VA Office of Inspector General

OFFICE OF AUDITS & EVALUATIONS

Veterans Benefits Administration

Audit of 100 Percent Disability Evaluations

January 24, 2011
09-03359-71

ACRONYMS AND ABBREVIATIONS

CAP	Combined Assessment Program
CAPRI	Compensation and Pension Records Interchange
OIG	Office of Inspector General
MAP-D	Modern Awards Processing-Development
RVSR	Rating Veterans Service Representative
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VETSNET	Veterans Service Network
VSC	Veterans Service Center

To Report Suspected Wrongdoing in VA Programs and Operations:

Telephone: 1-800-488-8244

E-Mail: vaoighotline@va.gov

(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)

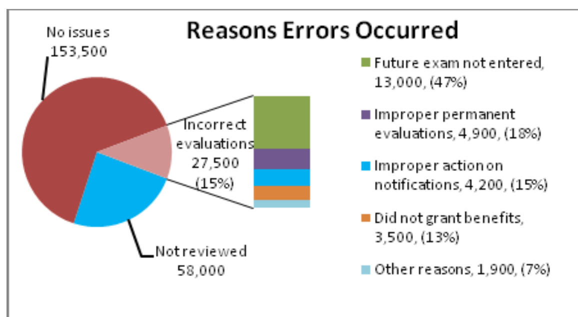
Report Highlights: Audit of 100 Percent Disability Evaluations

Why We Did This Audit

The OIG conducted this audit to determine whether VARO staff correctly assigned 100 percent disability evaluations as either permanent or temporary and effectively monitored and adjusted temporary 100 percent disability evaluations.

What We Found

Veterans Benefits Administration (VBA) is not correctly evaluating and monitoring 100 percent disability evaluations. We identified approximately 239,000 veterans who had at least one service-connected condition rated 100 percent disabling as of September 2009. We eliminated from our review approximately 58,000 veterans with conditions that indicated no likelihood of improvement, such as double amputees. We projected that of the remaining 181,000 veterans, VARO staff did not correctly process evaluations for about 27,500 (15 percent).



We projected that since January 1993, VBA paid veterans a net amount of about $943 million without adequate medical evidence. If VBA does not take timely corrective action, it will overpay veterans a projected $1.1 billion over the next 5 years.

What We Recommended

We recommended the Acting Under Secretary for Benefits increase oversight by ensuring future exam dates are included in the electronic records and providing VARO staff the necessary training. VBA also needs to ensure claims folders with temporary evaluations are kept at the VARO and each temporary evaluation has a future exam date entered in the electronic record.

Agency Comments

The Acting Under Secretary for Benefits did not agree with the findings, particularly as they relate to the projected overpayment amounts, but agreed to implement the recommendations and provided responsive implementation plans. Appendix E includes the full text of the Acting Under Secretary's comments.

OIG Comments

The primary message in our report is that VBA paid veterans without adequate medical evidence. We believe our projection is a reasonable and conservative estimate of overpayments based upon our review of compensation records available.

(original signed by:)

BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

TABLE OF CONTENTS

Introduction....1

Results and Recommendations....2

Finding VBA Needs to Increase Oversight of Veterans' 100 Percent Disability Evaluations....2

Appendix A Scope and Methodology.... 15

Appendix B Previous OIG Reviews.... 17

Appendix C Statistical Sampling Methodology.... 19

Appendix D Monetary Benefits in Accordance with IG Act Amendments.... 25

Appendix E Acting Under Secretary for Benefits Comments.... 26

Appendix F OIG Contact and Staff Acknowledgments.... 32

Appendix G Report Distribution.... 33

INTRODUCTION

Objective

The audit determined whether the Veterans Benefits Administration (VBA) has adequate procedures to correctly assign 100 percent disability evaluations as either permanent or temporary, and effectively monitor and adjust temporary 100 percent disability evaluations.

Overview

VBA criteria allow veterans to receive 100 percent disability evaluations when an impairment of mind or body exists that would make it impossible for the average person to pursue a substantially gainful occupation.

Permanent Evaluations

VBA grants veterans a permanent evaluation if medical evidence shows the veteran's disability is not likely to improve. Veterans with a service-connected permanent and total (100 percent) disability evaluation are also eligible for ancillary benefits, such as educational assistance for his or her spouse or child. Once a 100 percent rating has been in place for 20 years, VBA cannot reduce the rating unless the veteran committed fraud in obtaining the benefits.

Temporary Evaluations

VBA grants veterans a temporary 100 percent disability evaluation for service-connected disabilities requiring surgery, convalescence, or specific treatment. At the end of a mandated period of convalescence or cessation of treatment, VA Regional Office (VARO) staff should review the veteran's medical condition to determine whether to continue the temporary evaluation. Generally, medical exams are required if evidence indicates a material change in a disability or that the current evaluation may be incorrect. If a medical exam shows a change in the veteran's condition, and VARO staff determines that a reduced evaluation is necessary, then they initiate action to reduce benefits.

Previous Reviews

In September 2004, the Office of Inspector General (OIG) first reported that a VARO did not have adequate procedures to ensure that staff entered dates of future medical exams in VBA's electronic records. As of September 30, 2010, 13 additional OIG reviews and inspections identified this same condition at other VAROs. Appendix B lists those reviews and inspections.

In December 2007, the Government Accountability Office reported that VBA's operational controls did not adequately ensure that staff schedule or conduct exams for disability evaluations as necessary (*Improved Operational Controls and Management Data Would Enhance VBA's Disability Rerating Process,* Report No. GAO-08-75).

RESULTS AND RECOMMENDATIONS

Finding VBA Needs to Increase Oversight of Veterans' 100 Percent Disability Evaluations

We projected that VARO staff did not adequately process 100 percent disability evaluations for about 27,500 (15 percent) of approximately 181,000 veterans. Generally, this occurred because staff did not enter required future medical exam dates into VBA's electronic records. In addition, we found that VARO staff did not:

- Monitor automated notifications entered into VBA's electronic records to ensure veterans received the required medical exams.
- Comply with VBA regulations that require VARO staff to ensure veterans' conditions were not likely to improve before assigning a permanent evaluation.
- Retain claims folders for veterans with temporary 100 percent disability evaluations at the VARO to ensure personnel could provide adequate oversight.

As a result, since January 1993 VBA paid veterans a net amount of about $943 million in compensation benefits without adequate medical evidence. Without further action to adjust the benefits, the payments will continue and VBA will overpay these veterans a projected $1.1 billion over the next 5 years.

100 Percent Disability Evaluations

VBA compensates veterans for disabilities that occurred in or were aggravated by their military service. Rating Veterans Service Representatives (RVSRs) assign each veteran an evaluation based on the extent of the veteran's disability. The evaluation determines the amount VA will compensate the veteran. VBA regulations provide veterans with a permanent evaluation (up to 100 percent) if their disability is not likely to improve. VBA regulations provide veterans a temporary 100 percent disability evaluation for service-connected disabilities requiring surgery, convalescence, or specific treatment.

As of September 2009, we identified approximately 239,000 veterans who had at least one service-connected condition rated 100 percent disabling. We eliminated approximately 58,000 veterans with conditions that clearly indicated no likelihood of improvement, such as double amputees. We reviewed a statistical sample selected from the remaining universe of approximately 181,000 veterans and projected VBA erred in processing

about 27,500 (15 percent) of these veterans' evaluations. The errors found approximated 43 percent of our sample of temporary disability ratings. Further, errors ranged from 6 to 18 percent in the samples of permanent disability ratings related to 5 diagnostic series of disability ratings as shown in Table 2 of Appendix C. VARO managers agreed with the errors we identified and initiated corrective action where necessary.

We identified 3 primary causes that accounted for more than 25,600 (93 percent) of the projected 27,500 processing errors. VARO staff did not:

- Enter required future medical exam dates into VBA's electronic records.
- Monitor automated notifications entered into VBA's electronic records.
- Comply with VBA regulations that require VARO staff ensure a veteran's conditions were not likely to improve before assigning a permanent evaluation.

The remaining errors (totaling almost 1,900 or 7 percent) occurred for a myriad of reasons. In addition, the VAROs' process of transferring claims folders for veterans with temporary 100 percent disability evaluations to the VA Records Management Center resulted in staff not taking appropriate actions to determine if they should change temporary evaluations.

Future Medical Exam Dates Not Entered

We projected that, for about 13,000 (47 percent) of approximately 27,500 incorrectly processed evaluations, VARO staff did not enter the required future medical exam date into VBA's electronic records. The 13,000 represents about 7 percent of the population we reviewed. Entering the future medical exam date generates an automatic notification that alerts VARO staff to request a medical exam to evaluate whether the veteran's temporary 100 percent disability evaluation should continue. Without this notification, improper payments could potentially continue for the veteran's lifetime.

For example, VARO staff granted a veteran a temporary 100 percent disability evaluation effective in July 2008. While VARO staff correctly annotated on the rating document that the veteran needed a medical exam in February 2009 to reevaluate the veteran's condition, they did not enter the requested future exam date into the veteran's electronic record. Therefore, the system did not generate an automatic notification to the VARO staff to request a medical exam. In November 2009, 9 months past the required exam date, we asked the VARO staff to request a medical exam to determine whether the veteran's 100 percent disability evaluation should continue. The medical exam revealed that the veteran completed treatment in September

2008. VARO staff reduced the veteran's evaluation to 70 percent to reflect the veteran's remaining disabilities. Because VARO staff did not request the medical exam and take appropriate timely action, the veteran received improper payments totaling $17,963 even though he completed medical treatment in September 2008.

VBA officials stated they modified VBA's electronic system in August 2009 to force RVSRs to enter the medical exam date on the rating document. However, we found the modification did not ensure that the medical exam date entered automatically populated the veteran's electronic record. Entering the future exam date is imperative to alert VARO staff to schedule medical exams as required. VBA needs to modify its electronic system to establish a mechanism that will automatically populate the future exam date on the rating document in the veteran's electronic record. VBA managers agreed with us and stated that, for some of the cases, VARO staff had updated the system with the requested future exam date. However, a computer system error prevented the update to the system. VBA managers further stated that computer programmers expect to complete necessary software corrections by February 2011.

Proper Action Not Taken on Exam Notifications

We projected that, for about 4,200 (15 percent) of approximately 27,500 incorrectly processed evaluations, VARO staff received automatic notifications to schedule the required medical exams but either did not schedule the exam or were not timely in scheduling it. The 4,200 evaluations represent about 2 percent of the population we reviewed. VBA policies and procedures require VARO staff to prioritize these notifications to prevent benefit errors. The VARO staff is required to determine the appropriate action to take on notifications for medical exams within 30 days. If an exam is required, VARO staff should schedule it as soon as possible in order to properly finalize the evaluation decision. If no exam is necessary, the VARO staff needs to annotate the reason in the veteran's electronic record and take appropriate action.

Scheduling the Exam

We estimated that VARO staff canceled or ignored about 2,300 notification requests (nearly 1 percent of the population we reviewed) without scheduling a medical exam or providing an explanation why they canceled or ignored the notification. In May 2004, for example, an RVSR granted a veteran a temporary 100 percent disability evaluation and requested the veteran receive a medical exam in July 2004 to reevaluate the condition. Even though the claims folder contained a copy of a July 2004 notification (VA Form 21-2507a, Request for Physical Examination), VARO staff did not send a request for a medical exam to the VA medical center.

At our request, VARO staff contacted the medical center requesting an exam for January 2010. The medical center reported that the veteran's treatment ended in July 2004. Therefore, in May 2010, because of the January 2010

exam results, VARO staff processed a reduction to the veteran's evaluation to 40 percent to reflect the veteran's remaining disabilities. Because VARO staff did not schedule the requested medical exam in July 2004 as intended, the veteran continued to receive improper monthly disability benefits eventually totaling $148,874.

Timely Exams

We estimated that VARO staff delayed requesting about 1,900 (approximately 1 percent of the population we reviewed) exams for 1 to 19 months after receiving the notification. For example, in September 2008, an RVSR granted a veteran a temporary 100 percent disability evaluation and requested the veteran undergo a medical exam in June 2009 to reevaluate the condition. Because of the RVSR's prior request for a future medical exam, the VARO staff received an electronically generated notification (810-work item) for a required medical exam in June 2009; however, they did not request the medical exam.

An 810-work item requires follow-up action by the Veterans Service Center (VSC). As part of Veterans Service Network (VETSNET), the 810-work item is an electronically generated notification that replaced the paper notifications previously used to inform VAROs of actions that may be required. However, the 810-work items also contained insurance deductions and vocational rehabilitation contacts, as well as notifications for future medical exams.

At our request, VARO staff requested a medical exam for this veteran in November 2009. The medical evidence at that time showed that the veteran was not undergoing any treatment, and had no residual symptoms related to his condition. Therefore, in December 2009, VARO staff proposed to reduce the veteran's evaluation to zero percent to reflect the veteran's current disability. Because VARO staff did not take timely action when notified about the required medical exam in June 2009, the veteran continued to receive improper monthly disability benefits eventually totaling $17,010. VARO management reported they spent an inordinate amount of time trying to identify those 810-work items that required future medical exams. As a result, each office did not treat 810-work items as a high priority. VBA officials agreed that the notifications should contain a specific label so staff could easily identify those that required a medical exam. In addition, VBA should provide training to ensure the VARO staff complies with established guidelines to take appropriate and timely action on exam notifications and document the action taken.

Granting Permanent 100 Percent Disability Evaluations without Adequate Medical Evidence

We projected that, for more than 4,900 (18 percent) of the approximately 27,500 incorrectly processed evaluations, VARO staff granted veterans permanent 100 percent disability evaluations without adequate medical evidence. The 4,900 represents about 3 percent of the population we reviewed. Regulations state that to grant veterans a permanent 100 percent disability evaluation, the medical evidence should establish one of the following conditions:

- The disability is permanent with no likelihood of improvement.
- The condition and symptoms have persisted without material improvement for a period of 5 years or more.

For example, an RVSR confirmed a veteran's 100 percent temporary evaluation in May 1996, and again in November 1998. In December 1998, an RVSR granted the veteran a permanent 100 percent disability evaluation. However, our review of the claims folder showed these ratings were in error because medical evidence from an April 1996 medical exam showed the veteran's treatment ended in 1995. In accordance with VBA criteria, the RVSR should have reduced the temporary 100 percent disability evaluation in the rating decision as of May 1996. The VSC manager agreed with our assessment that the RVSRs made incorrect decisions on 1996 and 1998 ratings. A medical exam in March 2010 confirmed the veteran was no longer being treated for the condition, and VARO staff reduced the veteran's evaluation and stopped the ancillary benefit eligibility. Because VARO staff inappropriately evaluated the veteran's disability as permanent in 1998, the veteran continued to receive improper monthly disability benefits eventually totaling $253,764.

Permanent evaluations are not subject to medical reexaminations so once granted, the evaluation and associated ancillary benefits generally continue for the veteran's lifetime. Current law states that once an evaluation has been in place for 20 years VBA cannot reduce the evaluation unless the veteran committed fraud to obtain the benefits (38 CFR §3.951 Preservation of disability ratings). To help reduce the number of inappropriate permanent evaluations, VBA should provide training to VARO staff on when it is appropriate to grant veterans permanent 100 percent disability evaluations.

Failing To Grant Additional Benefits When Supported by Medical Evidence

We projected that, for about 3,500 (13 percent) of approximately 27,500 incorrectly processed evaluations, VARO staff failed to grant additional benefits (such as special monthly compensation) when supported by the medical evidence or failed to grant entitlement to ancillary benefits. The 3,500 represents about 2 percent of the population we reviewed. VBA criteria require that RVSRs base their determinations on a review of the

entire evidence of record and that they grant additional benefits when the medical evidence supports the veterans' entitlement. For example:

- In December 2007, an RVSR granted a veteran service connection for Type 2 diabetes mellitus with a 20 percent evaluation effective May 2006, but denied service connection for amputation of both feet. The veteran passed away in November 2009. Our review of the claims folder identified the RVSR should have granted this veteran service connection for amputation of his feet based on May 2007 medical evidence from a private doctor showing it was due to complications of diabetes. The VSC manager agreed, and based on a rating from August 2010, awarded accrued benefits to the veteran's widow totaling $60,651.

- In October 2006, an RVSR increased a veteran's evaluation to 100 percent. The veteran had additional disabilities totaling 60 percent disabling. However, the RVSR did not grant statutory housebound benefits (special monthly compensation) in accordance with established regulations. Regulations entitle veterans with a 100 percent disability and additional disabilities rated at 60 percent or higher to receive special monthly compensation. Because VARO staff did not grant the special monthly compensation, the veteran was underpaid $20,800. The VSC manager agreed stating the prior evaluation was clearly erroneous and took action to grant the benefits.

To help ensure veterans receive benefits to which they are entitled, VBA managers should provide training to VARO staff on when it is appropriate to grant special monthly compensation and eligibility to ancillary benefits.

Claims Folders at the VA Records Management Center

We projected that VARO staff relocated approximately 3,600 claims folders to the VA Records Management Center for veterans with temporary evaluations. VA criteria state VAROs can relocate claims folders to the Records Management Center after there is no claim activity for at least 12 months. Veterans with temporary evaluations require periodic medical exams, which can be as much as 5 years in the future; therefore, VARO staff should treat these claims folders as active.

Of those 3,600 claims folders, we estimated that VARO staff did not take necessary actions to confirm that temporary 100 percent disability evaluations were still appropriate for almost 2,900 veterans. We recommend VARO staff need to retain possession of claims folders for veterans with temporary evaluations. We discussed this issue with VBA managers at Central Office and they agreed better guidance is needed to ensure the VARO staff retains veterans' claims folders with temporary 100 percent disability evaluations. Additionally, VARO staff should identify all claims

folders with temporary 100 percent disability evaluations located at the VA Records Management Center, and review the status of each evaluation to determine if transfer to the regional office is required to conduct an exam or revise the evaluation.

Monetary Effect of Errors

Of the more than 27,500 projected incorrectly processed evaluations, we identified about 12,800 (47 percent) that resulted in VBA making both overpayments and underpayments payments to veterans without adequate medical evidence to support the disability benefit payments. The 12,800 represents about 7 percent of the population we reviewed. In total, for those veterans with at least one service-connected condition rated 100 percent disabling as of September 2009, VBA improperly paid them a projected net $943 million in compensation benefits.

We reviewed the projected 12,800 payment errors to determine the future impact if VARO staff does not take appropriate corrective actions. For more than 800 of the approximately 12,800 payment errors, we determined no future monetary impact would result because an 810-work item was pending in VBA's electronic system or, in some cases, the veteran had died. However, VBA's system did not show exams were necessary for more than 12,000 of the 12,800 evaluations, which could result in overpaying veterans a projected $1.1 billion over the next 5 years.

For these 12,800 evaluations, we projected that approximately 8,200 veterans received improper overpayments for 1 year or more. The average overpayment for veterans receiving overpayments for less than 1 year is about $10,500. The average overpayment increases to about $66,000 for veterans receiving overpayments from 1 to 5 years. We further projected that about 3,100 of the 12,800 veterans had evaluations that were in error and received improper payments for 5 years or more. For each year the overpayment continues, the cumulative financial effect becomes increasingly more significant.

Once the error has been in place for 20 years, VBA cannot correct the erroneous payment unless the veteran obtained the benefits through fraud. We identified two veterans where, because of an erroneous 100 percent disability evaluation, VBA made improper benefit payments for more than 20 years amounting to $779,148 and $701,202. These two veterans are currently 50 and 66 years of age and they will continue to receive the improper payments for the remainder of their lifetime. Due to the ineffective control over temporary evaluations, the significant amount of improper payments and the potential for additional cases to reach the 20 year protected status, VBA needs to conduct a review of the remaining temporary 100 percent disability evaluations and ensure each evaluation has a future exam date entered in the veterans' electronic records.

Conclusion

Despite numerous audit and inspection reports since FY 2004 stating that the VARO staff was not consistently processing temporary 100 percent disability evaluations correctly, VBA has not fully corrected the problem. VARO staff did not consistently enter the required future exam dates into veterans' electronic records or monitor the notifications for exam requests. As a result, we concluded VBA lacks adequate procedures to assign 100 percent disability evaluations correctly and does not have effective procedures to monitor and adjust temporary 100 percent disability evaluations.

Additionally, RVSRs did not always comply with VBA regulations to grant permanent evaluations based on sufficient medical evidence or grant entitlement to special monthly compensation or ancillary benefits when appropriate. These actions resulted in a significant number of adjustments to recurring monthly benefit payments because they resulted in both underpayments and overpayments. For each year payment inaccuracies continue, the cumulative effect becomes increasingly more significant. We projected that VBA paid veterans a net amount of about $943 million without adequate medical evidence. If VBA does not take timely corrective action, they will overpay veterans a projected $1.1 billion over the next 5 years.

Recommendations

We recommended the Acting Under Secretary for Benefits:

1. Modify the Veterans Benefits Administrations electronic system to establish a mechanism that will automatically populate the future exam date on the rating document in the veteran's electronic record.

2. Establish a specific label for medical exam notifications to ensure responsible VA Regional Office staff can identify and take required actions on the notification.

3. Provide training to ensure VA Regional Office staff comply with established guidelines to take appropriate and timely action on exam notifications and document the action taken.

4. Provide training on when it is appropriate for VA Regional Office staff to grant veterans a permanent rating, special monthly compensation, and eligibility to ancillary benefits.

5. Issue guidance to ensure VA Regional Office staff does not relocate claims folders with temporary 100 percent disability evaluations to the VA Records Management Center.

6. Identify all claims folders with temporary 100 percent disability evaluations currently located at the VA Records Management Center, and review the status of each evaluation to determine if a transfer to the VA Regional Office of jurisdiction is required to conduct an exam or revise the evaluation.

7. Conduct a review of all temporary 100 percent disability evaluations and ensure each evaluation has a future exam date entered in the veterans' electronic records.

Management Comments and OIG Response

The Acting Under Secretary for Benefits did not agree with the overall findings particularly as they relate to the projected overpayment amounts and provided management comments to our report, which we address below. He agreed to implement the recommendations in the report and provided responsive implementation plans. Based on actions taken by VBA, we consider recommendation 2 closed. We will monitor VBA's progress and follow up on their implementation until all proposed actions are completed. (See Appendix E for the full text of the Acting Under Secretary's comments.)

Management Comment: The Acting Under Secretary for Benefits voiced concerns that the overall error rate of 15 percent is overstated because the population did not include 58,000 veterans with conditions that clearly indicated no likelihood of improvement, such as double amputees. Further, he stated that the removal of these 58,000 veterans with presumed error free cases skewed the analysis and resulted in a non-random sample. The Acting Under Secretary stated that a true random sample is necessary to obtain a normal distribution to support all the statistical projections in this report.

OIG Response: The Acting Under Secretary for Benefits is incorrect in his assertion that the analysis was skewed and the sample was not truly random. This implies that had we reviewed those 58,000 veterans our results would have been different. Our audit focused on those areas that presented the highest risk to VBA. Therefore, of the 239,000 veterans with at least one service-connected condition rated 100 percent disabling, we excluded 58,000 veterans from our review because their medical condition was not likely to improve.

The sample is representative of the stated audit universe of 181,000 veterans. We selected random samples from the audited universe and properly weighted projections based on the sample design. The sample design and size was more than sufficient to allow the assumption of a normal sampling distribution across the stated universe. In accordance with accepted sampling procedures, we projected the number of errors and potential monetary benefits only to the population we reviewed

(239,000-58,000=181,000 veterans). The report clearly states that VARO staff did not correctly process evaluations for about 27,500 (15 percent) of the approximately 181,000 veterans who might require periodic evaluations. Although the error rates may have been less had we included the 58,000 veterans in our universe, the potential monetary benefits could have potentially increased since we would have projected to a universe of $73 billion instead of $52 billion.

Management Comment: The Acting Under Secretary for Benefits raised concerns that the overpayment projection of $1.1 billion over the next 5 years is significantly overstated. He stated their review of records for 8 of the overpayments we identified found that 3 of these cases (38 percent) still warranted 100 percent evaluations or payment at the 100 percent rate. Therefore, he concluded that potentially 38 percent of the errors used to make monetary projections may not be valid.

OIG Response: The primary message of our report is VBA paid veterans without adequate medical evidence and the management of temporary disabilities needs strengthening. Whether the veteran was entitled to the 100 percent evaluations or payment at the 100 percent rate is inconsequential to our reported condition: VBA approved significant monthly benefits to veterans without knowing if the veteran's medical condition warranted the continued benefit.

For the first case, VBA incorrectly granted a 100 percent evaluation for the loss of use of the bilateral lower extremities even though a VA examination showed the veteran was not wheelchair bound due to service connected bilateral hip replacements. Based on the evidence recently provided by VBA, we agree the veteran was entitled to the 100 percent rate because he was unemployable. Regardless of the veteran's entitlement remaining at 100 percent, VBA did not process the 100 percent disability evaluation correctly. We agree an overpayment did not occur.

For the second case, the Acting Under Secretary for Benefits stated no evidence showed that an evaluation of less than 100 percent was warranted for a veteran rated service-connected for residuals of tuberculosis. Further, he states that the veteran died from complications related to tuberculosis in June 2010. Our review of the veteran's medical records found that VARO staff requested an exam in November 1990 to confirm the veteran's medical condition still existed but VARO staff did not ensure the medical exam was completed. The veteran's death certificate shows the cause of death was primarily cardiopulmonary arrest. Post (inactive) tuberculosis was listed as the last of the underlying causes to several other antecedent causes. No medical evidence was available to confirm the veteran's medical condition from November 1990 to June 2010. Without the exam or other supporting

medical evidence, neither VBA nor OIG can confirm the veteran's medical condition existed from 1990 to June 2010. As a result, we still conclude that the VARO's failure to process the 100 percent evaluation correctly resulted in a potential overpayment during that timeframe.

For the third case, the Acting Under Secretary for Benefits stated a March 2010 exam showed the veteran is warranted a 100 percent evaluation for residuals of tuberculosis derived from lung function tests. In February 1996, the tuberculosis board reviewed existing medical records and concluded the veteran had minimal active tuberculosis. To confirm the condition still existed, the VARO requested a medical exam in February 1997 but the exam was never completed. No medical evidence was available to confirm the veteran's medical condition until the March 2010 medical exam, which showed the veteran's tuberculosis, was intermittent and was currently inactive. However, the exam showed the veteran recently developed a restrictive respiratory condition (residual of tuberculosis), which meets the criteria for a 100 percent evaluation. In the absence of a medical exam or other supporting medical records, neither VBA nor OIG can confirm the veteran's medical condition existed from February 1997 to March 2010. As a result, we concluded that the VARO's failure to correctly process the 100 percent evaluation by ensuring the veteran received the required medical exam resulted in a potential overpayment during that timeframe.

We believe our projection is a reasonable and conservative estimate of overpayments and potential future overpayments based on our review of compensation records available at the time of the audit. VBA's review of eight cases is not sufficient to impugn the results of our statistical sample.

Throughout the audit, we briefed and received concurrences from VBA senior personnel at the VARO and Central Office on our findings. Where appropriate, we adjusted our findings to reflect new information VBA staff provided to us. We also reviewed the new information for the three cases in question and agree that the additional medical evidence VBA found is sufficient to continue the 100 percent evaluations for two of the cases. A future overpayment would not occur for the other case since the veteran is now deceased. Accordingly, we reduced our projection of future potential monetary benefits from $1.133 billion to $1.130 billion. However, after further review of the new information, we concluded a potential past overpayment still occurred for two of the three cases. Accordingly, we lowered our projection of potential improper payments to veterans since January 1993, from $946 million to $943 million to reflect the new information.

Management Comment: The Acting Under Secretary for Benefits contends that the sample may not be sufficient to accurately predict the average cost

per strata. Two of the six strata have only one payment error, causing the average cost to be based on just one case. Inspection of the sensory organs and cardiovascular strata also reveal significant outliers on both the low and high side of the averages. Further, he said removing these outliers reduces the averages from $135,458 to $87,044 and from $114,043 to $96,294, respectively. Based on the impact of these outliers, the two strata could be overstated by as much as 36 percent. The other strata do not have enough data to determine outliers by inspection, so the impact cannot be estimated.

OIG Response: The stated concerns have no bearing on the validity of our projections. We did not design the sample to estimate the average cost per stratum. The audit sampling was designed to ensure an adequate sample size from each stratum was reviewed to achieve sufficient precision for the estimate of the error rate.

Management Comment: The Acting Under Secretary for Benefits stated that two of the strata articulated in Table 2 of the report include errors with disabilities from additional body systems. The Sensory Organ strata include error findings for respiratory disabilities with Diagnostic Codes 6702, 6732, and 6819. The Cardiovascular, Digestive, and Genitourinary strata include additional error findings for gynecological and hemic/lymphatic disabilities with Diagnostic Codes 7627, 7703, 7709, and 7715.

OIG Response: We updated the strata in Table 2 to show the complete name of the body system. The purpose of dividing the population into strata was to ensure we reviewed a cross section of cases. Further, our decision to review all relevant disabilities associated with a case does not affect the outcome of our sample results and associated projections.

Management Comment: The Acting Under Secretary for Benefits stated that in the "Report Highlights" and throughout the report, the cause of the errors identified to VARO staff is attributed to not correctly processing evaluations. However, the report identifies a significant number of cases in which VARO staff correctly established future exam dates in the disability review process but the computer system did not properly maintain the future exam dates. VBA identified multiple computer system errors, rather than employee error, that accounted for a high percentage of the tracking or monitoring errors shown on page 4 of the report.

OIG Response: We projected that VARO staff did not adequately process 100 percent disability evaluations for about 27,500 (15 percent) of approximately 181,000 veterans. Generally, this occurred because staff did not enter required future medical exam dates into VBA's electronic records. The Acting Under Secretary's statement that system errors contributed to the

processing errors is correct and we address that cause in recommendation 1. The electronic record system is a VBA tool to process evaluations correctly. Ultimately, it is the VARO staff's responsibility to process the evaluations correctly.

Management Comment: The Acting Under Secretary for Benefits stated that VBA makes every effort to ensure that veterans are paid correctly and disability evaluations are assigned appropriately at all levels. VBA continues to identify system enhancements as the most effective protocol for providing reasonable assurance that the electronic record contains future examinations for all temporary 100 percent evaluations. VBA has identified system errors in addition to the errors cited that result in future examinations being removed from a veteran's medical record. VBA is actively working to resolve these types of errors through system modifications. These system safeguards will ensure correct future review of temporary 100 percent evaluations.

OIG Response: We are pleased that the Acting Under Secretary for Benefits recognized the need to resolve errors and ensure that veterans are paid correctly. VBA needs to correct the problems identified in a timely manner to mitigate the risk of making significant payments to veterans for unsupported medical conditions.

Appendix A Scope and Methodology

Scope

We conducted our audit work from September 2009 through October 2010. The audit focused on active compensation cases with at least one diagnostic code individually rated 100 percent disabling as of September 2009. We identified an audit universe of approximately 181,000 veterans with 100 percent permanent and temporary evaluations. These veterans were paid compensation benefits totaling about $52 billion since 1993.

Methodology

Our review of policies and procedures included discussions with VBA officials on the appropriateness of evaluations and controls. We reviewed claims folders and electronic records from VBA's electronic systems. VBA's electronic system consists of VETSNET, which includes SHARE[1], Virtual VA, and Modern Award Processing-Development (MAP-D). For some of the older evaluations, we accessed VBA's Benefits Delivery Network to review the claim data. We also reviewed VHA's electronic medical records system using the Compensation and Pension Records Interchange (CAPRI) system.

We performed an initial review of VBA's electronic compensation records for a sample of 1,402 veterans consisting of 538 temporary evaluations and 864 permanent evaluations. If we were not able to determine whether VARO staff appropriately assigned the evaluation (as permanent or temporary), we reviewed the claims folders. Based on our review of documentation, we determined if VARO staff properly processed disability evaluations. We discussed all errors with the Veterans Service Center Manager and provided VBA officials with copies of the correspondence.

To determine the dollar impact for any incorrectly processed evaluations, we obtained compensation benefits for each veteran. For the cases that VARO staff took corrective action, we estimated the monetary effect based on the date VARO staff should have adjusted the benefits. In some cases, VARO staff provided the over and under payment amount. We limited the dollar impact of our review to improper payments made since 1993 because electronic payment data was not available prior to 1993.

We conducted site visits at VAROs located in Denver, CO; Chicago, IL; Atlanta, GA; and Phoenix, AZ, where we reviewed claims folders and interviewed VARO staff regarding local procedures. We also visited the VA Records Management Center to review claims folders.

[1] SHARE is a computer application used to establish and manage claim data.

Reliability of Computer-Processed Data

We assessed the reliability of VBA electronic data by comparing selected data elements (such as veteran identifier information, diagnostic codes and percentages, and rating disposition dates) to documentation in the claims folders. We concluded that the data used to accomplish the audit objectives was sufficiently reliable.

Compliance with Government Audit Standards

Our assessment of internal controls focused on those controls relating to our audit objectives. We conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions.

Appendix B Previous OIG Reviews

From FY 2004–2006, four OIG Combined Assessment Program (CAP) reviews identified that VAROs did not have adequate procedures to ensure staff entered dates of future medical exams in VBA electronic systems. In FY 2009, OIG established a Benefits Inspection Division to provide recurring oversight of VSCs. The OIG's Benefits Inspection Division reviews the accuracy of disability claims processing during their site inspections.

Table 1. Previous Temporary 100 Percent OIG Reviews

Report Title	Report No.	Number Reviewed	Percentage with Errors
CAP Review of VARO Jackson, MS (September 29, 2004)	04-01016-220	10	60
CAP Review of VARO Little Rock, AR (February 25, 2005)	04-03331-91	41	49
CAP Review of VARO Providence, RI (March 24, 2005)	04-00731-110	25	52
CAP Review of VARO San Juan, PR (December 6, 2005)	05-02242-39	32	63
Inspection of VARO Philadelphia, PA (March 4, 2010)	09-03846-93	30	87
Inspection of VARO Togus, ME (March 23, 2010)	09-03659-111	30	60
Inspection of VARO Waco, TX (April 16, 2010)	09-03848-130	30	93
Inspection of VARO Albuquerque, NM (May 20, 2010)	10-00935-156	30	80
Inspection of VARO Muskogee, OK (May 21, 2010)	10-00936-158	30	53
Inspection of VARO Denver, CO (July 19, 2010)	10-01530-196	30	73
Inspection of VARO Cheyenne, WY (July 19, 2010)	10-02080-197	7	100
Inspection of VARO Detroit, MI (August 19, 2010)	10-02079-226	30	90
Inspection of VARO Jackson, MS (September 3, 2010)	10-02460-240	30	80
Inspection of VARO Newark, NJ (September 29, 2010)	10-03055-259	30	80

From March to September 2010, the Benefits Inspection Division issued 10 reports identifying that VARO staff incorrectly processed temporary 100 percent disability evaluations. At each location, the Benefits Inspection Division recommended, and VARO management agreed, that the VARO Director require the staff to conduct a review of all temporary 100 percent disability evaluations under the VARO's jurisdiction to determine if reexaminations are required and take appropriate action. Each of these reports is available at www.va.gov/oig/publications/reports-list.asp.

Appendix C Statistical Sampling Methodology

Introduction

To determine whether VBA adequately processed 100 percent disability evaluations, we reviewed a random sample of active compensation claims with at least one diagnostic code rated 100 percent disabling to ensure they were correctly assigned as a permanent or temporary evaluation and effectively monitored and adjusted.

Population

The population consisted of about 239,000 veterans with active compensation claims with at least one diagnostic code rated 100 percent disabling as of September 2009. VBA paid the 239,000 veterans approximately $73 billion in benefits from January 1993 through September 2009.

Of the almost 239,000 veterans, we did not review about 58,000 veterans with medical conditions that had little or no likelihood of improvement (such as double amputees). This reduced our population to approximately 181,000 veterans who may require periodic evaluations. VBA's electronic record system did not clearly distinguish veterans with permanent and temporary ratings. The Code of Federal Regulations provides for specific temporary evaluation designations for prestabilization (paragraph 28), hospitalization (paragraph 29), or convalescence (paragraph 30). Therefore, we classified veterans with ratings that did not have a future medical exam date or paragraph 28, 29, or 30 designation in VBA's electronic record system as permanent ratings.

VBA paid approximately $47 billion in benefits to about 144,000 veterans with evaluations we classified as permanent. We classified the remaining 37,000 (181,000 – 144,000) veterans with a future medical exam date or paragraph 28, 29, or 30 designation as temporary. VBA paid about $5 billion in benefits to these approximately 37,000 veterans. VBA paid about $52 billion in benefits to our audit population of almost 181,000 veterans.

Sampling Design

We divided the known population into six mutually exclusive and exhaustive strata and sampled from within those groups using simple random sampling methodology. Five strata were permanent evaluations grouped by diagnostic series, and the remaining stratum consisted of temporary evaluations.

To determine our sample sizes we used minimum precision requirements because this method would allow us to review enough sample cases to ensure a reasonable level of precision. We used initial sample sizes based on detecting a 10 percent difference between strata with a 90 percent confidence interval and a design effect of 1.2 to account for the stratification and unequal weights. We then added randomly selected sample cases to the larger strata based on resource constraints to improve the precision for our projections.

Weights

The 1,402 sampled veterans represented particular segments of the overall universe. We accounted for differences in the probability of selection between strata by weighting the sample results. To avoid any over or under sampling bias, we adjusted the sample result weights so that weighted sample totals were equal to known population totals (post-stratification).

Projections and Margins of Error

We projected that approximately 27,500 (15 percent) of almost 181,000 disability evaluations were not correctly assigned or effectively monitored and adjusted. Table 2 shows the results of our sample. We found errors in approximately 43 percent of the temporary sample and a range of errors from 6 to 18 percent for the 5 permanent strata samples.

Table 2. Universe and Results of Random Sample

Strata[2]	*Universe*	*Sample*	*Errors*	*Weighted Error (*) %*	*Margin of Error***	*90% Confidence*	
						Lower Limit %	*Upper Limit %*
Musculoskeletal	1,539	185	11	6.0	2.1	3.8	8.1
Sensory organs and respiratory conditions	2,040	202	27	13.4 (13)	1.0	12.4	14.4
Cardiovascular, digestive, genitourinary, gynecological, and hemic/lymphatic	24,766	277	49	17.7 (18)	0.5	17.2	18.2
Neurological conditions and convulsive disorders	1,726	100	7	7.0	3.5	3.5	10.5
Mental disorders	113,818	100	6	6.0	3.4	2.7	9.4
Temporary evaluations	37,059	538	229	42.6 (43)	0.3	42.3	42.9
Total Rounded Total	**180,948 (181,000)**	**1,402**	**329**	**15.2 (15)**	**2.1**	**13.1**	**17.3**

*Notes: * Parentheses show rounded values; ** 90% Confidence interval*

[2] The purpose of dividing the universe into strata was to ensure we reviewed a cross section of cases. We reviewed all relevant disabilities associated with each case.

Table 3 displays error rates for the issues we identified. Our overall error rate was 15.2 percent with a margin of error rate of 2.1 percent.

Table 3. Projections and Margins of Error for Sample Results

Finding	*Projection (*) Weighted Error [%]*	*Margin of Error** [%]*	*90% Confidence*		*Sample*
			Lower Limit [%]	*Upper Limit [%]*	
Future medical exam dates were not entered	12,989 (13,000) [47.3]	2,058 [8.5]	10,931 [38.8]	15,048 [55.8]	178
Proper action was not taken on exam notifications	4,232 (4,200) [15.4]	667 [3.3]	3,565 [12.1]	4,900 [18.7]	61
➢ Exams not scheduled	2,304 (2,300) [8.4]	685 [2.8]	1,619 [5.6]	2,989 [11.2]	33
➢ Exams not timely	1,929 (1,900) [7.0]	577 [2.3]	1,351 [4.7]	2,506 [9.4]	28
Granting permanent 100 percent disability evaluations without support	4,927 (4,900) [17.9]	3,103 [10.2]	1,824 [7.7]	8,030 [28.2]	32
Failing to grant additional benefits when supported by medical evidence	3,469 (3,500) [12.6]	2,613 [9.1]	856 [3.6]	6,082 [21.7]	26
Other reasons for errors	1,851 (1,900) [6.7]	565 [2.3]	1,286 [4.5]	2,416 [9.0]	32
Results of sample	27,469 (27,500) [15.2]	3,822 [2.1]	23,647 [13.1]	31,292 [17.3]	329
Temporary evaluations located at VA Records Management Center	3,582 (3,600) [9.7]	785 [2.1]	2,797 [7.6]	4,366 [11.8]	52
Temporary evaluations with errors located at VA Records Management Center	2,893 (2,900) [7.8]	729 [2.0]	2,164 [5.8]	3,622 [9.8]	42

*Notes: * Parentheses show rounded values; ** 90% Confidence interval*

Table 4 displays error rates for the issues we identified as compared to the population we reviewed of 181,000 veterans.

Table 4. Error Rates in Relation to the Audit Population of 181,000 Veterans

Finding	*Weighted Error (*) %*	*Margin of Error** %*	*90% Confidence*		*Sample*
			Lower Limit %	*Upper Limit %*	
Future medical exam dates were not entered	7.2 (7)	1.1	6.0	8.3	178
Proper action was not taken on exam notifications	2.3 (2)	0.4	2.0	2.7	61
➢ Exams not scheduled	1.3 (1)	0.4	0.9	1.7	33
➢ Exams not timely	1.1 (1)	0.3	0.8	1.4	28
Granting permanent 100 per-cent disability evaluations without adequate evidence	2.7 (3)	1.7	1.0	4.4	32
Failing to grant additional benefits when supported by medical evidence	1.9 (2)	1.5	0.5	3.4	26
Other reasons for errors	1.0	0.3	0.7	1.3	32

*Notes: * Parentheses show rounded values; ** 90% Confidence interval*

Table 5 displays the projections for improper payments. We project avoidable overpayments of approximately a net $943 million in the population of almost 181,000 veterans. We used ratio estimation for a more accurate projection of potential monetary errors.

Table 5. Projections and Margins of Error for Improper Payments

Finding	*Projection (*)* *Weighted Error [%]*	*Margin of Error ** [%]*	*90% Confidence*		*Sample*
			Lower Limit [%]	*Upper Limit [%]*	
Net improper payments	12,798 (12,800) [46.6]	4,053 [11.2]	8,745 [35.4]	16,851 [57.8]	167
Questionable costs	$942,930,600 ($943 million)	$374,103,260 ($374 million)	$568,827,340 ($569 million)	$1,317,033,860 ($1.3 billion)	167
Veterans with improper overpayments of 1 year or more	8,192 (8,200) [73.5]	2,221 [7.1]	5,972 [66.4]	10,413 [80.6]	110
Veterans with improper overpayments of 5 years or more	3,136 (3,100) [28.1]	1,954 [14.1]	1,182 [14.1]	5,090 [42.2]	35
Net improper payments 5-year projection	12,031 (12,000) [43.8]	4,034 [11.3]	7,997 [32.5]	16,064 [55.1]	151
Better use of funds	$1,130,283,193 ($1.1 billion)	$195,905,901 ($196 million)	$934,377,292 ($934 million)	$1,326,189,094 ($1.3 billion)	151
No future monetary impact	848 (800) [3.1]	439 [1.7]	409 [1.4]	1,288 [4.8]	16

*Notes: * Parentheses show rounded values; ** 90% Confidence interval*

Note: The margins of error and confidence intervals are indicators of the precision of the projections. If we were to select a large number of samples and compute the projections from each one, 90 percent of those projections would fall within the confidence interval.

We projected that in the next 5 years, VBA will pay about $1.1 billion in overpayments without further action to adjust the benefits. We selected the sample using probability-sampling methods that gave all veterans' records a chance of selection. The sample is representative of the population from which it was drawn. Our projections correctly accounted for the probabilities of selection of each sample unit. Our results for 329 of the 1,402 evaluations reviewed indicated that VARO staff did not correctly assign or effectively monitor and adjust evaluations for veterans creating improper payments totaling $12,208,674. Ninety percent of possible samples of the same size and design would result in a projection between $569 million and $1.3 billion in improper payments.

Appendix D Monetary Benefits in Accordance with IG Act Amendments

Recommendations	Explanation of Benefits	Better Use of Funds	Questioned Costs
1-6	We projected about 12,800 processing errors that resulted in VBA making improper payments to veterans (both overpayments and underpayments). VBA paid those 12,800 veterans a net amount of about $943 million in compensation benefits without adequate medical evidence.	$943,000,000	
7	Of the 12,800 evaluations that resulted in an improper payment, we determined that VBA would not have identified the error for more than 12,000 of the evaluations. Without action, VBA would overpay these veterans a projected net $1.1 billion over the next 5 years.	$1,130,000,000	
	Total:	$2,073,000,000	

Appendix E Acting Under Secretary for Benefits Comments

Department of Veterans Affairs **MEMORANDUM**

Date: November 24, 2010

From: Acting Under Secretary for Benefits (20)

Subj: OIG Draft Report—Veterans Benefits Administration: Audit of 100 Percent Disability Evaluations—VAIQ 7046884

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

1. Attached is VBA's response to the OIG's Draft Report: Veterans Benefits Administration: Audit of 100 Percent Disability Evaluations.

2. Questions may be referred to Catherine Milano, Program Analyst, at 461-9216.

(original signed by:)

Michael Walcoff

Attachment

Veterans Benefits Administration
Comments on OIG Draft Report
Audit of 100 Percent Disability Evaluations

The Veterans Benefits Administration (VBA) provides the following comments:

VBA has major concerns with this audit and does not concur with the overall findings particularly as they relate to the projected overpayment amounts articulated on page i and throughout the report.

VBA believes the overall error rate of 15 percent is overstated. The Office of Inspector General (OIG) admits to reducing the population from which to sample by approximately 58,000 Veterans with conditions that clearly indicated no likelihood of improvement, such as double amputees. Removing 58,000 presumed error free cases skews analysis and causes sampling to no longer be truly random. Without a true random sampling, you cannot assume a normal distribution. A normal distribution is necessary to make all the statistical projections in this report.

VBA believes that the OIG overpayment projection of $1.1 billion over the next five years is significantly overstated. VBA reviewed records for 8 of the top overpayments that were identified by the OIG, and found that 3 of these cases (38 percent) still warranted 100 percent evaluations or payment at the 100% rate. Therefore, potentially 38 percent of the errors used to make monetary projections may not be valid.

In one case, the OIG indicated that $319,504 was overpaid because VA benefits were granted or continued without sufficient evidence. VBA granted service connection for the loss of use of the bilateral lower extremities based on a VA examination which showed the Veteran was "wheelchair bound" due to service connected bilateral hip replacements. VBA believes this grant was justified. Prior to this decision, the Veteran was rated unemployable due to service-connected disabilities, that also entitled him to payments at the 100 percent disability rate. The OIG made incorrect projections of $126,120 for the next five years, as they determined these projections based on the difference between the 100 percent rate with special monthly compensation, and the 80 percent entitlement rate.

The other two cases involve 100 percent evaluations for Veterans that were rated service connected for residuals of tuberculosis. Unfortunately, one of the Veterans passed away from complications of tuberculosis during the course of this audit. In this case, there is no evidence that indicates an evaluation of less than 100 percent was warranted prior to his death. The OIG indicated that the Veteran was overpaid $223,924, and projection calculations show that we would have overpaid $80,220 in the next five years. A review of the third case indicates that a recent VA examination was conducted as a result of this audit. This examination revealed that the Veteran is still warranted 100 percent for residuals of tuberculosis, and a rating decision was completed to continue this entitlement and grant eligibility to Chapter 35 benefits. The OIG

indicated that VA overpaid $221,606 in this case, since the appropriate diary date was not input. They also projected that the error in not establishing diary control would have resulted in overpayments of $84,690 in the next five years.

VBA contends that the sample may not be sufficient to accurately predict the average cost per strata. Two of the six strata have only one payment error, causing the average cost to be based on just one case. Inspection of the sensory organs and cardiovascular strata also reveal significant outliers on both the low and high side of the averages. Removing these outliers reduces the averages from $135,458 to $87,044 and from $114,043 to $96,294, respectively. Based on the impact of these outliers, the two strata could be overstated by as much as 36 percent. The other strata do not have enough data to determine outliers by inspection, so the impact cannot be estimated.

In our analysis of the error findings provided by the OIG, we note that two of the strata articulated in Table 2 (page 16), include errors with disabilities from additional body systems. The Sensory Organ strata includes error findings for respiratory disabilities with Diagnostic Codes 6702, 6732, and 6819. The Cardiovascular, Digestive, and Genitourinary strata includes additional error findings for gynecological and hemic/lymphatic disabilities with Diagnostic Codes 7627, 7703, 7709, and 7715.

In the "Report Highlights" and throughout the report, the OIG attributes the cause of the errors identified to VA Regional Office (RO) staff not correctly processing evaluations. However, the OIG noted a significant number of cases identified in which RO staff did correctly establish future exam dates in the disability review process, but the computer system did not properly maintain the future exam dates. As was discussed with the OIG, VBA identified multiple computer system errors, rather than employee error, that accounted for a high percentage of the tracking or monitoring errors noted by the OIG. The OIG acknowledged such system errors on page 4 of their report.

VBA makes every effort to ensure that Veterans are paid correctly and disability evaluations are assigned appropriately at all levels. We continue to identify system enhancements as the most effective protocol for making certain that future examinations are entered in the electronic record for all temporary 100 percent evaluations. VBA has identified system errors in addition to the errors cited by the OIG that result in future examinations being removed from a record. VBA is actively working to resolve these types of errors through system modifications. We believe these system safeguards will ensure correct future review of temporary 100 percent evaluations.

The following comments are submitted in response to the recommendations in the OIG Draft Report:

Recommendation 1: Modify Veterans Benefits Administrations electronic system to establish a mechanism that will automatically populate the future exam date on the rating document in the Veteran's electronic record.

VBA Response: VBA concurs with the recommendation that the electronic system should automatically populate future exam dates. As mentioned in the OIG findings, VBA made modifications to the electronic system in August 2009 that would ensure that Rating Veterans Service Representatives enter a future examination date when a disability is not static. VBA will make additional system modifications to ensure that future diaries are established through the rating process, even when award action is not required.

Target Completion Date: February 28, 2011

Recommendation 2: Establish a specific label for medical exam notifications to ensure responsible VA Regional Office staff can identify and take required actions on the notification.

VBA Response: Early in the audit process, VBA concurred that this is an area where improvement was necessary to more clearly identify instances of future examination needs with a unique claim label. A new claim label for 810 series work items was installed on August 9, 2010, and is made available through VETSNET Operations Reports. The specific label is "Future Physical Examination."

VBA requests that this recommendation be closed.

Recommendation 3: Provide training to ensure VA Regional Office staff complies with established guidelines to take appropriate and timely action on exam notifications and document the action taken.

VBA Response: VBA concurs with the recommendation to provide training on taking appropriate and timely action on exam notifications. C&P Service is developing a training lesson on the topic of exam notifications (810 writeouts and hard copy 2507a's), which will include pertinent references and guidelines for taking appropriate and timely actions. Completion of this training lesson will be mandated by the annual C&P Service Core Curriculum Training Requirement hours for FY 2011, and the lesson will also include a component for evaluating evidence to determine if permanency exists, a future exam is required, or if a reduction is warranted.

Target Completion Date: January 31, 2011

Recommendation 4: Provide training on when it is appropriate for VA Regional Office staff to grant Veterans a permanent rating, special monthly compensation, and eligibility to ancillary benefits.

VBA Response: VBA concurs with the recommendation to provide training on granting permanency ratings, special monthly compensation, and eligibility to ancillary benefits. C&P Service is developing a training lesson on the topic of exam notifications (810 writeouts and hard copy 2507a's), which will include a component for evaluating evidence to determine if permanency exists, a future exam is required, or if a reduction is warranted. Completion of this training lesson will be mandated by the annual C&P Service Core Curriculum Training Requirement hours for FY 2011.

The current training lesson on Inferred Issues addresses entitlement to special monthly compensation and eligibility for ancillary benefits. This lesson is also part of the mandatory C&P Service Core Curriculum Training Requirement hours that must be completed by Rating VSRs each year. C&P Service will reinforce compliance in completing this lesson during the next Veterans Service Center Managers call.

Target Completion Date: January 31, 2011

Recommendation 5: Issue guidance to ensure VA Regional Office staff does not relocate claims folders with temporary 100 percent disability evaluations to the VA Records Management Center.

VBA Response: VBA concurs with the recommendation to update guidance for relocating claims folders to the Records Management Center. Currently, we prevent from relocation any disability award with a diary. Specifically, a folder is not relocated if a pending issue has existed for the last 14 months, a diary exists, there is a pending appeal, or the record (file number) is on an exclusion list that shows a record review or record consolidation is required. As of November 2008, system changes were put in place to not relocate any cases with pending diaries. During FY 2011, we plan to audit a station scheduled for relocation to confirm that the selection of cases eligible for relocation does not include cases with pending dairies. Current guidance requires that records remain at the field station if the folder has become active or has activity pending. During FY 2011, we will update the guidance to better define those cases that should remain on station.

Target Completion Date: September 30, 2011

Recommendation 6: Identify all claims folders with temporary 100 percent disability evaluations currently located at the VA Records Management Center, and review the status of each evaluation to determine if a transfer to the VA Regional Office of jurisdiction is required to conduct an exam or revise the evaluation.

VBA Response: VBA concurs with this recommendation and agrees to identify and review all folders with temporary 100% evaluations currently located at the Records Management Center.

For this purpose VBA will identify folders with Paragraph 28, 29, or 30 ratings, or with diaries of 01 or 39.

Target Completion Date: September 30, 2011

Recommendation 7: Conduct a review of all temporary 100 percent disability evaluations and ensure each evaluation has a future exam date entered in the Veterans' electronic records.

VBA Response: VBA concurs with the recommendation to review temporary 100 percent disability evaluations for the purpose of establishing future exam dates in electronic records. We requested that the OIG identify disability-specific problem areas within the test population, to focus on this recommendation. As noted in the OIG sampling methodology, some diagnostic codes were not subject to significant impacts. Review of the errors identified by the OIG showed 162 of the 229 errors in the temporary 100% strata were in three diagnostic codes:

- 7715 Non-Hodgkin's Lymphoma
- 7528 Malignant Neoplasms of the Genitourinary System (most commonly diagnosed as Prostate Cancer), and
- 9411 Post-traumatic Stress Disorder (PTSD).

VBA identified approximately 584 records with evaluations assigned for diagnostic code (DC) 7715 records, 3,254 cases for DC 7528 records, and 18,187 cases for DC 9411 records. VBA will establish procedures for review of these records, and we are running data on a static indicator that is used to identify all temporary 100 percent disability evaluations. This would ensure each evaluation has a future exam date entered in the Veterans' electronic records. The remainder of the cases will be identified through a batch process, and VBA will establish the appropriate future diary controls electronically.

Target Completion Date: September 30, 2011

Appendix F OIG Contact and Staff Acknowledgments

OIG Contact	Larry Reinkemeyer
Acknowledgments	Lee Giesbrecht Timothy Halpin Patti Hudon Brad Lewis Russ Lewis Daniel Morris Ken Myers Sandra Parsons Carla Reid Jason Schuenemann Brenda Uptain

Appendix G Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Veterans Benefits Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel

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

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 after it is issued.