VA Office of Inspector General

OFFICE OF AUDITS & EVALUATIONS

Inspection of the VA Regional Office Boston, MA

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ACRONYMS AND ABBREVIATIONS

COVERS	Control of Veterans Records System
NOD	Notice of Disagreement
OIG	Office of Inspector General
PTSD	Post-Traumatic Stress Disorder
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
STAR	Systematic Technical Accuracy Review
STR	Service Treatment Records
TBI	Traumatic Brain Injury
VACOLS	Veterans Appeals Control and Locator System
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the VA Regional Office, Boston, MA

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 Boston VARO correctly processed post-traumatic stress disorder (PTSD) disability claims. Management ensured staff followed the Veterans Benefits Administration (VBA) policy to establish correct dates of claims in the electronic record. Further, staff corrected all errors that VBA's Systematic Technical Accuracy Review (STAR) program identified.

VARO management needs to improve the control and accuracy of processing temporary 100 percent evaluations, traumatic brain injury (TBI) claims, and herbicide exposure-related claims. Overall, VARO staff did not accurately process 42 (35 percent) of the 120 disability claims reviewed.

Management also needs to strengthen controls over recording Notices of Disagreement (NODs) for appealed claims, timely completing Systematic Analyses of Operations (SAOs), and processing mail and final competency determinations.

What We Recommended

We recommended that Boston VARO management review all temporary 100 percent evaluations to determine if reevaluations are required and take appropriate action. Management needs to implement controls to ensure VSC staff establish diaries to request medical examinations for temporary 100 percent disability reevaluations. Further, we recommended management provide refresher training on the proper procedures for processing TBI and herbicide exposure-related disability claims, and implement a plan to have an additional level of review prior to finalizing claims decisions.

We also recommended that Boston VARO management strengthen controls to ensure timely establishment of NODs in the Veterans Appeals Control and Locator System (VACOLS). Additionally, we recommended that Boston VARO management implement plans to ensure timely and complete preparation of SAOs, and accurate and timely processing of incoming mail.

Agency Comments

The Director of the Boston 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
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INTRODUCTION

Objective

The Benefits Inspection Program is part of the efforts of the Office of Inspector General (OIG) to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Division contributes to improved management of benefits processing activities and veterans' services by conducting onsite inspections at VAROs. These independent inspections provide recurring oversight focused on disability compensation claims processing and performance of VSC operations. The objectives of the inspections are to:

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

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

Scope of Inspection

In August 2010, the OIG conducted an inspection of the Boston VARO. The inspection focused on 5 protocol areas examining 10 operational activities. The five protocol areas were disability claims processing, data integrity, management controls, workload management, and eligibility determinations.

We reviewed 90 (22 percent) of 414 disability claims related to PTSD, TBI, and herbicide exposure that the VARO completed during April to June 2010. In addition, we reviewed 30 (21 percent) of 146 rating decisions where VARO staff granted temporary 100 percent evaluations for at least 18 months, generally the longest period a temporary 100 percent evaluation may be assigned under VA policy without review.

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

RESULTS AND RECOMMENDATIONS

1. Disability Claims Processing

The OIG inspection team focused on disability claims processing related to temporary 100 percent evaluations, PTSD, TBI, and herbicide exposure. We evaluated claims processing accuracy and its impact on veterans' benefits.

Finding **VARO Staff Need To Improve Disability Claims Processing Accuracy**

The Boston VARO needs to improve the accuracy of disability claims processing. VARO staff incorrectly processed 42 (35 percent) of the total 120 disability claims reviewed. VARO management concurred with our findings and initiated action to correct the inaccuracies identified.

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

Table

Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Evaluations	30	25	4	21
PTSD	30	0	0	0
TBI	30	11	5	6
Disabilities Related to Herbicide Exposure	30	6	4	2
Total	**120**	**42**	**13**	**29**

Temporary 100 Percent Evaluations

VARO staff incorrectly processed 25 (83 percent) of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent evaluation for service-connected disabilities needing surgery or specific treatment. At the end of a mandated period of convalescence or cessation of treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability benefits.

Based on analysis of available medical evidence, 4 of the 25 processing inaccuracies affected veterans' benefits—all 4 involved overpayments

totaling $106,133. Two examples of the most significant overpayments follow:

- VARO staff did not request a future medical examination to evaluate a veteran's lung cancer. Medical evidence in the claims folder warranted a reduction in benefits as of May 1, 2009. As a result, VA overpaid the veteran a total of $40,800 over a period of 1 year and 4 months.
- VARO staff did not request a future medical examination to evaluate a veteran's bladder cancer. Medical evidence in the claims folder warranted a reduction in benefits as of June 1, 2009. As a result, VA overpaid the veteran a total of $40,376 over a period of 1 year and 2 months.

The remaining 21 inaccuracies had the potential to affect veterans' benefits. Following are summaries of these inaccuracies:

- In 14 cases, VSC staff did not schedule the follow-up medical examinations needed to determine whether the temporary 100 percent evaluations should continue.
- In three cases, VSC staff were not timely requesting reexaminations. The delay in requesting the reexaminations ranged from 7 months to 1 year and 3 months.
- In two cases, the Rating Veterans Service Representatives (RVSR) continued the 100 percent evaluations without requiring future examinations. In making these decisions, the RVSRs did not consider entitlement to the additional benefit of Dependents' Educational Assistance as required by VBA policy.
- In one case, the RVSR continued the 100 percent evaluation; however, the rating did not indicate whether a future examination was required.
- In one case, the RVSR proposed reducing the evaluation of a veteran's condition based on an examination conducted 30 days after the cessation of treatment. According to VBA's policy, VSC staff are to request reexaminations 6 months following cessation of treatment.

We could not determine if the 14 temporary 100 percent disability determinations would have continued because the veterans' claims folders did not contain evidence of the medical examinations needed to reevaluate each case. An average of 3 years and 4 months elapsed from the time staff should have scheduled these medical examinations until the date of our inspection—the date staff ultimately ordered the examinations to obtain the necessary medical evidence. The delays ranged from 3 months to 14 years and 11 months.

For temporary 100 percent evaluations, including those where rating decisions do not change a veteran's payment amount (confirmed and continued evaluations), VSC staff must input suspense diaries in VBA's electronic system. A diary is a processing command that establishes a date when VSC staff must schedule reexaminations. As diaries mature, the electronic system generates reminder notifications to alert VSC staff to schedule the reexaminations.

Eight of the 25 temporary 100 percent errors resulted from staff not establishing diaries for confirmed and continued evaluations. VSC staff stated that until just prior to our inspection, they were unaware of the requirement to input the suspense diaries. The Post Decision Team supervisor stated, and we verified, the office had no procedure in place that required senior staff members to review implementation of confirmed and continued rating decisions. As such, oversight did not occur to ensure staff properly established diaries for these decisions.

PTSD Claims

VARO staff correctly processed all 30 PTSD claims reviewed. Therefore, we made no recommendations for improvement in this area.

TBI Claims

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

VARO staff incorrectly processed 11 (37 percent) of 30 TBI claims. Five of the 11 processing inaccuracies affected veterans' benefits—2 involved underpayments totaling $41,283 and 3 involved overpayments totaling $30,946. Examples of the most significant underpayment and overpayment follow:

- An RVSR incorrectly evaluated the residual TBI-related disabilities as 70 percent disabling. The medical examination results showed these residual TBI-related disabilities were 100 percent disabling. As a result, the veteran was underpaid $31,797 over a period of 2 years and 1 month.
- An RVSR continued granting service connection for residual TBI-related disabilities without evidence showing the veteran actually experienced a TBI. Additionally, the rating decision increased the evaluation of TBI-related disabilities from 0 to 100 percent. As a result, the veteran was overpaid $16,995 over a period of 1 year and 3 months.

Following are details on the remaining six TBI inaccuracies that had the potential to affect veterans' benefits.

- In two cases, RVSRs denied claims for TBI-related disabilities without requesting evidence from the veteran as outlined in VA regulations. Although there was no evidence to support granting service connection for residuals of a TBI, the veterans may have submitted it if provided the opportunity.
- In one case, an RVSR incorrectly denied a combat veteran service connection for residuals of a TBI without a medical opinion to say no link existed between the medical diagnosis and the in-service injury. The examiner's opinion might have provided the link necessary to approve the benefits claimed.
- In one case, an RVSR evaluated residual TBI-related disabilities using an inadequate VA medical examination. Additionally, the RVSR failed to assign a separate evaluation for migraine headaches diagnosed at the VA medical examination. These errors do not immediately affect this veteran's benefits; however, failure to assign separate evaluations may affect future evaluations for additional benefits.
- In one case, an RVSR granted service connection for residuals of a TBI without a medical opinion linking the TBI-related residuals to an in-service event or injury. Neither VSC staff nor we can determine if the veteran's TBI-related residuals are service-connected without further clarification from the medical examiner.
- In one case, an RVSR granted service connection for residuals of a TBI without evidence indicating the veteran suffered an injury during service. This rating did not affect the veteran's monthly benefits, but it may affect future evaluations for additional benefits.

Generally, errors associated with TBI claims processing occurred because of a lack of training. Interviews with VSC management and staff revealed that the last training regarding TBI occurred on January 29, 2009. The Assistant VSC Manager stated she was aware that RVSRs felt TBI claims were confusing and difficult. According to VSC supervisory staff, RVSRs had not communicated any problems related to TBI claims processing. Additionally, VSC supervisory staff acknowledged a limited understanding of rating procedures due to a lack of prior RVSR experience. As a result of this lack of training and experience, veterans did not always receive correct healthcare entitlements or benefits payments.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 6 (20 percent) of 30 herbicide exposure-related claims reviewed. Four of the six processing inaccuracies affected veterans' benefits—two involved underpayments totaling $16,528 and two involved overpayments totaling $9,665. Examples of the most significant underpayment and overpayment follow:

- An RVSR failed to grant service connection for all secondary diabetic complications diagnosed at the VA exam. As a result, the veteran was underpaid $15,760 over a period of 1 year and 4 months.
- An RVSR incorrectly confirmed and continued a 40 percent diabetes evaluation. As a result, the veteran was overpaid $8,468 over a period of 3 years and 7 months.

Following are details on the two remaining herbicide exposure-related inaccuracies that had the potential to affect veterans' benefits.

- In one case, an RVSR failed to obtain the current VA medical examination results before evaluating the veteran's service-connected diabetes. This oversight did not affect the veteran's monthly benefits, but it may affect future evaluations for additional benefits.
- In one case, an RVSR failed to grant service connection for a diabetes-related complication diagnosed at the VA medical examination. This rating did not affect the veteran's monthly benefits, but it may affect future evaluations for additional benefits.

Generally, errors occurred because management did not provide adequate oversight of herbicide exposure-related claims. The VSC supervisory staff stated that RVSRs have expressed concerns over the complexity of diabetes claims and their ability to meet individual performance standards. However, the VSC supervisory staff responsible for quality reviews acknowledged being unaware that RVSRs were missing secondary conditions. VSC supervisory staff also had not indentified any error trends in processing herbicide exposure-related claims. Because of this lack of management oversight, veterans did not always receive correct healthcare entitlements or benefits payments.

Recommendations

1. *We recommend the Boston VA Regional Office Director conduct a review of all temporary 100 percent determinations under the regional office's jurisdiction to determine if reevaluations are required and, if they are, take appropriate action.*
2. *We recommend the Boston VA Regional Office Director implement controls to ensure staff establish suspense diaries for temporary 100 percent disability evaluations.*
3. *We recommend the Boston VA Regional Office Director conduct refresher training to ensure Rating Veterans Service Representatives properly evaluate disabilities related to traumatic brain injuries and herbicide exposure-related claims.*
4. *We recommend the Boston VA Regional Office Director implement a plan to provide an additional level of review prior to finalizing decisions*

on traumatic brain injury and herbicide exposure-related claims to ensure accurate benefit payments.

Management Comments

The VARO Director concurred with our recommendations and discussed actions taken to improve claims processing accuracy. VSC staff reviewed all remaining claims that we did not include in our sample and determined 56 of 107 of them did not have controls in place to ensure staff scheduled future examinations. VSC staff received training on the proper procedures for establishing future suspense diaries and on reviewing and authorizing awards where rating decisions indicate future examinations are required. The Director indicated authorizers would maintain a log of all awards requiring future examinations and management would conduct periodic audits to ensure compliance. Further, the Director amended VSC's statistical quality control reviews to ensure compliance with future examination procedures.

The Director stated that in November 2010, VSC staff received training on procedures for processing herbicide exposure-related claims and TBI claims. He reported the VSC had scheduled for January 2011 training on complications due to diabetes. He said VSC staff would receive additional training on processing TBI claims in August 2011. Also, VARO management implemented a Rating Quality Team to improve the overall quality of disability claims processing. The Director amended the VSC's quality control procedures to require a second review for accuracy of all herbicide exposure-related claims and TBI claims.

The Director did not concur with our characterization of the VARO's claims processing accuracy in a bar graph and related discussions in a draft of this report. He said that the VSC's staff review of the remaining temporary 100 percent disability evaluations showed a 52 percent error rate—a much lower error rate than the 83 percent we found in our sample. As such, the Director requested we add an appendix to the report outlining our sample selection methodology. Further, he asked that we include in our report a copy of a letter he sent to the OIG Project Manager requesting specific data filters we used to identify the sub-population of cases at risk of having errors.

OIG Response

Management comments and actions are responsive to the recommendations. We acknowledge that the Director obtained a lower error than we did in our sample of temporary 100 percent disability claims. In using a different sample population and possibly different criteria, it was inevitable that the resulting error rates would be different. However, regardless of the different outcomes, both our reviews disclosed an unacceptable rate of error in temporary 100 percent disability claims processing and the need for corrective action. The training, guidance, and quality control initiatives that the Director outlined are positive steps toward effecting improvement.

We do not believe it would be appropriate to include in our report a copy of the Director's letter requesting details on our review methodology. We will nonetheless forward to the Director, under separate cover, information on our sample selection approach. We will likewise provide other VARO officials our sample selection methodology prior to conducting future Benefits Inspections.

2. Data Integrity

We analyzed claims folders to determine if the VARO is following VBA policy to establish effective dates and dates of claims in electronic records and to timely record NODs in VACOLS.

Effective Dates

Generally, an effective date indicates when entitlement to a specific benefit arose. VARO staff incorrectly established an effective date for 4 (3 percent) of 120 disability claims we reviewed. All four errors affected veterans' benefits—two involved overpayments totaling $7,968 and one involved an underpayment totaling $21,637. The amount of the underpayment related to the fourth error could not be determined due to lack of medical evidence. Details on the most significant underpayment and overpayment related to incorrect effective dates follow:

- An RVSR granted an incorrect effective date for PTSD. The VARO received the veteran's original claim on January 20, 2005 and denied service connection for PTSD. The veteran's appeal was pending at the time of our review. The RVSR granted service connection for PTSD effective May 14, 2009, the date the VARO received a request from the veteran to reopen his claim. VA regulations state the effective date is the original date of claim. As a result, the veteran was underpaid $21,637 over a period of 4 years and 4 months.
- An RVSR incorrectly granted service connection for a veteran's prostate cancer effective August 15, 2008, approximately 2 months prior to the actual receipt of the claim. This occurred because the veteran had a claim pending for approximately 2 months for other disabilities at the time the VARO received the veteran's claim for prostate cancer on October 7, 2008. VA regulations state the effective date of benefits is the claim receipt date or the date evidence revealed the disability existed, whichever is later. As a result, the veteran was overpaid $5,520 over a period of 2 months.

Because we found only 4 inaccuracies out of a total of 120 claims, we determined the VARO is generally following VBA policy regarding data integrity. As such, we made no recommendation for improvement in this area.

Dates of Claim

In addition to establishing the timeframe for benefits entitlement, VBA generally uses a date of claim to indicate when a document arrives at a VA facility. VBA relies on accurate dates of claim to establish and track key performance measures, including the average days to complete a claim.

VARO staff established the correct dates of claim in the electronic records for all 30 claims reviewed. These claims were pending processing from 31 to 60 days at the time of our inspection. As a result, we determined the VARO is following VBA policy regarding dates of claims and we made no recommendations for improvement in this area.

Notices of Disagreement

An NOD is a written communication from a claimant expressing dissatisfaction or disagreement with a benefits decision and a desire to contest the decision. An NOD represents the first step in the appeals process. VACOLS is a computer application that allows VARO staff to control and track a veteran's appeal and manage the pending appeals workload. VBA policy states staff must create a VACOLS record within 7 days of receiving an NOD.

Accurate and timely recording of NODs is required to ensure appeals move through the appellate process expeditiously. VARO staff need to strengthen controls over recording NODs in VACOLS.

Finding Controls over Recording Notices of Disagreement Need Strengthening

The VARO's Appeals Team did not consistently record NODs in VACOLS within VBA's 7-day standard. VARO staff exceeded VBA's 7-day standard for 8 (27 percent) of the 30 NODs we reviewed. It took staff an average of 18 days to record these eight disagreements in VACOLS. The most untimely action occurred when staff did not create a record for 34 days. This delay occurred because VSC supervisory personnel and staff were unaware of the 7-day standard. VSC staff's untimely recording of NODs in VACOLS affects data integrity and misrepresents VARO performance.

VSC supervisory personnel and staff stated they were unaware of the VBA 7-day standard for entering NODs into VACOLS. In addition, a VSC supervisor did not receive any formal appeals training. According to the Assistant VSC Manager, she was aware of the 7-day standard, but was unaware of the supervisors lack of knowledge of the standard.

As of August 2010, the VARO averaged 23 days to control NODs, exceeding VBA's goal by 16 days. In addition to improving appeals control time, overall timeliness of NODs pending completion needs improvement. For August 2010, pending NODs averaged 246 days—38 days over the national average of 208 days.

Data integrity issues make it difficult for VARO and senior VBA leadership to accurately measure and monitor VARO performance. Further, VBA's National Call Centers rely upon VACOLS information to provide accurate customer service to veterans. Unnecessary delays in controlling NODs affect national performance measures for NOD inventory and timeliness.

Recommendation

5. *We recommend the Boston VA Regional Office Director develop and implement a plan to ensure staff record Notices of Disagreement in the Veterans Appeals Control and Locator System within 7 days as required by VBA policy.*

Management Comments

The VARO Director concurred with our recommendation. Management provided training to the Appeals Team Supervisor and appropriate Appeals Team staff on the timeliness standard and proper procedures for controlling NODs. Further, the Director modified local procedures to strengthen compliance and oversight.

OIG Response

Management comments and actions are responsive to the recommendation.

3. Management Controls

We assessed management controls to determine if VARO management adhered to VBA policy regarding correction of errors identified by VBA's STAR staff. Further, we assessed controls to determine if VARO management accurately and timely completed SAOs. We determined management needs to improve oversight to ensure SAOs are timely and complete.

Systematic Technical Accuracy Review

The STAR Program is VBA's multi-faceted quality assurance program to ensure that veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that the VARO take corrective action on errors that STAR identifies. VARO staff adhered to VBA policies by taking corrective action on all 29 errors identified by VBA's STAR program. Therefore, we made no recommendations for improvement in this area.

Systematic Analysis of Operations

An SAO is a formal analysis of a VSC organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish an annual SAO schedule designating the staff required to complete the SAOs by specific dates.

Finding — Improved Oversight Is Needed To Ensure Timely Completion of SAOs

The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 12 annual SAOs. The VARO completed 7 (58 percent) of the 12 SAOs later than scheduled. For example, management did not complete the Appeals SAO or follow VBA policy governing VACOLS. Furthermore, the VARO's workload management plan did not incorporate provisions to ensure timely entry of NODs in VACOLS. If management had completed the required SAO on time, it might have prevented unnecessary delays in the Appeals process.

The VSC Manager stated his primary focus was ensuring supervisors were writing quality SAOs. The Assistant VSC Manager shared this opinion. The VSC Manager accepted responsibility for the missing and deficient SAOs stating that he did not always have the time to review them due to shifting priorities. The delay in completing SAOs is attributable to the station's lack of VSC management oversight of the SAO process.

Further, 2 (17 percent) of the 12 SAOs were incomplete at of the time of our inspection. VARO management did not provide adequate oversight to ensure VSC staff addressed all required elements in accordance with VBA policy. As a result of these oversight issues, management may not have identified existing or potential problems for corrective actions to improve VSC operations.

Recommendation

6. *We recommend the Boston VA Regional Office Director develop and implement a plan to ensure staff complete Systematic Analyses of Operations timely and address all required elements.*

Management Comments

The VARO Director concurred with our recommendation. However, the Director felt the finding was misleading because the seven late SAOs were pending division-level management review and concurrence. He stated that although timeliness of SAOs is a concern, management is more concerned with the depth and quality of the analysis. The Director indicated VSC division-level management coordination with supervisors assigned to complete SAOs is considerable, given their lack of supervisory experience. The Director has emphasized to VSC division management the importance of timely completing SAOs.

The VARO Director also did not agree with the wording of our recommendation regarding SAO accuracy in a draft of this report. He indicated we did not address the quality of research or analysis in the SAOs and therefore lacked the basis for discussing SAO accuracy.

OIG Response

Management's action reinforcing the importance of SAO timeliness is responsive to the recommendation. We recognize that depth and quality of analysis are important; however, completing SAOs timely is also vital. At the time of our review, seven SAOs were late by an average of over 4 months from the day they were due for completion. Two were scheduled for completion in January 2010 and one had a due date of March 2010. The analysis conducted as part of an SAO is intended to address problems or potential problem areas and recommend corrective actions. When VSC management do not ensure SAOs are timely completed, areas of concern are not properly addressed, recommendations for corrective action are delayed, and problems continue.

Further, we agree with the Director that a review of accuracy in addition to timeliness and completion of SAOs would be beneficial. However, we lack the staff resources to review the detailed documentation supporting SAOs. Therefore, we changed the language of our report finding and recommendation to reflect the scope of our inspection work related to the accuracy of SAOs more accurately.

4. Workload Management

We assessed controls over VARO mailroom operations to ensure staff timely and accurately processed incoming mail. Further, we assessed the VSC's Triage Team mail processing procedures to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy. Controls over VARO mailroom operations and Triage Team mail processing procedures need strengthening.

Mail Room Operations

VBA policy states staff will open, date stamp, and route all mail to the appropriate locations within 4–6 hours of receipt at the VARO. The Boston VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division.

Finding Controls over Mail Processing Need Strengthening

VARO mailroom staff did not always date stamp mail the same day it arrived in the mailroom as required. This delay occurred because the Support Service Division management and mailroom staff were unaware of VBA's policy. As a result, beneficiaries may not have received accurate benefit payments.

According to the mailroom staff, approximately 1 to 2 days each month the VARO will receive a large volume of mail. When this occurs, the mailroom is unable to process all of the mail on the same day. As a result, some mail is processed and date stamped the following morning. The mailroom staff

expressed a lack of awareness of how delayed date stamping can adversely affect dates of claim.

Because the VARO did not always properly date stamp incoming mail, beneficiaries may not have been paid benefits on the correct dates. Generally, a benefit payment date is the first of the month following the date stamped on the incoming claim. For example, if mailroom staff properly date stamp claims-related mail received on January 31, the benefits would be payable on February 1. However, if mailroom staff improperly date stamp this same mail on February 1, the payment date would be March 1 and the VSC staff would inadvertently underpay the beneficiary by 1 month.

Neither VARO employees nor we could identify any veterans' claims affected by improper date stamping of mail. However, because mailroom staff does not always correctly date stamp all mail on the day it arrives, VA could potentially underpay veterans by 1 month.

Triage Mail Processing Procedures

VARO staff are required to use VBA's tracking system, Control of Veterans Records System (COVERS), to electronically track veterans' claims folders and control search mail. VBA defines search mail as active claims-related mail waiting to be associated with a veteran's claims folder. VBA defines essential mail as mail that has evidentiary value, which should be filed in the claims folder. Non-essential returned mail is mail that has no evidentiary value, such as letters provided to veterans informing them of cost of living increases. If a returned envelope contains a forwarding address, VSC staff must update VA systems to show the new address and resend the correspondence. Staff may destroy returned mail that does not contain a forwarding address.

Finding Triage Team Mail Management Procedures Need Strengthening

Triage Team members did not manage essential and non-essential mail according to VBA policy. We found approximately 4,000 pieces of unprocessed mail in containers under tables located in the VARO mailroom with some pieces date stamped in 2008. The majority of the 4,000 pieces of mail was non-essential returned mail; however, we also identified some essential mail such as marital questionnaires and dependency questionnaires. VSC supervisory personnel expressed a lack of awareness of this mail. Additionally, the Support Service Division Chief and mailroom employee stated they were unsure of how to process this mail. This occurred because supervisory personnel did not provide appropriate oversight of all essential and non-essential mail processing. The potential effect of not processing essential mail is a delay in claims processing and ultimately, incorrect benefits decisions.

Additionally, Triage Team staff did not always handle original Service Treatment Records (STRs) according to VBA policy. STRs were found improperly stored in cabinets labeled "Military Files." This occurred because the Boston VARO workload management plan incorrectly directed storage of STRs in such cabinets. VBA policy requires STRs to be associated with claims folders or stored at the VA's Records Management Center. Of the 30 STRs reviewed, staff stored 28 (93 percent) in the military file cabinets for more than 90 days, with the oldest being received by the VARO on October 17, 2007. Furthermore, 8 (27 percent) of the 30 STRs had claims for benefits either pending or decided without the RVSR reviewing the original STRs. VBA policy requires review of original STRs as part of claims processing. In one example, an RVSR denied service connection for all of the veteran's claimed conditions without considering the original STRs which were improperly stored. We provided this file to VSC management to reevaluate the veteran's claim.

Finally, Triage Team staff did not always manage search mail according to VBA policy. For 4 (13 percent) of 30 pieces of search mail reviewed, staff did not properly use COVERS to ensure timely processing and adequate control of it. These lapses occurred because the mail plan did not incorporate procedures for the Triage Team supervisor to oversee the search mail process. As a result, beneficiaries may not receive accurate payments. In one example, Triage staff received medical evidence on June 3, 2010, while the claims folder was located at the VA hospital pending a medical examination. The station received the file on June 14, 2010, but at the time of our inspection, the evidence was not properly marked for search in COVERS.

VSC management acknowledged weaknesses associated with mail processing. Specifically, the plan governing mail processing does not incorporate oversight procedures for controlling essential mail, reviewing military files, or managing search mail. Consequently, RVSRs may not have all available evidence when making disability determinations. Untimely association of STRs, search mail, or other essential mail with veterans' claims folders can cause delays in processing disability claims. As a result, beneficiaries may not receive accurate and timely benefit payments.

Recommendations

7. *We recommend the Boston VA Regional Office Director develop and implement controls to ensure Support Services Division staff process and date stamp all incoming mail the same day it arrives in the mailroom.*
8. *We recommend the Boston VA Regional Office Director develop and implement a plan to ensure proper oversight and control of all returned mail.*

9. *We recommend the Boston VA Regional Office Director add steps to the workload management plan to ensure proper handling of Service Treatment Records.*

10. *We recommend the Boston VA Regional Office Director amend the mail plan to incorporate procedures for management oversight and control of search mail.*

Management Comments

The VARO Director concurred with our recommendations. The Director provided training to the Support Services Division staff on the proper processing of incoming mail and to the Triage Team staff on procedures for handling returned mail. In January 2011, all VSC employees will receive training on search mail procedures and COVERS compliance. Further, in February 2011 all VSRs and Claims Assistants will receive refresher training on the proper management of Service Treatment Records.

Additionally, the Support Services Division Chief coordinated with the VSC Triage Team and the VARO Records Management Officer to review existing policy and reinforce proper procedures for processing returned mail. The Director has arranged to shift employee resources from other divisions in the VARO to assist with surges in mailroom workload at the end of each month. Division management has also increased oversight, including periodic random audits of mailroom activities. The Director ensured review and processing of the backlog of mail identified during our inspection. Further, the Director indicated the Workload Management Plan is undergoing extensive revisions, which will comply with our recommendations.

OIG Response

Management comments and actions are responsive to the recommendations.

5. Eligibility Determinations

Competency Determinations

VA must consider beneficiary competency in every case involving a mental health condition that is totally disabling or when evidence raises questions about a beneficiary's mental capacity to manage his or her affairs. The Fiduciary Unit supports implementation of competency determinations by appointing a fiduciary—a third party that assists in managing funds for an incompetent beneficiary. We reviewed competency determinations completed by the VSC Decision Team to ensure staff completed them accurately and timely. Delays in making these determinations ultimately affect the Fiduciary Unit's ability to be timely in appointing fiduciaries.

Finding Controls over Competency Determinations Need Strengthening

VARO staff unnecessarily delayed making final decisions in 6 (35 percent) of the 17 incompetency determinations completed during April–June 2010.

Delays ranged from 19 to 299 days, with an average completion time of 95 days. Delays occurred because VSC staff were unaware of the timeliness criteria. The risk of incompetent beneficiaries receiving benefit payments without fiduciaries assigned to manage those funds increases when staff do not complete competency determinations immediately.

VBA policy requires staff to obtain clear and convincing medical evidence that a beneficiary is incapable of managing his or her affairs prior to making a final competency decision. The policy allows the beneficiary a 65-day due process period to submit the evidence showing an ability to manage funds and other personal affairs. At the end of the due process period, VARO staff must take immediate action to determine if the beneficiary is competent.

In the absence of a definition of "immediate," we allowed 14 calendar days after the due process period to determine if staff were timely in completing a competency decision. We considered this a reasonable period to control, prioritize, and finalize these types of cases.

Using our interpretation of immediate, the most significant case we identified occurred when VARO staff unnecessarily delayed making a final incompetency decision for a veteran for approximately 10 months. During this period, the veteran received $15,470 in disability payments. While the veteran was entitled to these payments, fiduciary stewardship was not in place to ensure effective funds management and the welfare of the veteran.

VARO management and staff stated they were unaware of VBA's policy requiring immediate action to determine competency after the 65-day due process period. Although VSC supervisory staff reportedly reviewed all due process cases that had been pending for more than 100 days, these cases were already 35 days past the 65-day due process period when identified. As a result, incompetent beneficiaries received benefits payments for extended periods despite being determined incapable of managing these funds effectively.

We recommended in an August 16, 2010, Management Advisory Memorandum that VBA establish a clear standard for the timely completion of final competency determinations. We plan to raise this issue to senior management in our fiscal year 2010 summary. Therefore, we make no recommendation to the Director of the VARO regarding this issue.

Appendix A VARO Profile and Scope of Inspection

Organization

The Boston VARO is responsible for delivering non-medical VA benefits and services to veterans and their families in Massachusetts. The VARO fulfills these responsibilities by administering compensation and pension benefits, vocational rehabilitation and employment assistance, and outreach activities.

Resources

As of July 2010, the Boston VARO had a staffing level of 123 full-time employees. Of these, 96 employees (78 percent) were assigned to the VSC.

Workload

As of August 2010, the VARO reported 5,615 pending compensation claims. The average time to complete these claims during FY 2010 was 190.2 days—39 days longer than the national target of 151.2 days. As reported by STAR, accuracy of compensation rating-related issues was 76.3 percent—13.7 percent below the 90 percent VBA target. Accuracy of compensation authorization-related issues was 91.9 percent—4.1 percent below the 96 percent VBA target.

Scope

We reviewed selected management controls, benefits claims processing, and administrative activities to evaluate compliance with VBA policies regarding benefits delivery and non-medical services provided to veterans and other beneficiaries. We interviewed managers and employees and reviewed veterans' claims folders.

Our review included 90 (22 percent) of 414 claims related to PTSD, TBI, and herbicide exposure-related disabilities that the VARO completed during April–June 2010. For temporary 100 percent disability evaluations, we selected 30 (21 percent) of 146 existing claims from VBA's Corporate Database. We provided the VARO with the 116 claims remaining from the universe of 146 to assist in implementing the first recommendation in this report.

The 146 claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months. Because VARO staff processed too few temporary 100 percent evaluations during April–June 2010 for us to review and draw conclusions, we selected a sample from the universe of 146 existing claims.

We reviewed 17 available competency determinations and 29 errors identified by VBA's STAR Program during the period of April–June, 2010. VBA measures the accuracy of compensation and pension claims processing through its STAR Program. STAR's measurements include a review of work associated with claims that require a rating decision. STAR staff review original claims, reopened claims, and claims for increased evaluation.

Further, they review appellate issues that involve a myriad of veterans' disability claims.

Our process differs from STAR in that we review specific types of claims issues such as PTSD, TBI, and herbicide exposure-related disabilities that require rating decisions. In addition, we review rating decisions and awards processing involving temporary 100 percent disability determinations.

For our review, we selected dates of claims and NODs pending at the VARO during the time of our inspection. 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: **December 28, 2010**

From: **Director, VA Regional Office Boston**

Subj: **Inspection of the VARO Boston, MA**

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

1. Enclosed for your review is the response to the draft VA Office of Inspector General (VAOIG) Audit Inspection Report for the Boston VA Regional Office. A copy of this response was provided to the Eastern Area Director, the Office of Field Operations and the Compensation and Pension Service.

2. Specific responses to each VAOIG audit team recommendation are provided in the attachment to this memorandum.

3. Also included as an attachment to this memorandum is my formal request, dated September 1, 2010, to VAOIG audit team leader. To date, I have not received a response to my request. I again, respectfully request a copy of this letter be included in the VAOIG Audit Inspection Report and that the specific data filters used to identify the sub-population of cases at risk of having an error be provided to my Office. I believe this information could assist VARO Boston in improving service to Veterans in the Commonwealth of Massachusetts.

4. We appreciate the courtesy and cooperation your staff showed during the inspection. If you have any questions or would like to discuss our response, please contact me at 617-303-4250.

(Original signed)

BRADLEY G. MAYES
Director

Attachments

AUDIT RECOMMENDATIONS AND RESPONSES

Recommendation 1: *We recommend the Boston VA Regional Office Director conduct a review of all temporary 100 percent determinations under the regional office's jurisdiction to determine if reevaluations are required and, if they are, take appropriate action.*

Response: *Concur.*

The VA Office of Inspector General (VAOIG) audit team identified a total of 146 claims in which VA Regional Office (VARO) Boston claims processing personnel assigned a temporary total evaluation for at least 18 months. VARO Boston management concurs with the VAOIG finding that 25 claims from the sample of 30 claims reviewed during the audit were processed in error.

In addition to the 30 claims reviewed by the VAOIG audit team, VARO Boston claims processing personnel have reviewed all remaining claims identified by the VAOIG audit team that are located on-station. The results of that review indicate 56 out of 107 were improperly processed which equates to a 52 percent error rate. While this is unacceptable, it is significantly lower than the 83 percent error rate reported in the VAOIG Draft Inspection Report. Therefore, we do not concur with the characterization of VARO Boston's accuracy as depicted in the VARO Claims Processing Accuracy Comparison figure on page two or the narrative on page three of the VAOIG Draft Inspection Report. Further, in order to better understand and replicate the VAOIG conclusion for use in workload and training purposes, it is requested that a description of VAOIG's sample selection methodology be added as an Appendix to the Report. Corrective action has been initiated on all cases where an error was identified.

Analysis revealed that the majority of errors were the result of a failure to establish a future diary in the Corporate Database through VETSNET award action. This was traced to a training lapse associated with conversion from the legacy BDN system to the new VETSNET award processing application. Training has been completed on the proper procedure for establishing future review examinations.

Telephone contact with Dawn Provost, Director of the Benefits Inspection Division, verified that the 146 claims identified by the VAOIG audit team represent the universe of claims within VARO Boston's jurisdiction where a temporary total evaluation has been in existence for at least 18 months. Based on this clarification, we concur with the recommendation to review all claims fitting this profile under VARO Boston's jurisdiction and no additional claims beyond the 146 will be reviewed.

Recommendation 2: *We recommend the Boston VA Regional Office Director implement controls to ensure staff establish suspense diaries for temporary 100 percent disability evaluations.*

Response: *Concur.*

Training on the proper procedure for reviewing and authorizing awards where a future review examination is indicated was completed on December 22, 2010. Additionally, procedures have been implemented requiring authorizers to maintain a log of all awards requiring a future examination suspense control. Veterans Service Center (VSC) management will conduct periodic audits of claims identified on the log to ensure compliance with the future examination suspense requirement. Finally, compliance with future examination procedures has been emphasized as part of local statistical quality control reviews.

Recommendation 3: *We recommend the Boston VA Regional Office Director conduct refresher training to ensure Rating Veterans Service Representatives properly evaluate disabilities related to traumatic brain injuries and herbicide exposure-related claims.*

Response: *Concur.*

Refresher training on procedures for handling claims related to herbicide exposure was delivered to VARO Boston rating personnel on November 4, 2010. Refresher training on procedures for handling claims related to Traumatic Brain Injury (TBI) was delivered on November 9, 2010. The TBI training emphasized requirements published in Training Letter 09-01.

Additionally, members of the Compensation and Pension Service site survey team delivered training related to these topics on November 17, 2010, at the request of VARO Boston management. The fiscal year 2011 VARO Boston VSC training schedule provides for training on how to evaluate complications due to Diabetes in January and additional TBI training in August 2011.

Recommendation 4: *We recommend the Boston VA Regional Office Director implement a plan to provide an additional level of review prior to finalizing decisions on traumatic brain injury and herbicide exposure-related claims to ensure accurate benefit payments.*

Response: *Concur.*

In order to improve overall rating quality, VARO Boston constituted a Rating Quality Team responsible for local statistical quality control reviews. The Team will be monitoring quality trends for all types of claims, to include those related to TBI and herbicide exposure-related diseases in order to evaluate the effectiveness of VARO Boston training and quality improvement initiatives. Additionally, a delegation of authority requiring a mandatory second signature review for Traumatic Brain Injury and herbicide exposure-related claims was completed on December 28, 2010.

Recommendation 5: *We recommend the Boston VA Regional Office Director develop and implement a plan to ensure staff record Notices of Disagreement in the Veterans Appeals Control and Locator System within 7 days as required by VBA policy.*

Response: *Concur.*

The Appeals Team Supervisor and appropriate Appeals Team personnel have been trained on proper procedures and timeliness standards for the control of Notices of Disagreement. In addition to training, local procedures have been modified to strengthen compliance and oversight.

The new procedures require all Notices of Disagreement input into the Veterans Appeals Control and Locator System (VACOLS) that are older than seven days at the time of input to be tracked using an excel spreadsheet log. The log will record the date the VACOLS control was established, the date the Notice of Disagreement was received in VARO Boston, the VSR responsible for establishing the VACOLS control, and the reason for the delay in establishing the VACOLS control. The Appeals Team Coach is responsible for maintaining this log. Trends will be analyzed to identify the root cause of delays in establishing VACOLS controls. Adjustments will be made to correct any deficiencies that are identified as a result of this analysis. Finally, the Appeals Team Coach will be responsible for a monthly audit of five randomly selected VACOLS records to ensure compliance with appellate processing procedures. VSC division-level management will verify the results of these audits.

Recommendation 6: *We recommend the Boston VA Regional Office Director develop and implement a plan to ensure timely and accurate completion of mandatory Systematic Analyses of Operations.*

Response: *Concur in part.*

VARO Boston management does not question the finding that seven Systematic Analysis of Operations (SAOs) were not timely and two were not complete at the time of the audit, however we believe the finding is misleading in that the seven "late" SAOs were pending division-level management review and concurrence. While VARO Boston management is concerned with the timeliness of the SAOs, we are more concerned with the depth and quality of the analysis. As a result, there is considerable involvement of VSC division-level management with the supervisors assigned responsibility for completion of the majority of SAOs within the division. This is necessitated by the fact that, with the exception of one Coach, all division first-line supervisors are Assistant Coaches with less than two years of supervisory experience. Therefore, there have been delays in "finalizing" SAOs, however it is our opinion that the quality of the analysis and proposed corrective actions are far more important than the deadline established in the SAO schedule.

The Veterans Benefits Administration *M21-4 Manpower Control and Utilization in Adjudication* manual describes the purpose of a Systematic Analysis of Operations as "a formal analysis of an organizational element or an operational function of the Veterans Service Center (VSC)." The Manual goes on to state: "A researched and well-written SAO is a valuable management tool. It provides an organized means for reviewing operations to identify existing or potential problems and proposing corrective actions. This self-audit technique, when applied conscientiously, is a positive guide for operational improvement." The VA OIG audit team finding does not address the quality of the research and/or analysis in VARO Boston SAOs, which in our opinion would be more useful for evaluating the effectiveness of our SAO program.

Therefore, we concur with the finding that improved oversight is needed to ensure the timely completion of our SAOs, however we do not concur with the implication in the VA OIG audit team's recommendation that our SAOs are inaccurate. In response to the recommendation, the Director of VARO Boston has reinforced with VSC division management the importance of timely completion of SAOs as an important component of the local SAO program.

Recommendation 7: *We recommend the Boston VA Regional Office Director develop and implement controls to ensure Support Services Division staff process and date stamp all incoming mail the same day it arrives in the mailroom.*

Response: *Concur.*

Prior to the conclusion of the VA OIG audit, Support Services Division (SSD) staff was provided training with regards to the proper processing of incoming mail. The training focused on the potential impact to Veterans and their dependents of delays in processing mail, especially at the end of the month.

In addition to training, arrangements have been made to shift resources from the VSC and VR&E divisions to assist with end of month surges in mailroom activity as needed. Finally, division management has increased oversight to include periodic random audits of mailroom activities. Mail processing is now compliant with VBA policy as it relates to the receipt, date stamping, and timely routing of incoming mail.

Recommendation 8: *We recommend the Boston VA Regional Office Director develop and implement a plan to ensure proper oversight and control of all returned mail.*

Response: *Concur.*

The SSD Chief coordinated with the VSC Triage Team and the VARO Boston Records Management Officer to review existing policy and reinforce proper procedures for processing mail returned to the station by the United States Postal Service as undeliverable. As noted above, SSD management has increased oversight to include periodic random audits of mailroom activities including returned mail. In addition, the backlog of "dead" mail, which existed during the inspection, has been reviewed and processed.

Training was also provided to Triage Team staff on proper returned mail procedures, to include destruction procedures for non-essential mail with no evidentiary value, on November 9, 2010. The training incorporated procedures published in Compensation and Pension Service Fast Letter
09-46.

Recommendation 9: *We recommend the Boston VA Regional Office Director add steps to the workload management plan to ensure proper handling of Service Treatment Records.*

Response: *Concur.*

The VARO Boston workload management plan is undergoing extensive revision and will comply with the VAOIG audit team recommendation. Additionally, refresher training on the proper handling of Service Treatment Records is scheduled for all VSR and Claims Assistants in February as part of VARO Boston's approved local training plan. The training will incorporate procedures outlined in M21-1MR, Part III iii.2.A.2.c and Compensation and Pension Service Fast Letter 10-17.

Recommendation 10: *We recommend the Boston VA Regional Office Director amend the mail plan to incorporate procedures for management oversight and control of search mail.*

Response: *Concur.*

A previously indicated, the VARO Boston workload management plan is undergoing extensive revision and will incorporate additional procedures for management oversight and control of search mail per the VAOIG audit team recommendation.

Additionally, training on mail handling procedures was provided to employees of the Triage team during October 2010. Refresher training on Search Mail procedures is scheduled for all VSC employees in January as part of VARO Boston's approved local training plan. The training will emphasize compliance with the Control of Veterans Records System (COVERS).

Appendix C Inspection Summary

10 Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. 100 Percent Disability Evaluations	**Determine if VARO staff properly reviewed temporary 100 percent disability evaluations**. (38 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1MR, Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR, Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Post-Traumatic Stress Disorder	**Determine whether VARO staff properly processed claims for PTSD.** (38 CFR 3.304(f))	X	
3. Traumatic Brain Injury	**Determine whether service connection for all residual disabilities related to an in-service TBI were properly processed.** (Fast Letters 08-34 and 08-36, Training Letter 09-01)		X
4. Disabilities Related to Herbicide Exposure	**Determine whether VARO staff properly processed claims for service connection for disabilities related to herbicide exposure (Agent Orange).** (38 CFR 3.309) (Fast Letter 02-33) (M21-1MR, Part IV, Subpart ii, Chapter 2, Section C.10)		X
Data Integrity			
5. Date of Claim	**Determine if VARO staff properly recorded the correct date of claim in the electronic record.** (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)	X	
6. Notices of Disagreement	**Determine if VARO staff properly entered NODs into VACOLS.** (M21-1MR, Part I, Chapter 5)		X
Management Controls			
7. Systematic Analysis of Operations	**Determine if VARO staff properly performed a formal analysis of their operations through completion of SAOs.** (M21-4, Chapter 5)		X
8. Systematic Technical Accuracy Review	**Determine if VARO staff properly corrected STAR errors in accordance with VBA policy.** (M21-4, Chapter 3, Subchapter II, 3.03)	X	
Workload Management			
9. Mail Handling Procedures	**Determine if VARO staff properly followed VBA mail handling procedures.** (M23-1) (M21-4, Chapter 4) (M21-1MR, Part III, Subpart ii, Chapters 1 and 4)		X
Eligibility Determinations			
10. Competency Determinations	**Determine if VAROs properly assessed beneficiaries' mental capacity to handle VA benefit payments.** (M21-1MR, Part III, Subpart v, Chapter 9, Section A) (M21-1MR, Part III, Subpart v, Chapter 9, Section B) (Fast Letter 09-08)		X

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	Dawn Provost
Acknowledgments	Dana Sullivan Bridget Bertino Brett Byrd Madeline Cantu Kelly Crawford Lee Giesbrecht Brian Jeanseau Kerri Leggiero-Yglesias David Pina Brandi Traylor

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