

# VA Office of Inspector General

## OFFICE OF AUDITS AND EVALUATIONS



## Inspection of the VA Regional Office Des Moines, Iowa

May 11, 2011  
11-00511-164

## ACRONYMS AND ABBREVIATIONS

COVERS	Control of Veterans Records System
NOD	Notice of Disagreement
OIG	Office of Inspector General
PTSD	Post-Traumatic Stress Disorder
RVSR	Rating Veterans Service Representative
SAO	Systematic Analyses of Operations
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VACOLS	Veterans Appeals Control and Locator System
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

**To Report Suspected Wrongdoing in VA Programs and Operations:**  
**Telephone: 1-800-488-8244**  
**E-Mail: [vaoinfo@va.gov](mailto:vaoinfo@va.gov)**  
**(Hotline Information: <http://www.va.gov/oig/contacts/hotline.asp>)**



# Report Highlights: Inspection of the VA Regional Office, Des Moines, Iowa

## Why We Did This Review

The Benefits Inspection Division conducts onsite inspections at VA Regional Offices (VAROs) to review disability compensation claims processing and Veterans Service Center operations.

## What We Found

Of the VAROs we have inspected since April 2009, the Des Moines VARO has exhibited one of the best accuracy rates for disability claims processing. The VARO correctly processed herbicide exposure-related disability claims and established correct dates of claim in the electronic record. VARO performance was generally effective in processing post-traumatic stress disorder claims, correcting errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program, and ensuring Systematic Analyses of Operations were timely and complete.

However, VARO management lacked effective controls and accuracy in processing temporary 100 percent disability evaluations and traumatic brain injury claims. Overall, staff did not accurately process 11 (11 percent) of the 99 disability claims we reviewed. Controls also need strengthening to ensure timely processing of Notices of Disagreement for appealed claims, proper mail handling, and accuracy of final competency determinations.

## What We Recommended

We recommended VARO management implement controls to ensure staff establish

suspense diaries for the temporary 100 percent disability reevaluations and follow up as appropriate. We also recommended management provide refresher training on proper procedures for processing traumatic brain injury claims and ensure staff return inadequate medical examination reports to the appropriate hospitals for correction.

Additionally, we recommended VARO management strengthen controls to ensure timely establishment of Notices of Disagreement in the Veterans Appeals Control and Locator System. We also recommended management provide clear guidance on proper mail processing and ensure that staff obtain training on evaluating evidence required to make accurate 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.

*(original signed by:)*

**BELINDA J. FINN**  
Assistant Inspector General  
for Audits and Evaluations

# TABLE OF CONTENTS

Introduction.....	1
Results and Recommendations .....	2
1. Disability Claims Processing .....	2
2. Data Integrity .....	6
3. Management Controls .....	8
4. Workload Management.....	8
5. Eligibility Determinations .....	10
Appendix A    VARO Profile and Scope of Inspection .....	12
Appendix B    VARO Director’s Comments.....	14
Appendix C    Inspection Summary.....	17
Appendix D    OIG Contact and Staff Acknowledgments.....	18
Appendix E    Report Distribution .....	19

## 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 if management controls ensure compliance with VA regulations and policies, assist management in achieving program goals, and minimize the risk of fraud, waste, and other abuses.
- Identify and report systemic trends in VARO operations.

In addition to this standard coverage, inspections may examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

### **Scope of Inspection**

In January 2011, the OIG conducted an inspection of the Des Moines VARO. The inspection focused on five protocol areas examining ten operational activities. The five protocol areas were disability claims processing, data integrity, management controls, workload management, and eligibility determinations.

We reviewed 69 (16 percent) of 433 disability claims related to post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and herbicide exposure that the VARO completed from July through September 2010. In addition, we reviewed 30 (18 percent) of 165 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months, generally the longest period a temporary 100 percent disability evaluation may be assigned under VA policy without review.

Appendix A provides details on the Des Moines VARO and the scope of our inspection. Appendix B provides the Des Moines 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 inspection team focused on disability claims processing related to temporary 100 percent disability evaluations, PTSD, TBI, and herbicide exposure. We evaluated claims processing accuracy and its impact on veterans' benefits.

#### **Finding 1**      **VARO Staff Need To Improve Disability Claims Processing Accuracy**

Of the VAROs we have inspected since April 2009, the Des Moines VARO has exhibited one of the best accuracy rates for disability claims processing. However, the VARO still needs to improve the accuracy of processing temporary 100 percent disability evaluations and TBI-related disability claims. VARO staff incorrectly processed 11 (11 percent) of the total 99 disability claims reviewed. We advised VARO management regarding the inaccuracies noted during our inspection and they initiated corrective measures to address them. The table below reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Des Moines VARO.

*Table*

**Disability Claims Processing Results**

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
<b>Temporary 100 Percent Disability Evaluations</b>	30	8	3	5
<b>PTSD</b>	30	1	0	1
<b>TBI</b>	9	2	1	1
<b>Herbicide Exposure-Related Claims</b>	30	0	0	0
<b>Total</b>	<b>99</b>	<b>11</b>	<b>4</b>	<b>7</b>

**Temporary  
100 Percent  
Disability  
Evaluations**

VARO staff incorrectly processed 8 (27 percent) of 30 temporary 100 percent disability evaluations we reviewed. Veterans Benefits Administration (VBA) policy requires a temporary 100 percent disability evaluation for a service-connected disability needing surgery or specific treatment. At the end of a mandated period of convalescence or cessation of treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability benefits.

Based on analysis of available medical evidence, 3 of the 8 processing inaccuracies identified affected veterans' benefits and involved overpayments totaling \$415,648. The most significant overpayment occurred when VARO staff did not schedule a medical reexamination in October 2004 as required. Our review of VA treatment records revealed medical evidence that the veteran's condition had improved and he was no longer entitled to receive temporary 100 percent disability benefits. As a result, the veteran was overpaid \$201,431 over a period of 5 years and 10 months.

The remaining five inaccuracies had the potential to affect veterans' benefits. In four of these cases, VSC staff did not establish or improperly cancelled reminder notifications in the electronic record. These notifications ensure staff are alerted when future reexaminations must be scheduled. In the remaining case, VSC staff did not schedule a required reexamination to assess the veteran's disability. We could not determine if these five temporary 100 percent disability evaluations would have continued because the veterans' claims folders did not contain the medical examination reports needed to reevaluate each case.

The delays in scheduling the reexaminations ranged from 1 year and 2 months to 6 years and 4 months. An average of 2 years and 11 months elapsed from the time staff should have scheduled these medical reexaminations until the date of our inspection—the date staff ultimately took corrective actions to obtain the necessary medical evidence.

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 diary is a processing command that establishes a date when VSC staff must schedule a reexamination. As the diary matures, the electronic system generates a reminder notification alerting VSC staff to schedule a reexamination.

The most common processing errors occurred when VARO staff did not properly establish suspense diaries for future VA reexaminations. VSC management stated, and we verified, the VARO did not have a procedure in place requiring VSC staff to review confirmed and continued rating

decisions mandating future reexaminations. Because staff did not schedule reexaminations as required, veterans did not always receive correct benefit payments.

***PTSD Claims***

VARO staff incorrectly processed 1 (3 percent) of 30 PTSD claims. In this case, the Rating Veterans Service Representative (RVSR) prematurely granted service connection for PTSD using an inadequate medical examination report instead of returning the report to the hospital for correction as required. We did not consider the frequency of errors significant, so we made no recommendations for improvement in this area.

***TBI Claims***

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

VARO staff incorrectly processed two (22 percent) of nine TBI claims we reviewed. In both cases, RVSRs incorrectly evaluated TBI residual disabilities by using veterans' subjective complaints instead of the VA examiners' medical opinions. As a result, VA overpaid one veteran \$2,985 over a period of 1 year and 3 months. In the other case, this inaccuracy did not affect the veteran's current 50 percent disability evaluation, but has the potential to affect future evaluations for additional benefits.

VARO management stated these errors were due to a lack of understanding of TBI evaluation procedures and staff's reluctance to seek clarification in cases where examination results were incomplete or inadequate. VARO staff indicated the process of returning inadequate medical examinations was time consuming. This led to the two RVSRs using their own interpretation of medical examination results to decide TBI claims instead of those provided by medical professionals. As a result, veterans did not always receive accurate benefits payments.

***Herbicide Exposure- Related Claims***

In accordance with VBA policy, VARO staff correctly processed all 30 herbicide exposure-related disability claims we reviewed. We made no recommendations for improvement in this area.

***Recommendations***

1. We recommend the Des Moines VA Regional Office Director implement controls to ensure staff establish suspense diaries for temporary 100 percent disability reevaluations.
2. We recommend the Des Moines VA Regional Office Director ensure Rating Veteran Service Representatives receive refresher training on the proper evaluation of disabilities related to traumatic brain injuries.

3. We recommend the Des Moines VA Regional Office Director develop and implement a plan to ensure VARO staff return inadequate medical examination reports to the appropriate VA medical facilities for correction.

**Management  
Comments**

The VARO Director concurred with our recommendations related to improving disability claims processing. The Director informed us that RVSRs received refresher training on properly rating TBI injuries, requesting TBI medical examinations, and identifying and returning inadequate VA medical examinations for correction. This training occurred during March 2011. In addition, the Director designated a VA Medical Center Liaison to manage the return of Compensation and Pension medical examinations identified as inadequate.

**OIG Response**

The VARO Director's comments and planned actions are responsive to our recommendations for improving disability claims processing. We will follow up as required on all actions.

A draft of this inspection report included an additional recommendation that the VA Regional Office Director review the remaining temporary 100 percent disability evaluations identified but not included in our inspection sample to determine if reevaluations are required and take appropriate action. We have removed the recommendation, from this individual VARO inspection report, since the Acting Under Secretary for Benefits has already concurred with a corresponding recommendation in our national report, "Veterans Benefits Administration: Audit of 100 Percent Disability Evaluations," (Report Number 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 has a future exam date entered in the electronic record. The Acting Under Secretary explained that VBA's national review plan entails use of three medical diagnostic codes to comprise a sample for testing whether future examination dates are established in the electronic record. Those diagnostic codes relate to Non-Hodgkin's Lymphoma, Malignant Neoplasms of the Genitourinary System, and Post-traumatic Stress Disorder. Further, the Acting Under Secretary stated, "the remainder of the cases will be identified through a batch process, and VBA will establish the appropriate future diary controls electronically."

While the Acting Under Secretary for Benefits' national review plan differs from the approach we previously recommended in a draft of this VARO inspection report, we believe the intent is the same. Removing the recommendation from our draft inspection report allows VBA time to implement its national plan for reviewing all temporary 100 percent disability evaluations to correct processing errors, with a target completion date of September 30, 2011, as the Acting Under Secretary for Benefits

previously indicated. We nonetheless are requesting that VBA's Office of Field Operations provide a copy of both VBA's national review plan for sample testing using the diagnostic codes specified above, as well as a documented explanation of its batch process for identifying the remaining cases and establishing appropriate future diary controls electronically. Such information will enable us to monitor implementation progress and gauge effectiveness of VBA's national review plan approach as we move forward in conducting our individual VARO inspections. Based on the magnitude of errors and associated financial risks we have identified in temporary 100 percent disability evaluation processing to date, we have an ongoing responsibility to exercise continued oversight in this area.

## **2. Data Integrity**

### ***Effective Dates***

We reviewed claims folders to determine if the VARO was following VBA policy on establishing effective dates in the electronic record. Generally, an effective date indicates when entitlement to a specific benefit arose. VARO staff followed VBA policy and correctly established effective dates for all 99 disability claims we reviewed. As such, we made no recommendation for improvement in this area.

### ***Dates of Claim***

We analyzed claims folders to determine if the VARO was following VBA policy on establishing dates of claim in electronic record. VBA generally uses the date of claim to indicate when a document arrives at a VA facility. VBA relies on accurate dates of claim to establish and track key performance measures, including the average days to complete a claim. VARO staff established the correct dates of claim in the electronic record for all 30 claims reviewed. As such, we made no recommendation for improvement in this area.

### ***Notices of Disagreement***

We reviewed claims folders to determine if the VARO was timely recording Notices of Disagreement (NODs) in the Veterans Appeals Control and Locator System (VACOLS). An NOD is a written communication from a claimant expressing dissatisfaction or disagreement with a benefits decision and a desire to contest the decision. An NOD is the first step in the appeals process.

VACOLS is a computer application that allows VARO staff to control and track veterans' appeals and manage the pending appeals workload. VBA policy states staff must create a VACOLS record within 7 days of receiving an NOD. Accurate and timely recording of NODs is required to ensure appeals move through the appellate process expeditiously.

## **Finding 2      Controls Over Recording Notices of Disagreement Need Strengthening**

The VSC did not have controls in place to ensure staff recorded NODs in VACOLS within VBA's 7-day standard. The VSC had not trained all Claims Assistants on the proper use of VACOLS to timely record incoming appeals-related mail. Untimely recording of NODs in VACOLS affects data integrity and misrepresents VARO performance.

The VARO exceeded VBA's 7-day standard for 5 (17 percent) of the 30 NODs we reviewed. It took staff an average of 17 days to record these 5 NODs in VACOLS. These delays ranged from 11 to 34 days. As of December 31, 2010, VBA performance reports showed the average time for the Des Moines VARO to complete an NOD was 283 days, 44 days worse than the national average of 239 days.

Prior to September 2010, the Appeals Team had two Claim Assistants assigned to process NODs. However, in September 2010 one Claim Assistant transferred to another office, leaving the team with one trained employee. Because of the vacancy, the VSC was unable to record NODs timely. To compensate for the personnel shortage, other Appeals Team employees volunteered to help the Claim Assistant record NODs in VACOLS. Claim Assistants assigned to other teams could not help because they were not familiar with how to use VACOLS or process NODs.

Data integrity issues such as untimely recording of NODs in VACOLS make it difficult for VARO and senior VBA leadership to accurately measure and monitor VARO performance. Further, VBA's National Call Centers rely upon accurate VACOLS information to provide quality customer service to veterans. Unnecessary delays in controlling NODs affect national performance measures for NOD inventory and timely appeals completion.

**Recommendation**      4. We recommend the Des Moines VA Regional Office Director develop a plan to train all Claim Assistants on the proper procedures for processing appeals-related mail and timely entering Notices of Disagreement in the Veterans Appeals Control and Locator System.

**Management Comments**      The VARO Director concurred with our recommendation. The Director informed us all Claims Assistants received training on the proper procedures for processing appeals-related mail in January and April 2011.

**OIG Response**      Management's comments and actions are responsive to the recommendation and we will follow up as required on all actions.

### 3. Management Controls

***Systematic  
Technical  
Accuracy  
Review***

We assessed management controls to determine if VARO management adhered to VBA policy regarding correction of errors identified by VBA's Systematic Technical Accuracy Review (STAR) staff. The STAR program is VBA's multifaceted quality assurance program to ensure that veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that VAROs take corrective action on errors that STAR staff identify. In general, VARO staff followed VBA policy regarding the correction of STAR errors.

VARO staff did not correct 1 (4 percent) of 23 errors identified by VBA's STAR program staff. In this instance, VARO staff erroneously reported to STAR that they had completed the corrective action identified by STAR program staff. We did not consider the error rate significant, so we made no recommendation for improvement in this area.

***Systematic  
Analyses of  
Operations***

We assessed whether VARO management had controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs). An SAO is a formal analysis of a VSC 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 an annual SAO schedule designating the staff required to complete the SAOs by specific dates.

The Des Moines VARO management generally followed VBA policy by ensuring SAOs were timely and complete. Our analysis revealed VARO staff did not timely complete 1 (8 percent) of 12 required SAOs according to their annual schedule. Specifically, VSC management delayed completing the Quality of Developmental Activity SAO by 64 days. Management did not submit to the VARO Director a request for an extension to complete this SAO until two months after the initial deadline passed. We did not consider the error rate significant, so we made no recommendation for improvement in this area.

### 4. Workload Management

***Mail Room  
Operations***

We assessed controls over mailroom operations to ensure VARO staff timely and accurately processed incoming mail. VBA policy states staff will open, date stamp, and route all mail to the appropriate locations within 4–6 hours of receipt at the VARO. The Des Moines VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division. Because VARO mailroom staff processed, date stamped, and delivered all VSC mail to the Triage Team daily as required, we made no recommendation for improvement in this area.

**Triage Mail  
Processing  
Procedures**

We assessed the VSC Triage Team's mail processing procedures to ensure staff reviewed, controlled, and processed all claims-related mail. 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 success and control of workflow within the VSC.

VBA policy requires that staff use the Control of Veterans Records System (COVERS), an electronic tracking system, to track claims folders and search mail. VBA defines search mail as active claims-related mail waiting to be associated with a veteran's claim folder.

**Finding 3 VSC Mail Procedures Need Strengthening**

The Triage Team did not always control and process active claims-related mail according to VBA policy. This occurred because management did not provide clear guidance to ensure staff processed and controlled mail properly. As a result, staff unnecessarily delayed processing veterans' claims.

For 7 (23 percent) of 30 pieces of active claims-related mail reviewed, staff did not properly use COVERS to ensure timely processing and adequate control of mail. For example, staff delayed processing one claim by 135 days because they did not place the mail on search in COVERS upon receipt at the VARO. VSC staff were unaware of this claim until we identified it during our inspection. Additionally, VSC staff did not remove 32 electronic notifications in COVERS when staff associated claims-related mail with veterans' claims folders.

In an attempt to improve mail processing VSC management removed the previously designated search mail point, thereby changing procedures for processing search mail. However, management did not modify the Mail Plan to designate the new location for storing and controlling search mail or provide instructions on how staff should implement the new procedures. A VSC supervisor stated this change confused staff. In some instances, staff temporarily stored search mail at their workstations or other locations because they were not sure where else to put it.

Additionally, the Mail Plan provided conflicting guidance to staff regarding responsibility for deleting electronic notifications in COVERS when no longer needed. In one section of the plan, management indicated every employee had the responsibility to delete electronic notifications once they obtained the search mail. In another section, management gave employees the option to print the electronic notification and provide it to supervisors to remove the electronic notifications from COVERS. VSC management

agreed the search mail procedures were not clear and that oversight of this process needed improvement.

**Recommendation** 5. We recommend the Des Moines VA Regional Office Director amend the Mail Plan to provide clear, updated guidance and delineation of responsibilities for controlling search mail and deleting electronic notifications in the Control of Veterans Records System.

**Management Comments** The VARO Director concurred with our recommendation and revised the Mail Management Plan in February 2011. Management ensured the Mail Plan provided proper guidance and delineation of responsibilities for controlling search mail and deleting electronic notifications in the Control of Veterans Records System.

**OIG Response** Management's comments and actions are responsive to the recommendation and we will follow up as required on all actions.

## 5. Eligibility Determinations

**Competency Determinations** We reviewed competency determinations completed by the VSC Decision Team to ensure staff completed them accurately and timely. Delays in making these determinations ultimately affect the Fiduciary Unit's ability to be timely in appointing fiduciaries.

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, which is a third party that assists in managing funds for an incompetent beneficiary.

VBA policy requires staff to obtain clear and convincing medical evidence that a beneficiary is incapable of managing his or her affairs prior to making a final competency decision. The policy allows the beneficiary a 65-day due process period to submit the 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 if the beneficiary is competent.

In the absence of a definition of "immediate", we allowed 14 calendar days after the due process period to determine if VARO staff timely completed a competency decision. We considered this a reasonable period to control, prioritize, and finalize these types of cases. Our analysis revealed VARO staff timely processed all 11 competency determinations we reviewed. Therefore, we made no recommendation for improving timeliness in processing competency determinations.

## **Finding 4      VARO Staff Need to Improve Accuracy in Processing Competency Determinations**

VARO staff did not always accurately process competency determinations. These errors occurred because VSC staff misinterpreted VBA policy and did not obtain medical evidence to support court determinations of veterans' incompetency as required. As a result, veterans were determined to be incompetent and denied the ability to manage their funds independently even though such decisions may have been unwarranted.

VBA policy states that when a court finds a veteran incompetent, the VARO must obtain additional medical evidence to support the court's incompetency determination. VBA policy requires review of all medical evidence related to incompetency prior to making a final competency determination. Judicial findings of a court with respect to the competency of a veteran are not binding upon VBA decisions. They are compelling evidence, but not the only deciding factor.

Our analysis revealed 2 (18 percent) of 11 competency determinations we reviewed contained processing inaccuracies. In both cases, VARO staff determined the veterans were incompetent based solely upon court decrees of incompetency. Instead, VARO staff should have requested medical evidence before making these determinations and assigning fiduciaries to manage the veterans' affairs. VARO management agreed with our assessment that the decisions in both cases were premature and initiated corrective actions to obtain the required medical evidence to determine if the veterans were incompetent.

**Recommendation** 6. We recommend the Des Moines VA Regional Office Director ensure Rating Veterans Service Representatives receive refresher training on evaluating evidence required to make accurate competency determinations.

**Management Comments** The VARO Director concurred with our recommendation and informed us that on April 20, 2011, Rating Veterans Service Representatives received training on evaluating evidence to make accurate competency determinations.

**OIG Response** Management's comments and actions are responsive to the recommendation and we will follow up as required on all actions.

## **Appendix A VARO Profile and Scope of Inspection**

**Organization** The Des Moines VARO is responsible for delivering non-medical VA benefits and services to veterans and their families in Iowa. The VARO fulfills these responsibilities by administering compensation and pension benefits, vocational rehabilitation and employment assistance, and outreach activities.

**Resources** As of January 2011, the Des Moines VARO had a staffing level of 131 full-time employees. Of these, the VSC had 105 employees (80 percent) assigned.

**Workload** As of December 2010, the VARO reported 4,780 pending compensation claims. The average time to complete these claims was 174 days—1 day better than the national target of 175 days. As reported by STAR, accuracy of compensation rating-related issues was 90.4 percent, or .4 percent above the 90 percent target set by VBA.

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

Our review included 69 (16 percent) of 433 disability claims related to PTSD, TBI, and herbicide exposure that the VARO completed from July to September 2010. For temporary 100 percent disability evaluations, we selected 30 (18 percent) of 165 existing claims from VBA's Corporate Database. We provided the VARO with the 135 claims remaining from the universe of 165 to assist in implementing our first report recommendation. These claims represented instances in which staff granted temporary 100 percent disability determinations for at least 18 months.

We reviewed 23 errors identified by VBA's STAR program during the period of July to September 2010. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR measurements include a review of work associated with claims requiring rating decisions. STAR staff review original claims, reopened claims, and claims for increased evaluations. Further, they review appellate issues that involve a myriad of veterans' disabilities claims.

Our process differs from STAR as we review specific types of disability claims such as PTSD, TBI, and herbicide exposure that require rating decisions. In addition, we review rating decisions and awards processing involving temporary 100 percent disability claims.

We selected for review dates of claim and NODs pending at the VARO during the time of our inspection. We completed our review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspections*.

## Appendix B VARO Director's Comments

### Department of Veterans Affairs

### Memorandum

**Date:** April 15, 2011  
**From:** Director, VA Regional Office Des Moines  
**Subj:** Inspection of the VA Regional Office, Des Moines, Iowa  
**To:** Assistant Inspector General for Audits and Evaluations (52)

1. Attached are the Des Moines VARO's comments on the OIG Draft Report: Inspection of the VA Regional Office, Des Moines, Iowa.
2. Questions may be referred to Gregory Reed, Acting Director at 515-323-7503.

*(original signed by:)*

*Gregory C. Reed*

Attachment

**Des Moines VA Regional Office  
Response to the OIG  
Benefits Inspection Division  
Draft Report of the Des Moines Regional Office**

**Recommendation 1** - We recommend the Des Moines VA Regional Office Director review the remaining 135 temporary 100 percent disability evaluations identified but not included in our inspection sample to determine if reevaluations are required and take appropriate action.

**Non-Concur with recommendation**

**Response:** We do not believe this recommendation is necessary or appropriate. In response to OIG Report, "Audit of 100 Percent Evaluations," dated January 24, 2011, VBA developed a national plan to review 100 percent evaluation cases which was accepted by OIG. Therefore, the Regional Office will follow the national review plan.

**Recommendation 2** - We recommend the Des Moines VA Regional Office Director implement controls to ensure staff establish suspense diaries for temporary 100 percent disability reevaluations.

**Concur with recommendation**

**Response:** We agree that the electronic system should automatically populate future exam dates. In response to OIG Report, "Audit of 100 Percent Evaluations," dated January 24, 2011, VBA developed a national plan to review 100 percent evaluation cases, which was accepted by OIG. Therefore, the Regional Office will follow the national review plan.

**Recommendation 3** - We recommend the Des Moines VA Regional Office Director ensure Rating Veterans Service Representatives receive refresher training on the proper evaluation of disabilities related to traumatic brain injuries.

**Concur with recommendation**

**Response:** Rating Veterans Service Representatives received refresher training on Rating TBI Injuries (LMS 1209939) and TBI Exam Requests (LMS 1209934) on March 16, 2011.

**Recommendation 4** - We recommend the Des Moines VA Regional Office Director develop and implement a plan to ensure VARO staff return inadequate medical examination reports to the appropriate VA medical facilities for correction.

**Concur with recommendation**

**Response:** Training on TBI Exam Requests was delivered on March 16, 2011 and was intended to improve the staff's ability to identify and return inadequate VA examinations. In addition, the Des Moines Service Center has a designated VA Medical Center Liaison who is responsible for managing the return of C&P exams deemed insufficient by Veterans Service Representatives, Rating Veterans Service Representatives, and Decision Review Officers.

**Recommendation 5** - We recommend the Des Moines VA Regional Office Director develop a plan to train all Claim Assistants on the proper procedures for processing appeals-related mail and timely entering Notices of Disagreement in the Veterans Appeals Control and Locator System.

**Concur with recommendation**

**Response:** Training on the proper procedures for processing appeals-related mail and timely entering Notices of Disagreement in the Veterans Appeals Control and Locator System was held on January 5, 2011 with Claims Assistants assigned to the Appeals Team. Training for all Claims Assistants was held on April 6, 2011. Claims Assistants have been instructed to bring any new NOD pending establishment greater than seven days to the supervisor's attention to determine the cause for the discrepancy.

**Recommendation 6** - We recommend the Des Moines VA Regional Office Director amend the Mail Plan to provide clear, updated guidance and delineation of responsibilities for controlling search mail and deleting electronic notifications in the Control of Veterans Records System.

**Concur with recommendation**

**Response:** The Mail Management Plan was revised effective Feb 1, 2011 to provide proper guidance and delineation of responsibilities for controlling search mail and deleting electronic notifications in COVERS.

**Recommendation 7** - We recommend the Des Moines VA Regional Office Director ensure Rating Veterans Service Representatives receive refresher training on evaluating evidence required to make accurate competency determinations.

**Concur with recommendation**

**Response:** Refresher training for Rating Veterans Service Representatives on evaluating evidence to make accurate competency determinations is scheduled for April 20, 2011.

## Appendix C Inspection Summary

10 Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
<b>Claims Processing</b>			
<b>1. Temporary 100 Percent Disability Evaluations</b>	<b>Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations.</b> (38 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1MR Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
<b>2. Post-Traumatic Stress Disorder</b>	<b>Determine whether VARO staff properly processed claims for PTSD.</b> (38 CFR 3.304(f))	X	
<b>3. Traumatic Brain Injury</b>	<b>Determine whether claims for service connection for all residual disabilities related to in-service TBI were properly processed.</b> (Fast Letters 08-34 and 08-36, Training Letter 09-01)		X
<b>4. Herbicide Exposure-Related Claims</b>	<b>Determine whether VARO staff properly processed claims for service connection for herbicide exposure-related disabilities.</b> (38 CFR 3.309) (Fast Letter 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)	X	
<b>Data Integrity</b>			
<b>5. Date of Claim</b>	<b>Determine whether VARO staff properly recorded dates of claim in the electronic records.</b> (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)	X	
<b>6. Notices of Disagreement</b>	<b>Determine whether VARO staff properly entered NODs into VACOLS.</b> (M21-1MR Part I, Chapter 5)		X
<b>Management Controls</b>			
<b>7. Systematic Technical Accuracy Review</b>	<b>Determine whether VARO staff properly corrected STAR errors in accordance with VBA policy.</b> (M21-4, Chapter 3, Subchapter II, 3.03)	X	
<b>8. Systematic Analyses of Operations</b>	<b>Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.</b> (M21-4, Chapter 5)	X	
<b>Workload Management</b>			
<b>9. Mail Handling Procedures</b>	<b>Determine whether VARO staff properly followed VBA mail handling procedures.</b> (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapters 1 and 4)		X
<b>Eligibility Determinations</b>			
<b>10. Competency Determinations</b>	<b>Determine whether VAROs properly assessed beneficiaries' mental capacity to handle VA benefit payments.</b> (M21-1MR Part III, Subpart v, Chapter 9, Section A) (M21-1MR Part III, Subpart v, Chapter 9, Section B) (Fast Letter 09-08)		X

CFR=Code of Federal Regulations, M=Manual, MR=Manual Re-write

## 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	Brent Arronte, Director Kristine Abramo Daphne Brantley Robert Campbell Madeline Cantu Danny Clay Lee Giesbrecht Mark Ward
-----------------	---

## **Appendix E Report Distribution**

### **VA Distribution**

Office of the Secretary  
Veterans Benefits Administration  
Assistant Secretaries  
Office of General Counsel  
Veterans Benefits Administration's Central Area Director  
VA Regional Office Des Moines 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: Charles Grassley, Tom Harkin  
U.S. House of Representatives: Leonard Boswell, Bruce L. Braley, Steve King, David Loebsack, Tom Latham

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.