VA Office of Inspector General

OFFICE OF AUDITS & EVALUATIONS

Inspection of the VA Regional Office Albuquerque, NM

May 20, 2010
10-00935-156

ACRONYMS AND ABBREVIATIONS

C&P	Compensation and Pension
COVERS	Control of Veterans Records System
NOD	Notice of Disagreement
OIG	Office of Inspector General
PTSD	Post-Traumatic Stress Disorder
RVSR	Rating Veterans Service Representative
SHARE	SHARE is a computer application used to establish and manage claim data
STAR	Systematic Technical Accuracy Review
SAO	Systematic Analyses of Operations
TBI	Traumatic Brain Injury
VACOLS	Veterans Appeals Control and Locator System
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center
VSCM	Veterans Service Center Manager

Report Highlights: Inspection of VA Regional Office Albuquerque, NM

Why We Did This Review

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

What We Found

VARO management needs to improve the accuracy of disability claims processing for temporary 100 percent disability evaluations, post-traumatic stress disorder (PTSD), and traumatic brain injury (TBI) claims. VARO staff did not accurately process disability claims for 37 (36 percent) of 103 claims reviewed.

Management also needed to improve controls over the following areas:

- Establishing timely Notices of Disagreement (NODs) for appealed claims.
- Completing Systematic Analysis of Operations (SAOs) accurately and timely.
- Correcting errors identified by Veterans Benefits Administration's (VBAs) Systematic Technical Accuracy Review (STAR).
- Handling mail appropriately.

During FY 2009, the VARO Director's position was vacant for approximately 3 months and from FY 2009–2010, the Veterans Service Center Manager (VSCM) position was vacant for approximately 6 months. Both positions are key leadership positions within the VARO. Three different acting managers filled the vacant VSCM position, two of whom reported they never received training or guidance on the responsibilities associated with that position. We believe these vacancies were a contributing factor to the high error rates for the claims we reviewed.

What We Recommended

We recommended the VARO Director ensure staff correctly establish future medical examination dates for temporary 100 percent evaluations and improve oversight of PTSD and TBI claims processing.

We also recommended the VARO Director improve oversight to ensure staff establish NODs in the electronic system timely, prepare SAO reports timely and accurately, correct errors identified by STAR, and improve the VARO mail-processing plan.

Agency Comments

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

(original signed by:)

BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

The Benefits Inspection Program is part of the 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 VAROs. The purpose of these independent inspections is to provide recurring oversight of VAROs by focusing on disability compensation claims processing and performance of VSC operations. The objectives of the inspections are to:

- Evaluate how well VAROs are accomplishing their mission of providing veterans with convenient access to high quality benefit 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 VARO operations.

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

Scope of Inspection

During January 2010, the OIG conducted an inspection of the Albuquerque VARO. The inspection focused on four protocol areas examining nine operational activities. The four protocol areas included disability claims processing, data integrity, management controls, and information security.

We reviewed 30 (75 percent) of 40 claims where VARO staff granted a temporary 100 percent evaluation that was paid for 18 months or longer, the longest period a temporary 100 percent evaluation may be assigned without review under VA policy. In addition, the VARO completed a total of 282 claims for PTSD, TBI, and disabilities related to herbicide exposure during July–September 2009. We reviewed 73 (26 percent) of these claims.

Appendix A provides for additional details on the scope of the inspection. The VARO Director's comments are located in Appendix B. Appendix C provides a summary of the inspection results and includes the criteria used to evaluate each operational activity.

RESULTS AND RECOMMENDATIONS

VARO management needs to improve the accuracy of disability claims processing for temporary 100 percent disability evaluations, PTSD, and TBI claims. Management also needs to improve controls over establishing timely NODs for appealed claims, completing SAOs accurately and timely, correcting errors identified by Veterans Benefits Administration's (VBA) STAR, and handling mail appropriately.

In addition, quality controls were lacking in several areas due to the lack of continuity and inexperience of management at the VARO. The Albuquerque VARO did not have a permanently assigned VSCM from the period July 2009–January 2010. Further, the VARO Director position was vacant from August–November 2009. During that time, three different managers filled the VSCM position, two of whom reported they had not received training or guidance on the duties and responsibilities of the senior VSC management position. Detailed inspection results for the four protocol areas and nine operational activities follow.

1. Disability Claims Processing

Finding VARO Personnel Need to Improve Disability Determination Accuracy

The Albuquerque VARO needs to improve the accuracy of disability claims processing. VARO staff did not accurately process disability claims for 37 (36 percent) of 103 claims reviewed although two of the inaccuracies were attributable to work completed at other VAROs. VARO management concurred and initiated action to correct the mistakes. Table 1 reflects the errors affecting veterans' benefits and those potentially affecting veterans' benefits.

Table 1. Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Evaluations	30	24	4	20
PTSD	30	6	2	4
TBI	13	5	1	4
Disabilities Related To Herbicide Exposure	30	2	1	1
Total	**103**	**37**	**8**	**29**

Temporary 100 Percent Evaluations

VARO staff at Albuquerque and another VARO incorrectly processed 24 (80 percent) of 30 temporary 100 percent evaluations. VBA policies provide a temporary 100 percent evaluation for certain service-connected disabilities requiring surgery or specific treatment. At the end of a mandated period of convalescence or cessation of treatment, VARO staff must review the disability to determine if they should continue the temporary evaluation. Based on an analysis of medical evidence available, four of the processing inaccuracies affected veterans' benefits as follows:

- Two were overpayments totaling $306,162. The most significant overpayment occurred when a Rating Veterans Service Representative (RVSR) incorrectly granted service connection and assigned a 100 percent evaluation for a disability not related to military service. As a result, the veteran was overpaid $299,568 over approximately 11 years. The remaining overpayment occurred because VARO staff did not schedule a future medical examination required to determine if the veteran had continued entitlement to the temporary 100 percent evaluation.
- Two involved the VARO failing to find the veterans' disabilities to be permanent and total in nature despite evidence indicating so within the claims folders. Additional benefits such as a reduction in the state and local taxes and entitlement to education benefits for family members affect the veteran's disability once VARO staff determines veterans' disabilities to be permanently and totally disabling. We cannot determine the monetary affect of these additional benefits until VARO staff corrects the inaccuracies and veterans apply for reduced state and local taxes or education benefits for family members.

Twenty of the temporary 100 percent evaluations had the potential to affect veterans' benefits because VARO staff did not schedule medical examinations needed to determine whether the temporary 100 percent evaluations should continue. An average of 858 days elapsed from the time staff should have scheduled these medical examinations through the date of our inspection.

These 20 evaluations ranged from September 1999–December 2009. We could not determine if the temporary evaluations would have continued without the results of medical examinations or other medical evidence. Following is a summary of these claims:

- For 16 claims, VARO personnel did not input a required date into SHARE, a computer application used to establish and manage claim data. This action would have generated an automatic notification to schedule an examination to reevaluate the need to continue the 100 percent evaluation.

- For four claims, VARO personnel did not schedule examinations to reevaluate the veterans' disabilities even though the SHARE application generated an electronic notification indicating a review examination was required.

VARO management stated staff did not record required dates for future examinations in the electronic system because station personnel did not have an understanding of the computer system's capabilities and they were not familiar with the policies regarding the use of the system. They reported the first time the VARO became aware of the need to input a date for a future examination into the electronic system was after a VBA conference call in November 2009.

Despite management's contention of a lack of awareness of this policy, a December 2007 VBA policy addresses the process for recording future examination dates in SHARE. Because management and staff were unaware of the VBA policy, veterans provided a temporary 100 percent evaluation did not always receive accurate benefits.

PTSD Claims

VARO staff incorrectly processed 6 (20 percent) of 30 PTSD claims. Two of these errors affected veterans' benefits resulting in underpayments totaling $33,638:

- An RVSR did not properly grant the veteran a 100 percent disability evaluation despite a VA medical examination showing a total occupational and social impairment due to symptoms of PTSD. As a result, the veteran was underpaid $30,642 over a period of 21 months.
- An RVSR assigned the incorrect effective date for payment of PTSD benefits. The veteran submitted a claim on January 26, 2007. However, the RVSR incorrectly used the date of August 23, 2007. As a result, the veteran was underpaid a total of $2,996 over a period of 7 months.

The remaining four processing inaccuracies could potentially affect the veterans' benefits. Two of the inaccuracies involved the VARO staff not correctly obtaining all necessary evidence to substantiate the claimed in-service stressful event required for a grant of service connection for PTSD. One was inaccurate because the VARO failed to make a determination that a veteran was incompetent for VA purposes. The final inaccuracy resulted because the VARO did not schedule a medical examination to determine if the veteran's PTSD symptoms had improved.

VARO management indicated inconsistent quality oversight of claims processing occurred during the time the Veterans Service Center Manager position was vacant. Due to ineffective oversight of the quality assurance process, veterans did not always receive the accurate benefits.

TBI Claims

The Department of Defense and VBA commonly define a TBI as a traumatically induced structural injury or physiological disruption of brain function because of an external force. The major residual disabilities of a TBI fall into three main categories: (1) physical, (2) cognitive, and (3) behavioral. VBA policies require staff to evaluate these residual disabilities.

VARO staff incorrectly processed 5 (38 percent) of 13 TBI claims. VARO staff did not properly evaluate all residual disabilities related to the in-service TBI claims. One of these inaccuracies affected a veteran's benefits because VARO personnel incorrectly denied service connection for residuals of an in-service TBI. We could not determine specific monetary benefits the veteran might be entitled to because staff did not schedule a medical examination to assess all of the residual disabilities related to the in-service TBI.

The other four inaccuracies could potentially affect the veterans' benefits because the examinations required to evaluate residuals of an in-service TBI were inadequate or incomplete. Neither the VARO nor we can correctly ascertain all of the residual disabilities of the TBI without adequate or complete medical examinations.

VARO management indicated the vacancy of the Veterans Service Center Manager position contributed to the lack of oversight associated with the quality review process. Due to ineffective oversight of the quality assurance process, veterans did not always receive accurate benefits.

Disabilities Related to Herbicide Exposure Claims

VARO staff at Albuquerque and another VARO incorrectly processed 2 (7 percent) of 30 claims. One affected the veteran's benefits because VARO personnel incorrectly granted service connection for diabetes, a presumptive disability associated with herbicide exposure, even though evidence in the claims file did not show a relationship between the disability and the veteran's service. The veteran was overpaid $3,619 over a period of 15 months. This inaccuracy was attributable to claims processing at another VARO as part of VBA's claims redistribution program also referred to as claims brokering.

The second processing inaccuracy had the potential to affect the veteran's benefits because VARO personnel incorrectly denied service connection for diabetes. The total disability evaluation could not be determined based on medical evidence available at the time of our inspection. The frequency of processing inaccuracies for disabilities related to herbicide exposure was not significant. Consequently, we determined the VARO is generally following VBA policy in this area and are not making any recommendations for corrective action.

Recommendations

1. *We recommend the Albuquerque VA Regional Office Director conduct a review of all temporary 100 percent evaluations under the regional office's jurisdiction to determine if reevaluations are required and take appropriate action.*
2. *We recommend the Albuquerque VA Regional Office Director strengthen controls to ensure staff correctly establish and monitor future examinations for temporary 100 percent evaluations.*
3. *We recommend the Albuquerque VA Regional Office Director develop and implement a mechanism to improve oversight of the quality assurance process to ensure staff are following the correct procedures for processing post-traumatic stress disorder and traumatic brain injury claims.*

Management Comments

The Albuquerque VARO Director concurred with our recommendations for improving disability determination accuracy. By May 7, 2010, the Director stated VARO staff would complete a review of all temporary 100 percent evaluations and take corrective action on all errors found. Management increased oversight and implemented new procedures to ensure staff properly input diary dates for future examinations into the computer system.

On January 28, 2010, the VARO Director stated staff received training on processing TBI claims. Management also scheduled quarterly refresher training for PTSD and TBI claims. Additionally, the VARO Director established new procedures that require a second level review of all claims involving PTSD and TBI.

OIG Response

Management comments and actions are responsive to the recommendations.

2. Data Integrity

Date of Claim

VARO staff properly established the correct dates of claim in the electronic record for the 30 files we reviewed. A date of claim designates when a document is received at a specific VA facility. The date of claim in the electronic record should directly correspond to the earliest date-of-receipt stamp from any VA facility recorded on the hard copy claim document. Generally, VAROs use the date of claim as the effective date for awarding benefits. Further, VBA relies on an accurate date of claim in the electronic record to establish and track a key performance measure that determines the average days to complete claims.

Notices of Disagreement

The VARO's Appeals Team did not always process NODs within VBA's 7-day standard. An NOD is a written communication from a claimant expressing dissatisfaction or disagreement with a decision and a desire to contest the decision. The Appeals Team is responsible for timely entering NODs into the Veterans Appeals Control and Locator System (VACOLS).

VACOLS is an application that allows staff to control and track a veteran's appeal and manage pending appeals workload. VBA policy states VARO staff must create a VACOLS record within 7 days of receiving an NOD.

Finding **Controls over Notices of Disagreement Need Strengthening**

VARO staff exceeded VBA's 7-day standard for 4 (13 percent) of 30 NODs pending input in VACOLS. These four NODs had been pending for an average of 13 days. An NOD is the first step in the appeals process and accurate and timely updating of VACOLS is required to help ensure the appeal moves through the appellate process expeditiously.

VARO management assigned employees hired under the American Recovery and Reinvestment Act of 2009 to process NODs. A supervisor stated, and we confirmed, that the new employees did not receive training and were unaware of VBA's 7-day standard to establish a VACOLS record.

Untimely VARO recording of NODs in VACOLS affect data integrity and misrepresents VARO performance. Data integrity issues make it difficult for VARO and senior VBA leadership to accurately measure and monitor regional office performance. A delay in recording NODs into VACOLS understates the total inventory of pending NODs, thus misrepresenting national performance measures.

Recommendation

4. *We recommend the Albuquerque VA Regional Office Director develop and implement a plan to train staff in the process of establishing Notices of Disagreement in the Veterans Appeals Control and Locator System.*

Management Comments

The VARO Director concurred with our recommendation. On January 13, 2010, members of the Appeals Team received refresher training on the procedures for establishing NODs in VACOLS. The Director stated the VSCM performed a review within 30 days of the training to ensure staff properly followed established procedures.

OIG Response

Management comments and actions are responsive to the recommendation.

3. Management Controls

VARO management needs to strengthen oversight to ensure timely and accurate completion of SAOs and correcting errors identified by VBA's STAR staff. We assessed management controls to determine if VARO management adhered to VBA policy regarding proper completion of SAOs and the correction of errors identified by STAR staff.

A 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 VAROs to perform SAOs annually, and they must cover all aspects of claims processing, including quality, timeliness, and related factors. In addition, the VARO is required to publish an annual schedule indicating when each SAO is to be completed.[1]

STAR is VBA's multi-faceted quality assurance program to ensure veterans and other beneficiaries receive accurate and consistent Compensation and Pension (C&P) benefits. VBA policy requires the VARO take corrective action on errors identified by STAR.

Finding Improved Oversight is Needed to Ensure Timely and Accurate Completion of SAOs

Systematic Analyses of Operations

The VSCM is responsible for the ongoing analysis of VSC operations to include completing 11 annual mandatory SAOs. Our analysis revealed 7 (64 percent) of 11 SAOs were untimely and/or incomplete at the time of our inspection. Specifically, 2 (18 percent) of the 11 SAOs were untimely, 3 (27 percent) were incomplete, and 2 (18 percent) were both untimely and incomplete. This occurred because the previous VSCM neglected to provide oversight of the process.

The Acting VSCM stated the previous manager did not review and approve SAOs for months. This lack of leadership caused delays in completing SAOs and implementing corrective action for areas requiring additional management attention. Our analysis revealed the previous manager did not complete the Division Management SAO and ensure the mandatory SAO for Quality Control Actions was included on the annual SAO schedule.

Management did not ensure completion of the mail management portion of the Quality of Files Activities SAO. Had management completed this analysis, they would have identified the deficiencies in their mail plan, making staff aware that search mail was waiting to be associated with veterans' claims folders. We further discuss deficiencies related to search mail in our review of mail handling procedures under the Information Security protocol later in the report. Consequently, a thorough analysis of VSC operations to identify existing or potential problems did not occur as required by VBA policy.

[1]VBA Policy M21-4, "Manpower Control and Utilization in Adjudication," *Systematic Analyses of Operations,* updated April 1, 2009.

Recommendation

5. *We recommend the Albuquerque VA Regional Office Director develop and implement a plan to ensure timely and accurate completion of mandatory Systematic Analyses of Operations.*

Management Comments

The VARO Director concurred with our recommendation. The Director stated the VSCM is responsible for timely and accurate completion of each SAO. Further, management created an annual schedule that included due dates and the individual responsible for completion of each SAO.

OIG Response

Management's actions and comments are responsive to the recommendation.

Finding Errors Identified by STAR Program Not Always Corrected

Systematic Technical Accuracy Review

During the period July–September 2009, STAR identified 18 Albuquerque claims files with errors. The VARO did not correct 2 (11 percent) of these errors. However, VARO staff erroneously informed STAR program staff they had corrected all 18 errors.

One of the two uncorrected errors had the potential to affect a veteran's benefits. STAR instructed the VARO to correct a rating decision where an RVSR incorrectly granted separate evaluations for two different respiratory diseases, asthma, and sleep apnea. VBA policy states the two specific respiratory disabilities only warrant a single evaluation. Despite reporting the errors as corrected, VARO staff did not amend the rating decision. Although the veteran's combined disability evaluation did not change, future disability determinations could result in the veteran receiving a higher evaluation than warranted.

A management analyst informed us the VARO did not have local written guidance regarding the processes to correct STAR errors, which we confirmed. Further, the Acting VSCM was not aware of oversight responsibilities associated with the VSCM position and did not have previous exposure to provide this level of review. Because the VARO Director and VSCM position were vacant and the VARO did not have written policies for reviewing STAR errors, the acting manager did not provide adequate oversight of the review process. Therefore, VARO employees did not follow VBA's quality assurance policy.

Recommendation

6. *We recommend the Albuquerque VA Regional Office Director develop and implement a plan to ensure corrective action is taken to address errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program.*

Management Comments

The VARO Director concurred with our recommendation. The Director informed us management established a standard operating procedure that requires RVSRs to submit corrected STAR errors to a supervisor for tracking and review.

OIG Response

Management's comments and actions are responsive to the recommendation.

4. Information Security

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

VARO staff is required to use the Control of Veterans Records System (COVERS) to track a veteran's claims folder and control search mail. VBA defines search mail as active claims-related mail waiting to be associated with a veteran's claims folder. We analyzed mail-processing procedures within the Triage team to ensure staff accurately and timely processed mail.

Finding Mail Management Procedures within Triage Team Need Strengthening

Mail Handling Procedures

Triage Team employees did not always process incoming mail according to VBA policy. For 5 (17 percent) of 30 pieces of mail reviewed, staff did not properly use COVERS to notify personnel that mail was waiting to be associated with a veteran's claims folder. Further, staff did not retrieve search mail even though COVERS contained an electronic notice of the pending search mail.

Following are examples of weaknesses identified with mail processing within the Triage Team.

- VARO staff received a new claim for anxiety disorder on November 6, 2008. Staff did not properly control this mail by placing it on search in COVERS. Although the veteran had a pending claim for PTSD, the VARO was unaware of the additional piece of mail that contained a claim for anxiety disorder. As a result, staff delayed processing the claim for anxiety disorder for 431 days.
- VARO staff properly placed mail on search in COVERS. However, an employee failed to retrieve the mail after receiving several notifications of pending search mail. We determined this by reviewing the electronic history in COVERS and noted the employee accessed COVERS several

times while search mail was pending. This resulted in a 14-day delay in claims processing.

VARO management stated the issues regarding mail occurred because the mail plan did not incorporate procedures to provide supervision of the mail control points. Management additionally stated the supervisor did not provide oversight of mail processing. We determined the VARO's mail plan did not describe procedures for reviewing and routing mail to veterans' claims folders and controlling search mail using COVERS. In addition, management needed to improve oversight of mail processing to ensure all mail is processed, controlled, and routed timely and accurately.

Recommendation

7. *We recommend the Albuquerque VA Regional Office Director amend the current mail handling plan to incorporate management oversight procedures for mail processing, controlling, routing of search mail.*

Management Comments

The VARO Director concurred with our recommendation. On February 19, 2010, management developed and implemented a new Mail Management Plan for the VARO mailroom and the Triage Team. The Director stated the Triage Coach is responsible for daily implementation of the plan. The VSCM conducted a review of the mailroom and Triage Team 30 days after management distributed the plan to ensure staff followed the new procedures.

OIG Response

Management's comments and actions are responsive to the recommendation.

Appendix A VARO Profile and Scope of Inspection

Organization

The Albuquerque VARO is responsible for delivering non-medical VA benefits and services to veterans and their families. They fulfill these responsibilities through the administration of C&P Benefits, Vocational Rehabilitation and Employment Assistance, and Outreach activities.

Resources

As of September 30, 2009, the Albuquerque VARO had a staffing level of 108 Full-Time Employees—8 hired with American Recovery and Reinvestment Act of 2009 funds. Of the 108 Full-Time Employees within the VARO, 81 (75 percent) were assigned to the VSC.

Workload

As of September 30, 2009, the VARO had 2,881 pending C&P claims. Further, as of September 30, 2009, it took the VARO an average of 150 days to complete C&P claims, which is 19.2 days better than the national target of 169.2 days. Accuracy for C&P rating-related issues, as reported by STAR, was 82.1 percent, below the national target of 90 percent. Accuracy for C&P authorization-related issues, as reported by STAR, was 98.3 percent, above the national target of 95 percent.

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 and other beneficiaries. We interviewed managers and employees, reviewed veterans' claims folders, and inspected work areas. We did not inspect fiduciary activities as VBA centralized fiduciary processes performed within their Western Area to the Salt Lake City VARO.

The review of disability claims processing for PTSD, TBI, disabilities related to herbicide exposure, and errors identified by VBA's STAR covered the period July–September 2009.

For temporary 100 percent disability evaluations, we selected all 40 existing claims from VBA's Corporate Database. These temporary evaluations were not specific to the period July–September 2009 because VARO staff would have processed too few claims for us to provide an objective summary of this work. The 40 claims represent all instances in which VARO staff paid a temporary 100 percent evaluation for 18 months or longer. From these 40, we selected a random sample of 30 claims for our review.

For our review of claim dates and NODs, we selected claims and NODs pending within the VARO at the time of our inspection. We completed our review in accordance with the President's Council for Integrity and Efficiency's *Quality Standards for Inspections.*

Appendix B VARO Director's Comments

Department of Veterans Affairs

MEMORANDUM

Date: **April 14, 2010**

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

Subject: **Inspection of VARO Albuquerque, NM**

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

1. Enclosed is the Albuquerque VA Regional Office response to the OIG Draft Report: Inspection of the VA Regional Office, Albuquerque, NM, conducted in January 2010. The Albuquerque Regional Office concurs with all the findings and recommendations regarding the VARO. Attached are our responses to the specific recommendations and improvement actions resulting from the review.

2. Questions may be referred to Loren Pierce, Veteran Service Center Manager at 505-346-4775.

(original signed by:)
Grant L. Singleton
Director

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

Recommendation 1 - *We recommend the Albuquerque VA Regional Office Director conduct a review of all temporary 100 percent evaluations under the regional office's jurisdiction to determine if reevaluations are required and take appropriate action.*

Concur with recommendation

Response: The Albuquerque VARO Director agrees with this recommendation. Albuquerque VA Regional Office staff will complete this review by close of business (COB) May 7, 2010. All errors found will be immediately corrected.

Recommendation 2 - *We recommend the Albuquerque VA Regional Office Director strengthen controls to ensure staff correctly establish and monitor future examinations for temporary 100 percent evaluations.*

Concur with recommendation

Response: The Albuquerque VA Regional Office Director agrees with this recommendation. New procedures were established in January 2010 to ensure the Veteran Service Representatives (VSR) properly input the diary issue when processing rating decisions involving future examinations. The VSR authorizing the case then verifies the future examination is correctly entered during promulgation of the rating action. This is followed up with the Senior Veterans Service Representative via an electronic log to track these claims to ensure the diary for future action remains in the computer system. These actions are verified with quality reviews and additionally with supervisory spot-checks of claims identified with future examinations prior to the claim reaching the Post Determination team. This procedure will remain in place until such time, as the Veterans Service Center Manager (VSCM) is confident all future examinations are properly entered and maintained till that examination is completed.

Recommendation 3 - *We recommend the Albuquerque VA Regional Office Director develop and implement a mechanism to improve oversight of the quality assurance process to ensure staff are following the correct procedures for processing post-traumatic stress disorder and traumatic brain injury claims.*

Concur with recommendation

Response: The Albuquerque VA Regional Office Director agrees with this recommendation. Training for Traumatic Brain Injuries was held January 28, 2010. Refresher training for both Post Traumatic Stress Disorder and Traumatic Brain Injury will be held within the next 30 days. Additionally, periodic training on these subjects will be held no less than quarterly. We will establish procedures for a second signature review of all claims involving post-traumatic stress disorder and traumatic brain injury by a subject matter expert. Training dates and procedures were established April 16, 2010. These will remain in place until such a time, as the VSCM is confident all Rating Veterans Service Representatives (RVSR) are properly completing these claims.

Recommendation 4 - *We recommend the Albuquerque VA Regional Office Director develop and implement a plan to train staff in the process of establishing Notices of Disagreement in the Veterans Appeals Control and Locator System.*

Concur with recommendation

Response: The Albuquerque VA Regional Office Director agrees with this recommendation. Refresher training was provided to the Appeals Team on January 13, 2010. The Appeals Team Coach is doing spot checks to ensure continued compliance. The VSCM performed a follow-up review within 30 days ensuring established procedures were properly followed.

Recommendation 5 - *We recommend the Albuquerque VA Regional Office Director develop and implement a plan to ensure timely and accurate completion of mandatory Systematic Analyses of Operations.*

Concur with recommendation

Response: The Albuquerque VA Regional Office Director agrees with this recommendation. A Systematic Analyses of Operations schedule was prepared to include the individual responsible for preparing the analyses and a due date for completion. The VSCM will be responsible for timely and accurate completion of each report by the due date.

Recommendation 6 - *We recommend the Albuquerque VA Regional Office Director develop and implement a plan to ensure corrective action is taken to address errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program.*

Concur with recommendation

Response: The Albuquerque VA Regional Office Director agrees with this recommendation. The training Decision Review Officer (DRO) has

incorporated tighter controls on claims returned from Systematic Technical Accuracy Review staff with identified errors. To further strengthen the correction of claims with identified errors, a standard operating procedure was established requiring RVSRs to submit their completed corrective action and a copy of the reported error to the Rating Board Supervisor for tracking and review. The training DRO will continue to track identified errors for quarterly reports and training purposes.

Recommendation 7- *We recommend the Albuquerque VA Regional Office Director amend the current mail-handling plan to incorporate management oversight procedures for mail processing, controlling, routing of search mail.*

Concur with recommendation

Response: The Albuquerque VA Regional Office Director agrees with this recommendation. A new Mail Management Plan was developed and implemented in the Mailroom/Triage Team on February 19, 2010. The Triage Coach is responsible for daily application and use of the Mail Management Plan. The VSCM conducted a follow-up review within 30 days of the plan's distribution ensuring established procedures were followed.

Appendix C Inspection Summary

9 Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. 100 Percent Disability Evaluations	Determine if VARO staff properly reviewed temporary 100 percent disability evaluations. (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 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 an in-service TBI. (Fast Letters 08-34 and 08-36, Training Letter 09-01)		X
4. Disabilities Related to Herbicide Exposure	Determine whether VARO staff properly processed claims for service connection for disabilities related to herbicide exposure (Agent Orange). (38 CFR 3.309) (Fast letter 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)	X	
Data Integrity			
5. Date of Claim	Determine if VARO staff properly recorded the correct date of claim in electronic records. (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)	X	
6. Notices of Disagreement	Determine if VARO staff properly entered NODs into VACOLS. (M21-1MR Part I, Chapter 5)		X
Management Controls			
7. Systematic Analysis of Operations	Determine if VARO staff properly performed a formal analysis of their operations through completion of SAOs. (M21-4, Chapter 5)		X
8. Systematic Technical Accuracy Review	Determine if VARO staff properly corrected STAR errors. (M21-4, Chapter 3, Subchapter II, 3.03)		X
Information Security			
9. Mail Handling Procedures	Determine if VARO staff properly followed VBA mail handling procedures. (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapters 1 and 4)		X

Appendix D OIG Contact and Staff Acknowledgments

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Appendix E Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Assistant Secretaries
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VBA Western Area Director
VARO Albuquerque Director

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Jeff Bingaman, Tom Udall
U.S. House of Representatives: Martin T. Heinrich, Ben R. Lujan, Harry Teague

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