

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Inspection of the VA Regional Office Buffalo, New York

August 25, 2011
11-00523-258

ACRONYMS AND ABBREVIATIONS

C&C	Confirmed and Continued
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

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Report Highlights: Inspection of the VA Regional Office, Buffalo, New York

Why We Did This Review

The Veterans Benefits Administration has a nationwide network of 57 VA Regional Offices (VAROs) that process disability claims and provide a range of services to veterans. We conducted this inspection to evaluate how well the Buffalo VARO accomplishes this mission.

What We Found

Buffalo VARO staff correctly established dates of claim in the electronic record. VARO performance was generally effective in processing post-traumatic stress disorder claims and correcting errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program staff.

The VARO lacked accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations resulted when staff did not schedule future medical reexaminations as required. Staff incorrectly interpreted policy and used insufficient medical examinations to process traumatic brain injury claims. Errors in herbicide exposure-related disability claims were due to inadequate training and oversight. Overall, VARO staff did not correctly process 32 (32 percent) of the 101 disability claims reviewed.

VARO management did not ensure staff completed Systematic Analyses of Operations, properly processed mail, and immediately completed final competency

determinations. Although the VARO did not meet the 7-day standard in recording Notices of Disagreement, it exceeded the national average for appeals processing timeliness.

What We Recommended

We recommended the VARO Director follow policy on timely processing temporary disability reevaluations, and implement a plan to review adequacy of training on processing herbicide exposure-related claims. Management needs to provide refresher training and ensure staff return inadequate medical examination reports to hospitals for correction to support proper processing of traumatic brain injury claims. Additionally, management needs to ensure oversight and control of mail handling, as well as completion of Systematic Analyses of Operations.

Agency Comments

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

A handwritten signature in black ink that reads "Belinda J. Finn".

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 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 May 2011, the OIG conducted an inspection of the Buffalo VARO. The inspection focused on 5 protocol areas examining 10 operational activities. The five protocol areas were disability claims processing, data integrity, management controls, workload management, and eligibility determinations.

We reviewed 71 (14 percent) of 518 disability claims related to post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and herbicide exposure that the VARO completed from January 2011 through March 2011. In addition, we reviewed 30 (13 percent) of 228 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months, generally the longest period a temporary 100 percent disability evaluation may be assigned under VA policy without review.

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

RESULTS AND RECOMMENDATIONS

1. Disability Claims Processing

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

Finding 1 Disability Claims Processing Accuracy Could Be Improved

The Buffalo VARO lacked accuracy in disability claims processing. VARO staff incorrectly processed 32 (32 percent) of the total 101 disability claims we reviewed. VARO management agreed with our findings and initiated action to correct the inaccuracies identified.

The following table reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Buffalo 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	17	4	13
Post-Traumatic Stress Disorder Claims	30	1	1	0
Traumatic Brain Injury Claims	11	8	0	8
Herbicide Exposure-Related Disabilities Claims	30	6	1	5
Total	101	32	6	26

Source: VA OIG

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 17 (57 percent) of 30 temporary 100 percent disability evaluations we reviewed. Veterans Benefits Administration (VBA) policy requires a temporary 100 percent disability evaluation for a service-connected disability following surgery or when specific treatment is needed. At the end of a mandated period of

convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

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

Available medical evidence showed that 4 of the 17 processing inaccuracies affected veterans' benefits—2 involved overpayments totaling \$124,552 and 2 involved underpayments totaling \$45,356. Details on the most significant overpayment and underpayment follow.

- A Rating Veterans Service Representative (RVSR) did not include in a rating decision a future date to reevaluate a veteran's service-connected prostate cancer. VA medical treatment records supported no more than a 0 percent evaluation entitling the veteran to health care for the condition but not monetary compensation. As a result, VA overpaid the veteran \$104,772 over a period of 3 years and 8 months.
- An RVSR correctly granted a 100 percent disability evaluation for a veteran's prostate cancer. Six months following completion of treatment, the RVSR reduced the evaluation to 20 percent disabling on the same rating decision document although no medical evidence existed to support the change. The RVSR also assigned an incorrect effective date of November 1, 2005 for the 20 percent reduction. However, a VA medical examination in January 2006 supported a 60 percent disability evaluation, effective February 1, 2006. In a subsequent disability decision on this same condition, an RVSR correctly increased the evaluation to 100 percent disabling based on private treatment records showing residual prostate cancer, but again assigned an incorrect effective date. Medical evidence showed entitlement should have been granted one month earlier. As a result of these multiple inaccuracies, VA underpaid the veteran \$40,946 over a period of 4 years and 3 months.

The remaining 13 inaccuracies had the potential to affect veterans' benefits. Following are descriptions of these inaccuracies.

- In nine cases, VSC staff did not schedule follow-up medical reexaminations needed to determine whether the temporary 100 percent evaluations should continue. An average of 4 years and 8 months elapsed from the time staff should have scheduled the medical

reexaminations until the date of our inspection—the date staff ultimately ordered the reexaminations to obtain the necessary medical evidence. The delays ranged from 5 months to 9 years and 9 months.

- In three cases, RVSRs incorrectly requested future reexaminations for veterans diagnosed with incurable Chronic Lymphocytic Leukemia. In making these decisions, the RVSRs also did not consider entitlement to additional benefits for Dependents' Educational Assistance as required by VBA policy.
- In one case, an RVSR proposed reducing a veteran's 100 percent disability evaluation. VARO staff received the veteran's request for a personal hearing on May 27, 2010; however, VSC staff had not taken action on this request at the time of our inspection in May 2011. Until VSC staff conduct the requested hearing, neither VARO staff nor we can ascertain the current level of the veteran's disability.

Six of the 17 errors resulted from staff not establishing suspense diaries when they processed rating decisions requiring temporary 100 percent disability reexaminations. Five of these errors involved C&C rating decisions. In November 2009, VBA provided guidance reminding VAROs about the need to add suspense diaries in the electronic record for C&C rating decisions. However, VARO management had no oversight procedure in place for C&C rating decisions to ensure VSRs established suspense diaries as reminders of the need for reexaminations.

In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each evaluation had a future exam date entered in the electronic record. Therefore, we made no additional recommendations for improvement in this area. To assist in implementing the agreed upon review, we provided the VARO with 198 claims remaining from our universe of 228 temporary 100 percent disability evaluations.

Additionally, VARO staff did not follow VBA policy or the VSC workload management plan guidance on 810 work items. An 810 work item is a system-generated reminder notification to take future action on a claim. For work items related to temporary disability evaluations, VSC staff are responsible for reviewing the notifications and the corresponding claims files to determine the need to schedule medical reexaminations. We found 75 pending work items for temporary 100 percent disability evaluations; the oldest had been pending since August 2010. The VSC's workload management plan requires biweekly review of work items. Although VSC management was aware of the increased number of these work items, both

VSC management and staff stated they focused attention on other VSC priorities. As a result, VSC staff did not schedule medical reexaminations timely.

PTSD Claims

VARO staff incorrectly processed 1 (3 percent) of 30 PTSD claims we reviewed. In this case, an RVSR improperly evaluated a veteran's PTSD as 10 percent disabling. The VA examination report provided medical evidence supporting a 30 percent evaluation. As a result, VA underpaid the veteran \$759 over a period of 3 months.

Because we did not consider the frequency of errors significant, we determined the VARO generally followed VBA policy related to PTSD claims processing. Therefore, we made no recommendations for improvement in this area.

TBI Claims

The Department of Defense and VBA commonly define a TBI as a traumatically induced structural injury or a 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 8 (73 percent) of 11 TBI claims. All of these processing inaccuracies had the potential to affect veterans' benefits. Following are summaries of these inaccuracies.

- In six cases, RVSRs and a Decision Review Officer prematurely evaluated residual TBI-related disabilities using inadequate medical examinations. According to VBA policy, when a medical examination does not address all required elements, VSC staff should return it to the clinic or healthcare facility as insufficient for rating purposes. Neither VARO staff nor we can ascertain all of the residual disabilities related to TBI without an adequate or complete medical examination.
- In two cases, RVSRs incorrectly continued 10 percent evaluations for TBI-related disabilities. The medical examiner attributed the symptoms to the veterans' service-connected PTSD, not the TBI-related disabilities. Because of the veterans' multiple service-connected disabilities, these errors did not affect the veterans' monthly benefits but may affect future evaluations for additional benefits.

Generally, errors associated with TBI claims processing occurred because VSC staff incorrectly interpreted VBA policy and used VA medical examinations that were inadequate for decision-making purposes. Interviews with staff revealed RVSRs and Decision Review Officers were using their own interpretations of medical examination results to decide TBI claims when medical professionals failed to provide opinions. VSC management

and training staff were not aware of issues regarding inadequate TBI examinations prior to our inspection. As a result, veterans did not always receive correct benefit payments.

**Herbicide
Exposure-Related
Claims**

VARO staff incorrectly processed 6 (20 percent) of 30 herbicide exposure-related claims—1 of these claims processing inaccuracies affected a veteran's benefits. In this case, an RVSR incorrectly established an effective date of July 16, 2009—the date VA received a claim for herbicide exposure-related conditions. However, the correct effective date should have been July 16, 2008. According to VA regulations, when a claimant submits a claim more than 1 year after a legislative change, VA may authorize benefits for a period of 1 year prior to the date of receipt of the claim, if the veteran is eligible. In this instance, eligibility existed to pay the veteran a year prior to submission of the claim because medical evidence showed a diagnosis at the time of the law change. As a result, VA underpaid the veteran \$4,776 over a period of 1 year.

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

- In two cases, RVSRs failed to consider service connection for diabetes-related complications diagnosed in VA treatment and private medical records. The RVSRs should have requested compensation and pension medical examinations to rate these cases. Neither VARO staff nor we can ascertain all of the disabilities related to diabetes without a medical examination.
- An RVSR failed to increase a diabetes evaluation as required when medical evidence showed treatment with medication warranting a 20 percent disability evaluation. This rating did not affect the veteran's monthly benefits but may affect future evaluations for additional benefits.
- An RVSR prematurely evaluated diabetes complications using an inadequate medical examination. According to VBA policy, when a medical examination does not address all required elements, VSC staff should return it to the clinic or healthcare facility as insufficient for rating purposes. Neither VARO staff nor we can ascertain all of the disabilities related to diabetes without an adequate or complete medical examination.
- An RVSR correctly granted service connection for a veteran's amputated right foot. However, in making this decision, the RVSR did not consider the veteran's entitlement to an automobile allowance as required by VBA policy.

Generally, errors in herbicide exposure-related claims processing resulted from inadequate quality assurance oversight. In May 2010, the VARO

completed an internal Systematic Analyses of Operations (SAO) addressing station processing errors. Although the SAO identified a significant number of rating errors associated with diabetes-related complications, VSC management did not provide training until April 2011. VSC management and staff stated no mechanism was in place to evaluate the effectiveness of the training provided. Further, prior to our inspection, VSC quality assurance staff completed an additional level of review of one of the six inaccuracies without identifying any errors. Because of these deficiencies, veterans did not always receive correct benefits.

- Recommendations**
1. We recommend the Buffalo VA Regional Office Director review all pending 810 work items related to temporary 100 percent disability evaluations to determine if medical reexaminations are required and take appropriate action.
 2. We recommend the Buffalo VA Regional Office Director implement oversight mechanisms to ensure staff follow Veterans Benefits Administration guidance and the local workload management plan for reviewing 810 work items.
 3. We recommend the Buffalo VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives and Decisions Review Officers return inadequate medical examination reports to healthcare facilities to obtain the evidence needed to support traumatic brain injury claims rating decisions.
 4. We recommend the Buffalo VA Regional Office Director ensure Rating Veteran Service Representatives and Decision Review Officers receive refresher training on how to evaluate disabilities related to traumatic brain injuries.
 5. We recommend the Buffalo VA Regional Office Director develop and implement a plan to monitor the effectiveness and adequacy of training provided on proper processing of herbicide exposure-related claims.

**Management
Comments**

The VARO Director concurred with our recommendations. In response to recommendations 1 and 2, the Director stated VSC staff completed a review of all pending work items and established appropriate controls. To meet requirements of the workload management plan, a VSC staff member now provides supervisors with a list of pending 810 work items weekly for review and processing. In response to recommendation 3, VSC management provided training to VSC staff in June 2011 on inadequate medical examinations and during its monthly conference call with VA Medical Centers, VSC management emphasized medical examiners must comply with the TBI examination template. In response to recommendation 4, the Director stated, effective August 2011, all TBI ratings require a second

review by a Decision Review Officer. Additionally, VSC will provide refresher training on all aspects of TBI ratings before the end of September 2011. Further, in response to recommendation 5, the Director stated the VARO would review errors identified by national quality review for fiscal year 2010 and 2011 and structure training to address noted recurring inaccuracies. Additionally, VSC management will monitor all errors identified during local quality reviews and provided individual training as needed.

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

2. Data Integrity

Dates of Claim We analyzed claims folders to determine if the VARO was following VBA policy to establish correct dates of claim in the electronic record. In addition to establishing the timeframe for benefits entitlement, VBA generally uses a date of claim to indicate when a document arrives at a VA facility. VBA relies on accurate dates of claim to establish and track key performance measures, including the average days to complete a claim.

VARO staff established correct dates of claim in the electronic record for all 30 claims we reviewed. As a result, we determined the VARO was following VBA policy and we made no recommendations for improvement in this area.

Notices of Disagreement We analyzed claims folders to determine if the VARO was following VBA policy to timely record Notices of Disagreement (NODs) in the Veterans Appeals Control and Locator System (VACOLS). An NOD is a written communication from a claimant expressing dissatisfaction or disagreement with a benefits decision and a desire to contest the decision. An NOD is the first step in the appeals process. VACOLS is a computer application that allows VARO staff to control and track a veteran's appeal and manage the pending appeals workload. VBA policy states staff must create a VACOLS record within 7 days of receiving an NOD. Accurate and timely recording of NODs is required to ensure appeals move through the appellate process expeditiously.

VARO staff did not meet this standard for 4 (13 percent) of the 30 NODs we reviewed. Staff took an average of 20 days to record these four NODs in VACOLS. As of April 30, 2011, the VARO's total NODs had been pending completion an average of 123 days, exceeding the national average of 273 days by 150 days. Therefore, we made no recommendations for improvement in this area.

3. Management Controls

***Systematic
Technical
Accuracy
Review***

We assessed management controls to determine whether 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 VAROs to take corrective action on errors identified by STAR.

VARO staff did not correct 1 (5 percent) of 20 errors identified by VBA's STAR program from October through December 2010. Because VARO management generally followed VBA policy regarding correction of STAR errors, we made no recommendations for improvement in this area.

***Systematic
Analysis of
Operations***

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs). An SAO is a formal analysis of an 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 annual SAO schedules designating the staff required to complete the SAOs by specific dates.

Finding 2 Oversight Needed To Ensure Complete SAOs

Five (42 percent) of the VARO's 12 SAOs were incomplete (missing required elements). The VSC Manager is responsible for completing the 12 SAOs annually as part of ongoing analysis of VSC operations. VARO management did not provide adequate oversight to ensure VSC staff completed the 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.

VSC staff stated they use the previous year's SAO as a model, rather than following VBA's policy to complete the current SAO. They also said they have not had any formal training on the requirements for SAOs. Similarly, VSC staff responsible for reviewing SAOs indicated they primarily check for completeness by comparing them to previous year's SAOs and do not always refer to VBA policy. The VSC Manager accepted responsibility for the incomplete SAOs, stating she did not always have time to do a thorough review due to her multiple responsibilities and lack of assistance. An Assistant VSC Manager was recently hired; however, the position had been vacant for 15 months.

One of the SAOs that VARO staff did not thoroughly complete involved quality of rating decisions. VARO Buffalo did not achieve VBA's FY 2010 rating quality goal and at the time of our inspection its performance was below the FY 2011 goal. If VARO management had ensured proper completion of this required SAO, it might have identified deficiencies in rating decisions and developed a plan to improve rating quality.

Recommendation 6. We recommend the Buffalo VA Regional Office Director develop and implement a plan for staff to address all required elements of Systematic Analyses of Operations.

Management Comments The VARO Director concurred with our recommendation. The Director stated VSC staff will receive training in September 2011 on the requirements of completing an SAO. Additionally, in an effort to improve quality, management will provide feedback to VSC staff who completed the SAO.

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

4. Workload Management

Mailroom Operations

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

Triage Mail Processing Procedures

We assessed the VSC's Triage Team mail processing procedures to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy. VARO staff are required to use VBA's tracking system, Control of Veterans Records System, to electronically track veterans' claims folders and control search mail. VBA defines search mail as active claims-related mail waiting to be associated with veterans' claims folders. Conversely, drop mail requires no processing action upon receipt. VBA policy allows the use of a storage area, known as the Military File, to hold mail temporarily when staff are unable to identify associated claims folders in the system.

Finding 3 Oversight Needed to Ensure Proper Control and Processing of Triage Team Mail

The Triage Team staff did not properly manage 12 (13 percent) of 90 pieces of mail we reviewed. Staff did not control search mail through COVERS for 6 (20 percent) of 30 pieces of mail. At the time of our inspection, approximately 425 pieces of mail were on search awaiting association with the appropriate claims folders. The most significant delay occurred when the VARO received a new claim from a veteran on March 4, 2011, and placed it in the search mail holding area. By the time of our inspection in May 2011, the VARO had not initiated action on the claim.

Further, the Triage Team staff did not always manage mail in the Military File according to VBA policy. Five (17 percent) of 30 items we reviewed were incorrectly stored in this cabinet. As an example, the VARO received a veteran's request for documentation verifying his military service on December 16, 2010, and incorrectly placed it in the Military File cabinet. By the time of our inspection in May 2011, the VARO had not taken any action on this request.

The above errors in search mail resulted from inadequate management oversight to ensure compliance with VSC's Workload Management Plan. Although Triage Team staff completed weekly reviews of search mail and reported noncompliance issues to management, VSC management did not follow up to ensure station-wide compliance with Workload Management Plan search mail requirements. Further, errors related to the Military File occurred because staff did not thoroughly review documents prior to placing them in the Military File cabinet. Untimely association of mail with veterans' claims folders can cause delays in processing benefits claims. As a result, beneficiaries may not receive accurate and timely benefits payments.

Recommendation 7. We recommend the Buffalo VA Regional Office Director implement a plan for increased oversight to ensure Veterans Service Center staff process mail according to Veterans Benefits Administration policy and local guidance.

Managements Comment The VARO Director concurred with our recommendation. The Director stated VSC staff drafted a standard operating procedure for search mail and updated its COVERS plan. Additionally, VSC staff will review all incoming military mail prior to placing it in the military file. VSC management will conduct a quarterly review of the military file.

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

5. Eligibility Determinations

Competency Determinations

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

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

Until recently, VBA did not have a clear, measurable definition of "immediate," and this timeframe varied from office to office. In response to our summary report for FY 2010, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report Number 11-00510-167, May 18, 2011), the Acting Under Secretary for Benefits defined "immediate" as 21 days following expiration of the due process period.

Finding 4 Inadequate Controls Over Competency Determinations

Using VBA's newly defined interpretation of immediate, VARO staff unnecessarily delayed making final decisions in 9 (64 percent) of 14 competency determinations completed from January through March 2011. The delays ranged from 1 to 111 days, with an average completion time of 36 days. Delays occurred because VARO staff responsible for overseeing and processing final competency determinations stated they were unaware of VBA's policy requiring immediate action and therefore did not prioritize these cases. The risk of incompetent beneficiaries receiving benefits without fiduciaries assigned to manage those funds increases when staff do not complete competency determinations timely.

The most significant case of placing funds at risk occurred when VARO staff unnecessarily delayed making a final incompetency decision for a veteran for approximately 4 months. During this period, the veteran received \$10,692 in disability payments. While the veteran was entitled to these payments, fiduciary stewardship was not in place to ensure effective funds management and the welfare of the veteran. VBA plans to implement the new 21-day

policy nationwide in June 2011. Therefore, we made no recommendation to the VARO Director regarding this issue.

Appendix A VARO Profile and Scope of Inspection

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

Resources As of March 2011, the Buffalo VARO had a staffing level of 416.4 employees. Of these, the VSC had 109 employees assigned.

Workload As of April 2011, the VARO reported 6,168 pending compensation claims. The average time to complete claims was 196.3 days—21.3 days more than the national target of 175 days. As reported by STAR staff, the accuracy of compensation rating-related decisions was 86.9 percent, which was 3.1 percent below the 90 percent VBA target. The accuracy of compensation authorization-related processing was 93.7 percent—2.3 percent below the 96 percent VBA target.

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

Our review included 71 (14 percent) of 518 claims related to PTSD, TBI, and herbicide exposure-related disabilities that the VARO completed from January 2011 through March 2011. For temporary 100 percent disability evaluations, we selected 30 (13 percent) of 228 existing claims from VBA's Corporate Database. We provided VARO management with the 198 claims remaining from the universe of 228 for further review. These claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months.

We reviewed the 12 mandatory SAOs completed in fiscal years 2010 and 2011. Additionally, we reviewed 14 competency determinations completed by the Buffalo VARO during the 3-month period from January through March 2011. We reviewed 20 errors identified by VBA's STAR program during October through December 2010. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR's measurements include a review of work associated with claims that require rating decisions. STAR staff review original claims, reopened claims, and claims for increased evaluation. Further, they review appellate issues that involve a myriad of veterans' disability claims.

Our process differs from STAR as we review specific types of disability claims related to PTSD, TBI, and herbicide exposure that require rating

decisions. In addition, we review rating decisions and awards processing involving temporary 100 percent disability evaluations.

For our review, we selected dates of claim, NODs, and Triage Team mail pending at the VARO during the time of our inspection. We completed our review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*. We planned and performed the review to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our review objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our review objectives.

Appendix B VARO Director's Comments

**DEPARTMENT OF VETERANS AFFAIRS
BUFFALO REGIONAL OFFICE**

Memorandum

To: Director, Benefits Inspection Division, San Diego

From: Director, VA Regional Office Buffalo (307/00)

Date: August 12, 2011

Subj: Inspection of the VARO Buffalo, NY

1. Attached are the Buffalo VARO's comments on the OIG Draft Report: Inspection of VARO Buffalo.
2. Questions may be referred to Ms. Donna Terrell, Director, at 716.857.3450, or Ms. Suzanne DeNeau, Veterans Service Manager, at 716.857.3030.

(original signed by:)

Donna Terrell

Director

Attachment

Recommendation 1: *We recommend the Buffalo VA Regional Office Director review all pending 810 work items related to temporary 100 percent disability evaluations to determine if medical reexaminations are required and take appropriate action.*

Buffalo VSC Response: Concur

The IG audit team identified 75 pending 810 work items for routine future examinations at the time of review. Following the IG audit, Buffalo Veterans Service Center (VSC) reviewed all pending 810 work items and identified additional cases requiring review for routine future examinations (total of 374 pending 810s). As of August 1, 2011, there are 43 pending 810 work items. The Triage Team properly ensured establishment of a 310 end product (EP) for all pending 810 work items for routine future examinations. These were handed out to the Pre-Determination Team VSRs per digit assignment. The complete list was reviewed and all appropriate action taken as of August 1, 2011. Currently, the Triage Team Coach runs the appropriate workload report each Monday to stay current with the 810 work items for routine future examinations.

We request closure of this recommendation based on ongoing VSC actions taken to monitor progress in this area.

Recommendation 2: *We recommend the Buffalo VA Regional Office Director implement oversight mechanisms to ensure staff follow Veterans Benefits Administration guidance and the local workload management plan for reviewing 810 work items.*

Buffalo VSC Response: Concur

Per the Buffalo VSC Workload Management Plan, the Senior Veterans Service Representative (VSR) runs the entire 810 work item list weekly. The list is divided by team, and is forwarded to each Coach's area of responsibility. The Coaches are responsible for ensuring that their VSRs are completing their portion of the 810 work items by digit assignment. To increase emphasis on this portion of the VSC workload, each team's total 810 work items will be discussed during the Veterans Service Center Monday Morning Workload Meeting and added to the weekly workload report. Additionally, the Senior VSR responsible for running the weekly report will identify and contact other regional offices when 810 work items appear on Buffalo's workload.

We request closure of this recommendation based on ongoing VSC actions taken to monitor progress in this area.

Recommendation 3: *We recommend the Buffalo VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives and Decisions Review Officers return inadequate medical examination reports to healthcare facilities to obtain the evidence needed to support traumatic brain injury claims rating decisions.*

Buffalo VSC Response: Concur

On June 2, 2011, the Quality/Training Decision Review Officers (DRO) and Rating Team Coach held a training session with all Rating VSRs and DROs to explain the inadequate TBI/Mental Disorder examination results the OIG had identified. In addition, during the monthly Medical Center/VSC joint conference call in June 2011, it was emphasized to all examination units that it is imperative for the TBI/Mental Disorder examiners to comply with the Note Section of the TBI examination template in order for the examinations to be considered sufficient for rating purposes.

Additionally, a discussion was held with regard to manifestations of a comorbid mental or neurologic, or other physical disorder. Rating Veterans Service Representative (RVSRs) and DROs were informed that any case lacking the comorbidity statement must be returned to the VA examiner for clarification.

The Buffalo RO also instituted the requirement that all TBI ratings require second signature review by one of the Quality/Training DROs. The specific procedures for this were conveyed and are outlined in the local TBI Second Signature SOP dated August 2, 2011.

We request closure of this recommendation based on ongoing VSC actions taken to monitor progress in this area.

Recommendation 4: *We recommend the Buffalo VA Regional Office Director ensure Rating Veteran Service Representatives and Decision Review Officers receive refresher training on how to evaluate disabilities related to traumatic brain injuries.*

Buffalo VSC Response: Concur

The Buffalo RO conducted refresher training on traumatic brain injury (TBI) with the Rating Activity on March 7 and March 9, 2011. Additionally, the VSC Exam Coordinator will continue to work closely with the VA Medical Centers to ensure TBI examinations are complete and sufficient for rating purposes.

We also explained the requirement that all TBI ratings be second signed by the Quality DROs. The specific procedures for this were conveyed and are outlined in the August 2, 2011 *TBI Second Signature Policy at the Buffalo Regional Office*. Additional TBI training is scheduled prior to the end of fiscal year 2011 (FY2011) to ensure compliance with all directives.

Recommendation 5: *We recommend the Buffalo VA Regional Office Director develop and implement a plan to monitor the effectiveness and adequacy of training provided on proper processing of herbicide exposure-related claims.*

Buffalo VSC Response: Concur

Training was completed in April 2011 to provide an overview of Agent Orange claims and associated presumptive conditions. This training was part of the nationally mandated training curriculum for FY2011. Additionally, medical information and rating guidelines associated with chronic complications and existing policy have been provided to RVSRs in order to achieve

consistency in Rating Decisions pertaining to diabetic complications. Training specific to rating diabetes complications was completed in both February 2010 and April 2011, using the national training curriculum.

With the recent addition of the three new presumptive conditions in August 2010, extensive training was completed during FY 2011 to include *Nehmer* and 38 CFR 3.114(a). Local and National quality reviews will be monitored to ensure compliance and understanding of these issues.

For FY2012, the Buffalo RO will review trends of local errors called during national review, including missed diabetes complications from FY2010 and FY2011 and will structure training to address recurring errors. Additionally, the local errors will be monitored monthly and reviewed for commonality among RVSRs so that individual training can be completed if necessary.

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

Buffalo VSC Response: Concur

Training will be conducted in September 2011 on M21-4 Chapter 5 and the OIG's *SAO Notification of Errors*. The training will utilize previous incomplete SAOs, as well as providing examples of proper SAOs. Additionally, all coaches and assistant coaches will be provided with electronic and hard copies of the updated M21-4 Chapter 5 as a guideline to assist with completion of their assigned SAO(s). Feedback, both positive and negative, for each SAO will be shared with each SAO preparer to improve overall quality and accuracy.

Recommendation 7: *We recommend the Buffalo VA Regional Office Director implement a plan for increased oversight to ensure Veterans Service Center staff process mail according to Veterans Benefits Administration policy and local guidance.*

Buffalo VSC Response: Concur

A Search Mail SOP and an updated COVERS plan have been drafted and will be implemented within the Veteran Service Center, upon approval from the Veterans Service Center Manager.

A Claims Assistant has been assigned to review all incoming military pending mail prior to the mail being filed into the military pending file. The file will be reviewed quarterly by the Triage Coach to ensure all documents in the file are appropriate.

Appendix C Inspection Summary

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

Source: VA OIG

CFR=Code of Federal Regulations, FL=Fast Letter, M=Manual, MR=Manual Re-write

Appendix D **OIG Contact and Staff Acknowledgments**

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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