VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Albuquerque, New Mexico

August 28, 2013
13-00993-274

ACRONYMS AND ABBREVIATIONS

C&C	Confirmed and Continued
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the VA Regional Office, Albuquerque, NM

Why We Did This Review

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

What We Found

Overall, VARO staff did not accurately process 23 (40 percent) of 58 disability claims reviewed. We sampled claims we considered at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Claims processing that lacks consistent compliance with VBA procedures can result in paying inaccurate and unnecessary financial benefits.

Specifically, 13 of 30 temporary 100 percent disability evaluations we reviewed were inaccurate, generally because VARO staff did not establish controls to request future medical reexaminations. Further, VARO staff incorrectly processed 10 of 28 traumatic brain injury claims. These errors occurred primarily because staff misinterpreted VBA policy for rating a traumatic brain injury with a coexisting mental condition and used insufficient VA medical examination reports to evaluate traumatic brain injury claims.

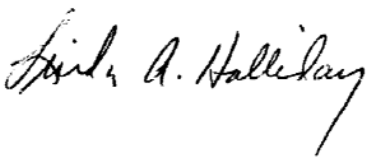
Three of the 11 SAOs were either untimely or not completed due to a lack of management oversight. VARO staff did not always properly grant Gulf War veterans entitlement to mental health treatment, but provided adequate outreach to homeless veterans. Due to a lack of performance measures, we could not fully assess the effectiveness of the VARO's homeless veterans outreach efforts.

What We Recommend

We recommend the VARO Director develop and implement a plan to review all temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action. The Director should provide refresher training on processing traumatic brain injury claims and monitor its effectiveness. The Director should also develop and implement a plan to ensure staff return insufficient medical reports to examiners to obtain the evidence needed to support traumatic brain injury claims.

Agency Comments

The Director concurred with our recommendations, although VARO staff did not agree with 5 of the 23 claims processing errors identified. Thus, 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 Divisions contribute 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 March 2013, we inspected the Albuquerque VARO. The inspection focused on the following four protocol areas: disability claims processing, management controls, eligibility determinations, and public contact. Within these areas, we examined two high risk claims processing areas: temporary 100 percent disability evaluations and traumatic brain injury (TBI) claims. We also examined three operational activities: Systematic Analyses of Operations (SAOs), Gulf War veterans' entitlement to mental health treatment, and the homeless veterans outreach program.

We reviewed 30 (14 percent) of 220 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months. This is generally the longest period a temporary 100 percent disability evaluation may be assigned without review, according to Veterans Benefits Administration (VBA) policy. We also examined 28 (85 percent) of 33 disability claims related to TBI that VARO staff completed from October through December 2012.

Other Information

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

RESULTS AND RECOMMENDATIONS

I. Disability Claims Processing

Claims Processing Accuracy

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

Finding 1 Albuquerque VARO Could Improve Disability Claims Processing Accuracy

The Albuquerque VARO did not consistently process temporary 100 percent disability evaluations and TBI cases accurately. Overall, VARO staff incorrectly processed 23 of the total 58 disability claims we sampled. Claims processing that lacks consistent compliance with VBA procedures can result in paying inaccurate and unnecessary financial benefits. We identified 169 improper payments to 7 veterans totaling $134,918 from April 2001 until February 2013.

We sampled claims related to specific conditions that we considered at higher risk of processing errors. As a result, the errors identified do not represent the universe of disability claims or the overall accuracy rate at this VARO. As reported by VBA's Systematic Technical Accuracy Review (STAR) program as of February 2013, the overall accuracy of the VARO's compensation rating-related decisions was 81.2 percent—8.8 percentage points below VBA's target of 90 percent. The STAR program information was not reviewed during the scope of this inspection.

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

Table 1

Albuquerque VARO Disability Claims Processing Accuracy

Type of Claim	Number of Claims Reviewed	Claims Inaccurately Processed		
		Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits	Total Errors
Temporary 100 Percent Disability Evaluations	30	6	7	13
Traumatic Brain Injury Claims	28	1	9	10
Total	**58**	**7**	**16**	**23**

Source: VA OIG analysis of VBA's temporary 100 percent disability evaluations paid at least 18 months or longer and TBI disability claims completed in the first quarter FY 2013

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 13 of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a service-connected disability following a veteran's surgery or when specific treatment is needed. At the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

For temporary 100 percent disability evaluations, including confirmed and continued (C&C) 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 medical reexamination. As a suspense diary matures, the electronic system generates a reminder notification for VSC staff to schedule the medical reexamination.

Three of the 13 processing errors involved C&C rating decisions where VSC staff did not input suspense diaries as required. The reasons for the remaining 10 errors varied; we did not identify a common trend or pattern related to errors in processing these temporary 100 percent disability evaluations.

In response to a recommendation in our national report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, dated January 24, 2011), VBA updated the electronic system to automatically establish a diary for a C&C rating decision when a future medical reexamination is required. VBA confirmed the update was successful in June 2011. After the update, we did not identify any errors involving C&C rating decisions. As such, we made no recommendation for improvement in this area.

Without effective management of temporary 100 percent disability ratings, VBA is at increased risk of paying inaccurate financial benefits. Available medical evidence showed 6 of the 13 processing errors we identified affected veterans' benefits. The errors resulted in 168 improper monthly payments to 6 veterans totaling $134,598 from April 2001 until February 2013. Details on the most significant overpayment and underpayment follow.

- A Rating Veterans Service Representative (RVSR) correctly continued a 100 percent evaluation for a veteran's prostate cancer and annotated the need for a future medical reexamination. VSC staff established a suspense diary; however, they did not schedule the reexamination. VA treatment records showed the veteran had completed medical treatment with no evidence of recurrent disease, warranting a reduction in benefits as of March 1, 2010. As a result, VA overpaid the veteran $91,692 over a period of 2 years and 11 months.

- An RVSR established a veteran's entitlement to a special monthly compensation for loss of use of a creative organ due to prostate cancer, as required. However, the effective date of January 29, 2013, was incorrect because the date used to calculate benefits was not the date of entitlement. The actual date of entitlement to benefits was February 11, 2008. As a result, VA underpaid the veteran $5,663 over a period of 4 years and 11 months.

The remaining 7 of the 13 errors had the potential to affect veterans' benefits. For various reasons, VARO staff did not schedule medical reexaminations as required for some of the errors we identified. In seven cases we found scheduling delays from approximately 1 year and 1 month to 10 years and 3 months.

Summaries of the total 13 errors we identified follow.

- Three errors occurred when staff did not establish suspense diaries in the electronic system, thereby removing the possibility that staff would receive reminder notifications to schedule medical reexaminations. These three errors involved C&C rating decisions; however, they occurred prior to VBA's June 2011 update to the electronic record to automatically generate suspense diaries.
- Three errors occurred when RVSRs assigned improper effective dates for veterans' disabilities, resulting in incorrect benefits payments.
- Two errors occurred when staff proposed to reduce veterans' benefits payments but did not establish controls to manage the proposed reductions. The delay for one claim was 235 days while the other was 1,763 days from the time staff should have taken final action to reduce benefits until February 2013.
- Two errors occurred when staff established controls to reduce veterans' benefits payments but did not take final actions to reduce benefits. The delays for one claim was 120 days, while the delay in processing the other was 221 days from the time staff should have taken final action to reduce benefits until February 2013.
- Two errors occurred when staff established suspense diaries, but did not request medical reexaminations when alerted to do so.
- One error occurred when an RVSR over-evaluated a veteran's disability although medical evidence showed improvement, which required a reduction in benefits.

Follow Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Albuquerque, NM* (Report No. 10-00935-156, dated May 20, 2010), we stated errors in processing temporary 100 percent evaluations generally occurred because VARO staff did not input suspense diaries for future medical reexaminations

in the electronic system. The Director of the Albuquerque VARO concurred with our recommendation to strengthen controls to ensure staff correctly establish due dates and monitor future medical reexaminations for temporary 100 percent evaluations. Effective January 2010, VARO management established new procedures to ensure Veterans Service Representatives properly input suspense diaries when processing claims decisions requiring future medical reexaminations. Also, Senior Veterans Service Representatives were required to track claims with suspense diaries and additional reviews were conducted. The OIG closed this recommendation on September 28, 2010. All three processing errors we identified in the current inspection involved C&C rating decisions and occurred after management implemented the new procedures.

The Director of the Albuquerque VARO also concurred with our recommendation to review all temporary 100 percent disability evaluations under his jurisdiction to determine whether reevaluations were required and take appropriate actions. The OIG closed this recommendation on September 28, 2010, after VARO managers indicated they had completed reviews of the temporary 100 percent evaluations that we did not include in our inspection.

Actions Taken in Response to Prior Audit Report

In response to a recommendation in our national report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, dated January 24, 2011), the then-Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each 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 then-Acting Under Secretary for Benefits stated in response to our audit report that the target completion date for the national review would be September 30, 2011.

However, VBA did not provide each VARO with a list of temporary 100 percent disability evaluations for review until September 2011. VBA subsequently extended the national review deadline to December 31, 2011, then to June 30, 2012, and then again to December 31, 2012. Based on the numerous delays and our continued findings, we are concerned about the lack of urgency in completing this review, which is critical to minimize the financial risk of making inaccurate benefits payments.

During our March 2013 inspection, we followed up on VBA's national review of its temporary 100 percent disability evaluation processing. We examined 40 temporary 100 percent disability evaluations on VBA's lists of cases for review. We determined VARO staff accurately took actions, such as inputting suspense diaries or scheduling reexaminations, on all 40 cases we reviewed. However, in comparing VBA's national review list with our data on temporary 100 percent disability evaluations, we found three cases

that VBA had not identified. We will continue monitoring this situation as VBA works to complete its national review.

TBI Claims

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

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

VARO staff incorrectly processed 10 of 28 TBI claims—1 affected a veteran's benefits and resulted in an overpayment of $320, representing 1 improper monthly payment. This overpayment occurred when an RVSR correctly granted the veteran entitlement to a special monthly compensation based on evaluations of multiple disabilities. However, the effective date of October 15, 2011, was incorrect because the date used to calculate benefits was not the date of entitlement. The actual date of entitlement to benefits was November 15, 2011.

The remaining 9 of the total 10 errors had the potential to affect veterans' benefits. In all of these cases, RVSRs prematurely evaluated TBI residuals using insufficient VA medical examination reports. Eight cases involved medical reports where the examiners did not indicate whether the veterans' symptoms were associated with a TBI or a coexisting mental condition, as required. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without adequate or complete medical evidence.

Generally, errors associated with TBI claims processing occurred because VSC staff misinterpreted VBA policy on rating a TBI with a coexisting mental condition. Some VSC staff felt they had the authority to separately evaluate TBI and coexisting mental disorders, even when VA medical reports did not state which symptoms were due to which condition. However, VBA policy requires that RVSRs evaluate these conditions based on a medical examiner's determination of the cause of the symptoms. As a result, veterans may not have always received correct benefits.

Follow Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Albuquerque, NM* (Report No. 10-00935-156, dated May 20, 2010), we indicated errors in processing TBI claims occurred due to ineffective oversight of the quality assurance process. Generally, TBI errors involved insufficient examination reports. The Director of the Albuquerque VARO concurred with our recommendation to develop and implement a mechanism to improve oversight of the quality assurance process to ensure staff follow the correct procedures for processing TBI claims. The OIG closed this recommendation on September 28, 2010, after staff completed TBI training and management began requiring a second signature by an experienced RVSR on every TBI rating. We cannot access the effectiveness of the VARO's second-signature requirement for all TBI ratings because management discontinued the local requirement as a result of the national second-signature policy.

The VARO held TBI training in July 2010, June 2011, and May 2012. However, we continued to identify errors in processing TBI claims based on insufficient examinations because some VSC staff misinterpreted VBA policy for rating a TBI with a coexisting mental condition. We concluded the corrective actions taken in response to our 2010 VARO inspection were not adequate.

Recommendations

1. We recommend the Albuquerque VA Regional Office Director conduct a review of the 190 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.
2. We recommend the Albuquerque VA Regional Office Director conduct refresher training on processing traumatic brain injury claims and implement a plan to monitor the effectiveness of this training.
3. We recommend the Albuquerque VA Regional Office Director develop and implement a plan to ensure staff return insufficient medical examination reports to obtain the evidence required to support traumatic brain injury evaluations.

Management Comments

The VARO Director concurred with our recommendations and indicated a review of the 190 temporary 100 percent disability evaluations remaining from our inspection universe will be completed by December 31, 2013. In addition, staff will generate awards on all rating decisions that have future medical examination dates to protect against any omission of future diary codes.

VARO staff completed TBI training in April 2013 and the Director stated additional TBI training will be included in the FY 2014 training plan. The Director indicated staff are in place to review examinations and return any identified as insufficient. Additionally, meetings are held between VARO

and VA Medical Center staff to identify training needs and prevent issues that cause insufficient TBI examinations.

The VARO staff did not agree with two of the errors associated with temporary 100 percent disability evaluations and three errors associated with TBI claims processing. The Director stated "no benefit entitlement error was identified". A benefit entitlement error is a classification for a specific type of error identified by VBA's STAR staff. While STAR utilizes several levels of classifications to identify errors that affect their national performance, we do not differentiate among degrees of errors. We identify errors based on whether or not VARO staff follow requirements or policy established by VBA for claims processing.

II. Management Controls

Systematic Analysis of Operations

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

Finding 2 VARO Lacked Oversight To Ensure Timely SAOs

Three of the 11 SAOs were either untimely or not completed. Two untimely SAOs were due to inadequate oversight prior to the current VSC Manager's arrival. The VSC Manager deliberately did not complete a third SAO because he had been at the VARO for only 2 months at the time it was due, and the VSC was preparing to implement changes to its claims processing methods. The 10 completed SAOs included thorough analyses using appropriate data, identified deficient areas, and made recommendations for improvement of VSC operations. Staff indicated the current VSC Manager has made SAOs a priority, and SAOs completed after his arrival in June 2012 were timely. Therefore, we concluded the SAO issues found were resolved, and we made no recommendation for improvement in this area.

Follow Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Albuquerque, NM* (Report No. 10-00935-156, dated May 20, 2010), we indicated the majority of SAOs reviewed were incomplete and untimely, resulting from a lack of adequate management oversight. The Director of the Albuquerque VARO concurred with our recommendation to develop and implement a plan to ensure timely and accurate completion of SAOs. The OIG closed this recommendation on September 28, 2010, after the VARO noted it conducted a review and stated the Director's Management Analyst was providing SAO deadline notifications. The VARO stated all FY 2010 VSC Division SAOs were completed. During our current inspection, we found improvement in the SAOs, as all completed SAOs addressed all required elements.

III. Eligibility Determinations

Entitlement to Medical Treatment for Mental Disorders

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

In December 2012, VBA modified this policy to state that RVSRs no longer have to address Gulf War veterans' entitlement to mental health care in all cases. RVSRs only have to address this entitlement when a veteran's mental health benefit can be granted based on diagnosis of a mental disorder that developed within 2 years of separation from military service.

VARO staff did not properly grant entitlement to mental health treatment in two of the four claims we reviewed. Details on the two processing errors follow.

- An RVSR did not grant entitlement to treatment for a mental disorder on a current disability decision. A previous review of the claim also did not address this entitlement.
- An RVSR denied service connection for a mental disorder on a current disability decision and did not grant entitlement to medical treatment as required.

RVSRs we interviewed were able to explain the correct process for addressing Gulf War veterans' entitlement to mental health treatment. Because there were only two errors and they were unique, we did not consider these errors to be a systemic issue. As a result, we made no recommendation for improvement in this area.

IV. Public Contact

Outreach to Homeless Veterans

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

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

The Albuquerque VARO had a part-time Homeless Veterans Outreach Coordinator who was familiar with the requirements for improving the effectiveness of VARO outreach to homeless veterans. We interviewed a local homeless shelter representative, members of the New Mexico VA Health Care System Homeless Veterans Program, and Veterans Service Organization officials. These interviews confirmed VSC staff maintained liaison with homeless outreach facilities and provided information on VA benefits and services. Our inspection further confirmed that VARO staff participated in regular outreach events, during which they explained VA benefits. Because we determined the Homeless Veterans Outreach Coordinator provided outreach services to homeless veterans as required, we made no recommendation for improvement in this area. However, without established performance measures we could not fully assess the effectiveness of the VARO's homeless veterans outreach efforts. VBA needs a measurement to assess the effectiveness of this program.

Appendix A VARO Profile and Scope of Inspection

Organization

The Albuquerque VARO administers a variety of services and benefits, including compensation and pension benefits; vocational rehabilitation and employment assistance; benefits counseling; and outreach to homeless, elderly, Native American, minority, and women veterans.

Resources

As of December 2012, VBA reported the Albuquerque VARO reported a staffing level of 96 full-time employees. Of this total, the VSC had 76 employees assigned.

Workload

As of February 2013, the VARO reported 4,952 pending compensation claims. The average time to complete claims was 254.7 days—approximately 5 days more than the national target of 250.

Scope

VBA has 56 VAROs and 1 VSC in Cheyenne, Wyoming, that process disability claims and provide a range of services to veterans. We evaluated the Albuquerque VARO to see how well it accomplishes this mission.

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. Prior to conducting our onsite inspection, we coordinated with VA OIG criminal investigators to provide a briefing designed to alert VARO staff to the indicators of fraudulent claims processing.

Our review included 30 (14 percent) of 220 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of January 5, 2013. We provided VARO management with 190 claims remaining from our universe of 220 for its review. As follow-up to our January 2011 audit, we sampled 40 temporary 100 percent disability evaluations from the list VBA provided to the VARO as part of its national review. We also reviewed all 28 available disability claims related to TBI that the VARO completed from October through December 2012.

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

We assessed the 11 mandatory SAOs the VARO was responsible for completing. We examined the four completed claims processed for Gulf War veterans from October through December 2012 to determine whether VSC staff had addressed entitlement to mental health treatment in the rating decision documents as required. Further, we assessed the effectiveness of the VARO's homeless veterans outreach program.

Data Reliability

We used computer-processed data from the Veterans Service Network's Operations Reports and Awards. To test for reliability, we reviewed the data to determine whether any data were missing from key fields, included any calculation errors, or were outside the time frame requested. We also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Further, we compared veterans' names, file numbers, Social Security numbers, VARO numbers, dates of claim, and decision dates as provided in the data received with information contained in the claims folders we reviewed related to temporary 100 percent evaluations, TBI, and Gulf War veterans' entitlement to mental health treatment.

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 reviewed as part of our inspection of the Albuquerque VARO did not disclose any problems with data reliability.

While this report references VBA's STAR review data, the overall accuracy of the Albuquerque VARO's compensation rating-related decisions was 81.2 percent—8.8 percentage points below VBA's FY 2013 target of 90 percent. We did not review these data as part of this inspection.

Inspection Standards

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

Appendix B Inspection Summary

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

Table 2. Albuquerque VARO Inspection Summary

Five Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Disability Claims Processing			
1. Temporary 100 Percent Disability Evaluations	**Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations.** (38 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1 MR Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Traumatic Brain Injury Claims	**Determine whether VARO staff properly processed claims for disabilities related to in-service TBI.** (FL 08-34 and 08-36) (Training Letter 09-01)		X
Management and Administrative Controls			
3. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)	X	
Eligibility Determinations			
4. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War veterans' claims, considering entitlement to medical treatment for mental illness.** (38 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			
5. Homeless Veterans Outreach Program	**Determine whether VARO staff provided effective outreach services.** (Public Law 107-05) (VBA Letter 20-02-34) (VBA Circular 27-91-4) (FL 10-11) (M21-1, Part VII, Chapter 6) (M27-1, Part II, Chapter 2)	X	

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

Appendix C VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: July 21, 2013

From: Director, VA Regional Office Albuquerque, New Mexico

Subj: Inspection of the VA Regional Office, Albuquerque, New Mexico

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

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

2. Please refer questions to Emmett O'Meara, Veterans Service Center Manager, at (505) 346-4775.

(original signed by:)

Chris Norton
Director

Attachment

The Albuquerque VARO's comments are attached on the OIG Draft Report: Inspection of the VA Regional Office, Albuquerque, New Mexico.

A. *Temporary 100 percent disability evaluations.* The Albuquerque Regional Office concurs with the overall findings regarding vulnerabilities discovered in the processing of temporary 100 percent evaluations. However, we do not agree with two of the thirteen errors called as no benefit entitlement error was demonstrated upon further review.

B. The Albuquerque Regional Office will complete a review of the remaining 190 temporary 100 percent disability evaluations identified by OIG and appropriate action will be completed. The review will commence on or before October 1, 2013 with an expected completion date of December 31, 2013. Files located at the Records Management Center that have a service connected cancer diagnostic code evaluated at 100 percent disabling will be electronically reviewed to determine permanent and total status.

   Additionally, RO staff will generate awards on all rating actions that have a future examination to protect against any omission of the future diary code. Additional training will be provided to VSRs in the first quarter of fiscal year 2014 on future examinations and associated end products; and recognizing ancillary benefits.

C. *Traumatic Brain Injury (TBI) Claims Processing.* The Albuquerque Regional Office concurs with the overall findings regarding vulnerabilities discovered in the processing of TBI claims. However, we do not agree with three of the ten errors called as no benefit entitlement error was identified upon further review.

   Consistent with the TBI training requirement for personnel deciding these claims and those conducting quality assurance reviews, training was conducted and completed in April 2013. Additional TBI training will be included in the fiscal year 2014 training plan based on official guidance (Training Letter 09-11, Compensation Service Bulletin dated October 2011) regarding examination results. Effectiveness of the training will be monitored based on local and national quality reviews, as well as in-process reviews (IPRs).

D. *Insufficient examinations.* The Albuquerque Regional Office concurs with the recommendation regarding development and implementation of a plan to ensure that staff return insufficient medical examination reports to obtain the required evidence to support traumatic brain injury evaluations.

Personnel are in place to review examinations and return any identified as insufficient within the required time limits. An on-site physician is also utilized to provide clarification of examinations which may not meet the insufficient criteria. Meetings are also held between RO and VAMC personnel to identify training needs and prevent issues that cause insufficient TBI examinations.

Appendix D Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Brent Arronte, Director Ed Akitomo Daphne Brantley Brett Byrd Scott Harris Jeff Myers David Piña Nelvy Viguera Butler Diane Wilson

Appendix E Report Distribution

VA Distribution

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VA Regional Office Albuquerque Director

Non-VA Distribution

House Committee on Veterans' Affairs
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Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Martin Heinrich, Tom Udall
U.S. House of Representatives: Ben Lujan; Michelle Lujan Grisham; Steve Pearce

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