VA Office of Inspector General

OFFICE OF AUDITS & EVALUATIONS

Inspection of the VA Regional Office Boise, ID

February 17, 2011
10-03858-92

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
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, Boise, ID

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 operations.

What We Found

The Boise VARO staff corrected errors identified by the Veterans Benefits Administration's (VBA) Systematic Technical Accuracy Review program. In general, VARO staff established correct dates of claim in the electronic record and followed VBA mail handling procedures. Additionally, the VARO staff generally processed post-traumatic stress disorder disability claims accurately.

The VARO needs to improve the control and accuracy of processing disability claims for temporary 100 percent disability evaluations, traumatic brain injury, and herbicide exposure. Overall, VARO staff did not accurately process 30 (30 percent) of the 101 disability claims reviewed. Controls also need strengthening to ensure timely processing of Notices of Disagreement for appealed claims, as well as timely and complete Systematic Analyses of Operations.

What We Recommended

We recommended the Boise VARO Director ensure staff review all temporary 100 percent disability evaluations to determine if reevaluations are required and take appropriate actions. We recommended VARO management implement controls to ensure the staff establishes reminder notifications for temporary 100 percent disability reevaluations.

We recommended that VARO management provide refresher training on the proper procedures for processing traumatic brain injury claims and implement an additional level of review for all TBI rating decisions prior to finalizing those decisions. We also recommended VARO management strengthen controls to ensure timely establishment of Notices of Disagreement in the Veterans Appeals Control and Locator System as well as implement a plan to ensure timely and complete preparation of Systematic Analysis of Operations.

Agency Comments

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

(original signed by:)

BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

The Benefits Inspection Program is part of the Office of Inspector General's (OIG) efforts 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 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 October 2010, the OIG conducted an inspection of the Boise VARO. The inspection focused on four protocol areas examining nine operational activities. The four protocol areas are disability claims processing, data integrity, management controls, and workload management. We did not examine eligibility determinations because VBA has centralized all Western Area fiduciary activities at the Salt Lake City VARO.

We reviewed 71 (54 percent) of 132 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 (39 percent) of 77 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 our inspection. Appendix B provides the Boise 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 Boise VARO needs to improve the accuracy of disability claims processing. VARO staff incorrectly processed 30 (30 percent) of the total 101 disability claims reviewed. We advised VARO management of the inaccuracies noted during our inspection and they initiated corrective measures to address them. The table below reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Boise 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	20	9	11
PTSD	30	2	0	2
TBI	11	4	3	1
Herbicide Exposure-Related Disabilities	30	4	3	1
Total	**101**	**30**	**15**	**15**

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 20 (67 percent) of 30 temporary 100 percent disability evaluations 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 the 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, 9 of the 20 processing inaccuracies identified affected veterans' benefits—8 involved overpayments totaling $307,679 and 1 involved an underpayment totaling $2,240. Examples of the most significant overpayment and underpayment follow:

- A Rating Veterans Service Representative (RVSR) correctly continued a temporary 100 percent disability evaluation for a veteran with bladder cancer and established a need for a future reexamination; however, VARO staff did not enter the suspense diary, or reminder notification, into the electronic record. At the time of our inspection, medical evidence showed that the cancer was no longer active. As a result, the veteran was overpaid $72,160 over a period of 2 years and 3 months.
- An RVSR did not grant a veteran special monthly compensation based on an evaluation of multiple disabilities, as required. As a result, VA underpaid the veteran a total of $2,240 over a period of 7 months.

The remaining 11 inaccuracies had the potential to affect veterans' benefits. In 10 of these cases, VSC staff did not establish reminder notifications needed to alert VARO staff that a VA reexamination needed to be scheduled. The remaining error had a reminder notification; however, VSC staff did not schedule the reevaluation examination.

We could not determine if these 11 temporary 100 percent disability evaluations would have continued because the veterans' claims folders did not contain evidence of the medical examinations needed to reevaluate each case. The delays in scheduling the examinations ranged from 3 months to 4 years and 8 months. An average of 1 year and 6 months elapsed from the time staff should have scheduled the medical examinations until the date of our inspection—the date staff ultimately took corrective actions to obtain the necessary medical evidence.

For temporary 100 percent disability evaluations, including confirmed and continued evaluations where rating decisions do not change a veteran's payment amount, VSC staff must input a suspense diary in VBA's electronic system. A suspense diary is a processing command that establishes a date when VSC staff must schedule a reexamination. As the diary matures, the electronic system generates a reminder notification alerting VSC staff to schedule the reexamination.

The most frequent processing errors noted in 16 (80 percent) of the 20 cases reviewed occurred when VARO staff did not properly establish suspense diaries for future VA examinations. At the time of our inspection, VARO management staff did not have a local policy or sufficient oversight measures in place to ensure staff entered suspense diaries into the electronic record to generate reminder notifications to schedule the reexaminations.

PTSD Claims

VARO staff incorrectly processed 2 (7 percent) of 30 PTSD claims. We did not consider the frequency of errors significant. However, we found that RVSRs incorrectly granted service connection for PTSD for these two claims without clear medical opinions from the examining physicians linking the PTSD diagnoses to the veterans' stressful in service events. In one case, the RVSR properly requested a medical opinion; however, the examination did not contain the requested opinion and the RVSR did not return the examination for clarification. Rather, the RVSR used the results of two separate examinations to conclude that the physicians provided a clear opinion. In the second case, instead of returning the examination report for correction, the RVSR used the report along with the results of a Social and Industrial Survey to conclude the physicians provided a clear opinion.

In both cases, based on its review of the examining physicians' medical reports, VARO management disagreed with our assessment that the RVSRs processed the claims without clear medical opinions. Management indicated RVSRs have the responsibility to interpret an examination report in light of a veteran's entire recorded medical history. However, VBA policy states the examiner must still opine whether the current symptoms are linked to the identified stressor or stressors. In neither case did the medical examiners provide this opinion.

Given the infrequency of these types of errors, the VARO generally followed VBA policy when processing PTSD claims. 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: physical, cognitive, and behavioral. VBA policy requires staff to evaluate these residual disabilities.

VARO staff incorrectly processed 4 (36 percent) of 11 TBI claims—3 of these claims processing inaccuracies impacted veterans' benefits and resulted in overpayments of approximately $13,683. Following is a summary of the processing inaccuracies related to TBI disability claims.

- In three cases, RVSRs did not correctly evaluate residual disabilities associated with TBI. In two of these cases, the improper evaluations occurred when RVSRs over-evaluated symptoms. In these cases, RVSRs based evaluations on the veterans' personal histories rather than the results of the VA examination findings. VARO management did not agree with one of the inaccuracies we identified.

- In the remaining case, VARO staff did not request a new VA examination, as required, to determine if a veteran's disability evaluation would increase under new evaluation criteria.

Although VARO staff received training on how to evaluate TBI disability claims, interviews with VARO managers and staff indicate the training was inconsistent. While most RVSRs did establish compensation evaluations based on VA medical examination reports, two of the four claims processing errors occurred because RVSRs based disability evaluations on subjective symptoms reported by the veterans and not on medical examination testing as reported by the VA medical examiner. As a result, veterans may not always receive correct benefits payments.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 4 (13 percent) of 30 herbicide exposure-related claims reviewed. Among the processing inaccuracies identified, three of the four affected veterans' benefits and resulted in approximately $37,180 in underpayments. The remaining inaccuracy had the potential to affect a veteran's benefits.

In the three cases that affected benefits, processing inaccuracies occurred because the RVSR did not assign the earliest payment date possible, as required by VBA policy. A review of the VARO's 2009 and 2010 training schedules indicate RVSRs received training on how to assign payment dates in July and October 2010. Because the three errors affecting benefits occurred prior to this training, we made no recommendation for improvement in this area

Recommendations

1. *We recommend the Boise VA Regional Office Director review the remaining universe of 47 temporary 100 percent disability evaluations under the regional office's jurisdiction to determine if reevaluations are required and take appropriate action.*
2. *We recommend the Boise VA Regional Office Director implement controls to ensure staff establish suspense diaries for temporary 100 percent disability reevaluations.*
3. *We recommend the Boise VA Regional Office Director ensure Rating Veterans Service Representatives receive training on how to properly evaluate disabilities related to traumatic brain injuries.*
4. *We recommend the Boise VA Regional Office Director establish an additional level of review for all traumatic brain injury decisions prior to finalizing the decision to ensure accurate benefit payments.*

Management Comments

The VARO Director concurred with our recommendations for improving disability claims processing accuracy. The Director indicated VSC staff completed reviews of 47 additional temporary 100 percent disability evaluations and requested medical examinations when appropriate. Further, the Director implemented a new policy requiring that experienced staff process temporary 100 percent disability evaluations and ensuring staff properly record diaries in the electronic record.

In December 2010, staff received refresher training regarding the proper procedures for processing TBI claims. Further, in January 2011, the Director instituted a second level review for all TBI claims. This additional level of review will involve RVSRs as well as Decision Review Officers.

OIG Response

Management's actions are responsive to the recommendations.

2. Data Integrity

We analyzed claims folders to determine if the VARO is following VBA policy to establish effective dates and dates of claim in electronic records, and timely record Notices of Disagreement (NODs) in the Veterans Appeals Control and Locator System (VACOLS). VARO management needs strengthened controls to ensure timely establishment of NODs in VACOLS.

Effective Dates

Generally, an effective date indicates when entitlement to a specific benefit arose. VARO staff followed VBA policy and correctly established an effective date for all 101 disability claims we reviewed. As such, we made no recommendation for improvement in this area.

Dates of Claim

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 number of days to complete a claim. VARO staff established incorrect dates of claim in the electronic record for 1 (3 percent) of the 30 claims we reviewed. Generally, VARO staff followed VBA policy when establishing dates of claim, so we made no recommendation 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 is the first step in the appeals process. VACOLS is a computer application that allows VARO staff to control and track veterans' appeals 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 an NOD is required to ensure an appeal moves through the appellate process expeditiously.

Finding 2 Controls Over Recording Notices of Disagreement Need Strengthening

VARO staff did not always record NODs in VACOLS within VBA's 7-day standard. The VARO exceeded VBA's 7-day standard for 29 (97 percent) of the 30 NODs we reviewed. It took staff an average of 23 days to enter these 29 NODs in VACOLS. The most untimely action occurred when staff did not record an NOD for 50 days. This occurred because management and staff were unaware of VBA's requirement to enter NODs within 7 days. Instead, the VARO had a local policy in place that required staff to establish NODs in a 10-day period, which was in conflict with VBA's 7-day standard. Untimely recording of NODs in VACOLS affects data integrity and misrepresents VARO performances.

According to VBA performance reports as of September 30, 2010, VARO staff averaged 14 days to record NODs, exceeding VBA's 7-day standard by 7 days. Although staff can improve appeals control time, the VARO's NODs have been pending completion on average for 98 days, 47 days better than VBA's national average target of 145 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 timely completion of appeals.

Recommendation

5. *We recommend the Boise VA Regional Office Director amend the local policy to require staff to record Notices of Disagreements within the Veterans Benefits Administration's 7-day policy, thereby ensuring timely recording of Notices of Disagreement in the Veterans Appeals Control and Locator System.*

Management Comments

The VARO Director concurred with our recommendation and updated the FY 2011 Performance Standards for Claims Assistants to include the requirement to process NODs within 7 days. Further, the VARO Workload Management Plan now incorporates guidance to complete NODs within VBA's 7-day standard. The Director also assigned an additional Claims Assistant to assist with NOD processing.

OIG Response

Management's actions are responsive to the recommendations.

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 VAROs take corrective action on errors that STAR staff identifies. VARO staff followed the policy by taking corrective actions to address all 14 errors VBA's STAR program identified. As such, we made no recommendation for improvement in this area.

Systematic Analysis of Operations

Further, we assessed whether VARO management had controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs). Inspection findings indicate VARO managers need to strengthen controls for ensuring SAOs are complete and timely. 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 that identifies specific dates for completing each analysis and designating staff to complete them.

Finding 3 Strengthened Controls Needed to Ensure Systematic Analysis of Operations are Timely and Complete

The Veterans Service Center Manager is responsible for ongoing analysis of VSC operations, including completing 11 annual SAOs. Our analysis revealed 6 (55 percent) of the 11 SAOs were not completed timely per the annual schedule, were incomplete (missing required elements), or were not done at all. This occurred because VARO management did not provide adequate oversight to ensure VSC staff completed SAOs in accordance with VBA policy. As a result, VARO management may not have adequately identified existing and potential problems for corrective actions to improve VSC operations.

Specifically, 4 (36 percent) of the 11 SAOs were incomplete, 1 (9 percent) was untimely, and 1 (9 percent) was not completed at all. The VSC Manager indicated staff only completed those elements of SAOs where they knew problems existed rather than completing analyses of all elements as required by VBA policy.

We identified several areas where, by not providing adequate oversight to ensure complete SAOs, VARO management did not identify VSC operational problems for corrective action. For example, had management thoroughly completed the Appeals SAO, it might have determined the VARO was not meeting its local goal to establish NODs in VACOLS within 10 days, as outlined in the workload management plan. More importantly,

management might have identified its local standard was not in line with VBA's national standard of 7 days.

Recommendation

6. *We recommend the Boise 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 and updated the FY 2011 SAO schedule to reflect all SAOs mandated for completion. The SAOs are to include all required elements.

OIG Response

Management's action is responsive to the recommendation.

4. Workload Management

We assessed controls over mailroom operations to ensure VARO staff timely and accurately processed incoming mail. VBA uses various plans and applications to control workload. VBA policy indicates the most important part of workload management is oversight to ensure the staff efficiently uses the plans and systems available. It also states that effective mail management is crucial to the success and control of workflow within the VSC.

Mailroom 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 Boise VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division. Because VARO mailroom staff processed, date stamped, and delivered all VSC mail to the Triage Team mail pick-up point on a daily basis as required, we made no recommendations for improvement in this area.

Triage Mail-Processing Procedures

We assessed the VSC Triage Team's mail processing procedures to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy. VBA policy requires VARO staff to establish a claim in the electronic record within 7 days from the date the VARO receives the mail. VBA relies on accurate information in the electronic record to establish and track a key performance measure that determines the average number of days to complete a claim. Additionally, VBA policy requires that staff use the Control of Veterans Records System (COVERS), VBA's electronic tracking system, to track claims folders and search mail. VBA defines search mail as active claims-related mail waiting to be associated with a veteran's claim folder.

Of the 30 claims established in the electronic records, 1 (3 percent) was established outside of VBA's 7-day goal. Because of the infrequency of this occurrence, we made no recommendations for improvement in this area.

Additionally, the Triage Team correctly used COVERS to electronically track veterans' claims folders and control search mail.

Appendix A VARO Profile and Scope of Inspection

Organization

The Boise VARO is responsible for delivering nonmedical VA benefits and services to veterans and their families in Idaho. The VARO fulfills these responsibilities by administering compensation and pension benefits, vocational rehabilitation and employment assistance, and outreach activities.

Resources

As of June 2010, the Boise VARO had a staffing level of 74 full-time employees. Of these, the VSC had 60 employees (81 percent) assigned.

Workload

As of September 2010, the VARO reported 1,762 pending compensation claims. The average time to complete these claims during FY 2010 was 111.2 days—approximately 39 days better than VBA's target of 150 days. As reported by STAR, accuracy of compensation rating-related issues was 87.6 percent, which is below the 90 percent target set by VBA.

Scope

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

Our review included 71 (54 percent) of 132 disability claims related to PTSD, TBI, and herbicide exposure that the VARO completed during April to June 2010. For temporary 100 percent disability evaluations, we selected 30 (39 percent) of 77 existing claims from VBA's Corporate Database. We provided the VARO with the 47 claims remaining from the universe of 77 to assist in implementing our first report recommendation. The 77 claims represented all instances in which VARO staff granted temporary 100 percent disability evaluations for at least 18 months.

We reviewed 14 errors identified by VBA's STAR program during the period of April to June 2010. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR's assessments include a review of work associated with claims requiring rating decisions. The STAR staff reviews original claims, reopened claims, and claims for increased evaluation. Further, they review appellate issues that involve a myriad of veterans' disabilities claims.

Our process differs from STAR as we review specific types of disability claims such as PTSD, TBI, and herbicide exposure that require rating decisions. In addition, we review rating decisions and awards processing involving temporary 100 percent disability evaluations. We selected for review dates of claim and NODs 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: February 2, 2011

From: Director, Boise VA Regional Office

Subj: Inspection of the VARO Boise, ID

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

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

2. Questions may be referred to Stephanie Pinque, Human Resource Specialist, at 208-429-2204.

(original signed by:)

James O. Vance
Director

Attachment

Comments on Draft Report
OIG Office of Audits and Evaluations
Benefits Inspection of the Boise Regional Office

Recommendation 1: *We recommend the Boise VA Regional Office Director review the remaining universe of 47 temporary 100 percent disability evaluations under the regional office's jurisdiction to determine if reevaluations are required and take appropriate action.*

RO Response: Concur

Boise RO completed the review of the remaining 47 cases left by the OIG. Exams were ordered on those cases requiring them. Adjustments or continued evaluations were processed when appropriate.

The Veterans Benefits Administration recommends closure of this recommendation.

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

RO Response: Concur

In October 2010, the Boise VARO implemented a new policy to ensure diary suspense dates were established. The OIG findings showed the majority of the future exams were not being carried forward when a new decision did not warrant a change (C&C ratings).

The Boise VARO now requires all rating decisions to be processed through authorization. This ensures the claim is being reviewed for accuracy by more experienced personnel. By allowing the claim to fully process in VETSNET, the system will carry forward any future examination. VSRs no longer clear pending end products on continued decision when no change to the master record is required. VSRs were trained on the outcome of this measure and trained on our new policy immediately following the OIG Exit Briefing.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 3: *Recommend the Boise VA Regional Office Director ensure Rating Veterans Service Representatives receive training on how to properly evaluate disabilities related to traumatic brain injuries.*

RO Response: Concur

The Boise VARO conducted training on traumatic brain injuries on December 9, 2010. Refresher TBI training for fiscal year 2011 will be scheduled when appropriate.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 4*: Recommend the Boise VA Regional Office Director establish an additional level of review for all traumatic brain injury decisions prior to finalizing the decision to ensure accurate benefit payments.*

RO Response: Concur

In January 2011, the Boise VARO instituted a second signature review of all traumatic brain injury decisions. The second signature review has been assigned to all DROs and the Rating Coach.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 5: *We recommend the Boise VA Regional Office Director amend the local policy to require staff to record Notices of Disagreements within the Veterans Benefits Administration's 7-day policy, thereby ensuring timely recording of Notices of Disagreement in the Veterans Appeals Control and Locator System.*

RO Response: Concur

The Boise VARO updated the fiscal year 2011 Job Performance Standards for Claims Assistants assigned to inputting Notices of Disagreements. The updated standards require that Notices of Disagreements must be recorded in VACOLS within 7 days 90% of the time. Updates to the RO Workload Management Plan will also be done to reflect the 7-day standard. The RO has also assigned an additional Claims Assistant to input Notices of Disagreement when the primary Claims Assistant needs assistance.

The Veterans Benefits Administration recommends closure of this recommendation.

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

RO Response: Concur

The SAO Schedule for fiscal year 2011 has been updated to reflect all required SAOs per M21-4, Chapter 5. All SAOs completed in fiscal year 2011 will include all required elements.

The Veterans Benefits Administration recommends closure of this recommendation.

Appendix C Inspection Summary

Nine Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Disability Claims Processing			
1. 100 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) 21-1 Manual 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 claims for service connection for all residual disabilities related to in-service TBI.** (Fast Letters (FL) 08-34 and 08-36 (Training Letter 09-01)		X
4. Herbicide Exposure-Related Claims	**Determine whether VARO staff properly processed claims for service connection for disabilities related to herbicide exposure.** (38 CFR 3.309) (FL 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)	X	
Data Integrity			
5. Dates of Claim	**Determine if VARO staff properly recorded correct dates 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 formal analyses 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	

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	Brent Arronte
Acknowledgments	Nora Stokes Brett Byrd Madeline Cantu Kelly Crawford Lee Giesbrecht Kerri Leggiero-Yglesias Lisa Van Haeren

Appendix E Report Distribution

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