VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Salt Lake City, Utah

April 13, 2011
10-03880-142

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

Report Highlights: Inspection of the VA Regional Office, Salt Lake City, Utah

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

Salt Lake City VARO management ensured staff generally followed Veterans Benefits Administration policy for processing post-traumatic stress disorder and herbicide exposure-related disability claims. VARO staff ensured timely completion of Systematic Analyses of Operations and corrected errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program.

VARO management lacked effective controls and accuracy in processing temporary 100 percent disability evaluations and traumatic brain injury claims. Overall, VARO staff did not accurately process 32 (27 percent) of the 120 disability claims we reviewed. Additionally, VARO management lacked control of outstanding action items related to disability claims processing.

Although VARO staff were not timely in recording Notices of Disagreement for appealed claims, they were better than the national average for processing the appeals. Further, establishing correct dates of claim in the electronic record and managing mail in the Triage Team also were not fully effective.

What We Recommended

We recommended Salt Lake City VARO management review all remaining temporary 100 percent disability evaluations identified during our inspection to determine if reevaluations are required and take appropriate action. We recommended management implement controls to ensure Veterans Service Center staff establish suspense diaries to request medical examinations for temporary 100 percent disability reevaluations and follow policy for processing related action items. We recommended VARO management provide comprehensive training for processing traumatic brain injury claims. Further, we recommended management strengthen controls to ensure accurate dates of claim in the electronic record and timely processing of incoming mail.

Agency Comments

The Director of the Salt Lake City VARO concurred with all recommendations. Management's planned actions are responsive and we will follow up as required on all actions.

(original signed by:)
BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

The Benefits Inspection Program is part of the efforts of the Office of Inspector General (OIG) to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Division contributes to improved management of benefits processing activities and veterans' services by conducting onsite inspections at VA Regional Offices (VAROs). These independent inspections provide recurring oversight focused on disability compensation claims processing and performance of Veterans Service Center (VSC) operations. The objectives of the inspections are to:

- Evaluate how well VAROs are accomplishing their mission of providing veterans 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 November 2010, the OIG conducted an inspection of the Salt Lake City 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 VBA has centralized all Western Area fiduciary activities at the Salt Lake City VARO.

We reviewed 90 (18 percent) of 502 disability claims related to post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and herbicide exposure that the VARO completed from July through September 2010. In addition, we reviewed 30 (35 percent) of 85 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 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 Salt Lake City VARO needs to improve the accuracy of disability claims processing. VARO staff incorrectly processed 32 (27 percent) of the total 120 disability claims reviewed. VARO management agreed with our findings and initiated action to correct the inaccuracies identified.

The following table reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Salt Lake City 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	16	4	12
PTSD	30	2	1	1
TBI	30	12	2	10
Herbicide Exposure-Related Disabilities	30	2	1	1
Total	**120**	**32**	**8**	**24**

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 16 (53 percent) of 30 temporary 100 percent disability evaluations we reviewed. Veterans Benefits Administration (VBA) policy requires a temporary 100 percent disability evaluation for service-connected disabilities 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 100 percent disability benefits.

Based on analysis of available medical evidence, 4 of the 16 processing inaccuracies affected veterans' benefits—2 involved overpayments totaling $113,834 and 2 involved underpayments totaling $11,674. Details on the most significant overpayment and underpayment follow.

- A Rating Veterans Service Representative (RVSR) incorrectly granted one of the highest levels of special monthly compensation based on the veteran needing assistance dressing and bathing. VBA policy states a veteran is entitled to the higher level of special monthly compensation when medical evidence shows the need for daily services provided by a licensed healthcare provider or a person under the supervision of a licensed healthcare provider. In this case, the VA medical examination did not show the veteran met this criterion. As a result, VA overpaid the veteran $80,294 over a period of 2 years and 3 months.
- An RVSR did not grant a veteran entitlement to special monthly compensation based on evaluations of multiple disabilities, as required by VBA policy. As a result, VA underpaid the veteran $7,662 over a period of 2 years.

The remaining 12 inaccuracies had the potential to affect veterans' benefits. Following are summaries of these inaccuracies:

- In one case, VSC staff proposed reducing a veteran's temporary 100 percent disability evaluation, but failed to take final action on the proposal. However, medical evidence showed residual complications that might negate a reduction in the service-connected condition. Without a current medical reexamination and review of the evidence, it is not possible to determine whether the temporary 100 percent disability evaluation should continue.
- In 11 cases, VSC staff failed to schedule the follow-up medical examinations needed to determine whether the temporary 100 percent disability evaluations should continue.

For these 11 cases, we could not determine whether the temporary 100 percent disability evaluations would have continued because the veterans' claims folders did not contain the medical evidence needed to reevaluate each case. An average of 2 years and 9 months elapsed from the time staff should have scheduled 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 3 months to 11 years and 5 months.

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 diary is a processing command that establishes a date when VSC staff must schedule a reexamination. As a diary matures, the electronic system generates a reminder notification, known as an 810 work item, to alert VSC staff to schedule the reexamination.

Eight of the 16 temporary 100 percent disability evaluation errors resulted from staff not establishing suspense diaries to schedule reexaminations for confirmed and continued evaluations. VSC management and staff believed suspense diaries were automatically generated from the rating decision and were not aware these diaries required manual input. VARO management had no procedure or oversight measures in place to ensure staff properly input suspense diaries to VBA's electronic system to generate reminder notifications to schedule the reexaminations.

We found approximately 390 pending reminder notifications (i.e., 810 work items); the oldest had been pending since May 2010. VSC's Workload Management Plan requires bi-weekly review of work items. However, VSC staff indicated that based on misunderstanding of requirements for scheduling reexaminations, supervisors instructed them to stop reviewing 810 work items. As a result, medical reexaminations were not timely scheduled.

PTSD Claims

VARO staff incorrectly processed 2 (7 percent) of 30 PTSD claims. We did not consider the frequency of errors as significant; however, one error affected a veteran's benefit, and one error had the potential to affect a veteran's benefit. Following are summaries of the inaccuracies identified regarding PTSD claims:

- In one case, an RVSR incorrectly granted service connection for PTSD based on an inadequate VA medical examination conducted by a non-mental health practitioner. As a result, the veteran was overpaid $10,764 over a period of 1 year and 6 months.
- In one case, an RVSR determined a veteran was unemployable due to service-connected disabilities. However, the RVSR did not address either the need for a future examination or entitlement to the additional benefit of Dependents' Educational Assistance as required by VBA policy.

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

TBI Claims

The Department of Defense and VBA commonly define a TBI as traumatically induced structural injury or physiological disruption of brain function caused by an external force. The major residual disabilities of TBI

fall into three main categories—physical, cognitive, and behavioral. VBA policy requires staff to evaluate these residual disabilities.

VARO staff incorrectly processed 12 (40 percent) of 30 TBI claims. Two of the processing inaccuracies affected veterans' benefits with overpayments totaling $3,186. Details on the two overpayments follow.

- An RVSR incorrectly evaluated a veteran's residual TBI-related disabilities as 40 percent disabling based on symptoms related to the veteran's PTSD. The VA medical examination showed TBI-related subjective symptoms warranting no more than a 10 percent disability evaluation. The VA medical examiner attributed all other symptoms to the veteran's service-connected PTSD. As a result, the veteran was overpaid $2,301 over a period of 1 year and 1 month.
- An RVSR incorrectly assigned a 10 percent disability evaluation for residual TBI-related disabilities based on cognitive impairment. The medical examiner determined the cognitive impairment was related to the veteran's currently service-connected PTSD and not related to a TBI. As a result, VBA was compensating the veteran's cognitive symptoms under both PTSD and TBI-related disabilities. Therefore, the veteran was overpaid $885 over a period of 5 months.

Following are details on the remaining 10 TBI inaccuracies that had the potential to affect veterans' benefits:

- In six cases, RVSRs prematurely evaluated residual TBI-related disabilities using inadequate medical examinations. In these cases, the medical examinations did not specifically state, as required, whether the veterans' complaints and symptoms were due to either TBI or a mental disorder. 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 adequate or complete medical evidence.
- In three cases, RVSRs incorrectly evaluated TBI-related residuals in veterans who were also service-connected for PTSD. In each case, the RVSR attributed symptoms to the veteran's TBI-related residual disabilities; however, the medical examiners stated the symptoms were due to the veteran's service-connected PTSD. These ratings did not affect the veterans' overall disability evaluations but may affect future evaluations for additional benefits.
- In one case, an RVSR evaluated residual TBI-related disabilities using an inadequate medical examination. Pertinent medical evidence was available in Virtual VA—the Department's system for electronically

maintaining veterans' claims folders. However, the medical examiner did not review this evidence because Virtual VA is not available to medical examiners. VSC staff should have provided a copy of this medical evidence to the medical examiner. 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 management did not provide adequate training. Although VSC management conducted TBI training in May 2010, a Systematic Analysis of Operations (SAO) completed in July 2010 continued to identify a high error rate in TBI-related rating decisions and local quality reviews disclosed errors similar to those found during our inspection. The most recent TBI training occurred in August 2010; however, the training lasted approximately 10 minutes and did not address what to do in case of inadequate medical examinations. Because of this lack of adequate training, veterans did not always receive correct benefits.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 2 (7 percent) of 30 herbicide exposure-related claims we reviewed. We did not consider the frequency of errors significant; however, one error affected a veteran's benefit and one error had the potential to affect a veteran's benefit. Following are summaries of the inaccuracies identified regarding herbicide exposure-related disability claims.

- In one case, an RVSR granted a 0 percent disability evaluation for prostate cancer due to Agent Orange exposure although the latest medical evidence showed active cancer warranting a 100 percent disability evaluation. As a result, the veteran was underpaid $16,992 over a period of 7 months.
- In one case, an RVSR failed to increase a diabetes evaluation from 10 to 20 percent disabling. Medical evidence showed treatment with medication warranting a 20 percent disability evaluation. Because of the veteran's multiple service-connected disabilities, this error does not immediately affect this veteran's benefits; however, failure to assign a higher evaluation may affect future evaluations for additional benefits.

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

Recommendations

1. We recommend the Salt Lake City VA Regional Office Director conduct a review of the 55 temporary 100 percent disability claims remaining

from our universe of 85 to determine if reevaluations are required and take appropriate action.

2. We recommend the Salt Lake City VA Regional Office Director implement controls to ensure staff establish suspense diaries for scheduling temporary 100 percent disability reevaluations.
3. We recommend the Salt Lake City VA Regional Office Director develop and implement comprehensive training to ensure Rating Veterans Service Representatives properly evaluate disabilities related to traumatic brain injury claims.
4. We recommend the Salt Lake City VA Regional Office Director conduct a review of all pending 810 work items to determine if medical reexaminations are required and take appropriate actions.
5. We recommend the Salt Lake City 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.

Management Comments

The VARO Director concurred with our recommendations for improving disability claims processing accuracy. To address Recommendations 1 and 2, VSC staff reviewed an additional 55 temporary 100 percent disability cases identified by the OIG and determined 30 required reexaminations. The Director stated that until May 2010, VSC management incorrectly assumed the electronic system automatically established suspense diaries for confirmed and continued rating decisions. Given this misunderstanding, VARO management proceeded to review all of its temporary 100 percent disability evaluation decisions since February 2007 and scheduled immediate reexaminations or established suspense diaries as needed. As a result of the inaccuracies identified, VSC management provided additional guidance and procedures to its claims processing staff for properly establishing suspense diaries.

Similarly, to address Recommendation 3, VARO management requested for review all of its recent TBI decisions. To ensure improved processing in the future, the VARO provided training in September 2010 and December 2010 to all RVSRs on the proper procedures for rating TBI claims. Additionally, the Director stated Quality Decision Review Officers would conduct a local inter-rater reliability study in the current month, review a random sample of 36 (10 percent) of the 364 TBI cases identified, and conduct a second inter-rater reliability study in May 2011 to assess effectiveness of the training provided.

Further, in response to Recommendations 4 and 5, the VARO Director indicated that VSC management had incorrectly interpreted VBA guidance to mean that review and processing of 810 work items were no longer

necessary. VSC staff reviewed all 810 work items pending at the VARO during our inspection and requested reexaminations, as appropriate. To meet requirements of the workload management plan, VSC supervisors now provide staff with a list of pending 810 work items every Monday and Thursday for review and processing. Additionally, VSC management will review all pending 810 work items the first day of each month.

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

2. Data Integrity

Effective Dates We analyzed claims folders to determine if the VARO is following VBA policy to establish correct effective dates in the electronic record. Generally, an effective date indicates when entitlement to a specific benefit arose. VARO staff incorrectly established an effective date for 1 (less than 1 percent) of 120 disability claims we reviewed.

In the one inaccuracy, the VARO denied the veteran's claim for service connection on August 23, 2001, because the veteran did not have a diagnosis of prostate cancer. The veteran reopened the claim on May 22, 2002, and provided medical evidence showing a diagnosis of prostate cancer on April 15, 2002. The RVSR granted service connection for prostate cancer with an incorrect effective of May 22, 2002. Because the veteran submitted the medical evidence within 1 year of the denial, VA regulations state the effective date is the date of diagnosis. As a result, the veteran was underpaid $1,682 over a period of 1 month.

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

Notices of Disagreement An NOD is a written communication from a claimant expressing dissatisfaction or disagreement with a benefit decision and a desire to contest the decision. An NOD represents 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.

VARO staff did not meet this standard for 13 (43 percent) of 30 NODs we reviewed. Staff took an average of 24 days to record these 13 disagreements in VACOLS. However, as of October 2010, the VARO was achieving VBA's goal by averaging 6 days to control NODs, which was 1 day below the 7-day standard. In addition, the VARO's NODs have been pending completion an average of 126 days, 95 days better than the national average

of 221 days. Therefore, we made no recommendations for improvement in this area.

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 using the date of claim to establish the timeframe for benefits entitlement, VBA generally uses it 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.

Finding 2 Controls over Recording Dates of Claim Need Strengthening

VSC staff did not establish the correct dates of claim in the electronic record for 4 (13 percent) of 30 documents reviewed. Details on the four inaccuracies follow.

- The date of claim could not be verified because VSC staff used a hand-held date stamp. VBA policy required VARO management to replace all hand-held date stamps located in a VARO, with lockable electronic date stamps no later than May 15, 2009.
- VSC staff did not select the earliest date to establish a veteran's claim as required, even though the document contained two official date stamp entries.
- VSC staff established an incorrect date of claim of August 27, 2010, based on the use of a hand-held date stamp on the claim. The claim document, located in Virtual VA—the Department's system for electronically maintaining veterans' claims folders, showed the veteran requested to file a claim on September 3, 2010. Neither VARO staff nor we can ascertain why the hand-held date stamp was earlier than the actual receipt of the claim.
- The date of claim for a paperless claim could not be verified. The original claim document could not be located in either the claims folder or Virtual VA.

Generally, errors occurred because management did not provide adequate quality review oversight to ensure staff accurately documented dates of claim. Although the VSC Workload Management Plan dated January 15, 2010, and updated June 11, 2010, indicates management will conduct local quality reviews, a VSC supervisor stated the reviews started only 1 month prior to our November 2010 inspection. The supervisor also reported staff had been using an unofficial date stamp for any undated mail received by the Triage Team. VSC management stated staff had submitted a request to obtain an official electronic date stamp for the Triage Team;

however, the date stamp had not been received by the time we completed our inspection.

Incorrect dates recorded in the electronic record affect data integrity and misrepresent VARO performance. Data integrity issues make it difficult for senior leadership to accurately determine office performance. Further, not ensuring the correct date of claim increases the risk of inaccurate benefits payments.

Recommendations

6. We recommend the Salt Lake City VA Regional Office Director develop and implement a plan for providing adequate quality review oversight to ensure staff correctly establish dates of claim.

Management Comments

The VARO Director concurred with our recommendation. The Director stated VSC management provided refresher training to its staff and now conducts monthly quality reviews on proper dates of claim. Additionally, the VARO Director indicated that date of claim accuracy, as reported by STAR, was 100 percent in December 2010, 95.8 percent in January 2011, and 100 percent in February 2011.

The Director provided additional comments regarding our mention of the use of a hand-held date stamp. The Director stated the VARO neither uses nor possesses a hand-held date stamp and our reference to the existence of one at the regional office was inaccurate.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions. We are encouraged by the Director's information regarding STAR findings on the accuracy of dates of claim.

With respect to the Director's additional comments, our review found two pieces of documentation that obviously had been stamped with a hand-held date stamp. VBA policy states that "All VBA date stamps, both electronic and manual, must contain the regional office name, station number and date received (mm/dd/yyyy)." In both of the examples we identified, the date stamp did not contain the VARO name and station number, and the date of receipt was not in the required format. Although we cannot determine whether the VARO or an intake site used the hand-held date stamp, we maintain VARO personnel should have stamped the documentation with an official date stamp as required when they received the documentation.

3. Management Controls

Systematic Technical Accuracy Review

We assessed management controls to determine if VARO management adhered to VBA policy regarding correction of errors identified by VBA's Systematic Technical Accuracy Review (STAR) staff. The STAR program is VBA's multi-faceted quality assurance program to ensure veterans and

other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires the VARO take corrective action on errors identified by STAR.

VARO staff did not correct 1 (6 percent) of 16 errors identified by VBA's STAR program staff from April through June 2010. Because Salt Lake City VARO management generally followed VBA policy regarding correction of STAR errors, we made no recommendations for improvement in this area.

Systematic Analysis of Operations

We assessed controls to determine whether VARO management had controls in place to ensure complete and timely submission of Systematic Analysis of Operations (SAOs). An SAO is a formal analysis of an organizational element or operational function of the VSC. 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 designating the staff required to complete the SAOs by specific dates.

All SAOs were complete at the time of our inspection. However the VSC completed three of the required SAOs more than 30 days after the assigned due dates. The delays had no impact on VSC operations. Because Salt Lake City VARO management generally followed VBA policy regarding SAOs, we made no recommendations for improvement in this area.

4. Workload Management

Mail Room 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 Salt Lake City VARO assigns responsibility for mailroom activities (including the 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 was following VBA policy. Therefore, we made no recommendations for improvement in this area.

Triage Mail Processing Procedures

We assessed the VSC's Triage Team mail processing procedures to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy. 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 a veteran's claims folder. VBA policy also allows the use of a storage area, known as the Military File, to hold mail temporarily when staff are not able to identify an associated claims folder in the system. We found controls

over Triage Team mail processing search mail and use of the military file needs strengthening.

Finding 4 Triage Team Mail Management Procedures Need Strengthening

Triage Team staff did not always manage search mail according to VBA policy. For 8 (27 percent) of 30 pieces of search mail reviewed, staff did not properly use COVERS to ensure timely processing and adequate control of search mail. This occurred because the workload management plan did not include supervisory oversight procedures to ensure periodic review of mail remaining in the search bin. As a result, beneficiaries may not receive accurate and timely benefit payments.

VSC Triage Team staff did not manage the Military File according to VBA policy. The staff stored mail according to the date it was received at the regional office, instead of alphabetically as required by VBA policy. Filing by date received made it difficult for staff to quickly retrieve the mail and place it with the associated claims folder once the folder was located. Further, VSC staff placed Service Treatment records in the Military File, instead of sending them to the Records Management Center as required by VBA policy. This occurred because the workload management plan did not address oversight of the Military File. Additionally, supervisory staff were unaware of VBA's policy requiring documents be filed alphabetically. As a result, mail may not be associated with claims and beneficiaries may not receive accurate and timely benefit payments.

Recommendations

7. We recommend the Salt Lake City VA Regional Office Director develop and implement procedures to ensure management oversight and control of Triage Team search mail activity and the Military File.

Management Comments

The VARO Director concurred with our recommendation. The Director stated that on November 17, 2010, VSC management conducted training on proper procedures for maintaining the Military File. Management oversaw reorganization of the Military File to meet VBA policy requirements. The Directors stated that VSC management would update the workload management plan to require monthly review of the Military File. Further, VSC management assigned a staff member to review pending search mail weekly, instead of sporadically as prior to our inspection. Additionally, VSC supervisors drafted standard operating procedures for managing search mail.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

The Salt Lake City VARO is responsible for delivering non-medical VA benefits and services to veterans and their families in Utah. The VARO fulfills these responsibilities by administering compensation and pension benefits, vocational rehabilitation and employment assistance, and outreach activities.

Resources

As of September 2010, the Salt Lake City VARO had a staffing level of 492 full-time employees. Of these, the VSC had 249.6 employees (51 percent) assigned.

Workload

As of the end of FY 2010, the VARO reported 4,092 pending compensation claims. The average time to complete claims during FY 2010 was 156.6 days—6.6 days longer than the national target of 150 days. As reported by STAR staff, the accuracy of compensation rating-related issues was 81.3 percent—8.7 percent below the 90 percent VBA target. The accuracy of compensation authorization-related issues was 95 percent—1 percent below the 96 percent VBA target.

Scope

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

Our review included 90 (18 percent) of 502 claims related to PTSD, TBI, and herbicide exposure-related disabilities that the VARO completed from July through September 2010. For temporary 100 percent disability evaluations, we selected 30 (35 percent) of 85 existing claims from VBA's Corporate Database. The 85 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 55 claims remaining from our universe of 85 to assist in implementing our first report recommendation.

We reviewed 16 errors identified by VBA's STAR program from April through June 2010. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR's measurements include a review of work associated with claims that require a rating decision. 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 in that 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 determinations.

For our review, we selected dates of claims and NODs 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.*

Appendix B VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: March 17, 2011

From: Director, Salt Lake City VA Regional Office (341/00)

Subj: Inspection of the Salt Lake City VA Regional Office

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

1. Enclosed are the Salt Lake City (SLC) VA Regional Office's (RO) comments and responses to the OIG Draft Report, *Inspection of the VA Regional Office, Salt Lake City, Utah*, received March 9, 2011. Except as otherwise noted below, the RO concurs with the findings and recommendations regarding RO activities requiring improvement, which include the accuracy of disability claims processing, data integrity, and workload management. Attached are our comments and responses to the specific recommendations and action items that arose as a result of the review.

2. We appreciate the professionalism and courtesy exhibited by the audit team members during their review of our operations, as well as the analysis they provided. This analysis and the corresponding recommendations for improvement are invaluable in our continued efforts to provide the best possible service to our veterans.

3. Please feel free to contact me at (801) 326-2400 with any questions or concerns regarding our reply.

(original signed by:)

MARK M. BILOSZ
Director

Attachment

Responses to the Office of Inspector General, Benefits Inspection Division, Draft Report – *Inspection of the Salt Lake City VA Regional Office*

Recommendation 1: We recommend the Salt Lake City VA Regional Office (RO) Director conduct a review of the 55 temporary, 100-percent, disability claims [awards] remaining from our universe of 85 to determine if reevaluations are required and take appropriate action.

RO Comments: Concur

The Salt Lake City RO completed a review of the 55 temporary, 100-percent, disability awards remaining from the OIG's original universe of 85 award actions on January 5, 2011. Thirty of the 55 cases required reexamination/reevaluation. The Pre-Determination Team has since scheduled all of the review examinations.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 2: We recommend the Salt Lake City VA Regional Office Director implement controls to ensure its staff establishes suspense diaries for scheduling temporary 100-percent disability reevaluations.

RO Comments: Concur

Up until May 2010, the Post-Determination management team was operating under the mistaken assumption that VETSNET pulls future examination dates from RBA 2000 and automatically establishes a diary to control for scheduling of the review examination, regardless of whether or not the VSR promulgating the rating decision takes award action in VETSNET. The result was that no future diaries for review examinations were being established on rating decisions that only confirmed and continued the current disability evaluation(s) (i.e., when no award action in VETSNET was necessary).

Once RO management discovered the oversight described above, it submitted a data request to the Office of Performance Analysis & Integrity (OPA&I) in an attempt to identify the claim numbers for all rating decisions promulgated since February 2007, which contained a future examination date, but for which there was no corresponding future diary in the corporate record. On January 31, 2011, OPA&I provided the results of the data request to the Salt Lake City Regional Office. The Post-Determination Team reviewed each of the rating decisions in question and established future diaries, as necessary, or forwarded the claim folder to the Pre-Determination Team for scheduling an at-once review examination. The RO completed action on these claim folders by the end of February 2011.

In order to ensure that diaries are consistently established in the corporate record for future examination dates identified in rating decisions, the Post-Determination management team has taken the following action: The Post-Determination management team met with Veterans Service Representatives (VSRs) and Senior VSRs (authorizers) in November 2010 to reemphasize the importance of checking the corporate record after promulgating a rating

decision, and confirm establishment of a future diary, whenever the need for a review examination is indicated in the rating decision.

The following procedures were specified for paper rating decisions: **1)** If the rating decision requires award action in VETSNET, VSRs will confirm establishment of a future diary in the corporate record. Regardless of whether establishment is confirmed or manual establishment of the diary is required, VSRs will annotate the corresponding award print to document their actions; **2)** If no award action is required (i.e., the rating decision confirms and continues the current disability evaluation(s), VSRs will manually establish a future diary for a review examination and annotate the award/notification letter to document they took this action; **3)** Senior VSRs will, similarly, confirm establishment of a future diary in the corporate record before authorizing/approving the actions VSRs take and annotate either the award print or award/notification letter to document their review. For paperless rating decisions, the process for confirming the establishment of future diaries for review examinations is the same as described above for both VSRs and Senior VSRs. However, because no hard-copy award print or award/notification letter exists, VSRs and Senior VSRs must document their actions by inserting a "public annotation" into the veteran's electronic folder.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 3: We recommend the Salt Lake City VA Regional Office Director develop and implement comprehensive training to ensure Rating Veterans Service Representatives properly evaluate disabilities related to traumatic brain injury (TBI) claims.

RO Comments: Concur

The RO submitted a data request to OPA&I to identify recently rated claims involving TBI. The purpose for identifying these cases was to review the corresponding rating decisions to ensure they were in compliance with national guidance on the handling of these claims. The RO received the report from OPA&I, which contained a total of 364 claim numbers, on March 15, 2011.

The RO provided training to all its RVSRs on the proper method for rating claims involving TBI in September 2010 and again (following the OIG visit) in December 2010. The RO also took the opportunity to provide one-on-one training with those RVSRs who prepared the rating decisions OIG identified as erroneous during the course of its inspection.

The RO will take the following actions to ensure its RVSRs are implementing the rating principles they learned through training: **1)** Quality Decision Review Officers (QDROs) will conduct a local inter-rater reliability (IRR) study, using a rating scenario involving TBI, before the end of the current month; **2)** The QDROs will review a random sample of 36 rating decisions (approximately 10%) from the list of 364 claim numbers OPA&I provided in its report. Based on the results of this review and the IRR study referenced above, the Veterans Service Center (VSC) will provide additional training to all RVSRs in April 2011; **3)** The QDROs will conduct a second IRR study, using a rating scenario involving TBI, in May 2011. The RO will randomly select 30 RVSRs (approximately 30 percent of all RVSRs) to participate in the study, the purpose of which is to validate the effectiveness of the training provided to that point in time. If the results of the second IRR

study show the average quality of rating decisions involving TBI is at or above the current national average for rating quality, the RO will discontinue further training on this topic (other than routine refresher training). If the results of the second IRR study show the average quality of rating decisions involving TBI remain substandard, the RO will draft a supplemental training plan by May 31, 2011, and continue training on the topic until the average quality of rating decisions involving TBI reaches an acceptable level.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 4: We recommend the Salt Lake City VA Regional Office Director conduct a review of all pending 810 work items to determine if medical reexaminations are required and take appropriate actions.

RO Comments: Concur

Pre-Determination Team management misinterpreted Fast Letter 10-14, *Procedural Change Regarding Routine Future Examinations*, by inferring that the review/processing of end product (EP 810) work items was no longer necessary.

The RO completed its review of the EP 810 work items, which were pending at the time of the OIG visit, in December 2010, and ordered review examinations, as appropriate.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 5: We recommend the Salt Lake City 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.

RO Comments: Concur

The oldest 810 work items currently pending are only three days old. The Pre-Determination management team currently runs a VOR report of pending work items twice each week (Mondays and Thursdays, as per the workload management plan) and assigns them to VSRs for review and processing.

The RO believes the Pre-Determination team now has the 810 work items under control. However, to ensure the team continues to effectively manage this element of its operations, the Assistant Veterans Service Center Manager (AVSCM) overseeing the Pre-Determination team will run a VOR report of pending 810 work items on the first workday of each month. Once the AVSCM has run the report for three consecutive months without finding any work items that are out of control, the AVSCM will continue to monitor the volume of pending work items but on a less-frequent basis.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 6: We recommend the Salt Lake City VA Regional Office Director develop and implement a plan to ensure adequate quality review oversight to ensure staff correctly establish dates of claim.

RO Comments: Concur

The Salt Lake City RO concurs with the OIG recommendation. The RO would like to point out that on pages eight and nine of the OIG draft report, reference is made to a hand-held stamp that the VSC staff uses. The RO does not possess a hand-held stamp, nor does it use one. The RO destroyed all hand-held stamps in May 2009, per the instructions in VBA Letter 20-09-10, *VBA Policy to Maintain Accountability of Official Date Stamps.*

The OIG's findings with regard to the existence of a hand-held date stamp are inaccurate. Regional Office management felt it was important to point out this inaccuracy to avoid future questions regarding the VARO's compliance with VBA Letter 20-09-10. VBA Letter 20-09-10 allows *intake sites* to possess and use hand-held date stamps. The SLC VARO is a rating activity site, not an intake site. Reference was made to "intake sites" in the VARO's response for the sole purpose of attempting to explain how the OIG might have inferred from a conversation with Triage Team management that the Triage Team used a hand-held date stamp.

For convenience, and because VBA Letter 20-09-10 prohibits the use of hand-held date stamps, the VSC requested placement of a third electronic date stamp in the Triage Team's work space, which is noted in the OIG's report.

The Triage management team held a meeting with its team members on November 17, 2010, to provide refresher training on identifying proper dates of claim. As part of this training, the team reviewed each of the date-of-claim discrepancies the OIG identified during its site visit. Moreover, the Triage management team continues to conduct monthly quality reviews of the actions its employees take, to include claims establishment and the selection of proper dates of claim.

Date-of-claim accuracy, based on national Systematic Technical Accuracy Review (STAR), was 100 percent for two of the last three months since the OIG's visit. (Accuracy was 100 percent for December 2010 and February 2011, and 95.8 percent for January 2011.)

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 7: We recommend the Salt Lake City VA Regional Office Director develop and implement procedures to ensure management oversight and control of Triage Team search mail activity and Military File.

RO Comments: Concur

Triage management team held a meeting with its team members on November 17, 2010, during which it reviewed the proper procedures for maintenance of the Military File as set forth in M21-1MR, III.ii.4.H.25. Shortly thereafter, the management team oversaw reorganization of the Military File, to include placement of documents in alphabetical order and removal of those documents that were erroneously stored in the Military File. On March 1, 2011, the Triage management team reviewed the Military File to ensure employees are maintaining it properly. In addition, the Veterans Service Center will add monthly reviews of the Military File to its workload management plan to ensure the file remains in proper order. The Triage management team will be responsible for conducting the review.

In regard to search mail, the Files Activity had been reviewing its search mail on a somewhat sporadic basis prior to the OIG visit. The Triage management team has since assigned one file clerk the specific responsibility of reviewing pending search mail on a weekly – if not daily – basis. The Files Activity supervisor additionally drafted standard operating procedures (SOP) for handling and managing search mail. Once the SOP is finalized, it will be distributed to Files Activity personnel.

The Veterans Benefits Administration recommends closure of this recommendation.

Appendix C Inspection Summary

9 Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Disability Claims Processing			
1. 100 Percent Disability Evaluations	**Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations.** (38 Code of Federal Regulation (CFR) 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (Manual (M)21-1Manual Rewrite (MR), Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR, Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Post-Traumatic Stress Disorder	**Determine whether VARO staff properly processed claims for PTSD.** (38 CFR 3.304(f))	X	
3. Traumatic Brain Injury	**Determine whether service connection for all residual disabilities related to in-service TBI were properly processed.** (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 herbicide exposure-related disabilities (Agent Orange).** (38 CFR 3.309) (FL 02-33) (M21-1MR, Part IV, Subpart ii, Chapter 2, Section C.10)	X	
Data Integrity			
5. Date of Claim	**Determine whether VARO staff properly recorded correct dates of claim in the electronic records.** (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)		X
6. Notice of Disagreement	**Determine whether VARO staff properly entered NODs into VACOLS.**(M21-1MR, Part I, Chapter 5)		X
Management Controls			
7. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analysis of their operations through completion of SAOs.** (M21-4, Chapter 5)	X	
8. 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	
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

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