VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Roanoke, Virginia

July 1, 2013
12-04456-232

ACRONYMS AND ABBREVIATIONS

HVOC	Homeless Veterans Outreach Coordinator
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

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Report Highlights: Inspection of VA Regional Office, Roanoke, VA

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and 1 Veterans Service Center nationwide that process disability claims and provide a range of services to veterans. We evaluated the Roanoke VARO to see how well it accomplishes this mission.

What We Found

Overall, VARO staff did not accurately process 17 (28 percent) of 60 disability claims we reviewed. We sampled claims we considered at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Claims processing lacked consistent compliance with VBA procedures and is resulting in paying inaccurate and unnecessary financial benefits.

Specifically, 14 of 30 temporary 100 percent disability evaluations we reviewed were inaccurate. Errors in processing the temporary evaluations generally occurred because VARO staff did not schedule medical reexaminations, enter suspense diaries in the electronic record to ensure reminders to schedule the reexaminations, or take actions to reduce benefits as appropriate. Additionally, management did not provide effective oversight of second signature reviews and therefore incorrectly processed 3 of 30 traumatic brain injury (TBI) claims.

VARO managers ensured Systematic Analyses of Operations were complete and timely. However, staff did not always address Gulf War veterans' entitlement to mental health treatment. Further, staff did not provide adequate outreach to homeless veterans in the VARO's area of jurisdiction. We could not fully assess the effectiveness of these outreach activities because VBA needs performance metrics for its homeless veterans outreach program.

What We Recommend

The VARO Director should implement a plan to ensure staff schedule medical reexaminations, enter suspense diaries in the electronic record, and follow up to reduce temporary 100 percent disability evaluations as appropriate. The Director should ensure staff review the accuracy of 709 temporary evaluations we provided at the end of this inspection. Further, management should implement a plan to ensure effective second signature reviews of TBI claims and ensure staff provide outreach to homeless veterans within the VARO's area of jurisdiction.

Agency Comments

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

LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

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

- Evaluate how well VAROs are accomplishing their mission of providing veterans with access to high-quality benefits and services.
- Determine 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 November 2012, we inspected the Roanoke VARO. The inspection focused on the following four protocol areas: disability claims processing, management controls, eligibility determinations, and public contact. Within these areas, we examined two high-risk claims processing areas: temporary 100 percent disability evaluations and traumatic brain injury (TBI) claims. We also examined three operational activities: Systematic Analysis of Operations (SAOs), Gulf War veterans' entitlement to mental health treatment, and the homeless veterans outreach program.

We reviewed 30 (4 percent) of 739 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months. This is generally the longest period a temporary 100 percent disability evaluation may be assigned without review, according to Veterans Benefits Administration (VBA) policy. We examined 30 (40 percent) of 75 disability claims related to TBI that VARO staff completed from July through September 2012.

Other Information

- Appendix A includes details on the VARO and the scope of our inspection.
- Appendix B outlines 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

Claims Processing Accuracy

The OIG Benefits Inspection team focused on accuracy in processing temporary 100 percent disability evaluations and TBI claims. We evaluated these claims processing issues and assessed their impact on veterans' benefits.

Finding 1

Roanoke VARO Could Improve Disability Claims Processing Accuracy

The Roanoke VARO did not consistently process temporary 100 percent disability evaluations and TBI cases accurately. Overall, VARO staff incorrectly processed 17 of the 60 disability claims we sampled, resulting in 129 improper monthly payments to 6 veterans totaling $186,929 ranging from April 2008 until November 2012.

We sampled claims related to specific conditions 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 September 2012, the overall accuracy of the VARO's compensation rating-related decisions was 81.3 percent—5.7 percentage points below VBA's target of 87 percent. This program information was not reviewed during the scope of this inspection.

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

Table 1

Roanoke VARO Disability Claims Processing Accuracy

Type of Claim	Reviewed	Claims Inaccurately Processed		
		Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits	Total
Temporary 100 Percent Disability Evaluations	30	5	9	14
Traumatic Brain Injury Claims	30	1	2	3
Total	**60**	**6**	**11**	**17**

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 fourth quarter FY 2012

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 14 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 needed. At the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

For temporary 100 percent disability evaluations, including confirmed and continued 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 risk of paying inaccurate financial benefits. Available medical evidence showed 5 of the 14 processing errors affected veterans' benefits and resulted in 116 improper monthly overpayments payments to 5 veterans totaling $184,562, from as early as April 2008 until November 2012. The most significant overpayment occurred when VARO staff did not schedule a medical reexamination for a veteran's cancer condition. As a result, VA continued processing monthly benefits and ultimately overpaid this veteran a total of $90,018 over a period of 4 years and 3 months.

The remaining 9 of the 14 errors had the potential to affect veterans' benefits. We could not determine whether the evaluations would have continued because the veterans' claims folders did not contain the medical examinations reports needed to evaluate each case. Where routine future medical reexaminations were not scheduled as required, claims processing delays ranged from 1 year and 5 months to 8 years. An average of 3 years and 10 months elapsed from the time staff should have scheduled these medical examinations until November 2012.

Summaries of the 14 total errors identified follow.

- Five errors occurred when staff did not schedule medical reexaminations after receiving or cancelling reminder notifications to do so.
- Four errors occurred when staff did not establish suspense diaries in the electronic record, thereby removing the possibility that staff would receive reminder notifications to schedule medical reexaminations.
- Four errors occurred when staff did not take final action to reduce benefits after notifying veterans of the intent to do so. On average, approximately 3 months elapsed from the time staff should have reduced

the benefits until November 2012. The delays ranged from 1 to 5 months.

- One error occurred when a Rating Veterans Service Representative (RVSR) prematurely determined a veteran's medical condition was permanently disabling without any medical evidence to support that conclusion. Had we not identified this case during our inspection, VARO staff may not have been alerted to take action to schedule a required mandatory reexamination to determine the residual disabilities associated with the temporary medical condition.

In November 2009, VBA provided refresher guidance to VARO staff about the need to input suspense diaries to the electronic record to provide reminders to schedule medical reexaminations. However, VARO managers had no oversight procedures in place to ensure VSC staff established suspense diaries and scheduled reexaminations timely. Temporary 100 percent disability evaluations could have continued uninterrupted over the veterans' lifetimes if we had not identified the need for VARO staff to take actions to schedule reexaminations.

Additionally, VARO managers did not have oversight in place to ensure staff reduced benefits payments to veterans in a timely manner after advising them of the intent to do so. Management also did not ensure staff complied with a local policy requiring them to closely monitor and take appropriate follow-up actions on benefit reduction cases. Managers stated staff did not complete actions on benefits reductions because the VARO diverted efforts to support other national production goals. As a result, veterans may be at risk of receiving inaccurate benefits payments.

Actions Taken in Response to Prior Audit Report

In response to a recommendation in our national report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, dated January 24, 2011), the then-Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each 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 then-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 June 30, 2012, and then again to December 31, 2012. We remain concerned about the lack of urgency VBA demonstrated in completing this review, which is critical to minimize the financial risks of making inaccurate benefits payments. To date, our national audit recommendation for VBA to

review all temporary 100 percent disability evaluations remains open. We do not intend to close this recommendation to VBA until our inspection results show a significant decrease in the types of errors identified during our national audit.

During this 2012 inspection, we followed up on VBA's national review of its temporary 100 percent disability evaluation processing. We sampled 40 cases from the lists of cases needing corrective actions that VBA provided to the Roanoke VARO for review. We determined VARO staff accurately reported taking actions, such as inputting suspense diaries or scheduling reexaminations, on all 40 cases. However, in comparing VBA's national review lists with our data on temporary 100 percent disability evaluations, we found six cases involving prostate cancer that VBA had not identified. We could not determine why VBA did not identify these cases; however, we provided VA regional office officials the complete listing of 709 claims needing their review before we left the VARO. This review is important because the VARO is experiencing a high error rate processing claims in this area. As a result, we will monitor this situation as VBA works to complete its national review.

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.

In response to a recommendation in our annual report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-167, dated May 18, 2011), VBA agreed to develop and implement a strategy for ensuring accurate TBI claims rating decisions. In June 2011, the Under Secretary for Benefits provided guidance to VARO Directors to implement a policy requiring a second signature on each TBI case an RVSR evaluates until the RVSR demonstrates 90 percent accuracy in TBI claims processing. The policy indicates second signature reviewers come from the same pool of staff as those used to conduct local station quality reviews.

VARO staff incorrectly processed 3 of 30 TBI claims we reviewed. One of the processing errors affected a veteran's benefits. In this case, an RVSR used the same symptoms to evaluate TBI-related disabilities and a coexisting mental disorder. However, VBA policy prohibits using the same manifestations or symptoms to evaluate different disabilities. As a result, the veteran was overpaid approximately $2,367 over a period of 1 year and 1 month.

The remaining two cases had the potential to affect veterans' benefits. Descriptions of these two cases follow.

- An RVSR used an incomplete VA medical examination report to evaluate disabilities related to a TBI. Specifically, the Disability Benefits Questionnaire examination template requires the examiner to identify residual disabilities of a veteran's TBI; however, the VA examiner did not complete this section of the medical report. VBA policy requires that VARO staff return examination reports that are incomplete for rating purposes to the examining facility for clarification. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without adequate or complete medical evidence.
- An RVSR established compensation benefits for a veteran without evidence required by VBA policy to show the veteran had sustained a TBI while on active duty. This error did not affect the veteran's overall combined monthly benefits; however, if left uncorrected, the error has the potential to affect future benefits.

VARO staff complied with VBA's policy requiring that TBI claims undergo an additional level of review; however, in the three cases we identified as having errors, the second-level reviewers also missed the errors. Management stated the TBI claims processing errors we observed were due to a lack of accountability in the second signature review process. Because staff did not always recognize TBI errors when processing these claims, veterans may not receive accurate benefits.

Follow-Up to Prior VA OIG Inspection

Our prior report, *Inspection of the VA Regional Office Roanoke, VA* (Report No. 09-01995-63, dated January 14, 2010), stated 13 of the total 28 TBI claims we reviewed had processing errors. The majority of the errors occurred because RVSRs did not recognize and return insufficient VA medical reports submitted by examiners who had used incorrect examination worksheets. In response to our recommendations, the VARO Director agreed to ensure RVSRs received training on identifying and returning insufficient examinations, as well as to coordinate with medical staff to ensure use of the most current examination worksheets. As a result, the OIG closed these recommendations in June and September 2010.

During our November 2012 inspection, one of the three errors we identified involved staff using an insufficient medical examination; however, the majority of the claims folders we reviewed contained medical reports sufficient for evaluating TBI disability claims. We concluded the VARO's corrective actions taken in response to our 2010 recommendations were adequate.

Recommendations

1. We recommend the Roanoke VA Regional Office Director develop and implement a plan to ensure claims processing staff input suspense diaries in the electronic record as required.

2. We recommend the Roanoke VA Regional Office Director develop and implement a plan to ensure claims processing staff timely schedule medical reexaminations when the reminder notifications are received.

3. We recommend the Roanoke VA Regional Office Director develop and implement a plan to ensure claims processing staff take timely actions to finalize reductions in benefits.

4. We recommend the Roanoke VA Regional Office Director develop and implement a plan to review for accuracy the 709 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate actions.

5. We recommend the Roanoke VA Regional Office Director develop and implement a plan to ensure effective second signature reviews of traumatic brain injury claims decisions.

Management Comments

The VARO Director concurred with our recommendations. Subsequent to our inspection, Roanoke VARO staff began completing rating-related decisions using the Veterans Benefits Management System-Rating application. This system requires staff to enter a reexamination date or declare a veteran's disability as permanent, thereby ensuring suspense diaries are input to the electronic record. An updated workload management plan requires monthly reporting and assigns managers oversight responsibility for ensuring staff schedule medical examinations timely after receiving reminder notifications. On a biweekly basis, the VSC's management analyst identifies benefit reduction notifications with overdue suspense dates to ensure staff take actions and finalize reductions as appropriate.

As recommended, VARO staff began a review of the 709 cases remaining from the OIG's inspection universe and took appropriate actions on 355 of these cases. Management expects to complete reviews and necessary actions for the remaining 354 cases by September 30, 2013. Additionally, to ensure effective second signature reviews of TBI claims, QRT managers will review at least one second signature review completed by QRT staff during their regular monthly quality reviews.

OIG Response

The Director's comments and actions are responsive to the recommendations. However, we are concerned with the VARO's assessment that the majority of the 100 percent disability evaluations VBA identified for

VARO review were unnecessary since controls were already in place to manage these cases. Our inspection results showed that despite these controls, 9 of the 14 total errors in temporary 100 percent disability evaluation processing occurred when staff did not timely schedule medical examinations or follow up to reduce benefits as appropriate. As such, we believe the additional review is warranted.

II. Management Controls

Systematic Analysis of Operations

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of 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 mandated SAOs annually.

VARO management ensured SAOs contained thorough analyses using appropriate data, identified deficiencies, and made recommendations for improvements where appropriate. SAOs were also submitted by the required due date. Management attributed success in this area to a unique tracking schedule containing three interim due dates. By using interim due dates, management allowed sufficient time to thoroughly review SAOs before their final submission.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office Roanoke, VA* (Report No. 09-01995-63, dated January 14, 2010), we found staff generally followed policy in completing the required SAOs. Our current inspection results further indicate VARO staff consistently used adequate data to support SAOs analyses and recommendations and submitted them timely according to the annual schedule. As such, we made no recommendation for improvement in this area.

Further, our 2010 inspection disclosed issues regarding a lack of adequate space to store veterans’ claims files. In response to our recommendation, VARO managers agreed to temporarily lease an off-site facility to store 40-60 percent of the VARO’s existing file cabinets as an interim solution while management continued to search for a permanent storage remedy. In June 2012, VA OIG closed this recommendation upon receiving a structural analysis and a plan to reinforce the building girders. The Benefits Inspectors observed that claims file storage in the VARO’s primary offices appeared under control. However, we did not observe the management of claims folder storage at VBA’s off-site temporary space. VBA had responded to the recommendation in our 2010 report by temporarily relocating claims folders previously stacked on top of file cabinets to an alternate location while Government Services Administration renovates the permanent workspace.

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 policy in effect prior to December 21, 2012, whenever an RVSR denied a Gulf War veteran service connection for any mental disorder, the RVSR had to consider whether the veteran was 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. This pop-up notification does not generate if a previous decision did not address entitlement to mental health services and a mental condition is not part of the current claim.

Finding 2 Gulf War Veterans Did Not Always Receive Entitlement Decisions for Mental Health Treatment

VSC staff did not properly address whether 8 of 30 Gulf War veterans were entitled to receive treatment for mental disorders, according to the policy in effect at the time of our November 2012 inspection. As a result, veterans may be unaware of their possible entitlement to treatment for mental disorders and may not get the care they need. Following are summaries of the eight errors we identified.

- Four errors occurred when RVSRs did not address veterans' entitlement to treatment for mental disorders on current decisions when previous decisions also did not address the issue.
- Two errors occurred when RVSRs did not address veterans' entitlement to mental health treatment in current disability decisions—in spite of pop-up notifications reminding them to do so.
- Two errors occurred when RVSRs correctly addressed the entitlement decisions, but did not formally annotate them on the decision documents.

In December 2012, VBA modified its policy to state that RVSRs no longer have to address Gulf War veterans' entitlement to mental health care in all cases. RVSRs have to consider this entitlement when the veteran's mental health benefit can be granted based on diagnosis of a mental disorder within 2 years of separation from military service. Because this policy modification became effective after we concluded our inspection, we cannot determine whether the change might have affected the number of errors we identified. Therefore, we made no recommendation for improvement.

IV. Public Contact

Outreach to Homeless Veterans

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

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 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 government, and advocacy groups to provide information on VA benefits and services.

Finding 3 Oversight of Homeless Outreach Program Needs Improvement

The Roanoke VARO has jurisdiction over veterans residing in the Commonwealth of Virginia and the District of Columbia and is 1 of the 20 VAROs designated to have a full-time Homeless Veterans Outreach Coordinator (HVOC). The HVOC did not regularly contact or provide information to homeless shelters and service providers to all areas under VARO jurisdiction as required by VBA policy and local HVOC performance standards. Because VARO managers were unaware of VBA's policy, they did not provide adequate oversight of the homeless veterans outreach program. As a result, homeless shelters and service providers may not be aware of available VA benefits and services.

Our review confirmed the HVOC maintained a collaborative partnership with homeless coordinators at VA Medical Centers; however, contact with homeless shelters and service providers was limited to Roanoke and Richmond, Virginia. Further, VARO managers were unaware that staff had not contacted the majority of the homeless shelters and service providers within the VARO's jurisdiction and had not updated their homeless resource directory as required. Although the HVOC provided supervisors monthly handwritten calendars of outreach activities, details such as the names, locations, or contact numbers of the facilities visited were lacking.

Had management provided adequate oversight of the VARO's outreach efforts, it may have realized staff were not contacting all homeless shelters and service providers within the VARO's jurisdiction. Further, management may have also determined shelters and service providers were not receiving information on VA benefits and services available to homeless veterans.

VBA also needs performance measures for its homeless veterans outreach program. Without such measures, we cannot fully assess the effectiveness of its outreach activities.

Recommendation

6. We recommend the Roanoke VA Regional Office Director develop and implement a plan to ensure staff update the resource directory and regularly contact and provide outreach to homeless shelters and service providers within the VA Regional Office's jurisdiction.

Management Comment

The VARO Director concurred with our recommendations. Subsequent to our inspection, the VARO filled its full-time HVOC position vacancy, which had existed since the second quarter of FY 2013. In April 2013, the HVOC mailed information on available VA benefits and services to 118 homeless shelters and service providers within the VARO's jurisdiction. The HVOC is now required to contact homeless shelters and service providers annually. Since appointment, the HVOC has travelled to the Richmond and Hampton VA Medical Centers and conducted homeless outreach at the Salvation Army and the Union Mission. Additional outreach events were scheduled to take place in Northern Virginia in June 2013.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of September 22, 2012, the Roanoke VARO had a staffing level of 453 full-time employees. Of this total, the VSC had 310 employees assigned.

Workload

As of September 30, 2012, the VARO reported 27,827 pending compensation claims. The average time to complete claims was 332.3 days—102.3 days more than the FY 2012 national target of 230.

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 (4 percent) of 739 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 October 1, 2012. We provided VARO management with 709 claims remaining from our universe of 739 for its review. As follow-up to our national audit, we sampled 40 temporary 100 percent disability evaluations from the SharePoint list VBA provided to the VARO as part of its national review. We also reviewed 30 (40 percent) of 75 TBI-related disability claims that the VARO completed from July through September 2012.

Where we identify potential procedural inaccuracies, we provide this information to help the VARO understand the procedural improvements it can make for enhanced stewardship of financial benefits. We do not provide this information to require VAROs to adjust specific veterans' benefits. Processing any adjustments per this review is clearly a VBA program management decision.

We assessed the 11 mandatory SAOs the VARO completed in FY 2012. We examined 30 completed claims processed for Gulf War veterans from July through September 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 by reviewing its directory of homeless shelters

and service providers and determining whether staff regularly attended meetings and provided information on VA benefits and services.

Data Reliability

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, included any calculation errors, or were outside the time frame requested. We also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Further, we compared veterans' names, file numbers, Social Security numbers, VARO numbers, dates of claim, and decision dates as provided in the data received with information contained in the claims folders we reviewed.

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

VBA's Systematic Technical Accuracy Review program information as of September 2012 was not reviewed during the scope of this inspection nor was the information relied upon to draw the conclusions in this report.

Inspection 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 2 reflects the operational activities inspected, applicable criteria, and whether or not we had reasonable assurance of VARO compliance.

Table 2. Roanoke VARO Inspection Summary

Five Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	**No**
	Disability Claims Processing		
1. Temporary 100 Percent Disability Evaluations	**Determine whether VARO staff properly processed temporary 100 percent disability evaluations.** (38 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)		X
2. Traumatic Brain Injury Claims	**Determine whether VARO staff properly processed claims for all disabilities related to in-service TBI.** (FL) 08-34 and FL 08-36) (Training Letter 09-01)		X
	Management Controls		
3. 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		
4 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 USC 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		
5. Homeless Veterans Outreach 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) (M27-1, Part II, Chapter 2)		X

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

Appendix C VARO Director's Comments

Department of Veterans Affairs **Memorandum**

Date: June 10, 2013

From: Director, VA Regional Office, Roanoke (314)

Subj: Inspection of the VA Regional Office, Roanoke, Virginia

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

1. The Roanoke VA Regional Office's comments are attached regarding the OIG Draft Report: *Inspection of the VA Regional Office, Roanoke, Virginia.*

2. Please refer questions to Mr. Keith Wilson at (540) 597-1122.

(original signed by:)

Keith M. Wilson
Director

Attachment

Attachment

OIG Recommendation 1: We recommend the Roanoke VA Regional Office Director develop and implement a plan to ensure claims processing staff input suspense diaries in the electronic record as required.

Roanoke RO Response: Concur.

Action Taken by VARO: During the November 2012 inspection, 40 cases from the lists of cases needing corrective actions that VBA provided to the Roanoke VARO were reviewed by OIG staff. OIG's report noted that Roanoke VARO staff accurately reported taking actions, such as inputting suspense diaries or scheduling reexaminations, on all 40 cases. However, when OIG compared VBA's national review lists with their data on temporary 100 percent disability evaluations, they found six cases involving prostate cancer that VBA had not identified.

Subsequent to OIG's review, VBA developed and implemented a plan to ensure claims processing staff input suspense diaries in the electronic record as required. Under this plan, End product (EP) 684s batch generate every two weeks for any 100% evaluation that does not have a future exam diary control, P&T status reflected in SHARE, or EP 310 pending.

In January 2013 and May 2013, Compensation Service provided guidance to the field regarding the review of the temporary 100 percent disability evaluations. Since February 2013, the Veterans Service Center's Management Analyst (MA) has been conducting bi-weekly reviews of newly batch generated EP 684s to ensure proper processing, reviewing for any error trends, and taking action as needed. This review shows that since March 2013, no EP 684s have generated for the station due to a suspense diary not being entered in the electronic record.

This review has shown that the majority of EP 684s that have generated since February 2013 were not needed as a rating decision was of record reducing the 100% disability to a lower evaluation at a future date, an EP 600 was pending for a proposal to reduce, or a 100% evaluation had been assigned under a rating EP that was continued at authorization for an at once examination of the 100% disability.

Additionally, subsequent to OIG's inspection, the Roanoke VARO is now rating in VBA's newly launched web-based technology, VBMS-R. This rating application requires the rating specialist to input a date when VSC staff must schedule a reexamination or declare the disability static before a rating decision can be generated. Furthermore, in-process reviews and the Quality Review Team (QRT) provide a second level of assurance that decision-makers are making the correct decision when determining whether or not to schedule a routine future examination.

The above plans now in place provide oversight to ensure claims processing staff input suspense diaries in the electronic record as required.

OIG Recommendation 2: We recommend the Roanoke VA Regional Office Director develop and implement a plan to ensure claims processing staff timely schedule medical reexaminations when the reminder notifications are received.

Roanoke RO Response: Concur.

Action Taken by VARO: The VSC transitioned into the Organizational Model on November 6, 2012. The transition had impacted the station's workflow and oversight of the workload at the time of OIG's inspection as employees were reassigned to teams, underwent significant training, became familiar with new workflow procedures using segmented lanes, and experienced physical changes of location due to new team assignment.

The station's workload management plan (WMP) was revised in January 2013 to reassign responsibility for reviewing the pending message work items, which include work items to determine whether routine future examinations should be scheduled. The station's Express teams have been assigned responsibility by digit for the 800 series work-items. These teams also process the station's EP 310 (routine future examinations) by digit. Each Express Team Coach has the responsibility to run the reports monthly and take appropriate action.

The above workload management plan provides the oversight to ensure medical examinations are timely scheduled when reminder notifications are received.

OIG Recommendation 3: We recommend the Roanoke VA Regional Office Director develop and implement a plan to ensure claims processing staff take timely actions to finalize reductions in benefits.

Roanoke RO Response: Concur.

Action Taken by VARO: The VSC transitioned into the Organizational Model on November 6, 2012. The transition had impacted the station's workflow and oversight of the workload at the time of OIG's inspection as employees were reassigned to teams, underwent significant training, became familiar with new workflow procedures using segmented lanes, and experienced physical changes of location due to new team assignment.

The station's workload management plan (WMP) was revised in January 2013 to designate areas of responsibility for processing timely actions to finalize reductions in benefits. In addition, the Veterans Service Center MA has been conducting bi-weekly reviews to ensure proper processing, review for any error trends, and take action as needed. Through this newly implemented oversight procedure, any past due EP 600 is immediately identified, and notification is sent to the appropriate Coach to have action taken.

The above workload management plan and additional oversight will ensure that claims processing staff take timely actions to finalize reductions in benefits.

OIG Recommendation 4: We recommend the Roanoke VA Regional Office Director develop and implement a plan to review for accuracy the 709 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate actions.

Roanoke RO Response: Concur.

Action Taken by VARO: The Roanoke Regional Office completed the original tasking of processing the 810 Work Items that were established in response to OIG's Audit of 100 Percent Disability Evaluations (Report Number 09-03359-71, issued January 24, 2011). As noted in OIG's draft inspection report for Roanoke VARO, there was a discrepancy found between OIG's data on temporary 100 percent disability evaluations and those VBA had identified to VAROs.

Subsequent to OIG's review, VBA developed and implemented a plan to ensure all temporary 100 percent disability claims were put under proper control to prevent potential overpayment. The Veterans Service Center MA has been conducting bi-weekly reviews of newly batch generated EP 684s to ensure proper processing, review for any error trends, and take action as needed. This review has shown that the majority of EP 684s that have generated since February 2013 were not needed as a rating decision was of record reducing the 100% disability to a lower evaluation at a future date. An EP 600 was pending for a proposal to reduce, or a 100% evaluation had been assigned under a rating EP (i.e. – 010, 110, 020 series) that was continued at authorization for an at once examination of the 100% disability.

The station has confirmed that Roanoke has completed review of 355 of the 709 cases and has taken appropriate action on all cases. The station will have the remaining reviews and necessary action completed by September 30, 2013.

OIG Recommendation 5: We recommend the Roanoke VA Regional Office Director develop and implement a plan to ensure effective second signature reviews of traumatic brain injury claims decisions.

Roanoke RO Response: Concur.

Action Taken by VARO: The Roanoke VARO is compliant with VBA policy on processing traumatic brain injury claims. We do, however, concur with OIG's recommendation that an additional level of oversight should be implemented to ensure effective second signature reviews of traumatic brain injury (TBI) claims decisions.

TBI second signature reviews are completed by the Rating Quality Review Specialists (RQRSs) on the QRT. A spreadsheet of all TBI reviews is maintained on a shared drive in order to track reviews, identify error trends, and validate when an RVSR is ready to be released from second signature reviews for TBI claims.

The QRT Coach and Assistant Coaches conduct monthly quality review of the local aspen reviews completed by the RQRS. This regular monthly review has been amended to now include an additional review of at least one TBI 2nd signature review completed for each RQRS.

The additional review of TBI second signature actions provides additional assurance that claims processing staff has effective second signature reviews of TBI claims.

OIG Recommendation 6: We recommend the Roanoke VA Regional Office Director develop and implement a plan to ensure staff update the resource directory and regularly contact and provide outreach to homeless shelters and service providers within the VA Regional Office's jurisdiction.

Roanoke RO Response: Concur.

Action Taken by VARO: The Roanoke VARO has a full-time Homeless Veterans Outreach Coordinator (HVOC) as required by PL 107-95; however, the Public Contact Coach was the acting HVOC for a portion of the 2nd quarter of FY13, as the previous HVOC left the RO.

Subsequent to OIG's inspection, the full-time HVOC position has been filled, and the resource directory has been updated to include all contact information. The Public Contact Coach has also held meetings with the new HVOC to emphasize the importance of regular and timely updates to this listing.

OIG's report found that the HVOC maintained a collaborative partnership with homeless coordinators at VA Medical Centers; however, contact with homeless shelters and service providers was limited to Roanoke and Richmond, Virginia.

To address this finding, the HVOC sent letters to the 118 homeless shelters and service providers within the VA Regional Office's jurisdiction in April 2013 to provide information on VA benefits and services available to homeless veterans, and request updated contact information for the shelter/provider. The HVOC at the Roanoke VARO will now contact the available homeless shelters and service providers within the VA Regional Office's jurisdiction annually to ensure continued contract and outreach.

During FY2012, there were 52.5 hours of homeless outreach events completed, with a total of 483 veterans seen and 19 claims taken. Subsequent to OIG's inspection the newly appointment HVOC, traveled to Richmond VA Medical Center and Hampton VA Medical Center, where homeless outreach was conducted at the Salvation Army and Union Mission. There is also planned homeless outreach in northern Virginia from June 25, 2013 to June 27, 2013.

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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