VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Sioux Falls, South Dakota

August 29, 2012
12-00248-250

ACRONYMS AND ABBREVIATIONS

OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the VA Regional Office, Sioux Falls, South Dakota

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 Sioux Falls VARO accomplishes this mission of providing veterans with access to high-quality benefits and services.

What We Found

Sioux Falls VARO staff lacked effective controls and accuracy in processing some disability claims. Specifically, 30 percent of the temporary 100 percent disability evaluations we reviewed were inaccurate, generally because staff did not schedule or establish controls for future medical reexaminations as required. Errors in processing 40 percent of the herbicide exposure-related disability claims we sampled occurred primarily because management did not adequately monitor the effectiveness of related claims processing training. Staff accurately processed traumatic brain injury claims. Overall, VARO staff did not accurately process 21 (31 percent) of the 67 disability claims we sampled. 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.

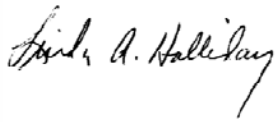
VARO staff followed VBA's policy for correcting errors identified by Systematic Technical Accuracy Review staff. They were generally effective in timely completing all elements of Systematic Analyses of Operations and managing mail. Staff also properly addressed Gulf War veterans' entitlement to mental health treatment and provided adequate outreach to homeless veterans as required. However, processing of competency determinations was ineffective, resulting in incompetent beneficiaries receiving benefits payments without fiduciaries in place to manage their resources.

What We Recommended

We recommended the VARO Director develop and implement a plan to monitor the effectiveness of training on processing herbicide exposure-related disability claims. VARO management also needs to implement controls to ensure staff follow current VBA policy on processing competency determinations.

Agency Comments

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



LINDA A. HALLIDAY
Assistant Inspector General for
Audits and Evaluations

TABLE OF CONTENTS

INTRODUCTION

Objective

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

- Evaluate how well VAROs are accomplishing their mission of providing veterans with access to high-quality benefits and services.
- Determine 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 April 2012, the OIG conducted an inspection of the Sioux Falls VARO. The inspection focused on five protocol areas examining nine operational activities. The five protocol areas were disability claims processing, management controls, workload management, eligibility determinations, and public contact.

We reviewed 37 (49 percent) of 75 disability claims related to traumatic brain injury (TBI) and herbicide exposure that VARO staff completed from October through December 2011. In addition, we reviewed 30 (67 percent) of 45 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 (VBA) policy.

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 we used to evaluate each operational activity and a summary of our inspection results.

RESULTS AND RECOMMENDATIONS

1. Disability Claims Processing

The OIG Benefits Inspection team focused on disability claims processing related to temporary 100 percent disability evaluations, TBI, and herbicide exposure. We evaluated claims processing accuracy and its impact on veterans' benefits.

Finding 1 The Sioux Falls VARO Needs To Improve Disability Claims Processing Accuracy

The Sioux Falls VARO lacked adequate controls and accuracy in processing temporary 100 percent disability evaluations and herbicide exposure-related claims. VARO staff incorrectly processed 21 of the total 67 disability claims we sampled and overpaid a total of $62,599 and underpaid a total of $6,071. VARO management agreed with our findings and began to correct the errors identified.

Because we sampled claims related to specific conditions, these results do not represent the universe of disability claims processed at this VARO. As reported by VBA's Systematic Technical Accuracy Review (STAR) program as of February 2012, the overall accuracy of the VARO's compensation rating-related decisions was 88.2 percent—1.2 percentage points above VBA's 87 percent target.

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

Table 1

Sioux Falls VARO Disability Claims Processing Results				
Type	**Reviewed**	**Claims Incorrectly Processed**		
		Affecting Veterans' Benefits	**Potential To Affect Veterans' Benefits**	**Total**
Temporary 100 Percent Disability Evaluations	30	1	8	9
Traumatic Brain Injury Claims	7	0	0	0
Herbicide Exposure-Related Claims	30	4	8	12
Total	**67**	**5**	**16**	**21**

Source: VA OIG analysis of VBA's disability claims files

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 9 of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a service-connected disability following surgery or when specific treatment is needed. At the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's temporary 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.

Available medical evidence showed one of the nine processing errors affected a veteran's benefits. This error occurred because a Rating Veterans Service Representative (RVSR) correctly continued a temporary 100 percent evaluation for a veteran's prostate cancer and annotated the need for a future medical reexamination. However, VSC staff did not establish a suspense diary to schedule the reexamination. VA medical treatment records showed the veteran had completed treatment, warranting a reduction in benefits as of September 1, 2009. As a result, VA continued processing monthly benefits and ultimately overpaid the veteran $61,606 over a period of 2 years and 7 months.

The remaining eight errors had the potential to affect veterans' benefits. Following are descriptions of these errors.

- In six cases, RVSRs correctly continued the temporary 100 percent disability evaluations and annotated the need for future reexaminations. However, VSC staff did not establish suspense diaries to ensure reminders to schedule the medical reexaminations.
- VSC staff did not schedule an examination immediately needed to determine whether a temporary 100 percent disability evaluation should continue.
- An RVSR prematurely granted service connection for an herbicide exposure-related disability without first verifying such exposure. VSC staff should have obtained substantiating evidence of such exposure prior to making a determination, as required by VBA policy.

For three of the eight errors with the potential to affect veterans' benefits, medical reexaminations were required. An average of 2 years and 2 months elapsed from the time staff should have scheduled medical reexaminations

until the date of our inspection. The delays ranged from approximately 1 year and 7 months to 3 years.

Seven of the nine errors resulted from staff not establishing suspense diaries when they processed temporary 100 percent disability evaluations requiring medical reexaminations. All seven of these errors involved confirmed and continued rating decisions. At the time these errors occurred, VSC management had no oversight procedure in place to ensure staff established suspense diaries as required. Prior to our inspection, VSC management implemented oversight procedures to ensure that staff process electronic awards for all confirmed and continued rating decisions.

In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each evaluation had a future examination date entered in the electronic record. 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 deadline to December 31, 2011, then to June 30, 2012, and then again to September 30, 2012. To assist in implementing the agreed upon review, we provided the VARO with 15 claims remaining from our universe of 45 temporary 100 percent disability evaluations. At the time of our inspection, the VARO had completed the review. As such, we made no specific recommendation for this VARO.

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.

VSC management and staff stated they had a collaborative relationship with Veterans Health Administration examiners to ensure adequacy of TBI medical examination reports. VARO staff followed VBA policy and correctly processed all seven TBI claims we reviewed. Therefore, we made no recommendation for improvement in this area.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 12 of 30 herbicide exposure-related claims we reviewed. Four of the 12 processing errors affected veterans' benefits—1 involved an overpayment totaling $993 and 3 involved underpayments totaling $6,071. Details on the most significant underpayment and the overpayment follow.

- An RVSR correctly granted service connection for a veteran's coronary artery disease associated with herbicide exposure; however, the effective date of August 22, 2011, and the evaluation of 10 percent were incorrect. The actual date of entitlement was August 31, 2010—the date of a related legislative change. Further, VA treatment records showed the veteran's disability warranted an evaluation of 30 percent. As a result, VA underpaid the veteran $3,602 over a period of 1 year and 7 months. We discussed this underpayment with VARO officials who agreed to take corrective action.
- An RVSR correctly granted service connection for a veteran's ischemic heart disease associated with herbicide exposure and assigned a temporary 100 percent evaluation with an additional special monthly benefit. Following expiration of the temporary evaluation period, the RVSR did not reduce the evaluation and discontinue the special monthly benefit as required. As a result, VA incorrectly continued processing the special monthly benefit and ultimately overpaid the veteran $993 over a period of 3 months.

The remaining eight errors had the potential to affect veterans' benefits. Following are descriptions of these errors.

- In four cases, RVSRs did not consider service connection for all issues associated with veterans' claims as required by VBA policy.
- An RVSR failed to properly notify the veteran of evidence needed to establish an earlier effective date for diabetes mellitus as required by VBA policy.
- An RVSR prematurely denied a veteran's claim without providing the veteran with proper notification of the evidence needed to support the claim prior to making a determination.
- An RVSR prematurely evaluated a veteran's disabilities based on an inadequate medical examination. According to VBA policy, when a medical examination does not address all required elements, VSC staff should return it to the issuing clinic or health care facility as insufficient for rating purposes.
- An RVSR improperly granted service connection for a urinary condition associated with a veteran's service-connected diabetes mellitus without medical evidence showing a relationship between the two conditions.

Generally, errors in herbicide exposure-related claims processing resulted from the lack of a mechanism to monitor the effectiveness of training. VSC staff received training on several topics associated with herbicide exposure-related claims prior to our inspection. An effective quality review process might have identified opportunities for additional training to improve

the VARO's accuracy in processing herbicide exposure-related claims. For example, 11 of the 12 cases in which we found errors received additional levels of review, but no errors were identified. VSC management stated that the additional levels of review were ineffective due to a combination of competing workload priorities, RVSR trainees requiring additional levels of review, and limited staffing resources to perform these reviews. Our review indicated that raters lacked understanding regarding proper processing of herbicide exposure-related disability claims and would benefit from additional training. Because of these deficiencies, RVSRs did not properly evaluate herbicide exposure-related disability claims and veterans may not have always received correct benefits.

Recommendation

1. We recommend the Sioux Falls VA Regional Office Director conduct refresher training to all staff on processing herbicide exposure-related claims and implement a plan to monitor the effectiveness of this training.

Management Comments

The VARO Director concurred with our recommendation. The Director stated the VARO conducted refresher training on May 21, 2012, and only one inaccurate decision has been identified since that training. Quality Review Specialists are tracking herbicide exposure-related claims processing deficiencies and will provide training as needed.

OIG Response

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

2. Management Controls

Systematic Technical Accuracy Review

We assessed whether VARO management adhered to VBA policy regarding correction of errors identified by VBA's STAR staff. The STAR program is VBA's multifaceted quality assurance program to ensure veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that VARO staff take corrective action on errors identified by STAR.

Sioux Falls VARO staff adhered to VBA policy by taking corrective action on all five cases with errors identified by VBA's STAR program from October through December 2011. Therefore, we made no recommendation for improvement in this area.

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 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 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.

VARO management did not complete 1 of 11 required SAOs. The remaining 10 SAOs included thorough analyses based on appropriate data, identified areas for improvement, and made recommendations. As a result, we determined the VARO was generally following VBA policy and we made no recommendation for improvement in this area.

3. Workload Management

Mailroom Operations

We assessed controls over VARO mailroom operations to ensure staff timely and accurately processed incoming mail. VBA policy states staff will open, date-stamp, and route all mail to the appropriate locations within 4 to 6 hours of receipt at the VARO. The Sioux Falls VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Triage Team. The Sioux Falls VARO does not have its own mailroom. Instead, the VA Medical Center mailroom, located on the same VA campus, receives all incoming mail for the VARO. VSC staff are responsible for retrieving and processing the VARO's mail on a daily basis. Staff were timely and accurate in processing, date-stamping, and delivering VSC mail. As a result, we determined staff were following VBA policy and we made no recommendation for improvement in this area.

Triage Mail Management Procedures

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

VSC staff did not properly manage 3 of 60 pieces of mail we reviewed. As a result, we determined the Sioux Falls VARO was generally compliant with national and local mail-handling policies. Therefore, we made no recommendation for improvement in this area.

4. Eligibility Determinations

Competency Determinations

VA must consider beneficiary competency in every case involving a mental health condition that is totally disabling or when evidence raises questions as to a beneficiary's mental capacity to manage his or her affairs. The Fiduciary Unit supports implementation of competency determinations by appointing a fiduciary, a third party who assists in managing funds for an incompetent beneficiary. We reviewed competency determinations made at

the VARO to ensure staff completed them accurately and timely. Delays in making these determinations ultimately affect the Fiduciary Unit's ability to appoint fiduciaries timely.

VBA policy requires that staff obtain clear and convincing medical evidence that a beneficiary is capable of managing his or her affairs prior to making a final competency decision. The policy allows the beneficiary a 60-day due process period to submit evidence showing an ability to manage funds and other personal affairs. At the end of the due process period, VARO staff must take immediate action to determine whether the beneficiary is competent. Effective July 2011, VBA defines "immediate" as 21 days.

Finding 2 Inadequate Controls Over Competency Determinations

As measured against VBA's definition of immediate, VARO staff unnecessarily delayed making final decisions in all four competency determinations completed from October through December 2011. The delays ranged from 1 to 42 days, with an average delay of 12 days. Delays occurred because the workload management plan did not contain oversight procedures emphasizing immediate completion of competency determinations. The risk of incompetent beneficiaries receiving benefits without fiduciaries assigned to manage those funds increases when staff do not complete competency determinations timely.

The most significant case of placing funds at risk occurred when VARO staff unnecessarily delayed making a final competency decision for a veteran for approximately 1 month. During this period, the veteran received a disability payment of $2,673. While the veteran was entitled to this payment, fiduciary stewardship was not in place to ensure effective funds management and the welfare of the veteran.

Recommendation

2. We recommend the Sioux Falls VA Regional Office Director implement controls to ensure staff follow current Veterans Benefits Administration policy regarding the processing of competency determinations.

Managements Comments

The VARO Director concurred with our recommendation. The Director indicated VSC management has included in the Workload Management Plan controls to review competency determinations on a weekly basis. These reviews began in July 2012 and findings will be included in the annual SAO on Claims Processing Timeliness.

OIG Response

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

Entitlement to Medical Care and 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.

VARO staff correctly addressed whether Gulf War veterans' were eligible for medical care or treatment in all five cases we reviewed. As a result, we determined the VARO was following VBA policy and we made no recommendation for improvement in this area.

5. 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 the 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 Sioux Falls VARO had a part-time Homeless Veterans Outreach Coordinator. Our review confirmed that the coordinator provided adequate outreach and contacted local homeless service providers as required by VBA policy. Therefore, we made no recommendation for improvement in this area.

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of March 2012, the Sioux Falls VARO had a staffing level of 55 full-time employees. Of this total, the VSC had 41 employees (75 percent) assigned.

Workload

As of February 2012, the VARO reported 1,170 pending compensation claims. The average time to complete claims was 125 days—105 days less than the 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 37 (49 percent) of 75 disability claims related to TBI and herbicide exposure that the VARO completed from October through December 2011. For temporary 100 percent disability evaluations, we selected 30 (67 percent) of 45 existing claims from VBA's Corporate Database. We provided VARO management with 15 claims remaining from our universe of 45 for its review. These claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months, as of February 14, 2012.

We reviewed the 11 mandatory SAOs completed in FYs 2011 and 2012. We also reviewed five errors identified by VBA's STAR program during October through December 2011. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR measurements include a review of work associated with claims that require rating decisions. STAR staff review original claims, reopened claims, and claims for increased evaluation. Further, they review appellate issues that involve a myriad of veterans' disability claims. Our process differs from STAR as we review specific types of disability claims related to TBI and herbicide exposure that require rating decisions. In addition, we review rating decisions and awards processing involving temporary 100 percent disability evaluations.

For our review, we selected mail in various processing stages in the VSC. We also reviewed five completed claims that had been processed for Gulf War veterans from October through December 2011 to determine whether

VSC staff addressed entitlement to mental health treatment in the rating decision documents as required. We reviewed four competency determinations completed for the same 3-month period and assessed the effectiveness of the VARO's homeless veterans outreach program.

Reliability of Data

During our inspection, 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 provided in the data received with information contained in the 76 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 Sioux Falls did not disclose any problems with data reliability.

Compliance With Inspection Standards

We conducted this inspection in accordance with the Council of the Inspectors General on Integrity and Efficiency *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 VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: July 26, 2012

From: Director, Sioux Falls VA Regional Office (438)

Subj: Inspection of the VA Regional Office, Sioux Falls, South Dakota

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

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

2. Questions may be referred to Mr. James L. Brubaker, Director, at 605-333-6839, or Ms. Donna Meyer-Hickel, Veterans Service Center Manager at 605-336-3230 ext 6147.

(original signed by:)

JAMES L. BRUBAKER

Attachment

VARO Director's Comments

Finding 1 Disability Claims Processing Accuracy Could Be Improved

Recommendation: *Audit of Herbicide Exposure-Related Claims* (Report No. 2012-00248SD0024, July 20, 2012), recommended the Sioux Falls VA Regional Office Director conduct training for all staff on processing herbicide exposure- related claims and implement a plan to monitor the effectiveness of training.

Response: Concur. On May 21, 2012, the Sioux Falls VA Regional Office conducted refresher training on herbicide claims development and processing. One herbicide exposure related claim deficiency was identified in the 95 local quality reviews completed since the training. Additionally, Quality Review Specialists have begun tracking in-process deficiencies identified as part of herbicide exposure related claims. Additional training will be provided as may be required.

We request closure of this recommendation due to the training completed and the actions taken to monitor effectiveness in this area

Finding 2 Inadequate Controls Over Competency Determinations

Recommendation: We recommend the Sioux Falls Regional Office Director implement controls to ensure staff follow current Veterans Benefits Administration policy regarding the processing of competency determinations.

Response: Concur. The Sioux Falls VA Regional Office has incorporated controls into its Workload Management Plan to review competency determinations on a weekly basis and effective in July supervisory reviews. A copy of the Workload Management Plan is attached. Findings will be incorporated into the annual Systematic Analysis of Operations (SAO) on Claims Processing Timeliness. VOR data for May thru today's date in July 2012 show the office processed 10 final incompetency determinations in an average of 68 days. Four of those 10 cases exceed the 81-day goal. The controls established in the July 2012 revision of the Workload Management Plan would have enabled the RO to timely process three of the four outliers. Due to the typographical error on the fourth cases, the RO would not have been able to prevent the case from being processed greater than the 81-day goal.

We request closure of this recommendation due to the changes instituted in the Workload Management Plan and the validation of the established controls.

Appendix C Inspection Summary

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

Table 2. Sioux Falls VARO Inspection Summary

Nine Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. Temporary 100 Percent Disability Evaluations	**Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations.** (38 Code of Federal Regulations (CFR) 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (Manual (M)21-1 Manual Rewrite (MR) Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Traumatic Brain Injury Claims	**Determine whether VARO staff properly processed claims for service connection for all disabilities related to in-service TBI.** (Fast Letter (FL) 08-34 and 08-36, Training Letter 09-01)	X	
3. Herbicide Exposure-Related Claims	**Determine whether VARO staff properly processed claims for service connection for herbicide exposure-related disabilities.** (38 CFR 3.309) (FL 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)		X
Management Controls			
4. 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	
5. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)	X	
Workload Management			
6. 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	
Eligibility Determinations			
7. Competency Determinations	**Determine whether VARO staff properly assessed beneficiaries' mental capacity to manage VA benefits payments.** (M21-1MR Part III, Subpart v, Chapter 9, Section A) (M21-1MR Part III, Subpart v, Chapter 9, Section B) (FL 09-08)		X
8. 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			
9. 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 Rewrite

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Dawn Provost, Director Ed Akitomo Nelvy Viguera Butler Madeline Cantu Lee Giesbrecht Jeff Myers David Pina Brandi Traylor Diane Wilson

Appendix E Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Assistant Secretaries
Office of General Counsel
Veterans Benefits Administration Central Area Director
VA Regional Office Sioux Falls Director

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Tim Johnson, John Thune
U.S. House of Representatives: Kristi Noem

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