VA OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDITS & EVALUATIONS

Inspection of VA Regional Office Philadelphia, PA

March 4, 2010
09-03846-93

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, Philadelphia, PA

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 did not meet the requirements for several operational areas reviewed. The VARO management team acknowledged this was due to a lack of management oversight.

The VARO management team needs to provide additional oversight and training of personnel who process benefits claims for temporary 100 percent disability evaluations, traumatic brain injury (TBI), and disabilities related to herbicide exposure. Management also needs to improve controls over the following areas:

- Safeguarding of veterans' personally identifiable information (PII).
- Processing adjustments for fiduciary claims related to incompetent veterans.

What We Recommend

We recommended the VARO correctly process required future examinations for temporary 100 percent evaluations and that Rating Veterans Service Representatives receive training on how to recognize inadequate traumatic brain injury examinations and accurately process claims for disabilities related to herbicide exposure.

We also recommended the VARO improve oversight to ensure the proper safeguarding of veterans' PII, and process fiduciary adjustments in a timely manner.

Agency Comments

The Director of the Philadelphia VARO concurred with all recommendations. The management team'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 Philadelphia VA Regional Office (VARO) in October 2009. The inspection focused on 5 protocol areas examining 11 operational activities.

VARO Activities Requiring Management Attention

Disability Claims Processing

The Philadelphia VARO needs to improve the accuracy of disability claims processing. VARO staff incorrectly processed rating decisions for 39 (33 percent) of 120 claims we reviewed. Veterans Service Center (VSC) management concurred and initiated action to correct the inaccuracies.

During the period April–June 2009, the VARO completed action on 917 claims for post-traumatic stress disorder (PTSD), disabilities related to herbicide exposure, and traumatic brain injury (TBI). We reviewed 90 (10 percent) of these claims. In addition, we reviewed 30 (22 percent) of 137 claims where VSC staff granted a temporary 100 percent evaluation that was paid for 18 months or longer. We chose the 18-month timeframe based on the longest period a temporary 100 percent evaluation may be assigned without review under VA policy.

The following table reflects the processing inaccuracies by disability claim type and identifies both those affecting veterans' benefits and those that can potentially affect veterans' benefits:

Table 1. Disability Claims Processing Results

Claim Type	Claims Reviewed	Claims Incorrectly Processed	Claims with Procedural Errors	Claims Incorrectly Processed Affecting Veterans' Benefits	Claims Incorrectly Processed Having The Potential To Affect Veterans' Benefits
Temporary 100 Percent Evaluations	30	26	1	7	18
TBI	30	7	1	3	3
Disabilities related to herbicide exposure	30	6	2	4	0
PTSD	30	0	0	0	0
Total	**120**	**39**	**4**	**14**	**21**

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.

VSC staff incorrectly processed 26 (87 percent) of the 30 temporary 100 percent evaluations we reviewed. Based on medical evidence available at the time of our review, we determined seven of the processing inaccuracies affected veterans' benefits. The most egregious overpayment and underpayment being the following:

- A Rating Veterans Service Representative (RVSR) improperly continued an erroneous temporary 100 percent evaluation granted by the Chicago VARO. The veteran was overpaid $224,880 over a period of approximately 7 years.
- A RVSR should have granted special monthly compensation because the veteran met specific statutory criteria for the benefit. The veteran was underpaid $24,708 over a period of 40 months.

The remaining errors that affected veterans' benefits resulted in three overpayments totaling $164,890 and two underpayments totaling $5,261. For the 18 other claims, VSC personnel allowed 100 percent temporary evaluations to continue without scheduling future medical examinations and it could not be determined if the temporary evaluations would have continued without the results of medical examinations or other available medical evidence. Therefore, the 18 errors had the potential to affect veterans' benefits. The other processing inaccuracy was procedural in nature and did not affect the veteran's benefits.

VSC management stated that 20 of the 26 processing inaccuracies were due to a computer application failure. Management indicated staff input the dates for examinations; however, the dates would not remain in the electronic record. Our analysis did not support management's contention of a computer application failure. Processing inaccuracies related to 22 of the 26 temporary 100 percent evaluations occurred because staff did not schedule the required date in the electronic system to initiate an automatic notification for staff to schedule future examinations.

A management official at VBA's Compensation and Pension Service confirmed that a computer system failure could not cause the errors. The remaining four errors were a result of VSC employees not fully reviewing the details of the cases prior to completing decisions. As a result, the VARO Director lacked assurance that VSC staff accurately processed claims for temporary 100 percent evaluations.

TBI Claims. The Department of Defense and VBA commonly 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 in addition to the initial injury.

VSC staff incorrectly processed 7 (23 percent) of the 30 claims we reviewed. VSC staff did not properly evaluate all residual disabilities related to the in-service TBIs. Three of these processing inaccuracies affected veterans' benefits:

- A RVSR over evaluated the veteran's TBI residual disabilities. The medical evidence in the claims folder did not support the evaluation assigned by the RVSR. The veteran was overpaid $5,605 over a period of 13 months.
- RVSRs under evaluated two veterans' TBI residual disabilities and did not grant special monthly compensation. Based on medical evidence in the claims folder, the RVSRs should have granted higher evaluations. The veterans were underpaid $18,706 over a period of 12 months and $16,235 over a period of 13 months, respectively.

Three of the other processing inaccuracies could potentially affect the veterans' benefits. RVSRs incorrectly used inadequate examinations to evaluate the claims and did not fully assess all residual disabilities associated with the TBIs. We determined that VA medical examiners did not use the correct TBI worksheets required for completing TBI examinations. Management stated the RVSRs should have recognized the examinations were inadequate and returned them to the VA medical facilities for correction.

The final TBI processing inaccuracy was procedural in nature, and did not affect the veteran's benefits. Based on our analysis, the VARO Director lacked assurance that VSC staff accurately processed TBI claims.

Disabilities Related to Herbicide Exposure Claims. VSC staff incorrectly processed 6 (20 percent) of the 30 claims we reviewed. Four of these processing inaccuracies affected veterans' benefits:

- RVSRs over evaluated two veterans' disabilities related to herbicide exposure. The overpayments were $5,964 over a period of 7 months, and $3,580 over a period of 10 months, respectively.
- RVSRs under evaluated two veterans' disabilities related to herbicide exposure. The underpayments were $2,560 over a period of 8 months, and $2,126 over a period of 12 months, respectively.

The remaining two processing inaccuracies were procedural in nature, and did not affect veterans' benefits. The processing errors for disabilities related to herbicide exposure occurred because RVSRs did not follow VBA policies related to processing these types of claims and some RVSRs lacked sufficient experience to process these claims accurately. VSC management indicated a number of RVSRs had less than 2 years experience. After reviewing the VARO's organization chart we confirmed that 22 (56 percent) of 39 RVSRs had less than 2 years experience as RVSRs. As a result, the VARO Director lacked assurance that VSC staff accurately processed claims related to disabilities related to herbicide exposure.

PTSD Claims. Our analysis of PTSD claims processing revealed no processing inaccuracies. As such, we determined the VARO was following VBA policy in this area.

Recommendation 1. *We recommend the Philadelphia VA Regional Office Director strengthen controls to ensure staff correctly establish and monitor future examinations for temporary 100 percent evaluations.*

Management Comment

The VARO Director concurred with our recommendation and the VSC implemented a change in processing future examinations. Based on the review of temporary 100 percent evaluations, the OIG identified problems with future examinations. As a result, VBA's Compensation and Pension Service published guidance in the Compensation and Pension Bulletin in November 2009, which advised stations on proper system input for these types of cases.

OIG Response

Management comments and actions are responsive to the recommendation.

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

Management Comment

The VARO Director concurred with our recommendation. The VSC has taken action on all cases identified by the OIG in October 2009. The OIG provided VARO staff with a list of the remaining universe of temporary 100 percent evaluations on February 1, 2010. As appropriate, end products have been established and exams requested on all files where our review has disclosed that further action is required.

OIG Response

Management comments and actions are responsive to the recommendation.

Recommendation 3. *We recommend the Philadelphia VA Regional Office Director coordinate with VA medical staff responsible for completing examinations for traumatic brain injury to ensure examiners use the most current examination worksheets.*

Management Comment

The VARO Director concurred with our recommendation. The Philadelphia Director held conference calls with the Philadelphia VA Medical Center Director and Assistant Director on October 1, 2009, and on January 14, 2010, concerning insufficient examinations. In addition, our liaison representatives made contact with each VA Medical Center in our jurisdiction to ensure compliance with the use of the newest exam sheet.

OIG Response

Management comments and actions are responsive to the recommendation.

Recommendation 4. *We recommend the Philadelphia VA Regional Office Director implement training to ensure Rating Veterans Service Representatives can recognize inadequate traumatic brain injury examinations and accurately process claims related to herbicide exposure.*

Management Comment

The VARO Director concurred with our recommendation. At the time of the OIG visit, the Rating Team Coaches provided training to the RVSRs and Decision Review Officers on the proper exam sheet and the use of the text generator [an automated tool used by RVSRs to determine the evaluation of a TBI disability]. Refresher training on TBI examinations and claims related to herbicide exposure was conducted for RVSRs and Decision Review Offices on February 9, 2010.

OIG Response

Management comments and actions are responsive to the recommendation.

Data Integrity

VSC staff generally followed VBA policy regarding the establishment of the correct dates of claim in SHARE. The date of claim indicates when a document arrives at a specific VA facility. 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 and for correct payment of benefits. Of 30 claims reviewed, 1 (3 percent) had an incorrect date of claim, which VSC management corrected.

Management Controls

The Philadelphia VARO management team followed VBA policies by timely and accurately completing all 12 required Systematic Analysis of Operations. VARO staff adhered to VBA policy regarding the accounting for and safeguarding of VARO date stamps by maintaining an accurate accountability log and securing all date stamps from unauthorized use. Further, VSC management followed VBA policies to address errors identified by VBA's Systematic Technical Accuracy Review (STAR) staff by taking corrective actions and removing STAR documentation from the claims folder.

Information Security

VARO management needs to strengthen oversight to ensure veterans' personally identifiable information (PII) is safeguarded. The OIG inspection team conducted random inspections of employee workstations and determined staff did not properly follow VBA's policy to safeguard veterans' PII. The 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. 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 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. The policy also requires supervisors to perform inspections of the workstations to ensure adherence with

policy. Further, we reviewed the VARO's process for destruction of documents and found they were following policy regarding proper shredding procedures.

In addition, we analyzed mail-handling procedures in the mailroom and within the VSC's Triage team to ensure the accurate and timely processing of mail. We determined the VARO mailroom followed VBA policy regarding the processing of mail to other divisions within the VARO. In addition, the Triage team followed policy as mail was controlled, processed, and routed to the appropriate locations within the VSC.

Veterans' Personally Identifiable Information Not Always Safeguarded

We performed unannounced inspections of 30 (9 percent) of the 337 employees' workstations and unassigned areas located in the VSC. We found unredacted PII at 10 (33 percent) of the 30 workstations consisting of original documents, training materials, and reports. We also found PII in unassigned areas within the VSC. The following are examples of the PII found:

- A veteran's original service treatment records in one employee's desk drawer. VSC staff should have included these records in the veteran's claims folder, which was located at the St. Petersburg, Florida VARO. VA reviews service treatment records when making determinations on claims for disability benefits.
- An original document regarding the veteran's intent to appeal a previous benefit decision. VSC staff received the document on September 12, 2003, and did not take action to process the appeal.
- An original request from a veteran's service organization dated June 28, 2007, requesting the VARO provide a veteran's claims folder for their review. Our review showed that the veteran's service organization did not receive the claim file until March 31, 2009.
- A copy of a reopened claim from the spouse of a deceased veteran for widow's benefits received on July 3, 2008. We found no evidence that VSC staff processed this request.

The employees stated they had received training regarding information security policies. Management also stated the Records Management Officer and the Division Records Management Officers performed routine desk inspections. We analyzed the results of these inspections and determined management only performed inspections on 19 (6 percent) of the 337 employees workstations since VBA issued the policy on November 26, 2008. Analysis of these 19 inspections revealed that VARO staff found only one workstation in violation of policy.

Management indicated they had not conducted a 100 percent review of all workstations since the implementation of the policy. 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 lacked assurance that staff properly safeguarded veterans' PII.

Recommendation 5. *We recommend the Philadelphia VA Regional Office Director perform an immediate inspection of all employees' workstations and develop and implement a plan to*

increase the number of inspections to ensure proper safeguarding of veterans' personally identifiable information.

Management Comment

The VARO Director concurred with our recommendation. As of November 10, 2009, the VSC has completed a 100 percent review of all areas and will continue to conduct quarterly random desk audits as directed in the station's policy.

OIG Response

Management comments and actions are responsive to the recommendation.

Public Contact

The OIG inspection team reviewed fiduciary adjustments to determine if VSC staff properly appointed fiduciaries to oversee the funds of incompetent veterans and other beneficiaries. We inspected the fiduciary adjustment process from the time staff becomes aware a beneficiary may be incompetent through when the staff appoints a fiduciary to manage VA funds.

VARO Staff Inaccurately Processed Fiduciary Adjustments

VSC staff incorrectly processed 5 (19 percent) of the 26 fiduciary adjustments we reviewed. All of these processing inaccuracies affected the beneficiaries' benefits:

- VSC staff delayed making a determination regarding the veteran's ability to manage VA disability payments. Although staff properly notified the veteran regarding the proposed determination of incompetency, they delayed making a final decision for 9 months. The veteran continued to receive disability payments of $15,549 without a fiduciary to manage these funds. Further, staff withheld additional payments of $34,857 pending the appointment of a fiduciary.
- VSC staff determined a beneficiary was incompetent. However, they did not track the appointment of a fiduciary in the electronic record, losing control of the issue for 11 months. The beneficiary had benefit payments of $31,382 withheld pending appointment of a fiduciary.
- VSC staff determined a beneficiary was incompetent without affording the mandatory due process period. Due process allows the beneficiary to provide evidence to contest the determination. In addition, prior to making the incompetency determination, VSC staff did not track the issue in the electronic record, losing control of the fiduciary adjustment for approximately 14 months. The beneficiary did not receive benefit payments of $4,892 during this period.
- VSC staff incorrectly appointed a fiduciary for a veteran who was not determined to be incompetent. As a result, the fiduciary erroneously received the veteran's benefit payments of $4,242 from the time the VSC appointed the fiduciary through the date of our review.

- VSC staff delayed making a determination regarding a veteran's ability to manage VA disability payments. Although staff properly notified the veteran regarding the proposed determination of incompetency, staff delayed making a final decision for 3 months. The veteran continued to receive benefit payments of $720 pending appointment of a fiduciary.

VSC management concurred with our findings and took steps to correct these processing inaccuracies. Although the VSC provided training to fiduciary staff, RVSRs and VSRs involved with processing fiduciary adjustments did not receive training during FY 2009. Further, because of the inaccuracies we found, it appears management is not providing adequate oversight regarding fiduciary adjustments. As a result, the VARO Director lacked assurance that VSC staff accurately processed fiduciary adjustments.

Recommendation 6. *We recommend the Philadelphia VA Regional Office Director implement a plan to increase oversight and provide training to ensure accurate and timely processing of fiduciary adjustments.*

Management Comment

The VARO Director concurred with our recommendation and provided comment. The Director indicated the fiduciary unit received training on fiduciary adjustments in February, June, and November 2009. Staff provided refresher training to the Post team when the OIG was on station in October 2009. VSC staff is responsible for 3,231 fiduciary records in the Tri-state area of responsibility. The OIG reviewed 26 records, finding 5 errors. Further, coaches are directed through the VSC Workload Management Plan to provide oversight in the processing of incompetency decisions. Weekly reviews utilizing VETSNET Operations Reports ensure these claims are being worked timely.

OIG Response

Management comments and actions are responsive to the recommendation. The Director is correct in stating staff received training on topics related to processing fiduciary claims such as scheduling field exams, accounting requirements, and selecting fiduciaries. However, our analysis of the VARO training calendar for FY 2009 revealed RVSRs and VSRs did not receive specific training regarding determinations as to whether a beneficiary is competent to handle VA funds and methods to track and timely process fiduciary claims. In addition, the 26 records reviewed are a randomly selected representative sample of fiduciary claims processed at the Philadelphia VARO. We will evaluate the effectiveness of the most recent training and additional oversight during a future follow-up site inspection.

Appendix A

VARO Profile

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

Resources. As of April 2009, the Philadelphia VARO and Insurance Center had a staffing level of 1,141.2 Full-Time Employees. Of the 1,141.2 Full-Time Employees within the VARO, 312 (27 percent) were assigned to the VSC and 25 (2 percent) were assigned to the Rating Resource Center.

Workload. As of August 2009, the VARO had 7,182 pending C&P claims. Further, as of August 2009, it was taking the VARO an average of 121.6 days to complete C&P claims, which is 46.8 days less than the national target of 168.4 days. Accuracy for C&P rating-related issues was 85.5 percent, below the national standard of 90 percent. Accuracy for C&P authorization-related issues was 95.9 percent, above the national standard of 95 percent.

Scope of the Inspection

Scope. 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.

The review of fiduciary adjustments and disability claims processing for PTSD, TBI, and disabilities related to herbicide exposure covered the period April–June 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 October 2008–September 2009. For our review of claim dates, we selected claims pending as of October 2009 within the VARO. 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: **February 19, 2010**

From: **Director, VA Regional Office and Insurance Center, Philadelphia**

Thru: **Eastern Area Director**

Subject: **Inspection of VAROIC Philadelphia, PA**

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

1. Attached are the Philadelphia VAROIC's comments on the OIG Draft Report: Inspection of VAROIC Philadelphia.

2. Questions may be referred to Zavia Scott, Program Analyst, at 215-381-3020.

(original signed by:)

Thomas M. Lastowka

Director

Attachment

Appendix B

VARO Director's Comments

Philadelphia Regional Office and Insurance Center Response

OIG Recommendations

Recommendation 1: *We recommend the Philadelphia VA Regional Office Director strengthen controls to ensure staff correctly establish and monitor future examinations for temporary 100% evaluations.*

Response: Concur. The Veterans Service Center (VSC) initiated the review of all claims identified in the temporary 100% evaluation category while the OIG was on station. The results of our review required 19 future exams, reduced the benefits in 15 cases, and rendered 2 permanent and total (P&T) decisions. On October 27, 2009, we requested that the OIG provide us with a listing of the remaining universe of temporary 100% evaluation claims where action is necessary. The OIG provided us with that list on February 1, 2010. A review of this listing is in progress.

The VSC has implemented a change in processing future examinations. Post Determination Veterans Service Representatives (VSR) are now required to print the VETSNET screen identifying the future exam and file this document in the claims folder. Additional refresher training was conducted with Post Determination VSRs on February 3, 2010.

Based on OIG's audit of temporary 100% evaluations, a problem was identified with future exams. The OIG identified cases in which a rating was made with a future exam indicated; however, the date of that future examination was not retained in the electronic record. Based on this finding, the ROIC contacted C&P Service for guidance. Guidance received from C&P Service during this time resulted in training to our staff on October 26, 2009. This finding and contact with C&P Service also resulted in the C&P Bulletin guidance of November 2009 which advised stations of proper system input for these types of cases.

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

Response: Concur. The VSC has taken action on all cases identified during the OIG visit of October 2009. On October 27, 2009, we requested that the OIG provide us with a listing of the remaining universe of temporary 100% evaluation claims where action may be necessary. The OIG provided us with that list on February 1, 2010. A review of that listing is in progress. As appropriate, end products have been established and exams requested on all files where our review has disclosed that further action is required.

Recommendation 3: *We recommend the Philadelphia VA Regional Office Director coordinate with VA medical staff responsible for completing examinations for traumatic brain injury to ensure examiners use the most current examination worksheets.*

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VARO Director's Comments

Response: Concur. The VSC review of the claims involving TBI revealed that some of the claims were pending at the time of the change in the TBI worksheet released with FL 08-34, dated October 10, 2008. The VSC conducted extensive training on the subject in April 2009 and May 2009, for all RVSRs and DROs. The Philadelphia VAROIC Director held conference calls with the Philadelphia VAMC Director/Assistant Director on October 1, 2009 and on January 14, 2010, concerning insufficient examinations. In addition, our liaison representatives made contact with each of the VAMC facilities in our jurisdiction to ensure compliance with the use of the newest exam sheet. At the time of the OIG visit, the Rating Team Coaches provided refresher training to the RVSRs and DROs on the proper exam sheet and use of the text generator on October 26-28, 2009. Our review of the 7 TBI claims identified by the OIG has resulted in a correction to the procedural error in 1 claim, 2 claims are still pending determination at the VAMC, 3 claims have resulted in increased benefits to our Veterans, and 1 claim is pending a rating decision.

Recommendation 4: *We recommend the Philadelphia VA Regional Office Director implement training to ensure Rating Veterans Service Representatives can recognize inadequate traumatic brain injury examinations and accurately process claims related to herbicide exposure.*

Response: Concur. At the time of the OIG visit, the Rating Team Coaches provided training to the RVSRs and DROs on the proper exam sheet and the use of the text generator (October 26-28, 2009). Refresher training on TBI examinations and claims related to herbicide exposure was conducted for RVSRs and DROs on February 9, 2010.

Recommendation 5*: We recommend the Philadelphia VA Regional Office Director perform an immediate inspection of all employees' workstations and develop and implement a plan to increase the number of inspections to ensure proper safeguarding of veterans' personally identifiable information.*

Response: Concur. On October 20, 2009, inspections of employee workstations began while the OIG was still on station. As of November 10, 2009, the VSC has completed a 100% review of all areas. In addition to the instructions provided by the station RMO, the VSC Coaches review common areas on a quarterly basis to ensure personally identifiable information (PII) is not placed in vacant cabinets or workstations. We continue to conduct quarterly random desk audits as directed in the station's policy.

Recommendation 6: *We recommend the Philadelphia VA Regional Office Director implement a plan to increase oversight and provide training to ensure accurate and timely processing of fiduciary adjustments.*

Response: Concur, in part. The VSC is responsible for 3,231 fiduciary records in our Tri-state area of responsibility. The OIG requested a review of 26 records containing fiduciary adjustments where an end product 290 was credited to the station. The OIG review disclosed 5 errors; 3 of the errors occurred while the claim was pending due process under end product 600 and 2 errors occurred in the actual appointment of the fiduciary. The OIG further stated that

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VARO Director's Comments

training on processing fiduciary adjustments did not occur in 2009. During 2009, training was provided to all members of the Fiduciary Team in February and June. Training was also conducted October 26-27, 2009, within the Post Determination teams as the errors were called and while the OIG was still on station. Refresher training was provided to the Fiduciary Team in November 2009. Further, coaches are directed through the VSC Workload Management Plan to provide oversight in the processing of end products 600 and 290. Weekly reviews utilizing VETSNET Operations Reports ensure these claims are being worked timely.

Appendix C

Inspection Summary

11 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 correctly 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 was 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	
Management Controls			
6. 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	
7. 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	
8. 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			
9. 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	
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
Public Contact			
11. 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	Karen Gooden Kristine Abramo Joseph Brett Byrd Kelly Crawford Kerri Leggiero-Yglesias

Appendix E

Report Distribution

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This report will be available in the near future on the OIG's website at http://www.va.gov/oig/publications/reports-list.asp. This report will remain on the OIG website for at least 2 fiscal years after it is issued.