VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Reno, Nevada

June 24, 2011
11-00517-204

ACRONYMS AND ABBREVIATIONS

COVERS	Control of Veterans Records System
NOD	Notices 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
VAMC	Veterans Affairs Medical Center
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the VA Regional Office, Reno, Nevada

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

The Reno VARO staff correctly processed post-traumatic stress disorder disability claims and errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program. VARO performance was generally effective in processing herbicide exposure-related disability claims, establishing correct dates of claim in the electronic record, and timely establishing Notices of Disagreement for appealed decisions.

However, VARO management lacked effective control and accuracy in processing temporary 100 percent disability evaluations as well as traumatic brain injury claims. Overall, VARO staff did not accurately process 23 (24 percent) of the 95 disability claims reviewed. Further, controls over completion of Systematic Analyses of Operations and mail handling were not adequate.

What We Recommended

VARO management needs to provide refresher training and develop a plan to ensure staff follow the proper procedures for identifying and returning inadequate traumatic brain injury examination reports. VARO management needs to establish an additional level of review for traumatic brain injury rating decisions.

We recommended VARO management develop and implement a plan to ensure staff timely complete and address all required elements of Systematic Analyses of Operations. Finally, we recommended that management strengthen mail handling by developing a plan to ensure compliance with the Control of Veterans Record System and amending the mail plan to ensure proper mail handling procedures.

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.

(original signed by:)

BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

TABLE OF CONTENTS

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 March 2011, the OIG conducted an inspection of the Reno 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 eligibility determinations because VBA has centralized all Western Area fiduciary activities at the Salt Lake City VARO.

We reviewed 65 (31 percent) of 207 disability claims related to post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and herbicide exposure completed by the VARO from October through December 2010. In addition, we reviewed 30 (22 percent) of 139 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 Reno 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 Reno VARO needs to improve the control and accuracy of processing temporary 100 percent disability evaluations and TBI residual disability claims. VARO staff incorrectly processed 23 (24 percent) of the total 95 disability claims reviewed. We advised VARO management regarding the inaccuracies noted during our inspection and management initiated corrective measures to address them.

The table below reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Reno 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	18	5	13
PTSD	30	0	0	0
TBI	5	4	1	3
Herbicide Exposure-Related Disabilities	30	1	1	0
Total	**95**	**23**	**7**	**16**

Source: VA OIG analysis.

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 18 (60 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 needing surgery or specific treatment. At the end of a mandated period of convalescence or cessation of

treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's temporary 100 percent disability evaluations.

Based on analysis of available medical evidence, 5 of the 18 processing inaccuracies identified affected veterans' benefits—4 involved overpayments totaling $399,638 and one involved an underpayment totaling $9,930. Examples of the most significant overpayment and underpayment follow:

- A Rating Veterans Service Representative (RVSR) correctly proposed reducing a veteran's prostate cancer evaluation from 100 percent to 40 percent disabling. However, at the time of our inspection, VSC staff had not taken the final action to reduce the veteran's benefits. As a result, VA overpaid the veteran $242,153 over a period of 11 years and 8 months.
- An RVSR did not grant service-connection for bone cancer caused by a veteran's prostate cancer. Further, the RVSR did not grant entitlement to special monthly compensation as required based on an evaluation of multiple disabilities. As a result, VA underpaid the veteran $9,930 over a period of 3 years and 2 months.

The remaining 13 inaccuracies had the potential to affect veterans' benefits. In 11 of these cases, VSC staff did not establish or improperly canceled reminder notifications in the electronic record to schedule future reexaminations. We could not determine if these 11 temporary 100 percent disability evaluations would have continued because the veterans' claims folders did not contain the medical examination reports needed to reevaluate each case. In the two remaining cases, VSC staff erroneously scheduled reexaminations although the veterans had medical conditions known to be incurable.

Delays in scheduling reexaminations ranged from approximately 6 months to 7 years and 8 months. An average of 3 years and 1 month elapsed from the time staff should have scheduled these medical reexaminations until the date of our inspection—the date staff ultimately took corrective actions to obtain the necessary medical evidence.

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

The most frequent temporary 100 percent disability claims processing errors occurred when VARO staff did not properly establish suspense diaries for future medical reexaminations. VSC management stated, and we verified, the VARO did not have a procedure in place requiring VSC staff to review confirmed and continued rating decisions mandating future reexaminations. As a result, veterans did not always receive correct benefit payments.

The Acting Under Secretary for Benefits has already concurred with a recommendation regarding temporary 100 percent disability evaluations 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 agreed, as part of VBA's national review plan, to review all temporary 100 percent disability evaluations and ensure each evaluation has a future exam date entered in the electronic record. We will monitor implementation progress and gauge effectiveness of VBA's national review plan as we move forward in conducting our individual VARO inspections.

PTSD Claims

In accordance with VBA policy, VARO staff correctly processed all 30 of the PTSD claims we reviewed. 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 four (80 percent) of five TBI claims we reviewed. One of these processing inaccuracies affected a veteran's benefits, while the remaining three had the potential to affect veterans' benefits. The inaccuracy that affected a veteran's benefits occurred when an RVSR incorrectly evaluated residuals of a TBI as 40 percent disabling although VA medical examination results showed the disability warranted a 10 percent evaluation. As a result, VA overpaid the veteran $3,375 over a period of 1 year and 3 months.

In all four cases, RVSRs incorrectly evaluated TBI-related disabilities because they used inadequate medical examination reports when making disability determinations. In these cases, the veterans had residual disabilities associated with TBI and coexisting mental conditions. VA policy requires medical examiners to attribute cognitive and behavioral symptoms to either TBI or coexisting mental conditions, which best supports claims rating decisions.

In these instances, the medical examiners did not attribute the symptoms to either of the specific disabilities as required. Instead of returning the medical examination reports to the appropriate medical centers for correction, RVSRs made their own decisions in attributing the symptoms to either of the specific disabilities. Neither VARO staff nor we can ascertain whether residual disabilities are the results of TBI without adequate or complete medical examination reports.

VARO management stated these errors occurred because of insufficient VBA training provided, ongoing problems with inadequate medical examination reports from local VA Medical Centers (VAMCs), and pressure on RVSRs to process claims quickly to meet production standards. RVSRs generally supported the assertions made by management. Because of the processing errors, veterans did not always receive correct healthcare entitlements or benefits payments.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 1 (3 percent) of 30 herbicide exposure-related claims we reviewed. An RVSR incorrectly granted entitlement to special monthly compensation benefits a month before the veteran was entitled. As a result, VA overpaid the veteran $96. Given the infrequency of errors, we concluded the VARO generally followed VBA policy when processing these claims and made no recommendations for improvement in this area.

Recommendations

1. We recommend the Reno VA Regional Office Director ensure Rating Veterans Service Representatives receive refresher training on how to identify inadequate traumatic brain injury medical examinations.
2. We recommend the Reno VA Regional Office Director develop and implement a plan to ensure traumatic brain injury medical examinations determined to be inadequate for rating purposes are returned to the appropriate VA medical facilities for correction.
3. We recommend the Reno VA Regional Office Director establish an additional level of review for all traumatic brain injury claims prior to finalizing ratings decisions as a means of ensuring accurate benefit payments.

Management Comments

The VARO Director concurred with our recommendations related to improving disability claims processing. The Director informed us that in March 2011, Rating Veterans Service Representatives received refresher training on identifying inadequate VA medical examinations. The Director stated Supervisory Veterans Service Representatives will review all TBI medical examinations and return inadequate examinations to the appropriate VA medical facility for correction. Further, the Reno VARO will follow VBA's national guidance, which requires a second level of review for all TBI claims.

OIG Response

A draft of this inspection report included an additional recommendation that the VA Regional Office Director implement controls to ensure staff establish suspense diaries for scheduling temporary 100 percent disability evaluations. We have removed the recommendation because the Acting Under Secretary for Benefits has already concurred with a corresponding recommendation in our national report, V*eterans 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. We will monitor implementation progress and gauge effectiveness of VBA's national review plan approach as we move forward in conducting our individual VARO inspections.

2. Data Integrity

Dates of Claim

We analyzed claims folders to determine whether the VARO is following VBA policy to establish dates of claim in the electronic record. 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 number of days to complete a claim. VARO staff established an incorrect date of claim in the electronic record for 1 (3 percent) of the 30 claims we reviewed. Generally, VARO staff followed VBA policy when establishing dates of claim, so we made no recommendation for improvement in this area.

Notices of Disagreement

We reviewed claims folders to determine whether VARO staff timely recorded 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 it. 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.

The VARO exceeded VBA's 7-day standard for 3 (10 percent) of 30 NODs reviewed. However, of the 30 NODs we reviewed, the average time to create a VACOLS record was 4 days, well below the standard. Therefore, we made no recommendations 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 that veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that the VARO take corrective action on errors that STAR identifies.

VARO staff adhered to the policy by taking corrective actions to address all eight errors VBA's STAR program identified during the first quarter of Fiscal Year 2011. In addition, VARO management appropriately used information regarding these errors to develop a plan to train staff. As such, we made no recommendations for improvement in this area.

Systematic Analyses 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 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 an annual SAO schedule that identifies specific dates and designates staff to complete each analysis.

Finding 2 Improved Oversight Is Needed To Ensure SAOs Are Timely and Complete

VARO staff did not always ensure SAOs were timely and complete. This occurred because VARO management did not provide adequate oversight to ensure VSC staff timely completed SAOs according to the annual schedule and addressed all elements required by VBA policy. As a result, VARO management may not have identified existing and potential problems, which after taking correction action, could have improved VSC operations.

The VSC Manager is responsible for ongoing analysis of VSC operations, including completing the required 11 annual SAOs. Our analysis revealed 6 (55 percent) of the 11 SAOs were either incomplete or not completed

within the time frames listed on the annual SAO schedule. Specifically, staff did not complete three by the date on the annual SAO schedule, two were never completed, and one did not address all required elements. For the SAOs not timely completed, the delays ranged from 32 to 91 days. Management had not completed two SAOs, Division Management and Internal Controls, since 2006 and 2007, respectively. Additionally, staff did not address the required element of "Implementation of Workload Management Plan and Effectiveness" for the Claims Processing Timeliness SAO.

Management informed us they placed a higher priority on meeting end-of-year performance goals than on oversight of the SAO process. Based on this finding, the VSC manager recommended changing the annual schedule to allow SAO completion earlier in the year when the VARO has fewer conflicting priorities.

We identified several areas where, by not providing adequate oversight to ensure timely and complete SAOs, management did not identify VSC operational problems for corrective action. For example, had management thoroughly completed the Claims Processing Timeliness SAO, it might have determined the current workload management plan was not effective to ensure staff followed search mail and claims folder follow-up procedures, as required.

Recommendation

4. We recommend the Reno 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 Director concurred with our recommendation and assigned oversight responsibility for Systematic Analyses of Operations to a VARO management analyst. Further, the Director indicated management created a VARO circular that will provide additional guidance for the management analyst to follow.

OIG Response

Management's comments and actions are responsive to the recommendation.

4. Workload Management

Mailroom Operations

We assessed controls over mailroom operations to ensure VARO 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 Reno VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the VSC. VARO mailroom staff processed, date stamped, and delivered all VSC mail to the Triage mail point on a daily basis as required; therefore, we made no recommendations for improvement in this area.

Military File Mail

VBA policy allows the use of a storage area, known as the Military File, for VSC staff to store mail temporarily. Typically, the mail stored in this area involves matters over which VA has jurisdiction or the mail does not refer to a claim for benefits and/or does not have a return address. The VARO correctly processed all 10 pieces of mail maintained in the Military File; therefore, we made no recommendations for improvement in this area.

Drop Mail

We found 4 (13 percent) of 30 pieces of drop mail had been erroneously processed or misrouted. Generally, this means staff did not correctly categorize and follow local procedures for processing this mail. VSC management provided on-the-spot training to a Triage Team employee responsible for three of the errors. Our findings do not indicate a systemic issue; therefore, we concluded the Triage Team generally followed policy when processing drop mail. As such, we made no recommendations for improvement in this area.

Triage Mail Processing Procedures

We assessed the VSC mail processing procedures to ensure Triage Team staff reviewed, controlled, and processed all claims-related mail in accordance with VBA and local policies. VBA policy indicates that oversight to ensure staff use available plans and systems is the most important part of workload management. It also states that effective mail management is crucial to the success and control of workflow within the VSC.

VBA policy requires staff use the Control of Veterans Records System (COVERS), an electronic tracking system, to track claims folders and search mail. Additionally, VBA policy states VSC staff will route and process mail requiring action according to established procedures. VBA defines search mail as active claims-related mail waiting to be associated with a veteran's claims folder and drop mail as mail received where no processing action is necessary.

Finding 3 Controls Over Mail Processing Need Strengthening

The Triage Team did not always process mail according to VBA and local policies. This occurred because current local policies did not incorporate oversight of all search mail procedures, lacked specific procedures for drop and search mail functions, and conflicted with current procedures. Consequently, RVSRs may not always have all available mail in the claims folders to support making disability determinations and claimants may not always receive prompt and accurate benefits.

Overall, VARO staff did not correctly process or control 21 (28 percent) of 75 pieces of mail reviewed from search, drop, and military mail. Specifically, we identified weaknesses associated with the processing of

search mail, which included mail related to claims folders temporarily transferred to medical centers.

Search Mail

For 17 (49 percent) of 35 pieces of search mail reviewed, VSC staff did not properly use COVERS functions to ensure accurate and timely processing. Staff did not retrieve and associate 13 individual pieces of search mail with the claims folders as required even though COVERS contained electronic notices of pending search mail requests. For the remaining four inaccuracies, staff did not conduct follow-up requests to ensure staff returned claims folders with pending searches to the VARO. Following are examples of inaccuracies associated with search mail.

- VSC staff temporarily transferred a veteran's claims folder to a VAMC for a medical examination while search mail was pending. VSC staff did not ensure that medical facility personnel returned the claims folder upon completion of the medical examination, as required. As a result, VSC staff delayed processing the veteran's claim for 177 days after the medical examination was completed.
- VSC staff received a veteran's claim for benefits and properly placed it on search in COVERS. The staff then temporarily transferred the claims folder to a VAMC for the veteran's medical examination without first associating the mail with the file and completing the initial development of additional evidence to support the claim. As a result, VSC staff delayed initial processing on this claim for 114 days despite three separate inquiries by the veteran to the National Call Center and one inquiry on behalf of the veteran by a veteran's service organization.
- VSC staff received a form from a veteran allowing VA to obtain private medical records to support a pending claim for benefits. Despite receiving electronic notifications in COVERS, staff did not associate this mail with the claims folder. Consequently, VSC staff delayed requesting the medical records for 62 days until the time of our inspection.

VARO leadership acknowledged weaknesses associated with search mail procedures. VSC management prepared an initial mail plan in January 2011; however, the plan did not contain the minimum requirements required by VBA policy. Specifically, the plan did not incorporate workload management procedures to ensure compliance with COVERS search mail requirements to timely associate mail with veterans' claims folders. Additionally, the plan did not incorporate specific information on how drop and search mail should be managed within the VSC. For example, we identified VSC staff placing drop mail on search in COVERS even though the related claims folders were located within the VSC. VBA policy states that staff will not place mail on search if the claims folder is located at the VARO.

Further, current VSC procedures conflicted with the VSC's written policy regarding how staff would follow-up with VAMCs to ensure the return of claims folders to the VARO. The COVERS written user plan requires Triage Team staff to follow up every 2 weeks on claims folders transferred to VAMCs. However, VSC management verbally informed Veterans Service Representatives assigned to the Pre-Determination Team that they were responsible for conducting such follow-up. Because of this conflicting guidance, neither the staff on the Triage Team nor Predetermination Teams ensured the timely return of claims folders from the VAMCs after completion of medical examinations. One team expected the other team would carry out the responsibility and at times, amid the confusion, the responsibility lapsed. Ultimately, delays in returning claims folders to the VARO caused delays in overall time to process veterans' claims.

Recommendations

5. We recommend the Reno VA Regional Office Director develop a plan to ensure compliance with Control of Veterans Records System procedures for staff to associate search mail with related claims folders.

6. We recommend the Reno VA Regional Office Director amend the mail plan to include specific information regarding how drop and search mail should be managed within the Veterans Service Center.

7. We recommend the Reno VA Regional Office Director ensure Veterans Service Center management provides clear, consistent guidance for ensuring timely return of claims folders from VA Medical Centers.

Management Comments

The VARO Director concurred with our recommendations to strengthen controls over mail processing. The Director informed us that in March 2011, supervisors received training on their COVERS oversight responsibilities as delineated in the VARO's COVERS user plan. He stated the VARO mail plan will be amended to include detailed guidance on how search and drop mail will be managed in the VSC.

Further, VSC management provided refresher training to supervisors regarding procedures for following-up on all claims folders temporarily transferred to other locations, as outlined in the Workload Management Plan. The COVERS user plan will be updated to define user responsibilities for performing follow-up actions for pending claims.

OIG Response

Management's comments and actions are responsive to the recommendations.

Appendix A VARO Profile and Scope of Inspection

Organization

The Reno VARO is responsible for delivering nonmedical VA benefits and services to veterans and their families in Nevada and the California counties of Alpine, Lassen, Modoc, and Mono. The VARO fulfills these responsibilities by administering compensation and pension benefits, vocational rehabilitation and employment assistance, and outreach activities.

Resources

As of February 2011, the Reno VARO had a staffing level of 96 full-time employees. Of these, the VSC had 83 employees (86 percent) assigned.

Workload

As of February 2011, the Reno VARO reported 6,934 pending compensation claims. The average time for VARO staff to complete these claims was 259.7 days—84.7 days longer than the national target of 175 days. As reported by STAR, accuracy of compensation rating-related processing was 89.4 percent, just below the 90 percent target set by VBA.

Scope

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

Our review included 65 (31 percent) of 207 disability claims related to PTSD, TBI, and herbicide exposure that the VARO completed from October through December 2010. For temporary 100 percent disability evaluations, we selected 30 (22 percent) of 139 existing claims from VBA's Corporate Database. We provided the VARO with the 109 claims remaining from our universe of 139 for their review. The 139 claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months.

We reviewed eight errors identified by VBA's STAR program during the period from October through December 2010. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR 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 disability claims such as PTSD, TBI, and herbicide exposure 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: June 8, 2011

From: Director, Reno VA Regional Office (354/00)

Subj: Inspection of the VA Regional Office, Reno, Nevada

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

1. Attached are the Reno VARO's comments on the OIG Draft Report: Inspection of the VA Regional Office, Reno, Nevada.

2. Please feel free to contact me at (75) 321-4701 with any questions or concerns regarding our reply.

/s/

Edward Russell

Director

Attachment

IG Recommendations:

Recommendation 1: We recommend the Reno VA Regional Office Director implement controls to ensure staff establishes suspense diaries for scheduling temporary 100 percent disability reevaluations.

RO Comments: Non-Concur

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 Reno Regional Office will follow the national review plan.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 2: We recommend the Reno VA Regional Office Director ensure Rating Veterans Service Representatives receive refresher training on how to identify inadequate traumatic brain injury medical examinations.

RO Comments: Concur

Refresher training was provided to Rating Veterans Service Representatives on how to identify inadequate traumatic brain injury medical examinations on March 23, 2011.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 3: We recommend the Reno VA Regional Office Director develop and implement a plan to ensure traumatic brain injury medical examinations determined to be inadequate for rating purposes are returned to the appropriate VA medical facilities for correction.

RO Comments: Concur

All TBI medical examinations are routed to a Supervisory Veterans Service Representative for initial review. Those found to be inadequate for rating purposes are returned to the appropriate VA medical facility for correction. This change was implemented March 23, 2011.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 4: We recommend the Reno VA Regional Office Director establish an additional level of review for all traumatic brain injury claims prior to finalizing ratings decisions as a means of ensuring accurate benefit payments.

RO Comments: Concur

In response to OIG report “Systemic Issues Reported During Inspections at VA Regional Offices”, dated May 18, 2011, the Office of Field Operations issued second signature guidance for traumatic brain injury claims on May 31, 2011. Therefore, the Regional Office will follow this national guidance.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 5: We recommend the Reno VA Regional Office Director develop and implement a plan to ensure staff complete Systematic Analyses of Operations timely and address all required elements.

RO Comments: Concur

The RO Management Analyst has been assigned to provide oversight to ensure SAOs are timely and complete. The Management Analyst will follow the detailed guidance provided by RO Circular 00-10-3, dated February 5, 2010.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 6: We recommend the Reno VA Regional Office Director develop a plan to ensure compliance with Control of Veterans Records System procedures for staff to associate search mail with related claims folders.

RO Comments: Concur

The COVERS user plan dated November 2009, includes direction to team supervisors designed to ensure compliance with the plan in the Veterans Service Center. Refresher training on supervisor responsibilities was provided to the team supervisors on March 21, 2011.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 7: We recommend the Reno VA Regional Office Director amend the mail plan to include specific information regarding how drop and search mail should be managed within the Veterans Service Center.

RO Comments: Concur

The RO mail plan will be amended to include specific information regarding how drop and search mail will be managed within the Veterans Service Center. The revised plan will be completed by July 1, 2011.

Recommendation 8: We recommend the Reno VA Regional Office Director ensure Veterans Service Center management provides clear, consistent guidance for ensuring timely return of claims folders from VA Medical Centers.

RO Comments: Concur

The Veterans Service Center Workload Management Plan dated January 14, 2011, clearly establishes responsibility for follow-up actions on all pending claims. On March 21, 2011, refresher training on the Workload Management Plan was provided by the Veterans Service Center Manager to team supervisors. The COVERS user plan dated November 2009, assigns responsibility to members of the Triage team to follow up on all claims folders temporarily

transferred to other locations. This includes claims folders sent to VA Medical Centers as well as a number of other locations. This COVERS user plan will be amended to define user responsibilities for performing follow-up actions when claims are pending. The revised plan will be completed by July 1, 2011.

Appendix C Inspection Summary

9 Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. 100 Percent Disability Evaluations	**Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations**. (38 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1MR 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 claims for service connection for all residual disabilities related to in-service TBI were properly processed.** (Fast Letters 08-34 and 08-36, Training Letter 09-01)		X
4. Herbicide Exposure-Related Claims	**Determine whether VARO staff properly processed claims for service connection for herbicide exposure (Agent Orange).** (38 CFR 3.309) (Fast Letter 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 Analyses 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

CFR=Code of Federal Regulations, M=Manual, MR=Manual Re-write

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Brent Arronte, Director Kristine Abramo Daphne Brantley Robert Campbell Madeline Cantu Danny Clay Lee Giesbrecht Kerri Leggiero-Yglesias Mark Ward

Appendix E Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Assistant Secretaries
Office of General Counsel
VBA Western Area Director
VARO Reno Director

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Dean Heller, Harry Reid
U.S. House of Representatives: Shelley Berkley, Joe Heck

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/publications/reports-list.asp. This report will remain on the OIG Web site for at least 2 fiscal years.