VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Columbia, South Carolina

August 24, 2011
11-00236-257

ACRONYMS AND ABBREVIATIONS

C C	Confirmed and Continued
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

Report Highlights: Inspection of the VA Regional Office, Columbia, South Carolina

Why We Did This Review

The Veterans Benefits Administration has a nationwide network of 57 VA Regional Offices (VAROs) that process disability claims and provide a range of services to veterans. We conducted this inspection to evaluate how well the Columbia VARO accomplishes this mission.

What We Found

Columbia VARO staff followed the Veterans Benefits Administration's policy for establishing dates of claim, processing incoming mail, completing Systematic Analyses of Operations, and correcting errors identified through the Systematic Technical Accuracy Review program. VARO performance was generally effective in processing post-traumatic stress disorder claims and handling mail.

The VARO lacked effective controls and accuracy in processing some disability claims. Inaccuracies processing temporary 100 percent disability evaluations occurred because staff did not schedule future medical reexaminations as required. Inaccuracies related to traumatic brain injury claims and herbicide exposure-related claims resulted from inadequate quality assurance. Overall, VARO staff did not accurately process 33 (32 percent) of the 104 disability claims reviewed.

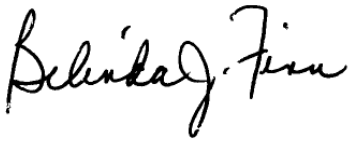
The VARO did not meet the 7-day standard in recording Notices of Disagreement for appealed claims. However, the VARO's processing timeliness for Notices of Disagreement was 73 days less than the national average.

What We Recommended

We recommended VARO management implement controls to improve its quality review process for traumatic brain injury and herbicide exposure-related claims processing.

Agency Comments

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



BELINDA J. FINN
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for Audits and Evaluations

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INTRODUCTION

Objective

The Benefits Inspection Program is part of the Office of Inspector General's (OIG) efforts to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection 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 May 2011, the OIG conducted an inspection of the Columbia VARO. The inspection focused on four protocol areas examining nine operational activities. The four protocol areas were disability claims processing, data integrity, management controls, and workload management. We did not examine competency determinations because the VARO did not complete any such determinations from January through March 2011.

We reviewed 74 (8 percent) of 876 disability claims related to post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and herbicide exposure that the VARO completed from January through March 2011. In addition, we reviewed 30 (7 percent) of 427 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 Disability Claims Processing Accuracy Could Be Improved

The Columbia VARO needs to improve the accuracy of disability claims processing. VARO staff incorrectly processed 33 (32 percent) of the total 104 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 Columbia 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	21	11	10
PTSD	30	2	0	2
TBI	14	6	0	6
Herbicide Exposure-Related Disabilities	30	4	3	1
Total	**104**	**33**	**14**	**19**

Source: VA OIG Analysis, May 2011

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 21 (70 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 evaluation.

For temporary 100 percent disability evaluations, including confirmed and continued (C C) evaluations where rating decisions do not change veterans' payment amounts, 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.

Available medical evidence showed that 11 of the 21 processing inaccuracies affected veterans' benefits—all 11 involved overpayments totaling about $440,156. Details on the two most significant overpayments follow.

- VARO staff did not schedule a follow-up examination to evaluate a veteran's non-Hodgkin's lymphoma. VA medical treatment records showed the veteran had completed treatment, warranting a reduction in benefits as of February 1, 2002. As a result, VA overpaid the veteran $270,204 over a period of 9 years and 3 months.
- VARO staff did not schedule a follow-up examination to evaluate a veteran's prostate cancer. VA medical treatment records showed the veteran had completed treatment, warranting a reduction in benefits as of April 1, 2009. As a result, VA overpaid the veteran $55,500 over a period of 2 years and 1 month.

The remaining 10 inaccuracies had the potential to affect veterans' benefits. Following are summaries of these inaccuracies.

- In nine cases, Rating Veteran Service Representatives (RVSRs) continued the temporary 100 percent disability evaluations and annotated the need for future reexaminations. For all 21 processing inaccuracies, an average of approximately 2 years 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 9 years and 8 months.
- In one case, an RVSR granted a temporary 100 percent disability evaluation although medical evidence showing chronic lymphocytic leukemia warranted a permanent 100 percent disability evaluation instead. The RVSR also did not consider entitlement to the additional benefit of Dependents' Educational Assistance as required.

Twelve of the 21 errors resulted from staff not establishing suspense diaries when they processed rating decisions requiring temporary 100 percent

disability reexaminations. Nine of these errors involved C C rating decisions. In November 2009, VBA provided guidance reminding VAROs about the need to add suspense diaries in the electronic record for C C rating decisions. However, VARO management had no oversight procedure in place to ensure VSC staff established suspense diaries as reminders of the need for reexaminations.

In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each evaluation had a future examination date entered in the electronic record. Therefore, we made no additional recommendation for improvement in this area. To assist in implementing the agreed upon review, we provided the VARO with 397 claims remaining from our universe of 427 temporary 100 percent disability evaluations.

PTSD Claims

VARO staff incorrectly processed 2 (7 percent) of 30 PTSD claims we reviewed. In both cases, RVSRs prematurely granted service connection for PTSD without clarification from the examiner, which had the potential to affect veterans' benefits. VA medical examiners also diagnosed an additional mental disorder without discussing the relationship between this condition and PTSD and the extent of impairment, as required. 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 the relationship or the extent of impairment without adequate or complete medical evidence.

Because the frequency of errors was insignificant, we determined the VARO generally followed VBA policy related to PTSD claims processing. Therefore, we made no recommendation 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 6 (43 percent) of 14 TBI claims. All of these processing inaccuracies had the potential to affect veterans' benefits. Following are summaries of the inaccuracies.

- An RVSR did not grant service connection for a diagnosed condition related to a TBI. This decision did not affect the veteran's existing

monthly benefits but may affect future evaluations for additional benefits.

- An RVSR did not follow up to determine service connection when a VA medical examination showed a possible diagnosis of a TBI. 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.
- An RVSR did not establish service connection correctly when medical evidence showed a diagnosis of a TBI with no residuals. The TBI warranted a 0 percent evaluation, entitling the veteran to healthcare for the condition, but not monetary compensation. This rating did not affect the veteran's monthly benefits, but may affect future evaluations for additional benefits.
- An RVSR incorrectly evaluated TBI-related residuals as 40 percent disabling. Medical evidence showed residuals warranting no more than a 10 percent disability evaluation. Because of the veteran's multiple service-connected disabilities, this error did not affect the veteran s monthly benefits, but may affect future evaluations for additional benefits.
- In two cases, RVSRs incorrectly evaluated TBI-related residuals using 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 resulted from inadequate quality assurance. RVSR trainees completed all six rating decisions and prior to our inspection, VSC staff conducted an additional review of these decisions without identifying any errors. However, interviews with VSC staff indicated that a combination of workload and pressure to produce rating decisions negatively affected the quality of the additional review. RVSR mentors specifically reported difficulty accomplishing quality reviews of trainee rating decisions when they mentored more than one trainee. Because of such deficiencies, RVSRs did not properly evaluate TBI-related residuals.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 4 (13 percent) of 30 herbicide exposure-related claims we reviewed. Three of the four processing inaccuracies affected veterans' benefits—two involved overpayments totaling about $39,941 and one involved an underpayment totaling $2,560. Details on the most significant overpayment and the underpayment follow.

- An RVSR correctly granted service connection for chronic renal failure with hypertension associated with diabetes mellitus; however, the effective date of August 10, 2005, was incorrect. The actual date of entitlement was June 10, 2009—the date VA medical records showed the diagnosis of chronic renal failure associated with diabetes mellitus. As a result, VA overpaid the veteran $38,683 over a period of 3 years and 10 months.
- An RVSR correctly granted service connection for coronary artery disease with an evaluation of 30 percent disability. However, the RVSR did not address entitlement to an additional special monthly compensation based on evaluations of multiple disabilities as required by VBA policy. As a result, VA underpaid the veteran $2,560 over a period of 8 months.

The remaining inaccuracy had the potential to affect the veteran's benefits. An RVSR did not grant service connection as required for a diabetes-related complication diagnosed in a VA medical examination report. This rating did not affect the veteran's monthly benefits, but may affect future evaluations for additional benefits.

Generally, errors associated with herbicide exposure-related claims processing resulted from inadequate quality assurance. Prior to our inspection, VSC staff conducted an additional level of review on three of four rating decisions completed by RVSR trainees without identifying any errors. Interviews with VSC staff indicated that a combination of workload and pressure to produce rating decisions negatively affected the quality of the additional review. RVSR mentors specifically reported difficulty accomplishing quality reviews of trainee rating decisions when they mentored more than one trainee. In addition, staff indicated a lack of understanding of regulations and policies involving effective dates. Because of such deficiencies, RVSRs did not properly evaluate herbicide exposure-related disabilities.

Recommendation

1. We recommend the Columbia VA Regional Office Director implement a plan to improve effectiveness of the quality review process for traumatic brain injury and herbicide exposure-related claims processing.

Management Comments

The VARO Director concurred with our recommendation. The Director stated the VARO provided training on the proper processing of TBI claims in July 2011. Additionally, VSC management now require TBI claims receive a second review by an RVSR and a third review by VSC management or a member of the VARO's Accuracy Review Team. Further, management included a Division-wide reminder on herbicide exposure-related claims addressing the proper effective date and service-connect requirements. Training tailored to address the noted deficiencies was conducted in June 2011.

OIG Response

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

2. Data Integrity

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 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 recommendation 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 veterans' appeals 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 11 days to record these five NODs in VACOLS. However, as of April 30, 2011, the VARO's NODs had been pending completion an average of 200 days, which was 73 days earlier than the national average of 273 days. Therefore, we made no recommendation for improvement in this area.

3. Management Controls

Systematic Technical Accuracy Review

We assessed management controls to determine whether 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 identified by STAR.

Columbia VARO staff adhered to VBA policy by taking corrective action on all eight errors identified by VBA's STAR program from October through December 2010. Therefore, we made no recommendation 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.

VARO management timely completed all 12 required SAOs. As a result, we determined the VARO was following VBA policy, and we made no recommendation 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 to 6 hours of receipt at the VARO. The Columbia VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the VSC Triage Team. 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 mailroom staff were following VBA policy, and we 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, 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 unable to identify associated claims folders in the system.

The Triage Team staff did not properly manage 2 (2 percent) of 90 pieces of mail we reviewed. As a result, we determined the Columbia VARO was generally complying with national and local mail handling policies. Therefore, we made no recommendation for improvement in this area.

Appendix A VARO Profile and Scope of Inspection

Organization

The Columbia 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 March 2011, the Columbia VARO had a staffing level of 558 employees. In May 2011, the VSC had 366 employees assigned.

Workload

As of April 2011, the VARO reported 17,639 pending compensation claims. The average time to complete claims was 215.6 days—40.6 days greater than the national target of 175 days. As reported by STAR staff, the accuracy of compensation rating-related decisions was 88.8 percent, which was 1.2 percent below the 90 percent VBA target. The accuracy of compensation authorization-related processing was 97.5 percent—1.5 percent above 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 delivery and nonmedical services to veterans and other beneficiaries. We interviewed managers and employees and reviewed veterans' claims folders.

Our review included 74 (8 percent) of 876 claims related to PTSD, TBI, and herbicide exposure-related disabilities that the VARO completed from January through March 2011. For temporary 100 percent disability evaluations, we selected 30 (7 percent) of 427 existing claims from VBA's Corporate Database. These claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months. We provided the VARO with the 397 claims remaining from the universe of 427 to facilitate its planned reviews of these types of claims.

We reviewed eight errors identified by VBA's STAR program during the 3-month period from October through December 2010. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR's assessments include a review of work associated with claims requiring 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 Inspection and Evaluation.* 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: August 1, 2011

From: Director, VA Regional Office Columbia, South Carolina

Subj: Inspection of the VARO Columbia, South Carolina

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

1. Attached are the Columbia VARO's comments on the OIG Draft Report: *Inspection of the VA Regional Office Columbia, South Carolina*.

2. Questions may be referred to James R. Ard, Veterans Service Center Manager (803) 647-2556.

(original singed by:)

Carl W. Hawkins, Jr., Director

Attachment

Columbia VA Regional Office Response to the Office of Inspector General, Benefits Inspection Division
Inspection of the VA Regional Office Draft Report

Comments and Implementation Plan

The VA OIG visited the Columbia VA Regional Office from May 17 through May 26, 2011. This paper outlines the Columbia VA Regional Office's response, as well as concerns regarding the visit and findings.

The employees of the Columbia VA Regional Office appreciate the recent visit of the OIG in connection with our Benefits Inspection Program. In the current climate, the Columbia VA Regional Office faces many challenges. The Veterans Service Center (VSC) management is constantly re-evaluating personnel assignments and strategic priorities based on the directives from Southern AREA and Central Office. We welcome the outside observation and inspection provided by the OIG staff as methods to assist us in becoming more proficient and efficient in processing Veterans claims for benefits. The Columbia VA Regional Office personnel pride themselves on being a top performing station and embrace the opportunity to become even better. We would like to thank the OIG staff for their professionalism, insight, and recommendations. Below is the response to the OIG Team recommendation.

Recommendation: We recommend the Columbia VA Regional Office Director implement a plan to improve effectiveness of the quality review process for traumatic brain injury and herbicide exposure-related claims processing.

Columbia VARO Response: The Columbia VARO concurs with the recommendation and implemented action prior to the conclusion of the on-site inspection. A more detailed response outlining all corrective measures follows.

The VSC Management Team has developed a training plan for the processing of claims involving traumatic brain injuries. This training incorporates the applicable portions of the Rating Schedule and Training Letter 09-01 into a flowchart for use when processing these claims. The training was provided for all of the station's RVSRs and DROs in various sessions during July 2011. In addition, on May 27, 2011, the VSC Manager expanded the review/signature procedures for claims involving traumatic brain injuries. These claims now require a second signature by an RVSR and a third signature from either a Division Manager or a member of the station's Accuracy Review Team (ART).

Management's actions to improve the processing of herbicide exposure-related claims included a Division-wide reminder specifically addressing the proper effective date and service-connection requirements for such cases in an email dated May 31, 2011.

Training tailored to address the deficiencies noted by the OIG followed this reminder and was conducted for the Rating Activity in June 2011.

Although no specific recommendation was made concerning diaries for Temporary 100 percent evaluations, the OIG staff provided the Columbia VA Regional Office with 397 claims remaining from our universe of 427 temporary 100 percent disability evaluations.

On May 24, 2011, the VSC Manager released interim guidance to the VSC in order to improve the review/control process of all future diaries. On June 20, 2011, a VSC Memorandum was formally released outlining the procedures implemented to ensure significant improvement in the control of all control diaries including routine examinations. In June 2011, VSC Management initiated a process to review the entire list provided by the OIG. In addition, the Columbia VA Regional Office has prepared an Office of Performance Analysis and Integrity (PA I) Data Request for additional information regarding these diaries and initiated the initial approval process with Southern Area in July 2011.

Additionally, the VBA policy to timely record Notices of Disagreement (NODs) in the Veterans Appeals Control and Locator System (VACOLS) was analyzed. It was noted the Columbia VA Regional Office staff did not meet this standard for 17 percent of the NODs reviewed. There was no recommendation for improvement in this area as the VARO's NODs pending completion time was 73 days earlier than the national average. To improve in this area, review training was held on June 16, 2011 for Triage personnel responsible for initiating a VACOLS record within 7 days of receiving an NOD.

Appendix C Inspection Summary

Nine 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 Claims	**Determine whether VARO staff properly processed claims for PTSD.** (38 CFR 3.304(f))	X	
3. Traumatic Brain Injury Claims	**Determine whether VARO staff properly processed claims for 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 Claims	**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 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	

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 Rachel Stroup Nelvy Viguera Butler Diane Wilson

Appendix E Report Distribution

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