VA OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDITS & EVALUATIONS

Inspection of VA Regional Office Waco, TX

April 16, 2010
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Office of Inspector General

Benefits Inspection Program

The Benefits Inspection Program is part of the Office of Inspector General's (OIG's) efforts to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Division contributes to the improvement and management of benefits processing activities and veteran services by conducting onsite inspections at VA's Regional Offices (VAROs). The purpose of these independent inspections is to provide recurring oversight of VAROs by focusing on disability compensation claims processing and the performance of Veterans Service Center (VSC) operations. The inspection objectives are to:

- Evaluate how well VSCs are accomplishing their missions of providing veterans with convenient access to high quality benefits services.
- Determine if management controls ensure compliance with VA regulations and policies; assist management in achieving program goals; and minimize risk of fraud, waste, and other abuses.
- Identify and report systemic trends in VSC operations.

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

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Report Highlights: Inspection of VA Regional Office, Waco, TX

Why We Did This Review

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

What We Found

The VARO management team needed to improve the accuracy of disability claims processing for temporary 100 percent disability evaluations, post-traumatic stress disorder (PTSD), and traumatic brain injury (TBI) claims. Our analysis revealed VARO staff incorrectly processed rating decisions for 43 (36 percent) of 120 claims reviewed.

In addition, management needed to improve controls over processing fiduciary claims as incompetent beneficiaries continued to receive benefit payments without a fiduciary appointed to manage their funds and some fiduciaries erroneously received veteran's benefit payments they were not entitled to receive. Management also needed to improve controls over the following areas:

- Establishing correct dates of claims.
- Establishing Notices of Disagreement (NOD) for appealed claims timely.
- Completing Systematic Analysis of Operations (SAO) accurately and timely.
- Safeguarding of veterans' personally identifiable information (PII).
- Handling mail appropriately.

What We Recommended

We recommended the VARO ensure staff establishes future medical examination dates correctly for temporary 100 percent evaluations and provide training to Rating Veterans Service Representatives (RVSRs) on the proper procedures for processing claims associated with PTSD and TBI.

We also recommended the VARO provide training to Veterans Service Representatives on the proper procedures for claims establishment, improve oversight to ensure staff timely record NODs in the electronic system, and prepare timely and accurate SAOs. Finally, we recommended the VARO ensure the proper safeguarding of veterans' PII, improving mail handling procedures, and improving timeliness in processing fiduciary adjustments.

Agency Comments

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

(original signed by:)
BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

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Results and Recommendations

The OIG conducted an inspection of the Waco VA Regional Office (VARO) during December 2009. The inspection focused on 5 protocol areas examining 12 operational activities.

VARO Activities Requiring Management Attention

Disability Claims Processing

The Waco VARO needs to improve the accuracy of disability claims processing. VARO staff incorrectly processed rating decisions for 43 (36 percent) of 120 claims reviewed. Veterans Service Center (VSC) management concurred and initiated action to correct the inaccuracies.

During the period July–September 2009, the VARO completed 1,516 claims for post-traumatic stress disorder (PTSD), disabilities related to herbicide exposure, and traumatic brain injury (TBI). We reviewed 90 (6 percent) of these claims. In addition, we reviewed 30 (8 percent) of 384 claims where VSC staff granted a temporary 100 percent disability evaluation that was paid for 18 months or longer—the longest period a temporary 100 percent disability evaluation may be assigned without review under VA policy.

Table 1 reflects the processing inaccuracies by claim type and identifies those affecting veterans' benefits and those potentially affecting veterans' benefits:

Table 1. Disability Claims Processing Results

Type	Reviewed	Incorrectly Processed	Incorrectly Processed Affecting Veterans' Benefits	Incorrectly Processed with Potential to Affect Veterans' Benefits
Temporary 100 Percent Evaluations	30	28	5	23
PTSD	30	5	1	4
TBI	30	8	8	0
Disabilities Related To Herbicide Exposure	30	2	1	1
Total	**120**	**43**	**15**	**28**

VSC Personnel Need to Improve Disability Determination Accuracy

Temporary 100 Percent Evaluations. VBA policies provide a temporary 100 percent evaluation for service-connected disabilities that require surgery or specific treatment. At the end of a mandated period of convalescence or cessation of treatment, VSC staff must review the disability to determine if they should continue the temporary evaluation.

Our analyses of 30 temporary 100 percent evaluations revealed 28 (93 percent) were incorrectly processed, of which the Salt Lake City VARO processed one. Based on medical evidence available at the time of our review, we determined five temporary evaluations were incorrect and affected veterans' benefits. Four evaluations involved overpayments totaling $115,255 and one

involved an underpayment of $7,720. The most significant over- and underpayments were the following:

- An RVSR assigned a 100 percent evaluation for a total right knee replacement. VBA regulation states a 100 percent evaluation must be assigned for 1 month following discharge from the hospital for implantation of prosthesis and for an additional 1 year after this initial month. However, after the 13 months, the RVSR did not reduce the veteran's temporary evaluation to the appropriate level. As a result, VA overpaid this veteran $61,667 over a period of 36 months.
- A Decision Review Officer failed to grant entitlement to special monthly compensation based on the loss of use of a creative organ secondary to a prostatectomy, effective June 21, 2002. As a result, VA underpaid the veteran $7,720 over a period of 89 months.

Twenty-three temporary evaluations were incorrect and had the potential to affect veterans' benefits. However, we could not determine if the temporary evaluations would have continued without the results of medical examinations or other medical evidence. The following is a summary of these claims:

- For 19 claims, the VSC staff did not input a required diary date in the electronic record that would have generated an automatic notification to schedule an examination to reevaluate whether a 100 percent evaluation should continue.
- For four claims, VSC staff did not schedule examinations to reevaluate the veterans' disabilities even though the electronic system notified them to do so.

PTSD Claims. VSC staff incorrectly processed 5 (17 percent) of the 30 claims we reviewed. One of these errors affected veterans' benefits. A RVSR assigned an incorrect effective date to a claim for PTSD received at the VARO on May 21, 2009. The RVSR granted service connection for PTSD effective April 28, 2009, instead of the date VA received the claim. As a result, VA overpaid this veteran $647 for 1 month.

Four of the other PTSD claims processed incorrectly had the potential to affect veterans' benefits:

- RVSRs prematurely denied two veterans' claims for PTSD. The veterans provided information regarding their in-service stressful events, but VSC staff failed to develop further evidence to verify the stressful events occurred as required by VBA policy.
- RVSRs granted service connection for PTSD for two veterans based on medals the veterans received in service. According to VBA policy, the medals are not sufficient for conceding the occurrence of an in-service stressful event.

TBI Claims. The Department of Defense and VBA define a TBI as a traumatically induced structural injury or physiological disruption of brain function because of an external force. The major residual disabilities of a TBI fall into three main categories: (1) physical, (2) cognitive, and (3) behavioral. VBA policies require staff to evaluate these residual disabilities.

VSC staff incorrectly processed 8 (27 percent) of the 30 claims. VSC staff did not properly evaluate all residual disabilities related to the in-service TBIs. Eight claims affected veterans' benefits—four involved overpayments totaling $21,118 and four involved underpayments totaling $14,395. The most significant over- and underpayment were the following:

- An RVSR did not use a correct effective date for the evaluation of residuals from an in-service TBI. The RVSR granted a 70 percent evaluation effective March 13, 2008. The RVSR should have only granted a 10 percent evaluation effective March 13, 2008, and a 70 percent evaluation effective October 23, 2008, the date of a regulatory change regarding evaluation of TBI residual disabilities. As a result, VA overpaid this veteran $6,258 over a period of 7 months.
- An RVSR did not use the correct effective date when granting service connection for residual disabilities due to an in-service TBI at the 70 percent disability rate. The RVSR should have used October 23, 2008, as the effective date (the effective date of a regulatory change regarding evaluation of TBI residual disabilities) instead of July 28, 2009. As a result, VA underpaid this veteran $11,146 over a period of 9 months.

Disabilities Related to Herbicide Exposure Claims. VSC staff incorrectly processed 2 (7 percent) of the 30 claims we reviewed. The frequency of errors was not significant; however, one error affected a veteran's benefits. An RVSR assigned an incorrect effective date for service-connected disabilities associated with herbicide exposure. The RVSR relied on the veteran's personal statement regarding the effective date of payment, instead of the correct date of claim. As a result, the veteran was overpaid $3,870 over a period of 12 months. Because of the low frequency of errors, we determined the VARO is generally following VBA policy in processing claims related to herbicide exposure and we made no recommendations for improvement.

Conclusion: VSC management informed us errors related to temporary 100 percent evaluations occurred because staff did not record required dates in the electronic system that initiates notifications to schedule review examinations, which we confirmed. Further, errors occurred because staff did not schedule needed examinations once they received notification.

VSC management stated errors regarding PTSD were due to RVSRs needing refresher training on stressor development. A review of the VARO's training plan for PTSD revealed RVSRs have not received training on stressor development. In addition, RVSRs need further training on processing disabilities associated with TBIs because of the complexity of these claims. As a result of the claims processing errors, VARO staff did not always ensure veterans received accurate benefit payments.

Recommendation 1. *We recommend the Waco VA Regional Office Director strengthen controls for correctly establishing future examination dates and monitor future examinations for temporary 100 percent disability evaluations.*

Management Comment

The VARO Director concurred with our recommendation. VSC staff provided training on December 16, 2009, and on January 26, 2010, regarding the proper procedures for correctly

establishing future examination dates. In addition, the VSC implemented policy whereby staff refers cases requiring a future examination to Senior Veterans Service Representatives for confirmation that the future examination is in the electronic record. The VARO Director also noted one of the processing errors associated with temporary 100 percent evaluations occurred at another VARO.

OIG Response

Management comments and actions are responsive to the recommendation. The Director indicated another Regional Office processed one of the errors associated with temporary 100 percent evaluations and thought it inappropriate to charge that error to the Waco VARO. We changed the report to acknowledge that the Salt Lake City VARO inaccurately processed one claim on which we found an error.

Recommendation 2. *We recommend the Waco VA Regional Office Director conduct a review of all temporary 100 percent disability evaluations under the Regional Office's jurisdiction to determine if reevaluations are required and take appropriate action.*

Management Comment

The Director concurred with our recommendation. The VSC initiated action on all cases identified during the OIG inspection. On January 22, 2010, the OIG provided the VARO a list of additional cases where the veteran had been receiving temporary 100 percent evaluations over 18 months requiring a VA examination. The Director stated reviews of those cases were in progress, and as appropriate, staff will request examinations on those claims where further action is required. The expected completion date of the review is March 31, 2010.

OIG Response

Management comments and actions are responsive to the recommendation.

Recommendation 3. *We recommend the Waco VA Regional Office Director develop and implement a training plan for Rating Veterans Service Representatives on stressor development for rating post-traumatic stress disorder claims and refresher training to ensure their rating skills are maintained for claims involving disabilities associated with traumatic brain injury.*

Management Comment

The Director concurred with our recommendation and implemented a three-part PTSD training program between the periods January 13–February 2, 2010. Decision Review Officers, RVSRs, and Veterans Service Representatives received training through the Training and Performance Support System (a series of training modules) and through formal instruction. In addition, Decision Review Officers and RVSRs received TBI refresher training on February 10, 2010.

The Director agreed all five PTSD claim identified during the review were in error. However, the VSC found two claims, previously granted incorrectly based on medals the veterans received in service, could be granted based on in-service stressors without consideration of the medals. Therefore, no further corrective action was required on these two claims and the other three

PTSD claims have been corrected. Therefore, only 3 (not 5) out of the 30 claims reviewed by the OIG affected veterans' benefits.

OIG Response

Management comments and actions are responsive to the recommendation. The Director agreed all five PTSD cases were in error. At the time of our review, we were unable to determine if four of the five errors affected veterans' benefits. From the Director's comments, it appears that three errors affected benefits and the other two were procedural.

Data Integrity

We reviewed claims folders to determine if the VARO is following VBA policy regarding the correct establishment of the date of claim in the electronic record. The date of claim indicates when a document arrives at a specific VA facility. Generally, VAROs use the date of claim as the effective date for awarding benefits. In addition, VBA relies on an accurate date of claim to establish and track a key performance measure that determines the average days to complete a claim.

In addition, we reviewed Notices of Disagreement (NODs) submitted to the Appeals Teams to determine if VARO personnel were timely when entering NODs into the Veterans Appeals Control and Locator System (VACOLS). An NOD is a written communication from a claimant expressing dissatisfaction or disagreement with a decision and a desire to contest the result. This is the first step in the appeals process. VACOLS is a VBA application that allows VARO staff to record and monitor pending appeals. VBA policy states VSC staff must create a VACOLS record within 7 days of receipt of a NOD.

Incorrect Dates of Claim Established

VSC staff did not establish the correct date of claim in the electronic record for 7 (12 percent) of 60 documents reviewed. In February 2009, VBA reported a combined 7 percent inaccuracy rate associated with dates of claim for all 57 VAROs. The 12 percent inaccuracy rate for the Waco VARO was significantly higher than VBA's reported national average. The following is a description of the discrepancies identified at the Waco VARO:

- Five documents contained multiple VARO date stamps and staff did not select the earliest date to establish the claim.
- One document contained a Louisiana Veterans Service Office date stamp and a VARO Waco mailroom date stamp. VSC staff incorrectly used the date associated with the Veterans Service Office stamp instead of the correct date located on the VARO Waco stamp.
- VSC staff established a claim using a date one day after the date stamped on the document.

Of the 7 date of claim inaccuracies, 6 (86 percent) incorrectly improved the VAROs performance by an average of 8 days. VSC management stated that staff entered the wrong date of claim in the electronic record because of inadequate training. The VARO training schedule did not include training regarding the proper procedures to establish the correct date of claim. As a

result, incorrect dates recorded in the electronic record affect data integrity and misrepresent VARO performance. Data integrity issues make it difficult for senior leadership to determine station performance accurately.

Recommendation 4. *We recommend the Waco VA Regional Office Director develop and implement a training plan to ensure Veterans Service Center staff follow policies regarding the proper procedures to establish the correct date of claim.*

Management Comment

The Director concurred with our recommendation and VSC training staff provided Claims Assistants training on the proper procedures for establishing the correct dates of claim. In addition, the Director informed us dates of claim training has been incorporated into initial training requirements for new Claims Assistants and will be addressed semi-annually as recurring training for all Claims Assistants. Further, the Director stated dates of claim accuracy will continue to be stressed during workload management reviews.

OIG Response

Management comments and actions are responsive to the recommendation.

Controls Over Notices of Disagreement Need Strengthening

VARO staff exceeded VBA's 7-day standard for 53 (63 percent) of the 84 NODs pending input in VACOLS. These 53 NODs had been pending for an average of 17.6 days. The most untimely action occurred when VSC staff did not create a VACOLS record for 82 days as of the date of our review. An NOD is the first step in the appeals process and accurate and timely updating of VACOLS is required so that the appeal moves through the appellate process expeditiously.

Supervisors in the Appeals Teams were not aware of VBA's policy to establish NODs in VACOLS within 7 days. Subsequently, the VARO's performance measure regarding the total number of pending NODs is misleading because staff did not accurately report all NODs within VBA's standard. NODs not promptly recorded in VACOLS affect data integrity and misrepresent VARO performance. Data integrity issues make it difficult for VARO and senior VBA leadership to determine station performance accurately. Ultimately, supervisors within the Appeals Team could not effectively manage their workload, thus causing delays within appeals processing, as they were unaware of the additional NODs that staff did not accurately and timely track in VACOLS.

Recommendation 5. *We recommend the Waco VA Regional Office Director strengthen controls to ensure staff correctly establish Notices of Disagreement in Veterans Appeals Control and Locator System to ensure timely processing of appealed decisions.*

Management Comment

The Director concurred with our recommendation. After our inspection, the Director stated staff completed an additional review of appeals mail to determine other factors causing the out of line control time for NODs. The review found that staff placed appeals mail in a search status until it

was associated with the claims folder. The Director informed us they changed the process and staff will use Virtual VA to research the appealed decision and enter the NOD into VACOLS prior to placing mail in a search status. Further, staff consolidated pending NODs in one area to be processed in date of receipt order. New American Recovery and Reinvestment Act employees are being used to help with timely NOD input into VACOLS.

Although management concurred with the recommendation, the Director took exception with the statement "Supervisors in the Appeals Teams were not aware of VBA's policy to establish Notices of Disagreements (NODs) in the Veterans Appeals Control and Locator System (VACOLS) within 7 days.

OIG Response

Management comments and actions are responsive to the recommendation. An additional review performed after the OIG inspection by VARO staff is a proactive measure to improve timeliness of NODs. During our interview with both supervisors of the Appeals Teams, for which the VARO Director was not present, the supervisors informed the OIG inspectors they were unaware of national or local policies regarding a timeliness standard for processing NODs.

Management Controls

We assessed management controls to determine if VARO management adheres to VBA policy regarding proper completion of SAOs, correction of errors identified by VBA's STAR staff, and VARO date stamp accountability. VARO staff generally followed VBA policy regarding the correction of STAR errors as we found 2 (7percent) of 28 errors not corrected. Further, staff followed VBA policy regarding the accounting for and safeguarding of VARO date stamps by maintaining an accurate accountability log. Staff also secured all stamps from unauthorized use.

Inadequate Oversight for Timely and Accurate Completion of SAOs

An SAO is a formal analysis of an organizational element or operational function of the VSC. SAOs provide an organized means for reviewing operations to identify existing or potential problems and propose corrective actions. VBA policy requires VAROs to perform SAOs annually and must cover all aspects of claims processing, including quality, timeliness, and related factors. In addition, the VARO is required to publish an annual schedule indicating when each SAO is to be completed.[1]

The VARO's annual SAO schedule indicated staff must complete 12 mandatory SAOs during FY 2009. Our analysis revealed 10 (83 percent) of 12 SAOs were untimely and incomplete. Of those 10, 3 (30 percent) were untimely, 2 (20 percent) were incomplete, and 5 (50 percent) were both untimely and incomplete.

We identified several operational activities where the VSC did not follow VBA policy. If VSC management had properly completed the required SAOs, they might have identified some of the

[1]VBA Policy M21-4, "Manpower Control and Utilization in Adjudication," *Systematic Analyses of Operations*, updated April 1, 2009.

existing problems affecting operations. For example, staff failed to complete the Review of Workload Management Plan Compliance portion of the Appeals SAO. Managers would have identified the requirement to enter NODs in VACOLS within VBA's 7-day standard, had they completed this analysis.

VSC management stated SAOs were incomplete because they followed outdated VBA guidance in creating the annual schedule. Once management became aware of the change in policy, they did not ensure staff followed the new guidance. With regard to SAOs being untimely, VSC management stated that staff completed SAOs; however, the documents were subject to lengthy reviews and subsequently not completed by the due date. Because management did not follow current guidance, a thorough analysis of VSC operations to identify existing or potential problems did not occur as required by VBA policy.

Recommendation 6. *We recommend the Waco VA Regional Office Director develop and implement a mechanism to ensure Veterans Service Center management perform complete, accurate, and timely Systematic Analysis of Operations.*

Management Comment

The Director concurred with our recommendation and improved controls by shortening the deadlines for the review process of SAOs. In addition, the Director informed us the VSC Management Analyst would control SAOs, follow up with supervisors to avoid missed deadlines, and review all SAOs for accuracy.

OIG Response

Management comments and actions are responsive to the recommendation.

Errors Identified by STAR Not Always Corrected

Our review of 28 files containing errors identified by VBA's STAR program during the period July–September 2009 revealed 2 (7 percent) of the STAR errors were not corrected in accordance with VBA policy.[2] However, staff erroneously informed STAR they had corrected all 28 errors. One error affected a veteran's benefits and one had the potential to affect a veteran's benefits.

- STAR instructed the VARO to grant service connection for chronic obstructive pulmonary disease secondary to a service-connected disability. Our review showed that VSC staff prepared a new rating decision correcting historical rating data but failed to grant service connection for chronic obstructive pulmonary disease. Based on medical evidence in the claims folder, this condition warranted a 100 percent disability evaluation. The veteran was underpaid $16,079 over a period of 7 months.
- STAR instructed the VARO to consider a regulation regarding multiple service-connected disabilities that were not compensable. Our review showed that VSC staff prepared a new

[2]VBA Policy M21-4, "Manpower Control and Utilization in Adjudication," *Quality Assurance*, dated June 29, 2007.

rating decision granting an increase in evaluation of a service-connected disability but they did not address the regulation as required. The potential outcome for the veteran could be receipt of an additional 10 percent evaluation.

VSC management concurred with the findings and initiated actions to correct them. The frequency of processing inaccuracies related to correcting STAR errors was not significant. Consequently, we determined the VARO is generally following VBA policy in this area and made no recommendations for improvement.

Information Security

We reviewed the VARO's process for destruction of documents and found they were following policy regarding proper shredding procedures. However, VARO management needs to improve safeguards over veterans' personally identifiable information (PII). The OIG inspection team conducted random inspections of employee workstations and determined staff did not properly follow VBA's policy to safeguard veterans' PII. We did not include employees' desktops as a part of our review because employees may keep material on the desk for processing claims.

VBA's policy states under no circumstances will claims or guardianship files, loose mail, or material of any kind that has claimant/veteran PII be stored in desk drawers, credenzas, personal two-drawer lockable cabinets, or other personal storage containers. The policy also states material used to develop training courses must be promptly and clearly redacted and stored in a location obviously designated for training course material. Further, supervisors are required to perform inspections of the workstations to ensure adherence with policy.

In addition, we analyzed mail-handling procedures in the mailroom and the VSC Triage Team to ensure the accurate and timely processing of mail. VARO mailroom staff ensures that all mail is date stamped, processed, and picked up by assigned VSC staff every day.

Veterans' Personally Identifiable Information Not Always Safeguarded

We performed unannounced inspections of 40 (8 percent) of the 482 employees' workstations and unassigned areas located in the VSC. We found unredacted PII at 6 (15 percent) of the 40 workstations and 4 (40 percent) of the 10 unassigned areas consisting of original documents, training materials, and reports. The following are examples of the PII found:

- Sixteen computer generated notices requiring staff to verify beneficiary payment information in a desk drawer. The date of all the notices was May 2007 and the VSC had not processed them as of the date we discovered them.
- Six binders containing copies of screen prints, letters, and forms with PII in an unlocked file cabinet.

We additionally found a paper-shredding machine in an area accessible to VARO staff. Effective March 2009, VAROs must strictly control methods of document destruction. The VARO took immediate action to remove the shredder from the workspace.

VARO management stated they misinterpreted VBA policy by allowing employees to have PII in their overhead shelving. Management further stated VSC supervisors are required to conduct quarterly desk inspections on all employees assigned to their team. The PII violations we found were at the desks of employees who had VSC internal desk inspections completed during the period September–November 2009, and the supervisors did not find PII violations at that time. We concluded VSC management did not perform adequate inspections of employees' workstations, nor did they ensure employees followed VBA policy. Although we found no evidence of improper destruction of documents, the VARO Director lacks assurance employees are properly safeguarding PII.

Recommendation 7. *We recommend the Waco VA Regional Office Director develop and implement a plan for supervisors to perform thorough desk inspections for proper safeguarding of veterans' personally identifiable information.*

Management Comment

The Director concurred with our recommendation and stated the Waco Regional Office requires supervisors to review all employees' work areas quarterly. Further, the Director informed us supervisors received additional training on completing thorough page-by-page reviews of material stored in work areas. In addition, the Director stated supervisors review 25 percent of other teams' workstations quarterly and managers perform quarterly spot checks of work areas.

OIG Response

Management comments and actions are responsive to the recommendation.

Mail Management Procedures within Triage Team Need Strengthening

The Claims Process Improvement Model Implementation Plan requires the Triage Team to review, control, and process or route all incoming mail. Effective mail management is crucial to the success and control of workflow within the VSC. We observed mail handling procedures within the Triage Team of the Waco VARO and concluded employees did not always process incoming mail according to VBA policy. Further, VSC supervisors did not ensure the timely and accurate processing of mail in accordance with the VARO's workload management plan.

Following are examples of control weaknesses found regarding mail management in the Triage Team:

- VSC staff did not record 3 (10 percent) of 30 pieces of incoming mail in the electronic system (claims establishment) within VBA's standard of 7 days. For example, the VSC received medical evidence on November 5, 2009, and did not record it until December 3, 2009.
- VSC staff did not associate 8 (27 percent) of 30 pieces of mail related to active claims with beneficiaries' claims folders in accordance with the workload management plan. For example, we found a new claim for multiple disabilities received at the Waco VARO on October 6, 2009. However, the veteran's claims folder was located at the St. Petersburg, FL. VARO and staff should have mailed the claim to that location.

- Mail waiting to be associated with a file (also known as drop mail that does not require immediate action) contained documents that did require action located at drop mail distribution points. For example, we found original service treatment records with no assurance that VSC personnel ever reviewed this evidence in conjunction with a claim for benefits.

On October 1, 2009, VSC management made changes to the workload management plan because the previous plan did not follow VBA's policy for handling mail. Employees were unaware of the new procedures outlined in the workload management plan because management did not disseminate the plan and train all employees involved with processing mail. As a result, VSC staff did not process mail timely and accurately.

Recommendation 8. *We recommend the Waco VA Regional Office Director develop and implement a plan to effectively train Veterans Service Center staff on local mail handling policies.*

Management Comment

The Director concurred with our recommendation and informed us mail sorting staff received additional mail handling training. Further, the Director stated the Triage team received training on the proper procedures to review action, priority drop, and drop mail. In addition, the Director informed us additional emphasis has been added to ensure the staff reviews and expedites mail to the teams and that mail is attached to the claim files.

OIG Response

Management comments and actions are responsive to the recommendation.

Public Contact

The OIG inspection team reviewed incompetency determinations to ensure the VARO accurately and timely completed decisions involving a beneficiary's ability to manage their affairs, including VA benefits. VA must consider the competency of beneficiaries in every case involving a mental condition that is totally disabling or when evidence raises a question as to a beneficiary's mental capacity to manage their affairs.

Controls Over Incompetency Determinations Need Strengthening

The VARO completed action on 94 incompetency determinations during July–September 2009. Of the 30 reviewed, staff unnecessarily delayed making final decisions in 6 (20 percent) of the cases. All six resulted in an increased risk as incompetent beneficiaries continued to receive benefits payments without a fiduciary to manage the funds. These delays ranged from approximately 1 month to approximately 5 months.

VBA policy requires staff to prepare a decision proposing a finding of incompetency after receiving clear and convincing medical evidence that the beneficiary is incapable of managing their affairs. Prior to making a final decision, policy allows a 65-day due process period for the beneficiary to submit evidence showing they are capable of handling funds and managing their affairs. At the end of the due process period, VARO staff must take immediate action to determine if the beneficiary is incompetent.

In the absence of a definition of "immediate", we have applied 14 calendar days after the due process period in determining if staff timely completed the competency decision. We believe this period is reasonable if staff properly follow the VARO Workload Management Plan to identify these types of cases and complete the final decision. Further delays would increase the risk that incompetent beneficiaries mishandle VA benefits.

In the most significant case, VARO staff unnecessarily delayed making a final incompetency decision for a period of approximately 5 months resulting in the veteran receiving disability payments of $5,463. In addition, staff withheld $12,087 in disability payments (and not readily available for the veteran) during this delay. While the veteran was entitled to these payments, fiduciary stewardship was not in place to provide effective management of funds and ensure the welfare of the veteran.

For 2 (7 percent) of the 30 fiduciary adjustments, staff did not follow VBA policy when determining if beneficiaries were incompetent to handle VA funds.

- VSC staff determined the beneficiary was incompetent without medical evidence demonstrating the beneficiary was unable to manage his affairs. As a result, an erroneously appointed fiduciary received $8,586 of the veterans benefit payment over a period of approximately 3 months. We found no evidence the fiduciary misused the funds.
- VSC staff determined a beneficiary was incompetent without affording mandatory due process. Due process allows the beneficiary an opportunity to provide evidence to contest the determination. As a result, an erroneously appointed fiduciary received $7,020 of the veteran's benefit payment over a period of approximately 4 months. We found no evidence the fiduciary misused the funds.

VSC management concurred with our findings and initiated action to correct the issues identified. The VARO workload management plan requires specific teams to generate weekly reports to identify incompetency determinations that need processing. However, VSC management indicated staff did not follow the procedures outlined due to lack of oversight. As a result, incompetent beneficiaries received benefit payments for an extended period in spite of being incapable of managing these funds effectively.

Recommendation 9. *We recommend the Waco VA Regional Office Director improve workload management plan oversight to ensure timely completion of cases requiring a final competency decision.*

Management Comment

The Director concurred with our recommendation and informed us Veterans Service Representatives received training on January 21, 2010, regarding cases requiring a final competency decision. Further, supervisors reviewed the local workload management plan with emphasis on cases requiring a final competency decision.

OIG Response

Management comments and actions are responsive to the recommendation.

Appendix A

VARO Profile and Scope of Inspection

VARO Profile

Organization. The Waco VARO is responsible for delivering non-medical VA benefits and services to veterans and their families in Texas. They fulfill these responsibilities through the administration of Compensation & Pension (C&P) Benefits, Vocational Rehabilitation and Employment Assistance, Burial Benefits, and Outreach activities. The Waco VARO also has an Appeals Resource Center.

Resources. As of September 30, 2009, the Waco VARO had a staffing level of 710 full-time employees. Of the 710 full-time employees, 527 (74 percent) were assigned to the VSC.

Workload. As of October 2009, the VARO reported 19,084 pending C&P claims and that processing took an average of 157.6 days to complete—approximately 2.2 days better than the national target of 159.8 days. Accuracy for C&P rating-related issues was 83.8 percent—below the national standard of 90 percent. Accuracy for C&P authorization-related issues was 95 percent—equal to the national standard of 95 percent. As reported by VBA's STAR, date of claim accuracy was 93.4 percent—above the national standard of 90 percent.

Scope of the Inspection

Scope. The OIG inspected the Waco VARO during the period December 2009. We reviewed selected management controls, benefits claims processing, and administrative activities to evaluate compliance with VBA policies as they related to benefits delivery and non-medical services provided to veterans. As part of our inspection, we interviewed managers and employees, reviewed veterans' claims folders, and inspected work areas.

Our review of fiduciary adjustments and disability claims processing for PTSD, TBI, and disabilities related to herbicide exposure covered the period July–September 2009. In addition, for temporary 100 percent disability evaluations, we reviewed claims where VSC staff granted a temporary evaluation that continued for 18 months or longer. The review of errors identified by VBA's STAR covered the period July–September 2009. For our review of claim dates, we selected claims within the VARO pending as of December 2009. We completed our review in accordance with the President's Council for Integrity and Efficiency's *Quality Standards for Inspections.*

Appendix B

VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: March 19, 2010

From: Director, VA Regional Office Waco

Subj: Inspection of VARO Waco, TX

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

1. Attached are the Waco VARO's comments on the OIG Draft Report: Inspection of VARO Waco.

2. Questions may be referred to Virginia Richards (254) 299-9209.

(original signed by:)

CARL E. LOWE, II, Director
Waco VA Regional Office (349)

Attachment

Appendix B

VARO Director's Comments

Waco VA Regional Office (VARO) Comments to VA Office of Inspector General (OIG)
Draft Report: Inspection of VARO Waco, TX

Disability Claims Processing

Recommendation 1. *We recommend the Waco VA Regional Office Director strengthen controls for correctly establishing future examination dates and monitor future examinations for temporary 100 percent disability evaluations.*

Concur. Based on the OIG's audits of temporary 100% evaluations in several ROs nationwide, a problem was identified with future exam controls. C&P Service issued guidance in C&P Bulletin dated November 2009, which advised stations of proper system input for these types of cases.

The Veterans Service Center (VSC) provided training on correctly establishing and following up on future exam controls to the Rating Veterans Service Representatives (RVSRs) on December 16, 2009, and to the Veterans Service Representatives (VSRs) on January 26, 2010. Also, the VSC has implemented the following processing changes:

- Post Determination VSRs are now required to print the VETSNET screen identifying the future exam and file this document in the claims folder.
- All continued and confirmed ratings must be reviewed and signed off by a Senior VSR to ensure the future control (diary) has been input into the system. The VSR and Senior VSR will initial the letter to show that the diary was input into the system.

It is noted that one of the cases OIG identified in error was processed as a Benefits Delivery at Discharge (BDD) case at another RO. The VSC has taken action to propose a reduction based on the OIG review; however, we do not feel it is appropriate to charge the Waco RO with an error on this case.

Recommendation 2. *We recommend the Waco VA Regional Office Director conduct a review of all temporary 100 percent disability evaluations under the Regional Office's jurisdiction to determine if reevaluations are required and take appropriate action.*

Concur. The VSC is taking action on all cases identified during the OIG visit of December 2009. During the exit briefing, we requested that the OIG provide us with a listing of the remaining temporary 100% evaluation claims where action may be necessary. The OIG provided the VSC with the list on January 22, 2010, and a review of these cases is in progress. As appropriate, end products (EPs) have been established and exams requested on all files where our review has disclosed that further action is required. The expected completion date of this review is March 31, 2010.

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Recommendation 3. *We recommend the Waco VA Regional Office Director develop and implement a training plan for Rating Veterans Service Representatives on stressor development for rating post-traumatic stress disorder claims and refresher training to ensure their rating skills are maintained for claims involving disabilities associated with traumatic brain injury.*

Post-traumatic stress disorder claims (PTSD). Concur. An e-mail was sent to all RVSRs and Decision Review Officers (DROs) on January 13, 2010, laying out a three-part training session on PTSD (two parts Training and Performance Support System (TPSS) lesson, and one part formal instruction). On January 13, 2010, RVSRs and DROs completed the PTSD TPSS module introduction and Lesson 1 (Understanding PTSD). On January 20, 2010, RVSRs and DROs completed Lesson 2 (The Law, the Veteran, and You). On January 27, 2010, and February 3, 2010, formal training was provided to RVSRs and DROS on development of PTSD claims. In addition, training was provided to all VSRs on February 2, 2010, on development of PTSD claims.

After reviewing the five PTSD claims in error, it is agreed that all 5 cases were in error. However, the VSC found that the two claims that had been previously granted incorrectly based on medals the veterans received in service, could be granted based on in-service stressors without the consideration of the medals. Therefore, no further corrective action was required of these two claims. The other three PTSD claims have been corrected. Therefore, only 3 (not 5) out of the 30 claims reviewed by the OIG affected veterans' benefits.

Traumatic Brain Injury (TBI): Concur. Refresher training was provided to RVSRs and DROs on traumatic brain injury on February 10, 2010.

Data Integrity

Recommendation 4. *We recommend the Waco VA Regional Office Director develop and implement a training plan to ensure Veterans Service Center staff follow policies regarding the proper procedures to establish the correct date of claim.*

Concur. All Claims Assistants (CAs) have received training to ensure the correct dates of claim (DOC) were used in claims establishment. Additionally, the VSC training staff provided DOC training in December 2009, Global War On Terrorism training in January 2010, and end product establishment training on March 18, 2010. DOC training has been incorporated into initial training requirements for new CA hires, and will be addressed semi-annually as recurring training for all CAs. DOC accuracy will continue to be stressed during workload management reviews.

Recommendation 5. *We recommend the Waco VA Regional Office Director strengthen controls to ensure staff correctly establishes Notice of Disagreements in Veterans Appeals Control and Locator System to ensure timely processing of appealed decisions.*

Concur, with the exception of the statement "Supervisors in the Appeals Teams were not aware of VBA's policy to establish Notice of Disagreements (NODs) in the Veterans Appeals Control and Locator System (VACOLS) within 7 days." To clarify, the OIG staff asked a supervisor if

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they were aware of VBA's policy of establishing NODs in VACOLS and the supervisor responded, "I think it is 7 days." This response is correct. VBA's policy is to establish NODs in VACOLS is 7 days.

A step-by-step analysis of appeal mail was reviewed to determine the root causes of the out of line control time for NODs. The operational process for appeal mail was to have the mail expedited for 24 hours, and then it was placed in search mail. When NODs were associated with the claims file, they were then sent to the Appeals team for VACOLS entry. Since the OIG site visit, the process has been changed so that the rating decision and notification will be researched in Virtual VA and the NOD entered into VACOLS daily prior to a file search. Pending NODs are also consolidated in one team area to be worked in date of receipt order. New American Recovery and Reinvestment Act (ARRA) VSR employees have been hired and are being utilized to help with timely NOD input into VACOLS.

Management Controls

Recommendation 6: *We recommend the Waco VA Regional Office Director develop and implement a mechanism to ensure Veterans Service Center management perform complete, accurate, and timely Systematic Analysis of Operations.*

Concur. Tightened controls have been put into place to shorten the deadlines on the review process of Systematic Analysis of Operations (SAOs). In addition, control of the SAOs has been placed under the jurisdiction of the VSC Management Analyst (MA), who has been given authority to follow up with coaches to avoid missed deadlines. The VSC MA also reviews all SAOs for accuracy.

Information Security

Recommendation 7: *We recommend the Waco VA Regional Office Director develop and implement a plan for supervisors to perform thorough desk inspections for proper safeguarding of veterans' personally identifiable information.*

Concur. The Waco RO currently has a requirement in place that ensures all employees' work areas are reviewed quarterly and the supervisor completes a spreadsheet when the review is completed. The following additional controls have been put in place:

- Supervisors have been provided additional training on completing thorough page-by-page reviews of any material stored in the work area.
- Coaches will pair up and review 25% of another coach's team each quarter, thus providing a second review to focus on quarterly desk inspections.
- Each AVSCM will also perform a spot check of random desks in their area each quarter.

Waco's 100% quarterly desk inspections exceed the national VBA requirements of 100% annually.

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Recommendation 8: *We recommend the Waco VA Regional Office Director develop and implement a plan to effectively train Veterans Service Center staff on local mail handling policies.*

Concur. Additional mail handling training has been provided to the mail sorting staff and the Triage team on the proper procedures to review action, priority drop, and drop mail. Additional emphasis has been added to ensure the mail is reviewed and expedited to the teams and attached to the files.

Public Contact

Recommendation 9: *We recommend the Waco VA Regional Office Director improve workload management plan oversight to ensure timely completion of cases requiring a final competency decision.*

Concur. Training on cases requiring a final competency decision was provided to all VSRs on January 21, 2010, which included training on proper control procedures. In addition, the local workload management plan has been reviewed and emphasized with all supervisors.

Appendix C

Inspection Summary

12 Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. 100 Percent Disability Evaluations	Determine if VARO staff reviewed temporary 100 percent disability evaluations in accordance with VBA policy. (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. Post-Traumatic Stress Disorder	Determine whether service connection for PTSD was processed in accordance with VBA policy. (38 CFR 3.304(f))		X
3. Traumatic Brain Injury	Determine whether service connection for TBI and all residual disabilities were processed in accordance with VBA policy. (Fast Letters 08-34 and 36, Training Letter 09-01)		X
4. Disabilities Related to Herbicide Exposure	Determine whether service connection for disabilities related to herbicide exposure (Agent Orange) was processed in accordance with VBA policy. (38 CFR 4.119) (M21-1MR Part IV, Subpart ii, Chapter 1, Section H.28)	X	
Data Integrity			
5. Date of Claim	Determine if VAROs accurately recorded the correct date of claim in electronic records in accordance with VBA policy. (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)		X
6. Veterans Appeals Control and Locator System	Determine if VA Regional Offices were timely when entering NODs into VACOLS in accordance with VBA policy. (M21-1MR Part I, Chapter 5)		X
Management Controls			
7. Systematic Analysis of Operations	Determine if VAROs performed a formal analysis of their operations through completion of SAOs in accordance with VBA policy. (M21-4, Chapter 5)		X
8. Systematic Technical Accuracy Review	Determine if VAROs timely and accurately corrected STAR errors in accordance with VBA policy. (M21-4, Chapter 3, Subchapter II, 3.03)	X	
9. Date Stamp Accountability	Determine if VAROs accounted for and safeguarded date stamps in accordance with VBA policy. (M23-1 1.12, b. (1), (2), (3), (4)) (VBA Letter 20-09-10 Revised, dated March 19, 2009)	X	
Information Security			
10. Destruction and Safeguarding of Documents	Determine if VAROs complied with VBA policy regarding proper destruction and safeguarding of documents. (VBA Letter 20-08-63 Revised, dated March 13, 2009 and attachments).		X
11. Mail Handling Procedures	Determine if VAROs complied with VBA mail handling procedures. (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapters 1 and 4)		X
Public Contact			
12. Fiduciary Adjustments	Determine if VAROs properly assessed beneficiaries' mental capacity to handle VA benefit payments in accordance with VBA policy. (M21-1MR Part III, Subpart v, Chapter 9, Section A) (M21-1MR Part III. Subpart v, Chapter 9, Section B) (Fast Letter 09-08)		X

Appendix D

OIG Contacts and Staff Acknowledgments

OIG Contact	Brent Arronte (727) 395-2425
Acknowledgments	Danny Clay Kristine Abramo Joseph Brett Byrd Robert Campbell Kelly Crawford Kerri Leggiero-Yglesias Lisa Van Haeren

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