VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Chicago, Illinois

June 2, 2011

11-00521-183

ACRONYMS AND ABBREVIATIONS

COVERS	Control of Veterans Records System
NOD	Notice of Disagreement
OIG	Office of Inspector General
PTSD	Post-Traumatic Stress Disorder
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VACOLS	Veterans Appeals Control and Locator System
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

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Report Highlights: Inspection of the VA Regional Office, Chicago, Illinois

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

Chicago VARO staff correctly processed post-traumatic stress disorder disability claims, properly established the correct dates of claim in the electronic record, and ensured staff corrected errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review Program. The VARO's performance was generally effective in processing herbicide exposure-related claims and final competency determinations.

VARO management lacked effective controls to ensure accurate processing of temporary 100 percent disability evaluations and traumatic brain injury claims, as well as action items related to disability claims processing. Overall, VARO staff did not accurately process 21 (20 percent) of the 103 disability claims reviewed and they were not timely recording Notices of Disagreement for appealed claims. Further, they did not complete Systematic Analyses of Operations and manage mail effectively.

What We Recommended

We recommended Chicago VARO management implement controls to ensure the Veterans Service Center staff establishes suspense diaries to request medical reexaminations for temporary 100 percent disability reevaluations and follow policy for completing related action items. Management should also develop and implement plans to monitor the effectiveness of training and improve accuracy and oversight of traumatic brain injury claims.

Further, we recommended management implement a plan to ensure timely establishment of Notices of Disagreement in the Veterans Appeals Control and Locator System. Management also needs to implement a plan to ensure timely and complete Systematic Analyses of Operations and oversight of search mail.

Agency Comments

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

BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objectives

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 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 March 2011, the OIG conducted an inspection of the Chicago 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 73 (18 percent) of 397 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 (6 percent) of 469 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 our 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 Chicago VARO needs to improve the accuracy of disability claims processing. VARO staff incorrectly processed 21 (20 percent) of the total 103 disability claims we 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 Chicago 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	13	5	8
PTSD	30	0	0	0
TBI	13	7	1	6
Herbicide Exposure-Related Disabilities	30	1	0	1
Total	**103**	**21**	**6**	**15**

Source: VA OIG Analysis March 2011

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 13 (43 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 treatment, VARO staff must request a follow-up medical

examination to help determine whether to continue the veteran's 100 percent disability benefits.

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 in VBA's electronic system. A suspense diary is a processing command that establishes a date when VSC staff must schedule a medical reexamination. As a suspense diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the reexamination.

Based on analysis of available medical evidence, 5 of the 13 processing inaccuracies affected veterans' benefits—3 involved overpayments totaling $40,275 and 2 involved underpayments totaling $12,414. Details on the most significant overpayment and underpayment follow.

- A Rating Veterans Service Representative (RVSR) incorrectly granted special monthly compensation for a veteran's service-connected active prostate cancer and multiple residual disabilities determined to be due to the prostate cancer. In accordance with VBA policy, RVSRs should not separately evaluate complications of prostate cancer when the disease is active. As a result, VA overpaid the veteran $17,799 over a period of 4 years and 10 months.
- An RVSR did not grant a veteran special monthly compensation as required for loss of use of a creative organ. As a result, VA underpaid the veteran $10,110 over a period of 9 years and 8 months.

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

- In six cases, VSC staff did not input suspense diaries or establish local controls to schedule follow-up medical reexaminations needed to determine whether the temporary 100 percent disability evaluations should continue.
- In one case, an RVSR correctly continued the 100 percent disability evaluation without requiring a future reexamination. In making this decision, the RVSR did not consider entitlement to the additional benefit of Dependents' Educational Assistance as required by VBA policy.
- In one case, an RVSR incorrectly requested a future reexamination for a veteran with an incurable disease. In making this decision, the RVSR did not consider entitlement to the additional benefit of Dependents' Educational Assistance as required by VBA policy.

An average of 4 years elapsed from the time staff should have scheduled medical reexaminations until the date of our inspection—the date staff ultimately ordered the medical reexaminations to obtain the necessary medical evidence. The delays ranged from 1 year and 2 months to 11 years and 1 month.

The most frequent error noted in 7 of the 13 temporary 100 percent disability evaluations occurred when VARO staff did not properly establish suspense diaries for future VA medical reexaminations. Four of the seven errors involved rating decisions where medical reexaminations were required within 60 days of VSC staff finalizing the decisions. VBA policy requires VAROs establish local procedures to maintain control of claims requiring medical reexaminations within 60 days of final processing actions. VSC staff stated they were unaware of any local policy regarding control of these types of medical reexaminations. As such, VARO staff did not always schedule medical reexaminations as required.

Additionally, VARO staff did not follow VBA policy or the VSC workload management plan guidance on 810 work items. The 810 work item is a system-generated reminder notification to take future actions on a claim. VSC staff are responsible for reviewing the 810 work items and taking the follow-up actions needed. For temporary 100 percent disability evaluations, the 810 work items provide notification to review the claims to determine the need to schedule medical reexaminations. We found 198 pending 810 work items; the oldest had been pending since August 2010. VSC's workload management plan requires weekly review of work items. However, VSC staff indicated management promoted the person responsible for the weekly review and did not reassign the duty. As a result, VSC staff did not schedule medical reexaminations timely.

We provided the VARO with 439 temporary 100 percent disability claims remaining from the universe of 469 reviewed. We make no recommendation for the VARO to review these claims as 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).

PTSD Claims

VARO staff correctly processed all 30 PTSD claims we reviewed. Therefore, we made no recommendations for improvement in this area.

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.

VARO staff incorrectly processed 7 (54 percent) of 13 TBI claims. One of the errors affected a veteran's benefits and six had the potential to affect veterans' benefits. Following are summaries of these inaccuracies.

- In the one case that affected a veteran's benefits, an RVSR incorrectly continued a grant of service connection for a residual TBI-related disability without evidence of an in-service event or injury. The service treatment records did not show treatment, diagnosis, or complaints of TBI. Further, the VA medical examination did not link residuals of TBI to the veteran's military service. As a result, VA overpaid the veteran $23,144 over a period of 2 years.
- In six cases that had the potential to affect veterans' benefits, RVSRs and Decision Review Officers prematurely evaluated residual TBI-related disabilities using inadequate medical examinations. According to VBA policy, when a medical examination does not address all required elements, VSC staff should return it to the clinic or healthcare facility as insufficient for rating purposes. Neither VARO staff nor we can ascertain all of the residual disabilities related to TBI without an adequate or complete medical examination.

Generally, errors associated with TBI claims processing occurred because VARO staff incorrectly interpreted VBA policy and used VA medical examinations that were inadequate for decision-making purposes. Prior to our inspection, three of the seven inaccuracies received second reviews by Decision Review Officers and VSC staff completed a local quality review on one of the seven inaccuracies without identifying any errors. Although VARO staff received training on how to evaluate TBI disability claims, interviews with VSC supervisors, RVSRs, and Decision Review Officers indicated that TBI regulations and policies were difficult to understand. As a result, veterans did not always receive correct benefit payments.

VARO training staff provided refresher TBI training in response to the errors we identified during our site inspection. Interviews with VSC staff indicated this new training corrected problems with previous guidance regarding VBA policy for processing TBI claims; however, management would benefit from monitoring the training provided to ensure that it is effective and adequate.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 1 (3 percent) of 30 herbicide exposure-related claims. In this case, an RVSR incorrectly denied service connection for a diabetes-related complication diagnosed in both private and VA medical examinations. Because we found only one inaccuracy, we determined the VARO generally followed VBA policy for herbicide exposure-related claims. Therefore, we made no recommendations for improvement in this area.

Recommendations

1. We recommend the Chicago VA Regional Office Director establish mechanisms to ensure staff control claims requiring medical reexaminations within 60 days of final processing action, as required.
2. We recommend the Chicago VA Regional Office Director review all pending 810 work items to determine if medical reexaminations are required and take appropriate action.
3. We recommend the Chicago VA Regional Office Director implement oversight to ensure staff follow Veterans Benefits Administration guidance and the local workload management plan for reviewing 810 work items.
4. We recommend the Chicago VA Regional Office Director develop and implement a plan to monitor the effectiveness and adequacy of training provided in March 2011, on proper processing of disabilities related to traumatic brain injuries.
5. We recommend the Chicago VA Regional Office Director develop and implement a plan to improve accuracy and oversight of traumatic brain injury claims processing.

Management Comments

The VARO Director concurred with our recommendations. In response to recommendation 1, the Director stated the VARO would follow the Compensation and Pension Service guidance provided in May 2011 to ensure staff control claims requiring medical reexaminations. In response to recommendations 2 and 3, the VSC revised its workload management plan to ensure rating staff review pending work items on a monthly basis and take appropriate action as needed. In response to recommendations 4 and 5, the Director stated the VARO provided training on all aspects of TBI ratings and, effective May 2011, all TBI ratings require a second review by a Decision Review Officer. The Decision Review Officers will provide feedback to management and VSC staff will receive targeted training based on errors noted. At the end of the fiscal year, management will reevaluate the need to continue the second review of all TBI ratings.

OIG Response

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

2. Data Integrity

Dates of Claim

We analyzed claims folders to determine if the VARO is following VBA policy to establish correct dates of claim in the electronic record. In addition to establishing the time frame 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 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.

Finding 2 Controls Over Recording Notices of Disagreement Need Strengthening

The VARO Appeals Team did not consistently record NODs in VACOLS within VBA's 7-day standard. VARO staff did not meet the 7-day standard for 7 (23 percent) of the 30 NODs we reviewed. Staff took an average of 21 days to record these seven disagreements in VACOLS. The most untimely action occurred when staff did not create a record for 36 days.

Although the Appeals Team was aware of the 7-day standard, delays occurred because the workload management plan and local procedures did not incorporate provisions to ensure prompt control of NODs in VACOLS. VARO staff's untimely recording of NODs in VACOLS affects data integrity and misrepresents VARO performance.

As of February 2011, the VARO averaged 73 days to establish NODs, 66 days over VBA's 7-day standard. NODs at the VARO have been pending completion an average of 326 days, 68 days over the national average of 258 days.

Data integrity issues make it difficult for VARO and senior VBA leadership to accurately measure and monitor VARO performance. Further, VBA's National Call Centers rely upon VACOLS information to provide accurate customer service to veterans. Unnecessary delays in controlling NODs affect national performance measures for NOD inventory and timeliness.

Recommendation

6. We recommend the Chicago VA Regional Office Director develop and implement a plan to ensure staff record Notices of Disagreement in the Veterans Appeals Control and Locator System within 7 days as required by Veterans Benefits Administration policy.

Management Comments

The VARO Director concurred with our recommendation. The Director stated the existing workload management plan dictates Appeals Team Veteran Service Representatives will enter NODs into VACOLS. However, effective April 2011, when the volume of incoming NODs would become too large for the Veteran Service Representatives to complete, Claims Assistants would help enter the NODs into the system. Management will continue to monitor the incoming NOD volume and assign staff as needed to timely complete NOD entry.

OIG Response

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

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 multifaceted 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 identified by STAR.

VARO staff adhered to VBA policies by taking corrective action on all 17 errors identified by STAR from October through December 2010. Therefore, we made no recommendations for improvement in this area.

Systematic Analysis of Operations

We assessed 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 an organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish annual SAO schedules designating the staff required to complete the SAOs by specific dates.

Finding 3 Improved Oversight Is Needed To Ensure Timely Completion of SAOs

Seven (58 percent) of the 12 SAOs were not completed timely per the annual schedule, were incomplete (missing required elements), or were not done at all. The VSC Manager is responsible for completing the 12 annual SAOs as part of ongoing analysis of VSC operations. VARO management did not provide adequate oversight to ensure VSC staff completed the SAOs in accordance with VBA policy. As a result, VARO management may not have adequately identified existing and potential problems for corrective actions to improve VSC operations.

At the time of our inspection, 3 (25 percent) of the 12 SAOs were partially completed, 2 (17 percent) were not started, 1 (8 percent) was not timely, and 1 (8 percent) was both partially completed and not timely. VSC management indicated supervisors complete the same SAO every year and use the previous year's SAO as a model rather than following VBA's policy to complete the current SAO. In turn, VARO staff responsible for SAO tracking stated that VSC managers also did not review VBA's policy when analyzing completed SAOs. The VSC Manager identified a lack of SAO oversight by previous management in FY 2010 and is currently developing a plan to improve this area.

One of the SAOs that VARO staff did not complete involved medical examinations. If VARO managers had ensured proper completion of this required SAO, they might have identified deficiencies in the quality of TBI examinations similar to what we found during our inspection.

Recommendation

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

Management Comments

The VARO Director concurred with our recommendation. The Director stated management updated the SAO schedule. Management reviews SAOs to ensure all required elements are addressed and monitors the schedule to ensure they are timely completed.

OIG Response

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

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 Chicago VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division. Mailroom staff were timely and accurate in processing, date-stamping, and delivering VSC mail to the Triage Team control point daily. As a result, we determined the VARO Support Services mailroom is following VBA policy and made no recommendation 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. VARO staff are 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 veterans' claims folders. 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 staff are not able to identify associated claims folders in the system.

Finding 4 Triage Team Mail Management Procedures Need Strengthening

The Triage Team staff did not properly manage 12 (14 percent) of 83 pieces of mail we reviewed. The most significant error occurred when staff did not control search mail through COVERS for 8 (27 percent) of 30 pieces of mail reviewed. At the time of our inspection, approximately 1,200 pieces of search mail were pending. The most egregious error occurred when the VARO received service treatment records on July 28, 2010, and placed them in the search mail holding area with another veteran's COVERS information attached. The service treatment records were for a veteran who submitted a claim for benefits on May 25, 2010. At the time of our inspection in March 2011, the VARO had not made a decision on the veteran's claim and had no search mail control in COVERS for the service treatment records.

The above errors occurred because of a lack of supervisory oversight to ensure timely and accurate movement of mail throughout the VSC. Triage Team employees complete reviews of search mail; however, supervisors did not provide adequate oversight to ensure search mail was properly marked in COVERS. In addition, the station's workload management plan does not thoroughly define search mail procedures. The VSC Manager acknowledged weaknesses associated with search mail processing.

Untimely association of mail with veterans' claims folders can cause delays in processing benefits claims. As a result, beneficiaries may not receive accurate and timely benefits payments.

Recommendation

8. We recommend the Chicago VA Regional Office Director develop and implement a plan to ensure management oversight and control of search mail.

Management Comments

The VARO Director concurred with our recommendation. The Director stated, as part of its integration into the Lean Team model, the VSC updated its workload management plan to require the teams review search mail weekly.

OIG Response

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

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 who 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 appoint fiduciaries timely.

VARO staff unnecessarily delayed making final decisions in 1 (9 percent) of the 11 competency determinations completed from October through December 2010. Because we found only one delay, we determined the VARO generally followed VBA policy regarding competency determinations and made no recommendation for improvement in this area.

Appendix A VARO Profile and Scope of Inspection

Organization

The Chicago 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 January 28, 2011, the Chicago VARO had a staffing level of 227 employees. Of these, the VSC had 184 employees (81 percent) assigned.

Workload

As of February 28, 2011, the VARO reported 14,766 pending compensation claims. The average time to complete claims was 228.9 days—53.9 days longer than the national target of 175 days. As reported by STAR staff, the accuracy of compensation rating-related decisions was 79.6 percent, which was 10.4 percent below the 90 percent VBA target. The accuracy of compensation authorization-related processing was 93.9 percent, which was 2.1 percent below the national target of 96 percent.

Scope

We reviewed selected management controls, benefits 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 73 (18 percent) of 397 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 (6 percent) of 469 existing claims from VBA's Corporate Database. We provided the VARO with the 439 claims remaining from our universe of 469. These claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months.

We also reviewed 11 competency determinations completed by the Chicago VARO during the 3-month period from October through December 2010. We reviewed 17 errors identified by VBA's STAR program during the same time period. 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. STAR staff review original claims, reopened claims, and claims for increased evaluation. Further, they review appellate issues that involve a myriad of veterans' disability 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 claims, NODs, and 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: May 18, 2011

From: Director, VA Regional Office Chicago, Illinois (328)

Subj: Inspection of the VARO Chicago, Illinois

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

1. Attached are the Chicago VARO's comments on the OIG Draft Report: Inspection of VARO Chicago.
2. Questions may be referred to Mary Hainey, Management Analyst, at telephone number (312) 980-4203.

(original signed by:)

DUANE A. HONEYCUTT

Attachment

Department of Veterans Affairs
Regional Office
2122 W. Taylor Street
Chicago, IL 60612

RE: VA Office of Inspector General
Office of Audits and Evaluations
Inspection of the VA Regional Office Chicago, Illinois

Recommendations Response from Chicago VA Regional Office (328)

RECOMMENDATION #1: We recommend the Chicago VA Regional Office Director establish mechanisms to ensure staff control claims requiring medical reexaminations within 60 days of final processing action, as required.

Response: Concur. We agree that the electronic system should automatically populate future exam dates. In response to OIG Report, *Audit of 100 Percent Evaluations*, dated January 24, 2011, VBA developed a national plan to review 100 percent evaluation cases, which was accepted by OIG. Therefore, the Regional Office will follow the national review plan.

On May 11, 2011, Compensation and Pension Service provided interim guidance to the Field that provided the four basic scenarios where Future Exam Diary control is either being cancelled unexpectedly or not being set at all during the VETSNET Award generation process. This interim guidance will be utilized where appropriate.

RECOMMENDATION #2: We recommend the Chicago VA Regional Office Director review all pending 810 work items to determine if medical reexaminations are required and take appropriate action.

Response: Concur. We agree that additional attention is required to accurately control and process the 800-series work items for medical reexaminations. As part of our integration into the Lean Team model, we have amended our workload management plan specifically for 800-series work items. Effective immediately, RVSRs will review the pending reevaluation work items on a monthly basis and take appropriate action to complete or clear the work item.

RECOMMENDATION #3: We recommend the Chicago VA Regional Office Director implement oversight to ensure staff follows Veterans Benefits Administration guidance and the local workload management plans for reviewing 810 work items.

Response: Concur. We agree that additional attention is required to accurately control and process the 810 work items. As part of our integration into the Lean Team model, we have

amended our workload management plan specifically for 810 work items. Effective immediately, VSRs will review the pending work items on a monthly basis and take appropriate action to complete or clear the work item.

RECOMMENDATION #4: We recommend the Chicago VA Regional Office Director develop and implement a plan to monitor the effectiveness and adequacy of training provided in March 2011, on proper processing of disabilities related to traumatic brain injuries.

Response: Concur. The Chicago RO conducted training on rating traumatic brain injuries (TBI) on March 17, 2011. This training, conducted by a DRO on the Quality Review Team, covered all aspects of TBI ratings, particularly including the VA examination requirements. The newly implemented 100% DRO review (discussed in the following paragraph) will allow us to monitor the effectiveness of this training.

RECOMMENDATION #5: We recommend the Chicago VA Regional Office Director develop and implement a plan to improve accuracy and oversight of traumatic brain injury claims processing.

Response: Concur. Effective May 6, 2011, all TBI ratings require a DRO second signature review until September 30, 2011, at which point the need for 100% review will be re-evaluated. Coaches will keep track of errors noted, and targeted training will be provided. DROs will provide feedback each month to the Appeals coach, who will disseminate the data and training needs to the leadership team.

RECOMMENDATION #6: We recommend the Chicago VA Regional Office Director develop and implement a plan to ensure staff record Notices of Disagreement in the Veterans Appeals Control and Locator System within 7 days as required by Veterans Benefits Administration policy.

Response: Concur. The existing Workload Management Plan dictates that VSRs on the Appeals Team will review and record Notices of Disagreement (NODs) into VACOLS. Effective April 1, 2011, in situations when the incoming NOD volume is too high for the VSRs to complete input within 7 days, the Appeals Claims Assistants will assist in entering NODs into VACOLS. The Appeals Coach will monitor the incoming NOD volume to ensure there are sufficient personnel to complete this action in the required timeframe.

RECOMMENDATION #7: We recommend the Chicago VA Regional Office Director develop and implement a plan to ensure staff complete Systematic Analyses of Operations timely and address all required elements.

Response: Concur. The SAO schedule has been updated and is being monitored for timely completion of SAOs. SAOs are being closely reviewed to ensure they contain all required elements.

RECOMMENDATION #8: We recommend the Chicago VA Regional Office Director develop and implement a plan to ensure management oversight and control of search mail.

Response: Concur. As part of our integration into the Lean Team model, we have updated our existing Workload Management Plan. Effective April 4, 2011 (Lean Teams 1-2), and May 2, 2011 (Lean Teams 3-5), each individual Lean Team will maintain control of their own search mail. Search mail will be reviewed on a weekly basis to ensure that it is being properly consolidated with the claims folder and the appropriate development, rating, or promulgation action taken on the mail.

Appendix C Inspection Summary

Ten Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
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) 21-1 Manual 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	**Determine whether VARO staff properly processed claims for service connection for disabilities related to herbicide exposure.** (38 CFR 3.309) (FL 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)	X	
Data Integrity			
5. Dates 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. Notices 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	

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 Bridget Bertino Madeline Cantu Lee Giesbrecht Brian Jeanseau David Pina Dana Sullivan Brandi Traylor

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