VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Cleveland, Ohio

September 27, 2012
12-00241-296

ACRONYMS AND ABBREVIATIONS

COVERS	Control of Veterans Records System
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
VSCM	Veterans Service Center Manager

Report Highlights: Inspection of the VA Regional Office, Cleveland, Ohio

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

What We Found

Overall, VARO staff did not accurately process 26 percent of the disability claims we reviewed. These results do not represent the overall accuracy of disability claims processing at this VARO as we sampled claims we considered at higher risk of processing errors.

The Cleveland VARO did not always process disability claims accurately. VARO staff inaccurately processed 53 percent of the temporary 100 percent disability evaluations we reviewed generally because staff did not schedule medical reexaminations as required to determine whether to continue these evaluations. Additionally, VARO staff inaccurately processed 17 percent of the sampled traumatic brain injury claims when they incorrectly interpreted VBA policy. In contrast, VARO staff accurately processed 93 percent of the herbicide exposure-related claims we reviewed. Where claims processing is inaccurate, VBA risks paying inaccurate and often unnecessary financial benefits.

VARO staff generally corrected errors identified by VBA's Systematic Technical Accuracy Review program. VARO management ensured staff completed and used adequate data to support Systemic Analyses of Operations.

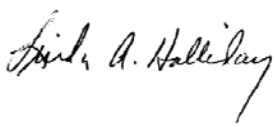
However, due to insufficient management oversight, VARO staff did not properly process mail to ensure decision makers had all of the evidence available to make accurate and timely claims decisions. VARO staff also inconsistently addressed Gulf War veterans' entitlement to mental health treatment. The Cleveland VARO provided outreach to homeless veterans. However, VBA needs a measure to assess its outreach programs.

What We Recommended

We recommended the VARO Director provide refresher training on proper processing of traumatic brain injury claims. The Director should also ensure staff properly process all mail and address Gulf War veterans' entitlement to mental health treatment 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
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 June 2012, the OIG conducted an inspection of the Cleveland VARO. The inspection focused on five protocol areas examining eight operational activities. The five protocol areas were disability claims processing, management controls, workload management, eligibility determinations, and public contact. We did not examine eligibility determinations related to fiduciary competency determinations because the Veterans Benefits Administration (VBA) centralized the Eastern Area fiduciary activities at the Indianapolis VARO.

We reviewed 60 (7 percent) of 902 disability claims related to traumatic brain injury (TBI) and herbicide exposure that VARO staff completed from January through March 2012. We also reviewed 30 (4 percent) of 742 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months, generally the longest period a temporary 100 percent disability evaluation may be assigned under VBA policy without review.

Appendix A provides details on the VARO and the scope of our inspection. Appendix B provides the VARO Director's comments on a draft of this report. Appendix C provides criteria 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 Cleveland VARO Could Improve Disability Claims Processing Accuracy

The Cleveland VARO did not always process temporary 100 percent disability evaluations and TBI cases accurately. However, VARO staff correctly processed 93 percent of the herbicide exposure-related disability claims we reviewed. Overall, VARO staff incorrectly processed 23 of the total 90 disability claims we sampled and processed $579,117 in improper benefit payments. VARO management disagreed with monetary calculations related to overpayments of three temporary 100 percent evaluation errors. Management nonetheless agreed to take corrective action on all errors we identified.

Because we sampled specific types of claims, our results do not represent the universe of disability claims processed at the VARO. As reported by VBA's Systematic Technical Accuracy Review (STAR) program as of April 2012, overall accuracy of the Cleveland VARO's rating-related decisions was 89.7 percent—2.7 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 Cleveland VARO.

Table 1

Cleveland VARO Disability Claims Processing Results				
Type	**Reviewed**	**Claims Incorrectly Processed**		
		Potential To Affect Veterans' Benefits	**Affecting Veterans' Benefits**	**Total**
Temporary 100 Percent Disability Evaluations	30	9	7	16
Traumatic Brain Injury Claims	30	4	1	5
Herbicide Exposure-Related Disability Claims	30	0	2	2
Total	**90**	**13**	**10**	**23**

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

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 16 of the 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 a veteran needs a specific treatment. 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.

Available medical evidence showed that 7 of 16 processing inaccuracies affected veterans' benefits—6 overpayments totaled $561,519, and 1 underpayment totaled $8,175. Details on the most significant overpayment and underpayment follow.

- The most significant overpayment occurred when VARO staff did not schedule a medical reexamination for a veteran's non-Hodgkin's lymphoma as required. VA treatment records revealed the condition improved and the veteran was no longer entitled to receive a temporary 100 percent disability evaluation. Nonetheless, VA continued processing monthly benefits and ultimately overpaid the veteran $236,655 over a period of 7 years and 6 months.
- The underpayment occurred when VARO staff did not schedule a medical reexamination for a veteran's squamous cell carcinoma of the left vocal cord. VA treatment records revealed the veteran underwent a total laryngectomy that warranted a higher level of monthly compensation. As a result, VA underpaid the veteran $8,175 over a period of 7 years and 5 months. We discussed the underpayment with VARO officials who agreed to take corrective action.

Management concurred with all of the errors except three monetary calculations related to improper payments. We notified the VSCM that these overpayment calculations were determined based on evidence already in the veterans' claims folders and the calculation of improper payments was based on available evidence at the time of our inspection. Further, our calculations did not include any projected improper payment amounts beyond the date of our inspection.

The remaining 9 of the 16 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 examination reports needed to reevaluate each case.

The most frequent processing inaccuracies in 7 of the 16 errors resulted from VARO staff not establishing suspense diaries in the electronic record so they would receive reminder notifications to schedule required VA medical reexaminations. Four of these errors involved confirmed and continued rating decisions. We found no systemic trends in the remaining processing inaccuracies and determined they occurred because of human error.

In November 2009, VBA provided guidance reminding VARO staff about the need to add suspense diaries in the electronic record as reminders to schedule medical reexaminations to support follow-on rating decisions. However, VARO management had no oversight procedure in place to ensure VSC staff established the suspense diaries and scheduled reexaminations timely as required. Because effective controls were not in place, temporary 100 percent disability evaluations could have continued uninterrupted over the veterans' lifetimes if we had not identified the need for reexaminations.

For those cases requiring medical reexaminations, delays ranged from approximately 9 months to 11 years and 3 months. An average of 4 years and 11 months elapsed from the time staff should have scheduled these medical examinations until the date of our inspection—the date staff ultimately ordered the examinations or obtained the necessary medical evidence.

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. To assist in implementing the agreed-upon review, we provided the Cleveland VARO with 712 claims remaining from our universe of 742 temporary 100 percent disability evaluations. VBA is still working to complete this national review requirement and has since extended the national review deadline to September 30, 2012.

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 5 of 30 TBI claims. One of these processing errors affected a veteran's benefits, and four had the potential to affect veterans' benefits. Following are examples of these errors.

- A Rating Veteran Service Representative (RVSR) evaluated residuals of TBI as 40 percent disabling based on moderate impairment of subjective symptoms described by the veteran. However, the VA physician's examination report noted a mild impairment, which supported a 10 percent evaluation. VA continued processing monthly benefits and ultimately overpaid the veteran $5,209 over a period of 2 years and 2 months.
- An RVSR prematurely evaluated headaches as a symptom of a veteran's previously diagnosed TBI without requesting a medical examination to determine the current level of severity of the headaches. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without an adequate or complete medical examination.

Two of the three remaining errors occurred when an RVSR incorrectly used the same symptoms to evaluate TBI-related disabilities and coexisting mental disorders. This was contrary to VBA policy directing that staff cannot use the same symptoms to evaluate two separate disabilities, even though symptoms of cognitive impairment and mental disorders such as post-traumatic stress disorder often overlap. The final error occurred because an RVSR did not return the insufficient examination report for clarification as required.

Most of the RVSRs we interviewed indicated the TBI regulations and policies were challenging when rating cases where symptoms of a TBI and mental conditions coexisted. Management also agreed the TBI regulations and policies were complex and time consuming to read, which resulted in incorrect decisions. Management explained that while RVSRs are not instructed to rate on insufficient examinations, they are encouraged to rate on the totality of evidence available or return the examinations for clarification. Generally, errors associated with TBI claims occurred because staff incorrectly interpreted VBA policy and used their own interpretations of medical examination results to rate claims. As a result, veterans may not always receive correct benefits.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 2 of 30 herbicide exposure-related claims we reviewed. Both processing errors affected veterans' benefits and resulted in underpayments totaling $4,214. In one case, an RVSR did not establish entitlement to a special monthly compensation as required. The veteran was entitled to this benefit based on having both a total disability and additional service-connected disabilities independently evaluated at 60 percent disabling or more. Because of the processing error, VA underpaid the veteran $2,615 for a period of 8 months. We discussed the underpayment with VARO officials who agreed to take corrective action.

The remaining error occurred when an RVSR correctly established a veteran's service connection for ischemic heart disease; however, the RVSR used an incorrect effective date to start paying the veteran disability compensation. According to VA regulations, when a claimant submits a claim within 1 year of a legislative change, if the veteran is eligible, VA may authorize benefits from the date of the legislative change. An underpayment occurred because medical evidence showed a diagnosis of ischemic heart disease prior to the legislative change; therefore, the veteran was eligible for an earlier payment date. As a result of the error, VA underpaid the veteran $1,599 over a period of 1 year.

We did not consider this error rate significant and determined the VARO was generally complying with VBA's policy for processing herbicide exposure-related claims. Therefore, we made no recommendation for improvement in this area.

Recommendation

1. We recommend the Cleveland VA Regional Office Director conduct refresher training on the proper processing of traumatic brain injury claims involving coexisting mental conditions.

Management Comments

The VARO Director concurred with our recommendation. VARO staff will receive refresher training on properly establishing suspense diaries for temporary 100 percent disability evaluations and on evaluating TBI claims that involve coexisting medical conditions. The Director indicated staff would complete this training by January 2013. Further, until improvement is noted, VARO staff will conduct quarterly random sampling reviews of these claims.

OIG Response

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

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 VAROs to take corrective action on errors identified by STAR.

VARO staff did not correct 1 of 10 files containing claims-processing errors identified by VBA's STAR program from July through September 2011. In this instance, VARO staff erroneously reported that they had completed the corrective action identified by STAR. Because VARO management generally followed VBA policy regarding correction of STAR errors, we made no recommendation for improvement in this area.

Systematic Analysis of Operations

We assessed whether VARO management had controls in place to ensure complete and timely submission of each 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 propose corrective actions. VARO management must publish annual SAO schedules designating the staff required to complete the SAOs by specific dates. The VSCM is responsible for the ongoing analysis of VSC operations, including completing 11 mandated SAOs annually.

VARO management timely completed all 11 required SAOs. The completed SAOs contained thorough analyses using appropriate data, identified areas for improvement, and made recommendations for improvement of business operations. The VSC used a control sheet to monitor the SAO concurrence process. Additionally, the VSC management conducted reviews to ensure implementation of SAO recommendations. The VSCM stated staff assess recommendations throughout the year to determine if they are achieving the required results. We determined the VARO was following VBA policy and 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 Cleveland VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division and VSC. Mailroom staff were timely and accurate in processing, date-stamping, and delivering mail to the VSC's Triage Team control point daily. Because we determined the VARO was following VBA policy, we made no recommendation for improvement in this area.

VSC Mail Management Procedures

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

Search and Drop Mail

VBA policy requires VARO staff to use the Control of Veterans Records System (COVERS), an electronic tracking system, to track claims folders and control search mail. VBA defines search mail as active, claims-related mail waiting to be associated with veterans' claims folders. Conversely, drop mail requires no immediate action after staff place the mail in claims folders.

Finding 2 Controls Needed for Proper Processing of Veterans Service Center Mail

VSC staff did not correctly manage 20 of 60 pieces of mail we reviewed. Search mail inaccuracies occurred because management did not ensure staff properly used electronic systems to control the mail. Our inspectors examined 30 individual pieces of search mail and 30 individual pieces of drop mail during our review. The VSCM did not believe the VSC had a problem with processing search mail despite results from their internal reviews and our independent review that indicated otherwise. Inaccuracies in drop mail occurred due to a lack of oversight in this area. Because of ineffective mail management, VSC staff may not always have all of the evidence needed to make claims decisions; therefore, beneficiaries are at increased risks of not receiving accurate and timely benefits payments.

Search Mail

Staff improperly used electronic applications to manage search mail and claims folders. Staff did not accurately control search mail in COVERS or update this system to track claims folders and manage mail received in support of claims. Overall, staff did not accurately process 16 of 30 pieces of search mail we reviewed. Following are examples of these discrepancies.

- On August 1, 2011, VSC staff received medical reports, military service records, and a statement in support of a veteran's pending claim. Staff forwarded the mail to a mail control point, but did not place it on search in COVERS. An RVSR subsequently completed a disability decision without having this evidence available to support the determination. Although the evidence in this case did not change the rating decision, the potential existed for decision makers to not have all available evidence to make a disability determination. Staff had delayed associating the medical evidence with the veteran's claim folder for 315 days.

- On May 7, 2012, VSC staff received a physician's response to VA's request for medical records and correctly placed this mail on search in COVERS. However, staff did not timely associate this mail with the claim folder for processing on May 23, 2012, or June 6, 2012, the days COVERS notified them of the pending search mail. According to the electronic record, this was the last piece of outstanding evidence in support of the pending claim. Staff unnecessarily delayed processing this claim for 35 days.

Triage Team supervisors conducted weekly reviews of the VSC's pending search mail. Supervisors stated these reviews have occurred for approximately 2 years; however, they did not begin recording the results until January 2012. The 10 most recent reviews had occurred from March 31, 2012, through June 8, 2012. Triage Team supervisors reviewed 87 pieces of search mail during this period and found 47 (54 percent) had not been managed in compliance with VBA and local policies. Although VSC supervisors indicated they addressed mail management deficiencies with individual employees and provided remedial training as needed, staff continued to mishandle search mail.

Drop Mail

VSC staff did not properly handle 4 of 30 pieces of drop mail pending at the time of our inspection. Following are examples of these discrepancies.

- On September 12, 2011, VSC staff received a veteran's statement to support his pending claim for benefits. On March 8, 2012, staff transferred the claim folder to the Louisville VARO without this mail. Staff should have forwarded this mail to the Louisville VARO rather than leaving it at the drop mail point. The Cleveland VARO had been in possession of the evidence for 273 days.
- On March 7, 2012, VSC staff received through the mail a veteran's dependency claim that should have been associated with the veteran's claim folder. Instead, staff incorrectly placed the mail at the drop mail point. Because staff could not find the mail, they ultimately sent the veteran a letter indicating the claim was lost. We found the veteran's dependency claim during our review of the drop mail point. The incorrect processing of this mail led to a 97-day delay in completing the claim.

Drop mail errors occurred due to a lack of management oversight. VSC policies do not require supervisory reviews of this mail. Supervisors confirmed they did not routinely review mail marked for drop. Additionally, the Quality of Files SAO did not include a sample of drop mail to determine whether staff properly categorized and processed this mail. VBA policy encourages the use of samples in SAOs. If management had required staff to

sample drop mail when completing this SAO, they might have identified the weaknesses we found in drop-mail processing.

Recommendations

2. We recommend the Cleveland VA Regional Office Director ensure compliance with requirements for using the Control of Veterans Records System application.
3. We recommend the Cleveland VA Regional Office Director develop and implement a plan to ensure oversight of drop mail.

Management Comments

The VARO Director concurred with our recommendations and indicated the VARO will conduct random COVERS audits and quarterly inspections to ensure measurable improvement in this area. Further, the VARO will incorporate a review of drop mail in the Quality of File Activities SAO and staff will complete this SAO quarterly until measurable improvement is attained.

OIG Response

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

4. Eligibility Determinations

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 their 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 decisions. The application provides a pop-up notification, known as a tip master, to remind staff to consider a Gulf War veteran's entitlement to health 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 3 Gulf War Veterans Did Not Always Receive Entitlement Decisions for Mental Health Treatment

VSC staff did not address whether 12 of 30 Gulf War veterans' were entitled to receive treatment for mental disorders. The majority of these inaccuracies occurred because RVSRs did not receive refresher training emphasizing the need to determine whether prior rating decisions addressed this entitlement. As a result, staff did not accurately inform veterans of entitlement to treatment for mental disorders.

In 7 of the 12 errors we reviewed, RVSRs did not address treatment for mental disorders on current decisions when previous decisions did not address the issue. In these cases, the pop-up notification did not generate. For the remaining five errors, pop-up notifications should have generated in four instances; however, RVSRs did not address the entitlement. For one error, an RVSR addressed a Gulf War veteran's entitlement to treatment, but staff failed to notify the veteran of the decision.

Although the RVSRs and Decision Review Officers we interviewed were able to explain the correct process for addressing Gulf War veterans' mental health care entitlement, they stated it was easy to overlook the entitlement. Based on staff interviews and a review of training documentation, we determined RVSRs did not receive any refresher training emphasizing the need to ensure prior rating decisions addressed entitlement to mental health treatment for Gulf War veterans. RVSRs received training in May 2012; however, we could not determine the effectiveness of that training as the cases reviewed were completed prior to the most recent training.

Recommendation

4. We recommend the Cleveland 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 Director concurred with our recommendation. The Director stated staff would receive additional refresher training on Gulf War Veterans' entitlement to medical treatment by January 2013. Following the training, the VARO will conduct quarterly random sampling to review these cases.

OIG Response

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

5. 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 service. VBA generally defines homeless as lacking a fixed, regular, and adequate nighttime residence.

Congress mandated at least one full-time employee oversee and coordinate programs for homeless veterans 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 program coordinators at the remaining 37 VAROs be familiar with the 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, program coordinators should attend regular

meetings with local homeless service providers, community governments, and advocacy groups to provide information on VA benefits and services.

The Cleveland VARO has a full-time Homeless Veterans Outreach Coordinator. Our review confirmed the coordinator provided effective outreach to homeless veterans as required. Therefore, we made no recommendation to the VARO management for improvement in this area. However, we noted that VBA lacks performance metrics to measure the adequacy of its outreach services.

The VSCM attributed the success of the Cleveland VARO's homeless outreach program to its practice of ensuring several full-time VSC employees were located within the five Ohio VA Medical Centers. Management believed this practice had created a unique one-on-one customer service environment between homeless veterans and VSC employees. We concluded the VARO was providing valuable customer service to the homeless veterans of Ohio.

Appendix A VARO Profile and Scope of Inspection

Organization

The Cleveland Regional Office administers a variety of services and benefits including Compensation and Pension and Vocational Rehabilitation and Employment. Other services include specially adapted housing grants, benefits counseling, fiduciary services, and outreach to homeless, elderly, minority, and women veterans.

Resources

As of April 2012, the Cleveland VARO had a staffing level of 556.6 full-time employees. Of these, the VSC had 267.4 employees assigned.

Workload

As of April 2012, the VARO reported 25,575 pending compensation claims. The average time to complete these claims was 271.9 days—41.9 days above 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 60 (7 percent) of 902 claims related to TBI and herbicide exposure-related disabilities the VARO completed from January through March 2012. For temporary 100 percent disability evaluations, we selected 30 (4 percent) of 742 existing claims from VBA's Corporate Database. We provided the VARO management with 712 claims remaining from our universe of 742 for further review. The 712 claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months or longer as of April 1, 2012.

We reviewed the 10 files containing a total of 13 errors identified by VBA's STAR program during July 2011 through September 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. We also review rating decisions and awards processing involving temporary 100 percent disability evaluations. Additionally, we reviewed the 11 mandatory SAOs completed in FY 2011 and 2012.

We reviewed selected mail in various processing stages in the VARO mailroom and VSC. We reviewed 30 completed claims processed for Gulf War veterans from January through March 2012 to determine whether VSC staff addressed entitlement to mental health treatment in the rating decision documents as required. We also reviewed 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 the reliability of data, we reviewed it to determine whether any data were missing from key fields and whether they contained:

- Data outside of the timeframe requested
- Calculation errors
- Obvious duplication of records
- Alphabetic or numeric characters in incorrect fields
- Illogical relationships of one data element to another

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 included in the claims folders we reviewed.

Our testing of the data disclosed they were sufficiently reliable for our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders at VARO Cleveland also 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'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 review objectives.

Appendix B VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: September 21, 2012

From: Director, VA Regional Office Cleveland, Ohio

Subj: Inspection of the VA Regional Office, Cleveland, Ohio

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

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

2. Thank you for the opportunity to provide feedback. You may refer questions to me at 216-522-3600.

(original signed by:)

Joyce A. Cange

Attachment

Cleveland VARO's comments

Recommendation 1:

We recommend the Cleveland VA Regional Office Director conduct refresher training on the proper processing of traumatic brain injury claims involving coexisting mental conditions.

Concur: The Cleveland VARO will provide refresher training on establishing proper suspense diaries for temporary 100% evaluations and training on TBI claims involving coexisting medical conditions by January 2, 2013. Following this training, the Cleveland VARO conduct a quarterly random sampling review until measurable improvement is attained. It should be noted that in 2011, VBA leadership directed all RVSRs undergo second signature on all TBI claims until they attain 90% accuracy over 10 consecutive cases. It is also important to note that some of the cases reviewed by the OIG were rated prior to implementation of this policy. The Cleveland RO is very stringent in their tracking of this information. To date, only 19 of 97 RVSRs have been released to single signature on TBI claims.

Recommendation 2:

We recommend the Cleveland VA Regional Office Director ensure compliance with requirements for using the Control of Veterans Records System application.

Concur: The Cleveland VARO will continue to conduct random COVERS audits and conduct inspections quarterly to ensure measurable improvement in this area.

Recommendation 3:

We recommend the Cleveland VA Regional Office Director develop and implement a plan to ensure oversight of drop mail.

Concur: The Cleveland VARO will incorporate a review of Drop Mail into the Quality of File Activities SAO. Additionally, this SAO will be completed quarterly until measurable improvement is attained. In addition, routine spot checks will continue, to ensure timely training and correction of errors.

Recommendation 4:

We recommend the Cleveland 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 Cleveland VARO will provide additional refresher training on Gulf War Veterans' entitlement to medical treatment for mental illness by January 2, 2013. Following this training, the Cleveland VARO conduct a quarterly random sampling review. In addition, VBA will be implementing the rating component of the Veterans Benefits Management System (VBMS) in the near future.

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. Cleveland VARO Inspection Summary

Eight 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 disabilities related to in-service TBI.** (Fast Letters 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) (Fast Letter 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 errors STAR staff identified 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. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War veterans' 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) (Fast Letter 08-15) (38 CFR 3.384) (38 CFR 3.2)		X
Public Contact			
8. Homeless Veterans Outreach Program	**Determine whether VARO staff provided effective outreach services.** (Public Law 107-05) (M21-1MR Part III Subpart ii, Chapter 1, Section B) (M21-1MR Part III Subpart iii, Chapter 2, Section I) (VBA Letter 20-02-34) (C&P Service Bulletins, January 2010 and April 2010) (M21-MR, Part VII, Chapter 6.06)	X	

Source: VA OIG
C&P=Compensation and Pension, CFR=Code of Federal Regulations, 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.
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