VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Houston, Texas

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10-03770-125

ACRONYMS AND ABBREVIATIONS

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

Report Highlights: Inspection of the VA Regional Office, Houston, Texas

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

Houston VARO management ensured staff generally followed Veterans Benefits Administration (VBA) policy to correctly establish dates of claims in the electronic record and process incoming mail. VARO management lacked effective controls and accuracy in processing temporary 100 percent disability evaluations, and post-traumatic stress disorder, traumatic brain injury, and herbicide exposure-related claims. Overall, VARO staff did not accurately process 68 (57 percent) of the 120 disability claims reviewed.

The VARO also was not timely in recording Notices of Disagreement for appealed claims, correcting errors identified by VBA's Systematic Technical Accuracy Review program, and completing Systematic Analyses of Operations. Processing competency determinations, managing mail in the Triage Team, and safeguarding personally identifiable information also were not fully effective.

What We Recommended

We recommended that Houston VARO management review all remaining temporary 100 percent disability evaluations identified during our inspection to determine if reevaluations are required and take appropriate actions. Management needs to implement controls to ensure VSC staff establish suspense diaries for temporary 100 percent disability reevaluations. We recommended management implement controls to improve accuracy and quality review of post-traumatic stress disorder claims. Further, management needs to provide refresher training and improve quality review of traumatic brain injury and herbicide exposure-related disability claims.

We recommended VARO management strengthen controls to ensure timely establishment of Notices of Disagreement in the Veterans Appeals Control and Locator System and timely completion of Systematic Analyses of Operations. Management also needs to implement plans to ensure oversight of mail handling, accurate processing of final competency determinations, and safeguarding of personally identifiable information.

Agency Comments

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

(original signed by:)

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for Audits and Evaluations

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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 VA Regional Offices (VAROs). These independent inspections provide recurring oversight focused on disability compensation claims processing and performance of Veterans Service Center (VSC) operations. The objectives of the inspections are to:

- Evaluate how well VAROs are accomplishing their mission of providing veterans with access to high quality benefits and services.
- Determine 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 October 2010, the OIG conducted an inspection of the Houston 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 (9 percent) of 971 disability claims related to post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and herbicide exposure that the VARO completed from April through June 2010. In addition, we reviewed 30 (4 percent) of 765 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months, generally the longest period a temporary 100 percent disability evaluation may be assigned under VA policy without review.

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

RESULTS AND RECOMMENDATIONS

1. Disability Claims Processing

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

Finding 1 VARO Staff Need to Improve Disability Claims Processing Accuracy

The Houston VARO needs to improve the accuracy of disability claims processing. VARO staff incorrectly processed 68 (57 percent) of the total 120 disability claims reviewed. VARO management agreed 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 Houston VARO.

Table

Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Disability Evaluations	30	27	10	17
PTSD	30	7	2	5
TBI	30	22	3	19
Herbicide Exposure-Related Disabilities	30	12	3	9
Total	**120**	**68**	**18**	**50**

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 27 (90 percent) of 30 temporary 100 percent disability evaluations we reviewed. Veterans Benefits Administration (VBA) policy requires a temporary 100 percent disability evaluation for a service-connected disability 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 evaluation.

Based on analysis of available medical evidence, 10 of the 27 processing inaccuracies affected veterans' benefits—all 10 involved overpayments totaling $730,768. Two examples of the most significant overpayments follow.

- VARO staff did not request a future medical examination to evaluate a veteran's acute lymphocytic leukemia. Medical evidence in the claims folder warranted a reduction in benefits as of September 1, 1998. As a result, VA overpaid the veteran $355,476 over a period of 11 years and 8 months.
- VARO staff did not request a future medical examination to evaluate a veteran's prostate cancer. Medical evidence in the claims folder warranted a reduction in benefits as of November 1, 2005. As a result, the veteran was overpaid $133,128 over a period of 4 years and 6 months.

The remaining 17 inaccuracies had the potential to affect veterans' benefits. Following are summaries of these inaccuracies.

- In 12 cases, VSC staff did not schedule the follow-up medical examinations needed to determine whether the temporary 100 percent disability evaluations should continue.
- In two cases, the Rating Veterans Service Representatives (RVSRs) continued the 100 percent disability evaluation 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 two cases, an RVSR continued the temporary 100 percent disability evaluations and annotated the need for follow-up medical examinations. However, VSC staff did not establish controls for scheduling the future medical examinations.
- In one case, an RVSR proposed reducing the veteran's temporary 100 percent disability evaluation. However, the medical examination results showed a diagnosis of active prostate cancer and that the evaluation should not be reduced. No action had been taken at the time of our inspection. The RVSR should have continued the 100 percent disability evaluation and requested a follow-up medical examination.

We could not determine if 12 of the 17 temporary 100 percent disability evaluations would have continued because the veterans' claims folders did not contain medical evidence needed to reevaluate each case. An average of approximately 3 years and 6 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 approximately 2 months to 12 years and 7 months.

For temporary 100 percent disability 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 suspense diary is a processing command that establishes a date when VSC staff must schedule a reexamination. As a diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the reexamination.

Twenty-four of the 27 errors resulted from staff not establishing suspense diaries when processing rating decisions requiring temporary 100 percent disability reevaluations. Twelve of these errors involved confirmed and continued rating decisions. VSC management stated, and we verified, that the office had no procedure in place requiring senior staff members to review implementation of confirmed and continued rating decisions. As such, oversight did not occur to ensure staff properly established suspense diaries for reevaluating these decisions.

PTSD Claims

VARO staff incorrectly processed 7 (23 percent) of 30 PTSD claims we reviewed. Two of these errors affected veterans' benefits resulting in an overpayment totaling $22,087 and an underpayment of $640.

- An RVSR incorrectly increased a veteran's 30 percent service-connected PTSD evaluation to 100 percent based only on a VA medical examination. However, treatment reports from the Houston VA Medical Center showed entitlement for no more than a 50 percent disability evaluation. The RVSR is required to review all available medical evidence before rendering a decision. As a result, VA overpaid the veteran over a period of 1 year and 1 month.
- An RVSR granted service connection for PTSD with an evaluation of 70 percent disability. However, the RVSR did not address entitlement to an additional special monthly compensation as required by VBA policy. As a result, VA underpaid the veteran over a period of 2 months.

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

- In three cases, RVSRs did not grant service connection for associated disorders diagnosed through VA examinations. Granting service connection for additional disorders would not change the overall assigned evaluations, but may affect future evaluations for additional benefits.
- In one case, an RVSR continued the evaluation of a veteran's service-connected PTSD. However, the VA medical examiner also

diagnosed major depressive disorder without discussing the relationship between the newly diagnosed condition and the PTSD, and the extent of impairment as required by VBA policy. Neither VARO staff nor we can ascertain the relationship or the extent of impairment without adequate or complete medical evidence.

- In one case, an RVSR incorrectly granted service connection for PTSD based on medical evidence that did not satisfy requirements outlined by VBA policy. Neither VARO staff nor we can establish service connection for PTSD without adequate or complete medical evidence.

Generally, errors associated with PTSD claims processing resulted from ineffective quality assurance. Interviews with VARO staff revealed the office provided training on PTSD regulations and policies. Staff told us they understood the regulations and policies. However, our inspection revealed that RVSRs made decisions on seven PTSD claims without following the regulations and policies. RVSRs incorrectly established or evaluated PTSD, or incorrectly established or denied service connection for conditions associated with PTSD. A local quality review conducted by the VSC on one of the seven inaccuracies had not identified any errors, despite what we found during our inspection. As a result, veterans did not always receive correct healthcare entitlements or benefit payments.

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: physical, cognitive, and behavioral. VBA policy requires staff to evaluate these residual disabilities.

VARO staff incorrectly processed 22 (73 percent) of 30 TBI claims. Three of the 22 processing inaccuracies affected veterans' benefits—one involved an overpayment of $10,344 and two involved underpayments totaling $11,649. Details on the overpayment and most significant underpayment follow.

- An RVSR incorrectly evaluated a residual TBI-related disability as 30 percent disabling. A VA medical examination showed this residual TBI-related disability warranted no more than a 10 percent evaluation. As a result, the veteran was overpaid $10,344 over a period of 2 years.
- An RVSR incorrectly continued an evaluation for residuals of TBI at 10 percent disabling based on a VA medical examination. However, the examination results showed entitlement to a 40 percent disability evaluation. As a result, the veteran was underpaid $9,723 over a period of 1 year and 9 months.

Following are details on the remaining 19 TBI inaccuracies that had the potential to affect veterans' benefits. These ratings did not affect the veterans' current disability evaluations, but may affect future evaluations for additional benefits if these inaccuracies remain unaddressed.

- In six cases, RVSRs incorrectly assigned separate evaluations for headaches as residuals of TBI based on the medical evidence. However, medical evidence showed no diagnoses of migraine headaches or Meniere's disease to support entitlement to the separate evaluations for headaches.
- In five cases, RVSRs incorrectly evaluated residual TBI-related disabilities shown on VA medical examination reports.
- In five cases, RVSRs incorrectly evaluated residual TBI-related disabilities based on the results of inadequate VA medical examinations.
- In one case, medical evidence showed a diagnosis of traumatic brain injury. An RVSR correctly granted service connection for post-traumatic migraine headaches. The RVSR also did not establish service connection for residuals of TBI as required.
- In one case, an RVSR prematurely granted service connection for residuals of TBI based on an inadequate VA medical examination. The veteran was previously service-connected for PTSD, and the VA examination did not separate symptoms associated with PTSD from those for TBI.
- In one case, an RVSR incorrectly granted service connection for a residual TBI-related disability without adequate evidence of an in-service event. The service treatment records did not show complaints of, medical diagnosis of, or treatment for a TBI.

Generally, errors associated with TBI claims processing occurred because VSC staff incorrectly interpreted VBA policy. This resulted in the VSC staff inadequately training RVSRs in rating TBI cases. Given such training, the RVSRs did not properly evaluate residuals of TBI based on the results of VA examinations and incorrectly addressed TBI-related residuals in making rating decisions. As a result, veterans did not always receive correct benefits payments.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 12 (40 percent) of 30 herbicide exposure-related claims reviewed. Three of the 12 processing inaccuracies affected veterans' benefits—two involved overpayments totaling $4,008 and one involved an underpayment of $1,632. Details on the most significant overpayment and the underpayment follow.

- An RVSR incorrectly evaluated residuals of non-Hodgkin's lymphoma following cessation of treatment as 30 percent disabling. Medical evidence reported non-Hodgkin's lymphoma in full remission with no residuals. This condition warrants a 0 percent evaluation, entitling the veteran to healthcare for the condition, but not monetary compensation. As a result, VA overpaid the veteran $2,230 over a period of 5 months.
- An RVSR did not grant service connection and entitlement to an additional special monthly compensation for a diabetes-related disability. As a result, VA underpaid the veteran $1,632 over a period of 1 year and 5 months.

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

- In five cases, RVSRs incorrectly granted service connection for conditions as complications of the veterans diabetes, although medical evidence showed conditions diagnosed prior to and subsequently worsened by diabetes. To properly rate conditions worsened by diabetes, the RVSRs needed to request additional medical evidence to justify granting benefits.
- In two cases, RVSRs did not address in the rating decision service connection for conditions worsened by the service-connected diabetes as required.
- In one case, an RVSR incorrectly denied service connection for a condition worsened by the service-connected diabetes.
- In one case, an RVSR did not grant service connection for a diabetes-related complication diagnosed in a VA medical examination as required. This rating did not affect the veteran's monthly benefits, but may affect future evaluations for additional benefits.

In eight of the nine inaccuracies summarized above, VSC staff did not properly request additional medical evidence from the veterans. VBA policy requires medical evidence showing the level of severity before the condition worsened and the current level of severity. VSC staff needs this medical evidence to determine a baseline level of severity prior to granting or denying a disability.

Generally, errors associated with herbicide exposure-related claims processing resulted from ineffective quality assurance and improper training. A VSC quality review conducted on 1 of the 12 inaccuracies did not identify any error. VSC staff provided training to RVSRs in July 2010. However, the training did not discuss VBA policy requirements that VSC personnel must take prior to addressing medical conditions worsened by a

service-connected disability. As a result, RVSRs made inaccurate decisions on herbicide exposure-related claims and veterans did not always receive correct benefits payments.

Recommendations

1. *We recommend the Houston VA Regional Office Director review the remaining universe of 735 temporary 100 percent disability evaluations to determine if reevaluations are required and take appropriate action.*
2. *We recommend the Houston VA Regional Office Director conduct refresher training and implement controls to ensure staff establish suspense diaries for temporary 100 percent disability reevaluations.*
3. *We recommend the Houston VA Regional Office Director develop and implement a plan to improve processing accuracy and quality review of post-traumatic stress disorder claims.*
4. *We recommend the Houston VA Regional Office Director conduct refresher training and develop and implement a plan to improve the quality review process for traumatic brain injury and herbicide exposure-related claims.*

Management Comments

The VARO Director concurred with our recommendations. VSC staff reviewed 356 of the additional 735 temporary 100 disability evaluations identified by OIG. The Director estimated VSC staff will complete the reviews by September 30, 2011. The Director reported VSC staff received training on the proper procedures for establishing suspense diaries for medical reexaminations shortly after our visit in October 2010 and again in November 2010 and early March 2011.

Further, the VARO Director stated RVSRs and Decision Review Officers received training on TBI-related claims in November 2010. The VSC has scheduled training on PTSD and herbicide exposure-related claims for April 2011. Additionally, the VSC is developing a plan to improve the quality review process for PTSD, TBI, and herbicide exposure-related claims; the VSC expects to implement the plan by May 2011.

OIG Response

Management actions are responsive to the recommendations. We will follow up as required on all actions.

2. Data Integrity

Effective Dates

We analyzed claims folders to determine if the VARO was following VBA policy to establish correct effective dates in electronic records. Generally, an effective date indicates when entitlement to a specific benefit arose. We determined VARO staff incorrectly established an effective date for 4 (3 percent) of 120 disability claims we reviewed. All four errors affected veterans' benefits—three involved underpayments totaling $19,211 and one

involved an overpayment of $6,588. Details on the most significant underpayment and the overpayment follow.

- An RVSR incorrectly granted service connection for an herbicide exposure-related condition effective December 2, 2009. The actual date of claim for the herbicide exposure-related condition was June 27, 2009, and medical evidence showed the condition existed on that date. 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 underpaid $14,412 over a period of 6 months.
- An RVSR incorrectly established an effective date of January 23, 2008, for an herbicide exposure-related condition. The VARO did not receive the veteran's claim until a year later on January 23, 2009. According to VA regulations, when a claimant submits a claim more than 1 year after a legislative change, VA may authorize benefits for a period of 1 year prior to the date of receipt of claim, if eligible. In this case, eligibility did not exist to pay the veteran one year prior to submission of his claim because medical evidence did not show the veteran had the medical condition when the law changed. As a result, VA overpaid the veteran approximately $6,588 over a period of 1 year.

Because we found only 4 inaccuracies out of a total of 120 claims, we determined the VARO is generally following VBA policy regarding effective dates. Therefore, we made no recommendations for improvement in this area.

Dates of Claim

We analyzed claims folders to determine if the VARO was following VBA policy to establish correct dates of claim in electronic records. In addition to establishing the time frame 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.

We reviewed 30 claims folders to determine if the VARO is following VBA policy regarding correct establishment of dates of claim in the electronic record. We found only one inaccuracy; therefore, we determined the VARO is generally following VBA policy regarding dates of claim and we made no recommendations for improvement in this area.

Notices of Disagreement

We analyzed claims folders to determine if the VARO was following VBA policy to timely record Notices of Disagreement (NODs) in the Veterans Appeals Control and Locator System (VACOLS). 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 is 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 2 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 the standard for 21 (70 percent) of the 30 NODs we reviewed. It took staff an average of 14 days to record these 21 NODs in VACOLS. The most untimely action occurred when staff did not create a record for 36 days. Although the Appeals Team was aware of the 7-day standard, delays occurred because the Houston VARO workload management plan and local procedures did not incorporate provisions to ensure prompt control of NODs in VACOLS. VARO staff's untimely recording of NODs in VACOLS affects data integrity and misrepresents VARO performance.

As of October 2010, the VARO averaged 13 days to establish NODs, exceeding the VBA goal by 6 days. The VARO's NODs have been pending completion an average of 324 days, 103 days over the national average of 221 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 Houston 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 Veterans Benefits Administration policy.*

Management Comments

The VARO Director concurred with our recommendation. The Director reported the Appeals Team revised its procedures for controlling NODs, including those received from the VARO's offsite office.

OIG Response

Management actions are responsive to the recommendation. We will follow up as required on all actions.

3. Management Controls

Systematic Technical Accuracy Review

We assessed management controls to determine if VARO management adhered to VBA policy regarding correction of errors identified by VBA's Systematic Technical Accuracy Review (STAR) staff. The STAR program is VBA's multifaceted quality assurance program to ensure that veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that the VARO take corrective action on errors that STAR identifies.

VARO staff did not correct 4 (11 percent) of 36 errors identified by VBA's STAR program from April through June 2010. VARO management reported to STAR staff that corrective actions on two STAR errors were completed. However, review of the claims folders showed no evidence of the corrections. In addition, the VARO staff did not take action to correct the other two STAR errors. These errors had no impact on claimants' benefits.

VARO management did not provide adequate oversight for correction of STAR errors. By not fully completing and reporting their STAR error corrections, VARO management cannot provide assurance that they are fulfilling VBA's National Quality Assurance Program. While we were on on-site and based on the preliminary results of our inspection, VSC management amended its STAR Quarterly Error Report response procedures and now requires VSC supervisors to review claims folders and ensure correction of STAR errors. Because such actions provide oversight needed to address STAR errors, we make no recommendation in this area.

Systematic Analysis of Operations

We assessed controls to determine if VARO management completed timely Systematic Analyses of Operations (SAOs) that addressed necessary elements and operational functions of the VSC. 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 3 Improved Oversight is Needed to Ensure Timely Completion of SAOs

The VSC Manager is responsible for ongoing analysis of VSC operations, including completion of 12 annual SAOs. Two (17 percent) of the 12 SAOs were incomplete at the time of our inspection. This occurred because VARO management did not provide adequate oversight to ensure VSC staff completed SAOs in accordance with VBA policy.

The two SAOs identified problems within the VSC. However, one SAO did not provide processing improvement solutions because Central Area Office staff were monitoring the problem and, in VSC management's opinion, the system in place was sufficient. The second SAO did not contain sufficient depth of analysis to explain the problems clearly. The prior VSC Manager had reviewed the SAO and current VSC leadership could not explain why the depth of analysis was insufficient.

The VARO did not follow VBA policy for completion of SAOs. For example, in the Quality of Compensation, Pension, and Ancillary Actions SAO, VSC management indicated current controls were adequate. However, the SAO reported monthly internal quality review findings were trending upward, noting improvement, while STAR findings were trending downward. VSC management did not take adequate steps to address the discrepancies identified in the quality review trends, including developing and implementing a plan to improve quality. Additionally, the Quality and Training Team did not identify three claims processing errors we subsequently found during our inspection.

Recommendation

6. *We recommend the Houston 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. The Director stated that the VARO has implemented a plan to ensure VSC staff submit SAOs in accordance with established schedules. Additionally, the Director stated SAOs completed in January 2011 and March 2011 addressed concerns we raised during our inspection.

OIG Response

Management actions are responsive to the recommendation. We will follow up as required on all actions.

4. Workload Management

Mailroom Operations

We assessed controls over VARO mailroom operations to ensure staff timely and accurately processed incoming mail. VBA policy states staff will open, date stamp, and route all mail to the appropriate locations within 4–6 hours of receipt at the VARO. The Houston VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division. Mailroom staff timely and accurately processed, date stamped, and delivered VSC mail to the Triage Team control point daily. As a result, we determined the VARO Support Services mailroom is following VBA policy. Therefore, we made no recommendations for improvement in this area.

Triage Mail Processing Procedures

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. 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. If claims folders are located in the file storage area, staff should not place related mail on search.

VBA policy defines drop mail as mail received where no processing action is necessary and the VARO does not need the associated claims folder. VARO staff can initiate processing of priority drop mail without the related claims folder, but must ultimately associate the mail with the related folder for further processing. The folder for this type of mail is located in the local file storage area.

VBA policy defines permanent transfer in (PTI) mail as that received in Triage for which the related claims folder is located in other regional offices or Federal records storage centers. The Triage Team requests the claims folder and stores this type of mail in a holding area until the folder arrives. Once Triage Team staff receive the claims folder, they should remove the mail from the PTI holding area and associate it with the claims folder. Controls over Triage Team mail processing need strengthening.

Finding 4 Triage Team Mail Management Procedures Need Strengthening

Triage Team members did not consistently manage search mail according to VBA policy. For 15 (50 percent) of 30 pieces of search mail, VSC staff placed mail on search although the related files were located in the file storage area, did not control the mail through a corresponding search in COVERS, or did not retrieve the mail and clear each search in COVERS once the mail was located. The most significant error occurred when an employee acknowledged receipt of a claims folder in COVERS on October 1, 2010. COVERS includes a feature to alert employees when search mail associated with a claim is available for pick-up. However, in this case the VSC employee did not retrieve mail associated with this folder that had been on search since June 22, 2010.

Triage Team members did not consistently manage drop mail, including priority drop mail, according to VBA policy. Four (13 percent) of 30 pieces of drop mail reviewed were incorrectly placed into drop mail or priority drop mail holding areas. The most egregious error occurred when an employee placed a piece of mail requiring processing action into the drop mail holding area instead of associating it with the claims folder. Neither VSC staff nor

we can determine when an employee placed this piece of mail in the drop mail holding area.

Further, Triage Team members did not consistently manage PTI mail according to VBA policy. Nine (30 percent) of 30 pieces of PTI mail had related claims folders located at the Houston VARO. However, VSC staff did not associate this mail with the claims folders. The two most substantial errors identified during our October 2010 inspection involved mail found in the PTI holding area although VARO staff had received the related files on August 9, 2010.

The above errors occurred because of a lack of management oversight to ensure the timely and accurate movement of mail throughout the Service Center. For example, VSC management have no oversight procedures to ensure employees actually retrieve search mail. The Service Center sends out a weekly reminder to all employees to pick up search mail. All employees have access to the search "delete" function in COVERS and therefore an employee can delete a search without collecting the search mail.

Further, the quality review process for the Triage Team does not always address search mail and drop mail. Management also does not conduct quality reviews on a consistent basis. Triage Team supervisors told us they review between 5 and 10 pieces of mail from each employee monthly, if possible. The SAO on Quality of Files Activities recommended that for each employee a supervisor review handling of 20 pieces of mail per month.

The Quality of Files Activities SAO found other deficiencies in the search mail and drop mail sections and made recommendations for improvement. VSC management acknowledged weaknesses associated with mail processing but did not implement these recommendations or follow up on the deficiencies. VSC leadership stated they do not follow up on SAO recommendations and could not provide a reason why.

Until VSC management addresses these weaknesses, RVSRs may not have all available evidence when making disability determinations. Untimely association of search, drop, and PTI mail with veterans' claims folders can cause delays in processing disability claims. As a result, beneficiaries may not receive accurate and timely benefit payments.

Recommendation

7. *We recommend the Houston VA Regional Office Director develop and implement a plan to address all deficiencies and recommendations identified in the Systematic Analysis of Operations regarding mail handling.*
8. *We recommend the Houston VA Regional Office Director develop and implement a plan to ensure management oversight of mail handling.*

Management Comments

The VARO Director concurred with our recommendations. The Director stated starting in February 2011 the Central Area Immersion Team began working with VSC management and the Triage Team to develop and implement a plan to ensure management oversight of mail handling. The Director said efforts were also underway to develop efficient procedures for mail processing.

OIG Response

Management actions are responsive to the recommendations. We will follow up as required on all actions.

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 as to a beneficiary's mental capacity to manage his or her affairs. The Fiduciary Unit supports implementation of competency determinations by appointing a fiduciary, which is a third party that assists in managing funds for an incompetent beneficiary. We reviewed competency determinations made at the VARO 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 5 Controls over Competency Determinations Need Strengthening

VARO staff unnecessarily delayed final decisions in 15 (50 percent) of the 30 competency determinations completed from April through June 2010. The delays ranged from 17 to 461 days, with an average completion time of 103 days. Delays occurred because the VSC workload management plan did not contain procedures emphasizing immediate completion of competency determinations, managers were not aware of timeliness standards regarding these cases, and the VSC does not prioritize completion of these types of cases. The risk of incompetent beneficiaries receiving benefits 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 a final incompetency decision for a veteran for approximately 1 year and 3 months. During this period, the veteran received $24,191 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 staff responsible for overseeing and processing final competency determinations stated they were unaware of this policy and they did not prioritize these cases. They acknowledged that 14 days was a sufficient definition of "immediate." We also spoke with VSC leadership who defined "immediate" as the same day the due process period expires. However, the workload management plan lacked procedures to meet this goal and ensure oversight of the competency determination process. As a result, incompetent beneficiaries received benefits payments for extended periods despite being incapable of managing these funds effectively.

We plan to raise this issue to senior VBA management in our fiscal year 2010 summary. Therefore, we make no recommendation to the Director of the VARO regarding this issue.

Further, in 4 (13 percent) of 30 competency determinations reviewed, staff did not follow VBA policy to withhold retroactive payments until appointment of a fiduciary when beneficiary incompetency is proposed. In the most egregious case, the veteran received payment of all benefits with no withholding of $15,697 at the time incompetency was proposed. To fulfill VBA's policy, VARO staff should have paid the full monthly benefit of $1,427, and withheld the retroactive benefits of $14,270 from November 1, 2009, until the appointment of a fiduciary in June 2010.

These errors were a result of lack of understanding of VBA policy. When the policy changed in October 2009, VSC management sent an e-mail to all employees. Training schedules for fiscal year 2010 showed the VARO gave no additional training on this issue.

Recommendation

9. *We recommend that the Houston VA Regional Office Director conduct refresher training and implement controls to ensure staff follow current Veterans Benefits Administration policy regarding the processing of competency determinations.*

Management Comments

The VARO Director concurred with our recommendation. The Director reported providing training in December 2010 and February 2011 on

processing competency determinations. Further, refresher training was scheduled for March 2011.

OIG Response Management actions are responsive to the recommendation. We will follow up as required on all actions.

6. Safeguarding of Personally Identifiable Information

In addition to the 10 operational activities reviewed during the inspection, we identified another area requiring VARO management's attention. This area involves the failure to safeguard veterans' personally identifiable information by placing documents ready for destruction in unlocked containers. According to VBA's policy, access to shred bins must be strictly controlled and limited to senior management, Records Management Officers, and Division Records Management Officers. Further, VARO's are required to keep shred bins secured with locks or in locked rooms.

We observed documents in six unlocked shred bins on the loading dock leaving veterans' personally identifiable information potentially at risk. Additionally, some shred bins were overflowing and documents accessible through a slot in the top of the bins. After we notified management, they moved the shred bins into the mailroom. The Support Services Division management stated the mailroom and loading dock are lockable areas. Further, management informed us when the VARO receives a delivery, an employee is there at all times. Our subsequent observation revealed management did not lock one shred bin. Additionally, the shred bins were accessible to personnel other than those approved by VBA's policy.

VBA's policy requires two signatures on any document that could potentially affect benefit entitlement before the VARO can destroy the document. A review of 30 documents from the open shred bins found VARO staff complied with VBA's policy. However, one document was an incomplete and unsigned original claim for benefits and another was a request for a copy of a letter. Review of the claims folder and VA electronic systems confirmed the VARO took no action on these requests. We provided management with the two documents for further action. Because the shred bins were in an unsecured area, neither VARO staff nor we can ascertain who placed these documents in the shred bins.

Recommendation

10. We recommend that the Houston VA Regional Office Director implement additional controls to ensure staff follow current Veterans Benefits Administration policy regarding safeguarding personally identifiable information.

Management Comments

The VARO Director concurred with our recommendation. The Director stated Support Service Division personnel sealed the slots on the lids of the shredding bins when OIG was onsite. Additionally, the Director designated a secure office location for storing the shred bins.

OIG Response

Management actions are responsive to the recommendation. We will follow up as required on all actions.

Appendix A VARO Profile and Scope of Inspection

The Houston VARO is responsible for delivering nonmedical VA benefits and services to veterans and their families in 90 counties of southern Texas, the Republic of Mexico, Central and South America, and the Caribbean. The VARO fulfills these responsibilities by administering compensation and pension benefits, vocational rehabilitation and employment assistance, and outreach activities.

Resources

As of September 2010, the Houston VARO had a staffing level of 590 full-time employees. Of these, 387 employees (66 percent) were assigned to the VSC.

Workload

As of October 2010, the VARO reported 25,893 pending compensation claims. The average time to complete claims during fiscal year 2011 was 212.9 days—37.9 days greater than the national target of 175 days. As reported by STAR staff, accuracy of compensation rating-related issues was 78.9 percent—11.1 percent below the 90 percent VBA target, and accuracy of compensation authorization-related issues was 93.8 percent—2.2 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 and nonmedical services provided to veterans and other beneficiaries. We interviewed managers and employees and reviewed veterans' claims folders.

Our review included 90 (9 percent) of 971 claims related to PTSD, TBI, and herbicide exposure-related disabilities that the VARO completed from April through June 2010. For temporary 100 percent disability evaluations, we selected 30 (4 percent) of 765 existing claims from VBA's Corporate Database. We provided the VARO with the 735 claims remaining from the universe of 765 to assist in implementing our first recommendation. The 765 claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months.

We also reviewed a sample of 30 (65 percent) of 46 competency determinations completed by the Houston VARO during the 3-month period from April through June 2010. We reviewed 36 errors identified by VBA's STAR Program during the same 3-month period. 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 rating decisions. STAR staff review original claims, reopened claims, and claims for increased evaluations. Further, they review appellate issues that involve a myriad of veterans' disabilities claims.

Our process differs from STAR as 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 evaluations.

We selected and reviewed dates of claim and NODs and search mail pending at the VARO during the time of our inspection. We completed our review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspections.*

Appendix B VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: March 9, 2011

From: Pritz Navaratnasingam Director, VA Regional Office Houston, Texas

Subj: Inspection of the VARO Houston, Texas

To: Assistant Inspector General for Audits (52)

1. Attached are the Houston VARO's comments on the OIG Draft Repot: Inspection of VARO Houston.

2. Questions may be referred to Daryl Brady, Assistant Director, VARO Houston. He may be contacted at 713-383-1720.

(original signed by:)
Pritz Navaratnasingam
Director

Attachment

Houston VA Regional Office
Response to the Office of Inspector General,
Benefits Inspection Division,
Inspection of the VA Regional Office Draft Report

Recommendation 1 - *We recommend the Houston VA Regional Office Director review the remaining universe of 735 temporary 100 percent disability evaluations to determine if reevaluations are required and take appropriate action.*

Concur with recommendation

Response: The Houston VARO Director concurs with this recommendation. The Houston RO is in the process of reviewing the 735 cases. To date 356 have been reviewed, of which 102 have been completed. The estimated completion date of the project is September 30, 2011.

Recommendation 2 - *We recommend the Houston VA Regional Office Director conduct refresher training and implement controls to ensure staff establishes suspense diaries for temporary 100 percent disability reevaluations.*

Concur with recommendation

Response: The Houston VARO Director concurs with this recommendation. Houston VA Regional Office provided initial training to the POST Teams on November 23, 2010 for the 800 series work items. Refresher training is scheduled for March 8, 2011. The RVSRs were given training on March 2, 2011 for the 810 series work items. Prior to this date, in-team training was accomplished shortly after the OIG visit.

Recommendation 3 - *We recommend the Houston VA Regional Office Director develop and implement a plan to improve processing accuracy and quality review of post-traumatic stress disorder (PTSD) claims.*

Concur with recommendation

Response: The Houston VARO Director concurs with this recommendation. In late FY10 VSRs, RVSRs, and DROs were identified who had not completed the PTSD TPSS modules developed by C P Services in 2007. Training was completed in late FY2010. A five-hour PTSD training class is scheduled for April 4-5, 2011. The Houston VSC is working in collaboration with the Immersion Team to review the quality process. We expect to develop and implement changes to the process by May 1, 2011 to address accuracy and quality review of PTSD claims.

Recommendation 4 - *We recommend the Houston VA Regional Office Director conduct refresher training and develop and implement a plan to improve the quality review process for traumatic brain injury (TBI) and herbicide exposure-related claims.*

Concur with recommendation

Response: The Houston VARO Director concurs with this recommendation. Herbicide training is scheduled for April 20, 2011. Second signature reviews were required for the period of October 15, 2010 to December 1, 2010. The RVSRs and DROs received 5 hours of TBI training over the period covering November 17–18, 2010. The Houston VSC is working in collaboration with the Immersion team to review the quality process. We expect to develop and implement changes to the process by May 1, 2011 plan to improve the quality review process for traumatic brain injury (TBI) and herbicide exposure-related claims.

Recommendation 5 - *We recommend the Houston 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 Veterans Benefits Administration policy.*

Concur with recommendation

Response: The Houston VARO Director concurs with this recommendation. In October 2010, the Appeals team revised its procedures for controlling and processing Notices of Disagreements (NODs). The plan also included procedures for handling NODs received at the out-based office.

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

Concur with recommendation

Response: The Houston VARO Director concurs with this recommendation. A schedule was developed and plan was implemented to ensure SAOs are submitted timely and in accordance with VBA policy. The Quality of Compensation, Pension, and Ancillary Actions SAO dated January 28, 2011 and the Quality of Files Activity SAO dated March 2, 2011 addresses the OIG's concerns raised on the audit.

Recommendation 7- *We recommend the Houston VA Regional Office Director develop and implement a plan to address all deficiencies and recommendations identified in the Systematic Analysis of Operations regarding mail handling.*

Concur with recommendation

Response: The Houston VARO Director concurs with this recommendation. The Central Area Immersion Team began working with the Houston VSC management staff February 14, 2011 and is currently working closely with the Triage Team to develop efficient mail processing procedures. Training is being provided in all areas.

Recommendation 8 – *We recommend the Houston VA Regional Office Director develop and implement a plan to ensure management oversight of mail handling.*

Concur with recommendation

Response: The Houston VARO Director concurs with this recommendation. The Central Area Immersion Team is developing and implementing a plan to ensure management oversight of mail handling. The Triage Coach is responsible for daily implementation strategies. The VSCM and AVSCMs will be responsible for ensuring compliance with the plan.

Recommendation 9 – *We recommend that the Houston VA Regional Office Director conduct refresher training and implement controls to ensure staff follow current Veterans Benefits Administration policy regarding the processing of competency determinations.*

Concur with recommendation

Response: The Houston VARO Director concurs with this recommendation. Initial Fiduciary training for competency determinations was provided on December 21, 2010. Due process training was provided on February 14, 2011 to the POST Teams. Refresher training is scheduled for March 22, 2011 focusing specifically on the topic of incompetency ratings and subsequent processing following expiration of due process.

Recommendation 10 – *We recommend that the Houston VA Regional Office Director implement additional controls to ensure staff follow current Veterans Benefits Administration policy regarding safeguarding personally identifiable information.*

Concur with recommendation

Response: The Houston VARO Director concurs with this recommendation. During the OIG's visit, SSD personnel sealed all drop slots located on the lids of the shredding bins to prevent someone from being able to have access to documents inside the container when full. All bins have locks and are locked at all times. We have identified a secure office location for the RMO that is large enough to store all of the shredding bins, which allows us to remove the bins from the loading dock/mailroom area as an added security measure.

Appendix C Inspection Summary

10 Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Disability Claims Processing			
1. Temporary100 Percent Disability Evaluations	**Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations.** (38 Code of Federal Regulations (CFR) 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (Manual (M)21-1Manual Rewrite (MR), 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 VARO staff properly processed service connection for all residual disabilities related to in-service TBI.** (Fast Letter (FL) 08-34 and FL 08-36, Training Letter 09-01)		X
4. Herbicide Exposure-Related Disabilities	**Determine whether VARO staff properly processed claims for service connection for herbicide exposure-related disabilities (Agent Orange).** (38 CFR 3.309) (FL 02-33) (M21-1MR, Part IV, Subpart ii, Chapter 2, Section C.10)		X
Data Integrity			
5. Date of Claim	**Determine whether VARO staff properly recorded the correct dates of claim in the electronic record.** (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)	X	
6. Notices of Disagreement	**Determine whether VARO staff properly entered NODs into VACOLS.** (M21-1MR, Part I, Chapter 5)		X
Management Controls			
7. Systematic Technical Accuracy Review	**Determine whether VARO staff properly corrected STAR errors in accordance with VBA policy.** (M21-4, Chapter 3, Subchapter II, 3.03)		X
8. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)		X
Workload Management			
9. Mail Handling Procedures	**Determine whether VARO staff properly followed VBA mail handling procedures.** (M23-1) (M21-4, Chapter 4) (M21-1MR, Part III, Subpart ii, Chapters 1 and 4)		X
Eligibility Determinations			
10. Competency Determinations	**Determine whether VAROs properly assessed beneficiaries' mental capacity to handle VA benefit payments.** (M21-1MR, Part III, Subpart v, Chapter 9, Section A) (M21-1MR, Part III, Subpart v, Chapter 9, Section B) (FL 09-08)		X

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact&	Dawn Provost
Acknowledgments&	Diane Wilson Kristine Abramo Ed Akitomo Orlan Braman Madeline Cantu Danny Clay Michelle Elliott Lee Giesbrecht Rachel Stroup

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