

# VA Office of Inspector General

## OFFICE OF AUDITS & EVALUATIONS



### *Inspection of VA Regional Office San Juan, PR*

December 4, 2009  
09-01996-41

## **Office of Inspector General**

### **Benefits Inspection Program**

The Benefits Inspection Program is part of the Office of Inspector General's (OIG's) efforts to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Division contributes to the improvement and management of benefits processing activities and veteran services by conducting onsite inspections at 57 VA Regional Offices (VAROs). The purpose of these independent inspections is to provide recurring oversight of VAROs by focusing on disability compensation claims processing and the performance of Veterans Service Center (VSCs) operations. The objectives of the inspections are to:

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

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

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# Report Highlights: Inspection of VA Regional Office, San Juan, PR

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## Why We Did This Review

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

## What We Found

The San Juan Regional Office management team faces challenges in providing quality benefits and services to veterans, to include improving the quality of formal benefits decisions. At the end of March 2009, the VARO had the lowest accuracy associated with these decisions in the nation at 60 percent. Also, the Regional Office did not meet all requirements in 10 of the 15 operational areas reviewed.

The Regional Office management team needs to provide additional management oversight and training for responsible personnel in processing claims identified as diabetes, post-traumatic stress disorder (PTSD), and traumatic brain injury (TBI). The management team also needs to improve controls over the following areas:

- Correcting errors identified by the Veterans Benefits Administration's (VBA) Systematic Technical Accuracy Reviews (STAR).
- Completing Systematic Analysis of Operations (SAO) accurately and timely.

- Safeguarding veterans' personally identifiable information (PII).
- Safeguarding VARO date stamps.
- Handling claims-related mail.
- Responding to electronic inquiries.
- Processing fiduciary activities.

## What We Recommend

We recommend that the VARO improve oversight of the quality assurance process for the operational areas found lacking. We also recommend the VARO ensure mandatory PTSD training modules are completed.

## Agency Comments

The Director of the San Juan Regional Office concurred with all recommendations but offered qualifications and commentary on some issues. We have responded to each of management's assertions in the report. Management's planned actions are responsive and we will follow-up as required on all actions.

*(original signed by:)*  
**BELINDA J. FINN**  
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for Audits and Evaluations

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## Results of Inspection

The OIG conducted an inspection of the San Juan VARO from July 6–July 15, 2009. The inspection focused on 5 protocol areas examining 15 operational activities. The VARO did not ensure adequate performance for 10 of the 15 operational activities inspected. Appendix A describes the protocol areas and operational activities we reviewed. We also made observations pertaining to VSC staff taking credit for fiduciary claims that were not completed, thus affecting fiduciary performance measures. Observations pertain to operational activities that are not specifically required by VBA policy or procedure, but still affect benefits delivery or VARO performance.

## Management Challenges at the San Juan VARO

The San Juan VA Regional Office (VARO) management team faces multiple challenges in providing quality benefits and services to veterans. These challenges include improving the accuracy of formal rating benefits decisions (also known as rating decisions), safeguarding veterans' personally identifiable information (PII), handling mail within the Veterans Service Center (VSC), and processing fiduciary claims for our most vulnerable veterans. During our inspection, the VA Regional Office (VARO) Director's position was vacant and Director's responsibilities were remotely managed by the Director of the St. Petersburg VARO.

According to VBA's Systematic Technical Analysis Review (STAR) staff, as of the end of the second quarter for FY 2009, the San Juan VARO had an accuracy rate of 60 percent, the lowest rate in the nation for formal benefits decisions. As a result, several supervisors were reassigned in an effort to improve quality assurance reviews associated with rating benefits decisions. In addition, senior VSC management implemented a policy requiring a second level of review for rating decisions before finalization. We could not fully determine the effect of this policy change as it occurred less than two months prior to our inspection.

## VARO Activities Needing Additional Management Attention

### ***Disability Claims Processing***

We reviewed 81 (45 percent) of 179 completed diabetes (to include disabilities related to herbicide exposure), post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and Haas<sup>1</sup> claims for which the VARO made a decision regarding specified issues during the time period of January 1, 2009, through March 31, 2009. The San Juan VARO completed all claims reviewed as this station was not participating in VBA's brokering plan at the time of our review.

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<sup>1</sup>A Haas claim is a claim affected by a U.S. Court of Appeals for Veterans Claims decision in *Haas v. Nicholson*. Haas claims involve veterans who served in waters off Vietnam and did not set foot in Vietnam and whether those veterans are entitled to the presumption of exposure to herbicide agents, including Agent Orange. VA put a stay of adjudication on these claims; however, it lifted the stay in January 2009.

We concluded the San Juan VARO processed all of its Haas claims correctly according to VBA policy. For the other three categories, our analysis revealed errors in 33 (41 percent) of the 81 claims. The following table reflects the errors by claim type and identifies those errors impacting veterans' benefits by claim type.

**Table 1. Disability Claims Processing Errors**

Claim Type	Claims Reviewed	Claims with Errors	Errors with Impact on Veteran Benefits
Diabetes	30	12	5
PTSD	30	8	4
TBI	19	13	0
Haas	2	0	0
<b>Total</b>	<b>81</b>	<b>33</b>	<b>9</b>

**VSC personnel made inaccurate disability decisions.**

Diabetes and disabilities related to herbicide exposure. Five of the 12 processing errors identified impacted the veterans' benefits.

- A veteran was over evaluated for vision loss associated with diabetes. VSC staff incorrectly increased the disability evaluation from 10 percent to 70 percent disabling. The VA medical examination revealed the decrease in vision was not a result of diabetes. Therefore, no increase was warranted. This error resulted in the veteran receiving an overpayment of \$14,413.
- A veteran was under evaluated for diabetes. Medical records indicated the veteran was prescribed oral medication for this condition. Therefore, an evaluation of 20 percent was warranted. The veteran was underpaid \$2,170.
- A veteran was under evaluated for diabetes and over evaluated for diabetic nephropathy with hypertension (a single rating decision contained two processing errors). After determining the difference between the two incorrectly evaluated disabilities, the veteran was overpaid \$2,148.
- A veteran was incorrectly granted entitlement to special monthly compensation for erectile dysfunction. VA medical examination indicated this condition was not likely related to the veteran's diabetes. Therefore, entitlement to special monthly compensation was incorrect and related benefits should not have been granted. The veteran was overpaid \$1,400.
- A veteran's effective date for entitlement to special monthly compensation was incorrect. The correct effective date of payment should have been the date the veteran filed his claim. The veteran was overpaid \$989.

VSC management indicated the diabetes errors occurred because internal quality reviews were not thorough enough to identify these issues. The remaining seven errors were procedural in nature. For example, VSC staff had ordered VA medical examinations that were not necessary for making a formal decision and thus delaying the processing of the claims.

PTSD Claims. Four of the eight processing errors identified for PTSD cases impacted the veterans' benefits.

- The VARO staff did not correctly address the issue of competency for two veterans evaluated as 100 percent disabling for PTSD. VBA policy requires the issue of competency to be considered when mental disabilities are evaluated as 100 percent disabling.
- The VARO staff did not correctly address the issue of competency for one veteran. Although the veteran did not have a mental disability evaluated as 100 percent disabling, the VA medical examination indicated the veteran was shown not to be competent to handle his financial affairs.
- A veteran was under evaluated for PTSD. Medical evidence revealed the veteran's symptoms warranted an evaluation of 50 percent disabling instead of 30 percent. The veteran was underpaid \$4,356.

The remaining four errors were procedural in nature. For example, a mandatory medical examination should have been scheduled within 6 months following the veteran's discharge from military service to determine whether a change in evaluation was warranted.

TBI Claims. All of the 13 processing errors identified for TBI cases had the potential to impact the veterans' benefits. These 13 errors occurred as a result of inadequate or improper VA medical examinations. It is unclear what disability evaluation would have been assigned had all of the veterans' residual disabilities due to an in-service TBI been accurately evaluated. Ten of the errors involved VA medical examiners not using the correct examination worksheets required for completing TBI examinations despite the VSC sending the updated worksheets to the VA Medical Center (VAMC). For two errors, the correct TBI worksheet was used, however, an opinion regarding separating any psychiatric disorder from TBI residuals was not provided. The last error was the result of a medical examiner performing a neurological examination instead of the proper TBI examination.

Senior VSC management stated the PTSD errors occurred because Rating Veterans Service Representatives (RVSRs) had not completed the required Training and Performance Support System (TPSS) training module for PTSD. Management noted that this training did not occur because of the unavailability of a training room with computer access. Additionally, management indicated the PTSD errors occurred because internal quality reviews were not thorough enough to identify these issues.

Management told us the RVSRs should have recognized that the examinations did not follow the correct TBI worksheets and they should have returned the examinations to the VAMCs for correction. Senior management contacted the VAMC and received assurance that the examiners were now using the correct worksheet. VSC management ensured the 13 claims with inadequate or improper examinations were sent back to the VAMC for correction.

Ultimately, the lack of management oversight of the internal quality review process and lapses in the implementation of the training program led to a high occurrence of inaccurate disability decisions.

***Recommendation 1.*** We recommend the San Juan VA Regional Office Director develop and implement a mechanism to improve oversight of the quality assurance process to ensure the correct procedures for processing diabetes, post-traumatic stress disorder, and traumatic brain injury decisions are followed.

**Management Comment**

The VARO Director concurred with our recommendation and has developed and implemented a plan to review decisions for diabetes, PTSD, and traumatic brain injury. In addition, the VARO Director has rotated supervisors within the VSC and assigned a Decision Review Officer to the rating team in order to confront this challenge. The Director stated other counter-measures have been implemented with no apparent positive results and this is the most formidable challenge facing the VSC.

**OIG Response**

Management comments and actions are responsive to the recommendation.

***Recommendation 2.*** We recommend the San Juan VA Regional Office Director ensure the Training and Performance Support System training module for Post-Traumatic Stress Disorder is provided to all Rating Veterans Service Representatives.

**Management Comment**

The VARO Director concurred with our recommendation and informed us the training module for PTSD has been completed with the exception of two employees currently out of the office.

**OIG Response**

Management comments and actions are responsive to the recommendation.

***Data Integrity***

We assessed the data in VBA's Control of Veterans Records System (COVERS) to determine if the VARO is accurately tracking the location of veterans' claims folders. The primary function of COVERS is tracking the location of claims folders within and between VAROs. COVERS also supports VARO claims folder activities such as requesting folders and identifying mail to associate with folders.

In addition, we reviewed claims folders to determine if the VARO is following VBA policy regarding the correct establishment of the date of claim in the electronic record. The date of claim is generally used to indicate when a document arrives at a specific VA facility. VBA relies on an accurate date of claim to establish a key performance measure to determine the average days to complete a claim.

Our review of 30 claims folders revealed the San Juan VARO is meeting the requirements of VBA and local policies as the location of those files were properly recorded in COVERS. Further, our review of 30 claims folders revealed the date of claim was generally recorded

correctly in the electronic record. Our analysis revealed only 1 (3 percent) of 30 files contained the incorrect date of claim.

### **Management Controls**

We assessed management controls to determine if VARO management adheres to VBA policy regarding employee rotation within the Claims Process Improvement (CPI) business model, correction of errors identified by VBA's STAR staff, completion of Systematic Analysis of Operations (SAOs), and VARO date stamp accountability. According to senior VSC management, the San Juan VARO was not required to rotate employees under the CPI business model because the station workload was not under control.

#### **VBA's STAR errors were not always corrected by VSC staff.**

Our review of 29 files that were previously identified by VBA's STAR program as errors between January 1, 2009, and March 31, 2009, showed that 6 (21 percent) of the 29 errors were not corrected in accordance with VBA policy. The policy requires VARO staff to take and report on corrective actions and retain error documentation for training.<sup>2</sup> VSC staff erroneously informed STAR that 5 of the 6 errors had been corrected.

Supervisors at the San Juan VARO are responsible for ensuring errors identified by STAR are corrected. A VARO analyst is then tasked with the duty of verifying that these corrective actions have been implemented. VSC management stated the analyst failed to review the claims folders yet still provided assurance that corrective actions had been taken. As a result, the VARO Director received inaccurate information and ultimately lacked assurance employees adhered to VBA's national quality assurance program.

**Recommendation 3.** *We recommend the San Juan VA Regional Office Director develop and implement a plan to ensure timely corrective action is taken to address errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review staff.*

#### **Management Comment**

The VARO Director concurred with our recommendation and implemented a plan that requires VSC management to review each STAR error to ensure corrective action is taken.

#### **OIG Response**

Management comments and actions are responsive to the recommendation.

#### **Required SAO analysis was not completed in a timely and accurate manner.**

An SAO is a formal analysis of an organizational element or operational function of the VSC. SAOs provide an organized means for reviewing operations to identify existing or potential problems and propose corrective actions. VBA policy requires SAOs to be performed annually and must cover all aspects of claims processing, including quality, timeliness, and related factors.

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<sup>2</sup>VBA Manual M21-4, *Manpower Control and Utilization in Adjudication, Quality Assurance*, dated June 29, 2007.

Our review of 11 (92 percent) of the 12 mandatory SAOs for FY 2009 showed that 8 (73 percent) of 11 SAOs were not properly completed or timely in accordance with VBA policy.<sup>3</sup> One SAO was not completed until 3 months past the date it was due. We did not review one other SAO because it was not due for completion until after our inspection. Table 2 below reflects the 12 SAOs and the minimum requirements not addressed by the San Juan VARO.

**Table 2. Required SAOs**

SAO	Not Complete	Not Timely	Requirements Not Addressed By VARO Staff
<b>1. Claims Processing Timeliness</b>	X	X	Average days to complete a claim. Implementation of the workload management plan. Reviewing special claims submitted by Very Seriously Injured and Seriously Injured Veterans.
<b>2. Quality of Compensation, Pension, and Ancillary Actions</b>	X	X	Quality assessments of rating decisions containing clear and unmistakable errors.
<b>3. Quality of Development Activity</b>			All areas addressed.
<b>4. Quality of Files Activity</b>	X	X	Ensuring files are updated in COVERS.
<b>5. Hospital Summaries and Adjustments</b>			SAO was not due at the time of our inspection.
<b>6. Appeals</b>		X	All areas addressed (29 days late).
<b>7. Fiduciary</b>			All areas addressed.
<b>8. Quality of Control Actions</b>	X	X	How to process mail that does not contain information to identify the claimant. Ensuring the correct date of claim is recorded in VBA's electronic record.
<b>9. Division Management</b>	X	X	Ensuring proper delegations of authority memorandums have been completed.
<b>10. Direct Services and Outreach</b>			All areas addressed.
<b>11. Quality of Correspondence</b>	X	X	Reviewing letters for accuracy.
<b>12. Internal Controls</b>	X		Reviewing the large retroactive payment certification process. Ensuring files for employee veterans remain properly secured. Controlling records transfer procedures. Managing Income Verification Match Program.

During this inspection, we identified several operational activities where the VSC did not follow VBA policy. If VSC management properly completed the required SAOs, some of the existing or potential problems might have been identified. For example, in the *Quality of Files Activity* SAO, VSC management identified over 1,500 pieces of mail in Triage waiting to be processed and indicated this was an excessive amount of mail. Although management identified this issue as an area of concern, they did not develop a recommendation to address it as required by VBA

<sup>3</sup>VBA Manual M21-4, *Manpower Control and Utilization in Adjudication, Systematic Analyses of Operations*, dated April 1, 2009.

policy. At the time of our inspection, we estimate 2,200 pieces of mail were waiting to be processed. Thus, the condition appeared to be worsening.

We observed VSC staff completing SAOs during the course of our inspection—some were provided to us prior to completing our inspection. Senior VSC management stated the incomplete SAOs were a result of not monitoring employees who were responsible for ensuring corrective actions had been taken. SAOs were not completed in a timely manner because management did not closely monitor the annual schedule to determine when these assessments were due. Because of lapses in the required SAO analysis of VSC operations, the VARO Director lacked reasonable assurance that existing or potential problems were being identified and corrective actions were being developed.

***Recommendation 4.*** *We recommend the San Juan VA Regional Office Director develop and implement a mechanism to ensure Veterans Service Center management perform complete, accurate, and timely Systematic Analysis of Operations and take appropriate corrective action to fix problems identified.*

### **Management Comment**

The VARO Director concurred with our recommendation and conducted training in the conduct of SAOs and report preparation during the week of October 13, 2009. The Director and VSC Management Analysts are also closely monitoring SAOs to ensure complete, accurate, and timely submissions.

### **OIG Response**

Management comments and actions are responsive to the recommendation. The VARO Director indicated in most instances where SAOs were submitted past their due date, the responsible official had been given verbal extensions by VSC Management. At no time during our inspection did VSC management state they provided extensions to complete SAOs. Further, during our final briefing to VARO leadership, VSC management reiterated SAOs were untimely because management did not closely monitor the annual schedule to determine when these assessments were due.

### **VSC management did not always account for and safeguard VARO date stamps.**

VBA uses date stamps to indicate when information is received in any VA facility. The date a document is received at a VA facility is important because it may be relied upon to determine disability payment effective dates. On March 19, 2009, VBA issued policy providing guidance for the accountability and safeguarding of date stamps.<sup>4</sup> The policy states “manual (hand-held) date stamps will be replaced with electronic date stamps in all VBA regional offices,” and that “an Electronic Date Stamp Inventory Control Log will be created listing the date stamp manufacturer, model, serial number, and assigned location.”

A VARO manager indicated the office uses five electronic date stamps, which we inventoried and confirmed during our review. However, while conducting desk audits in the VARO, the

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<sup>4</sup>VBA Letter 20-09-10, *VBA Policy to Maintain Accountability of Official Date Stamps*, dated March 19, 2009.

inspection team found one additional electronic date stamp in an unlocked cabinet in the mailroom. This date stamp was not recorded in the Electronic Date Stamp Inventory Control Log.

We also observed one date stamp unattended at an employee's workstation, which was located within the Public Contact team. The employee was not at the workstation and the key allowing access to the machine was left in the unlocked, or "on" position. Leaving date stamps unsecured and readily accessible increases the risk of unauthorized use. The OIG completed work in June 2008 that revealed VBA lacked sufficient guidance directing VAROs to maintain adequate control over their official date stamps, thus making VAROs vulnerable to fraud from backdated claim documentation.<sup>5</sup> One of the sites visited during that review was the San Juan VARO. VBA issued guidance in response to our report stating, "Designated employees will be responsible for securing the machines during and after working hours. This includes securing the room when unattended."

VARO management did not properly secure or account for all electronic date stamps. As a result, the VARO Director did not have assurance that all date stamps were properly accounted for and safeguarded.

***Recommendation 5.*** *We recommend the San Juan VA Regional Office Director improve oversight by developing and implementing a plan to ensure accountability and safeguards of VA Regional Office date stamps.*

### **Management Comment**

The VARO Director concurred with our recommendation and implemented new directives to ensure accountability and safeguards of VARO Regional Office date stamps. In addition, the Director implemented monitoring procedures to ensure compliance with these directives.

### **OIG Response**

Management comments and actions are responsive to the recommendation.

### **Information Security**

The OIG inspection team conducted random inspections of employee workstations to determine if staff properly followed VBA's new policy to safeguard veterans' personally identifiable information (PII). The policy states that under no circumstances will claims or guardianship files, loose mail, or material of any kind that has claimant/veteran PII be stored in desk drawers, lockable cabinets, or other personal storage containers. Our inspections focused on these areas and did not include a review of employee's desktops where these materials are allowed for processing claims. VBA's policy also states materials used to develop training courses must be promptly and clearly redacted and stored in a location clearly designated for training course material.

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<sup>5</sup>OIG report *Review of Veterans Benefits Administration Large Retroactive Payments* (Report No. 08-01136-156, issued June 30, 2009).

We also analyzed mail-handling procedures in the VARO mailroom to ensure incoming mail was properly routed and processed to all divisions within the VARO. Further, we analyzed mail-handling procedures in the VSC Triage team to ensure the accurate and timely processing of mail.

The VARO staff was following policy regarding the destruction of documents as documents designated for destruction were properly reviewed and collected. However, staff was not following the policy for safeguarding veterans' PII. Our analysis revealed mail-handling procedures within the VARO mailroom were accurate and timely as mail was processed to each division daily.

**The VARO did not always safeguard veterans' personally identifiable information.**

During unannounced desk audits of 24 (20 percent) of the 120 employee's work stations located in the VSC, we found PII in unauthorized locations at 21 (88 percent) of the 24 employee's workstations. The PII was primarily related to veteran notification letters, military discharge certificates, military service department records, Social Security Administration records, and unredacted training materials. These documents were found in unmarked file folders and binders, desk drawers, and an unmarked locked file cabinet.

VBA policy requires all claims-related documents be stored in specified areas of the employee's workstation. Reference and training material stored in desk drawers, credenzas, personal lockable cabinets, or other personal storage containers must not contain veterans' personal identifying information. Also, the policy requires supervisors to perform inspections of the workstations to ensure adherence with the policy. At the San Juan VARO, supervisors were also assigned the responsibility of performing Division Records Management Officer duties.

We determined VSC desk audits were not being performed because Division Records Management Officers (DRMOs) were confused about their responsibilities. DRMOs incorrectly thought that once the Records Management Officer (RMO) was appointed they no longer had to inspect employee's workstations. Also, it appears the RMO was not consistently conducting thorough desk audits as evidenced by the number of employees with unredacted material found at workstations.

The VARO Assistant Director previously instructed VARO staff to review their workstations to ensure adherence to VBA policy by identifying and redacting documents that contain PII and properly storing claims-related material. However, VSC management made the decision that personnel were not allowed to take time off from processing claims to secure PII information properly in their work areas. VSC management indicated the VARO would have lost hundreds of hours of production time and with the pending workload, they could not afford to lose this time.

VSC staff did not follow VBA policy to protect information containing PII because management did not provide adequate oversight to ensure adherence to policy. As a result, the VARO Director lacked reasonable assurance that veteran's PII was properly safeguarded.

**Recommendation 6.** *We recommend the San Juan VA Regional Office Director develop and implement a plan to improve oversight of safeguarding veterans' personally identifiable information.*

### **Management Comment**

The VARO Director concurred with our recommendation and informed us RMOs and DRMOs are now conducting unannounced desk audits. DRMOs will also receive additional training during the week of November 3, 2009.

### **OIG Response**

Management comments and actions are responsive to the recommendation.

### **Mail management procedures within the Triage team needs strengthening.**

The Claims Process Improvement Model (CPI) Implementation Plan indicates the Triage team has the responsibility for reviewing, controlling, and processing or routing of all incoming mail. It is the critical "first step" for the effective coordination of other specialized teams within the VSC. VBA policy states, "Effective mail management is crucial to the success and control of workflow within the division."

We observed mail handling procedures in the San Juan VARO Triage team and concluded the team did not have an effective method to properly control and route mail to support VSC operations. Mail involving new claims was not placed under control within seven days and other mail (known as drop and search mail) was not properly routed to the respective claims folders. For example:

- Analysis of 30 pieces of incoming mail related to new claims revealed 5 (17 percent) of the 30 pieces of mail were not recorded in the electronic system within VBA's standard of 7 days. One piece of mail was a new claim for benefits received on April 13, 2009, and was not recorded until June 29, 2009. This mail was eventually recorded in VBA's electronic system 77 days later.
- Review of 30 pieces of claims-related mail (also known as search mail) to determine if incoming evidence was properly associated with the beneficiaries' claims folders showed 5 (17 percent) of 30 pieces of mail was evidence to support a claim and not properly associated with the claims folders, although the claims folders were located at the VARO.
- Approximately 2,200 pieces of mail not related to pending claims (also known as drop file mail) were waiting to be associated with the beneficiaries' claims folders. We examined this mail on July 14, 2009, and found the oldest piece of mail was dated February 1, 2009.

Senior VSC management stated the large volume of search and drop mail was a result of management oversight and the reallocation of Full Time Employees (FTE) in the Triage team. A supervisor in Triage told us quality performance reviews for claims assistants and program support clerks had not been completed. The supervisor also stated the mail handling processes in Triage were not properly managed because senior management reallocated FTE from Triage to support other VSC activities. As a result, the VARO Director has no assurance that

claims-related mail processed within the VSC is properly recorded in the electronic systems as required by VBA policy.

***Recommendation 7.** We recommend the San Juan VA Regional Office Director develop and implement a plan to improve management of Triage team activities to ensure all employees in Triage receive performance quality reviews and Triage is properly staffed to ensure mail is properly controlled and processed within the Triage team.*

### **Management Comment**

The VARO Director concurred with our recommendation with a qualification. The Director stated VARO Directors' Performance Standards require that 80 percent of the mail received be placed under control within 7 days of receipt. Further, the VSC met this target in 10 out of the last 11 months and the Director believes the VSC does not have a problem in this area.

In addition, the Director stated drop and search mail procedures needed strengthening and the VSC Workload Management Plan now contains specific procedures for handling this type of mail. Also, additional personnel resources were added to the Triage team to assist in the management of the team's workload. Periodic reviews of the team's workload staffing are conducted to ensure that the team is always properly manned.

### **OIG Response**

Although the VARO meets VBA's standard of placing 80 percent of mail under control in 7 days, this was not our concern. The VARO did not adequately staff the Triage team. This resulted in an extraordinarily large volume of drop mail. Further, staff did not timely associate search mail with veterans' claims folders. The VARO Director concurred drop and search mail procedures needed strengthening and modified the VSC workload management plan to address this issue. Therefore, management comments and actions are responsive to the recommendation.

### **Public Contact**

The Public Contact team provides benefit information to veterans, beneficiaries, and congressional staff through several methods including e-mail and written correspondence. We reviewed VA's Inquiry Routing and Information System (IRIS) and congressional inquiries to assess the accuracy and timeliness of the responses provided. In addition, we inspected Fiduciary Program activities to determine if VA designated fiduciaries were properly managing VA and personal funds of veterans who are unable to do so.

The San Juan VARO completed two congressional inquiries during the second quarter of FY 2009. Our review of those inquiries revealed VARO staff correctly followed VBA policy as both inquiries were accurate and completed within VBA's 5-day standard.

**VARO staff did not consistently provide veterans with accurate and timely responses to electronic inquiries.**

IRIS is VA's internet-based public message management system and is one method used by VSCs to communicate with veterans. Each written correspondence provided to the veteran

contains an e-mail address (<https://iris.va.gov>) that provides a method for veterans to send electronic inquiries to VA.

Analysis of 15 completed IRIS messages to determine if the VSC provided accurate and timely responses to veteran inquiries revealed all 15 IRIS responses did not meet VBA policy that requires accurate and complete responses be provided within five work days. Of the 15 errors, 9 contained inaccurate responses and exceeded the 5-day standard. Of the remaining 6 errors, 4 responses were untimely and 2 contained incomplete responses. For one inquiry, it took VSC staff 176 days to provide a response. Following is an example of one incomplete response:

*The veteran stated, "To anyone who may concern, I just want to know the status from my application." The VARO responded, "We regret to tell you that the status of your claim could not be provided since you failed to provide your social security number."*

A review of the actual IRIS inquiry clearly showed the veteran provided the required social security number. VSC staff should have provided the veteran an answer to the inquiry.

Senior VSC management stated the timeliness errors occurred because staff misinterpreted recent VBA Central Office guidance regarding IRIS program consolidation as meaning each VSC would no longer respond to IRIS inquiries. The misunderstanding led to the San Juan VARO not reviewing 14 IRIS inquiries from September 22, 2008, to February 27, 2009. Of those 14 inquiries, staff closed 4 of them without providing any responses to veterans. Responses should have been processed for each veteran.

A Public Contact team supervisor told us VARO staff began providing quick responses once they realized IRIS inquiries should have been processed. VSC management indicated quality reviews were not performed on the overdue responses. By not completing quality reviews of IRIS responses, the VARO Director lacked assurance that beneficiaries were receiving accurate and timely information.

***Recommendation 8.*** *We recommend the San Juan VA Regional Office Director develop and implement a plan to improve oversight of Inquiry Routing and Information System responses to ensure accurate and timely responses are provided to veterans.*

### **Management Comment**

The VARO Director concurred with our recommendation and provided training to personnel responsible for answering IRIS inquiries and supervisors are conducting daily monitoring to ensure the VARO provides accurate and timely responses. In November 2009, VSC management will conduct an analysis to measure the effectiveness of this plan.

### **OIG Response**

Management comments and actions are responsive to the recommendation.

### Controls over fiduciary activities need strengthening.

Analysis of 30 Principal Guardianship Folders (PGFs) completed by this office during April 1, 2009, through June 30, 2009, found processing errors in the following type of fiduciary activities:

- **Initial Appointments (IA)**—IA field examinations involve the qualification and appointment of a fiduciary to receive VA benefits on behalf of an incompetent beneficiary.
- **Fiduciary Beneficiary (FB)**—Follow-up field examinations involve the reassessment of incompetent veterans’ needs and determine whether funds have been properly used and protected. Generally, the first FB must be completed within 1 year of the initial appointment. Subsequent FB’s are determined by the field examiner’s assessment of the current status of the beneficiary and the fiduciary.
- **Accountings**—Fiduciary’s written report of the management of a beneficiary’s income and estate.

Table 3 reflects the number of errors by claim type and those errors that impacted veterans’ benefits:

**Table 3. Fiduciary Processing Errors**

Claim Type	Number of Cases Reviewed	Number of Cases in Error	Number of Cases with Errors Impacting Veterans’ Benefits
<b>Initial Appointment (IA)</b>	10	9	2
<b>Fiduciary Beneficiary (FB)</b>	10	7	1
<b>Accountings</b>	10	5	3
<b>Total</b>	<b>30</b>	<b>21</b>	<b>6</b>

Following is a description of errors that may impact the safeguarding of incompetent veterans’ benefits:

#### **Initial Appointments (IA):**

- 1 IA—Fiduciary unit had no assurance \$200,000 of income from the sale of real estate was spent in the veteran’s best interest. VBA policy states “VA is authorized to review a beneficiary’s total estate. For this reason, fiduciary personnel must review a fiduciary’s management of both VA and non-VA funds.”
- 1 IA—Fiduciary unit had not instructed one fiduciary on how to handle an anticipated \$5,387 retroactive payment. The fiduciary should have been informed about how to properly spend or invest this income. As a result, VA had no assurance these funds were properly managed effectively.

#### **Fiduciary Beneficiary (FB):**

- 1 FB—Fiduciary unit was 3 years past due in conducting their FB field exam. The IA field exam was conducted in April 2005. The next field exam should have been conducted by the end of April 2006, one year later. However, it was not conducted until April 2009. As a result, VA had no assurance of the beneficiary's well-being or fiduciary's proper use of funds during the 3-year period.

### **Accountings:**

- 1 Accounting—Fiduciary unit failed to properly analyze the fiduciary's expenditure of funds. VBA policy requires the Legal Instrument Examiners (LIEs) request copies of pertinent receipts to verify questionable expenditures. Our analysis revealed the LIEs did not request receipts to verify a \$3,000 legal expense. Ultimately, VA had no assurance that the \$3,000 legal expense was justified.
- 1 Accounting—Fiduciary unit had no assurance of actual funds on deposit at the end date of the accounting period. VBA policy states individual fiduciaries who are required to account must furnish verification of VA and non-VA estate funds on deposit as of the ending date of the accounting period. The accounting period ended on April 1, 2009. The PGF did not contain independent bank statements showing the actual funds on deposit at the end of that period. VSC staff should have ensured current bank statements were requested and received.
- 1 Accounting—Fiduciary unit did not take action to complete the required accounting although all necessary documents were located within the PGF. This occurred because LIEs did not properly establish an electronic control in Fiduciary Beneficiary System (FBS) that is designed to remind staff when accountings are due. VBA policy requires all accountings to be analyzed for approval or disapproval. As a result, VA had no assurance the fiduciary properly handled the veteran's funds during this accounting period.

A senior VSC official reviewed and concurred with all fiduciary errors. This official informed the inspection team that the identified errors occurred because of a lack of adequate training. The official also indicated the required number of quality reviews for each employee had not been completed.

***Recommendation 9.*** We recommend the San Juan VA Regional Office Director develop and implement a mechanism to improve oversight of the quality assurance process and provide training to Legal Instrument Examiners and Field Examiners emphasizing the correct procedures for processing Initial Appointments, Fiduciary Beneficiaries, and Accountings.

### **Management Comment**

The VARO Director concurred with our recommendation with a qualification. The Director indicated most errors found by the OIG team were related to Legal Instrument Examiners (LIE) not following the LIE Guide and the Fiduciary Form Guide. Further, VSC supervisors considered these publications guides and relied on the Manual, Law, and the Regulation to monitor and conduct the activities of the Fiduciary Unit. The Director informed us the errors have been corrected and LIEs received 12 hours of instructions in processing IAs, FBs, and Accountings with emphasis in following the guidance set forth in the LIE Guide.

## OIG Response

Management comments and actions are responsive to the recommendation as the errors were corrected and training to LIEs provided. Overall, 12 (57 percent) of the 21 errors were a result of not following the Manual, Law, and Regulation. The remaining errors were a result of not following guidance issued in the LIE Program Guide, Fiduciary Forms Program Guide, and FBS User Guide; the importance of these publications should not be diminished. While the responsibilities of the LIE are outlined in the Manual, the LIE Program Guide expands on and provides guidance for managing those responsibilities. It should be used as a guide for new trainees as well as a resource for experienced personnel.

During our inspection, a VSC supervisor informed us the fiduciary unit had not used this guide as part of their initial or supplemental LIE training. The Fiduciary Forms Program Guide contains information on the forms most frequently utilized in the Fiduciary Program. It includes when forms should be used and what information is required on the completed document to make it acceptable. Since the Director concurred with and implemented the recommendation, we will evaluate the effectiveness of the most recent training during a future follow-up site inspection.

## Observations

Observations pertain to issues that may affect benefits delivery or diminish VARO performance but are not specifically compliance-related. Several observations were noted during the onsite inspection:

- Workload Credit for Unfinished Claims. The San Juan VARO took credit for completing work for 16 (89 percent) of the 18 field exams prior to all work associated with those exams being finished. VBA policy states work should be completed as soon as practical. VARO management indicated the policy does not clearly outline a specific standard as to when the work credit should be taken, or if all work associated with a fiduciary claim must be completed, prior to taking credit for completing the claim. For example, VARO San Juan took work credit for one claim; however, work continued on that claim for an additional 40 days.

The work on the claims was ultimately completed. We are providing this observation because once the work credit has been taken; there is no control to ensure the completion of additional internal actions associated with fiduciary estate administration. Furthermore, senior VBA leadership does not receive accurate information related to the actual time required to complete fiduciary claims.

## Management Comment on Observations

The VARO Director concurred with our observation. The Director stated no specific national standard indicates when credit for work should be taken, or if all work associated with a fiduciary claim must be completed prior to taking credit for completing the claim. The Director further stated he understood that this may be a systemic problem and the OIG will address this trend with VA management.

**OIG Response**

Observations pertain to issues that may affect benefits delivery or diminish VARO performance but are not specifically compliance-related issues. We provided this observation to inform VARO leadership of the potential risk associated with fiduciary estate administration.

## VARO Profile

**Organization.** The San Juan VARO is responsible for delivering non-medical VA benefits and services to veterans and their families in Puerto Rico. This is accomplished through the administration of Compensation and Pension Benefits (C&P), Vocational Rehabilitation and Employment (VR&E) Assistance, Burial Benefits, and Outreach activities. The San Juan VARO has four out-based offices and also provides monthly itinerant services to the U.S. Virgin Islands; however, the inspection team did not perform any work at those facilities.

**Resources.** As of March 2009, the San Juan VARO had a staffing level of 144 Full Time Employees (FTE). Of the 144 FTE, 120 (83 percent) were assigned to the VSC.

**Workload.** As of June 2009, the VARO had 2,985 pending C&P claims that took an average of 143.8 days to complete, which is approximately 25.5 days better than the national target of 169.3 days. At the end of March 2009, accuracy for C&P rating-related issues, as reported by VBA's STAR, was 60 percent, below the national standard of 90 percent. At the end of March 2009, accuracy for C&P authorization-related issues, as reported by VBA's STAR was 87 percent, below the national standard of 95 percent. As of June 2009, reported by VBA's STAR, accuracy for fiduciary-related activities was 88 percent, below the national standard of 90 percent.

## Scope of the Inspection

**Scope.** We reviewed selected management controls, benefits claims processing, and administrative activities to evaluate if the VARO is following VBA policies as they related to benefits delivery and non-medical services provided to veterans. As part of our inspection, we interviewed managers and employees, reviewed veterans' claims folders, and inspected work areas.

The review of disability claims processing, STAR, IRIS, and congressional inquiries, covered the period January 1, 2009, through March 31, 2009. Fiduciary activities review covered cases completed from April 1, 2009, through June 30, 2009 because this was the most current data available from VBA's FBS system. The reviews were done in accordance with the President's Council for Integrity and Efficiency's *Quality Standards for Inspections*.

The inspection covered 15 operational activities in the 5 protocol areas of claims processing, data integrity, management controls, information security, and public contact, as detailed in Table 4.

**Table 4. Protocols with Activities Reviewed**

<b>Inspection Protocols</b>				
<b>Claims Processing</b>	<b>Data Integrity</b>	<b>Management Controls</b>	<b>Information Security</b>	<b>Public Contact</b>
<b>15 Activities Reviewed</b>				
Haas Claims	Date of Claim	Systematic Analysis of Operations	Mail Handling Procedures	Inquiry Routing and Information System
Post-traumatic Stress Disorder Claims	Control of Veterans Records System	Systematic Technical Accuracy Review Compliance	Destruction of Documents	Congressional Inquiries
Traumatic Brain Injury Claims		Employee Rotation in Claims Process Improvement Model		Fiduciary
Diabetes Claims		Date Stamp Accountability		

**Department of  
Veterans Affairs**

**MEMORANDUM**

**Date:** October 26, 2009  
**From:** Acting Director, VA Regional Office San Juan  
**Subject:** **Inspection of VARO San Juan, PR**  
**To:** Assistant Inspector General for Audits and Evaluations (52)

1. Attached is the San Juan Regional Office response to the OIG Draft Report: Benefits Inspection Division, OIG visit.
2. Questions may be referred to Al Zabala, Assistant Veterans Service Center Manager, at (787) 772-7396.

*(original signed by:)*

THOMAS MURPHY

Director

Attachment

**San Juan VA Regional Office*****Response to OIG Draft Report Finding***

The VA OIG visited the San Juan Regional Office from July 6 to July 15, 2009. This paper outlines the San Juan VA Regional Office's response, as well as concerns regarding the visit and findings.

The employees of the San Juan Regional Office appreciate the recent visit of the OIG in connection with their Benefits Inspection Program. We are cognizant of the many challenges facing the Regional Office and the Veterans Service Center (VSC) in particular, and had been addressing most of these challenges enumerated in the report prior to the OIG visit. Below are specific responses addressing each observation made by the OIG Team.

Under report highlights, below the heading "What We Found," we suggest that the last sentence be changed to read as follows: "Also, the Regional Office did not meet "all" the requirements in 10 of the 15 operational areas reviewed." This sentence more accurately reflects actual findings. In some of the areas, only procedural errors were found that have no impact on services or identify systemic trends in VSC operations.

***Recommendation 1.*** *We recommend the San Juan VA Regional Office Director develop and implement a mechanism to improve oversight of the quality assurance process to ensure the correct procedures for processing diabetes, post-traumatic stress disorder, and traumatic brain injury decisions are followed.*

***San Juan VA Regional Office Response:*** Concur.

We concur with the errors found and the recommendation made. The VSC Quality Review Committee (QRC) implemented a plan to carefully review decisions made regarding claims for diabetes mellitus II (DMII), Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). A local checklist was developed by the team to aid in spotting errors prior to implementation of the rating decision. The checklist is now in use and its impact in improving rating quality will be evaluated over the coming months. All DROs and VSRs meet with the QRC once each month to discuss new directives, errors found in local and STAR reviews and to develop countermeasures to prevent the reoccurrence of these errors. The training plan is also reviewed to determine if it adequately addresses the needs of these employees. Suggested changes to the training plan are made at these meetings.

The San Juan Regional Office has also been on an Action Plan to improve rating quality for the past year. We have implemented a number of counter-measures in an effort to improve this measure with no apparent positive results. In order to better confront this and other challenges facing the VSC and improve overall performance, we have rotated Coaches. In addition, we have assigned an Assistant Coach and DRO to the Rating Team. This has been done in an effort to improve rating quality, the most formidable challenge now facing the VSC today.

The C&P staff at the San Juan VA Medical Center (VAMC) was using an outdated exam worksheet and protocol in the conduct of TBI examinations. RVSRs working on these claims failed to identify, or point out, this discrepancy. We have since met with the VAMC C&P staff and the correct exam protocol is now in use. A new exam was ordered for all TBI claims with inadequate exams. Cases will be re-adjudicated based on the evidence of record and the new exam results.

Correction of three of the errors require due process notice to the veterans involved and those claims will be re-adjudicated upon expiration of the due process notice.

***Recommendation 2.*** We recommend the San Juan VA Regional Office Director ensure the Training and Performance Support System training module for Post-Traumatic Stress Disorder is provided to all Rating Veterans Service Representatives.

***San Juan VA Regional Office Response:*** Concur.

Training of DROs and RVSRs on the training module for Post-Traumatic Stress Disorder has been completed with the exception of two RVSRs who are out of the office on extended sick leave.

***Recommendation 3.*** We recommend the San Juan VA Regional Office Director develop and implement a plan to ensure timely corrective action is taken to address errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review staff.

***San Juan VA Regional Office Response:*** Concur.

We concur with the errors found and recommendation made. VSC Management Analyst is responsible for ensuring errors identified by STAR are corrected in a timely fashion. In some instances, the analyst relied on the word of the employees involved that the errors were corrected and of the action taken on each individual case and reported that information to VSC Management Staff, RO Director, and STAR. VSC Management has since taken action to physically review each case, without exception, to ensure that the errors were corrected. EP 930 is cested to control the issue in each case needing correction and appropriate diaries established. A flash in the corporate database is also created to readily identify the cases and establish proper control. Cases are followed-up until completion.

***Recommendation 4.*** We recommend the San Juan VA Regional Office Director develop and implement a mechanism to ensure Veterans Service Center management perform complete, accurate and timely Systematic Analysis of Operations and take appropriate corrective action to fix problems identified.

***San Juan VA Regional Office Response:*** ***Concur.***

We concur with the findings and recommendations made. In the case of the SAO not completed until 3 months following its due date, the responsible official had been given an extension for valid reasons. In most instances where SAOs were submitted past their due date, the responsible official had been given verbal extensions by VSC Management.

Training in the conduct of Systemic Analysis of Operations (SAO) and report preparation is scheduled for the week of October 13, 2009. All officials responsible for preparation of SAOs are required to attend the training session. The Director and VSC Management Analysts are closely monitoring SAOs to ensure complete, accurate, and timely submissions. The Director and VSC Manager are ensuring that appropriate corrective actions are taken to fix problems identified.

***Recommendation 5.*** *We recommend the San Juan VA Regional Office Director improve oversight by developing and implementing a plan to ensure accountability and safeguards of VA Regional Office date stamps.*

***San Juan VA Regional Office Response:*** Concur.

With reference to the unattended date stamp at an employee's workstation, the management official responsible for the supervision of that employee did not instruct the employee to properly safeguard the date stamp when leaving his work area. Current directives now in place to ensure accountability and safeguard of VA Regional Office date stamps are adequate. Monitoring procedures have been strengthened to ensure compliance.

Regarding the electronic date stamp found in the Mail Room that had not been accounted for in the Electronic Date Stamp Inventory Control Log, all date stamps, electronic and manual, in the San Juan VA Regional Office are now properly accounted for.

***Recommendation 6.*** *We recommend the San Juan VA Regional Office Director develop and implement a plan to improve oversight of safeguarding veterans' personally identifiable information.*

***San Juan VA Regional Office Response:*** Concur.

We concur with the observations and recommendations made. Division Records Management Officers (DRMO) had incorrectly thought that the Records Management Officer (RMO) was solely responsible for conducting desk audits. The subject may not have been properly covered in our initial training sessions. However, individual employees have been constantly advised to remove from their workstations all material containing personal identifiable information (PII) and that training material they wish to keep must be properly redacted. All employees have been encouraged to keep subject training materials in electronic files in their individual computers.

After departure of the OIG Team, DRMOs conducted desk audits of all members of their teams. They are now conducting unannounced monthly desk audits of a number of their employees. The RMO is also conducting unannounced monthly desk audits on a random basis. Follow-up training sessions for DRMOs are scheduled for the week of November 3, 2009.

***Recommendation 7.*** *We recommend the San Juan VA Regional Office Director develop and implement a plan to improve management of Triage team activities to ensure all employees in Triage receive performance quality reviews and Triage is properly staffed to ensure mail is properly controlled and processed within the Triage team.*

***San Juan VA Regional Office Response:*** Concur, with qualifications.

We concur with the observations and recommendations made. Directors' Performance Standards require that 80% of the mail received be placed under control within seven days of receipt. The VSC met this target in 10 out of the last 11 months. The month that we failed to meet the target was December 2008 and there were extenuating circumstances for missing the target. We do not believe we have a problem in this area. However, the Triage Team Coach is now closely coordinating with the Support Service Division Chief to ensure mail is delivered to Triage on a daily basis. When the Mail Clerk is absent, Triage provides personnel to ensure the timely delivery of mail.

Drop and search mail procedures needed strengthening. The VSC Workload Management Plan now contains specific procedures for handling this type of mail. The backlog of returned mail has been eliminated. As of Monday, September 24, 2009, there were 318 pieces of returned mail awaiting disposition. None of the pieces was over seven days old. There were only 14 pieces of drop mail pending.

The VSC Workload Management Plan has been modified to strengthen procedures for the handling of mail and strict measures were developed and implemented to ensure compliance.

Additional personnel resources have been added to the Triage to assist in the management of the team's workload. Periodic review of the team's workload and staffing is conducted to ensure that the team is always properly manned. When conducting required personnel rotations, care is taken to ensure that the Triage receives properly trained employees.

**Recommendation 8.** We recommend the San Juan VA Regional Office Director develop and implement a plan to improve oversight of Inquiry Routing and Information System responses to ensure accurate and timely responses are provided to veterans.

***San Juan VA Regional Office Response:*** Concur.

We concur with the observations and recommendations made. Confusion with instructions issued during the consolidation of IRIS resulted in this office not timely responding to a number of pending IRIS inquiries. Our Public Contact Team was under the impression that responses would be provided by centralized location and that the office need no longer respond to IRIS inquiries.

Personnel responsible for answering IRIS inquiries have received training and supervisors are conducting daily monitoring to ensure that we are providing accurate and timely responses. An SAO will be conducted during the month of November 2009 to measure the effectiveness of the plan.

**Recommendation 9.** We recommend the San Juan VA Regional Office Director develop and implement a mechanism to improve oversight of the quality assurance process and provide training to Legal Instrument Examiners and Field Examiners emphasizing the correct procedures for processing Initial Appointments, Fiduciary Beneficiaries, and Accountings.

***San Juan VA Regional Office Response:*** Concur, with qualifications.

We concur with the observations and recommendations. The Fiduciary Activity enjoys one of the best track records in the Nation. It's the fifth largest in the Nation and operates with far less FTEs than similar size activities.

Most errors found by the OIG Team were related to Legal Instrument Examiners (LIE) not following the LIE Guide and/or the Fiduciary Form Guide. Supervisors considered these publications guides and relied on the Manual, Law, and the Regulation to monitor and conduct the activities of the Fiduciary Unit.

Errors found in the processing for IAs, FBs, and Accountings were corrected. We continue to discuss these errors with the Fiduciary STAR reviewers to ensure we are complying with their quality standards.

LIE received 12 hours of instructions in processing IAs, FBs, and Accountings. Emphasis was placed in following the guidance set forth in the LIE Guide. Field Examiners were trained in the correct procedures for processing IA, and FBs. Special emphasis was placed on the procedural errors found by OIG Team.

### ***Observations***

Concur with observation made. There is no specific National standard indicating when work credit should be taken, or if all work associated with a fiduciary claim must be completed prior to taking credit for completing the claim. We understand that this may be a systemic problem throughout the Nation and that the OIG will make the parties concern aware of this trend.

## Inspection Summary

15 Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
<b>Claims Processing</b>			
1. Haas	Determine if Haas claims were properly identified and if service connection was correctly granted or denied. (38 CFR 3.313) (M21-1MR Part IV, subpart ii, Chapter 1, Section H) ( Fast Letter 09-07 and 06-26)	X	
2. Post-traumatic Stress Disorder (PTSD)	Determine whether service connection for PTSD was correctly granted or denied. (M21-1MR Part III, Subpart iv, Chapter 4, Section H.28.B)		X
3. Traumatic Brain Injury (TBI)	Determine whether service connection for TBI and all residual disabilities was correctly granted or denied. (Fast Letters 08-34 and 36, Training Letter 09-01)		X
4. Diabetes	Determine whether service connection for diabetes related to herbicide exposure (Agent Orange) and all related disabilities were correctly granted or denied. (38 CFR 4.119) (Fast letter 02-33) (M21-1MR Part III, Subpart iv, Chapter 4, Section F)		X
<b>Data Integrity</b>			
5. Date of Claim	Determine if VAROS accurately recorded the correct date of claim in electronic records. (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)	X	
6. Control Of Veterans Records System (COVERS)	Determine if VAROs complied with the use of COVERs to track claims folders.	X	
<b>Management Controls</b>			
7. Systematic Analysis of Operations (SAO)	Determine if VAROs performed a formal analysis of their operations through completion of SAOs. (M21-4, Chapter 5)		X
8. Systematic Technical Accuracy Review (STAR)	Determine if VAROs timely and accurately corrected STAR errors. (M21-4, 3.03)		X
9. Date Stamp Accountability	Determine if VAROs accounted for and safeguarded date stamps. (M23-1 1.12, b. (1), (2), (3), (4)) (VBA Letter 20-09-10 Revised dated March 19, 2009)		X
10. Claims Process Improvement (CPI)	Determine if VAROs complied with VBA's CPI Implementation Plan 08-05.	X	
<b>Information Security</b>			
11. Mail Handling Procedures	Determine if VAROs complied with mail handling procedures. (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapter 1 & 4)		X
12. Destruction and Safeguarding of Documents	Determine if VAROs complied with VBA policy regarding proper destruction of documents. (VBA Letter 20-08-63 revised March 13, 2009 and attachments)		X
<b>Public Contact</b>			
13. Inquiry Routing and Information System (IRIS)	Determine if IRIS responses were accurately and timely processed. (M21-1MR Part II, Chapter 6.)		X
14. Congressional Inquiries	Determine if congressional inquiries were timely in processing. (OFO Letter 201-02-64) (Fast Letter 01-40) (VA Directive 8100)	X	
15. Fiduciary	Determine if the Fiduciary unit was properly overseeing the welfare of beneficiaries to include protecting their assets, assuring their benefit entitlement rights, and selecting and monitoring the best-suited fiduciary. (38 CFR 13.100-13.111) ( M21-1MR, Part XI) (FBS Users Guide) (LIE Program Guide)		X

## OIG Contacts and Staff Acknowledgments

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Acknowledgments	Danny Clay Joseph Byrd Robert Campbell Kelly Crawford Maya Ferrandino Lisa Van Haeren
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