

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Inspection of the VA Regional Office Montgomery, Alabama

February 1, 2012
11-04432-77

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

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Report Highlights: Inspection of the VA Regional Office, Montgomery, Alabama

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 Montgomery VARO accomplishes this mission.

What We Found

Montgomery VARO staff timely processed homeless veterans' claims and provided adequate outreach to homeless shelters and service providers. In general, the VARO accurately processed herbicide exposure-related claims, corrected errors identified by VBA's Systematic Technical Accuracy Review program, and completed all elements of Systematic Analyses of Operations timely.

However, the VARO lacked accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations occurred when staff did not schedule required medical reexaminations. Inaccuracies related to traumatic brain injury claims resulted from staff using insufficient medical examinations to make final disability determinations. Overall, VARO staff did not accurately process 24 (29 percent) of 83 disability claims we sampled as part of our inspection. These results do not represent the overall accuracy of disability claims processing at this VARO.

VARO staff did not properly process mail or accurately address Gulf War veterans' entitlement to mental health treatment. Further, delays in making final competency determinations occurred when staff did not prioritize these decisions as required.

What We Recommend

We recommend the Montgomery VARO Director implement a plan that ensures staff return insufficient traumatic brain injury medical examination reports to healthcare facilities for correction. The Director should develop and implement a plan to monitor search mail management and provide consistent guidance for processing mail.

We recommend the Director develop a plan to ensure Rating Veterans Service Representatives address Gulf War veterans' entitlement to mental health treatment. Further, the Director should amend the VARO workload management plan to include VBA's 21-day timeliness standard for processing competency determinations.

Agency Comments

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

A handwritten signature in black ink that reads "Belinda J. Finn".

BELINDA J. FINN
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 standard coverage, inspections may examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

Scope of Inspection

In October 2011, the OIG conducted an inspection of the Montgomery VARO. The inspection focused on five protocol areas examining nine operational activities. The five protocol areas were disability claims processing, management controls, workload management, eligibility determinations, and public contact.

We reviewed 53 (7 percent) of 732 disability claims related to traumatic brain injury (TBI) and herbicide exposure that VARO staff completed from July through September 2011. In addition, we reviewed 30 (6 percent) of 502 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 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 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 **VARO Staff Could Improve Disability Claims Processing Accuracy**

The Montgomery VARO lacked accuracy in processing claims for temporary 100 percent evaluations and TBI-related disabilities. Due to inadequate controls, VARO staff incorrectly processed 24 (29 percent) of the total 83 disability claims we sampled and overpaid \$117,333 in benefits payments. VARO management agreed with our assessment and initiated actions to correct the inaccuracies identified.

Because we sampled claims related to specific conditions, these results do not represent the universe of disability claims processed at this VARO. As reported by VBA's Systematic Technical Accuracy Review (STAR) program in August 2011, the overall accuracy of the Montgomery VARO's compensation rating-related decisions was 82 percent—8 percent below the 90 percent VBA target. The table below reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Montgomery VARO.

Table

Montgomery VARO Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Disability Evaluations	30	19	3	16
Traumatic Brain Injury Claims	23	4	0	4
Herbicide Exposure-Related Disability Claims	30	1	0	1
Total	83	24	3	21

Source: VA OIG

**Temporary 100
Percent Disability
Evaluations**

VARO staff incorrectly processed 19 (63 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 following surgery or when specific treatment is needed. At the end of a mandated period of convalescence or upon cessation of treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's temporary 100 percent disability evaluation.

Available medical evidence showed that 3 (16 percent) of 19 processing inaccuracies we identified affected veterans' benefits. These inaccuracies involved overpayments totaling \$117,333. The most significant overpayment occurred when VSC staff did not take final action to reduce a veteran's prostate cancer evaluation from 100 percent to 20 percent disabling. VA overpaid the veteran \$95,037 over a period of 3 years and 1 month. The remaining 16 inaccuracies had the potential to affect veterans' benefits—in most cases, we could not determine if 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 inaccuracy noted in 7 (37 percent) of the 19 cases occurred because VARO management did not provide adequate oversight between March 2003 and January 2006 to ensure staff took action on reminder notifications to schedule VA reexaminations. Because effective controls were not in place, temporary 100 percent disability evaluations could have continued uninterrupted over these veterans' lifetimes.

A February 2009 Compensation and Pension Service site visit identified a backlog of over 7,000 VA reexamination and various other reminder notifications. As a result, Compensation and Pension Service had monitored the VARO's progress in reducing the number of notifications pending action until March 2011.

For those cases requiring reexaminations, delays ranged from approximately 2 months to 10 years and 3 months. An average of 4 years and 5 months elapsed from the time staff should have scheduled the reexaminations until the date of our inspection—the date staff ultimately took corrective actions to obtain the necessary medical evidence.

In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each had a future examination date entered in the electronic record. In September 2011, VBA provided each VARO with a list of temporary 100 percent disability evaluations for review by the end of March 2012. As such, we made no specific

recommendation for this VARO. To assist in implementing the agreed upon review, we provided the VARO with 472 claims remaining from our universe of 502 temporary 100 percent disability evaluations.

Additionally, we observed for one temporary 100 percent disability evaluation a medical reexamination date that extended 3 years beyond the date selected by the Rating Veterans Service Representative (RVSR). A review of the claims processing award document revealed VSC staff had accurately entered the reexamination date in the electronic record. VSC staff stated they took no action to extend the future examination date beyond the date selected by the RVSR. Neither VARO staff nor we could explain this anomaly. If not for our inspection, the temporary 100 percent evaluation for this veteran would have continued inappropriately beyond the reexamination date. We will continue monitoring reexamination date entries in other offices to determine the frequency of such occurrences.

TBI Claims

The Department of Defense and VBA commonly define a TBI as a 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 that staff evaluate these residual disabilities.

VARO staff incorrectly processed 4 (17 percent) of the 23 TBI claims—all 4 of these processing inaccuracies had the potential to affect veterans' benefits. In all four cases, RVSRs used insufficient medical examinations to evaluate TBI-related disabilities. The medical examiners did not indicate, as required, whether the veterans' symptoms were associated with residuals of TBI or a coexisting mental condition.

According to VBA policy, when a medical examination report does not address all required elements, VSC staff should return it to the issuing clinic or health care facility as insufficient for rating purposes. Neither VARO staff nor we can ascertain TBI-related disabilities without sufficient or complete medical evidence.

Generally, errors associated with TBI claims occurred because VSC staff incorrectly interpreted VBA policy and used their own interpretations of medical examination results to decide TBI claims when medical professionals failed to provide opinions. As a result, veterans may not always receive correct evaluations.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 1 (3 percent) of the 30 herbicide exposure-related claims. In this case, an RVSR assigned a 20 percent disability evaluation for diabetes mellitus; however, the medical examination report did not show the veteran met the criteria for this evaluation. This

inaccuracy did not affect the veteran's existing disability evaluation but may affect future evaluations for additional benefits.

We did not consider the error rate significant and determined the VARO is generally following VBA policy when processing herbicide exposure-related claims. As such, we made no recommendation for improvement in this area.

- Recommendation**
1. We recommend the Montgomery VA Regional Office Director develop and implement a plan to ensure staff return insufficient medical examination reports to healthcare facilities to obtain the evidence needed to support decisions on traumatic brain injury claims.

Management Comments

The VARO Director concurred with our recommendation. The Director stated VARO staff will follow VBA's national initiative to implement in-process review checkpoints to ensure medical examination requests are adequately addressed. As part of this initiative, Quality Review Specialists will work with VARO Medical Center Liaison to ensure RVSRs and healthcare providers receive feedback to improve the quality of medical examination requests.

OIG Response

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

2. Management Controls

Systematic Technical Accuracy Review

We assessed management controls to determine whether 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 VARO staff take corrective action on errors that STAR staff identify.

VARO staff did not correct 1 (6 percent) of the 17 claims files containing errors that STAR program staff identified from April through June 2011. In this instance, VARO management reported to STAR that staff would address the error in the veteran's pending claim. However, by the time of our inspection, staff had not corrected the STAR error or taken action on the pending claim. 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 adequate controls in place to ensure complete and timely submission of each Systematic Analysis of Operations (SAO). 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 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 VSC manager is responsible for ongoing analysis of VSC operations, including completing 12 SAOs annually.

VARO management did not complete 1 (8 percent) of 12 required SAOs. Due to lack of oversight, management did not address all required elements in the SAO for Quality of Files Activities. The VSC manager stated she assigned the SAO to an inexperienced manager but did not follow up to ensure the SAO addressed all required elements and related analysis. Because staff did not address all elements of the SAO, managers were unaware staff did not always process search mail as discussed in our finding regarding mail processing.

For the remaining 11 SAOs, management used adequate data to support its analyses. For example, management obtained data from the Fiduciary Beneficiary System that revealed staff did not always update the Fiduciary Beneficiary System to show a bond or special agreement was in place to financially protect estates with assets greater than \$20,000 as required by VBA policy. Management recommended staff receive training on these requirements. Because management generally followed VBA policy by ensuring SAOs were timely and complete, we made no recommendation for improvement in this area.

3. Workload Management

Mailroom Operations

We assessed controls over VARO mailroom operations to ensure staff timely and accurately processed incoming mail. VBA policy states staff will open, date-stamp, and route all mail to the appropriate locations within 4 to 6 hours of receipt at the VARO. The Montgomery VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the VSC. VARO mailroom staff processed mail according to VBA policy; therefore, we made no recommendation for improvement in this area.

VSC Mail-Processing Procedures

We assessed mail-processing procedures within the VSC 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 that VARO staff 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 the claims folders.

Finding 2 Controls Over Veterans Service Center Mail Management Procedures Need Strengthening

VSC staff did not correctly process or control 11 (18 percent) of the 60 pieces of search and drop mail according to policy. This occurred because VSC management did not monitor employee compliance with established search mail procedures. Further, we identified conflicting guidance between the Workload Management Plan and employee performance standards. Because of inadequate mail processing and control, VSC staff may not always have all available evidence to make claims decisions and beneficiaries may not receive accurate and timely benefits payments.

VSC staff did not properly use VBA's COVERS to process and control search mail in 10 (91 percent) of the 11 mail processing inaccuracies we identified. Of these 10 pieces of mail, 6 contained electronic notices of pending search mail requests in COVERS; however, staff did not retrieve the mail and associate it with claims folders as required. For the remaining four pieces of mail, staff did not input electronic notices of pending search mail in COVERS—thereby making it difficult for VSC staff to know the mail existed. Following are examples of these inaccuracies.

- In September 2011, a veteran submitted a claim for disability compensation. Staff did not associate this mail with the claims folder despite receiving an electronic notification in COVERS that the records were available at the VARO. As a result, staff unnecessarily delayed processing this claim by approximately 42 days.
- In September 2011, the VARO received an amended claim from a veteran who wanted to add disabilities to a pending claim. At the time of our inspection in October 2011, this claim had been pending for approximately 39 days. A review of the veteran's electronic claims record indicated the pending claim was ready for a decision on October 17, 2011. Had we not identified this mail, the RVSR might not have considered the veteran's amended claim for benefits.

Supervisors did not always monitor search mail processes to ensure employees complied with local policy. The VSC manager stated supervisory staff were required to conduct compliance checks to determine whether staff followed COVERS policies for electronically tracking and controlling search mail. However, the Workload Management Plan did not provide guidance for supervisors to perform these checks. As such, managers were not

carrying out this oversight responsibility—one manager had not conducted any checks since October 2010. Another manager stated it was too cumbersome to monitor search mail. The VSC manager agreed supervisors did not follow search mail oversight procedures. Had management been conducting these compliance checks, it might have determined that staff were not routinely retrieving search mail needed to support accurate and timely claims.

Further, the Workload Management Plan contradicted guidance in employees' performance standards on processing search mail. The Workload Management Plan indicated staff should run weekly reports to identify search mail pending more than 30 days, while employees' performance standards prohibited search mail pending for longer than 5 days. A supervisor informed us he was unaware of a 5-day standard for processing search mail.

Additionally, we noted during our inspection that the VSC completed an SAO on its Quality of Files Activity in March 2011. However, the SAO did not include any analysis of search mail, as required by VBA policy. VSC management agreed that had it completed the SAO, it might have identified weaknesses in search mail processing.

- Recommendations**
2. We recommend the Montgomery VA Regional Office Director develop and implement a plan to ensure supervisors monitor search mail management.
 3. We recommend the Montgomery VA Regional Office Director revise the Workload Management Plan and employee performance plans to establish consistent guidance for processing search mail.

**Management
Comments**

The VARO Director concurred with our recommendations and informed us management will complete revisions to the Workload Management Plan by January 31, 2012. These revisions include ensuring consistency between the Claims Assistant performance plans and the VSC Workload Management Plan. Additionally, the Director will monitor weekly Monday Morning Workload reports to identify trends or concerns related to mail management.

OIG Response

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

4. Eligibility Determinations

**Competency
Determinations**

VA must consider beneficiary competency in every case involving a mental health condition that is totally disabling or when evidence raises questions as to a beneficiary's mental capacity to manage his or her affairs. The Fiduciary Unit supports implementation of competency determinations by

appointing a fiduciary, a third party who assists in managing funds for an incompetent beneficiary. We reviewed competency determinations made at the VARO to ensure they were completed accurately and timely. Delays in making these determinations ultimately affect the Fiduciary Unit's ability to appoint fiduciaries timely.

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

Finding 3 Controls Over Competency Determinations Are Inadequate

VARO staff delayed making final decisions in 13 (43 percent) of the 30 competency determinations we reviewed. Delays occurred because the VSC workload management plan did not contain procedures emphasizing immediate completion of competency decisions as required by VBA policy. The risk of incompetent beneficiaries receiving benefits payments without fiduciaries assigned to manage those funds increases when staff do not complete competency determinations timely.

Delays in making final competency determinations for these 13 cases ranged from 3 to 56 days, with an average completion time of 27 days. In the most egregious case, the veteran received \$16,948 in disability payments. While the veteran was entitled to these payments, fiduciary stewardship was not in place to ensure effective funds management and the welfare of the veteran.

In an October 2010 Compensation and Pension Service Bulletin, VBA reinforced the importance of immediately completing competency determinations and mandated that VAROs update workload management plans to identify responsibility for managing the determinations. However, in February 2011 when VARO management revised the workload management plan, it stated staff would deal with all cases involving due process as quickly as possible after the due process expires. It did not provide separate processing instructions for competency determinations or assign specific responsibility for managing these determinations.

Delays in making the final competency determinations occurred from January through June 2011, which predated VBA's newly defined 21-day timeliness standard implemented in July 2011. After this policy change, VARO management did not update the workload management plan to reflect the new standard. Although management emailed staff regarding the policy

change, most staff we interviewed were unaware of the 21-day timeliness standard. VSC managers agreed that sending a mass email to staff with this policy change was not effective.

Recommendation: 4. We recommend the Montgomery VA Regional Office Director amend the Workload Management Plan to ensure staff complete competency determinations within the Veterans Benefits Administration's 21-day timeliness standard.

Management Comments The VARO Director concurred with our recommendation to amend the Workload Management Plan. The revision includes establishing an internal target of 14 days to ensure staff timely address competency determinations.

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

Entitlement to Medical Treatment for Mental Disorders Gulf War veterans are eligible for medical treatment for any mental disorder developed within 2 years of the date of separation from military service. According to VBA, whenever an RVSR denies a Gulf War veteran service connection for any mental disorder, the RVSR must consider whether the veteran is entitled to receive mental health treatment.

In February 2011, VBA updated its Rating Board Automation 2000, a computer application designed to assist RVSRs in preparing disability ratings. The application provides a pop-up notification, known as a tip master, to remind staff to consider a Gulf War veteran's entitlement to health care treatment when they deny service connection for a mental disorder.

Finding 4 Gulf War Veterans Are Not Receiving Entitlement Decisions for Mental Health Treatment

VARO staff did not properly address whether 19 (63 percent) of the 30 Gulf War veterans were entitled to receive treatment for mental disorders. Management was unaware staff continued to neglect this entitlement decision despite providing training and an understanding of the policy. As a result, staff did not accurately inform veterans of entitlement to treatment of mental disorders.

In August 2011, the VARO provided refresher training to most RVSRs and Decision Review Officers on the requirement to consider Gulf War veterans' entitlement to mental health treatment. Most RVSRs we interviewed accurately explained the correct process for addressing this entitlement; nonetheless, five of the errors we identified occurred after the VARO provided training. VSC management and training staff were unaware of continuing RVSR problems addressing entitlement to mental health treatment for Gulf War veterans.

In 12 (63 percent) of the 19 cases reviewed, pop-up notifications reminded RVSRs to consider entitlement to mental health treatment. For the remaining seven cases, pop-up notifications were not generated. The majority of staff and management we interviewed felt the pop-up notification was not effective as it was easy to ignore.

Recommendation 5. We recommend the Montgomery VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives correctly address Gulf War veterans' entitlement to mental health treatment.

Management Comments The VARO Director concurred with our recommendation. The Director implemented an in-process review to be completed by Quality Review Specialists to assess claims related to Gulf War veterans' entitlement to mental health treatment. Further, staff received training on the proper procedures for processing these types of decisions.

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

5. Public Contact

In November 2009, VA developed a 5-year plan to end homelessness among veterans by assisting every eligible homeless veteran willing to accept service. VBA generally defines homelessness as lacking a fixed, regular, and adequate nighttime residence. VBA provided guidance to all VAROs that homeless veterans' claims should receive priority processing.

Expedited Claims Processing for Homeless Veterans VBA established its national performance measure for processing homeless veterans' claims based on the average days the claims were pending. At the time of our inspection, VBA's national target was that the claims be pending no more than an average of 75 days. This measure did not reflect how long it took VARO staff to make determinations on the claims and inform the veterans; it only reflected the average time elapsed from claims receipt at the VARO until the current date.

At the time of our inspection, 9 (30 percent) of the 30 claims reviewed exceeded VBA's 75-day national target. These 9 claims were pending from 82 to 306 days. In two of these cases, VARO staff were not aware the veterans were homeless until after the claims were received. For example, one claim was pending processing for 306 days; however, the VARO did not receive the veterans' claims file until 293 days had passed. We adjusted the average time pending for the 30 claims reviewed based on the dates the Montgomery VARO first became aware of the veterans homelessness. Once adjusted, the 30 claims reviewed had actually been pending an average of 61 days—14 days better than VBA's 75-day national target. As such, we made no recommendation for improvement in this area.

***Outreach to
Homeless Shelters
and Service
Providers***

Congress mandated that at least one full-time employee oversee and coordinate homeless veterans programs at each of the 20 VAROs that VA determined to have the largest veteran populations. VBA guidance, last updated in September 2002, directed that the coordinators at the remaining 37 VAROs be familiar with requirements for improving the effectiveness of VARO outreach to homeless veterans. These requirements include developing and updating a directory of local homeless shelters and service providers. Additionally, the coordinators should attend regular meetings with local homeless service providers, community governments, and advocacy groups to provide information on VA benefits and services.

The VSC provided a list of 11 homeless shelters and service providers in the local area. Although we made multiple attempts to contact each facility, we were only able to contact six; each confirmed it had received information on VA benefits and services. Additionally, we confirmed the VARO homeless coordinator worked collaboratively with homeless coordinators at the Montgomery, Tuskegee, Tuscaloosa, and Birmingham VA treatment facilities, assisting in community service events specific to homeless veterans. Therefore, we made no recommendation for improvement in this area.

Appendix A VARO Profile and Scope of Inspection

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

Resources As of September 2011, the Montgomery VARO had a staffing level of 276.7 full-time equivalent employees. Of this number, the VSC had 220.9 employees assigned.

Workload As of August 2011, the VARO reported 12,770 pending compensation claims. The average time to complete claims was 236.6 days—61.6 days beyond the national target of 175 days.

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

Our review included 53 (7 percent) of 732 disability claims related to TBI and herbicide exposure completed from July through September 2011. For temporary 100 percent disability evaluations, we selected 30 (6 percent) of 502 existing claims from VBA's Corporate Database. We provided VARO officials with 472 claims remaining from our universe of 502 for their review. These 502 claims represented all instances where VARO staff had granted temporary 100 percent disability evaluations for at least 18 months or longer as of September 21, 2011.

We reviewed all 17 files containing errors identified by VBA's STAR program from April through June 2011. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR assessments 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' disability claims.

Our process differs from that of STAR as we review specific types of disability claims, such as those related to TBI and herbicide exposure that require rating decisions. We reviewed rating decisions and awards processing involving temporary 100 percent disability evaluations. Additionally, we reviewed the 12 mandatory SAOs completed in FY 2011.

We reviewed selected mail in various processing stages in the mailroom and throughout the VSC. We reviewed 30 claims completely processed for Gulf War veterans from July through September 2011 to determine whether VSC

staff addressed entitlement to mental health treatment in the rating decision documents. We reviewed 30 competency determinations and 30 homeless veterans' claims pending at the time of our inspection. Further, we reviewed the effectiveness of the VARO's homeless veterans outreach program.

We completed our review 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 review to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our 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: January 20, 2012
From: Director, Montgomery VA Regional Office (322/00)
Subj: Inspection of the VA Regional Office, Montgomery, Alabama
To: Assistant Inspector General for Audits and Evaluations (52)

1. Attached are the Montgomery VARO's comments on the OIG Draft Report: Inspection of the VA Regional Office, Montgomery, Alabama
2. Questions may be referred to Ricardo F. Randle, VARO Director, at (334) 213-3400.

(original signed by:)
Ricardo F. Randle

Attachment

This is the VARO Montgomery's response to the OIG Benefit Inspection conducted October 2011.

Finding 1: VARO Staff Could Improve Disability Claims Processing Accuracy

Recommendation 1: We recommend the Montgomery VA Regional Office Director develop and implement a plan to ensure staff return insufficient medical examination reports to healthcare facilities to obtain the evidence needed to support decisions on traumatic brain injury claims.

Comments: The Montgomery VARO concurs with the findings that 4 of 23 TBI cases were rated without specific clarification regarding concurrent disabilities and the effects of those on a veteran's functional status versus the effects of traumatic brain injury

Implementation Plan: The Montgomery VARO Director will continue to ensure that all training related to the development, examination and decision-making of traumatic brain injuries cases is conducted. To assist with this concern at the Montgomery VARO and throughout VBA, a national initiative is underway to implement in-process review checkpoints to ensure examination requests are adequate to get the results needed to rate cases and address all items needed to make the decision. In addition, the Quality Review Specialists conducting the in-process reviews will work with the Regional Office's VA Medical Center Liaison to ensure feedback is provided to RVSRs and health care providers to improve the quality of requests and completed examinations in the future. The Disability Benefits Questions (DBQs) implemented by the Secretary of Veterans Affairs will support efforts to ensure the accuracy of benefit claims reaches 98%.

Finding 2: Control Over Veterans Service Center Mail Management Procedures Need Strengthening

Recommendations: 2) We recommend the Montgomery VA Regional Office Director develop and implement a plan to ensure supervisors monitor search mail management. 3) We recommend the Montgomery VA Regional Office Director revise the Workload Management Plan and employee performance plans to establish consistent guidance for processing search mail.

Comments: The Montgomery VA Regional Office Director concurs with both of these recommendations and will implement them.

Implementation Plan: The Veterans Service Center (VSC) Workload Management Plan (WMP) will be revised to ensure consistency between the Claims Assistant performance plans and the guidance provided in the WMP. This action will be completed in the Workload Management Plan before

January 31, 2012, and within the Claims Assistant performance plans before February 29, 2012. In addition to the modification of the Workload Management Plan, the VARO Director will monitor search mail counts and age through a weekly Monday Morning Workload Report. This report will be utilized to identify trends and/or concerns related to mail management procedures.

Finding 3: Controls Over Competency Determinations Are Inadequate

Recommendation 4: We recommend the Montgomery VA Regional Office Director amend the Workload Management Plan to ensure staff complete competency determinations within the Veterans Benefits Administration's 21-day timeliness standard.

Comments: The Montgomery VA Regional Office Director concurs with this recommendation.

Implementation Plan: The VSC Workload Management Plan will be revised to ensure that these cases are addressed as soon as possible after the due process period has expired. We will establish an internal target of 14 days, 7 days less than the National mandate within VBA. The revision to the WMP will be completed by January 31, 2012, and the training for employees will be conducted by February 10, 2012.

Finding 4: Gulf War Veterans Are Not Receiving Entitlement Decisions for Mental Health Treatment

Recommendation 5: We recommend the Montgomery VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives correctly address Gulf War veterans' entitlement to mental health treatment.

Comments: The Montgomery VA Regional Office Director concurs with this recommendation.

Implementation Plan: The Montgomery VARO conducted training on this issue immediately during the week the Benefits Inspection team identified the issue. We will also utilize the newly implemented in-process review completed by Quality Review Specialists as an assessment to ensure that all Gulf War veterans receive a decision regarding their entitlement to mental health treatment.

Appendix C Inspection Summary

Nine Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. Temporary 100 Percent Disability Evaluations	Determine whether VARO staff properly processed temporary 100 percent disability evaluations. (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
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 STAR errors in accordance with VBA policy. (M21-4, Chapter 3, Subchapter II, 3.03)	X	
5. Systematic Analysis of Operations	Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs. (M21-4, Chapter 5)	X	
Workload Management			
6. Mail-Handling Procedures	Determine whether VARO staff properly followed VBA mail-handling procedures. (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapters 1 and 4)		X
Eligibility Determinations			
7. 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)		X
8. Competency Determinations	Determine whether VAROs properly assessed beneficiaries' mental capacity to handle VA benefit payments. (M21-1MR Part III, Subpart v, Chapter 9, Section A) (M21-1MR Part III, Subpart v, Chapter 9, Section B) (FL 11-20)		X
Public Contact			
9. Homeless Veterans Outreach Program	Determine whether VARO staff expeditiously processed homeless veterans' claims and 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 Circular 20-91-9) (VBA Letter 20-02-34) (Compensation & Pension Service Bulletins August 2009, January 2010, April 2010, May 2010)	X	

Source: VA OIG

C&P=Compensation and Pension, CFR=Code of Federal Regulations, M=Manual, MR=Manual Rewrite

Appendix D Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Brent Arronte, Director Kristine Abramo Nelvy Viguera Butler Madeline Cantu Kelly Crawford Ramon Figueroa Lee Giesbrecht Nora Stokes Lisa Van Haeren
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