VA OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDITS & EVALUATIONS

Inspection of VA Regional Office Togus, ME

March 23, 2010
09-03659-111

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 VA's 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 (VSC) operations. The inspection objectives are to:

- Evaluate how well 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, Togus, ME

Why We Did This Review

The Benefits Inspection Division conducts inspections at VA Regional Offices (VAROs) to review disability compensation claims processing and Veterans Service Center (VSC) operations.

What We Found

The VARO management team needs to improve the accuracy of disability claims processing and provide additional oversight of personnel responsible for claims identified as temporary 100 percent disability evaluations, post-traumatic stress disorder (PTSD), and disabilities related to herbicide exposure. VARO management attributed this to inadequate staff training and management oversight.

Management also needs to improve controls over the following activities:

- Correcting errors identified by the Veterans Benefits Administration's (VBA) Systematic Technical Accuracy Review (STAR).
- Safeguarding of veterans Personally Identifiable Information (PII).
- Handling of claims-related mail.
- Processing adjustments for incompetent veterans' fiduciary claims correctly.

What We Recommended

We recommended the VARO improve oversight of the processing of temporary 100 percent evaluations to ensure staff complete required future medical examinations, correcting STAR errors timely and accurately, safeguarding veterans' PII, and managing mail within the VSC.

We also recommended the VARO provide training to Rating Veterans Service Representatives to ensure they properly assess and make competency determinations for veterans' that require assistance to manage VA benefit payments.

Agency Comments

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

(original signed by:)
BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

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Results of Inspection

The OIG conducted an inspection of the Togus VA Regional Office (VARO) in October 2009. The inspection focused on 5 protocol areas examining 11 operational activities.

VARO Activities Requiring Management Attention

Disability Claims Processing

The Togus VARO needs to improve the accuracy of disability claims processing. VARO staff incorrectly processed rating decisions for 26 (26 percent) of the 101 claims we reviewed. Veteran Service Center (VSC) management concurred and initiated action to correct the inaccuracies.

During the period April–June 2009, the VARO completed action on 240 claims for post-traumatic stress disorder (PTSD), disabilities related to herbicide exposure, and traumatic brain injury (TBI). We reviewed 71 (30 percent) of these claims. In addition, we reviewed 30 (48 percent) of 63 claims where VSC staff granted a temporary 100 percent evaluation that was paid for 18 months or longer. We chose the 18-month timeframe because it is the longest period a temporary 100 percent evaluation staff may assign without review under VA policy.

The following table reflects the processing inaccuracies by disability claim type and identifies both those affecting veterans' benefits and those that can potentially affect veterans' benefits:

Table 1. Disability Claims Processing Results

Type	Reviewed	Incorrectly Processed	Incorrectly Processed Affecting Veterans' Benefits	Incorrectly Processed Having The Potential To Affect Veterans' Benefits
Temporary 100 Percent Evaluations	30	18	4	14
PTSD	30	3	0	0
Disabilities related to herbicide exposure	30	4	2	0
TBI	11	1	1	0
Total	**101**	**26**	**7**	**14**

VSC Personnel Need to Improve Disability Determination Accuracy

Temporary 100 Percent Evaluations. VBA policies allow staff to provide veterans with a temporary 100 percent evaluation for service-connected disabilities that require surgery or specific treatment of service-connected disabilities. At the end of a mandated period of convalescence or cessation of treatment, VSC staff must review the disability to determine if they should continue the temporary evaluation.

VSC staff incorrectly processed 18 (60 percent) of the 30 temporary 100 percent evaluations we reviewed. Based on medical evidence available at the time of our review, we determined four processing inaccuracies affected veterans' benefits:

- A Veterans Service Representative (VSR) failed to input a required date into VA's SHARE computer application. As a result, VSC staff did not schedule a mandatory medical examination to determine if the temporary 100 percent evaluation should continue. The examination would have shown removal of the veteran's larynx. Therefore, VSC staff should have granted special monthly compensation for the inability to communicate by speech. The veteran was underpaid $2,497 over a period of 27 months.
- A Rating Veterans Service Representative (RVSR) improperly continued the temporary 100 percent evaluation for a veteran's prostate cancer. Based on available evidence, the RVSR should have initiated action to reduce the veteran's benefits in June 2007; however, the final action to discontinue the temporary evaluation was not effective until May 2009. In addition, staff misplaced the veteran's claims folder for 5 months, which contributed to the delay. The veteran was overpaid $25,499 over a period of 23 months.
- A VSR failed to input a required date into VA's Benefits Delivery Network computer application. As a result, VSC staff did not schedule a mandatory medical examination to determine if the temporary 100 percent evaluation should continue. The veteran was overpaid $9,184 over a period of 30 months.
- A RVSR did not properly schedule a mandatory examination 6 months after the veteran underwent surgery to remove the prostate. Instead, the RVSR requested private medical records in lieu of scheduling the examination. VSC staff waited 60 days as required; however, they never received the requested private medical records. Subsequently, the RVSR scheduled the mandatory examination. Due to this delay, the veteran was overpaid $4,673 over a period of 2 months.

VSC personnel allowed temporary 100 percent evaluations to continue without scheduling examinations for 14 claims. Without the results of these medical examinations or other available medical evidence, neither VBA nor we can determine if the temporary evaluations should continue. Therefore, in the absence of proper or timely follow-up actions to schedule medical examinations, VARO management was unsure the monthly disability payments to these 14 veterans were accurate. The following is a summary of these claims:

- For nine veterans' claims, VSC staff did not enter a date into the electronic record that would cause the system to generate a notification requiring a future medical examination.
- For three veterans' claims, VSC staff indicated they entered the dates for future examinations in VBA's Veterans Service Network (VETSNET) computer application. However, the dates did not remain in the electronic record after processing the claims. VETSNET staff rectified this condition with the computer application in February 2008.
- For one claim, a RVSR incorrectly continued a 100 percent evaluation based on inadequate VA medical examinations. The RVSR should have returned the examinations for clarification regarding the status of the disease.

- For one claim, VSC personnel did not request an examination to determine continued entitlement to the temporary 100 percent evaluation or possible entitlement to Dependents' Educational Assistance. VBA provides this benefit to veterans' dependents if the VARO determines a veteran has a permanent and total disability.

PTSD Claims. VSC staff incorrectly processed 3 (10 percent) of 30 claims we reviewed. These processing inaccuracies did not affect the veterans' benefits because they were procedural in nature. For all three, VSC staff did not properly document the issue of competency on the formal rating decisions.

Disabilities Related to Herbicide Exposure Claims. VSC staff incorrectly processed 4 (13 percent) of 30 claims we reviewed. Two of the four processing inaccuracies affected veterans' benefits:

- A RVSR failed to grant a veteran entitlement to an Automobile and Adaptive Equipment Allowance based on the loss of use of a foot. This was a secondary condition related to service-connected diabetes. This allowance has a maximum benefit potential of $11,000.
- A RVSR established an incorrect effective date for payment of a veteran's service-connected diabetes because staff used the incorrect date to establish the claim. They should have used the date VA medical records indicated the veteran's condition worsened. The veteran was underpaid $1,101 over a period of 7 months.

The two remaining processing inaccuracies were procedural in nature. RVSRs did not correctly document non-compensable diabetic conditions in the rating decision.

TBI Claims. We determined the Togus VARO generally followed VBA policy regarding the processing of TBI claims. A RVSR incorrectly processed 1 (9 percent) of 11 claims we reviewed. This affected the veteran's benefits because the RVSR did not properly grant service connection for disabilities related to a TBI. As a result, the veteran was underpaid $3,533 over a period of 15 months.

Conclusion. Findings related to temporary 100 percent evaluations occurred because staff either failed to record the required date in the electronic system to initiate an automatic request for a future examination or because of a known computer application problem at the time these claims were processed. Consequently, the VARO Director lacked assurance that VSC staff accurately processed these claims. VETSNET staff informed us they fixed the known computer application problem regarding dates for future examinations not remaining in the electronic record. However, controls over the processing of temporary 100 percent evaluations need strengthening. VSC management needs to improve oversight of these claims to ensure staff enters all required dates into the electronic record.

VSC management stated some of the issues regarding PTSD, TBI, and disabilities related to herbicide exposure were a result of 7 (58 percent) of the 12 RVSRs having less than 2 years experience. Management also informed us that staff had completed training and quality reviews yet acknowledged the claims were incorrectly processed. We confirmed 58 percent of the RVSRs had less than 2 years experience, staff had completed training, and VSC management performed quality reviews of their work.

Management addressed the issues we identified with the responsible staff members and scheduled additional training during our inspection. Therefore, we did not make recommendations regarding the issues found for processing claims associated with PTSD, TBI, and disabilities related to herbicide exposure.

Recommendation 1. *We recommend the Togus VA Regional Office Director develop and implement a plan to ensure staff correctly establish future examination dates and monitor future examinations for temporary 100 percent evaluations.*

Management Comment

The VARO Director concurred with our recommendation and implemented policy whereby cases that require a future examination are referred to senior Veterans Service Representatives for confirmation that the future examination is in the electronic record.

OIG Response

Management comments and actions are responsive to the recommendation.

Recommendation 2. *We recommend the Togus VA Regional Office Director conduct a review of all temporary 100 percent evaluations under the Togus jurisdiction to determine if re-evaluations are required and take appropriate action.*

Management Comment

The VARO Director concurred with our recommendation. The OIG provided the VARO a list of cases where the veteran had been receiving temporary 100 percent evaluations over 18 months requiring a VA examination. VARO staff is reviewing each case to determine if additional action is appropriate.

OIG Response

Management comments and actions are responsive to the recommendation.

Data Integrity

VSC staff followed VBA policy regarding the establishment of the correct dates of claim in the electronic record. The date of claim identifies when a document arrives at a specific VA facility. VBA relies on an accurate date of claim to establish and track a key performance measure that determines the average days to complete a claim. For all 30 claims reviewed, VSC staff established the correct dates of claim in the electronic record.

Management Controls

VSC staff followed VBA policies by timely and accurately completing all 12 required Systematic Analysis of Operations. In addition, VARO staff adhered to VBA policy regarding the accounting for and safeguarding of VARO date stamps by maintaining an accurate accountability log. Further, staff secured all stamps from unauthorized use.

VSC management did not always follow VBA policies to correct errors identified by VBA's Systematic Technical Accuracy Review (STAR) staff.[1] STAR is VBA's multi-faceted quality assurance program to ensure veterans and beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires the VARO to take corrective actions on errors identified by STAR. Further, staff is required to remove and retain the error notification documents from the claims folder and use this information to provide training to staff.

Strengthening Oversight Will Help Ensure VSC Staff Correct Errors Identified by STAR

Our review of 16 files that contained errors identified by VBA's STAR program during the period January–June 2009 showed that 4 (25 percent) of the STAR errors were not corrected in accordance with VBA policy. VSC management initiated action to correct the inaccuracies we identified and none affected veterans' benefits:

- STAR instructed the VARO to inform a widow that her child could be entitled to Dependency and Indemnity Compensation benefits. There was no evidence in the claims folder showing staff informed the widow of this potential entitlement. Further, VARO staff erroneously informed STAR that they corrected the error.
- STAR instructed the VARO to send a notification letter for a burial claim to the proper claimant. While VSC staff informed STAR they corrected this error, they did not send the revised letter to the proper claimant.

The remaining two errors were procedural in nature. VSC staff did not remove and retain STAR error notification documents from the claims folders for training purposes.

A VSC manager stated these errors occurred because supervisors were not physically reviewing claims files to ensure personnel completed corrective actions as reported to STAR. As a result, the VARO Director lacked assurance employees were adhering to VBA's quality assurance program.

Recommendation 3. *We recommend the Togus VA Regional Office Director develop and implement a plan to ensure timely and accurate 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 policy to ensure a central designee reviews all final actions. Management also agreed with the procedural errors found; however, the Director indicated the report suggests training is not provided on STAR errors or comments found. The Director also informed us each error/comment is routed to the training coordinators and appropriate team coach for training to the whole team.

[1]VBA Policy M21-4, "Manpower Control and Utilization in Adjudication," *Quality Assurance*, updated May 20, 2008.

OIG Response

Management comments and actions are responsive to the recommendation. We reported that staff did not remove and retain STAR error notification documents for training purposes for two procedural errors. We did not address or identify any training deficiency associated with these errors, or comment on VARO training on STAR errors or comments.

Information Security

The VARO management team needs to improve safeguards over veterans' Personally Identifiable Information (PII). The OIG inspection team conducted random inspections of employee workstations and determined staff did not properly follow VBA's new policy to safeguard veterans' PII. The policy states 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, credenzas, two-drawer lockable cabinets, or other storage containers. We did not include employees' desktops as a part of our inspection because employees may keep material there for processing claims.

VBA's policy also states material used to develop training courses must be promptly and clearly redacted and stored in a location designated for training course material. Additionally, supervisors are to perform inspections of the workstations to ensure adherence with policy. We reviewed the VARO's process for destruction of documents and found they were following policy regarding proper shredding procedures.

In addition, management needs to strengthen mail management procedures within the VSC. We analyzed mail handling procedures in the VARO mailroom and within the VSC to ensure the accurate and timely processing of mail. Staff delivered mail daily to the VARO, and we observed no deficiencies with this process. However, VSC staff did not properly track claims-related mail in VBA's Control of Veterans Records System (COVERS).

Veterans' Personally Identifiable Information Not Always Safeguarded

We performed unannounced inspections of 23 (20 percent) of the 114 employees' workstations located in the VSC. We found unredacted PII at 6 (26 percent) workstations consisting of training materials, work lists, and reports. In August 2009, VBA's Compensation and Pension Service Site Visit team had similar findings.

VSC management stated the employees received training regarding information security policies and the Division Records Management Officers performed inspections of employees' workstations. Management indicated their inspections might not have been thorough enough to identify these issues.

We concluded VSC management did not perform adequate inspections of employees' workstations nor did they ensure employee adherence to information security policy. Although we found no evidence of improper destruction of documents, the VARO Director lacked assurance that staff was properly safeguarding veterans' PII.

Recommendation 4. *We recommend the Togus VA Regional Office Director develop and implement a mechanism to ensure supervisors consistently perform thorough inspections of the Veterans Service Center to safeguard veterans' personally identifiable information more effectively.*

Management Comment

The VARO Director concurred with our recommendation and indicated all Veterans Service Center personnel had a 100 percent desk inspection completed during the period October 7–9, 2009, by Togus managers. The results of the VARO desk inspections revealed 26 of 119 personnel had discrepancies related to unredacted training materials. The Director also stated VARO Managers and the Records Management Officer continue to complete desk audits for all employees on a regular basis.

OIG Response

Management comments and actions are responsive to the recommendation.

Mail Management Procedures Need Strengthening

VSC staff did not track 7 (23 percent) of 30 pieces of claims-related search mail in VBA's COVERS. VSC management informed us that problems with search mail occurred because the mail plan did not incorporate procedures to provide management oversight of the search mail process or include specific procedures for staff to follow. We confirmed this through our review of the VSC workload management plan.

The mail plan is one element of the overall VSC workload management plan. VBA policy states the mail plan should provide staff with specific procedures regarding how to process search mail. Search mail is claims-related mail that could not readily be associated with the claims folder due to the folder being at an area other than the file storage location. The mail plan specifies how staff should use the search mail functions in COVERS to designate and identify mail on search and provide for management reviews of the search mail process.

Because VSC staff did not have an effective mail plan describing search mail procedures, delays in claims processing occurred as they were unaware of mail waiting to be associated with veterans' claims folders. Examples of claims-related mail not tracked in COVERS included:

- A new claim for service connection for a right knee condition—VSC staff did not track this mail in COVERS for 25 days.
- A document regarding the veteran's intent to appeal a previous decision regarding a denial for service connection of PTSD—VSC staff did not track this mail in COVERS for 47 days.

Because of inadequate oversight and unclear procedures, the VARO Director lacked assurance that all evidence was available to RVSRs when making final benefits decisions.

Recommendation 5. *We recommend the Togus VA Regional Office Director amend the current mail plan incorporating procedures establishing oversight of the search mail process to ensure proper control and processing of mail within the Veterans Service Center.*

Management Comment

The VARO Director concurred with our recommendation and incorporated a search mail procedure into the workload management plan.

OIG Response

Management comments and actions are responsive to the recommendation.

Public Contact

The OIG inspection team reviewed fiduciary adjustments to determine if VSC staff properly appointed fiduciaries to manage the funds of incompetent veterans. We inspected the fiduciary adjustment process from the time VARO staff becomes aware a beneficiary may be incompetent through when the VSC staff appoints a fiduciary to manage VA funds.

VARO Staff Inaccurately Processed Incompetency Claims

The Togus VARO did not always properly assess veterans' mental capacity to handle VA benefit payments. This resulted in the VARO staff not properly appointing a fiduciary in 1 (17 percent) of the 6 fiduciary adjustments we reviewed. VBA policy states RVSRs must address the issue of competency for a mental health disorder, or if evidence raises a question as to the beneficiaries' ability to manage VA funds, when granting a 100 percent evaluation.

In one claim, an RVSR did not properly assess the severity of a veteran's mental health disability at the earliest possible time based upon a physician's statement located in the veteran's claims folder. Although a physician stated the veteran needed assistance in handling personal finances, the RVSR did not propose to declare the veteran incompetent. A memorandum from a healthcare professional received over 5 months after the inaccurate rating decision stated the veteran and his family had suffered great financial losses to include the loss of homes and vehicles. The memorandum also indicated the veteran was homeless for the fourth time. After receiving the memorandum, a senior VSC manager deemed it necessary to establish an emergency fiduciary to manage the veteran's funds. VSC staff should have assessed the veteran's competency at the time of the original rating decision.

Senior VSC management informed us this occurred because of a lack of training to evaluate the evidence associated with mental competency. Our review of the VSC training plan confirmed training regarding mental competency determinations had not occurred during FY 2009. Consequently, as VSC staff was not timely in appointing a fiduciary to safeguard the veteran's funds, the veteran suffered a financial hardship.

Recommendation 6. We *recommend the Togus VA Regional Office Director conduct training to ensure Rating Veterans Service Representatives follow VBA policy when assessing and making competency determinations.*

Management Comment

The VARO Director concurred with our recommendation and provided comment. The Togus VARO conducted training on October 20, 2009, regarding competency determinations. The Director indicated the OIG identified one case with a competency error. The Togus Regional Office concurs with the finding that the competency error should have been addressed in the rating decision. However, based on the available evidence at the time of the rating decision, the Togus Regional Office disagrees that a proposal of incompetency would have been made.

OIG Response

Management comments and actions are responsive to the recommendation. Title 38 of the Code of Federal Regulations defines a mentally incompetent person as "one who because of injury or disease lacks the mental capacity to contract or to mange his or her own affairs, including disbursement of funds without limitation." The VA mental status medical examination located in the veteran's claims folder at the time of the original decision contained the following statement from the examining physician regarding the veteran's competency: "As long as [the veteran] relies on his wife to manage his finances, his financial best interests will be looked out for." This statement should have alerted the RVSR to propose a finding of incompetency because the veteran had to rely on his wife to manage his financial affairs. It is our position that a limitation clearly existed if the veteran must rely on his wife to manage his finances.

Subsequent to the original rating decision, a healthcare professional submitted documentation revealing the veteran and his family had suffered great financial losses to include the loss of homes and vehicles. The professional also noted the veteran had mismanaged his VA and Social Security benefits.

Appendix A

VARO Profile and Scope of Inspection

VARO Profile

Organization. The Togus VARO is responsible for delivering non-medical VA benefits and services to veterans and their families in Maine through the administration of Compensation and Pension Benefits, Vocational Rehabilitation and Employment Assistance, Burial Benefits, and Outreach activities. The Togus VARO also has a Rating Resource Center and a Development Resource Center.

Resources. As of March 29, 2009, the Togus VARO had a staffing level of 132 Full-Time Employees. Of the 132 Full-Time Employees, 114 (86 percent) were assigned to the VSC to include 17 (15 percent) located in the Rating Resource Center and 23 (20 percent) located in the Development Resource Center.

Workload. As of June 2009, the VARO had 1,796 pending C&P claims that took an average of 136.9 days to complete, which is approximately 33 days better than the national target of 169.3 days. Accuracy for Compensation and Pension rating-related issues was 91.5 percent, above the national standard of 90 percent. Accuracy for Compensation and Pension authorization-related issues was 98.2 percent, above the national standard of 95 percent.

Scope of the Inspection

Scope. We reviewed selected management controls, benefits claims processing, and administrative activities to evaluate compliance with 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 for PTSD, disabilities related to herbicide exposure, and TBI covered the period April–June 2009. In addition, we reviewed fiduciary adjustments for the period April–June 2009. Temporary 100 percent evaluations were reviewed where VSC staff granted a temporary 100 percent evaluation paid for 18 months or longer without reevaluation.

The review of errors identified by VBA's STAR covered the period January–June 2009. For our review of dates of claim, we selected claims currently pending within the VARO at the time of our onsite inspection. We completed our reviews in accordance with the President's Council for Integrity and Efficiency's *Quality Standards for Inspections.*

Appendix B

VARO Director's Comments

Date: **March 1, 2010**

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

Thru: **Director, Eastern Area**

Subject: **Inspection of the VARO in Togus, ME.**

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

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

2. Questions may be referred to Mr. Scott Karczewski, Director, at 207-621-4826, or Mrs. Denise Benson, Veterans Service Center Manager, at 207-626-4788 ext. 5522.

(original signed by:)
SCOTT KARCZEWSKI
Director

Attachment

Appendix B

VARO Director's Comments

VARO TOGUS
Benefits Inspection Division Visit

Recommendation 1. *We recommend the Togus VA Regional Office Director develop and implement a plan to ensure staff correctly establish future examinations dates and monitor future examinations for temporary 100 percent evaluations.*

VARO Response: Concur.

The Togus Regional Office has implemented a policy whereby cases that are confirmed and continued and require a future examination are referred to GS 11 Veterans Service Representatives (VSR) for confirmation that the future examination has been diaried. In all other cases, GS 12 VSRs are checking to confirm the future exam diary is intact.

Recommendation 2. *We recommend the Togus VA Regional Office Director conduct a review of all temporary 100 percent evaluations under the Togus jurisdiction to determine if re-evaluations are required and take appropriate action.*

VARO Response: Concur.

We received the list of cases provided by the OIG where the Veteran has been 100% over 18 months with diagnostic codes requiring a VA examination. We are reviewing each case to determine if additional action is appropriate.

Recommendation 3. *We recommend the Togus 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.*

VARO Response: Concur.

Management agrees with the procedural errors found; however, this report suggests training is not provided on STAR errors or comments found. Each error/comment is routed to our training coordinators and appropriate team coach for training to the whole team. The Togus Regional Office failed to make two corrections discovered by STAR. We have implemented a policy to ensure a central designee reviews all final actions.

Recommendation 4. *We recommend the Togus VA Regional Office Director develop and implement a mechanism to ensure supervisors consistently perform thorough inspections of the Veterans Service Center to safeguard veterans' personally identifiable information more effectively.*

VARO Response: Concur.

During and following the OIG Team's inspection in October 2009, all Veteran Service Center personnel had a 100% desk inspection completed during October 7–9, 2009, by Togus Managers.

Appendix B

VARO Director's Comments

Results of those audits are: 119 audits conducted with 26 personnel having discrepancies. All discrepancies were related to unredacted material. Some had no redaction, while others were not blacked out enough. In rare cases, unredacted material was found in binders on employees' shelves that had been issued by other training stations.

Once the review above was completed, the Veterans Service Center Manager, Assistant Veterans Service Center Manager and Records Management Officer conducted random desk audits on employees. Results of those audits are as follows: 13 audits were conducted with two employees having discrepancies. Both discrepancies were related to unredacted material.

VBA Managers and the RMO continue to complete desk audits for all employees on a regular basis. There have been no discrepancies since the random desk audits by VSCM/AVSCM and RMO. In accordance with the Togus Standard Operating Procedures, the goal is to have all personnel audited at least once per year.

Recommendation 5. *We recommend the Togus VA Regional Office Director amend the current mail plan incorporating procedures establishing oversight of the search mail process. The amended mail plan should include specific procedures for the proper control and processing of mail within the Veterans Service Center.*

VARO Response: Concur.

The Togus Regional Office has incorporated a search mail procedure into their workload management plan.

Recommendation 6. *We recommend the Togus VA Regional Office Director conduct training to ensure Rating Veterans Service Representatives follow VBA policy when assessing and making competency determinations.*

VARO Response: Concur, in part.

The Togus Regional Office conducted training on October 20, 2009 regarding when it is appropriate to make competency determinations.

There was one case identified by OIG with a competency error. In this case, the OIG contention was that the Togus Regional Office should have made the Veteran's competency at issue based on the 100% grant for PTSD. The OIG further contends that at the time of original rating decision, the Veteran should have been proposed incompetent. The Togus Regional Office concurs with the finding that competency should have been addressed in the rating decision. However, based on the available evidence at the time of the rating decision, the Togus Regional Office disagrees that a proposal of incompetency would have been made. A memorandum received from the Togus ME, VA Medical Center, following the initial rating decision raised the issue of competency. With the receipt of additional evidence, the Togus Regional Office appropriately proposed and later found the Veteran to be incompetent.

Appendix C

Inspection Summary

11 Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. 100 Percent Disability Evaluations	Determine if VARO staff reviewed temporary 100 percent disability evaluations in accordance with VBA policy. VA regulations allow for the assignment of a temporary 100 percent evaluation for certain disabilities for specified periods following cessation of certain treatments, surgeries, or manifestations of service-connected disabilities. (38 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1MR Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Post-Traumatic Stress Disorder	Determine whether service connection for PTSD was processed in accordance with VBA policy. (38 CFR 3.304(f))		X
3. Traumatic Brain Injury	Determine whether service connection for TBI and all residual disabilities was processed in accordance with VBA policy. (Fast Letters 08-34 and 36, Training Letter 09-01)	X	
4. Disabilities Related to Herbicide Exposure	Determine whether service connection for disabilities related to herbicide exposure (Agent Orange) was processed in accordance with VBA policy. (38 CFR 4.119) (M21-1MR Part IV, Subpart ii, Chapter 1, Section H.28)		X
Data Integrity			
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	
Management Controls			
6. Systematic Analysis of Operations	Determine if VAROs performed a formal analysis of their operations through completion of SAOs. (M21-4, Chapter 5)	X	
7. Systematic Technical Accuracy Review	Determine if VAROs timely and accurately corrected STAR errors. (M21-4, Chapter 3, Subchapter II, 3.03)		X
8. 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	
Information Security			
9. Mail Handling Procedures	Determine if VAROs complied with mail handling procedures. (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapters 1 and 4)		X
10. Destruction and Safeguarding of Documents	Determine if VAROs complied with VBA policy regarding proper destruction and safeguarding of documents. (VBA Letter 20-08-63 Revised dated March 13, 2009, and attachments).		X
Public Contact			
11. Fiduciary Adjustments	Determine if VAROs properly assess veterans' mental capacity to handle VA benefit payments. (M21-1MR Part III, Subpart v, Chapter 9, Section A) (M21-1MR Part III. Subpart v, Chapter 9, Section B) (Fast Letter 09-08)		X

Appendix D

OIG Contacts and Staff Acknowledgments

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Acknowledgments	Danny Clay Kristine Abramo Joseph Brett Byrd Robert Campbell Maya Ferrandino Lisa Van Haeren

Appendix E

Report Distribution

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Non-VA Distribution

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This report will be available in the near future on the OIG's website at http://www.va.gov/oig/publications/reports-list.asp. This report will remain on the OIG website for at least 2 fiscal years after it is issued.