VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Anchorage, Alaska

January 3, 2013
12-02089-60

ACRONYMS AND ABBREVIATIONS

OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center
WMP	Workload Management Plan

Report Highlights: Inspection of VA Regional Office, Anchorage, Alaska

Why We Did This Review

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

What We Found

Overall, VARO staff did not accurately process 18 of 38 disability claims we reviewed. Where claims processing is inaccurate, VBA risks paying inaccurate and unnecessary financial benefits. These results do not represent the overall accuracy of disability claims processing at this VARO as we sampled claims we consider at higher risk of processing errors.

The Anchorage VARO lacked effective controls and accuracy in processing some disability claims. Specifically, 50 percent of the 30 temporary 100 percent disability evaluations we reviewed were inaccurate, generally because staff did not establish controls to monitor proposed reductions, or schedule future medical reexaminations as required to determine whether to continue these evaluations. VARO managers generally ensured staff accurately reported to VBA actions taken on temporary 100 percent disability claims to address our prior audit report recommendations. Errors in processing three of the eight traumatic brain injury claims occurred primarily because staff misinterpreted policy requirements.

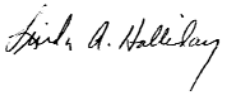
A lack of management oversight resulted in staff delays in gathering evidence and processing old claims. We reviewed the 10 oldest disability claims completed from January through March 2012. VBA staff took 594 to 789 days to complete these claims. VARO managers did not ensure staff accurately completed Systematic Analyses of Operations or addressed Gulf War veterans' entitlement to mental health treatment. In general, Anchorage VARO staff provided adequate outreach to homeless veterans. However, VBA needs a measure to assess its outreach program.

What We Recommended

We recommended the VARO Director develop and implement controls to ensure managers provide oversight of claims pending more than 1 year and monitor proposed reductions to disability evaluations. Managers need to monitor effectiveness of training on processing traumatic brain injury claims and addressing Gulf War veterans' entitlement to mental health treatment. Managers also should ensure staff complete Systematic Analyses of Operations as required.

Agency Comments

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



LINDA A. HALLIDAY
Assistant Inspector General
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INTRODUCTION

Objective

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

- Evaluate how well VAROs are accomplishing their mission of providing veterans with access to high-quality benefits and services.
- Determine whether 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 oversight, inspections may examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

Scope of Inspection

In June 2012, the OIG conducted an inspection of the Anchorage VARO. The inspection focused on four protocol areas examining six operational activities. The four protocol areas were disability claims processing, management controls, eligibility determinations, and public contact.

We reviewed the 10 oldest completed claims available at the time of our inspection, and 8 of 11 disability claims available for our review related to traumatic brain injury (TBI) that VARO staff completed during the period January through March 2012. In addition, we reviewed 30 of 57 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 without review, according to Veterans Benefits Administration's (VBA) policy.

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

RESULTS AND RECOMMENDATIONS

I. Disability Claims Processing

The OIG Benefits Inspection team focused on processing accuracy related to temporary 100 percent disability evaluations and TBI disability claims. We also assessed timeliness in processing the oldest completed disability claims at the VARO. We evaluated these claims processing issues and their impact on veterans' benefits.

Finding 1 Anchorage VARO Needs To Improve Disability Claims Processing Accuracy

The Anchorage VARO lacked adequate controls and accuracy in processing claims for temporary 100 percent disabilities and TBI. VARO staff incorrectly processed 18 of the total 38 disability claims we sampled. These errors resulted in overpayments to veterans totaling $139,177 and underpayments valued at $19,220. VARO management agreed with our findings and began to correct the errors identified.

We sampled claims related only to specific conditions that we considered at higher risk of processing errors. As a result, the errors identified do not represent the universe of disability claims processed at this VARO. As reported by VBA's Systematic Technical Accuracy Review program as of April 2012, the overall accuracy of the VARO's compensation rating-related decisions was 80.5 percent—6.5 percentage points below VBA's target of 87 percent.

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

Table 1

Anchorage VARO Disability Claims Processing Results				
Type of Claim	**Reviewed**	**Claims Incorrectly Processed**		
		Affecting Veterans' Benefits	**Potential To Affect Veterans' Benefits**	**Total**
Temporary 100 Percent Disability Evaluations	30	6	9	15
Traumatic Brain Injury Claims	8	0	3	3
Total	**38**	**6**	**12**	**18**

Source: VA OIG analysis of VBA's temporary 100 percent disability evaluations paid at least 18 months or longer and TBI disability claims completed in the 2nd quarter FY 2012.

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 15 of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a service-connected disability following a veteran's surgery or when specific treatment is required. At the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

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

Without effective management of these temporary ratings, VBA is at increased risk of paying excessive and unnecessary financial benefits. Available medical evidence showed that 6 of the 15 processing errors affected veterans' benefits—five involved overpayments totaling $139,177, and one involved an underpayment totaling $19,220. Details on the most significant overpayment and underpayment follow.

- VARO staff did not schedule a medical reexamination to evaluate a veteran's breast cancer. VA medical records showed the veteran had completed treatment, warranting a reduction in benefits effective August 2005. In the absence of the required follow-up medical reexamination, VA continued processing monthly benefits and ultimately overpaid the veteran $96,135 over a period of 5 years and 11 months.
- VARO staff did not grant a veteran entitlement to an additional special monthly benefit based on evaluations of multiple disabilities, as required. As a result, VA underpaid the veteran a total of $19,220 over a period of 5 years and 1 month. We discussed this underpayment with VARO officials who agreed to take corrective action.

The remaining nine errors in processing temporary 100 percent disability evaluations had the potential to affect veterans' benefits. Generally, these errors involved VSC staff not:

- Scheduling routine future medical reexaminations as required,
- Requesting the necessary medical examination, and
- Timely scheduling hearings for veterans to present evidence in response to proposals to reduce their benefits.

For three of the nine errors with potential to affect veterans' benefits, medical reexaminations were required. An average of 4 years and 2 months elapsed from the time staff should have scheduled medical examinations until the date of our inspection. The delays ranged from 2 years and 9 months to 6 years and 8 months.

Five of the 15 errors resulted from a lack of management oversight to ensure proper action on proposals to reduce veterans' temporary 100 percent disability evaluations. The Workload Management Plan (WMP) did not contain oversight procedures for processing these cases. Further, VSC staff revealed miscommunication between management and staff regarding procedures for timely managing veterans' hearing requests. Until our inspection in June 2012, VSC management had not assigned staff to schedule personal hearings associated with proposed reductions. As a result, veterans may be at increased risk of not receiving correct benefits payments.

Actions Taken in Response to Prior Audit Report

We assessed whether VARO management accurately reported actions taken on temporary 100 percent disability claims identified by VBA. In response to a recommendation in our national report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each evaluation had a future examination date entered in the electronic record. Our report stated, "If VBA does not take timely corrective action, they will overpay veterans a projected $1.1 billion over the next 5 years." The Acting Under Secretary for Benefits stated in response to our audit report that the target completion date for the national review would be September 30, 2011.

However, VBA did not provide each VARO with a list of temporary 100 percent disability evaluations for review until September 2011. VBA subsequently extended the national review deadline to December 31, 2011, and then again to June 30, 2012. VBA was working to complete this national review requirement and extended the national review deadline again to December 31, 2012.

Anchorage VARO staff accurately reported actions taken on 38 of 40 cases from the lists of temporary 100 percent disability evaluations provided by VBA for review. Therefore, we made no recommendation for improvement in this area.

TBI Claims

The Department of Defense and VBA commonly define a TBI as a traumatically induced structural injury or a physiological disruption of brain function caused by an external force. The major residual disabilities of TBI fall into three main categories—physical, cognitive, and behavioral. VBA policy requires staff to evaluate these residual disabilities.

VARO staff incorrectly processed three of eight TBI claims—none of these processing errors affected veterans' benefits. In all three cases, RVSRs prematurely evaluated TBI residuals using insufficient medical examination reports. According to VBA policy, when a medical examination report does not address all required elements, VSC staff should return it to the clinic or health care facility as insufficient for rating purposes. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without adequate or complete medical evidence.

Generally, errors associated with TBI claims occurred because VSC staff misinterpreted VBA policy. Interviews with VSC managers and staff revealed that despite recent training, staff continued to find TBI regulations and policies complex and confusing. Staff said they were unaware medical examination reports were insufficient if they did not state whether veterans' symptoms were due to TBI or a co-morbid mental disorder. Further, four of eight TBI claims did not receive a second level of review by more experienced decision-makers as required by VBA policy. As a result, veterans may not have always received correct benefits.

Follow-Up to Prior Inspection

In our previous report, *Inspection of the VA Regional Office, Anchorage, Alaska* (Report No. 09-01998-42, December 7, 2009), we identified two of seven TBI processing errors due to a lack of training. The Director of the Anchorage VA Regional Office agreed to develop and implement a training plan to ensure RVSRs consistently received training to maintain required skills. OIG closed this recommendation in June 2010, based on documents showing a training plan that included TBI. Although the Anchorage VARO conducted TBI training in December 2010, September 2011, and May 2012, VSC staff continue to report confusion due to complex TBI policy.

Recommendations

1. We recommend the Anchorage VA Regional Office Director develop and implement a plan to monitor proposed disability evaluation reduction processing actions.
2. We recommend the Anchorage VA Regional Office Director develop and implement a plan to ensure staff return insufficient medical examination reports to health care facilities to obtain the required evidence needed to support traumatic brain injury claims.
3. We recommend the Anchorage VA Regional Office Director develop and implement a plan to assess the effectiveness of training for properly processing traumatic brain injury claims.

Management Comments

The VARO Director concurred with our recommendations. The Director will revise the Workload Management Plan to include procedures for processing claims that involve future medical examinations and will require

RVSRs to review all incoming medical examination reports for sufficiency. Management will make these revisions no later than March 31, 2013. Further, RVSRs participated in a training session for rating TBI claims. The session included a review exercise to gauge the participants' knowledge of the subject and the instructor customized the training to address knowledge gaps. This training will be re-administered no later than March 31, 2012.

OIG Response The Director's comments and actions are responsive to the recommendations.

Finding 2 Anchorage VARO Needs To Improve Oversight To Ensure Timely Claims Processing

VBA policy requires VAROs to develop local processing timeliness goals within the WMP to meet VA's strategic target of completing all claims within 125 days. Workload management is a coordinated system used to control how claims and other work move through VBA's adjudicative process. The WMP should provide for timely review throughout claims processing, and prevent inefficient processing practices and delays. VBA has identified national average cycle times to measure performance at each phase of the claims process. Table 2 outlines the claims processing phases and associated performance measures.

Table 2

VBA's Claims Processing Phases and National Performance Measures

Phases	Definitions	Cycle Times
Control Time	Time from date of claim receipt at the VARO until establishment in the electronic record	7 days
Waiting to Develop for Evidence	Time from the date a claim is established until staff initiate requests for evidence	20 days
Waiting for Receipt of Evidence	Time from initial requests for evidence until the claim is ready for a decision	83 days
Waiting for Claims Decision	Time from when a claim is ready for a decision until a decision is complete	15 days
Waiting for Award	Time from when a decision is complete until the award for payment is generated	5 days
Waiting for Award Authorization	Time from when an award for payment is generated until the award payment is authorized	2 days

Source: VBA's Office of Performance Analysis and Integrity as of August 2012.

VBA policy requires VSC management conduct a monthly review of all claims pending more than 1 year. If it is not feasible to personally review the claims, as an alternative, the managers must review a monthly report prepared by designated staff.

We reviewed the 10 oldest disability claims completed from January through March 2012, available at the time of our inspection. VBA staff took 594 to 789 days to complete these claims. We reviewed these cases to identify opportunities for the Anchorage VARO to improve their local claims processing timeliness.

The Anchorage VARO lacked adequate controls to ensure timely claims processing. As of April 2012, 47 percent (948 claims) of Anchorage's 2,004 pending claims were over 125 days old. Our review of the VARO's 10 oldest completed cases showed significant delays in the development evidence-gathering phase, the amount of time it takes VBA staff to obtain all identifiable evidence and make the claim ready for a rating decision. The national goal for the average days awaiting evidence is 83 days; however, the average time these 10 cases spent in this phase was 523.3 days.

Generally, delays in claims processing caused by the Anchorage VARO were due to inadequate management oversight and non-compliance with the requirements of the WMP. The following are examples of some of the delays caused by the Anchorage VARO.

- On November 23, 2009, VARO staff entered a claim into the electronic record; however, VARO staff did not take action to obtain evidence until March 19, 2010—116 days later. The WMP had set a target for initial processing of claims to begin within 14 days of receipt. This claim took 780 days to complete.
- On June 10, 2011, VARO staff received evidence warranting a VA medical examination; however, VARO staff did not order the examination until January 6, 2012—210 days later. The WMP requires that staff follow up on evidence within 7 days of receipt. This claim took 694 days to complete.
- On November 9, 2011, VARO staff updated a claim that had been pending for 532 days as "ready for decision" in the electronic record. Staff did not complete a decision on this claim until January 7, 2012—59 days later. The WMP requires prioritization of claims over 365 days old that are in the ready for decision status. This claim took 594 days to complete.

We also identified significant delays in claims processing that were outside of the Anchorage VARO's control. VA OIG *Audit of Compensation Program Claims Brokering*, report 09-03154-271, published in September 2011, reported that a major challenge to VBA has been the processing of an increased number of veterans' compensation benefit claims. To address this challenge, VBA began forwarding claims from certain VAROs to 1 of 13 Day One Brokering Centers, or other VAROs, to better align workload with staffing resources. Seven of the 10 oldest completed claims we

reviewed were brokered during the claims processing period, two cases were transferred between VAROs due to the veterans moving to different states, and one was delayed when a veteran withdrew his claim. The following are examples of these delays.

- On December 30, 2009, Anchorage VARO staff forwarded a claim to another VARO, a brokering center, for development processing. This claim subsequently was sent to a brokering center a second time for a decision document, which was completed on May 13, 2010. Anchorage staff reviewed the decision, found errors in the development actions and the decision document, and completed a corrected decision. This claim took 789 days to complete.
- On November 14, 2010, Anchorage VARO staff forwarded a veteran's claim to a brokering center as part of a time-sensitive national project. At that time, the veteran already had a claim pending for 356 days. VBA requires a brokering center to complete a decision document on any time-sensitive claim that is ready for a decision while the claim is under its control. The brokering center returned the file to Anchorage on January 11, 2012, without taking the required action. Anchorage staff took immediate action and completed the claim. This claim took 780 days to complete.
- On October 26, 2010, the Anchorage VARO requested a diabetes mellitus exam from the VA Medical Center. The VA Medical Center completed an incorrect medical examination, which VSC staff returned as insufficient. Following completion of the correct exam, VSC staff completed the decision document on February 29, 2012. This claim took 594 days to complete.

VSC managers stated they were not aware if VSC staff conducted bi-weekly reviews of claims pending more than 1 year as required by the VARO's WMP. The VSC Manager revealed staff may not have followed policies related to monitoring year old claims as outlined in the station's WMP due to competing VARO priorities. Management also attributed delays in claims processing to a lack of experienced Veterans Service Representatives. As a result, veterans and their families may not always receive timely benefits decisions. We cannot determine the cause of the delays associated with work at the 13 Day One Brokering Centers, which were outside of the scope of this inspection.

Recommendation

4. We recommend the Anchorage VA Regional Office Director develop and implement controls to ensure management follows the Veterans Benefits

Administration's policy and workload management plan for all claims pending for more than 1 year.

Management Comments

The VARO Director concurred with our recommendation and assigned responsibility for monitoring and processing the 12 oldest claims to a newly created Special Operations Team.

OIG Response

The Director's comments and actions are responsive to the recommendation.

II. Management Controls

Systematic Analysis of Operations

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs). We also considered whether VSC staff used adequate data to support the analyses and recommendations identified within each SAO. An SAO is a formal analysis of an organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and to propose corrective actions. VARO management must publish annual SAO schedules designating the staff required to complete the SAOs by specific dates. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 11 SAOs annually.

Finding 3 Oversight Needed To Ensure Complete SAOs

All SAOs used sufficient data for analysis; however, 2 of 11 SAOs were incomplete (missing required elements). VARO management did not provide adequate oversight to ensure VSC staff completed the SAOs in accordance with VBA policy and did not have an effective mechanism in place to ensure SAOs were complete. As a result, VARO management may not have adequately identified existing and potential problems for corrective action to improve VSC operations.

Management did not ensure SAOs were complete, as required. An example of an SAO that did not include all required areas for review involved timeliness of claims processing. At the time of our review of the temporary 100 percent disability evaluations, we found cases where proposed reductions for benefits payments were not timely processed. If VARO managers had addressed this area of review in the SAO, they may have implemented measures to ensure control of these cases.

Follow-Up to Prior Inspection

In our previous report, *Inspection of the VA Regional Office, Anchorage, Alaska* (Report No. 09-01998-42, December 7, 2009), we identified a lack of management oversight over SAOs that resulted in five SAOs being completed late, two incomplete, and one only partially complete. In response to our report recommendation, the Anchorage VARO Director

agreed to develop and implement a mechanism to ensure VSC management performed complete, accurate, and timely SAOs and took appropriate corrective action to fix identified problems. The OIG closed this recommendation in June 2010 based on the VARO's submission of the FY 2010 SAO schedule and instructions to VSC staff to follow VBA requirements regarding SAO analysis.

During our June 2012 inspection, we found the SAOs contained time frames for recommendations and follow-up actions, and were timely. However, the workbook that outlines VBA policy on SAOs used by VSC management did not include all required areas of review. The VSC Manager stated that the errors in SAOs occurred because he did not ensure staff completed SAOs according to VBA policy.

Recommendation

5. We recommend the Anchorage VA Regional Office Director develop and implement a plan to ensure staff address all required elements of Systematic Analyses of Operations using thorough analysis.

Management Comments

The VARO Director concurred with our recommendation and will create a Division Directive that requires the author of an SAO to list all required elements and certify they address them for each SAO. The VSCM will also certify to the VARO Director that all required elements have been included. Management will create a tracking log to ensure all action items are timely maintained. Management will create the Division Directive and tracking log no later than March 31, 2013.

OIG Response

The Director's comments and actions are responsive to the recommendation.

III. Eligibility Determinations

Entitlement to Medical Treatment for Mental Disorders

Gulf War veterans are eligible for medical treatment for any mental disorder they develop within 2 years of the date of separation from military service. According to VBA, whenever an RVSR denies a Gulf War veteran service connection for any mental disorder, the RVSR must consider whether the veteran is entitled to receive mental health treatment.

In February 2011, VBA updated its Rating Board Automation 2000, a computer application designed to assist RVSRs in preparing disability ratings. The application provides a pop-up notification, known as a tip master, to remind staff to consider Gulf War veterans' entitlement to mental health care treatment when denying service connection for a mental disorder.

Finding 4 Gulf War Veterans Did Not Receive Accurate Entitlement Decisions for Mental Health Treatment

VARO staff did not properly address whether three of four Gulf War veterans were entitled to receive treatment for mental disorders. These inaccuracies occurred because VSC staff lacked understanding of VBA policy and overlooked reminder notifications to consider entitlement to mental health treatment. As a result, these three veterans may be unaware of their possible entitlement to treatment for mental disorders and may not get the care they need.

VSC staff confirmed they did not always follow VBA policy to consider entitlement to mental health treatment when denying Gulf War veterans service connection for mental health disorders. In January 2012, staff conducted training on mental health treatment for Gulf War veterans. VSC staff stated that, despite this recent training, they still did not have a clear understanding of VBA policy and it was easy to bypass the reminder notifications.

Recommendation

6. We recommend the Anchorage VA Regional Office Director develop and implement a plan to monitor the effectiveness of training to ensure staff follow current Veterans Benefits Administration policy regarding Gulf War Veterans' entitlement to mental health treatment when denying service connection for mental disorders.

Management Comments

The VARO Director concurred with our recommendation. Management will develop an assessment exercise and use these results to develop training to address any deficiencies identified. Management will administer the assessment exercise no later than March 31, 2013. Training will immediately follow to address any identified knowledge gaps. The assessment exercise will be re-administered no more than six months following the initial date of administration.

OIG Response

The Director's comments and actions are responsive to the recommendation.

IV. Public Contact

In November 2009, VA developed a 5-year plan to end homelessness among veterans by assisting every eligible homeless veteran willing to accept service. VBA generally defines "homeless" as lacking a fixed, regular, and adequate nighttime residence.

Outreach to Homeless Veterans

Congress mandated that at least one full-time employee oversee and coordinate homeless veterans programs at each of the 20 VAROs that VA determined to have the largest veteran populations. VBA guidance, last updated in September 2002, directed that coordinators at the remaining 37 VAROs be familiar with requirements for improving the effectiveness of VARO outreach to homeless veterans. These requirements include developing and updating a directory of local homeless shelters and service providers. Additionally, the coordinators should attend regular meetings with local homeless service providers, community governments, and advocacy groups to provide information on VA benefits and services.

The Anchorage VARO has a part-time Homeless Veterans Outreach Coordinator. Our review confirmed that the coordinator was familiar with requirements for improving the effectiveness of VARO outreach to homeless veterans. The coordinator had collaborative partnerships with local homeless outreach facilities to provide information on VA benefits and services. We made no recommendation for improvement in this area. However, VBA needs a measurement to assess the effectiveness of its outreach efforts.

Appendix A VARO Profile and Scope of Inspection

Organization

The Anchorage VARO administers a variety of services and benefits, including compensation benefits; vocational rehabilitation and employment assistance; specially adapted housing grants; benefits counseling; and outreach to homeless, elderly, minority, and women veterans.

Resources

As of May 2012, the Anchorage VARO had a staffing level of 39 full-time employees. Of this total, the VSC had 33 employees (85 percent) assigned.

Workload

As of April 2012, the VARO reported about 2,000 pending compensation claims. The average time to complete claims was 207.5 days—22.5 days less than the national target of 230. However, the number of claims pending greater than 125 days increased to 948 cases, comprising 47 percent of the Anchorage VARO's pending workload.

Scope

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

Our review included 30 (53 percent) of 57 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of April 19, 2012. We provided VARO management with 27 claims remaining from our universe of 57 for its review. We also reviewed 40 cases from the list of temporary 100 percent disability evaluations VBA provided to the VARO for review. We reviewed 8 of 11 disability claims available for review that were related to TBI that the VARO completed from January through March 2012. In addition, we analyzed the 10 oldest completed claims available for review.

We reviewed the 11 mandatory SAOs completed in FYs 2011 and 2012. We also reviewed four completed claims available for our review that were processed for Gulf War veterans during the period of January through March 2012 to determine whether VSC staff addressed entitlement to mental health treatment in the rating decision documents as required. Further, we assessed the effectiveness of the VARO's homeless veterans outreach program.

Reliability of Data

We used computer-processed data from the Veterans Service Network's Operations Reports and Awards. To test for reliability, we reviewed the data to determine whether any data were missing from key fields, contained data outside of the time frame requested, included any calculation errors, contained obvious duplication of records, contained alphabetic or numeric

characters in incorrect fields, or contained illogical relationships among data elements. Further, we compared veterans' names, file numbers, social security numbers, station numbers, dates of claim, and decision dates as provided in the data received with information contained in the 52 claims folders we reviewed.

Our testing of the data disclosed that they were sufficiently reliable for our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders at VARO Anchorage did not disclose any problems with data reliability.

Government Standards

We conducted this inspection in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.* We planned and performed the inspection to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our inspection objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our inspection objectives.

Appendix B Inspection Summary

Table 3 reflects the operational activities inspected, applicable criteria, and whether or not we had reasonable assurance of VARO compliance.

Table 3. Anchorage VARO Inspection Summary

Six Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Disability Claims Processing			
1. Temporary 100 Percent Disability Evaluations	**Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations.** (38 Code of Federal Regulations (CFR) 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1 MR Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e). (VBA response to OIG Audit Report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011)		X
2. Claims Processing Timeliness	**Determine whether VARO staff unnecessarily delayed processing disability claims.** (Manual (M) 21-4, Chapter 2) (Fast Letter (FL) 12-04 and 10-23) (M21-1Manual Re-write(MR))		X
3. Traumatic Brain Injury Claims	**Determine whether VARO staff properly processed claims for service connection for all residual disabilities related to in-service TBI.** (FL 08-34 and 08-36) (Training Letter 09-01)		X
Management Controls			
4. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)		X
Eligibility Determinations			
5. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War veterans' claims, considering entitlement to medical treatment for mental illness.** (38 United States Code 1702) (M21-1MR Part IX, Subpart ii, Chapter 2)(M21-1MR Part III, Subpart v, Chapter 7) (FL 08-15) (38 CFR 3.384) (38 CFR 3.2)		X
Public Contact			
6. VBA's Homeless Veterans Program	**Determine whether VARO staff provided effective outreach services.** (Public Law 107-05) (VBA Letter 20-02-34) (VBA Circular 27-91-4) (FL 10-11) (M21-1, Part VII, Chapter 6)	X	

Source: VA OIG
CFR=Code of Federal Regulations, FL= Fast Letter, M=Manual, MR=Manual Re-write

Appendix C VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: November 13, 2012

From: Director, VA Regional Office Anchorage, Alaska

Subj: Inspection of the VA Regional Office, Anchorage, Alaska

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

1. The Anchorage VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Anchorage, Alaska.*

2. Thank you for the opportunity to provide feedback. You may refer questions to me at (801) 326-2400.

(original signed by:)

Jon Skelly, Director
Salt Lake City, Anchorage
and Ft. Harrison VARO

Attachment

Recommendation 1: We recommend the Anchorage VA Regional Office Director develop and implement a plan to monitor proposed disability evaluation reduction processing actions.

Concur: The current workload management plan includes oversight for monitoring and processing claims involving proposed disability evaluation reduction processing actions. The update to the workload management plan places processing these types of claims near the top of the order for claims processing priority. A revision will be made to the current workload management plan to outline the procedures for processing claims that involve a future exam. The revision will be made no later than March 31, 2013.

Recommendation 2: We recommend the Anchorage VA Regional Office Director develop and implement a plan to ensure staff return insufficient medical examination reports to health care facilities to obtain the required evidence needed to support traumatic brain injury claims.

Concur: The workload management plan will be revised to include direction for all medical examination reports from the health care facility to be placed in one central location upon return to the Anchorage VARO. The Rating Veterans Service Representatives (RVSR) will be assigned workload, in accordance with lane assignment following transformation. RVSRs will be required to review all incoming examination results within their assigned lane for sufficiency. All examination results found to be insufficient for rating purposes will be returned to the healthcare facility providing the examination results. The revision will be made no later than March 31, 2013.

Recommendation 3: We recommend the Anchorage VA Regional Office Director develop and implement a plan to assess the effectiveness of training for properly processing traumatic brain injury claims.

Concur: On November 7, 2012, the RVSRs participated in a training session for rating traumatic brain injury claims. (TMS 1209939). The training included a review exercise that was administered before the training, to gauge the participant's knowledge. Based on the responses to that exercise the instructor was able to customize the training to reinforce the knowledge gaps. The training exercise will be re-administered to the participants no later than March 31, 2013. Future training needs will be re-evaluated at that time.

Recommendation 4: We recommend the Anchorage VA Regional Office Director develop and implement controls to ensure management follows the Veterans Benefits Administration's policy and workload management plan for all claims pending for more than 1 year.

Concur: The office has implemented a visual management initiative that includes the 12 oldest claims that are not ready for a decision being placed on a table at the front of the team area. In addition, a central storage for claims over a year old is also located at the front of the team area. The office will be moving through VBA transformation during first quarter of fiscal year 2013. Part of the transformation initiative includes implementation of a special operations team. Part of the responsibility of this team will be in monitoring and processing the oldest claims on station. This will be placed in the into the workload management plan.

Recommendation 5: We recommend the Anchorage VA Regional Office Director develop and implement a plan to ensure staff address all required elements of Systematic Analyses of Operations using thorough analysis.

Concur: The Anchorage VARO will prepare a Division Directive that requires the author of a Systematic Analysis of Operation (SAO) to list the required elements in the "Description" section of the SAO. The Division Directive requires the author of the SAO to certify, by signature, that all elements have been addressed. The Veteran Service Center Manager (VSCM) will review and verify that all elements have been addressed. The VSCM will certify to the Director that the required elements have been included in the SAO. In addition, a tracking log will be created to make sure all action items are timely maintained. The Division Directive and the tracking log will be created no later than March 31, 2013.

Recommendation 6: We recommend the Anchorage VA Regional Office Director develop and implement a plan to monitor the effectiveness of training to ensure staff follow current Veterans Benefits Administration policy regarding Gulf War Veterans' entitlement to mental health treatment when denying service connection for mental disorders.

Concur: The Anchorage VARO will develop an assessment exercise similar to the one used for TBI, to be administered to all staff responsible for making decision for Gulf War Veterans' entitlement to mental health treatment. Based on the results of the exercise, training will be developed to address any deficiencies noted. The assessment exercise will be administered no later than March 31, 2013. Training will immediately follow to address any identified knowledge gaps. The exercise will be re-administered no more than six months following the initial date of administration.

Appendix D Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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