actions are responsive to the recommendation. We will follow up as required on all action.

5. Eligibility Determinations

Competency Determinations VA must consider beneficiary competency in every case involving a mental health condition that is totally disabling or when evidence raises questions as to a beneficiary's mental capacity to manage his or her affairs. The Fiduciary Unit supports implementation of competency determinations by appointing a fiduciary, which is a third party that assists in managing funds for an incompetent beneficiary. We reviewed competency determinations made at the VARO to ensure staff completed them accurately and timely. Delays in making these determinations ultimately affect the Fiduciary Unit's ability to be timely in appointing fiduciaries.

VBA policy requires staff to obtain clear and convincing medical evidence that a beneficiary is incapable of managing his or her affairs prior to making a final competency decision. The policy allows the beneficiary a 65-day due process period to submit evidence showing an ability to manage funds and other personal affairs. At the end of the due process period, VARO staff must take immediate action to determine if the beneficiary is competent.

In the absence of a definition of "immediate," we allowed 14 calendar days after the due process period to determine if staff were timely in completing a competency decision. We considered this a reasonable period to control, prioritize, and finalize these types of cases.

Finding 3 Controls over Competency Determinations Need Strengthening

VARO staff unnecessarily delayed final decisions in 11 (37 percent) of 30 competency determinations completed from October through December 2010. The delays ranged from 15 to 188 days, with an average completion time of 53 days. Delays occurred because the VSC workload management plan did not contain procedures emphasizing immediate completion of competency determinations and managers were not aware of timeliness standards regarding these cases. The risk of incompetent beneficiaries receiving benefits without fiduciaries assigned to manage those funds increases when the staff does not complete competency determinations immediately.

Using our interpretation of immediate, the most significant delay we identified occurred when VARO staff unnecessarily delayed a final incompetency decision for a veteran for approximately 6 months. During this period, the veteran received $861 in disability payments. While the veteran was entitled to these payments, fiduciary stewardship was not in place to ensure effective funds management and the welfare of the veteran.

The workload management plan lacked procedures to ensure timeliness and ensure oversight of the competency determination process. VARO staff responsible for overseeing and processing final competency determinations stated they were unaware of VBA's policy requiring immediate action; however, they did know these cases were to be prioritized and acknowledged 14 days was a sufficient definition of "immediate." VSC management defined "immediate" as "once the case arrives at your desk, you work it." As a result of this unclear guidance, incompetent beneficiaries received benefit payments for extended periods despite being incapable of managing these funds effectively.

Until recently, VBA did not have a clear, measurable definition of "immediate" and this timeframe varied from office-to-office. In response to our summary report for FY 2010, *Systemic Issues Reported During Inspections at VA Regional Offices,* (Report Number 11-00510-167, May 18, 2011), the Acting Under Secretary for Benefits defined "immediate" as 21 days following the expiration of the due process period. VBA plans to implement this new policy nationwide in June 2011. Therefore, we made no recommendation to the Director of the VARO regarding this issue. The VARO processed 23 of 30 determinations in 21 days.

Further, VSC staff incorrectly processed 3 (10 percent) of 30 competency determinations reviewed. According to VBA policy, VARO staff should pay all current monthly benefits for existing disabilities, but should not release any retroactive benefits for these disabilities until they make a final determination on the issue of competency. In the most egregious case, on March 15, 2010, the RVSR increased the veteran's disability evaluation effective July 18, 2008, and proposed incompetency. VSC staff correctly paid the veteran's monthly benefit of $6,928 beginning April 1, 2010. However, staff incorrectly released a retroactive payment of $66,228 to the veteran, the amount due him for the period August 1, 2008 through March 31, 2010, before finalization of the incompetency determination.

These errors were a result of a lack of understanding of VBA policy. The VARO provided training in December 2009, shortly after the policy changed and in January 2011, just prior to our site inspection. VARO management's training of VSC staff on this issue is a positive step towards addressing these errors.

Recommendation

4. We recommend the Louisville VA Regional Office Director develop and implement a plan to monitor the effectiveness and adequacy of the training provided in January 2011, regarding proper processing of competency determination decisions and take appropriate action as needed.

Management Comments

The VARO Director concurred with our recommendation. The Director stated the VARO conducted refresher training for RVSRs on the proper processing of competency determinations. Further, effective May 2011, VSC will conduct monthly reviews to ensure accuracy and timeliness of competency determinations.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions.

Appendix A VARO Profile and Scope of Inspection

The Louisville VARO is responsible for delivering nonmedical VA benefits and services to veterans and their families. The VARO fulfills these responsibilities by administering compensation and pension benefits, vocational rehabilitation and employment assistance, and outreach activities.

Resources

As of November 2010, the Louisville VARO had a staffing level of 207 employees. As of January 2011, the VSC had 177 employees assigned.

Workload

As of December 2010, the VARO reported 5,887 pending compensation claims. The average time to complete claims was 114.8 days—60.2 days better than the national target of 175 days. As reported by STAR staff, the accuracy of compensation rating-related decisions was 88.5 percent, which was 1.5 percent below the 90 percent VBA target. The accuracy of compensation authorization-related processing was 95.6 percent, which was 0.4 percent below the 96 percent VBA target.

Scope

We reviewed selected management controls, benefits claims processing, and administrative activities to evaluate compliance with VBA policies regarding benefits and nonmedical services provided to veterans and other beneficiaries. We interviewed managers and employees and reviewed veterans' claims folders.

Our review included 80 (15 percent) of 548 claims related to PTSD, TBI, and herbicide exposure-related disabilities that the VARO completed from October through December 2010. For temporary 100 percent disability evaluations, we selected 30 (13 percent) of 231 existing claims from VBA's Corporate Database. We provided the VARO with the 201 claims remaining from the universe of 231. These claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months.

We also reviewed a sample of 30 (54 percent) of 56 competency determinations completed by the Louisville VARO during the 3-month period from October through December 2010. We reviewed 19 errors identified by VBA's STAR Program during the 3-month period from July through September 2010. VBA measures the accuracy of compensation and pension claims processing through its STAR Program. STAR's measurements include a review of work associated with claims that require rating decisions. The STAR staff reviews original claims, reopened claims, and claims for increased evaluations. Further, they review appellate issues that involve a myriad of veterans' disabilities claims.

Our process differs from STAR as we review specific types of claims issues such as PTSD, TBI, and herbicide exposure-related disabilities that require

rating decisions. In addition, we review rating decisions and awards processing involving temporary 100 percent disability evaluations.

For our review, we selected dates of claim, NODs, and Triage Team mail pending at the VARO during the time of our inspection. We completed our review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspections.* We planned and performed the review to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our review objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our review objectives.

Appendix B VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: April 22, 2011

From: Director, VA Regional Office (327/00)

Subj: Inspection of the VARO Louisville, KY

To: Director, Benefits Inspection Division, San Diego

1. Attached are the Louisville VARO's comments on the OIG Draft Repot: Inspection of VARO Louisville.

2. Questions may be referred to Mr. David J. Davis, Director, at 502.566.4500, or Mrs. Laura Kuerzi-Rodgers, Veterans Service Center Manager, at 502.566.4301.

(original signed by:)
DAVID J. DAVIS
Director

Attachment

VARO LOUISVILLE
Benefits Inspection Division Visit

Recommendation 1. We recommend the Louisville VA Regional Office Director review the 201 temporary 100 percent disability evaluations remaining from our universe of 231 to determine if medical reevaluations are required and take appropriate action.

VARO Response: Non-Concur.

We do not believe this recommendation is necessary or appropriate. In response to OIG report "Audit of 100 Percent Evaluations" dated January 24, 2011, VBA developed a national plan to review temporary 100 percent evaluation cases, which was accepted by OIG. Therefore, the Regional Office will follow the national review plan.

Recommendation 2. We recommend the Louisville VA Regional Office Director conduct refresher training and implement controls to ensure staff establish suspense diaries for temporary 100 percent disability reevaluations.

VARO Response: Concur.

The Louisville Regional Office (RO) conducted refresher training with the Rating Activity on April 11, 2011. Louisville will also conduct refresher training with employees that promulgate rating decisions. The training will be completed no later than May 31, 2011. The Veterans Service Center (VSC) Management Analyst currently conducts workload management compliance reviews. Effective May 1, 2011, the VSC will add a monthly review of five completed EP 310s to the compliance review to ensure diaries are properly set.

Recommendation 3. We recommend the Louisville VA Regional Office Director conduct refresher training and develop and implement a plan to improve the quality review process for traumatic brain injury claims.

VARO Response: Concur.

The Louisville RO conducted refresher training on traumatic brain injury (TBI) with the Rating Activity on March 7 and March 9, 2011. Additionally, the VSC Exam Coordinator will continue to work closely with the VA Medical Centers to ensure TBI examinations are complete and sufficient for rating purposes.

Recommendation 4. We recommend the Louisville VA Regional Office Director develop and implement a plan to ensure control of Triage Team permanent transfer in and temporary transfer out mail.

VARO Response: Concur.

We believe it is necessary for a station to have a plan to control Triage Team permanent transfer in and temporary transfer out mail. The Louisville RO contends M23-1 and the COVERS Users Guide allow the VSC Manager the discretion to develop local procedures for handling individual pieces of miscellaneous mail for files located off station.

The Louisville RO maintains a separate and distinct location for miscellaneous mail associated with folders located physically offstation. As the claims folders are returned, a physical check for mail is conducted. Additionally, each Claims Assistant conducts reviews of the mail to ensure all mail is timely associated with claims folders.

This process complies with M21-1MR, which defines search mail as, controlled active mail that has been attempted to be associated with a claims folder, but there is an indication the claims folder is charged out of files. Designated individuals are responsible for locating folders charged out of the file bank within the RO.

The findings did disclose a few instances in which folders returned to the RO and miscellaneous mail was not timely associated with the folder. Therefore, the RO has tightened controls in this area to ensure miscellaneous mail is timely associated with incoming folders.

Recommendation 5. We recommend the Louisville VA Regional Office Director develop and implement a plan to monitor the effectiveness and adequacy of the training provided in January 2011, regarding proper processing of competency determination decisions and take appropriate action as needed.

VARO Response: Concur.

The Louisville RO conducted refresher competency training for the Rating Activity on February 10, 2011. Effective May 2011, the Fiduciary Coach will review five completed EP 600s involving competency determinations to ensure accuracy and timeliness of the determination. Additionally, the Post-Determination Coach will review five completed EP 290s to ensure timeliness in the release of funds. The findings will be included in the monthly VSC Compliance Review.

Appendix C Inspection Summary

10 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 Code of Federal Regulations (CFR) 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (Manual (M)21-1Manual Rewrite (MR), Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR, Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Post-Traumatic Stress Disorder	**Determine whether VARO staff properly processed claims for PTSD.** (38 CFR 3.304(f))	X	
3. Traumatic Brain Injury	**Determine whether VARO staff properly processed service connection for all residual disabilities related to in-service TBI.** (Fast Letter (FL) 08-34 and FL 08-36, Training Letter 09-01)		X
4. Herbicide Exposure-Related Disabilities	**Determine whether VARO staff properly processed claims for service connection for herbicide exposure-related disabilities (Agent Orange).** (38 CFR 3.309) (FL 02-33) (M21-1MR, Part IV, Subpart ii, Chapter 2, Section C.10)	X	
Data Integrity			
5. Date of Claim	**Determine whether VARO staff properly recorded the correct dates of claim in the electronic record.** (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)	X	
6. Notice of Disagreement	**Determine whether VARO staff properly entered NODs into VACOLS.** (M21-1MR, Part I, Chapter 5)		X
Management Controls			
7. Systematic Technical Accuracy Review	**Determine whether VARO staff properly corrected STAR errors in accordance with VBA policy.** (M21-4, Chapter 3, Subchapter II, 3.03)	X	
8. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)	X	
Workload Management			
9. Mail Handling Procedures	**Determine whether VARO staff properly followed VBA mail handling procedures.** (M23-1) (M21-4, Chapter 4) (M21-1MR, Part III, Subpart ii, Chapters 1 and 4)		X
Eligibility Determinations			
10. Competency Determinations	**Determine whether VAROs properly assessed beneficiaries' mental capacity to handle VA benefit payments.** (M21-1MR, Part III, Subpart v, Chapter 9, Section A) (M21-1MR, Part III, Subpart v, Chapter 9, Section B) (FL 09-08)		X

Source: VA OIG

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	Dawn Provost, Director Ed Akitomo Orlan Braman Madeline Cantu Michelle Elliott Lee Giesbrecht Ambreen Husain Rachel Stroup Diane Wilson

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